Transsexual Recognition: Embodiment, Bodily Aesthetics and the Medicolegal System

Zowie Davy

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Abstract

This thesis develops recent work on transsexual/gender embodiment that has emerged from the field of transgender studies. The empirical study has been influenced by poststructuralist theory and feminist phenomenology and focuses on the constructed personal meanings of embodiment and bodily aesthetics for transpeople. Furthermore the thesis explores how trans embodiment is constructed within the medicolegal system and transgender politics in the United Kingdom. This study reviews the medical and legal work on transsexuality, which forms the basis of being recognised in law as either (trans) men or (trans) women and how medical theories and legal prescriptions have been adapted through time on the basis of trans bodily aesthetics. Transmen and transwomen's personal bodily aesthetics are discursively and materially constructed and recognised through body images of the "phenomenological," "sexual" and "social body," which all provide for understandings surrounding their gender identities. Moreover, the thesis investigates how embodiment and bodily aesthetics are framed in three Transgender Community Organisations (T-COs). The epistemological approach of phenomenology in this thesis allows for detailed descriptions surrounding the diverse bodily practices of the trans participants, and their experiences with the medicolegal system and T-COs.

The study employed semi-structured interviews and photograph elicitation methods with fourteen transwomen, eight transmen and one person who had had male to female SRS but had decided to live as "bi-gendered." The age range of the sample ranged from twenty two to sixty years old, who were at different stages of transition, and who all recognise themselves as being of a different gender to that which was given at birth. The thesis identifies diverse embodied practices by transpeople, which all help constitute a commitment to a specific gender identity. These findings challenge the traditional medical models, which constitutes the "true transsexual" as always requiring a normative bodily aesthetic. I consider the processes of attaining a masculine or feminine body and how different discourses of embodiment are utilised or challenged and how imaginatively anticipated bodies are actualised through technology. The thesis argues that transmen and transwomen differ in their engagement with technology and discourses of embodiment of the self, within transgender politics and within the medicolegal system. Furthermore, it suggests that bodily aesthetics are important aspects of lived experience in relation to transpeople's phenomenological, sexual and social selves.

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Introduction: Bodies in focus

This thesis explores transpeople's embodiment and bodily aesthetics. I use the concept "bodily aesthetics" to refer to the appearance of the body that is subjected to judgments, whether that is personal and/or public. These judgments feed into personal body images, which help to formulate understandings about identity formation. The thesis addresses bodily aesthetics rather than gender identity. This shift in emphasis is a response to the bulk of work on trans embodiment centring on gender and thereby excluding a more nuanced understanding of transpeople's bodies. Starting from a position, which foregrounds gender identity overlooks the specificity of the body and thus, leaves bodily aesthetics neutral or absent in the formation of bodily experiences and forms of consciousness. As is commonly the case, theorising trans bodies through a gender identity framework mistakenly suggests that the (modified) trans body is a result of a particular gender identity rather than the (modified) body becoming a part of the gender identity. By framing my analysis of (different) bodily aesthetics and the relationship they have with gender identities we will be able to understand more fully transpeople's body projects. Moreover, we will be able to consider how bodily aesthetics inform social relations and the judgments upon trans bodies. There is very little written on the psycho-social role of trans bodily aesthetics, as a set of discourses, practices, perceptions and experiences of embodiment. These aspects have neither been developed in transgender studies nor within the fields of UK medicine, law and politics, areas which this thesis aims to pay attention to.

Therefore, my main research questions are:

- How do transpeople consider and experience their bodily aesthetics?
- What are the similarities and differences between transpeople's desires to modify their bodies?
- What bodily aesthetics do transpeople; clinicians and the Gender Recognition Panel (GRP) consider as an adequate commitment to a gender identity?
- How far is the commitment to a gendered identity based upon bodily aesthetics?

Often bodily aesthetics of transpeople are situated within (social) psychological studies of pathology, such as "body dysmorphic disorder" (Money, 1996) and gender identity discomfort (Marone et al., 1998). There is still a dearth of empirical research relating to

transpeople's body images and bodily aesthetics in the discipline of sociology. My research differs substantially, then, from previous work by situating it in a phenomenological framework. Phenomenology suggests that meanings are produced by an active relationship between the human and *their* world. A phenomenological study is a study of experiences, actions and practices and their embodied meanings (Heinamaa, 1997).

I start by focussing on bodily aesthetics, which will allow us to understand the lived experiences of transpeople who have passing/non-passing, beautiful/ugly, normative/non-normative bodies. I do this by employing a heuristic device that divides the body into three different modalities, the "social body", "sexual body" and "phenomenological body" (see below). I focus on those transpeople who have had, or plan to have surgeries and who use body modification technologies as well as those who do not or can not. For example, I explore the narratives of transpeople who offer intimate details of their body projects and their understandings and experiences of aesthetic practices, such as clothing and prosthetics.

Whilst there has been a growth in sociological work on the body in recent years very few projects have been concerned with the aesthetic bodies of transpeople. Recent work has suggested that the materiality of the body, to apply sociologist Arthur Frank's (1990) understanding of bodily aesthetics consists of a set of "linkages between bodies as lived and bodies as inscribed" (1998: 101). To put it another way existentialist phenomenologist Merleau-Ponty, defines the "proprioceptive" sense of the body, summarised as, the felt sense of the body's relationship with space, time, objects, people and its action-in-the-world (Merleau-Ponty, 2002 [1962]), as the most decisive constituent of being a body. Complex relationships are established through intersubjective and interchanging aesthetic imaginings and personal reflections upon one's own transient "body image(s)" (2002 [1962]). The way we understand our bodies is through our body images (Weiss, 1999). These body images are adaptively produced through identifications and disidentifications with our own body, as well as upon the bodies of others. Judith Butler (1990) suggests that these appearances and styles are performative and produced in relation to "symbolic" norms and come to constitute what we know as gender. According to this perspective gender is a bodily style, a way of donning one's own body as a cultural sign. Whilst there is some agreement with this perspective in my thesis, I argue that some participants do

agentically transform the symbolic signs of gender in imaginative ways and, as such, are not purely the products of a Foucaultian discursive determinism employed by Butler. We can not dispense of discourses fully, but need to combine the fleshiness of the body with discourse.

Foucault's (1998) work on the body has been hugely influential even if somewhat lacking on the specific issue of bodily aesthetics and the judgements surrounding particular bodies. Foucault claims that bodies are inculcated with modes of being through subtle power relations, which he calls "bio-power." It is from this work that Foucault shows how the body is not a natural one but rather socially produced through regimes of knowledge and power. From the eighteenth century with the advent of capitalism, "bio-power" in the form of "knowledge-power" was, according to Foucault, present at every level of the body through the discourses of powerful institutions, such as law, army, schools, police, medicine and the family. "Bio-power" works upon members of the population's "social body." The "social body" is produced through the regulatory ideals of society's norms, rendered through these power relations a "docile body." The "docile body" becomes inscribed through discourses and the subject also inscribes him/herself by utilising these discourses. However, Foucault seems to conceive the body as a blank surface upon which power is inscribed (McNay, 2000), not a physical, material, fleshy entity of varied form, which this thesis addresses

Implicit in the "docile (social) body" framework is a hierarchy of bodily practices, which are split into simplistic dichotomies of "good" and "bad." We can perhaps see this best in Foucault's *History of Sexuality* in which the homosexual became a (lesser) species. Nonetheless, Foucault also leaves a space for discourses to be reversed, especially in his later work (Foucault, 1989). Reverse discourses come to fruition through the very discourse that was meant to exert power over bodies. These reverse discourses are seen as creative and agentic aspects of ethical living in Foucault's "aesthetics of existence" actualised through technologies of the self (1989). McNay (2000) suggests that Foucault's account of agency is too voluntaristic and therefore moves from untenable moments of submission to dominant discourses (docile), to moments of volutaristic self formation (agentic). This is because Foucault's focus is on a dichotomy of power/antipower, even though he seems to suggest otherwise (Foucault, 1982). This position also reduces differentiation between

people on the basis of "good" and "bad" practices as Foucault's focus is on aesthetics in the form of ascesis – technologies of the self – (McNay, 2000) rather than aesthetics in the form of experiential feelings about bodies and bodily aesthetics. The point is, for Foucault, discourse produces good (valued) and bad (reviled) bodies, but does not explain why those with socially valued bodies may still feel bad about them. Foucault does not contemplate (self) judgments surrounding aesthetic bodies as does Goffman (1963, 1969) for example, which leaves docile/agentic bodies with little form. This hinders our understanding of how, when and by whom bodily aesthetics are constituted through discourses and what effects this has on the docility and agency of bodies.

The use of discourse and reverse discourse is important for my study of transpeople; however, the docile/agentic dichotomy is problematic. Whilst participants were well versed in the discourses surrounding their trans-sexing, and whilst they utilised them to constitute their sense of self, bodily aesthetics problematised this dichotomy. For example, the "social body" of some participants could be interpreted as correctly adhering to prevailing norms of masculinity and femininity through the use of hormones and surgery, passing as gender normative – the goal of dominant discourse. The body of the transperson may also be accepted in more intimate surroundings by sexual partners even when that body is not non-normative according to hegemonic discourse, but the transperson may still be unhappy with their material body. Therefore, it was not social discourses of bodily aesthetics or acceptance by intimate partners that was important but whether or not the transperson was satisfied with their own body. This phenomenology of the self was sometimes more important than general social principles or judgments made by others. The social aspects of the body and the sexual aspects of the body in Foucault's discursive theory lack a phenomenology of the material bodily aesthetic.

Bourdieu goes some way to redress this deficiency and provides a more dynamic generative understanding of bodies within what he calls the "habitus" and the "field(s)." The habitus shapes the performances within, or access to, different fields, such as social spaces or sexual spaces, for instance. The idea of "capital" in its various forms – economic or cultural for instance – is utilised by "social agents" with the intention of creating (self) value. McNay (2000) embellishes Bourdieu's ideas by including a more profound focus on gender identity. She manages to convincingly retain some of the entrenched and embodied ways of

life of women (and men) by using the notion of the field in such a way as to show how women's internal differentiations of gender identities are not only deep-rooted, but can also be agentically transformed within fields. In this way transpeople can accrue "gender capital" in the fields of masculinity and femininity through using "economic capital" to purchase surgery or through "cultural capital" (accurate gender performance). In order to do this they must negotiate their gendered habitus. A similar argument has been made by Holliday (Holliday & Cairnie, 2007) using the notion of "body capital" to explore the experiences of cosmetic surgery patients.

However, Bourdieu gives little attention to the aestheticisation of society and the phenomenological dimension of lived experience and its potential for the transformation of attitudes and habits. He rejects aesthetic experiences by interpreting them as private subjectivism and self-centred narcissism (Shusterman, 2002). Whilst McNay's (2000) feminist project extends Bourdieu's through gender identity, it too fails to interrogate bodies in their particularity.

I suggest then that personal and public representations of transpeople's bodies are agentically constituted and that these are expressed and dependant on their being-in-the-world horizon. Following Scheper-Hughes and Lock (1987), Cromwell (1999) has gone some way in conceptualising the trans-body in a more nuanced way. Cromwell uses the concepts of the "social body," "political body" and "phenomenological body." The "social body" refers to the representational use of the body as a natural symbol with which to think about nature, society and culture. The political body or "body politic" (Cromwell, 1999; Scheper-Hughes & Lock, 1987) refers to the surveillance over and control of bodies by States in relation to sexuality, reproduction, human difference, deviance, work and leisure. The "phenomenological body" or "individual body" is a "body-for itself," where lived experience of the body is experienced as existing apart from others. Whilst this way of conceptualising transpeople's bodies may provide new insights into the ways that bodies are controlled and experienced, I suggest that we need to understand the body in an even more nuanced way than that offered by Cromwell. This is because the "body politic" is not just a top down means of controlling bodies, as I illustrated above, but simultaneously requires bodies to know and accept the discourses of sexuality, deviance, and other surveillance strategies for it to function effectively. I propose, therefore, that we include a

"sexual body" alongside the "social" and "phenomenological" and conceptualise them in slightly different ways. Furthermore, I suggest that the "body politic" be redeployed. Redeploying the "body politic" as a set of discourses that work on the body in different spaces is needed because they influence the representations of the "social," "sexual" and "phenomenological" bodies in subtle ways.

Thus, I suggest that what I call the "sexual body" and "phenomenological body" need as much attention as the "social body" to understand how bodily aesthetics enhance or worsen the generative aspect of the habitus and fields. I will introduce the concepts of the "social," "sexual," and "phenomenological body" to overcome this deficit in both discourse models and theories of habitus and fields that I find in Foucault's, Bourdieu's and McNay's work. And I will differentiate the discourses at work (body politic) on bodies in different spaces, which is missing in Cromwell's work.

The "social," "sexual" and "phenomenological body" in my research are not discrete ones, but heuristic devices to show how in particular spaces and at particular times body images are consciously produced, which then affect discursive and material presentations of the body. From these states of consciousness body images of self and of others help to stabilise our own body image, at least momentarily, into gestalts – unified wholes – which we identify or disidentify with. The concept "social body" is a body situated in various social spaces from which cultural meanings of other bodies may be incorporated. The social body image is understood through various instantaneous interactions, within various spaces, such as the workplace, the street, (sub)cultural spaces, doctor's surgeries, family gatherings and so on. The "social body" image covers only aspects of the body that is socially visible. Therefore the important aspects for a "social body" image are the face, hands, clothing, shape under clothing and gestures. The body politic is also influential here, but it is not the overarching determinant in the resultant body image. There are social rules that influence social interactions, and from which a sense of the body emerges. The sense of the body may be a sense that transpeople are successfully passing or complying with social rules, codes and attaining a legitimate "social body" aesthetic, which may feed into a positive body image. Transpeople may also feel that they are not attaining the body aesthetic they had hoped for, which may create a negative experience of their body image. Of course there may be a whole spectrum of experiences, which are dependent upon the cultural and gender

capital of interacting people within the social settings and it is these I explore in this study. The body image may further be influenced by various expected social roles and social status. The absorption of intersubjective meanings and experiences feed back to influence body imaging and informs the transperson about how their "social body" is valued. The "social body" image and "performance" shapes an ongoing engagement with, and negotiation of, discursively constructed meanings surrounding the "body politic", but they do so through an embodied process involving emotional responses. What distinguishes the "social body" and the "sexual body" is the space and the people who are interacting.

"Sexual body" images become focused and are "present" in different sexualised spaces. I am thinking here about the spaces in which people have sex or try to procure sex. The "sexual body" involves more intimate and stronger emotional responses than those that take place in social spaces. Often the "sexual body" heightens awareness of particular intimate aspects of bodily aesthetics. The "body politic" that influences this set of body imaging is the sexed body discourses that people are engaged with. However, once again, the "sexual body" images are not necessarily directed and determined by normative sexual discourse. "Sexual body" imaging is shaped through the interactions of sexual agents in relation to an ongoing engagement with meanings about the sexed body. Again body imaging is instantaneous and is influenced by embodied processes of sexual relations or potential sexual relations. For example, the experience of sexual pleasure may help create a body image, which goes beyond the normative discourses of sexual bodies. However, a sexual experience may also have adverse effects. The important aspect of the "sexual body" is the naked body. However, clothing, prosthetics and other aspects of bodies that are implicated in transpeople's sexual relations can be incorporated into the "sexual body" image.

The "phenomenological body" refers to a semi-private site in which reflection; ideals, imagination and intentionality are grounded or fantasised. Similar to Scheper-Hughes and Lock (1987) here the "phenomenological body" should be seen as the immediate, proximate ground upon which phenomenological truths and "sexual" and "social body" images are played out with the self to form a body image gestalt. The "phenomenological body" is therefore a locus of personal, social and sexual resistance, creativity, and struggle. In difference to Scheper-Hughes and Lock, I refer to the "phenomenological body" as an intersubjective body, which is intrinsically associated with its habitus and the discourses it

engages with, which aids in the evaluation of both possibilities and the limitations of the aesthetic body. These are marked by the

> the capacity [of the body] to open itself up to prosthetic synthesis, to transform or rewrite its environment, to continually augment its powers and capacities through the incorporation into the body's own spaces and modalities of objects, that, while external, are internalized, added to, supplementing and supplemented by the "organic body" (or what culturally passes for it), surpassing the body not "beyond" nature but in collusion with a "nature" (Grosz, 1994: 187-188).

My work describes the "social", "sexual" and "phenomenological body" images of transpeople, how they are valued and who evaluates them. I consider transmen's and transwomen's personal bodily aesthetics, their desires to modify bodies and their commitments to gender identity in separate chapters. This decision was premised on the fact that the body projects were different for both transmen and transwomen. There has never been a discussion about sex/gender differences within transgender literature. Therefore, to structure part of my argument around this aspect, offers a stronger analysis of transsexual embodiment. These differences are allowed to come into play because of the focus I give to bodily aesthetics, rather than to gender identity alone. Moreover, my analysis shows that while there are differences between transmen and transwomen there are also differences within each group.

Situating the thesis

In this thesis the term "transsexual"[1] conveys the notion that this work is interested in people who were raised as one gender yet identify with another. The concept further

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[1] Although "transsexual" is a concept with medical overtones, I use it throughout the thesis to indicate a specific trans identity, which connotes a sense of transition from one sex to the other. Many transsexual people do not necessarily identify with this concept. Some may identify as woman, man, transgender, trans and so on; as this indicates that there subject position is about gender. However, some transpeople do not like the term transgender as it is usually regarded as an umbrella term that includes a diverse range of (political) identities that may not transition socially or legally from one gender to another. Throughout the thesis I also use transwoman/women or transman/men and transpeople respectively. Transmen (transman) is often used in contemporary texts to indicate a female transsexual (in medical texts) or Female-to Male (FtM). Conversely transwomen (transwoman) indicates a male transsexual (in medical texts) or Male-to-Female transsexual (MtF).

reflects the participants' recognition of themselves as people desiring a change of their personal, social and medicolegal identities from male to female or female to male. "Transgender" is also considered in this thesis, but as a concept, which relates to a more diverse set of identities and practices, such as transvestites, cross-dressers, intersex, genderqueer and Drag. Originally "transgenderist" or "transgenderal" was conceptualised by Virginia Prince to connote "people like herself who, though male, elected to live full-time as women while retaining their genitalia" (Ekins & King, 2006: 16). More recently the term "transgender" has been used interchangeably with "transsexual" in medicolegal discourses and sometimes in place of "transsexual" and "transsexuality" (Bockting et al., 2006; May, 2002). This is to suggest a move away from medical models, which do not fully encompass the diverse phenomenology of "transsexual" practices. Some "transsexual" participants in this research do regard themselves as "transgender" but in this thesis I refer to these participants as "transman/woman/people" unless "transgender" is specified in the interview transcripts.

Over the last twenty years in both the humanities and social sciences there has been an increase in writing about transpeople's lives, identities, psychology and communities, much of which has been written by transpeople themselves. Transsexual and transgender people have become more "visible" practically everywhere. Transgender academic and activist Stephen Whittle has noted:

> embracing the trans community and its culture has led us to an exciting position at the cusp of one of the most significant social and political changes in the postmodern world. The struggles of trans people could have significant impact on all our freedoms (Whittle, 2006: xiv).

Therefore, part of this thesis considers public aspects of transsexual embodiment and bodily aesthetics particularly within the discourses of medicine and law, which I term the "medicolegal alliance" following Judith Butler (1990). Butler's concept is used throughout the thesis to highlight the interconnected relationship between legal and medical professionals, where the law privileges psycho/biomedical knowledge in the construction of (medicolegally) recognised bodies.

Transgender jurisprudence is another field where in recent years there have been highly visible debates and subsequent political gains, in particular the introduction of the Gender Recognition Act (2004) (GRA). Transpeople were actively involved in formulating the law as parliament consulted a report by the *Interdepartmental Group on Transsexual People* (see Home Office, 2000), which was drafted by prominent members of the trans community in the UK. The question of bodily aesthetics was a major issue in the formation and passing of legislation. There have been a number of empirical studies that address bodily aesthetics however, much of this work was conducted outside the UK where political contexts and medicolegal systems have their own particularities (Bolin, 1988; Griggs, 1998; Halberstam, 1998a; Namaste, 1996). To date research with a focus on the bodily aesthetics in UK law is surprisingly absent, especially when we consider that judging evidence of body modification as well as the diagnosis of gender dysphoria is a paramount consideration for the Gender Recognition Panel (GRP) which decides who can and can not acquire a Gender Recognition Certificate (GRC) and the changing of a birth certificate.

The political gains of legal recognition have not been wholeheartedly accepted by the transgender community. My interpretation shows that whilst most participants recognise that legal recognition is a step in the right direction, the medicolegal alliance presents another set of questions for participants concerning the ideological construction of bodily aesthetics, which occasionally, and rather surprisingly, conflicts with the Gender Recognition Act. I suggest that the diverse range of views that are apparent in this research are important for understanding the differences in the personal and public representations of transpeople's bodily aesthetics. These differences will afford a richer analysis of the aesthetic judgments that take place about trans subjects' bodies. My analysis suggests that stereotypes of masculinity and femininity, which permeates transgender literature, are being challenged. Contemporary transsexual/gender bodily aesthetics mark a cultural, political and legal turn in how bodies are constituted in relation to the state. Therefore, this is a significant and opportune moment to direct sociological attention to contemporary bodily aesthetics and to the embodiment of transpeople in the UK.

Academics/activists are beginning to produce theoretical work alongside politicised transgender communities, which has helped to create both an academic field of research as

well as highly organised political groups who provide critiques of the self, medicine, politics and law. This thesis is situated at the intersections of these fields. My analysis of the UK's political horizon suggests that theorising transgender politics become unproductive and divisive when dichotomies of assimilation and transformation are applied. I show how particular political praxes and cultural productions work to change the dominance of normative phenomenological, social and sexual bodily aesthetics in various ways, which are then far from assimilable into normative culture. Similarly, I suggest "queer" cultural productions are not actually so different in perspective to political praxes, which works through mainstream structures in an attempt to queer the status quo. In giving a more nuanced analysis of political work and cultural production, this research aims to contribute to the work on transgender politics.

There have been numerous research projects in the disciplines of medicine, psychology and social psychology, which have sex dimorphic and heteronormative models at their analytical base. Sex dimorphic models are based on the "expected" XX and XY chromosomal dimorphism and heterosexual/homosexual sexuality binary. Doctors, psychologists, and psychiatrist use these models to explain the aetiology of transsexualism in a pathological framework (Benjamin, 1966; R. Green, 1987, 1994; R. Green & Money, 1969; Money, 1995; Money & Ehrhardt, 1972; Money & Tucker, 1976; R. Stoller, 1975, 1985). I show that much of the sexological work on transsexualism relies on hegemonic understandings of social bodily aesthetics theorised as "masculinity" and "femininity" to augment essentialist claims about binary sexes. My research illustrates that some transpeople do not fit neatly into these "scientific" models, which causes a problem for the "diagnoses" and for the "cure." The phenomenological interpretation, in this thesis, highlights the insufficiency of traditional medical models for both the aetiology and the diagnoses of transsexualism (Benjamin, 1966; R. Green & Money, 1969; Money, 1995; Money & Ehrhardt, 1972; R. Stoller, 1975), because they do not consider the aesthetic considerations of transpeople today. Moreover, one interesting and I argue more positive aspect of sexological work that is evolving, with new practitioners coming to the field, is sexology influenced by feminism, queer and postmodernism (May, 2002; Wren, 2005). These new perspectives understand transsexual embodiment as adaptive rather than as an innate gender core. By researching into all these interesting contexts in the UK enables us

to gain more awareness about the agentic and reflective "nature" of transpeople's bodily aesthetic practices.

Chapter outline

Part one explores the theoretical approaches to transpeople's embodiment and bodily aesthetics. In Chapter I *Shifting the Medicolegal Constructions of Transsexuals' Bodily Aesthetics* I consider key medical and legal theoretical approaches to transsexuality. I outline a changing landscape of institutionalised transsexuality in order explain the medicolegal context within which part of this thesis is situated. By locating aesthetic judgements from the medicolegal perspectives this will illustrate the contemporary climate in which transpeople negotiate and constitute their bodily aesthetic. I move on to position my own analytical approach in Chapter II. In *Theorising Trans Embodiment and Bodily Aesthetics* I review key sociological and philosophical approaches to (trans) bodies and (trans) bodily aesthetics, which enables me to structure my analytical approach and connect it to the thesis' aims. In Chapter III: *Methods, Methodology and the Research Process* I explain the reasons behind my analytical approach to transsexual bodies, which includes deeper reflection on the research questions. Furthermore, I include an explanation of my methods, the limitations of the research and my ethical concerns. In this chapter I also provide pen portraits in order for the reader to familiarise themselves with the participants and the three Trans-Community Organisations (T-CO), which I focus on in this research.

Part two consists of two empirical chapters, which consider transmen and transwomen separately. In Chapter IV, *Recognising the Self: Transmen's Body Projects* I consider "body projects" in relation to the three organising themes (Attride-Stirling, 2001), of the "social," "sexual," and "phenomenological body." These themes inform us about how culture and the bodies therein are mutually influential in relation to embodiment and gendered feelings. This chapter will also illustrate how hormonal technologies affect the aesthetic and psychological positions of transmen. Idealised bodies are considered in relation to limitations of the technologies, such as aesthetic surgeries and how these situations are negotiated. These focal points will illustrate both the similarities as well as the range of transmen's "body projects."

In Chapter V, *Recognising the Self: Transwomen's Body Projects* I illustrate the broad range of transwomen's subject positions and move beyond monolithic and universalist understandings of transwomen and exploring instead the diversity of their narratives. I will also draw comparisons with the transmen's narratives explored in Chapter IV. Using the heuristic devices employed in the previous chapter on transmen – the "social body," "sexual body," and "phenomenological body" – I consider the participants' childhood recollections. Following this, I concentrate on the decision making processes and the emotional ambivalence inherent in the desire to transition from male to female. The penis as a potent symbolic signifier and understandings of the sartorial aspects of trans-sexing will be considered in relation to stereotypicality. I will then consider hormone therapy in relation to beauty and femininity. Finally, I will explore the various surgeries, aesthetic outcomes and the "passing" "social," "sexual" and "phenomenological" bodies of transwomen.

Part three considers public aspects of transpeople's embodiment and bodily aesthetics. Chapter VI, *Framing Bodies in Trans-Community Organisations in the UK* critically explores the particular political framings of "social bodily" aesthetics in three major Trans-Community Organisations in the UK, the Gender Identity Research & Education Society (GIRES), Press for Change (PFC) and a "DIY" Queer collective that is based in Manchester, UK, but which has contact with related collectives across the UK. In this chapter I will analyse and stress these frames in relation to bodily aesthetics that are absent from, have moved away from, or been integrated within the T-COs political considerations and ask: why might this be? In this chapter then I investigate how these frames of (absent) bodily aesthetics are used within campaigns, for legal, medical, and representational work. In the final empirical chapter, Chapter VII, *Negotiating Authenticity and Bodily Aesthetics within the UK's Medicolegal System*, I discuss the dialogues between general practitioners (GP) and transpeople at the preliminary stages of transition, and look at how these encounters are experienced. I move away from the concepts of the "social," "sexual," and "phenomenological body" and explore the concept of "authenticity" and how it is understood by clinicians and the transpeople in this study. I investigate how difficulties around "authenticity" are resolved. I then explore the experiences of transpeople's treatment by the NHS and the private healthcare sector. I move on to include how successive policy implementations may have affected treatment of Gender Identity

Disorder. Finally I assess how the Gender Recognition Act 2004 influences transsexual subjectivities and "authentic" bodily aesthetics in the UK.

Chapter I: Shifting the Medicolegal Constructions of Transsexuals' Bodily Aesthetics

After all, is there a problem? And if so, what is it? Are there [transsexuals], really? (de Beauvoir, 1997 [1949]: 33 my insertion).

Introduction

The picnicking of Simone de Beauvoir's quotation from the *The Second Sex* above is to highlight this chapter's central argument that, as with "woman," "female" and "feminine" in her project, I am not intending to reveal transsexuality as a problematic biological or psychological fact. My aim is to illustrate medicolegal ontological assumptions about transsexuals and instead present a phenomenological description of how meanings are constituted around the "transsexual" subject. In this chapter I will offer descriptions of the theories, nomenclature and medical procedures, which have become prominent in the "treatment" of transsexuality. I will introduce some of the main protagonists of transsexual medicalisation, their theories, and how these have been influenced by the wider academic context in which their work was conducted. This will include illustrations of the links to preceding medical theorists and workers in the field of transsexualism and transgender.

The medical recognition of transsexualism has allowed sex-changing to happen. Better surgical technologies in the 1950s allowed more successful and experimental sex-changing and development of institutions set-up specifically for the treatment, "diagnosis," and "cure" of transsexuals. However, across the history of transsexualism the terms, "diagnosis" and "cure" have evolved in tandem with wider academic perspectives, which have clearly influenced their development. Transsexualism retains, within some medical discourse, an assumed "biological sex" upon which a psychical "gender" is constructed using cultural notions of bodily aesthetics coded as "masculinity" and "femininity." This includes an aesthetic experience, through which masculinity and femininity are performed by subjects and judged by 'experts'. Distinctive masculine and feminine dimensions are intimately linked to and used by the "medicolegal alliance" (Butler, 1993) in the construction of a sex/gender order with regard to the transsexual subject, and constructs what it is to have a recognised, "authentic" trans embodiment and bodily aesthetic according to the law.

I will show the historical connections between medicine and law in the constitution of transsexuals, followed by the contemporary reasoning for this, which permits a medicolegal change of sex/gender identity for legal purposes in the UK. I will then look at the use of the medical conception of transsexual embodiment in law as it is deployed in the Gender Recognition Act 2004. While for the purpose of this research it is not necessary to consider the entire Act, I do, however, intend to explore the clauses within it that specifically relate to medical and surgical requirements of transitioning. I will consider the evidence that is required by, and the responsibilities of, the Gender Recognition Panel (GRP) and thereby explore the "medicolegal" construction of transsexual bodies. I will suggest psychosocial models of masculinity and femininity become the prominent models of sexed bodies within the medicolegal alliance's mandate on transpeople's bodies.

Establishing the terminology

Transsexualism has a long history. The sexological fervour in early twentieth century Europe attempted to order and taxonomise forms of "inversion" – a term used to denote gender and sexual transgressions from the gender and heteronormative – (H. Ellis, 1917; Foucault, 1998 [1976], 2003 [1963]; Freud, 1905; Laqueur, 1992). The historical nomenclature has not only problematised transsexuality through its pathologisation, but has also brought to the fore concepts that have produced knowledge and set precedents for subsequent theorists and practitioners. Sex change operations in the early twentieth century were experimental, as at this time there was no official diagnosis, treatment, or standard of care for transsexuals (Drogo, 1973). Sander Gilman (1999) claims that surgeons gained experience in plastic surgery through treating World War I injuries. Working on the genital wounds of soldiers, surgeons began to imagine the possibility of sex change surgery. Critics of these "sex change experiments" many years later provided evidence of plastic surgeons using transsexuals' bodies experimentally to hone their surgical skills, whilst also "expanding their disciplinary jurisdiction" (Billings & Urban, 1996: 103).

In 1931 Dr Felix Abraham reported in the medical literature that surgical conversion of a man to a woman had been accomplished (Drogo, 1973), and by the 1940s "transsexuality" began to gain credence as a medical definition. Transsexuals were understood as people wanting to live in the opposite sex to that assigned at birth. The American sexologist

Cauldwell (1949) used the term "transsexualist" in the professional literature to account for this phenomenon. Transsexualism or rather, "true transsexualism" (Benjamin, 1966), as opposed to transvestism and other "gender variant" positions, became popularised in the medical literature by Harry Benjamin (Benjamin, 1966) in the 1960s. It seems that the possibilities of male-to-female sex change may have entered wider public consciousness shortly before in 1953 due to Christine Jorgensen, an American soldier who had a highly publicised sex change in Denmark, and through Roberta Cowell, who had surgery in 1951 in England (Cowell, 1954; Whittle, 2002).

In Western sexology, from the 1950s onwards, there were a significant number of studies that attempted to understand transsexuality, its causes, diagnoses, and "cures." Just prior to these studies, biologists had determined five physical determinants of sex: (1) chromosomal sex, (2) gonadal sex, (3) hormonal sex, which happens at the prenatal and pubertal stages of development, (4) reproductive structures of the body, and (5) genital sex (Money et al., 1955). From the 1930s onwards, many scholars concerned with transsexualism took their ideas and theories from the proliferation of studies related to biological anomalies, such as intersex "conditions." The wider cultural debates were centred on whether "masculinity" and "femininity" and sex/gender configurations were a product of nature or nurture. One of the landmark studies in this area, was Terman and Miles' (1936) psychological research, *Sex and personality: Studies in masculinity and femininity.* They concluded that masculinity and femininity are the "bipolar" arrangement of elements – characteristics constituted at opposite extremes – and which produce gendered personality, (whether natural or cultural) and are a fundamental aspect of human personality. They go on to say:

> [m]asculinity and femininity [...] are not to be thought of as lending to it merely superficial coloring and flavor; rather they are one of a small number of cores around which the structure of personality gradually takes shape. The masculine-feminine contrast is probably as deeply grounded, whether by nature or by nurture, as any other which human temperament presents (Terman & Miles, 1936: 451).

It is unclear whether Terman and Miles believe masculinity and femininity is constituted by a biological disposition or is socially acquired. Nevertheless, masculinity and femininity are deemed "core" "bipolar" aspects of sex/gender differences. The stress on a "core" obscures

the extent to which masculinity and femininity are caught up in the complexities of lived relations and leaves them as overly simplistic and ahistorical stereotypes.

Nonetheless, these "bipolar" aspects of sex/gender differences were incorporated into theories by John Money and his colleagues (R. Green & Money, 1969; Money, 1973, 1975, 1995, 1996; Money & Ehrhardt, 1972; Money & Gaskin, 1970-1971; Money et al., 1955; Money & Tucker, 1976). John Money was one of the most prominent sexologists and psychologists at the John Hopkins School of Medicine, which has produced much sexological work in the US. Money has published widely on intersex conditions,[2] transsexualism, and "pathological" genders and sexualities since the 1950s and continues to be influential, being highly regarded and widely cited. Key principles about the standard of care and treatment practices in the area of transsexualism and intersex conditions are, according to the sociologist Kessler (1998), a result of Money and his colleagues' dominance and influence.

Money introduced the notion of "sex/gender dimorphic behaviour." The reciprocal sex/gender concept – where biological sex is intrinsically related to gender expression – used by Money is best illustrated and critiqued in Judith Butler's work on the heterosexual matrix (Butler, 1990). Butler (1993) suggests that "sex" was *produced* through regulatory forces, such as the medicolegal discourses. To regulate the notion of "sex" in society required a naturalisation process, which the sexually differentiated "biological" body stood in for. Sex differentiation was, in the majority of cases, authoritatively decided by the doctor based on the presence or absence of the penis, as I will explore below. From this, the cultural aspects of femininity and masculinity were applied dichotomously to the "naturalised" sexed body, which, if all is well, will procreate through the process of "natural" heterosexuality. Males were *encouraged* to do rough and tumble play, climb

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[2] There is a belief in traditional sexology that *Homo sapiens* are dimorphic with respect to sex chromosome composition, gonadal structure, hormone levels, and the structure of the internal genital duct systems and external genitals (Money & Ehrhardt, 1972). In relation to this assumption there is a 'complimentary' belief that there is a single, universally correct developmental pathway and outcome (Blackless et al., 2000), heterosexuality. If biological aspects do not develop accordingly, people are viewed by doctors as pathological and the label hermaphroditism (intersex) is applied. Intersex consists of numerous biological make-ups (see Fausto-Sterling, 1993). Rather than undermining the binary sex/gender system, intersex is instead utilised to reinforce notions of a sex/gender dichotomy through the discursive construction of pathological cases (see Longino & Doell, 1983), in need of medical intervention.

trees, interact with other masculine boys while girls were *encouraged* to wear dresses, practice at homemaking and mothering to fit their "natural" gender roles (Money, 1975). Any other behaviour was deemed deviant and therefore ripe for study. There are obvious similarities with 1950s Western middle-class gender ideologies in Money et al's theories, where the male is active, independent and rational and the female is passive, caring, and emotional (cf Friedan, 1964).

Money and his colleagues purport that in the case of transsexuals, the development of gender roles is hindered because of an over exposure in childhood to unstructured gender roles and, therefore, the child is able to absorb, *imagine*, or act out more diverse gender formations. It is apparent from this theory that transsexuals are not born transsexual in a biological sense, but develop cross-gender characteristics because of the extended developmental span in childhood. It could perhaps be argued as Freud (1974) did that all newborns are "polymorphously perverse" and that their development into socially determined binary roles and norms is coercive. Hird (2002b: 49) writes: "Freud repeatedly emphasizes that the undifferentiated infant enjoys a myriad of diffuse pleasures, which the subject learns to restrict according to societal strictures." Hird applies this to the pleasures of identification with gender and the melancholic formation of specific gender identities. Transsexuals refuse to suffer the melancholia of gender loss and are "eager to experience pleasure in all of its polymorphous possibility, [and] resist any attempts by the ego to narrow its sources of identification, and thus pleasure" (Hird, 2002b: 49). Cross gender behaviour in transsexuals can occur at any time due to this extended and yearned for exposure to both masculinity and femininity in the social setting.

In the 1960s social constructionism was gaining acceptance within second wave feminism and the social sciences (Berger & Luckmann, 1976 [1966]). Even though, in Money et al.'s view, socialisation plays a dominant part in the formation of masculinity and femininity in children (Money & Ehrhardt, 1972; Money et al., 1955; Money & Tucker, 1976) they are careful not to go down the purely social constructionist road. Money and Ehrhardt's (1972) psychosocial theory is based on both biology (nature) and socialisation (nurture) because juxtaposing nature and nurture was, they said, "an out of date strategy." Money uses evolutionary theory and biological psychiatry to enable this combination of the biological and the social and to intensify divisions between what is masculine and feminine. He

coined the term "Phylism" in 1983 to describe imprinted building blocks "found" in the human that are responsible for the most basic sex differences – so, women usually menstruate, lactate, and carry the foetus and men usually impregnate. These biological imperatives are imprinted on the brain and result in a mental "gendermap" of the sexed body. At this point in Money's work, there is a "procreative imperative." Money concedes that there is no real evidence for his assertions:

> [t]he map in the brain of the body image in its entirety is still pretty much a scientific *terra incognita* (Money, 1995: 103).

However, he continues:

> Its [the gendermap's] significance is made evident in the syndrome of transsexualism. In the transsexual's body image, the representation of the natal genitals is alien, and there is a fixation on having them surgically changed from male to female, or from female to male, to agree with the body image (Money, 1995: 103).

For "normally" gendered subjects, after the early years of infancy, coding of the gendermap reduces from a "bipotential" towards masculine or feminine "monopotentiality" (1995). This means that after infancy a person will feel comfortable with one gender identity and gender role (1995), rather than a polymorphous one. In this respect, Money's theory mirrors Freud's Oedipalised story (Freud, 1905 [1959]; Hird, 2002a). In transsexualism these anomalies are referred to as "incompatible gendermaps" (Money 1995).

More recently Money has refocused his theories to incorporate particular brain structures – especially the hypothalamus (Money, 1995; Zhou et al., 1995). This theory suggests that during the perinatal stage of brain development androgens in the uterus affect both sexual orientation and gender identity (Zhou et al., 1995). These types of neurochemical models of mental illness or disorders are increasingly popular in the contemporary psychology of deviance, especially in areas which consider violence and anti-social behaviour (N. Rose, 2005) as well as "atypical" gender identities (Kruijver et al., 2000). With the use of brain scan technologies some theorists have famously predicted the future possibility of aborting

foetuses that are likely to become homosexual (A. Greenberg & Bailey, 2001). These theories are based on the belief that functional brain scanning can give a definitive diagnosis of these "pathologies" due to recognising "deficiencies" in brain size and hormonal activity and that such technologies will eventually help in differentiating the "male" and "female" brain (Auyeung, 2006; M. Hines, 2006). However, the evidence that was offered in Auyeung and Hines' papers was contestable. Hines (2006) equates hormonal brain activity as the cause of masculine and feminine behaviour. Her evidence suggested that it was testosterone activity that was visible when a male monkey played with a toy truck (symbolic of masculinity) and oestrogen activity was witnessed when a female monkey looked at the genital area of a doll, which was theorised as a "caring," and by default, feminine activity.

This rather dubious evidence is further challenged by a new study based on US high school students from eight states, published in *Science* (Hyde et al., 2008) magazine. This study found no difference between boys and girls' academic attainment, now that both sexes are enrolling equally in advanced science courses. It would be interesting to scan the hormonal activity whilst these male and female students were "doing science," which is often seen as a stereotypically masculine venture, to see if it was testosterone or oestrogen providing the stimulus for "doing science." Hyde's research lends much weight to the "gender similarities" hypotheses (Hyde, 2005) by way of breaking down stereotypes relating to masculinity and femininity. This all suggests that "masculinity" and "femininity" are ideological constructs and not ahistorical aspects of behaviour, rendering evidence about sex differences, coded as masculinity and femininity, problematic. Whilst there is no doubt that hormonal brain activity can be *viewed*, the conclusions drawn from the aesthetic configuration within the scan require a much more systematic evaluation, removed from preconceived cultural notions of masculinity and femininity, for it to be convincing.

Similarly the evidence provided by Kruijver et al. (2000) is unconvincing. One deceased transman and a few more deceased transwomen's brains have been studied and found to have hypothalamus measurements in the range of "normal" men and "normal" women respectively (2000). However, some sexologists have incorporated this "evidence" alongside other endocrinological factors. Milton Diamond – a US sexologist who works

with transsexuals, intersex and transgender people - proposes that transsexuality is, in fact, a form of intersex. He states:

> [t]ranssexuals, who I believe are intersexed, have the body and genitals of one sex and the brain of the other making reconciliation of their sexual and gender identities problematic. They solve their problems of reconciling, their disparate sexual identity and gender identity, by saying, in essence, "Don't change my mind; change my body." (Diamond, 2000: 50).

This type of evidence has, however, been critiqued widely within medical discourse. Pfafflin (2006) a renowned psychotherapist and member of the World Professional Association for Transgender Health (WPATH) refuses to acknowledge the role of the "bed nucleus" of the hypothalamus area as the single factor that causes transgenderism. Instead Pfafflin argues that the phenomenology of transsexuality is not characterised by uniformity and is manifested in numerous ways. Furthermore, the fact that there may be regrets after sex reassignment surgery (SRS) challenges a biological basis to transsexuality (2006). Additionally, biologist Fausto-Sterling (2000) suggests that these brain studies have not given definitive statistics and evidence to support distinct sex differentiation, meaning there is no consensus about the evidence. However, while Money and his colleagues, Diamond and others, were formulating aetiology and definitions of transsexualism, from the 1950s Harry Benjamin was working with transsexuals to help formulate a diagnosis and care plan. This resulted in his hugely influential study, The *Transsexual Phenomenon* (Benjamin, 1966). His work continued until he retired in 1973.

Diagnoses and "Practices of Care": psychology and psychoanalysis

In 1980, the manual that logs psychiatric disorders, the DSM III (American Psychiatric Association, 1987), included transsexualism for the first time. This label had a sociological tinge to its criteria. Individuals who for a continuous period of two years had felt themselves to be of the wrong physical sex, to that which they were assigned at birth, were diagnosed as "transsexual." This diagnosis would be applied if the person *wanted* to change their body to that of the opposite sex. Another diagnostic label, *Gender Dysphoria,* was coined by Fisk in 1973 (Cohen-Kettenis & Gooren, 1999) was also used. Gender dysphoria is the term used to describe those suffering from a conflicting gender identity. In the revised

1994 version, the DSM IV (American Psychiatric Association, 1994), the word "transsexualism" was replaced by *Gender Identity Disorder* (GID), which signified a person who has a strong cross-gender identification and who suffers from Gender Dysphoria. This time there was no two year time limit placed on the diagnosis. However, a sub-classification relating to sexual orientation was added specifying whether patients were *attracted to males*, *attracted to females*, or *attracted to both sexes*. The sub-divisions were not meant to influence treatment but were intended as heuristic devices to ascertain the best possible, if any, therapy to be offered.

The *Standards of Care for Gender Identity Disorders* (Harry Benjamin International Gender Dysphoria Association, 2001) has been used by sexologists, psychiatrists and psychologists since the original version of 1979 (now version 6) as a way of standardising key diagnoses and treatments in the area of transgender and transsexualism. It states that the initial diagnosis of the transsexual should be dependent on a *thorough investigation* of the patient's background and childhood. Psychotherapy is followed by hormone treatment, if possible – which will help the transsexual by modifying the secondary sex characteristics, such as breast formation and fat deposits on the hips for transwomen, and the growth of facial hair and development of a deeper voice for transmen – as well as changing their *behaviour*. This social and technological intervention marks the start of the *Real Life Test* (RLT). The RLT has been ironically titled "the rite of passage to the surgical suite" by Richard Green (2006) and is used in the clinical setting to assess the social trials of cross-gender living. This can be read as the aetiological aspects of transsexualism being superseded by social and agentic aspects of the transsexual's trajectory. The RLT allows the transperson to decide if they will be able to successfully negotiate life in their gender of choice. After all these criteria have been met, and no other pathological signs are uncovered, sex reassignment surgery (SRS) may be offered.

The *Standards of Care* are presented as providing assistance to the "unfortunate" individual suffering from GID. It states:

> The general goal of the specific psychotherapeutic, endocrine, or surgical therapies for people with gender identity disorders is lasting personal comfort with the

> gendered self in order to maximize overall psychological well-being and self-fulfilment (Harry Benjamin International Gender Dysphoria Association, 2001).

Although the system seems quite straightforward, King (1996: 97) warned twenty years ago, that this shift in focus may have less altruistic motivations.

> Gender dysphoria widens the area of expertise of interest of the practitioner. No longer is he or she concerned only with a special type of person, the transsexual, but all who suffer from gender dysphoria.

Moreover, Billings and Urban (1996) have suggested that the surgical procedures involved in sex-changing are a lucrative business. This shift in emphasis from aetiology to managing a "condition," may have come about because adult transpeople's desire to have body modification, in varying degrees, could not be averted by the "reparative" medical practices that were, then, being performed in the clinical setting. I suggest, along with other critics (1996), that this focus was an attempt to control the sex-change industry. "Experts" in this area not only provided the diagnosis after a lengthy time span (recommended in the "Standards of Care") (Harry Benjamin International Gender Dysphoria Association, 2001), but worked closely with the surgeons who provided the surgical "cure" for adult transpeople.

If financial gain is the motive, which is suggested by Billings and Urban (1996), clinicians and surgeons would require safeguards against potential laws suits that clients may bring for misdiagnosis. Transgender people have themselves brought this problem to light recently with legal cases in Australia and an investigation by the General Medical Council in the UK (Jeffreys, 2008). The most convincing challenge to the diagnostic process, then, comes from transpeople themselves. Jillian St. Jacques (2007) suggests that people who *decide* that they are not transsexual after transitioning – "post-transsexuals" – are forcibly positioned in "narratives of regret" by the clinical researchers attending them (cf Olsson & Moller, 2006). St. Jacques' (2007) critique is based on the understanding that clinical writings on "post-transsexuals" are about them being unhappy in their new gender and, by default, then, being happier in their "old" gender. According to St. Jacques, these narratives are based on a misinterpretation in that the "post-transsexual" wishes to return to the

"original gender" identity and sexed body. In many cases, however, the "post-transsexual," in fact, wishes for a position beyond man or woman. These clinical misinterpretations are due to the framework used in medicine's "cultural repertoire," which only allows for two conceivable positions, male and female. There are no positions beyond the binary sex system. This secures two things: firstly, it preserves the pathologisation of transpeople by using the default genders, men and women, as the markers of truth, and, secondly, it secures the ongoing construction of "official" transsexual identities and, therefore, clinical intervention. Traditional sexologists need normative sexed cultures for their theories to retain any coherence, however, "post-transsexuals" pose immense problems for the diagnostic process and its reliability.

As early as the 1970s, Kessler and McKenna (1978) suggested that the clinicians' diagnostic process was not based, so much, within science, but was a highly subjective endeavour, which may depend on the aesthetic presentation of transpeople. They stated that one clinician:

> said that he was more convinced of the femaleness of a male to female transsexual if she was particularly beautiful and was capable of evoking in him those feelings that beautiful women generally do (Kessler & McKenna, 1978: 118).

The clinician cited by Kessler and McKenna was not the only one who regarded aesthetics as important in the diagnostic process (see Zucker et al., 1993). Stoller (1985), who brought psychoanalysis into the therapeutic setting to try to establish the reasons for patients' Gender Dysphoria, suggests that femininity is the "natural" disposition, rather than masculinity (as in Freud's theory), and that it is masculinity which is harder to attain. Stoller positioned transsexualism as the result of the unconscious nurturing of the child as the other sex. This theory is based on "family dynamics." If a male child has too much contact with the "mother's" psyche and body, and too little time is spent with the "father," it is argued that the boy will "fail masculinity." Furthermore, Stoller also suggested that if the boy was physically attractive, this would "spark" parental feminisation, especially by the mother. Commenting on the appearances of the boys in one of his studies, Stoller stated: "We have noticed that they [feminine boys] often have pretty faces, with fine hair, lovely complexions, graceful movements, and – especially – big, piercing, liquid eyes" (R.

Stoller, 1975: 42). Rather than reading like robust scientific evidence, the bodily aesthetics seem to be paramount in Stoller's analysis of "feminine boys" and provide reasons for the child's treatment by his mother. Contrary to this is the female situation: here too much time spent with the father, and too little with the mother, will Stoller argues create family dynamics that encourage masculinity in girls. Given the Western pattern of childrearing, all children would be able to identify with the mother more often, and thus, attain femininity more easily, unless of course *she* found the child ugly.

Despite the many problems of Stoller's theory, masculinity and femininity are not as fixed in his view as they were in Freud's (1905). Stoller (1985) suggests that masculinity and femininity are "a set of beliefs" fostered by the individual and are, therefore, not "unquestionable facts." Because of this belief system, *Gender Identity Disorder* in children, according to Stoller, can be averted. Stoller's "scientific" discourse, again, demonstrates a failure to fully establish viable sex differences based on ideas of "natural" masculinity and femininity. What Stoller unwittingly offers us though by theorising gender as a set of beliefs is that there are no fixed masculine and feminine criteria from which we can judge whether a transperson is a transperson. Furthermore, we may ask on what authoritative criteria anyone can judge the fate of being recognised as transsexual.

Thus, the medical view of abnormal development implies that the profound conflicts experienced by the child are based on societal and familial pressures that occur prior to them attending the Gender Identity Clinic. Therefore, some clinicians' attempted aversion of "inappropriate" "masculinity" or "femininity" *is for the benefit of those who cannot cope* with non-stereotypical behaviour and the social consequences that these may attract, such as violence, shame, and negative visibility. I agree with Hird when she shows, in her contemporary analysis of a Gender Identity Conference (Hird, 2003), that children usually have no psychological or cognitive problems that can be ascertained by tests, and that it is usually parents, peers and doctors who find "feminine" behaviour in boys and "masculine" behaviour in girls problematic. Therefore, why change the child to comply with normative rules of society rather than changing the ideas of acceptable masculinity and femininity?

Judging the efficacy of treatment

Many authors have stated that psychotherapy has made little difference to the outcome of adult transsexuals' g*ender dysphoria* (Benjamin, 1971; Hoenig & Kenna, 1974; Hoenig, Kenna, & Youd, 1970; Pauly, 1969, 1981). Transsexuals' transitions are successful so long as they have the "resourcefulness" required to adopt a new gender (Tully, 1992). Moreover, transitioning comes about not solely because of the medically ascribed label, but due to the person's strong and persistent desire to have surgery and cross-sex (1992). With this in mind, it would seem that the only real "cure" for transsexualism is to go down the hormonal and "surgical route" (Pauly, 1968), which many transsexuals desire in varying degrees. This view of surgery as successful treatment took relatively few years to be accepted. However, it has only been a somewhat short time since extensive follow-up studies have taken place, where post-operative transsexuals have been assessed for the efficacy of SRS (Lawrence, 2003; Ross & Need, 1989).

Post-operative evaluation studies are based on a number of criteria, which leads to methodological problems in comparing them. Some are based on improvement in employment opportunities, economic status, housing, education, and marital stability (Meyer & Reter, 1979), which may have little to do with psychological well-being and can be regarded as "objective" criteria (Cohen-Kettenis & Gooren, 1999). For example, transmen may fair better in the job market as males than they did as women. Moreover, we cannot be sure if there are other sociological variables that are taken into account in these studies, such as race (Schilt, 2006), age, disability, or being able to pass, which may adversely affect employment chances, housing, and education. Contrary to this, transwomen may actually be worse off in the workplace because of their gender. It is widely accepted that women, in general, still earn about 20% less than men (Eurostat, 2002) and many "female" jobs have less status. These studies, then, tell us something more about society's prejudices and gender stratification than whether or not the transsexual is happy with the outcome of SRS or their trans-sex status.

Studies that focus on mental health as the main criteria, which can be seen as subjective, in so far as the transsexual self-reports their own situation, found that SRS does improve the mental well-being of the transsexual (Kuiper & Cohen-Kettenis, 1988) and as such full adjustment to their new gender role is usually accomplished within a year (Tully, 1992).

Nonetheless, there are some who regret the surgery (Meyer & Reter, 1979), as I illustrated above, and it is advised that psychotherapy is continued after sex reassignment in order for "sex roles" and "gender identity" to be actualised in line with current social norms (Cohen-Kettenis et al., 2004). I suggest that these objective and subjective studies do not fully encompass the various contexts that illustrate the aesthetic dimensions of transpeople's lives. I propose that a phenomenological study would provide a more nuanced and complex understanding of the efficacy of such treatment. More recently, in the UK, there has been a move away from the traditional models of GID by some clinicians and it is to these I now turn.

Queer(y)ing the clinical gaze

In *The Birth of the Clinic* (Foucault, 2003 [1963]), Foucault suggested that medicine was founded on the perceptual gaze of doctors:

> [T]he gaze dominates the entire field of possible knowledge; the intervention of techniques presenting problems of measurement, substance, or composition at the level of the invisible structures are rejected. Analysis is not carried out in the sense of an indefinite descent towards the finest configurations, ultimately to those of the inorganic; in that direction, it soon comes up against the absolute limit laid down for it by the gaze, and from there, taking the perpendicular, it slides sideways towards the differentiation of individual qualities. On the line on which the visible is ready to be resolved into the invisible, on that crest of its disappearance, singularities come into play. A discourse on the individual is once more possible, or rather, necessary, because it is the only way in which the gaze can avoid renouncing itself, effacing itself in the figures of experience, in which it would be disarmed. The principle of visibility has its correlative in the differential reading of cases (Foucault, 2003 [1963]: 206).

In the Parisian clinics that Foucault was writing about, symptoms were observed and diagnoses offered based on how a disease presented itself on the surface of the skin, in other words, doctors incorporated "medical aesthetics" as a fundamental medical enterprise (Hick, 1999: 135). This worked to taxonomise multiple diseases that were *presenting themselves*. Foucault theorised this as an "artistic practice" (Foucault, 2003 [1963]). Hird

(2003), more recently, has highlighted the outdated "artistic practice" of determining ideas of masculinity and femininity. In her analysis of the Gender Identity Conference, attended by many of the leading psychotherapists in the field of transsexualism who I have previously mentioned, Hird states:

> [Psychiatrists] adhere to gender identity as both 'real' and fixed. This adherence then facilitates the continued use of highly stereotyped notions of gender to provide the framework for assessing and treating transsex [...] individuals (Hird 2003: 183).

To add weight to her criticism, Hird asked at a conference workshop why boys should be more aggressive, play at rough and tumble and only have male friends, and why girls should only play at house, and dress in skirts and dresses? Hird then asked, why are the majority of female psychiatrists in the room wearing trousers, with minimal use of make-up and no high heels? Following this we might ask: do these female psychiatrists have gender dysphoria (Hird, 2003)? Hird is implying that traditional therapeutic models are based on aesthetics which are culturally ordered, and not based on scientific models of "natural" and dichotomous genders.

Some gender identity clinics continue to ignore the differentiation of individual qualities of gender, what Judith Butler calls "queer crossings" (Butler, 2004), that happen in both heterosexual and queer lives, and which problematise binary configurations of masculinity and femininity. In a reflective article, Kathryn May (2002), a practising psychosexual therapist working in the UK's National Health Service (NHS), suggests that there has been a shift in thinking about what constitutes masculinity and femininity, and the aesthetic signifiers that help sustain them. May recognises her bias against stereotypical gender configurations when they are presented to her by her transwomen clients. She openly admits that the rigidity of heterobinarisms – dominant cultural standards of heterosexuality, hegemonic masculinity, and hegemonic femininity – that are maintained in traditional therapeutic and medical discourses in relation to *Gender Identity Disorders* do not fit satisfactorily with *her own images of femininity*.

Informed by feminism and queer theory, May (2002) highlights the tensions between her perspective and the old models of transsexuality. The traditional medical framework requires the transsexual to become "true" and "real" based on a stable socially acceptable gender. The sex change "metamorphosis," as May calls it, is highly problematic, as insights from both feminism and queer theory suggest that gendering is a fluid process and "trial and error" is therefore a part of acquiring normative femininity or masculinity through the play of aesthetic signifiers and bodily aesthetics. Put more simply, feminine and masculine embodiment is always in a state of flux and will never become stable.

Furthermore, May (2002) states that transsexuals are now becoming a fundamental challenge to outdated medical models because individuals desire different stopping points with regard to SRS. Reasons are numerous for the different stopping points, such as unsatisfactory aesthetic and functioning outcomes of surgery, the dangers involved, age and disability. Or, it may be because transpeople may only require social "passing" and so the focus is not on the genitals but on other parts of the bodily aesthetic (Griggs, 1998). It is no longer deemed necessary by some transsexuals to have full SRS – and this generates a problem, not only for diagnosing, but for the "cure" as well. In addition, this increasing bodily agency of transsexuals threatens to shift the power relations between patient and doctor.

Bernadette Wren is a Consultant Clinical Psychologist in the Child and Family Unit at the Tavistock Clinic in the UK, where *gender dysphoric* children and adolescents are "treated." Wren (2005) also highlights problems that arise when psychiatrists accept an "unambiguous developmental story" as the basis for diagnosis and treatment, as this model is dominated by an idealised and normatively defined endpoint, that of a stable gender, with the appropriate aesthetic expression of femininity or masculinity. In so doing, Wren highlights that heterosexuality and heterobinarisms are the organising principles in traditional models of transsexualism. Wren (2005) calls for a "postmodern way" in the clinical setting and for the psychiatrist to recognise gender as a creative and strategic compromise in an endless negotiation with the self. There are critics of the "postmodern way," who claim that its proponents appropriate transsexualism for their own

> intellectual project through presenting transgendered experiences as chimera, play, performance or strategy. It does so at the expense of investigating the actual lives, political demands or feelings expressed (MacDonald, 1998: 4).

However, bringing this "postmodern way" into the therapeutic office would allow children and adolescents to "play" with aesthetically gendered signifiers without imbuing them with intrinsic gendered meanings, and fixing them to judgments of gendered authenticity. This would enable a gender identity that could serve many diverse psychological needs and functions (Wren, 2005).

To summarise, the psychologists, psychoanalysts, feminist and queer practitioners seem to offer scientific solutions to the "biological," "psychical," "bio-psychical" and "social" anomalies of transsexualism. Knowledge about transsexualism is derived from naturalistic observations which are tainted by the partiality of the psychiatrist and surrounded by what both Porter and Rose (Porter, 1995; N. Rose, 2005: 20) understand in other contexts as "an aura of objectivity provided by numbers." I read "numbers" here as a metaphor for scientific studies, not necessarily statistical ones). Subsequently, key medical protagonists are awarded prestige and status for the sterling work in which they partake. Citation is the catalyst for this prestige. However, it is not any old citations that are awarded this reputation, as the sociologist Roy Boyne suggests: "when it comes to citation, there is an order of priorities, with scientifically established credentials appearing toward the top" (Boyne, 1999; see also Stacey, 1997). Even so, there is evidence to suggest that Hird (2003), May (2002) and Wren (2005) greatly mistrust of the main protagonists, Money, Stoller, and Green, their theories, and their institutionalised procedures within the GICs.

Although armed with "scientific knowledge," medical researchers have not yet found a biological, or any other form, of unified model to account for transsexualism (Fausto-Sterling, 2000; van den Wijngaard, 1997). This is demonstrated by the abundance of different theories of the "condition." What is clear is that theories about transsexuality are based on aesthetic configurations of masculinity and femininity, which are interpreted through the theorists' own gender belief system. There is a possibility that stereotypical aesthetic signifiers (Hird, 2003) will be disrupted if the feminist, postmodern, and queer theorists (Hird, 2003; May, 2002; Wren, 2005) make headway in influencing treatment and

diagnoses in therapeutic sessions. As I touched on earlier, this is dependent on the support of like-minded colleagues through networks and through citation (Boyne, 1999). Nonetheless, the new models are queer(y)ing masculinity and femininity in the traditional psychiatric models, and also highlighting the phenomenological diversity of transsexual patients. These contemporary influences could allow transsexuals to have multiple bodily aesthetics and styles. I suggest that this queers the past and present diagnosis of GID – that is challenges the theoretical applications of a dimorphic body system upon which masculinity and femininity rest.

The medicolegal alliance: Or, does "biological" sex equal legal sex?

Intersexed people, known historically as "(pseudo) hermaphrodites," are intimately linked to the medicolegal construction of transsexuals in various ways. Broadly, intersexuality, in its many forms, is defined as congenital aberrations of biological sex in sexological literature, which often "requires" medical attention and surgical intervention to modify genitals in line with a binary sex/gender system (Money, 1975; Money et al., 1955). This constitutes the intersexed person as a casualty of nature gone wrong. Transsexuality however, is represented mostly as a psychological disorder, as I illustrated above, where development into an "original" sex/gender within a binary sex/gender system is thwarted[3] (Benjamin, 1966; Money & Ehrhardt, 1972). In all the sexological perspectives concerning transsexuality, except maybe those that are based in psychoanalysis (Rekers et al., 1976; R. Stoller, 1975) and the reparative perspectives (Zucker & Bradley, 1995), the "anomalies" of embodiment should/could be rectified with surgical procedures (Pauly, 1981). The way in which the intersexed and transsexuals are marked differently in the medicolegal context is through the "discursive gymnastics" employed by doctors and judges when viewing the sex/gender system (Hird, 2000), where the same types of surgeries are viewed as essentially different in their *intention and deployment*.

The "Optimal-Gender" policy (Money et al., 1955) is one of Money's best-known theories. Money and the paediatric endocrine group at Johns Hopkins in the 1950s started to assign infants born with ambiguous genitals, known as "(pseudo) hermaphrodites" (now

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[3] Transsexuality is thought of as an intersex condition by some theorists (see Diamond, 2000). However, most biological accounts of transsexuality as an intersexed condition are inferred from brain studies, which do not have medical consensus (Fausto-Sterling, 2000). These studies also imply that brain functioning operates within a binary system of sex differentiation.

"intersexed"), an "Optimal Gender." Assignment decisions for these infants were based on the expected "optimal" outcome in relation to future psychosexual and reproductive functioning, which included a stable gender identity. Money et al (1955) proposed that newborns who have an intersex condition are psychosexually neutral. If for any reason the newborn is genitally and thus, "sexually ambiguous," this need not be a problem, for when the "Optimal Gender" assignment is decided, surgical procedures performed, and the gendered rearing commences the infant will automatically assume the gender of assignment as well as heterosexuality (Money, 1975). Money (1975) argued that gender becomes fixed in the first three years of a child's life, through the gender rearing and socialisation of the child, usually resulting in an appropriate gender identity, gender role, and the social gender of either masculinity or femininity. Money's theory was applied to all newborns.[4]

Medical and legal models incorporate only two sexes. Hester (2004) suggests that the way a doctor determines the sex of an infant is by regarding the aesthetic arrangement of their genitals. If the arrangement of the genitals is in anyway ambiguous then the doctor may require additional information in order to extract the "authentic" sex of the infant. Additional information could consist of phenotype, chromosomal make-up, hormonal and gonadal tissue, which would be considered along with the morphology of the genitals. However, as Dreger suggests:

> in the late twentieth century [doctors] do not search deep into an intersexual's body in the hope of finding a material marker of an ontologically "true" sex. Instead, doctors today see their approach as pragmatic and primarily attentive to a psychosocial gender identity theory rather than a biomedical-materialist philosophy of sex identity (Dreger, 1998: 181).

So the data deemed necessary by the paediatric team for a diagnosis of intersexuality would be considered against the back-drop of Money et al's psychosocial developmental "Optimal Gender" policy (Money et al., 1955). The experts' decisions would result in the assignment

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[4] For evidence contrary to Money's theory see John Colapinto's (2001) book about Money's "experiment" with a child who's circumcision went wrong. Following laser treatment that burnt the child's penis, a neovagina was constructed and the child's parents were advised to commence the rearing of the child inline with a female social role. Money's research records have been criticised for being misleading and, by some critics, as having been falsified (2001).

of an "Optimal Gender" that the child would be socialised into and, moreover, they would determine which sex should be placed on the birth certificate, which is a legal document that transmits many social, medical and legal significations. The birth certificate is an ontological claim, which organises many aspects of civil life (Whittle, 2002). In law the birth certificate affects a number of areas where men and women are distinguished, for example, in relation to some sexual offences, marking who can marry, deciding which sports someone can compete in,[5] and so on (Chau & Herring, 2002). The bodily sex of the infant, initially pursued by the doctor through the "art of perception" (Hick, 1999), is taken, in most cases, as both a routine medical and a legal truth. As Judith Butler (1993) asserts experts lay claim to ontology, and distribute ontological effects, which is an instrument of power. Ontological claims also affect recognition and exclusion, which Butler suggests produces domains of "unthinkability." What is excluded from medicolegal ontology, and remains "unthinkable," is intersexed embodiment. Legal theorist Andrew Sharpe (1998) suggests that in a legal context biological determinism is a prerequisite for having a legally sexed body. Biological determinism is, however, based less on internal chromosomal, hormonal and gonadal biology than on bodily aesthetics and the presence or absence of a penis. According to Chau and Herring (2002: 349; Meyers-Seifer & Charest, 1992):

> The accepted approach was that the penis of less than 2 cm should be removed, as should a clitoris greater than 1 cm. It was felt that boys with such short penises would suffer from low self-esteem and that girls with a large clitoris would feel unfeminine.

Children born with variations in their chromosomal, gonadal, and hormonal make-up could be classified as either male or female through a glance at the present or absent penis, except for when the doctors' suspicions are aroused by aesthetically ambiguous and therefore

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[5] After much wrangling within the House of Lords and the House of Commons about transsexuals competing in 'sport,' the UK government bowed to the sporting lobbyists while constructing the GRA. In Section 19 of the GRA, which attends to sporting bodies, it instructs that transpeople can be banned from competing in 'sports' on safety grounds or on grounds of competitive (dis)advantage. The International Olympic Committee (IOC), however, removed restrictions with regard to transsexual participation in the Olympics in 2004 (Cavanagh & Sykes, 2006). There are, however, restrictions on certain bodies in the IOC's rulings. The IOC state that competitors must have surgical anatomical changes, must have received appropriate hormone therapy for a specified length of time to minimise gender-related advantage, and must have their sex change *recognised* in their host jurisdiction (International Olympic Committee, 2004).

"inauthentic" genitals. The socio-legal theorist Greenberg (2003) suggests that when these suspicions are aroused a "complimentary" set of standards come into play in the pursuit of finding the "authentic" sex of the infant. The "Optimal Gender" policy dictates that penetration and procreation are the institutionalised goal, and is alluded to in some medical prognoses, but not fully adhered to in practice:

> [t]his penetration/procreation gender stereotype is further reinforced by the medical community's emphasis on the need for a female to have an *acceptable-looking* clitoris over her need for sexual satisfaction. Creation of a sensitive clitoris and a vagina that properly lubricates during sex are not the primary concerns during female genital modification surgery. *A successful surgical modification of a female is not defined as one that will likely result in her ability to achieve sexual pleasure; instead it is defined as one that results in the creation of a proper-sized clitoris* (that may not be as sensitive as the unaltered clitoris) and a vagina that will allow penetration by a penis (J. Greenberg, 2003: 278 emphasis added).

There were instances in Money's work where babies appeared otherwise "normal" except for a "micropenis of clitorine dimensions" (Money, 1975: 65). This was regarded as an anomaly and "rectified," by surgically creating a neovagina, and assigning the child as female in order for the parents to commence "appropriate" rearing in the female role. If the child was left as male, it was assumed that the small penis would negatively affect his life chances, reducing his self-esteem. The assignment of the child as female would save "the individual feel[ing] like a freak" (Money, 1975: 66). Moreover, doctors in both the US and UK have been accused of creating "female" genitals out of ambiguous "male" genitals and pressurising parents into rearing the child in a "female role," based on the (unfounded) notion that the aesthetic dimension of genitals is the most important factor for future psychological wellbeing (Kipnis & Diamond). It is more likely that this decision was, in fact, based on the notion that it is technologically easier to construct a neovagina than it is to construct a neophallus (Intersex Society of North America, 2004). However, there are now some Eastern European doctors who believe that functionality and sexual pleasure should be the surgeon's objective (see Krstic et al., 2000).

Writing on the sociology of intersex, Hester suggests that the objectivity of science is underwritten by a hierarchy of subjective values, which are premised upon the location and history of a discipline (Hester, 2004). At the turn of the 21st Century in the UK and US, when "inauthentic" genitals were categorised as either "too small to be a penis or too large to be a clitoris," surgeons started bringing genitals surgically inline with, what they perceived as, the statistically (and aesthetically) normative (Hester, 2004). This resulted in diagnoses that appeared bizarre to the individuals involved. For example, Cheryl Chase (2002: 207), herself intersex, explained:

> From my birth until the surgery, while I was Charlie, my parents and doctors considered my penis to be very small [...] Then at the moment the intersex specialist physicians pronounced my "true sex" as female, my clitoris was suddenly monstrously large. All this occurred without any change in the actual size or appearance of the appendage between my legs.

The cessation of "gendered" medical intervention in childhood, unless it is life threatening, has become the focus for political activists from the intersex community. Activists argue that people should be able to consent to medical intervention themselves and, because much intervention is performed during childhood, that doctors disregard intersex people's human rights (Hester, 2004). Furthermore, activists suggest that medical intervention is unnecessary and based on arbitrary, aesthetic reasons. The spokesperson for the Organisation Intersex International – UK, Sophia Siedlberg (2006), suggests that use of a "phallometer test" by surgeons to determine whether the phallus should be extended with phalloplasty or reduced to produce a "normal" sized clitoris is also wrong. Dreger's (1998) historical account of intersex management also highlights other aesthetic factors that have been considered in scientific theories of sexed bodies. What, by some doctors would be seen as labia majora would be classed by others as a "bifid (divided) scrotum." In some cases the growth pattern of pubic hair was observed and influenced the identification of a "true sex" (1998). After all these deliberations and subsequent surgeries, the modified genitals are finally considered "natural" and "normal" (Hester, 2004). The authenticity of sex is ordered by literally cutting away the ambiguity and, in many cases, denying it ever existed (Chase, 2002). Dreger (1998: 187) notes:

> Medical paternalism grew powerfully in the late nineteenth century and continued for much of the twentieth century; doctors assumed they knew what was best for patients and society and that therefore they should make the primary decisions about a patient's care [...] paternalism marked cases like those of Louise-Julia-Anna (in which the patient was told she was a man and told the doctor would refuse to repair her hernia if it meant she would keep having sex with "other" men) and of the Middlesex widow (whose surgeon removed her testicles without ever telling her what he had found).

Euphemisms were sometimes used by doctors to conceal from parents the truth about their child's surgical procedures, as a post on the Androgen Insensitivity Syndrome Internet Support Group website suggests:

> it was not until I was 17 that medical examination and subsequent surgery took place. My parents were told that my internal organs had not developed properly and that two "hernias" had been discovered and removed (Rosemary).

These "hernias" were in fact gonadal tissue. The doctors' paternalism was meant to save the family from stigma and shame (Intersex Society of North America, 2004). This, then, should help foster family stability and be conducive to the formation of the child's stable gender identity and complimentary heterosexual orientation (Money et al., 1955). In legal terms the "authentication" process of surgical assignment provides an unambiguous sex for the birth certificate.

In 2000 a Home Office publication stated:

> The law provides for an entry in a birth register to be corrected at any time if it can be shown that an error has been made. This includes the circumstances where a newborn baby was not in fact of the sex recorded in the register (Home Office, 2000: 6).

It continued:

> If the sex of a child is not evident at birth, parents are advised to delay the registration until medical investigations have been completed to determine the sex (Home Office, 2000: 6).

Although there is medical recognition of the "grey areas" of body aesthetics, for intersexed people, there is only partial acceptance of this in the law. UK law, as it stands in 2008, is willing to wait until doctors have decided upon an "Optimal Gender" (male/female) for those who do not "naturally" fit the system. However, doctors cannot contradict the binary sex of the birth certificate even though, more recently, there have been changes in the medical management of intersexuality. Even though surgical intervention and classification have begun to be questioned (Chau & Herring, 2002; Krstic et al., 2000) there is no legal space for intersexed people.

As was reported in the British media, a child named Joella, who had been assigned male at birth, could not have her birth certificate changed, even though doctors had subsequently created a "female" body (G. Finn, 1998). In this particular case her modified body did not adequately signify her "true" sex in law. Legal sex was determined in law by a ruling from Judge Ormrod, which stated that chromosomes and body morphology at birth were *the* deciding factors in the "true sex" of a person. Ironically, it was the case of a transsexual, April Ashley, which set the precedent for what "true sex" was. April Ashley and Arthur Corbett wanted to annul their marriage. At the time, the UK legal system did not recognize a mutual consent agreement between two parties as reason enough to grant an annulment. Judge Ormrod ruled, that because of this, the case's primary focus had to be the validity of the marriage between Corbett and Ashley. Ashley was known to be transsexual. The divorce, then, came to depend upon the "true" sex of Ashley, because if, through medical testing, she was determined to be male, the marriage would be void. Determining the "true" sex of the person was based on four factors. (1) Chromosomal factors. (2) Gonadal factors (i.e. the presence or absence of testes or ovaries). (3) Genital factors, which includes internal sexually dimorphic organs. (4) Psychological factors. Ashley had XY chromosomes and, therefore, was of male chromosomal sex; originally she had testicles and, therefore, was of male gonadal sex prior to sex reassignment surgery; had male external genitals without evidence of either internal or external female sex organs and was, therefore, of male genital sex. Psychologically, she was diagnosed as transsexual. These

factors are (in)significant in relation to Joella. Following an eight year court battle, a ruling by the Office of National Statistics stated that Joella, the intersex child who had XY chromosomes and had had gender reassignment surgery, could have her birth certificate changed to female (G. Finn, 1998). This decision meant that chromosomal tests were no longer regarded as definitive in determining a person's sex. Christine Burns, of the transsexual advocacy group Press for Change, said:

> In law, there is no difference between Joella and a transsexual woman and in practice the only actual difference is that gender reassignment surgery was inflicted upon her by others, whereas transsexual people are in the position of trying to get surgery. She has XY chromosomes, just like transsexual women and is sufficient to invalidate her marriage under the 'test' devised by Justice Ormrod (Press for Change, 1998b).

After this case, transsexuals were urged by community groups to apply for amendments to their birth certificates on the basis of this ruling. The law, however, still considered intersex and transsexuals differently, one as an *authentic* sex, created by a surgeon, and the other as *inauthentic* simulacra[6] created by a surgeon. The "inauthentic" transsexual was still defined in terms of the sex ascribed to them at birth, as someone who had psychosocial gender problems (gender dysphoria), in opposition to an intersexed person who had physiological (biological) "problems." This division can be seen, then, as the consequence of the privileging of certain corporeal and psychological relationships over others. By giving importance to purely psychological factors, without any definitive tests to confirm them, Chau and Herring (2002: 349) suggest that this may lead to self-defining intersex people considering "themselves as neither male nor female, but intersex (or some other designation)." This would create a legal precedent that would undermine what, over thirty years ago, Gayle Rubin called, the last bastion of heterosexual kinship systems, marriage.

> Marriage continues to have colossal relevance for the political economy of sexual systems (G. Rubin, 1997 [1975]) and sexed bodies, both in the UK and around the world.[7]

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[6] April Ashley was called a "pastiche of womanhood" by Judge Ormrod during the hearing (Sandland, 2007).

[7] Religious and Conservative objections to the GRA were defamatory during the parliamentary debates. Marriage as a social institution, it was argued, should be guarded against transsexualism at

Nonetheless, it was not until the implementation of the Gender Recognition Act 2004 that "authenticity" was legally granted to transsexuals in the UK. Legal recognition however, is premised on a number of criteria, such as a diagnosis of Gender Dysphoria and other "significant psychological factors," alongside the will to surgically alter (sexual) bodily characteristics. Legal authenticity for transsexuals is premised upon medical experts' ability to determine whether someone is gender dysphoric or not, which assures medicine's ongoing centrality to the construction of official transsexual identities (Sanger, 2008).

Recognising gender and the changing medicolegal gaze

Perceptions about discursive constructions of and acceptable bodily aesthetics of GID do not have *medical* consensus, as I explored above. In this section, however, I aim to show which of these assumptions are used by the law to constitute transsexualism. New legal precedents have come into force because of the implementation of the Gender Recognition Act 2004. Currently legal scholars are debating the theoretical importance of the Act (Cowan, 2005; Sandland, 2005; Sharpe, 2007b). It seems that GID is the only "psychological problem" that advances debate in the institutional domains of critical academia, medicine, and law. This is because of its potential to disrupt normatively structured genders (Sandland, 2005, 2007), which could have far reaching legal consequences.

The Gender Recognition Bill was introduced in response to the judgement from the European Courts of Human Rights (ECHR) on *Christine Goodwin v United Kingdom*[8] in the hope that it would provide legal recognition for people who are transsexual. The bill was presented by the government as part of their grand programme of "social inclusionism." Following a report by the Joint Committee on Human Rights of 11th December 2003, a government spokesperson introduced the second reading of the Gender Recognition Bill in 2004. He said: "[this is] possibly the most progressive system of gender recognition in Europe" (David Lammy MP cited in Sandland, 2007: 1). It has been argued that it was, in fact, various highly publicised legal battles at the ECHR that were at the forefront of the government's decision to look at the legal plight of transsexuals in the UK

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all costs. Lord Tebbit suggested that the government would, if the legislation went through, be denying the reality of biology (Sandland, 2005).

[8] *Christine Goodwin v United Kingdom* (Application no. 28957/95) [2002] I.R.L.R. 664.

(Sandland, 2007). A number of cases were taken to the ECHR with the support and expert backing of Press for Change, a prominent trans advocacy organisation. *Christine Goodwin v. United Kingdom*, in 2002, is one such case. Here a transsexual woman successfully argued that her rights were breached by the UK government's failure to provide legal recognition of her change of sex. This was by far the most often cited legal and political victory over the government's feet dragging in relation to legal change for transsexuals (Sandland, 2007).[9]

The Gender Recognition Act 2004 has recently become law in the UK and enables transsexuals to apply for gender recognition. This means that transsexuals who wish to have all their personal documentation changed to their acquired gender may do so, as long as the Gender Recognition Panel is satisfied with the evidence supplied.[10] At first this only applied to people who had been living in their "new" gender for more than six years. This time constraint was reduced to two years in April 2007. The GRP began work on 1st April 2005 deciding who could, or could not, gain recognition. The law does not force transpeople to apply for recognition. Thus, even if a transperson has had all the necessary surgery for them to successfully pass as the gender of choice, there is no mandate for them to change their documentation. Another interesting aspect of the law is that transsexuals do not have to have genital reconstructive surgery to attain their "acquired gender." Those who do not have the surgery, however, have to "face" a panel with information about which surgical operations were planned but unable to be actualised, in order for the transsexual to be assessed according to their new gender. Although this has been heralded as a success by many transpeople in the UK, granting transsexuals legal and citizenship rights, the newness of the law has yet to make visible any unforeseen problems. Prior to the GRP commencing their deliberations, Press for Change, the political group, which has influenced the passage of the Act at all stages, circulated some correspondence. It stated:

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[9] Prior to the implementation of the consultation process and the implementation of the GRA 2004, the UK along with Albania, Andorra, and Ireland were the only countries in Europe that did not recognise transsexuals' acquired genders.

[10] According to Schedule 1 of the Act, the panel must consist of legal and medical members appointed by the Lord Chancellor. The legal member must be a solicitor or a barrister with at least seven years experience. The medical members must be a chartered psychologists or registered medical practitioner (Schedule 1 para. 1(2) (b)). The panel must also have a President, or Deputy President, or the legal member to preside over the proceedings if the others are not available. All proceedings must be in private.

this is entirely new ground for everyone. It's a new law. Nobody has ever run a process of this type before. The panel hasn't yet sat and it hasn't established its own ground rules for how much detail it needs in medical evidence. Therefore the staff are being prudent and offering applicants their own best *guess* about where the panel may want to draw a line (Press for Change, 2005 emphasis added).

The law offers two main paths that the transsexual may travel to gain acceptance from the GRP: having been diagnosed with *Gender Dysphoria*, and having had, or planning to have, surgery that changes "sexual characteristics." The information provided by doctors is judged by at least one medical practitioner in the field of *Gender Identity Disorder* plus a legal expert. Firstly, then the surgical path: if the transsexual can show confirmation of surgical treatment for the purpose of modifying sexual characteristics, for example genital modification SRS (vaginoplasty, orchiodectomy etc), this is by far the easiest way to apply. A General Practitioner should be able to certify this, by looking at the patient's notes and correspondence in the individual's medical record. It is not yet known, however, how much of a challenge to traditional sex/gender dimorphism the panel will allow in relation to bodily aesthetics.

The second way in which the law allows an application to be accepted by the panel is through evidence of person having been diagnosed with *Gender Dysphoria*. This evidence needs to be given by a qualified practitioner from a Gender Identity Clinic. The *Gender Dysphoria* option allows someone who has *not* undergone genital surgery to obtain recognition. The UK parliament went further than was expected after the ruling by the European Court of Human Rights on *Goodwin v UK*. Other European countries, such as Sweden and France, insist on sex reassignment surgery as a condition of recognition (Sandland, 2005) while countries, such as Germany and Portugal, require sterilisation before recognition will be granted. Legal scholar, Sandland (2005: 51), has argued that this part of the UK law constitutes a "shift from gazing at bodies to accepting that things are (not) what they seem." Because genital reconstructive surgery is not necessary in the UK, he suggests that the possibility of authentication within a legal binary subject-position that is removed from the normal mode of categorisation, i.e. penis, or not, at birth, represents

"moments of beyondness" (2005: 54). These "moments," Sandland suggests, illustrate the fluidity and malleability of the terms "female" and "male." Rather than the legal precedent functioning as an opening up of how gender identity can be constituted in law, it reifies sexed identities through the authority of medicine. Sandland (2005: 47) argues rightly that gender, in the GRA, is not a "subset of sex: [where] "sex" defined the parameters, gender was the free play within those parameters." He uses Butler's assertion that gender has come to be seen as a "subset of sex," suggesting that the law has shifted its focus on transsexuality from a biologically determinist position to a psycho-social one. So, the law now focuses on gender rather than on sex. By showing that "orthodox" gender is so easily manipulable through (medicolegal) discourse and that gender – man and woman – is socially constructed, it allows for the potential of *queer* gender recognition through non-normative bodily aesthetics. Sandland fails to acknowledge that recognition is restricted to those who wish to change their sex from one to the other rather than the removal of the binary system all together.

In a later article, Sandland (2007) recognises these limitations of his theory and calls the GRA both a story of desire – desire of unambiguous sex/genders in law – and a story of denial, where "imaginary" or ambiguous sex/genders, such as transgendered people must continually be denied by the law. Sandland theorises this denial in law as a disregard for anything that may challenge the binary sex/gender system and make the law unreadable. Denial, then, is denial of the ambiguous and "inauthentic" "Other" sex/genders that always threaten "to exceed the either/or of the male and female" (2007: 3) divide in the law. Excess, here, is exposed as an embodied potentiality – similar to intersex embodiment – and must continuously be denied authenticity by the law and, thus, any possible deconstructive power. Whilst this may be true on one level, in that some bodies may be denied recognition, the decision to grant people a sexed status different to that on their original birth certificate would not be based on ambiguous bodies, but instead on the intentionality "behind" those bodies. Intentionality would require a submission to medical authority in order to obtain the diagnosis of gender dysphoria, which would give "legitimate" meaning (in the eyes of the law) to any sartorial or body modification practices of trans-sexing.

"Gender Reassignment" (GR) is a general term in the transgender literature for a number of surgical and hormonal body modification measures (Cohen-Kettenis et al., 2004). GR can include those operations that we do not necessarily think of in relation to transsexualism, such as hair transplants, and practices based on gender presentation, such as aesthetic surgeries to feminise, or masculinise, facial and bodily features. The panel does not yet have criteria that can be examined.[11] Therefore transgender community groups currently advise people who wish to apply to list all the surgeries they have had, or plan to have (Press for Change, 2005). It seems that the panel requires evidence of an actual, or intentional, aesthetic commitment to a particular gender. Transsexuals must have good medical reasons not to have hormone therapy or have surgery that changes sexual characteristics. One such reason is the inability to have surgery. This may be due to a risk to health and well-being. It is assumed, however, that the transsexual would have surgery if it was possible.[12] Doctors and surgeons would need to provide confirmation that the candidate for recognition satisfies this premise of wanting surgery and a letter indicating a refusal to perform surgery due to its potential dangers. This can only be obtained by acquiring a referral from a clinician specialising in Gender Identity Disorder. Confirmation would also have to be provided to show that the candidate has gone through the clinical process and been given the diagnosis of Gender Dysphoria.

The introduction of the GRA 2004 in the UK has been heralded as a success by transgender community groups. However, the success is only for those who can convince the panel they are the gender they say they are, while for those who are refused gender recognition more evidence will be required. At present the panel has no strict guidelines to adhere to. There is no research to date into who has, and who has not, been awarded recognition. This is not to say, however, that the Act is not progressive for transsexuals. It has progressive potential insofar as it removes the, once quite stable, legal precedents about men, women and

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[11] The president of Press for Change and World Professional Association of Transgender Health (WPATH) Stephen Whittle, said that he had sat in on some of the panel's sessions, as an invited guest, in order to oversee proceedings and comment on any of the procedures, in an attempt to make the system as fair as possible.

[12] In section 9(1) the Act states: "the person's gender becomes for all purposes the acquired gender (so that, if the acquired gender is the male gender, the person's sex becomes that of a man and, if it the female gender, the person's sex becomes that of a woman)." In section 20, a person can still be charged with a sexual offence in their assigned sex at birth. For example, in Scotland and Northern Ireland rape is still considered only possible by a man/male.

transsexuals' bodies. The precedent of what constitutes a man or woman was legally stabilised in the case of April Ashley, which stood for over 30 years. The law rested on the notion of "biological authenticity" that could be found in and on the body, which, in turn, according to Hird:

> rest[ed] upon three inter-related assumptions: that sex and gender exist; that sex and gender constitute measurable traits; and that the 'normal' population adheres to the first two assumptions (Hird, 2002a: 581).

The biological and bodily aesthetic evidence in the Ashley case – and only in relation to transsexuality – cedes to the new formulations of authentic psyche and/or aesthetic signifiers that are produced by the psychiatrist and transsexual through the notion of gender (dysphoria) and which are anchored in and on bodies (Hird, 2002a). Therefore, prescriptions by the medical authorities, using "authentic" evidence from their self-styled scientific models of "natural" signifiers, that are "able" to "measure" dichotomous genders, are still in play. Bodies are required to produce masculinity and femininity on "wrong bodies" respectively, in order to receive the "diagnosis" of *Gender Dysphoria*. So, it seems that the law has surrendered the "authenticity" of sex to the performativity of gender. However, medicolegal discourse concerning transsexuality has, in fact, surrendered a performative sexed body based on biological markers and bodily aesthetics for another performative based on the intentionality behind sartorial and bodily aesthetics and the will to be scrutinised by doctors who have the authority to diagnose Gender Dysphoria. The medical scrutiny in the gender clinics may vary and is dependent upon the paradigms and gender models the psychiatrists are most comfortable with and, thus, dependent upon a postcode lottery of "taste" and aesthetic judgement (Bourdieu, 1984).

Conclusion

In this chapter I have illustrated that "masculinity" and "femininity" are fluid aspects of gender aesthetics rather than being biologically determined. And, because medical models each advocate different "causes" for the "biological nature" of transsexualism, this reveals that they are applying, what Cromwell calls, "default assumptions" (Whittle, 2002: 72-73) about masculinity and femininity. I have demonstrated that the gender belief systems that traditional practitioners apply when diagnosing their trans patients are influenced by

hegemonic and stereotypical cultural ascriptions of masculinity and femininity. I have argued that the dominance of the medical "founding fathers" of transsexualism, the aetiology, and the standards of care and practice surrounding intersexed and "gender dysphoric" people, is being challenged. These models are being contested by feminist, queer, and postmodern understandings of gender, both within and outside the medical profession. Because traditional psychiatric models of masculinity and femininity are structured around heteronormative values there is much mistrust from contemporary perspectives. These novel contestations do not deny the ontological claims that there are (trans) men and (trans) women, but the emphasis has shifted from a biological model of bodily aesthetics to a psychosocial model of bodily aesthetics, which has the potential to undermine much traditional medical theory regarding transsexuality.

Nonetheless, the ontological claims which are made by doctors are also used by the law too. This affects notions of hierarchy, subordination, and exclusion within civil life, as Butler (2004) suggests, this produces domains of "unthinkability." What is excluded from medicolegal ontology and thus remains "unthinkable" (at present) is the intentionality behind intersexed and transgender (as opposed to transsexual) embodiment and bodily aesthetics. This is because these identity positions have the potential to disrupt the binary gender legal order. I have discussed the medicolegal constructions of transsexualism and the legal preferences for bodies and "gender" which authenticate transsexuals in law. I have suggested as there is no true consensus in the diagnostic process and that this demonstrates that the decision to grant legal recognition to transpeople is based on subjective, aesthetic evaluations by experts. The chapter has suggested that medicolegal approaches to transsexualism are influenced by wider cultural and academic aspects of embodiment and bodily aesthetics and it is to these aspects this research now turns.

Chapter II: Theorising Trans Embodiment and Bodily Aesthetics

Introduction

This chapter starts with an exploration of radical feminism's understanding of dichotomously-situated "good" and "bad" (trans)women's bodies. I start here because radical feminism was an academic field that responded negatively to transgender practices of embodiment. This strand of feminism, and their dominant position in second wave feminism, has considerably influenced how transsexual bodies are viewed. Much of this literature has been hostile towards transpeople (Jeffreys, 2005; Raymond, 1980). However, it was arguably the response by trans academics towards radical feminist hostility, which was the catalyst for the emergent field of transgender studies in the academe. In this chapter I consider how radical feminist perspectives fall too simplistically into moralising views of transgendering. Dichotomies run through this chapter, which, whilst extending our understanding of the bodily aesthetics of transsexuals, in various ways seem to repeatedly come down on an either/or or both/neither position (Roen, 2001) of "good" and "bad" intentions toward the representations of trans bodies.

So, I look at the Cartesian split between body and mind, and utilise Elizabeth Grosz's (1994) interpretation, which, she suggests, often assumes that there are two distinct, mutually exclusive and mutually exhaustive substances, mind and body, each of which inhabits its own self-contained sphere. She also points out that this duality favours the mind as the superior partner that dominates the body. In relation to transsexualism, this interpretation would firmly, but paradoxically, emphasise the transsexual mind as outweighing the "unruly" body through the "wrong body" trope. Here I develop a critique of the perspective that suggests the mind as being more important than the body and suggest that bodily aesthetics are intrinsic to transsexuals' embodiment. In the next two sections I consider trans body projects as a form of body management as well as the feminist responses to cosmetic surgery, because such theorisations reinforces the dichotomy of "good" and "bad" practices, and thus restricts our understanding of diverse practices in the trans community. Whilst this literature has the potential for answering questions about embodiment and bodily aesthetics, I question recent work on transsexual bodies because it generalises, rather than particularises, what it means to be transsexually embodied. However, "body projects" do allow us to consider agency as an aspect of

transgendering. To consider agency in all its complexity, McNay's assertion will be applied, by understanding:

> on the one hand, for the process of normalisation to be efficacious, it is assumed that individuals are not free to choose to accept whatever normative images are presented to them. However, on the other hand, the idea of resistance implies they are able to stand outside these same norms in order to reject them. This, however, undercuts the argument about the efficacity of norms resulting in an aporetic understanding where they are both insidiously inculcated and freely adopted. The complex dynamics of psychic investment are simplified by being reduced to the dichotomy of rejecting or mirroring prevailing social norms (McNay, 2000: 120-121).

As I will explore, this opens up new ways of exploring the trans body as a potentiality. Next I consider the "passing" and "non-passing" body, which develops the ideas that we are a body and have a body that is judged in social interactions. This leads on to the final two sections, where I consider phenomenological insights of embodiment and body image(s) in transgender studies, where, in varying degrees, identity formation involves both a negotiation with social and symbolic norms and agentic aspirations for (sex) change. I also draw on the phenomenological concept of "intentionality," where subjects illustrate productive ways of challenging dichotomous theorising about trans bodily aesthetics and embodied practices and, in so doing, highlight the diverse phenomenology of trans subjects.

Radical feminism and trans embodiment

In the 1960s, the development of a second wave feminist political agenda shaped the context in which women were encouraged, through conscious-raising activities and self-help groups, to reclaim their bodies:

> Learning to accept and love our bodies and ourselves is an important and difficult ongoing struggle. But to change the societal values underlying body image, we need to do more than love ourselves. We need to focus our attention on the forces that drive wedges between us as women: racism, sexism, ableism, ageism, and our national obsession with size and shape. To truly create change, to create a world in

> which *all women can make choices about our appearances for ourselves* and not others, we must incorporate all women into the heart of how we see ourselves (Boston Women's Health Book Collective, 1975: 37 emphasis added).

Focussing on the multidimensional facets of patriarchy that defined and organised the lives of women (Raymond, 1980), feminists started illustrating the ways in which social systems placed unequal values on male and female bodies. Extending this work, more elaborate theorising took place, which opened up our knowledge of the female body in relation to the different socialisation of men and women (Oakley, 1972), women's bodies and medical services, especially with regard to reproduction (Martin, 2002 [1991]), and the commodification of the female body, through research on prostitution and pornography (Singer, 1989). Intrinsic to this work was the re-evaluating of the (natural) (white) female body and highlighting the experiences (white) women faced in a sexist society, both of which were seen to be rooted in heteronormativity.

Radical feminists have argued that transsexuals and their aesthetic surgery *choices* denigrate women through their performance of normative femininity, which is endorsed by the heteronormative hegemony. In these writings, transsexuals are often viewed as demonstrating fetishistic idolising of patriarchal ideals of femininity or masculinity, which is accomplished through body modification. Much critical work on the Gender Identity Clinics (Billings & Urban, 1996; Hausman, 1995), which carry out SRS and aesthetic surgery, suggests that these institutions form part of a monolithic system that (re)produces stereotypical men and women by mutilating healthy bodies. As recently as 2005, Sheila Jeffreys (2005) makes the claim in her book *Beauty and Misogyny*, that transvestites and transsexuals are dupes of western cultural principles of femininity (and masculinity), referring to them as "male-to-*constructed*-females." Some radical feminists (Jeffreys, 2005; Raymond, 1980) also claim that gender identity clinics aid patriarchy by changing those "men" who do not attain "true" masculinity – through the oedipal drama – into women (Millot, 1990). Doctors stand accused of conspiring with transwomen to prop up patriarchy, by surgically and hormonally transforming them into "pseudo-women" (Jeffreys, 2005), who may therefore duplicitously infiltrate womyns' (especially radical lesbian feminist) spaces by "*pretending*" to be lesbian women and thus subverting feminism (Daly, 1978). By utilising a simplistic notion of social constructionist critique, Jeffreys positions

transpeople as holding essentialist understandings of masculinity and femininity that help secure male supremacy and female subordination.

In addition to these debates, some polemical works regard GID and transsexualism as pathological, whilst others tend to trivialise sex change surgery as only an aesthetic make-over, (based on a masochistically perverse sexuality) (Jeffreys, 2005). In the imaginings of some commentators, SRS may suggest the amputation and mutilation of an otherwise healthy body, rather than its "enhancement" perceived by transsexuals themselves.

Jeffreys (2005) ardently questions the biological basis of (trans) gender and positions transgender practices of femininity as being about sexuality rather than bodily aesthetics and gender identity. However, her argument is contradictory, stating on one hand that the doctors who "treat" transgender people are adding to the social stratification of males and females by relying on hierarchal, socially constructed ideas about masculinity and femininity. Whilst, on the other, they use medical research to posit that transpeople are delusional and want to become "constructed-women" and dominated as (pseudo) women (2005). Jeffreys' reading of transwomen seems to be very close to a patriarchal medical conception of "sexual pathology. Jeffreys' illustration of transwomen is of a group of people who all "fetishise" having sex as women or who are sexually aroused by the thought, or image, of themselves as women. This "pathology" is known as autogynephilia in sexological texts (Bailey, 2003; Blanchard, 1991; Lawrence, 2004). Feminists, who come from this perspective, then, retain the medical discourses of pathologisation, but reject surgery as a satisfactory remedy. They also accept the aesthetic judgement of one set of doctors, who claim the ability to assign sex, based on the visual bodily markers present at birth, but dismiss another set, whose aesthetic judgements diagnose transsexualism and transgenderism. Furthermore, such debates are based on scant empirical evidence.

The accusation of "deception," borne out by the use of body modification by transsexuals, is the fundamental idea, which runs through radical feminist criticisms about transsexuality. Through an unwitting essentialism, Mary Daly (1978) suggests that transpeople deceptively violate bodily boundaries of men and women, which allows them to infiltrate spaces not created for them. Raymond (1980: 125) argues: "the transsexually constructed lesbian-feminist may have renounced femininity, but not masculinity and masculinist behaviour

(despite deceptive appearance)", in order to insert themselves into positions of importance within the feminist movement.

Shepherdson (1994) evokes Catherine Millot's (1990) feminist psychoanalytic treatise on transsexuality, *Horsexe*, to "reveal" that doctors are unethical when they ignore the difference between transsexuals' demands for surgery and their "true" desire, which is, to deconstruct the "real," this being the symbolic meaning of "original" (natural) bodily materiality (Shepherdson, 1994). Millot (1990) suggests that transsexuals have an "impossible" psychic ideal – to change the body, but not the mind – which denies the symbolic meanings of oedipalised bodily materiality (Shepherdson, 1994). Transsexuals' deception here is couched specifically in what the transsexuals' demands evade. The reason doctors acquiesce to transsexuals' demands for body modification according to Millot is to bolster the doctor's own "phantasy" of scientific omnipotence (Millot, 1990) and to aid and abet, a false fantasy that positions transpeople "outsidesex." In (Lacanian) feminist psychoanalytical accounts, then, it is *only* the analyst who fully understands the "true" meanings of the cultural and linguistic aspects of bodily aesthetics, and both the doctor and transsexual patient are duped by their own pathologies.

The radical feminist objection to "misguided" and "deluded" (trans)women, who are encouraged by the medical establishment to undergo cosmetic surgery, is a polemical attack on (trans)women, which (at the level of "women") renders the radical feminist perspective paradoxical. As Sandra Bartky (1988: 78) suggests:

> to have a body felt to be "feminine" – a body socially constructed through the appropriate practices – is in most cases crucial to a woman's sense of herself as female and [...] as an existing individual [...] The radical feminist critique of femininity, then, may pose a threat not only to a woman's sense of her own identity and desirability but to the very structure of her social universe.

The self-confirming logic of radical feminist writing on transsexual bodies is based on moralising dichotomies that foreclose who, and how, (trans)women should be i.e. "good (real) women"/"bad (trans)women"; "natural women"/"constructed (trans)women,"; having

"authentic agency" (women who exercise the same choices as radical feminists)/being "dupes" ((trans)women who make (pseudo) choices directed by patriarchal forces) (Felski, 2006). These dichotomies simplify what we (could) know about trans bodily aesthetics. Furthermore, as Rita Felski warns us:

> [t]here is something troubling, both ethically and politically, about a view that would deny *any* genuine insight or agency to those with whom one disagrees (Felski, 2006: 274 emphasis added).

Moreover, as Colebrook points out:

> [t]he question for feminist politics then is not so much moral – is beauty [aesthetics] good or bad for [trans]women [and transmen] – but pragmatic: how is beauty [bodily aesthetics] defined, deployed, defended, subordinated, marketed or manipulated and how do these tactics intersect with [trans]gender and value? (Colebrook, 2006: 132 my insertions in parenthesis).

Transgender talking back

The Empire Strikes Back: A Posttranssexual Manifesto (Stone, 1991) directly takes radical feminist writings about transsexuality to task. Not only did transwoman Sandy Stone counter Janice Raymond's personal attack on her, which had claimed that Stone had duplicitously presented herself as a woman in a women-only feminist recording collective, but she also developed a poststructuralist critique of transsexual identity. Stone's (1991) article addressed representations in (auto)biographical accounts of transsexualism and suggested that these had been coerced by powerful medical discourses. Her goal was to encourage new forms of trans self-expression, which highlighted the multifaceted aspects of transpeoples lives. Stryker and Whittle (2006: 221) suggest that Stone's "Manifesto" was the "protean text from which contemporary transgender studies emerged." Over the last few decades a significant number of transsexual and transgender writers have employed poststructuralist, postmodern, and queer gender theory to highlight the multifaceted aspects of living non-normatively gendered lives. The methodologies employed in these transgender studies texts (see Stryker & Whittle, 2006) are also diverse, from (auto)biography aligned with political activism and commentary, qualitative empiricism, to

the theoretical and the subjective (S. Hines, 2007).

There are noticeably distinct political positions between transsexual and transgender theorising about bodily aesthetics, or rather, theorising is mostly about distinctive aspects. Roen (2001) calls this the either/or (transsexual) position and the both/neither (transgender) position. Transgender and transsexual theorists are far from analogous in their personal and political deployment of gender theory, which highlights the instability and "inhabitability" of simplistic binary gender models.

Transgender theorising has since the 1990s been more concerned with critiquing the meanings surrounding masculinity and femininity (Bornstein, 1994; Butler, 1990). Transgender theorising and politics are informed by postmodern subjectivities, queer understandings of sexuality and gender, radical politics of transgression, and the deconstruction of binaries, such as nature/nurture, man/woman, and mind/body (Stryker, 2006). From a transgender perspective bodily aesthetics are utilised to mix and match gendered signifiers in order to deconstruct and disrupt binary orders of gender. There are sometimes cross-overs within these positions. Kate Bornstein, for example who at one time saw herself as transsexual but who now identifies as an "out" "Transgender Warrior," suggests that she has been looking for a definition of woman, and a sense of what a man is, but concludes that she has found neither, and has instead only seen "fickle definitions of gender [that are] held-up by groups and individuals for their own [political] purposes" (Bornstein, 1994: 57). The temporal aspects of embodied experience, illustrated by Bornstein, show how meanings surrounding her own bodily aesthetic are not only intentional but are politically flexible too.

Stone (1991) observes that a liberal transsexual politics may direct its energies towards the human rights of transsexuals rather than, for example, at psychomedical constructions of transsexuality, for strategic reasons. Because of the psychomedicalisation of transsexuality and the need to engage with the medical system in order to secure body modification, these practices are often viewed as citizen rights in this literature. Transsexual writer Claudine Griggs suggests in *S/He: Changing Sex and Changing Clothes* (1998), that she produced her "core gender" – a medical term – by appropriating body modification technologies, gendered clothing and feminine style. However, Griggs also tells a story of meeting a man

in a bar who thought (at first) that she was a man, he said:

> Gee, I'm sorry [...] I feel terrible. [...] Now that I see you, I don't know how I could have possibly thought [that...] But maybe you shouldn't sit so rough, [...] Like you have a beautiful figure [...] a little makeup would soften you up [...] you could fix your hair (Griggs, 1998: 221-22).

Griggs' gender is premised upon her *performance* of femininity, which is subsequently judged. For Bornstein (Bornstein, 1994) the imperative to pass as a woman for Griggs, and those she interacts with, would not be based on what Griggs presumes is her "core gender," but judged instead on her bodily aesthetic, which has no intrinsic meaning, only personal and social meanings. Furthermore, to have a "core gender" suggests that it is something natural, which is yearning for representation through body modification and sartorial practices, rather than a socially constructed aesthetic. Twenty years ago, in, *In Search of Eve*, Anne Bolin (1988) observed that transsexuals have individualised clothing and bodily styles, which were dependent on their intentionality toward the world as well as their social context. For example, Bolin (1988) suggested that "Rosemary," who was an ardent feminist, would wear clothing such as jeans and tee-shirts, whereas "Tanya" was ultra-feminine. Butler (1990) suggests that diverse performances of femininity (and masculinity) can masquerade as essences, but that it is in fact the "mask" of masculinity and femininity that constitutes gender and sex, from which men and women are then judged and valued. Butler developed the concept of performativity to show that "there is no gender behind the expression of gender" (1990: 25) and that it is the repetitive and compulsive embodied actions and adornments that produce the impression of a naturalised gender. Using the practices of Drag, Butler (1990) highlights how the naturalisation of gender may be challenged. However, in Butler's work, and in other queer perspectives (Bornstein, 1994), there is a lack of consideration for the subjective experiences of having, and being, an aestheticised body. Butler (1990, 1993) only considers gender markers, such as clothing, make-up and styles of behaviour. Whilst these aspects are important in revealing some of the contingencies of aesthetic bodies and gender identity formation, it misses out on how such bodily aesthetics are lived, felt, and understood.

Griggs would certainly disagree with gender being a masquerade, as she rebuffs the

"postmodern" and Butler's performative theory of gender (Griggs, 1998). However, Griggs relies on unsubstantiated polemics that seem to come straight from sexologist John Money's book, *Gendermaps* (1995) and a single trans-medical "brain size" study (Zhou et al., 1995). Furthermore, it seems that Griggs is saying: I know this is the way it is, because I am transsexual. This does little by way of convincing anyone. Whilst it is unethical for me to deny Griggs' personal story, she does not account for many of the diverse practices in the trans community. I do suggest, though, that for both the transsexual and transgender positions the judgement of bodily aesthetics is intrinsic to people's perception of their gender and intrinsic to their presentation of gender at a phenomenological, sexual and social level, which Griggs aptly highlighted in her anecdote.

The breaking down, or propping up, of binary gender cannot account for the intentionality behind transgender practices, either, when wanting a gendered "home" (Prosser, 1998), or when not wanting one (Bornstein, 1994). This dichotomy is based on bodily aesthetics having either essential meanings or arbitrary ones. Nikki Sullivan (2006) calls for an ethics of "transmogrification" as a way of engendering a non-judgemental attitude to body modification practices. Furthermore, Leslie Feinberg (1998: 1) wishes for a more inclusive body politic, which celebrates bodily differences and suggests that "we are all works in progress." Setting up dichotomised ways of looking at transsexual body modification and transgender modification as "good" and "bad" practices, based on conformity and non-conformity, Sullivan suggests, sets up a false opposition between the "normal" and the "strange." She understands all bodies as intertwined, or chiasmatic, where the boundaries of the body are neither "normal" nor "strange," but are all different, unstable, and have many meanings. This position is significant for my research, which explores the situated aspects of trans body modification and the judgements that follow from them.

Cartesian thinking and the "wrong body" trope

The power of mind over matter (commonly known as Cartesian dualism), is an influential aspect of Western thought (Burkitt, 1999), which involves a splitting of two distinct "substance," mind/self and matter/body. "Wrong body" rhetoric follows the Cartesian juxtaposition of an outer body with an inner self, as well as a hierarchy in which the body follows the mind's will. In relation to transsexuality, the goal for those seeking surgery is not to find a way to accept their bodies, but to make their bodies more acceptable. Many

transsexuals argue that although they are comfortable with their inner self and feel psychologically stable, their outer body gives a false and harmful impression to others and threatens their emotional health. The matter of the body is relegated to a problematic aspect of lived relations, whilst the mind is elevated to the level of the "soul," which continues to think, reflect, and be. Transsexuality has been theorised as "the mind trapped in the wrong body" (Prosser, 1998), which is an inverted manifestation of Cartesian dualism. In early sexological writing, the invert's mental disposition was said to be on a continuum of psychical inversion (H. Ellis, 1942 [1905]), which could be read as the precursor of modern (medicalised) transsexuality. The mind is of one sex whilst the body is of an other (irrelevant) one. Through the power of Enlightenment medicine the invert was pathologised. The mind, in much sexological writing, is only considered rational if "inversion" does not take place. Medical experts were (and, to some extent, still are) at liberty to "purge" what was perceived as irrationality from the invert's mind through reparative practices (Zucker & Bradley, 1995). In Cartesian inflected thinking, then, paradoxically, it is the invert's body that is the site of truth and importance, rather than the "diseased" mind. The medicalisation of "inverts" meant that only certain heterosexual/gender normative subjects had rational minds and orderly bodies. Nonetheless, the common sense appeal of Cartesian dualism (Gatens, 1995) for transsexuals, it is claimed, allows for a distancing from the body's materiality while retaining a focus on the mind. Within some "subaltern" transgender literature, concerned with the "disembodied" psyche of the transsexual (Prosser, 1998), the mind is considered separate from the body and as such, compliments theories of transsexual Cartesian (dis)embodiment insofar as the mind as "master" outweighs in importance the abject "wrong body." Wilton notes that:

> It is whatever *inhabits* the transsexual body that matters [...] The surgeons act *on* the body to ease the pain of the dys/embodied self 'inside'. Cartesian dualism haunts every turn of phrase here (Wilton, 2000: 240).

Cartesian theorising of transsexualism, however, cannot maintain any coherence when the theory of the diseased mind and (wrong) body is utilised, because, firstly, Descartes thought that the body was distinct from the mind and renders the body invisible (M. Finn & Dell, 1999). Secondly, the "wrong body" of transsexualism is a precondition for thinking about

transitioning from one sex/gender to another even if all surgeries are not undertaken. Therefore, it is the mind that "follows" the body and not the other way round. As Didier Anzieu states: "the skin is so fundamental, its functioning is taken so much for granted that no one notices its existence until the moment it fails" (Anzieu, 1990: 63-64). Thus, the body is at the very basis of transsexualism, as we can see writ large within the trope of the "wrong *body*." It is present in that the very subject matter of transsexualism is embodied and shaped by the constraints that follow from having, and being, a (wrong) body. Cartesian dualism refuses to focus explicitly on the body, which cannot therefore tell us much about the aesthetic body, except, perhaps, that it is viewed as superficial or abject and is deemed too unruly for research.

The "wrong body" trope is a well recognised transsexual narrative and tends to position the transperson as a victim of a cruel and aberrant nature. According to Prosser (1998), the "wrong body" signifies exactly what the transsexual feels about his, or her, body. This perspective, in general, lacks the ability to shed any light on the "right body" and how these "right bodies" are phenomenologically and somatically understood and experienced. In her critique of the "wrong body" trope, Halberstam asks: "who, we might ask, can afford to dream of a right body? Who believes that such a body exists?" (Halberstam cited in S. Hines, 2007: 65). These rhetorical questions are utilised by Halberstam to critique Prosser's (1998) metaphor of "migrating" to a new body, which is constructed as the "new home" for transitioned transsexuals, suggesting that these "new bodies" are unproblematically actualised. This metaphor is also critiqued by Sally Hines (2007) in relation to accounting for transgender embodiment constructed at the "borderlands of gender." At what point does the body feel right? Does it ever feel right? It is these questions, in addition to Halberstam's, that this research attempts to answer. This is because descriptions and theories of "right bodies" have been shied away from in much transgender literature, perhaps for fear of accusations of narcissism (Chiland, 2000) and body fascism (Kaveney, 1999), or mere simulacra (Gilman, 1999).

It is useful, here, to draw on some aspects of Stryker's critical queer theory (2006). For Stryker, there are no right bodies *per se*, just bodies of difference. While Stryker is permitted distance from the restraints of her birth-assigned sex through the technology imparted by medical "experts" and legal recognition, her social body is not awarded the

same human recognition and value as gender normative people. She writes:

> Like the monster, I am too often perceived as less than fully human due to the means of my embodiment [...] my exclusion from human community fuels a deep and abiding rage in me that I [...] direct against the conditions in which I must struggle to exist (Stryker, 2006: 245).

Through her writing Stryker attempts to subvert the standards of the normative body, if only momentarily, through her "transgender rage" and her position as an academic. However, the social hierarchies through which bodies are judged tasteful and beautiful (Bourdieu, 1984) are difficult to challenge. Stryker's body is invigorated through subversive action but continues to be cast by others as monstrous. Nonetheless, Stryker's "monstrous body," she states, assumes an affinity with Mary Shelley's Frankenstein's monster (1888), as a participant in doctors' fantasies about mastering the limits of (gendered) life. Both the Shelleyian monster and Stryker's monstrously queer body stand in resistance to the "stylised" transsexual body and the gendered heterosexual order that doctors aspire to. Stryker argues:

> As we rise up from the operating tables of our rebirth, we transsexuals are something more [...] than the creatures our makers intended us to be. Though medical techniques for sex reassignment are capable of crafting bodies that satisfy the visual and morphological criteria that generate naturalness as their effect [...] Transsexual embodiment, like the embodiment of the monster, places its subject in an unassimilable, antagonistic, queer relationship to a Nature in which it must necessarily exist (Stryker, 2006: 248).

Stryker (2006) attempts a resurrection and revaluation of the "monstrous body" that, she hopes, will become a politically lucrative way of disrupting the "naturalised" "order of things" (Foucault, 1996). She wishes, further, to open up the possibilities surrounding gender, sexualities and styles, following Sandy Stone's (1991) groundbreaking "call to arms," which summoned multifaceted (auto)biographical accounts of transsexualism to be articulated. Stryker also desires the truthful specificity of transsexual embodiment and intentionality in relation to novel modes of self-expression through bodies of difference

(Spade, 2006; Stryker & Whittle, 2006). She does not, however, make bodies of difference "appear" in her own work and leaves them as literary metaphors. Nonetheless, I agree with Stryker, when she suggests, by making the bodies of difference appear and by making them a focus of research and discourse it will highlight the pervasive but unpredictability of bodily aesthetic orders within society.

Post-feminism, reflexive agency and financial considerations

One of the most developed ways to situate the issue of agency and structural forces in relation to (trans) bodily aesthetics has been within Michel Foucault's ideas concerning embodiment, that is, the material aspects of the body that are continuously processed through a "microphysics of power, bio-power or as the technology of the self" (Braidotti, 1994a: 17; Butler, 2004; Foucault, 1995, 1996; Morgan, 1991; Negrin, 2002; Spade, 2006). Foucault's (1991) concepts of "bio-power" – the "machinery of power," which manipulates bodies through disciplinary regimes, such as medicine and law, to produce "docile bodies" – and "reverse discourse" – the possibility of political agency through the manipulation of the very discourse that constitutes the (deviant) subject – have been employed often by many scholars, especially feminists, to theorise gender and the surgical body and the power relations that constitute an aestheticised body (Bartky, 1990; Bordo, 1993; Negrin, 2002). Aesthetic (cosmetic) surgery in relation to women (and, to a lesser extent, men) and transpeople has been a much contested ground in academia.

The cosmetic surgery debate that has taken place between feminists has been, on the one hand, concerned with women as "docile" and being duped by patriarchal beauty and cosmetic surgery/medical industries (Morgan, 1991), and, on the other hand, focuses on calling for these surgical technologies to be used as a site of resistance to normative femininity and masculinity and to destabilise "beauty" ideals of white, Western culture(s) (Balsamo, 1996; Morgan, 1991). For instance, Morgan (1991) and Balsamo (1996) suggest that cosmetic procedures may be used to destabilise current hierarchies of femininity and masculinity and their prominent positions within patriarchal structures. Both advocate using surgery as a critical feminist tool, on the one hand, to create "ugliness" as a benchmark of value and, on the other, to show the cultural construction of the body in general and, beauty, in particular. This, they propose, will show them as patriarchal laws rather than being determined by universal laws of nature. We can see similarities here with Stryker's

(2006) position, discussed above, in calling forth monstrous bodies. Balsamo and Morgan's position contends that:

> the 'natural body has been dramatically re-fashioned through the application of new technologies of corporeality [...] the merger of the biological with the technological has infiltrated the imagination of Western culture where the 'technological human' has become a familiar figuration of the subject of postmodernity....This merger relies on a re-conceptualisation of the human body as a 'techno-body', a boundary figure belonging simultaneously to at least two previously incompatible systems of meaning – the organic/natural' and the 'technological/cultural'. (Balsamo cited in Negrin, 2002:30).

Alternatively, Kathy Davis suggests that when women consider having cosmetic surgery they do so with reflexive agency. Davis observed women who recognise cosmetic surgery as their "best option" under the circumstances (Davis, 1997), and she sees it as a more complex dilemma than feminists have usually granted it (Davis, 1994). Cosmetic surgery is seen as a problem and a solution, a symptom of oppression and an act of empowerment (Davis, 1997). In Davis' (1994) study, she claimed that her participants were not having surgical procedures because of their male partners, but to feel at home in their bodies. There is an uncanny resemblance to transsexual stories of the "wrong body" in the narratives of Davis' participants, where the surgical procedures are set up to dispel the notion of a sick body. The participants had cosmetic surgery because their bodies did not fit their sense of who they were (Davis, 1997). Davis claims that some feminist objections to cosmetic surgery are premised on the understanding that women are misguided and deluded, encouraged by the medical establishment to conform to the ideals of the beauty system. Whereas the women she interviewed maintained their own personal agency and suggested that they were well aware of their choices, which were undertaken with knowledge of both the drawbacks and the benefits of surgery (1997). Nonetheless, Negrin (2002) critiques Davis' analysis because there is no deep consideration of why these women felt unhappy with their bodies in the first place. Other scholars highlight that the women's ability to act as fully active "consumer-citizens" is negated because they surrendered their stable subjectivity to the "pathologising" medical discourse of "psychological distress" in order to attain their ideal body (Holliday & Sanchez Taylor,

2006).

The relatively recent development of women as consumers of aesthetic surgery, and the correlative liberal feminist and post-feminist discourses, which examine neo-liberal subjectivities in relation to constant self-improvement, do, however, problematise the purely "docile body" and "women as victims" position. Instead, the emphasis in post-feminist discourse is on women's agency, whilst still not forgetting that relations between people are anything but equal (Holliday & Sanchez Taylor, 2006). Similarly, in transgender studies literature, Califia (1997: 224) positions transsexuals as informed consumers of healthcare and surgery by stating:

> Transsexuals are becoming informed consumers of medical services; they want more control over what they receive from their healthcare providers, and more accountability.

Rather than understanding transsexuals as the docile recipients of surgery, uncritically consuming these services, it may be better to recognise that the agency integral to consumption also acts as an indicator that the person can do as s/he pleases with her/his body. That is, of course; dependent on technological limitations and those of economic capital too. The aspect of finance has been one of the main critiques of liberal theorising of body modification, where the economic possibilities are anything but equal (see Feinberg, 1998; Halberstam, 1998a). Positioned between those transpeople who can financially attain body modification and those who cannot, there appears an obvious insight into structural inequalities based on class, race, age, and (dis)ability, which may affect bodily aesthetics. Whilst the lack of economic capital limits the scope of action it does not necessarily foreclose agency. Most of this literature is from the US, where it is much more difficult to access body modification due to the restrictions placed on health insurance payments in relation to (elective) (sex change) surgery. In the UK, although the system is not perfect and the waiting lists for sex reassignment surgeries, mastectomies, and so on have been critiqued as unethical (West, 2004), there is a system that provides free surgery to those who can satisfy the NHS Gender Identity Clinics' *modus operandi* of Gender Dysphoria. As I will illustrate in Chapter VII, due to these restrictions, many transpeople seek their gender reassignment and aesthetic surgeries from the private health sector and through

medical tourism. I propose that to research trans bodily aesthetics within these contexts (alongside legal and personal ones) contributes to a richer understanding of the experiences of transpeople in the UK.

Transgender body projects from inside out and outside out

Body maintenance, with an emphasis on the connection between the internal and external body, is not a new phenomenon (Featherstone, 1982). If we are to believe Freud, we need to remember that in his understanding the:

> ego is split between two extremes: a psychical interior, which requires continual stabilization, and a corporeal exterior, which remains labile [and] open to many meanings (Grosz, 1994: 43).

As Jay Prosser (1998: 82) observes in relation to transsexual bodies:

> the realization of identity hoped for and/or brought about as a result of the manipulation of the material surface of the body can be substantial; skin is anything but skin deep.

The emphasis on this connection between the "outer" and "inner" in sociological and philosophical theories of the body has added another dimension to the way we understand bodily aesthetics. The legacy of Nietzsche's insight of the body as incomplete and in need of adaptation in line with our sense of a (desired) self has fuelled an comprehension of the body as a "potentionality" (Turner, 1992), which can be elaborated on, manipulated, adorned, fed, loved, and desired and consequently given value (or not), by ourselves, others, and (sub)cultures. What "potentiality" also establishes is that agency is possible within both micro and macro social relations. The bodily aesthetic in this formulation continues to be a basic feature of social taste and distinction, of which, the organisation of bodily aesthetics becomes part of important qualities of cultural, physical and gender capital (Bourdieu, 1984). The functioning of cultural, physical, and gender capital takes place within the subject's habitus according to Bourdieu (1992), which:

> locates agency in the context of material and social forces but, in so far as it

> expresses a principle of differentiation, it replaces a uni-directional determinism with a generative and refractory logic (McNay, 2000: 162).

The "generative and refractory logic" that functions in the habitus emerges temporally within the "field" (sub cultures, social arenas, sexual spaces, and so on), where the individual tries to maximise their social worth, which can help explain the emergence of trans agency within gender orders (McNay, 2000). Moreover, because these qualities may become generative they may transform social relations. It is my contention, then, that it would be more helpful to think about the aesthetics of gender – femininities and masculinities – as central to transpeople's "habitus" and "fields" and as a form of generative cultural capital.

In Finn and Dell's (1999) social psychological study of transgender body management, "(re)embodiment" is shown to be positively experienced by transpeople. In this study, pleasurable, and potentially positive, mental health outcomes, derived from body management practices, are interpreted as symptomatic of choice. However, Finn and Dell (1999) divide "transgender" and "transsexual" as sites of "production" and "consumption" respectively. Transgender "production," on one hand, is viewed as a positive "non-distressed" self-production in which prescribed meanings of gender attributes are creatively contested and produced by the body without constraining choice. Transsexual "consumption," on the other hand, is taken as a negative aspect of transgendering, because transsexuals apparently consume their body parts based on gender norms, which are constructed through medical discourses of "distress." Here the transsexual is a "(consumptive) pathological individual" (1999: 466), whose

> gender role comfort[s] are portrayed as commodities, available through medicine…[pushing] patients towards an alluring world of artificial vaginas and penises rather than towards self-understanding (Billing and Urban cited in M. Finn & Dell, 1999: 465).

Finn and Dell's materialist analysis is founded on an arbitrary separation of transgender "production" from transsexual "consumption," which is problematic because it forecloses intentionality and agency on the part of the transsexual. Finn and Dell concede that the

"distinction between transgenderism and transsexualism is not an easy one to make" (M. Finn & Dell, 1999: 465), thus undermining their conceptualisation of "production" and "consumption." Moreover, because they do not develop diverse "categories" of trans subjects and contexts, they weaken their analysis by not acknowledging those transpeople who do "produce" their bodily aesthetic in many ways. As is illustrated by those transsexuals who refuse or aspire to normative bodies, and those who reject surgery, or by people who do not have access to the body modification technology they desire for health, or financial reasons, but continue to produce their gender presentations in creative ways (See Chapter IV and Chapter V). Moreover, what the notion of the habitus teaches us is that all consumption can be seen as a primary context of self-production, even though choices may be circumscribed by the limitations of technology (Smith Maguire & Stanway, 2008), by the lack of economic capital, or due to social relations. Transgender subjects are not situated outside their habitus anymore than transsexuals are, and both are analogously situated as social beings with the potential for agency. Finn and Dell's (1999) dichotomy cannot account for the diversity of trans subjectivity, and body modification, choices. Nonetheless, their ideas concerning agentic self-production and socially constructed bodies, in theory, allow subjects to reconfigure values. These insights are relevant for my research, which explores the transsexual diversity when accessing or rejecting body modification practices and personal and public understandings concerning the value placed on passing and non-passing trans bodies.

Symbolic interactions: passing and non-passing bodies

Much early transgender literature was concerned with the notions of "passing" and "non-passing" bodies in the clinical setting (Garfinkel, 1967; Kessler & McKenna, 1978), as a "rite of passage" into femaleness (Bolin, 1988), in relation to how transsexuals manage to minimise stigma through their gender presentation in social and familial settings (Garfinkel, 1967; Kando, 1972). Other work is concerned with the divisions between some transpeople, who find it easier to pass in their acquired gender, and some who do not (Whittle, 2001). In some transgender literature, "passing" refers to the process of fitting in as "unremarkable" men and women (Cromwell, 1999). Sociologists, more generally, have treated passing as a singular "movement" from one identity to another (Kando, 1972), which relies on symbolic verbal and non-verbal cues of bodily aesthetics. Some have suggested that these symbolic cues are accompanied by "biographical editing" in an attempt to hide any signs of male or

female history (Bolin, 1988).

One important insight from Kando (1972) is that passing for transsexuals is an ongoing process. However, Kando argues that passing is premised on different groups of people knowing about the transsexual's history. According to Kando (1972), some transpeople will be able to pass in their acquired gender with new friends and colleagues after transition and body modification. Problematically, however, he also suggests that passing is impossible with older friends and family members, because they tend to "read" the transsexual in relation to their "original" gender, or as transsexual. According to Bolin, there is a price to pay by transsexuals if they interact "with a knowing or sensitized audience [...,] a knowing audience has the ability to imprison them in the category transsexual" (Bolin, 1988: 136) and therefore discredit their identities as women (or men). I suggest that this is dependent upon the bodily aesthetic of the transperson and upon who is judging, as to whether transpeople are recognised as men or women or transsexual. It is generally thought that passing is easier for transmen than transwomen, because of the aesthetic outcomes of hormone therapy (Whittle, 2001). Transmen, who take testosterone, can grow a beard, have their voices break and pass "anywhere, anytime, with great success" (2001: 158). However, relatively few transmen have phalloplasty, yet they are still considered men by their partners, friends, and family. For transwomen, again, I argue that it depends on the judge. However, I suggest that these judgements of transwomen are dependent on different bodily aesthetics than transmen, such as a lack of a penis. Moreover, in my study non-passing is an accepted situation for some transpeople however, "looking good," as opposed to surreptitiously passing, is viewed as more important, as I will explore in Chapter V.

Early theorisations about "passing" in Bolin (1988) and Kando's (1972) work is a top down affair, where social roles are considered dominant enforcers of gender presentation conformity. Social roles are predicated upon social modes of control. Whilst there is no doubt that there are structural sanctions at work in modern society and that governments both past and present take great interest in legislating on, and thus, influencing our understanding of gendered, sexual, unruly, pathological, and healthy bodies, (Foucault, 1991, 1995, 1998 [1976]) this perspective does not adequately cover a micro analysis of the aesthetic body, which may affect the structural parameters of symbolic social control. For example, according to Schrock et al (2005), the "retraining," "redecorating," and

consequent change in subjectivity that transsexuals seem to undergo during, and after transition, where transformations of their bodily aesthetic shape "role taking" and "practical consciousness," secured a certain amount of "bodily sovereignty." This draws attention to how bodily aesthetics "inhabit" the social world and, simultaneously, how institutionalised gendered aesthetics "inhabit" bodies. Thus, cultural artefacts, such as symbols and language and relationships with specific bodily aesthetics, are important to consider, as we apply various standards of value, (aesthetics/ethics) and potentialities to them, depending on our specific perceptions. Perhaps it is the popularity of Lacan's work (1977) for gender studies and in certain feminist readings (Kristeva, 1982; Millot, 1990), that has given credence to claims about the submissive subject "trapped beneath the oppressive weight of political and social institutions that maintain their force at the level of the psyche" (McNay, 2000: 140) and which awards the socio-symbolic aspects of social life such great importance. McNay (2000) calls this the "negative paradigm." The importance awarded to the socio-symbolic order, as McNay (2000) identifies, misses out the possibility of agency, where subjects can rewrite ideology and change experiences within social fields because of the indeterminacy of subjectivity itself. The symbolic "order," then, may be noticeably diverse for different people, because people navigate institutional and cultural symbolic codes on the basis of their embodied experience of them.

From the late 1950s through to the 1970s, the sociologist Erving Goffman provided a serious look at, what, up until that point, had been regarded as the mundane aspects of the everyday social world (Goffman, 1953, 1963, 1967, 1969, 1976). It is important to draw on Goffman's critical symbolic interactionism, because for him, society is contextual and not a homogeneous whole, and he suggested that people act differently in different settings. The context then to be considered is not "society at large," but the specific one(s) in which people find themselves (Goffman, 1969). Goffman (1969) argues convincingly that people rely on a multitude of mechanisms to (re)present themselves in order to, for example, strive for honour and reduce stigma in everyday life. He grounded these observations in an eclectic mixture of empirical material. "Mechanisms," for Goffman, were not objective "facts," but rather actions, and the reasons for them that may be interpreted in many different ways.

Goffman's methods and interpretations paid direct attention to the necessity of presenting

"correctly" (passing?) in social situations and the consequences that came of these successful or failed performances. Along with this, we can see how some bodies may end up being viewed as stigmatised, through other's negative judgements of their bodily aesthetics, particularly by those in positions of power. Goffman's work allows us to analyse various social, spatial, temporal, and intercorporeal situations in minute detail. His micro analysis details how people use body techniques – a term attributed to Marcel Mauss (Crossley, 1995) – to negotiate everyday situations, within which he offers ways for us to consider the roles of bodily form, actions, and symbolic codes. Symbolic codes reflect types of verbal and non-verbal communication we employ in everyday life. These communications use codes, which often reflect and reinforce stereotypes. The codes may also act as "shortcuts" that allow the "maker" of the symbolic code to communicate background information in the most efficient way. With a few exceptions, such as laughing and crying, symbolic codes for Goffman are specific to a (sub)culture. Commenting on Goffman's work, Bourdieu suggests that it grasps "the logic of the work of representation; that is to say the whole set of strategies with which social subjects strive to construct their identity [and] shape their social image" (Bourdieu, 1983: 113).

"Normal appearances," read as "passing," aid the person in attaining social normativity and social standing. These symbolic appearances, or what Goffman calls "body glosses" and "body techniques," help make meanings "clearer" to others, assuming that there is a consensus on what the symbolic codes mean. For Travers (1991), symbolic codes of "normal appearances" neither have intrinsic properties nor are they static. These "normal appearances," then, can act as indicators of social identities, producing bodily techniques and body glosses that orient individuals toward an "agreed" cultural and moral order, which they both value and duplicate (Crossley, 1995). However, orientation is neither automatic nor is it always desired. Whilst this reading is valuable for this study, I think that it does not go far enough in relation to explaining what the aesthetic or symbolic means phenomenologically. Nor does it show how aesthetic values are considered intercorporeally and socially in different spaces and times. This is because "appearances" also have the ability to spawn diverse meanings, and potentialities, depending on the situational aspects of the interaction. Travers observes that:

> Since they [normal appearances] are animated by selves whose every interactional

> self-definition requires more such definition, normal appearances are constantly evolving, and in the evolution of normal appearances the idea of the self also evolves (Travers, 1991: 298).

Shilling's understanding of Goffman, in this respect, is accurate when he states:

> the notions of social classifications and shared vocabularies of the body idiom are simply too vague and abstract [...] we have little idea how they originated and how they are sustained or *challenged* (Shilling, 1993: 88 emphasis added).

Ekins (1997) succeeded in addressing some of these problems in relation to transgender in the UK in answering where, when, and how transpeople aesthetically constituted their identities through time and space. The concept of "male femaling" emerged from an extensive study that took many years to accomplish. Transpeople's behavioural patterns, in Ekins' study, were regarded as biological males doing "femaling" in "various ways, various contexts, at various times, with various stagings and various consequences" (1997: 2), thus illustrating the diverse phenomenology of transpeople. The modes of "femaling" that "emerged" from the grounded theory methodology were "body femaling", "erotic femaling", and "gender femaling." These were looked at through the broader concepts of sex, sexuality, and gender. However, he suggested that the few transsexuals who "moved from less serious to more serious involvement in femaling" (Ekins, 1996: 47) did so within transvestite sub-cultures, where bodily aesthetics were practiced permanently, through technology, or intermittently, with clothing. As my research will show, there are transsexuals who do have a "transvestite career" path prior to the decision to trans-sex, while, there are also many others who do not follow this route, as Ekins permits for in his concluding remarks. Also, Ekins' study did not consider transmen, who are a challenge to "normal appearances" due to the difficulties with, and aesthetic outcomes, of surgery. Furthermore, in Ekins' study we get little sense of the participants-lived-world experiences, when trans aesthetics are "tested" in non-fetishistic cultures, which will affect their sense of social, sexual, and phenomenological aesthetic worth. There is too much emphasis, then, on social symbolic norm-internalisation in this perspective. Whilst understanding "symbolic" performances alongside embodiment paves the way for a social analysis of trans bodily aesthetics we can still not fully understand the values and potentialities of aesthetic bodies

through symbolic hierarchies alone. This is because phenomenologically, socially, and sexually there are multiple aesthetic hierarchies present in all manner of situations, and which are employed by all manner of transpeople. Furthermore, these approaches to "passing" can be critiqued for negating the aspects of transsexual lives that may not be considered within the restraints of social roles, such as transpeople's phenomenological and sexual bodies and relationships.

In later work, Ekins and King (1999, 2006) develop a narrativised sociological analysis of transgendering in the UK. Drawing on Plummer's (1995) narrative methodology in *Telling Sexual Stories*, they suggest that there are various modes of transgendering, which include migrating, oscillating, negating, and transcending stories, and which transpeople utilise to build up a picture of their gender identity. This approach is useful insofar as it highlights some of the incipient processes that transpeople may practice, encounter, and pursue in their transgendering. It also shows how transwomen build a "female world" and female identity. I suggest this is useful for developing an analysis of transpeople in contemporary Britain. However, inner conflicts and tensions with regard to the transperson's embodiment and bodily aesthetic might perhaps be better served through a phenomenological study of trans embodiments and bodily aesthetics, which incorporates socio-symbolic aspects that are meaningful to its participants.

Interacting with Garfinkel

Whilst it is important to understand the symbolic aspects of bodily aesthetics for the transperson - how they are formulated, understood, and how they might challenge categorisations - we must not fall into the trap of giving emphasis to those categories important to us at the expense of those which are meaningful to the participants. Garfinkel (1967), who was a contemporary of Goffman's, reported on the gender presentation of the infamous transsexual Agnes based on thirty-five hours of interviews and "conversations." Garfinkel worked with the sexologist Stoller and the psychologist Rosen, who had previously diagnosed Agnes with Testicular Feminization Syndrome, albeit that Agnes apparently had an unusual case of it. Testicular Feminization Syndrome – known more often, now, as Androgen Insensitivity Syndrome – is classified as an intersex condition, which causes XY foetuses to feminise in uterus. Agnes was thought to have feminised at puberty (1967).

Garfinkel's ethnomethodological description of Agnes was premised on the notion that she was "passing" as a "normal" woman. Noting Agnes' "vital statistics" of 38-25-38 twice in the opening paragraphs of his report, Garfinkel suggests that these were important indicators of Agnes' "true" (inter)sexuality and were crucial in his analysis of her gender presentation. Garfinkel went into great detail about Agnes' aesthetic presentation, which was the primary gauge of his "common sense" analysis. However, this "common sense" analysis fails to acknowledge both his position as a white Western male and the gendered social experiences he encountered throughout life.

Agnes' facial and bodily features and sartorial presentation were described as unremarkable when compared to women of her own age and class, illustrating that she was measured against and successfully "passing" the aesthetic criteria derived from Garfinkel's "gender belief system" (R. Stoller, 1985). As Rogers (1992: 207) argues it shows that, like other (sexological) scholars, Garfinkel drew upon contemporary sociocultural values, most crucially ones concerning normative femininity and masculinity. The bodily aesthetic markers that Agnes' was compared to, in order to distinguish her from "sexual deviants," such as transvestites, was based on the assumption that all transvestites wear "garish" clothing and are "exhibitionistic." A reference to Agnes' voice in relation to "feminine appearing male homosexuals" was the closest Garfinkel got to aligning her bodily aesthetic to the "pathology" of the homosexual or transgender subject. Agnes was not thought of in these ways because she did not look out of the ordinary when compared to her contemporaries, at least according to Garfinkel. This highlights the immense influence that aesthetic signifiers play in the acceptability, categorisation, and recognition of transgender in researchers' reports in relation to normative bodies and their default sexed positions. Garfinkel constantly falls back into an intrinsic biological binary sex model. His account is intimately enmeshed in biological understandings of what constitutes a "normally sexed" and "natural" body, upon which femininity is represented as the appropriate gender expression. This analysis is theoretically limited because it does not take account of the diversity of trans bodily aesthetics that are recognised today. What if Agnes' presentation had been of a non-normative femininity? Would Garfinkel's analysis have been the same? Would her "true" gender have changed?

Phenomenology in transgender studies

Henry Rubin's (2003) acclaimed study of transmen and FtMs claims to illustrate his participants' phenomenological experiences situated within genealogies. He clarifies how his research participants construct meanings within historically specific sets of categories and structural conditions (2003). Drawing on Sartre's theory of the body, Rubin provides a phenomenological analysis of transmen as situated within "overlaid" bodies. These bodies can be described as follows: the "body-for-the-self," which is the site from which the world unfolds for us, from which a point of view is established. The second is the "body-for-others," an object, which can be seen and touched and so on. It is a corporeal reality for others and is also the "alienated body," where the subject is "vividly and constantly conscious of his [*sic*] body not as it is for him [*sic*] but as it is for the Other" (Sartre quoted in H. Rubin, 2003: 27). Rubin suggests that transsexuals are positioned in this second alienated body. He observes that Sartrean phenomenology has:

> split levels of bodily ontology [which] provide a particularly apt system for describing transsexual experience. Transsexual men have a body consciousness, a body image that is at odds with their second-level bodies, their physical bodies. They are in Sartrean terms alienated bodies. "[T]he existence of my body for the Others" (Sartre 1956, 353) sounds like nothing other than a transsexual's painful realization that his flesh, his body-for-others is female, and not what he sees in his body image (H. Rubin, 2003: 29).

However, to buttress this abstraction, Rubin teams it with a pair of Merleau-Pontian concepts in order to explain the alienation that transmen feel. He uses "agnosia" – the inability to recognise familiar objects – where the transman *fails* to recognise his female-bodiedness, and the phantom limb" – which is supposed to account for the "fantasization of a penis and a scrotum" (H. Rubin, 2003: 29). According to Rubin, agnosia allows transmen to have a body image consciousness that does not directly correspond with their physical bodies. In his 1927 meditation on ego formation, Freud (1960 [1927]) also insists on a distinction between the body's real surface and one's body image, as a mental projection of this surface. The projection may create a discrepancy between corporeal referent and psychic projection. Freud notes:

> A person's own body, and above all its surface, is a place from which both external and internal perceptions may spring. It is *seen* like any other object, but to the touch it yields two kinds of sensations, one of which may be equivalent to an internal perception. [...]. Pain, too, seems to play a part in the process, and the way in which we gain new knowledge of our organs during painful illnesses is perhaps a model of the way by which in general we arrive at the idea of our body (Freud, 1960 [1927]: 19-20).

Rubin claims that the space between consciousness and the physical body – the "psychic" and the "physiological" – is bridged by the transman finding "a means of linking the "psychic" and the "physiological," to each other to form an articulate whole" (Merleau-Ponty, 2002 [1962]: 77) via the body-for-itself project of transitioning. This "whole" is theorised as "body imaging" (Prosser, 1998), which I will explore below.

Rubin maintains that FtM transitioning is a situated, contextual project of "authenticity" based on principles and demands of gender recognition from others. Gender recognition by others is, for Prosser,

> in both its medical and its autobiographical versions [...] depend[ent] upon an initial crediting of this feeling as generative ground. It demands some recognition of the category of corporeal interiority (internal bodily sensations) and of its distinctiveness from that which can be seen (external surface): the difference between gender identity and sex [...] serves as the logic of transsexuality (Prosser, 1998: 43).

Whilst the Sartrean dimensions of the body are useful in understanding the various situational aspects of bodies-in-the-world in Rubin's work, the aspects of (mis)projection, agnosia of the surface of the body, and the phantom limb (the "opposite" pathology to agnosia), are less convincing. Agnosia is "the absence of *ability* to recognize the form and nature of persons and things" (translators note in Merleau-Ponty, 2002 [1962]: 145 emphasis added). Agnosia, as Rubin notes, is not a conscious decision, but a phenomenon, which somehow results in the refusal to acknowledge body parts, which, thus affects body imaging. Rubin, echoing Prosser's analysis, claims that many transsexuals in his study did

not acknowledge aspects of their post pubertal bodies, and thus asserts that these were cases of agnosia. However, I argue agnosia is rarely experienced as this would inevitably undermine the concept of "betrayal," which Rubin utilises to consider the experience of when a transman's body feminises at puberty. If the transman suffers from agnosia then there would be no feelings of "betrayal" by the body because those body parts that aid in the development of body imaging would hold no significance. Furthermore, in relation to Prosser's (1998) suggestion that agnosia helps explain the "wrong bodied" feelings of transsexual embodiment, I suggest that it would actually undermine, rather than "underline," any sense of a "wrong body" due to non-acknowledgment of body parts. In fact, acknowledgement of the body by the transperson is paramount otherwise there would be no intention to change it. Ignoring body parts until it is possible to reconstruct them – if this is what the transperson intends – is not the same as agnosia.

Moreover, the phantom limb in Merleau-Ponty's (2002 [1962]) work, is conceptualised in relation to severed/amputated body parts and the repression of the feelings about the loss of the limb. He states that this

> repression is [...] the transition from first person experience to a sort of abstraction of that existence, which lives on [in] a former experience or rather the memory of having had the memory (Merleau-Ponty, 2002 [1962]: 96).

It is not that all transmen do not fantasise about acquiring a penis (H. Rubin, 2003) that I take as misleading in Rubin's account as this is a minor point of refutation. The most fundamental mistake in Rubin's analysis is that the transman can not repress feelings about a lost limb, because he never had the penis to begin with. "Phantom limb" suggests an ongoing "natural" psychic malfunction rather than a metaphysical problem. By using this concept, Rubin unduly pathologises the transsexual subject. Whereas Rubin focuses on transmen only, Prosser (1998) uses this conceptual framework to consider both transmen and transwomen. Prosser suggests that:

> [The phantom limb] in the case of the transsexual, the body constructed through sex reassignment surgery is not one that actually existed in the past, one that is literally re-membered, but one that should have existed; sex reassignment surgery

> is a recovery of what was not (Prosser, 1998: 84).

Prosser is utilising the phenomenological concepts of agnosia and phantom limbs to perform "discursive gymnastics" (Hird, 2000) which make points about transpeople's "phantasisation" and imaginative anticipations of surgery, rather than pathologising agnosia and phantom limbs as Rubin did. By utilising Merleau-Ponty (2002 [1962]) and Schilder's (1935) understanding of body images as imaginatively anticipated scholars might begin to free the transsexual from this theoretical bind and pathology, and help to theorise the roles that desire, imagination, and agency play in trans bodily aesthetics. These body images do not, however, "appear" purely from the self but require social and, possibly, sexual interaction too as I will explore in chapters IV and V.

Gender and transgender "body image" literature has been developed over the last few decades (Crossley, 2005; Fallon & Hausenblas, 2005; Featherstone, 1999; M. Finn & Dell, 1999; Marone et al., 1998; Money, 1996; Yamamiya et al., 2005) and has often been understood in relation to psychological, psychiatric, and medical discourses (M. Finn & Dell, 1999). In this literature body image practices are often deemed problematic and disordered because they draw on "negative" types of body image management (1999), such as "body dysmorphia" (Phillips & Dufresne, 2000), anorexia nervosa (Bordo, 1993), and transsexual surgery (M. Finn & Dell, 1999). Merleau-Ponty (2002 [1962]) claims that subjectivity is only possible through the construction of a coherent body image (coherent does not necessarily mean normative). Using Schilder's (1935: 174) notion of body image, which suggests that the image is built up to a whole only momentarily, through various developmental processes and stages, such as the "mirror stage" in childhood and subsequent intersubjective "intercourse," Merleau-Ponty maintains that considering body image equilibrium(s) is necessary to overcome the problem of understanding how we know the world around us. Thus, body image is contextual and situational in its relation to the world and "to others and their iterations" (Salamon, 2002: 48). Merleau-Ponty's interpretation is of a body that can

> model itself on the other's, and the subject projects himself [*sic*] or loses his [*sic*] separate reality in the other, becomes identified with him [*sic*], and the change of co-ordinates is pre-eminently embodied in this existential process.

The transformations which body image undergoes in reaction to interactions with others, and the different situations experienced are not the only recognised processes and stages that sustain body image. Schilder (1935) and Merleau-Ponty (2002 [1962]) both suggest that body image can also be "corporeally anticipated" (Weiss, 1999). According to Weiss:

> while Merleau-Ponty is primarily thinking here about future actions and how they can be corporeally anticipated in and through the body image, Schilder emphasizes the role that fantasies and imagination play in constructing and reconstructing body image [...] Indeed, Schilder goes on to claim that each individual has "an almost unlimited number of body images (Weiss, 1999: 9).

This claim has not been developed in phenomenological studies of transgendering. I suggest that this framework can be utilised to incorporate the phenomenological, social, and sexual descriptions of (trans)bodily aesthetics.

Leaning on feminist phenomenology

Feminists following Foucault, for example, have illustrated that body image is not the only site to consider in understanding the body (Weiss, 1999). There is much to be gained from theorising the Merleau-Pontian concept "body image" in conjunction with experiences of hierarchal power relations, which differentiate between bodies on grounds of gender, race, morals, (technological) ability and disability (1999), to name a few. This allows us to interpret a subject's gender identity as an effect of the value placed on bodily aesthetics rather than purely as an attribute related to "natural" dichotomised gender.

Silvia Stoller (2005) uses a phenomenological approach to suggest that the asymmetry between the sexes constitutes the ontological categories of men and women. What she derives from this observation is that sexed, lived relations can never be symmetrical. Taking to task the vision of feminists who try to overcome political asymmetries between men and women in order to eradicate social inequalities (de Beauvoir, 1997 [1949]), Stoller postulates that it is not the asymmetry per se that accounts for the "political, ethical and social" (S. Stoller, 2005: 8) inequalities, but the evaluation of differences, which affects the ensuing treatment of the sexes.

Problematically, however, Stoller assumes that symmetry takes place between all men and between all women. In relation to transsexuals she suggests that:

> it remains questionable whether a *complete* change of gender identity can actually take place. Based on empirical data, sociological studies on transsexuality have shown that the identification with the new sex is not entirely unproblematic [...] This means that the difficulties of living with a new identity cannot be eliminated once the transsexual has made use of all his or her technical, medical, and legal possibilities. Here studies on the phenomenology of temporality have shown that the past is retained in the present as a dimension of the past (S. Stoller, 2005).

While I agree that this is paramount in understanding trans bodily aesthetics, I would like to paraphrase Dean Spade: Stoller (2005), who "picnics"

> on transsexual identity [in her] work to undermine transsexual alteration stabilize[s] exercises of normative gender production, even while they suggest that gender destabilization is their goal (Spade, 2006: 319).

The fact that everybody has historically different lives to others would render everybody asymmetrical, not solely transpeople. Stoller's (2005) assumption, here, is that transpeople discard some of their historical individuality in the construction of their gender identity and by default, therefore, become only an approximation of their acquired gender. I suggest instead that embodiment and bodily aesthetics are pursued precisely in relation to transpeople's specific history and their particular habitus.

Nonetheless, taking the idea that sex/gender differences can never be symmetrical (Braidotti, 1994b; Irigaray, 1985) because of the historical and material aspects of lived experiences – both economic and bodily – Stoller claims that this is the only conceivable way of understanding "the other" without reducing "the other" to the same (S. Stoller, 2005). Asymmetry also undermines the possibility that the standards of one person is, or should be, the goal of the other. These claims go unexplored in any great depth, which leaves a gap in knowledge about trans bodily aesthetics. For transgender studies we can

utilise the phenomenological concepts of "intentionality" and "asymmetry," which I will change to the less overstated concept of "difference," in relation to trans bodily aesthetics to look at multiple subject positions and to renounce judging "right" and "wrong," "passing" and "non-passing," "beautiful" and "monstrous," transsexual bodies. Difference(s) and intentionality can help convey the materialisation of difference by recognising the aesthetic tactics "deployed, defended, subordinated, marketed or manipulated and how [...] these tactics intersect with [trans]gender and value" (Colebrook, 2006: 132 my insertion in parenthesis) socially, sexually and phenomenologically.

Conclusion

This review explored key transgender, feminist and aspects of the phenomenological approach, to embodiment and bodily aesthetics. The purpose of this chapter was to highlight my analytical stance in the thesis. Questions concerning embodiment, bodily aesthetics, and beauty that have been previously debated have often ended up as dichotomous moral arguments based on what are viewed as "good" or "bad" practices. This was illustrated by my discussion of radical feminist theorising about transsexual practices of "duplicitous" embodiment, trans theorisation about Cartesian "right" and "wrong" bodies, and the dichotomisation of transsexual/transgender politics. All of which could only highlight two sides of the (political) divide in relation to intrinsic or constructed aspects of gender appearances. Moreover, I suggested that binary positions produce divisive and unproductive theorisations about trans embodiment and bodily aesthetics. However, I contend that if we assume diverse positions, and utilise the particular strengths of symbolic interactionism as well as the phenomenological aspects of embodiment and body images, we can ask productive questions concerning the tactics employed in attaining, subverting, or even enjoying bodily aesthetics. This will develop a more sophisticated understanding of transsexuals and their bodily aesthetics.

Chapter III: Methods, Methodology and the Research Process

Epistemological and analytical approach

The thesis draws on feminist and Merleau-Pontian phenomenology (de Beauvoir, 1997 [1949]; Merleau-Ponty, 2002 [1962]) that asserts that the basis of all meaning is first and foremost a bodily experience, which is engendered by an active relationship between the human and *their* world. A phenomenological study is a study of experiences, actions and practices and their meanings (Heinamaa, 1997). In combining the two definitions what this means is that this research is interested in the coexistence between the lived-body and its world, which allows an opportunity to develop conscious awareness and attitude – known as intentionality – and knowledge of the self through experiences. The body experiences and feels prior to articulating those feelings, experiences and knowledge. Thus, all knowledge is embodied and situated in the world that subjects occupy. Stoller (2005) suggests that the notion of asymmetry (difference) can account for the different social horizons that men and women encounter in their relationship to the world. She argues that asymmetry exists between the sexes, which is in some ways is understandable, in relation to various analogous social standards, discourses and life chances. However, her understanding of these differences is reductive in other ways, as, to suggest that men as a group and women as a group have similar experiences of the world, because of an analogous gendered history, this theoretical position assumes each man and woman experience analogous structures, bodies and so on in the same way (de Beauvoir, 1997 [1949]; S. Stoller, 2005). Nonetheless, the concept of "difference" is utilised in this research to highlight the analogousness and diversity of *queer* horizons and intentionality, which acknowledges the historically similar connections and disjuncture between transpeople in this research – and is a useful analytical perspective from which to explore the phenomena of transsexual embodiment and bodily aesthetics. My analytic stance for this research then, comes from a queer phenomenological perspective (Ahmed, 2006), which acknowledges that the social world is actively produced through everyday experiences, understandings and practices, but "orientate" from different positions and "orientate" within different horizons. Thinking, active subjects construct their realities through and within their lived-horizons (Shapiro, 1985). From this perspective I can explicate multiple realities within the relationships between transpeople and their social world. I will explore aesthetic social practices (Burkitt, 1999) and experiences of

transsexual subjects in the legal-horizon(s) and medical-horizon(s) (I have called the medicolegal) the transperson experiences.

This perspective is different from many of the transgender/transsexual studies as it moves away from the deconstructive and purely discursive accounts of transsexualism (Bornstein, 1994; Butler, 1993; Prosser, 1998; Stone, 1991), whilst not abandoning the discursive fully. Deconstructive and discursive approaches have highlighted that experience is historically specific and discursively produced (Davies, 1992; Scott, 1992), which allows us to understand through the reconstitution of narrative accounts the recollections and experiential factors of lives.

Although closely linked to the ethnomethodological studies (Kessler & McKenna, 1978, 2000, 2002) of transpeople, my research features trans subjects as diverse phenomena, which questions the "medically constructed" theories (Hausman, 1995, 2001; Raymond, 1980), which assert that the transsexual is purely a product of medical technology and medical language. I challenge sexological accounts using the phenomenological approach by de-homogenising the transsexual subject and exploring the lived world perceptions of diversely situated subjects.

My epistemic view upholds the responsibility of knowing the subjects and because these are my epistemic responsibilities I must offer my own accountability to the reader (Code, 1996). Following a phenomenological perspective my epistemological position stresses that knowledge should, primarily, be derived from people, actions, and the meanings of those actions to those people. However, it is important too, to stress that the research situation can be viewed as another specific intersubjective horizon, which may generate a specific kind of knowledge led by the design of the research and its focus. I acknowledge then that objectivity is impossible in the Enlightenment sense, of discovering data that is truly separate from the researcher who helps generate it; however, experiences and the recording of those experiences in the research setting are important sources of evidence. I saw participants as "active co-participants in the relationship within which the interview data was produced" (Hollway & Jefferson, 2000: 87).

Designing the research and reflecting on methods

The research covered three main themes. The first of these was to explore how transpeople understand and experience their aesthetic bodies. The sample was interviewed using life histories, which as Ken Plummer (2001) suggests can be a most effective method for eliciting details about subjective experiences. Connell (1991: 143) states that life histories have the capacity to reveal "social structures, collectivities and institutional change at the same time as personal life", all of which is useful for this thesis. In addition, "because it [the method] emphasises the temporal and existential specificity of a person's experience, it does not render such experience a mechanically determined outcome of social structure and culture" (Bryant & Schofield, 2007: 323), but allows for agentic aspects of lived relations. The combination of the life history method and the phenomenological approach helps to deal with all aspects of the dialectical interrelations between experience, memory and participants' narratives in the research setting. In the research setting I requested that the participant speak on a theme until they had no more to say within this particular sequence then I asked questions about issues relevant to the research and that had been expressed in the sequence to gain a more in depth account surrounding the theme. From these responses more questions were instantaneously formulated and asked within the interview or in a follow-up interview by email. This method is premised on the narrator "telling it like it is" from lived experience and provides a way for evaluating the present, past and anticipating the future (Letherby, 2003).

At the stage of choosing participants I asked whether they would talk about some photographs of themselves. All the participants I contacted to take part in the research said that they were willing to do this. In the research setting I requested that the personal photographs should depict different stages of transitioning/bodily aesthetics/ body parts in different spaces with friend, family and partners. This use of photographs in the interview is commonly known in the methodological literature as "photo-elicitation" (Collier, 1957; Emmison & Smith, 2000; Harper, 2002). Much of the literature surrounding photo-elicitation suggests that the benefits are immense, for example, photographs are said to generate responses that would have stayed dormant in conventional interviewing (Collier, 1957). Submerged feelings and emotions may be stimulated by viewing a photograph not seen for a while. My feelings of the interview, whilst using this method, were that it completely changed the "colour" and structure of the interview, for the better. In my

research, the photographs were a way of eliciting the metamorphosis of sex-changing, and the feelings of how bodily aesthetics (temporally and spatially) were recollected and contemporarily experienced. The initial reactions were telling of actual feelings about their bodily aesthetic in the photograph, which I noted in my research log book. The contemporary experience of the photograph was important in understanding how participants felt about their bodily aesthetics over time. Moreover, this visual method encouraged free floating narratives and shattered shielded replies about their bodies.

Collier (1957: 859) suggested over a half century ago that a photograph is a "restatement of reality; it presents life around us in new, objective, and arresting dimensions, and can stimulate the informant to discuss the world about him [*sic*]." The rationale behind this photo-elicitation method in my research was a simple one. At some point in the interview – in this research it was when the interview was "slowing down" – I asked the participant to choose the photographs they would like to talk about. I had not previously thought about the problems that would amount if they only talked positively about aspects of their bodily aesthetics – for instance, wanting to only talk about themselves in a good light – however, luckily this was not the case. It was surprising to find that most participants spoke about the photographs in both positive and negative ways. Nonetheless, even if the narratives were all positive it would have still allowed the dialogue to be primarily generated by the participant rather than led by the researcher. All of the participants explored and elicited various stages, spaces and intersubjective accounts of bodily aesthetics within the photographs, with little prompting.

The use of this interview technique yielded several more benefits, firstly participants responded often without hesitation. Moreover, by providing participants with a task similar to a naturally occurring conversational event, the peculiarity of the interview situation was circumvented to a degree, allowing it to become more spontaneous and conversational as well as more directed toward bodily aesthetics.

This visual method encouraged diverse personal narratives as opposed to what has been called "rehearsed narratives" (S. Hines, 2007). "Rehearsed narratives" are perhaps more likely to appear in the stories told by people who have knowledge of theoretical debates and concepts about their (usually) non-normative lives, for whom reflection on the concepts and

debates are an important process of identity construction. Whilst these aspects are important phenomenologically and were generated in the research setting; I wished for, in the words of Stone (1991), "truthful specificity." By using the photo-elicitation method, it generated wide-ranging explanations of lived world experiences.

The second theme of the research was concerned with how transpeople differed in their understanding of body modification practices and aesthetic bodies. I used the same biographical narrative method and photographic visual stimuli. This part of the research uncovered how hormones and surgical interventions are experienced by the diverse sample of transsexuals and how this affects their lived experience. Through this theme participants explored the extent to which understandings of masculinity, femininity and sexuality impact on them, relative to body modification and bodily aesthetics.

Finally an investigation in to how transsexuals fostered relationships and negotiated their subject positions within the political groups and their discourses and medicolegal institutions and their discourses, such as clinicians and the GRP and how these affected understandings of their bodily aesthetics and gender identity – again using the same interviewing methods. I looked at the negotiations between transpeople and politics, doctors and law when considering body modification and bodily aesthetics. This garnered significant personal understandings of structural constraints and freedoms in relation to political affiliations, medicine and the GRP and GRA. Furthermore, to be true to the phenomenological approach, I can not assume ideology and structure within the medicolegal and political relationships and must be informed by the experiences of participants in relation to the relationships fostered. Ideology and structure are only "there" if the subject reflects on experiences of them being "there." I wanted to find what transsexuals, political groups, medicine and the GRP, consider an adequate commitment to a gender identity in relation to bodily aesthetics. With a focus on these factors I explored evidence of whether the GRA 2004 queers the past and present diagnosis of transsexualism – that is challenges the medicolegally ascribed dimorphic body system.

Access, sampling and selection

There were some access issues that needed addressing. Although I felt confident that my access to a wide ranging sample from the transsexual population would not be a cause of

concern due to my existing knowledge of the transgender community (I have worked independently on political issues that Press for Change have circulated as politically relevant, such as local legal and health forums and petitions to members of parliament). I was, however, aware of the fact that the transsexual population are researched repeatedly, by journalists, television shows and so on. However, in light of my focus on aesthetics and the newly implemented GRA, this I assumed would offer a range of topic areas that has not been talked about in research by transsexuals, thus, reducing the possibility of participant refusal on the grounds that it had been covered before.

I used purposive sampling, which originated from a snowballing technique where sometimes participants suggested other participants from their own networks of friends and colleagues. The snowballing strategy commenced through some personal contacts, transsexual organisations and forums. I placed a "Call for Participants" (see appendix) on Press for Change's e-mailing list, which generated over a hundred responses and information requests about the research. Following up on all the responses, I requested a Participant Information Sheet (PIS), (see appendix) to be completed. The returned PISs were then used to contact people from all over the UK to arrange interviews. My sampling strategy tried to include a diverse range of ages, gender, sexuality and race, but did not expect it to be representative of the UK trans population.

I used a sampling strategy in order to explore the diversity and commonalities of the transsexual community. As the interviews with transsexual subjects were between one and two and a half hours long, I had a small sample of twenty three. The sample specifically focused on those whose have had or plan to have surgeries and use body-modification technologies and those who do not or can not have surgeries or use body modification technologies. I made judgements about participants that were most relevant to my analytical considerations. For example, from the PIS, which potential participants had returned to me, I chose people who I thought would offer intimate details of their body modification practices and their understanding and experiences of aesthetic practices or intimate details about not being able, for whatever reason, to modify their bodies. If the potential participant filled in extra information or said that they were willing to talk about personal photographs of themselves on the participant information sheet or responded positively through email I followed this lead and tried to arrange an interview. Also, I

selected those who did not rely upon traditional technologies to express their bodily aesthetic and gender identity and instead relied upon other aesthetic practices, such as clothing. I made sampling judgements about participants on the basis of their transition status, for example whether the participants were post-operative, part-operative, pre-operative or non-operative and tried to include people at different stages of transition. Age played another factor in my sampling choices and I tried to include a whole range of ages. These multifaceted choices I assumed would generate narratives, which would add to the differences between trans-sexing narratives. I also chose participants loosely on their class position. Social class was more difficult to evaluate, however, I did make some choices on the basis of career/ job/student and whether they lived in a village, town or city. The principles of "purposive" sampling employed in selecting participants helped me enhance my sample coverage and provided the framework of "difference" and multiple horizons for analysis, I did this to illuminate subtle but potentially important differences (Barbour, 2001), rather than to generate a representative sample of the transsexual population.

A follow-up email interview was conducted to develop the narratives provided and explore the meaning frames of the participants. Unfortunately only twelve out of twenty three participants responded to my emails. Nonetheless, of the twelve participants most added more in depth explication of experiences and clarified points of confusion I had had. I also offered participants the chance to read their transcripts and parts of the analytical chapters they featured in, to comment on or critique my analytical and theoretical points. One participant wanted to change some details in their interview transcript. None of the participants wanted to change analytical or theoretical points.

The sample[13] and other demographics

I interviewed thirteen transwomen and eight transmen and one person who had had male to female SRS but had decided to live as transgendered with a more masculine aesthetic. The age range of the sample ranged from twenty two to sixty years old.

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[13] I have used the gender identification and other information as stated on the participation information sheet provided by participants. This also includes the "name of choice," where participant chose their own pseudonyms. Some participants did not choose a pseudonym so I have created them myself in the name of anonymity.

AGE	M2F (Transwoman)	F2M (Transman)
22-25 years old	**Anna-Marie** (pre-op[14]/hormones) **Emily** (post-op[15]/hormones)	**Oscar** (pre-op) **Clifford** (pre-op)
26-35 years old	**Samantha** (Post-op/hormones/AS[16]) **Octavia** (Post-op/hormones)	**Benjamin** (post-op)
36-45 years old	**Brian** (post-op[17]/hormones)	**Jackson** (part-op[18]/hormones) **Gregory** (non-op[19]/hormones) **Kenneth** (pre-op/hormones) **Raymond**(part-op/hormones)
46-55 years old	**Courtenay** (post-op/hormones/AS) **Diane** (post-op/hormones) **Nancy** (post-op/hormones/AS) **Amelia** (post-op/hormones) **Penny** (post-op/hormones/AS)	**Daniel** (part-op/hormones)
55+	**Mariza** (post-op/hormones) **Jess** (post-op/hormones/AS) **Bernadette** (post-op/hormones) **Karen** (pre-op/hormones/AS) **Lesley** (pre-op/hormones)	

Pen portraits

Amelia: is a 52 year old white female who lives in a town. She is heterosexual and is married to her long-time partner. She is a self-employed historian and writer. Amelia has a Gender Recognition Certificate (GRC) and amended birth certificate.

Anna-Marie: is a 25 year old white female who lives in a large city. She works full-time in IT. She is single and describes herself as bisexual but more heterosexual. She is planning to apply for a GRC.

Benjamin: is a 26 year old white British male who lives in a town. He works full-time in retail. He is not in a relationship and describes himself as heterosexual. Benjamin has his GRC and amended birth certificate.

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[14] Pre-op refers to all those who have not undergone any surgery.
[15] Post-op refer to those who have had genital reconstructive surgery.
[16] AS refer to facial aesthetic surgery to the face or body.
[17] Brian was considering phalloplasty at the time of the interviews and had started taking testosterone by the time of the second interview.
[18] Part-op refers to those who have undergone double mastectomy to remove breasts.
[19] Non-op refers to those people who do not wish to or can not undergo surgery.

Bernadette: is a 60 year old white British woman who lives in a village. She is retired but works as a magistrate. Bernadette is in a relationship and describes herself as lesbian. She has a GRC and amended birth certificate.

Brian: had had MtF surgery when I first interviewed him as a transwoman. At the time of the interview he was thinking of beyond male and female with a more masculine aesthetic. In a subsequent email interview, Brian had started to live with a more masculine aesthetic. He is a 42 year old Scottish white bi-gender, who lives in a large city. He is an actor. He was not in a relationship and regards himself as asexual. Brian does not intend to apply for a GRC.

Clifford: is a 22 year old white Scottish transgender male who lives in a village. He is volunteering after a long term illness. Clifford is in a relationship with a man and describes himself as pansexual. The GRC is not a priority at the moment.

Courtenay: is a 48 year old white British female who lives in a city. She works full-time as a civil servant. Courtenay is not in a relationship and describes herself as Bisexual. She has a GRC and amended her birth certificate.

Daniel: is 47 year old white British male who lives in a large city. He is a self employed sex worker. Daniel is currently not in a relationship and describes himself as "a bit gay." He may apply for GRC.

Diane: is a 51 year old white English post-op woman who lives in a city. She is long-term disabled. Diane is not in a relationship and describes herself as lesbian. She has a GRC and amended birth certificate.

Emily: is a 27 year old British white transwoman who lives in a city. She works full-time as a civil servant. Emily is not currently in a relationship and describes herself as lesbian. She will apply for GRC if and when she decides to have a civil partnership.

Gregory: is a 40 year old white British male who lives in a town. He is a student and has a disability. He is not currently in a relationship and describes his sexuality as genderqueer. Gregory has a GRC and an amended birth certificate.

Jackson: is a 45 year old white British transman who lives in a town. He works full-time for the local council and is trying to set-up his own business. He is "sort of" in a relationship and describes himself as heterosexual. He plans to apply for a GRC.

Jess: is a 56 year old white Anglo Saxon transwoman who lives in a hamlet. She works pat-time, is a student and volunteers as a trainer on transgender issues. She is currently in a

lesbian relationship but considers herself bisexual. Jess plans to apply for a GRC, but must annul her marriage to an ex-partner as part of the GRC process.

Kenneth: is a 43 year old white British Celt who lives in a town. He works as a civil servant and a student. He is in a relationship and describes himself as queer. He plans to apply for GRC.

Karen: is a 55 year old white European transgender female who lives in a town. She works full-time in social services. Currently she is not in a relationship and is unsure about her sexuality, but says she is probably a lesbian. Karen is not planning to apply for GRC at the moment.

Lesley: is a 58 year old white British female who lives in a village. She is currently unemployed, but has trained as a librarian. She has divorced through mutual consent to apply for GRC and has received her birth certificate.

Mariza: is a 57 year old white Slavo-Celt female who lives in a small city. She is a full-time mature student. Mariza is currently in a relationship and now describes herself as heterosexual; she has been married to women in the past. She has received a GRC and an amended birth certificate.

Nancy: is a 51 year old white European female who lives in a hamlet. She is looking after the home. Nancy is in a relationship and describes herself as probably bisexual. She plans to apply for a GRC.

Octavia: is a 32 year old white female Goth and lives in a city. She is a full-time university researcher. Octavia is married to a woman and describes herself as Bi. She hopes to apply for GRC, but is presently going through a court case to have her marriage recognised.

Oscar: is a 25 year old white British transboy who lives in a city. He is a full-time student. Oscar is in a relationship and describes himself as queer/pansexual. He may possibly apply for GRC in the future.

Penny: is a 55 year old British white transwomen who lives in a large city. She work full-time, but specifically asked me not to disclose her line of work. Penny is currently in a long-term relationship and intends to get married shortly. Pre-transition she described herself as gay/queer and is mainly attracted to males. She plans to apply for GRC.

Raymond: is a 30 year old white transman who lives in a large city. He works as a teacher. Raymond is not in a relationship, but has sex with men.

Samantha: is a 32 year old white British post-op female who lives in a town. She is currently long-term sick and doing some voluntary work. She is not in a relationship at the moment and describes herself as bisexual. Samantha is planning to apply for a GRC.

Pen portraits of Trans-Community Organisations (T-CO)

GIRES was founded in 1997. The membership consists of both transpeople and non-transpeople. GIRES' approach is based on research into the aetiology of "atypical gender identity development" and transsexualism. One of its primary aims is to develop good practice guidelines, education programmes and literature for various professional audiences and transpeople. In addition, GIRES offer awards for research on aspects of gender variance and promote education about transgender. GIRES also offer bursaries for travel and grassroots educational work, in various locales that is taken on by transpeople on a low income. GIRES is a charity and is bound by charity law. GIRES' mission statement states:

> GIRES' first priority is to help those who are already experiencing some form of disadvantage, the charity intends to monitor very closely developments in the science relating to gender identity. GIRES recognises that identifying the biological determinants of gender identity and intersex conditions helps society generally to understand and accept that those they affect are naturally transgendered. The understanding that gender dysphoria is not a fantasy is especially important. However, the cost of research in this field is far too high for the charity to have a realistic possibility itself of obtaining the necessary funds. It therefore intends to keep abreast of the extensive research that other organisations are conducting in this field and produce papers that summarise and interpret the findings. GIRES recognises the risk that research into causality may lead on to searches for ways to prevent the conditions pre-natally rather than to make life better for those they have already affected. However, it is powerless to curb the intellectual curiosity of the scientists working in this field (Reed, 2006).

Press for Change is an organisation with many members and is known worldwide. Prior to 1996 Press for Change did not have a website. In the interim years the website has grown to what the organisers (justly) boast as a most "comprehensive" collection of information about campaigns, healthcare, politics, law, research, books and audio, press releases, media

coverage and archival materials about transgender and transsexualism. However, much of the organisations output is inn relation to law and social policy. Press for Change's mission statement states:

> Why we are here: Press for Change is a political lobbying and educational organisation, which campaigns to achieve equal civil rights and liberties for all trans people in the United Kingdom, through legislation and social change. This site is here to explain our work, and to support all those who campaign with us to achieve full equality and rights for gender diverse people in modern society. Nowhere else in the world will you find such a comprehensive collection of information about the trans rights campaign, and details about the legal, medical, political and social issues surrounding the people it represents. If you're a trans person, we aim to raise your consciousness. If you're a researcher or a journalist we want you to have everything you could possibly want to report us accurately and fairly. If you're a campaigner already, we want to provide you with the very best resources. And if you're not, we'd like to show you what an astonishing challenge we continue to face even though many fundamental forms of protection are now in place through UK law (Press for Change, 2004).

And Kaffequeeria is a DIY queer space where a number of events take place. Kaffequeeria focus on providing a safe space in which LGBTIQ people can experiment with representational work, and organise film, music, theatre and educational events. It is also used for engaging in non-mainstream politics, such as anarchism and queer. It provides information about events through the internet, such as through *Yahoo groups* and *Facebook*. Kaffequeeria's website states:

> Kaffequeeria is a queer collective based in Manchester. Not wanting to buy into the commercial gay scene we are creating spaces to share with like minded folk, putting on the sort of diy non profit events we'd like to go to. Most of these are based round the wonders of music and food (Kaffequeeria, 2006).

Kaffequeeria is a group that co-operates with and promotes many (gender) queer events throughout Manchester and has links to Queer Mutiny and other queer DIY groups throughout the UK. My analysis, in this part of the thesis, also engages with a particular event called "GetBent," which brought together an array of queer productions from 24th August and 1st September 2007. Its website states:

> Get Bent is a safe space for all genders and sexualities and seeks to engage with and foster the possibility of creating queer-positive spaces. Get Bent challenges the notion that you have to act or dress a certain way to be accepted. Get Bent follows a DiY ethic, creating wide variety of programming by supporting diverse people to create diverse events. Get Bent provides an alternative to commercial gay spaces by creating a queer autonomous space that is sex-positive without being sex-centered, doesn't depend on alcohol to have a good time, and is unafraid to put the politics back into pride. Get Bent fosters a sense of community by being inclusive: all ages, all incomes, all abilities, all ethnicities and cultural backgrounds, regardless of HIV status, those who are comfortable in commercial gay spaces and those who aren't. Everyone is welcome to participate in this celebration of queerness! (GetBent, 2007a).

Interviewing the participants

Interviews were recorded with a digital recorder and transcribed verbatim. Despite this being time-consuming, there were a number of advantages; it allows repeated examination of interviews and is superior to simply relying on memory and notes, which can be patchy. Furthermore, without a recorder it is extremely difficult to recall every detail. The interviews were usually conducted in the participants' homes; however, a few interviews were in public spaces, such as cafes, bars and an LGBT centre. The second interviews I conducted were done by email.

Limitations of the research

The primary limitation to the research is the sample size and the sample demographic itself. Whilst qualitative research seldom has a large sample, phenomenological researchers try to maximise the diversity of participants and understand the minutiae of their lived-world. I did seek to maximise the range of genders, races and ethnicity in the sample. Judging

whether I had achieved "diversity" within the sample was also problematic. The demographics of a trans sample are inadequately skewed towards advantaged transpeople, who have a financial status that can pay for their computers, where most of my participants were generated. The trans experience being reported here pretty much leaves out most of those I meet who have limited finances, who are from ethnic minorities, and older transpeople. My participants were however, drawn from an array of subject positions, in relation to employment status, gender, age, religion and trans trajectory; however, there was a lack of ethnic diversity within the sample. Generalisations to the whole population of transsexuals will not be possible. However, this was not a primary goal; my goal was to illustrate diversity within the trans community.

Another demographical problem, which I considered a hurdle that was impossible to counter, was: How should I contact those who do not have political affiliations, those who do not identify with the label transsexual and so on, in effect those who are "stealth"? On reflection I think the "call to participants" may be a point of consideration. When advertising for participants it may have been better to place requests in non-trans spaces as well as written with non-trans language. The wording may have been problematic as Mariza pointed out in her interview, she stated:

> I do not understand people who are similar to me who talk in terms of being transsexuals. What I have done, I have done to be the woman I should have been born as. Words like transsexual are irrelevant to me. I have agreed to do this interview with you because I think that you will probably have a lot of people call themselves that and I think that it may be a good for you to meet somebody who just wants to be a woman (transwoman Mariza).

In Mariza's case I was lucky; however, we might want to consider using language in behavioural terms as opposed to identity-based language. For example, rather than a call for "transpeople," I feel I should have considered: " I am interested in people who were raised as one gender, but identify with another" or "were perceived and treated by others as one gender but identify with another." This might allow for "stealth" people to realise they can contribute to a knowledge base that seems to include them, regardless of their current self-identity label.

Feminist and postcolonial critiques of methodological processes suggest that knowledge is produced in specific circumstances, such as in the interplay between participants and the researcher, in the research setting (G. Rose, 1997). My role as the researcher is situated in the research generation, interviews, coding and eventual interpretation and representation of the interviews (Mason, 2002). Thus, it is often suggested in the methodological literature, for the sake of openness, that the researcher situate themselves in the writing-up and to shed light on the research process.

In the past trans people have been understandably wary of non-trans researchers investigating trans issues and lives. Research has frequently been used to represent transpeople in ways that they have felt uncomfortable with (for example see Jeffreys, 2005; Raymond, 1980). In addition, non-trans researchers have used the accounts of transpeople from, for instance, autobiographies (see Hausman, 1995), and have not situated these in their appropriate historical context. This has resulted in them using these representations to talk about contemporary trans issues, when in effect they were written as long as 50 years ago, when gender cultures were somewhat different. The trans community responded to this by producing a number of texts and guidelines for non-trans researchers to follow in their research practice (see Hale, 1997). However, many trans people remained hostile to "outsider" research(ers).

In more recent years a growing number of "out" transpeople have entered the academy and begun their own investigations of the trans community – myself included. It has often been assumed that "insider" research produces more accurate and more sympathetic accounts of its subjects. However, there have also been some problems with this. For instance, Kate Bornstein's (1994) queer/ postmodern work has been celebrated by transgender people, but has met with some important reservations from transsexuals. I believe, therefore, that there are no guarantees that "insider" research automatically produces better results than "outsider" research but that research conducted reflexively with consideration for participant's views is the most important factor.

In my own research maintaining insider status had a number of advantages and disadvantages. On the one hand, my membership of Press for Change afforded me

significant advantages in terms of access. I also used snowballing from a number of people in the trans community I already know. Securing participants, then, was remarkably easy, although, it is possible that the participants in this study were therefore skewed towards a more educated and politically active group than someone else may have found. On the other hand, however, there was a clear assumption by some participants that I would already know about and understand some elements of what they were saying without detailed explanation, simply because I was assumed to have identical experience – an assumption that was often incorrect. And this also often worked in reverse, when I had initially assumed shared experiences which sometimes turned out to be markedly different. In order to fully elicit their accounts, then, it was sometimes necessary to ask multiple questions on the same topic to ask them to explain things they assumed I already understood, and sometimes these accounts were quite different from my own experiences.

One further and far less tangible issue was that at times I felt that my own appearance was quickly "evaluated" by some participants and that this coloured the research encounter somewhat. In some cases my appearance seemed to prompt an immediate affinity with the participant but at other times this was not the case. It is impossible to say exactly what this meant and it is likely that this takes place in all interview situations where the body of the researcher is "read" for signs of affinity or otherwise with the participant. One clear example of this "reading" of bodies occurred when I was interviewing Samantha. Although I was quite clear on my call for participants that I myself am trans, during the interview it became clear that Samantha read me as non trans, on this occasion saying that I wouldn't be able to understand some of the transitioning experiences she had had. In this case she seemed to disregard the statement on the call for participants in favour of her own reading of my embodied identity. To summarise, then insider research had advantages and disadvantages and was sometimes a profoundly slippery phenomenon, depending on how I was read by different people.

Analysing the interviews

I interviewed participants and analysed them concurrently. The analyses were conducted by using a computer software package, NVivo 7. I constructed a framework that identified themes within my own broader themes that emerged from the interviews. The thematic framework was then used and tested across the set of interviews and in a simultaneous

process in the follow-up interviews. The thematic framework was also set against theoretical frameworks that materialized from the literature review. Whilst the software was useful in many ways as an organisational tool, I continued to read the interview transcripts as a whole to get a feel for the whole narrative. From these re-readings I reviewed the coding and was then able to make queries through the software in relation to patterns and differences within the interviews.

NVivo enabled me to include my reflective notes, memos and links to sources, which were also linked to the coding of the interviews, from these connections I was always aware of my situatedness[20] in the research setting and thus, the influence I had during the interviews and research process. As my position is as an intermediary here, I take seriously my responsibility as a researcher. I wanted to minimize possibilities of distortion from personal bias and to make my own processes of investigation visible so readers can asses for themselves whether or not my interpretations are warranted.

Bourdieu (1988) argued that it has been important for academics to distinguish themselves and their "ivory tower" from the "messy world of the streets." The distinction of the tower and the street would help maintain pedagogical authority, which may falter if the academic tries to bridge the gap. In my messy world of the street, part of my life was taken up contributing to political praxis, in relation to trans issues, which were close to my political concerns. I wrote to Members of Parliament about the Gender Recognition Bill, marched in "Pride," sat on legal and healthcare forums fighting the "visibility" corner for transpeople in policy documents, attended and delivered workshops on trans issues at equality and diversity conferences and so on. These issues of bridging my politics with my research were at the forefront of my mind on numerous occasions during the fieldwork. My position as an activist undeniably affected the initial stages, process and outcome of the research. It is not possible to measure how much, in a positivist sense; however, one thing is sure, the project as a whole was guided by my involvement and knowledge of the social and political climate of the time concerning transpeople.

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[20] NVivo 7 has many functions. For example, if I had made notes on part of the interview (an annotation) this would be highlighted, I was quickly able to see my initial ideas and thoughts and any subsequent ideas and thoughts on that part of the interview, which captured my changes in analytical and theoretical approaches (see Richards & Q. S. R. International, 2002).

It is possible to situate this research as an "ethics of struggle" (hooks, 1994), which tries to bridge the distinction between research and activism on one level – the level of knowledge and theory, which can hopefully aid in some emancipatory work, from the clutches of the powerful who wish to erase or at best pathologise trans subjectivity – and be open and honest enough to not shave of the edges in order to "cleanse" the representational work that the research may do. Bridging academia and activism is nothing new in transgender Studies (see Stryker & Whittle, 2006), in fact I believe without activism there would be very little contemporary academic work on trans. Following Gayle Letherby I suggest our work should not just be about the Other, but about the interplay between the researcher and participants. I wanted to both

> enable the voices of Others to be heard, and to create social and political change for or on behalf of those Others [...] This creates a dilemma and involves us in a struggle between acknowledgement of the impossibility of full representation and the assertion that our work makes a difference. This leaves me then supporting an approach which may possibly involve a less than complete representation of the other, but I suggest that this is better than no representation at all (Letherby cited in Letherby, 2003: 119).

Ethical considerations

I was aware that there were ethical issues involved in a research such as this, as with all research, but due to my existing knowledge of the transgender community I feel confident that I conducted my research with sensitivity and care. In addition, I employed modes of professional conduct devised by academic institutions specifically in relation to ethical guidelines. In particular, the ethical statement by the British Sociological Association was employed (British Sociological Association, 2002).

Many of the debates surrounding ethics and research participants have stemmed from the feminist sensibilities of consent, deception, privacy, issues of harm and confidentiality (Punch, 1994). I would like to pull out some of these points, which I feel are intrinsic to my research design. Hollway and Jefferson's (2000) ethical principles for researching psychosocial subjects are honesty, sympathy and respect. I feel these aspects are central to my research design. The issue of honesty that is, telling the participant what the research is

about, what the possible consequences are if the work is published or presented at conferences or indeed available for inspection within the university library, by assessors, supervisors and students, in fact all who will actually see/hear the work. This principle of honesty will allow the participant to ponder on other related issues of anonymity and recognisability, which are usually regarded as fundamental principles of research ethics (Hollway & Jefferson, 2000). Sympathy can relate to authenticity in this research. I noted previously there were contentions within the clinical setting as well as within transgender politics about the subject's authenticity. On account of this I went into the research setting with openness, putting myself "alongside them" and used the self-knowledge I possess about the trans community and some of the concerns that have come to the attention of researchers through online forums, e-mailing lists and academic sources (Hale, 1997). In relation to respect, I felt the participants should be portrayed as the participants intended and not as fragmented pieces of information that fits nicely with the intended theory of the researcher. These sensibilities were adhered to at all times.

Chapter IV: Recognising the Self: Transmen's Body Projects

Introduction

It is my argument that transmen's commitment to a male identity is corporeally and discursively constituted in different ways to transwomen's commitment to a female identity. This may sound like an obvious claim but it is one that needs clarifying in relation to bodily aesthetics. Traditional medical and sexological literature exemplifies genitals as fixing sex and, consequently, suggests that transsexuals' commitment to a male or female identity is genitally focussed (Benjamin, 1966). The "true transsexual" is often seen to be one who demands genital surgery (1966). This genital focus also influences the various perspectives held by the sexological and medical literature concerned with transsexual embodiment and whether bodies should be orientated to a specific gender identity (Pauly, 1981), or whether the psyche should be "brought in line" with bodies which already have a (medically) ascribed sex (Levine & Lothstein, 1981; Lothstein & Levine, 1981). This focus has implications for, and influences, the transperson within the clinician's office, where the individual commences their official trans-sexing, and where a diagnosis of *Gender Identity Disorder* or *Gender Dysphoria* is sought.

The genital focus can also ultimately affect the citizenship rights of a transperson who lives in their preferred gender, when a "secure" diagnosis is not attained. However, in the "subaltern" transgender literature and within transgender politics, such a focus on the genitals is a contested area (Griggs, 1998; H. Rubin, 2003). Nonetheless, in transgender studies of embodiment, research rarely focuses on the various processes used in order to attain acceptable bodies by transmen and transwomen prior to, during, and after transitioning. No argument has been made regarding bodily aesthetics within transgender studies because the differences that come into play have been understood through a "gender identity" frame rather than through a consideration of the body. Bodily aesthetics, in most studies, act as "default" markers of "core" gender identity relying on "gender" being clearly understood and clearly demarcated into "core" binary characteristics. This research suggests bodily aesthetics are paramount in experiencing, presenting and being looked upon as a specific gender. I suggest further that whilst genital surgery is important for some, "body projects" are, in fact, realised in many ways. The (desired) bodies of transmen are not uniform. The aesthetics of transmen's bodies are orientated and produced, interpreted

and negotiated at the intersections of class, sexuality, medical opportunities and interventions, limits of the body, length of transition, and life histories. As such there is a complex interplay of sociological aspects, demographics, and aesthetic signifiers of gender which I aim to illustrate. Moreover, trans bodies are socially, sexually and intercorporeally "produced", that is, they are dependent on the intersubjective nature of lived life experiences with other significant bodies and inward reflection.

In this chapter, I look at transmen's "body projects." I consider "body projects" in relation to three organising themes (Attride-Stirling, 2001), "social bodies," "sexual bodies," and "phenomenological bodies." These "bodies" are not separate, but come into play at certain times and in different spaces. Moreover, "social bodies," "sexual bodies," and "phenomenological bodies" are aesthetically judged by the self and others. This chapter aims to help us understand how participants are creating new standards of being (trans) men, as they disrupt the old, by illustrating how transmen negotiate their bodily aesthetic. This chapter will also illustrate how hormonal technologies affect the aesthetic and psychological positions of transmen. Idealised bodies are considered in relation to the limitations of technologies, such as aesthetic surgeries. These focal points will illustrate both the similarities and the diversity of transmen's "body projects."

Childhood, puberty and sex differentiation

When relaying memories of childhood, the phrases, "being different" and "knowing something was wrong," were frequently voiced in the narratives of the transmen I interviewed. These specific, and widely recognisable, transgender discourses (see Kane-DeMaios & Bullough, 2006), were not explained to me in the interview and required in depth questioning on this topic. Clifford stated:

> [Throughout childhood] I guess I was just trying to figure out what it was; there was just something not right at all (transman Clifford).

As I mentioned in Chapter III: *Methods, Methodology, and the Research Process*, I revealed to the participants that I was a transwoman prior to interviewing them. This may have influenced some responses, insofar as that some participants may have assumed at certain times that I knew exactly what they were alluding to. However, I suggest that in

addition to this, that by not offering any indication of why they were "different" or "felt wrong" it indicates that "prediscursive" sense-impressions, experiences, and situations gave rise to disidentifications with their "phenomenological bodies," which intensified, for most participants, during puberty. The concept of "disidentification" I am using here relates to a process of critically questioning, rehearsing, and then (re)articulating the position they have within the gendered ideology that permeates the binary gender system (Munoz, 1999). This finding compliments Henry Rubin's US study (2003) and other accounts of transsexual men insofar as puberty, in most cases, marked an intensification of bodily awareness. This "disidentifying" awareness contributed to understandings concerning sex differences, as well as heightened feelings in relation to their "phenomenological (female) bodies." However, in Rubin's analysis he also argued that his participants suffered from agnosia, where they could not acknowledge certain aspects of their bodies. The pathology of agnosia does not appear in this research. My participants' "phenomenological bodies" were often felt as sites of distress and their bodies were experienced as fundamentally a part of them.

The feelings, expressed as "difference" by most of the transmen during the interviews, were clarified later in their narratives as experiences of incongruence between their sense of self, their "phenomenological" and "social body," and their ascribed gender role. These incongruities ultimately led them to transition. However, at this point it was a change in their intentionality with regard to their ascribed gender, in an attempt to establish an understanding of their "gendered" expressions, which seemed to be out of sync with their "social" and "phenomenological" body. These thought processes and embodied intentions, then, were consciously moving from situations, which had *queer* beginnings toward a "straightening" of thought and towards securer sensations about their bodies, gendered expressions, and situations even though these were non-normative. However, as Sara Ahmed (2006: 36) suggests:

> The "intending" of the object [feelings] through which it becomes more than just one impression involves [...] synthetic consciousness – that is, the connection of the new impression with what has gone before, in the very form of an active "re-collection" or synthesis. Significantly, the object becomes an object of perception only given [by] the work of recollection.

Participants' suggested that recollections about their lives offered significant moments of trying to understand themselves. As Gregory shows:

> When I was three years old I became aware people were using female gender pronouns and I couldn't understand why, of course because I was in hospital, I did not have the same social experience as everyone else. When I was in there I did not hear how other people were spoken to, or about. So when I became aware that I had a girl's name I wondered why and why I was wearing dresses, when obviously I was a boy. So I asked why and they thought I was retarded because of asking. I use the word retarded because it was the word used at the time, not because I believe that word is appropriate to use now. So I was treated as if I was stupid because in their view I didn't understand that I was a girl (transman Gregory).

Gregory was admitted to hospital and spent some time there, due to complications at birth, which left him with breathing and hearing impairments. Gregory's experience of social processes of sex differentiation came much earlier than most of the transmen I interviewed. While those around him expected a default and coherent gender identity based on his birth sex, Gregory thought of himself as a boy. His socialisation, he states, was not the same as most children's because of his spell in hospital. Gregory suggests that there is a need for socialisation to create a coherent gender identity, which undermines the notion of a biological basis to gender differences. Therefore, for Gregory, gender differences are only knowable through experiences of socialisation.

In their interviews most transmen, however, mentioned puberty as the beginning of their transitioning narratives. This was also a significant time for many participants – since it was the period they first began visually witnessing and noticing culturally dominant ascriptions of sex differences, which added to their sense of being different. This was coupled with inflated familial and peer pressure that attempted to enforce heteronormative and gender normative ideals.

> Raymond: Appearances matter a lot, it is public school for girls and everything about it was training to be conformed, you know, this is how you are going to fit

into society, this is the role you are going to play and this is how it is going to be. I failed at every juncture. I started cutting myself from the age of eight. I didn't know why, my mum said "stop being silly and you will have to hide it."

Zowie: *Was that self-harming?*

> Raymond: Yes and when I was fifteen, sixteen, I had a particularly bad cut, which stayed open for a year and that was on my appendix scar, literally I split it and overnight I must of scratched it, then over time I kept the scratch alive. It got a very, very deep infection in it. In hindsight I think, well my grandmother would always say my scar was the other way around – in the head. [...] I would try have something out, if I dig around a bit, I can do it myself, or stop things like periods and I never put the two together until later until you can step back from it and see (transman Raymond).

Intersubjective and social influences operating in relation to understanding sexual difference evolved in tandem with familial and locally dominant cultural and historically situated aspects of gender and sexuality. Raymond's "phenomenological body" was obviously a target for his distress, however, he did not consciously identify as a boy at this time. The transmen in this research did not necessarily have a fixed and coherent understanding of their trans position during their adolescent years either. Although Raymond's case of self harm is extreme compared to other transmen in this research, where feelings often manifested as "slippery" disidentifications with their "phenomenological bodies," "social bodies" and expected social roles. The onset of puberty and adolescence also had an affect on participants' "sexual bodies," as the kernel of sexual identities began to formulate within heteronormative discourses.

My interpretations of the interviews suggest that acknowledgement of the gender/sex differences through self ascription is not a sudden and singular realisation but an ongoing sensation of difference, as Benjamin's account suggests:

> In terms of really realising around thirteen or fourteen when I was going through puberty then it became a very big issue and that is when I started to become

> depressed but it wasn't until I was about sixteen before I started seeing a counsellor [...] So it was a long process in my head for me, but for an outsider it was from about fifteen onwards. I started seeing counsellors for that and went to [Gender Identity Clinic] at eighteen (transman Benjamin).

Kenneth also suggests that puberty was a significant time, however, for him the body and gendered accoutrements played a prominent part in his understanding of sex differences and where he positioned himself within the binary sex system:

> [I was] betrayed by my body when I was twelve, when my chest developed. I suppose for a lot of that time I did cross-dress, which did make you stand out and that led to a lot of bullying but at the end of the day I wasn't going to stop what I was doing because I felt comfortable (transman Kenneth).

Kenneth's story is similar to those of most of the transmen who were interviewed, where secondary sex characteristics induced through puberty, namely breasts and other characteristics, such as fat distribution and the onset of menses, were the cause of bodily disidentification. Many participants observed that the time around puberty was when their bodies started "betraying" them, which again compliments Rubin's study (2003).

In Kenneth's recollections, wearing masculine clothing was a necessity because he was overweight as a child and the female clothing that was available did not fit him. Nevertheless, he felt comfortable in masculine clothing, which reiterated his affinity to a masculine identity. At the age of twelve Kenneth was bending rules that the sexual difference "body politic" was meant to enforce on his "social body." The quotation above also shows the powerful intersubjective character of sex/gender, which was displayed by his peers at school when assigning his sex differently i.e. as female. The masculine clothing Kenneth wore drew reproaches from others because he was not conforming to the sartorial norms of femininity. These rules and social norms, however, were not as important to Kenneth as to those who had reproached him, although later this changed. Kenneth felt comfortable with the way he was expressing himself. This implies that the criticisms and bullying behaviour of others were not as traumatic as the disidentification he felt with his "phenomenological body" and his prescribed social role.

Nonetheless, when Kenneth was a teenager his clothing and gendered expression became more of a problem for his mother. Gender non-conformity at this age was seen to be a problem that required medical intervention. He states:

> I had a major breakdown when I was fifteen and a half, because of all the pressure. If I didn't wear female clothes my tranquilisers were increased. So it was aversion therapy. With the hormonal mood swings you went from being nice to horrible. I think if it was now instead of then, it would have been a lot better because my transgenderism was treated as schizophrenia. They got it so wrong. So my self-image has always been quite negative. It has been wrapped around family (transman Kenneth).

Societal institutions are prescriptive about certain aspects of masculinity and femininity, which act as both a restraint and a comfort as long as you can accomplish and produce the ideals "correctly." Because Kenneth wanted to continue his "incorrect" expressions of femininity at home, he was reprimanded via drug induced pacification. In Kenneth's case he was (mis)diagnosed with schizophrenia rather than what he calls "transgenderism," because he wanted to continue to wear "male" clothing.

Moreover, wearing feminine gendered clothing also caused concern for many participants and dresses were cited by almost all the transmen as the item of clothing that was the cause of their greatest disidentification. For example, Gregory said:

> When I started school my mum got me this evil pink gingham dress, which matched the kitchen curtains, I think it was the kitchen curtains [laugh]. I found that quite distressing and humiliating because obviously I would be seen in public wearing them clothes (transman Gregory).

Gregory joked a little about how the clothes his mother made him wear to school looked, however, there were emotional costs for Gregory. These came in the form of "distress" and "humiliation" because he was seen by others in feminine clothing that he did not feel comfortable in and did not identify with.

Raymond's chest was also a prominent feature of his disidentification through puberty. However, more emphasis was placed on the physical rather than the psychical, pain that his breasts caused. Nonetheless, the pain was represented both as physical and psychical. Raymond's painful body "calls" him to consider it, with the goal of eradicating this pain. He says:

> Of course at puberty your body changes and there is no way around that. I was a double D chest, which was pretty painful. To lose that flat chest and slim figure was awful (transman Raymond).

The pain brings into relief parts of his body that he once possessed. Absent body parts are reflected upon and puberty is seen as the event, which turned his prepubescent and sexually featureless body, into a distinctly female one. This generates a sense of "nostalgia" (H. Rubin, 2003) for his once sexually non-descript body.

Daniel's transitioning narrative did not start at puberty and was very different to most of the other transmen in the research. He observes:

> I had very long hair and before I transitioned I looked very female. I looked very Jaeger, Harvey Nichols with long blond hair and an Alice band sort of thing. I didn't walk around looking butch or anything. I am looking for a photo to show but I do keep them hidden away, because I don't want people to say: who's that? Someone did once, they said oh who's that it looks like you and I said it is my cousin, I lied massively. I was very glamorous and one of my gay male friends who thought I was this glamorous woman felt totally betrayed, we were talking about this the other day. He was very invested in me, basically I was his anima. I was very glamorous, big red lips, long blond hair, fur coat, big shades, I did really good drag. I really did like dressing up, almost drag queeny in a way (transman Daniel).

He offers a psychoanalytical narrative to account for his decision to transition:

> I first realised through a series of dreams also when I was about thirty eight, thirty nine [years old] I had done a workshop on anger, grief and fear, and anger was a particular issue. When I look back now, I thing that was the turning point, but I still did not know at that point that I was actually transsexual. It released something, something probably on a subconscious level that I wasn't or never had been female despite having a female body. When the lights started to go on I started to have dreams that I had transitioned, I had dreams that I had attended an FtoM group, which at the time I did not know even existed and subsequently found out that they did. I was having all these dreams and suddenly the light went on and the subconscious became the conscious and once I knew, I had to do something about it. There was no way that I could live with that once I knew what I knew (transman Daniel).

Nonetheless, the focus of most transmen's narratives at the time of puberty centred on bodily change, which sharpened bodily awareness and, more often than not, extended understandings around sex differences in relation to correct "social bodies". There were often overtones of "nostalgia" for a prepubescent body as well as resentment towards the pubescent one, which had gradually betrayed them, causing both psychical and physical pain. However, Daniel also illustrated a psychological change, introduced by dreams, which he saw as "subconscious" desires.

Decision making and transitioning

The processes of trans-sexing and of "body projects," which I will take up below, start with feelings of difference, which initiate the questioning of identity, gender, and bodies. The empirical material that follows, from two pre-operative transmen, allows insights into various "phenomenological," "social," and "sexual" forms of reasoning prior to, and at the initial stages of, trans-sexing. Thinking the process through for these participants was about weighing up their feelings about corporeal requirements in relation to their sense of self, along with personal dynamics of bodily discomfort and disidentification. This was further combined with self-reflection, the consideration of social and medical limitations, and thinking about the views of significant others.

Initially, oscillations between what is personally right or wrong, in the process of decision making about trans-sexing, were pitted against what was deemed socially important. Oscar, who is a twenty-four year old student and is an active member in queer transgender community groups, suggested that the primary step of his transition would be hormone ingestion and talks about the processes involved through the lens of "expert" literature:

> Well, out of all the literature I have read on the effects of testosterone it would seem that it affects people differently. I have read that maybe you would get a little more aggressive, impatient and short tempered you do literally become a teenager and that there are fluxes in hormone levels, which is like going through puberty again and so I am trying to prepare myself for that. So I will try to enjoy that experience rather than be terrorised by it. It is a scary thing but I want those changes. (transman Oscar).

Oscar's knowledge about the hormone process allowed him insights into the multiple possibilities that may occur while taking testosterone. From this he was able to prepare himself for the many eventualities. Transitioning for Clifford needed much broader considerations. His account goes like this:

> Clifford: I am swaying more towards it [transitioning] and yes I probably would, it is a huge decision because it is obviously for a lifetime.
>
> Zowie: *What kinds of things are you debating about with yourself?*
>
> Clifford: I suppose it is about, is it right or wrong for me, not for other people but for me. Is this something I should fight against? Is this something that I should accept or should I just learn to accept it? [...]
>
> Zowie: *Have you researched into hormones and other transmen's lives?*
>
> Clifford: Well I belong to the group [...] and there are a lot of people, so I have spoken to them. I think a lot of people find that there are a range of different ideas; some people feel that they have to have every possible option before they will be

happy. For me, if I do one thing, will that be fine for a little while? If it is not then you will have to go another step. I think there is a lot of dissatisfaction with phalloplasty for instance, and it is sad that people do not have enough information and feel that they have to go for that option. There are others that think that it is too risky and it is not satisfactory, so there is a range and I suppose you'll do what is right for you (transman Clifford).

Clifford's and Oscar's decision making processes are not at all, it seems, solitary endeavours. The decision making processes for them are restrained by the linkages between other transmen and knowledge of transgender literature as well as being understood through their own corporeal agendas. For Clifford, joining an FtM group in a city away from his home town allowed him to access a range of ideas, imagine diverse pathways, and, to understand risk factors that may be involved in transitioning from female to male. Both the "phenomenological body," which imposes a focus on body imaging and the social body politic that attempt to restrict what a male body could be, along with the possibility of unsatisfactory surgical outcomes, for Clifford, and the unpredictability of testosterone use, for Oscar, are all factors that are taken into account.

Oscar was also able to compare his bodily aesthetic and how he felt about it, to his friends' experiences of body dysmorphia, in the transgender social groups he attended:

> I feel lucky in a sense because I have other trans friends, who really hate their bodies and want to change their bodies. So I feel privileged because for me, I am not that bad, it is bearable and I can live with it. I am lucky because I have a boyish frame and very small breasts anyway. Binding is not essential and I can get away with not binding sometimes. So I don't feel obviously female with my body. [However,] I do feel disassociated with my sexual body (transman Oscar).

What is highlighted in the extract above is Oscar's tolerance of his personal bodily aesthetic due to his ability to present himself as a boy. He does, however, separate his feelings about his "phenomenological" and "social" bodies, of which he is tolerant, from those about his intolerable "sexual" body. Oscar's disassociation from his female body, in sexual spaces, is intentionally redirected away from those parts of the body that are causes of concern. This

is not disembodiment (a phenomenological impossibility) but instead a shift in focus, which is triggered by the parts of the body that affront him. In this sense, it is the lack of acknowledgement of, or refocusing on, parts of the body in certain ("sexual") situations, spaces, and times that this, and other participants, experience and understand rather than the denial of their material bodies. The disassociation the participants felt often lessened after hormone therapy and especially after surgical procedures were undertaken, as this changes the perception of the post-operative transmen's discrepancy between their own body image in relation to their modified "social," "sexual," and "phenomenological" body and acceptance by others. This was illustrated by Benjamin, who stated:

> I have more confidence each operation I have been through, but basically the one just gone [a phalloplasty] has given me confidence yet again. When I look in the mirror I am a lot more happy to see what I see (transman Benjamin).

To summarise, then, almost all the transmen had extracted information from trans groups and from sexological and transgender literature. Belonging to transgender groups allowed considerations to be made on the basis of the material bodies of others. Listening to anecdotal evidence, as well as utilising expert knowledge, also formed a large part of their understanding of what their future bodily trajectories could be. In addition, from these groups and from transgender literature transmen also understood that it was still possible to identify as male while not having genital surgery. Bodily aesthetics may, if so desired, be constructed with regard to personal bodily needs. There are a range of possibilities of what the constructed body can be in relation to becoming male, and the interactions in the trans groups and in the transgender literature make clear that there are no strict guidelines and that there are fluid notions of masculine bodies (albeit ones that are socially and medically restricted).

Male identities and bodies are understood from other vantage points too. Oscar, for example, understands that his "transgender trajectory" is informed by variables such as his age and his experience:

> [my identity] well, it kind of shifts and I am [now] identifying as FtM transboy, a transboy rather than a transman. I have been playing around with that concept. So I

identify as trans rather than male or purporting to be a man because I see my identity as being quite fluid and subject to change and quite a transitional identity. I think it has a lot of scope to be able to get away from the category of woman because I don't identify as woman either. I don't recognise myself as female even though I don't have the experience of growing up as a boy, so boy for me is the social experience of moving away from female into a male category. As I say, that could change, because I do want to take hormones. Eventually I want to have surgery and that experience may change how I identify as a transman and maybe a man but at the moment I am identifying as boy and still grappling with that. It has been a huge exploration and quite an adventure over the past five years. There has been a lot of processing and a lot of soul searching. I do feel very adolescent so it is not all about gender, my identity is very wrapped up with age, and I feel very youthful, also the problem[s] of youthfulness (transman Oscar).

Oscar's use of the term "boy" suggests the avoidance of a limited idea of masculinity that is wholly about male bodies. It is here that the phenomenological critique of bodies comes to bear. It questions intrinsically understood ideas about gender as a "core" aspect of experience. Oscar's experiences are adaptively situated rather than developmentally situated. Whilst accepting that there *may* be a trajectory towards an unknown and unrealised masculinity, analogous to the trajectory from boyhood to manhood or, in this case, from female to boy and then on to man, Oscar is also working out his situatedness in relation to past and present dimensions of his life. Oscar suggests that he is definitely not a woman and that he does not (yet) identify as a man and therefore, settles on "boy" as a transitional identity.

For Oscar and Kenneth there was no sense of urgency in confirming an identity either socially or personally. This allowed them time to work through the aesthetic desires of their bodies in relation to their sense of self. Nonetheless, social interaction always attracts the other's gaze, whether this is wanted or not. Such interactions continuously bring the "social body" into relief. Across various social spaces "identity work" is performed by others on the bodies of all the transmen in the research. I asked Oscar: *Does your body have any relation to your "boy" identity?*

Oscar: That is a large part of it I guess and from a heteronormative reading I am presumably a young heterosexual boy of thirteen or fourteen. A boy who is just entering into puberty whose voice hasn't broken yet. From appearances I am perceived as a young boy but when I speak there is another reading going on and then I am read as female and then interpreted as a boyish lesbian or butch dyke. Or sometimes I will be read as really young, eleven or twelve, when they hear the voice. So that is a big part of it (transman Oscar)

Kenneth, narrative differed and said that he is perceived as male in most social situations:

> Everybody, image-wise, has taken me as male. It is only when I have chosen to walk into somewhere that is female that their perceptions have been scandalised (transman Kenneth).

Whilst Oscar and Kenneth have very little influence on how they are seen, as this is dependent, for instance, on the context, "gender capital" (Bourdieu, 2001), and gender belief systems (R. Stoller, 1985) of the onlookers, both Oscar and Kenneth measured their personal bodily aesthetic, and consequent bodily requirements, against how others have perceived them. Therefore, there is a relationship between the body that is objectified and the gaze, which is instrumental to understand each transperson's "social" bodily aesthetic.

Sub-cultural ideals of masculinity are also important in this context, as the following quotation illustrates:

> Well last year at pride I was protesting, [...] these gay boys came up to me and I thought I looked like a gay boy that day and they just started chatting with me. I was aware that one was flirting with me and I was interested in him. Then he got a little confused because he looked at me and looked again, and said "ooh, ooh you don't have an Adam's apple" and I was trying not to get too confused by it all, and he said that he had been reading me as male, but you don't have an Adam's apple so therefore you are a dyke. Oh my god I am attracted to a dyke. I said I am not a dyke. "Oh sorry have I offended you then? Well what are you then?" At this point I totally lost interest in him. I have stopped worrying about all this though, people

will talk to me and look for signifiers of masculinity such as the Adam's apple or voice and not finding that then they would examine my face, "oh a pretty female face, oh it's got to be female." So yes [the photo] does capture male when it is that first impression that some people may have of me and then they look again. I don't know. I find it really hard because I look in the mirror and I think I look male and wonder why people cannot get that. But then I sometimes get a glance of me and paranoia comes over me because I look female and of course this is what the others see. It is so dependent on context and I think class plays a part in that and so does Gaydar, especially in the [gay village]. I am being read as lesbian so I have been avoiding going there recently. It just got a bit annoying really. I mean I don't mind really but I am trying to assert this transmale identity and it is just not getting read in those contexts. There has been a few times when I have been read as a gay male, which has been wow, great. I try to encourage that reading but it is very rare and outside a queer context I am read as a young male (transman Oscar).

Oscar's body takes on various aesthetic configurations in different "queer spaces." The figurations are dependent on various dimensions in relation to the "gender capital" and "queer capital" of those doing the looking. On occasions these figurations, as the quotation above suggests, are formed by the "lookers" in contradistinction to how Oscar felt he was expressing himself. When the wrong reading of Oscar's body is apparent, for example, when "one of them was flirting," and "look[ing] for signifiers of masculinity" or when he was "being read as lesbian" it highlighted that he did not have a convincingly male look to those who had the "gender capital" to evaluate the potential possibilities of Oscar's gender in that space. Rather than opting for transition by way of hormonal or surgical measures at this point, instead, Oscar removed himself from these "queer spaces." Oscar preferred to be in non-queer spaces because he was read as a young boy. "Queer spaces," then, do not necessarily provide a comfortable home for those who identify as trans. Halberstam (1998b) describes how in "queer spaces" butch and transmen's bodies are always read against each other on an aesthetic continuum. People "in the know" search for differentiating aesthetics between the two. Halberstam suggests that "passing tips" are commonly shared between transmen on the internet and at conferences, because of the problems of non-visibility in the desired gender. In these instances, the aesthetic which is offered, often assumes a traditional middle class masculinity. A preppy, clean-cut look is

often suggested (Halberstam, 1998b). Transmen are warned to avoid "punky" hair cuts, black leather jackets, and other aesthetic signifiers sometimes associated with butch lesbians. The notion of "gender capital," in the sense of being able to understand gender codes, is a precise tool, which determines clothes, clubs, and so on, and does much of the work in relation to gender presentation and how you carry yourself. A transman going to "queer spaces" has to be aware that "gender capital" can work to undermine the readings he wants to elicit, as well as to make him feel safer. The spaces and "lookers" vary from participant to participant, in the rest of this study. However, it is evident that the context, the "lookers," and their "gender capital" play an influential part in the decision making process of each transman in relation to his bodily aesthetic.

In addition to peoples' perceptions of him, Oscar's additional focus is on the effects that his transition will have on his family and partner:

> I suppose also that I am afraid of the changes and the impact on those who are close to me, family and my partner [...]. I have told my parents that I want to start hormones but I have been introducing the whole trans thing quite slowly. I have just started seeing someone who is quite open minded and very accepting and reads me as male but at the same time someone who doesn't trust drugs and someone who would go for more herbal remedies; so she is unaware of what they are going to do. So it is a way of making sure they are aware of the possible side effects and how relevant it is to my identity really (transman Oscar).

Whilst in the following quotation, Kenneth's decision making is related to his health. Kenneth has endocrinological problems that have influenced his decision making process about both hormones and surgical procedures. He says:

> I had to think about it a lot because my body is so damaged anyway, [even] before we get to the transition part of it. Then, am I going to be happy living my life with the way I am now? It was based on the experience that I was having at the time (transman Kenneth).

Kenneth's ailing body hampers the possibilities surrounding his transitioning and as such he reflects on the pros and cons of having a normative male body and the problems, which that may bring, on the one hand, or living with a non-normative male body that he may not feel comfortable with, on the other. It is his bodily aesthetic then, which is of paramount importance rather than his gender identity.

In this section I have highlighted only a selection of the possible intersecting circumstances that transmen review whilst considering procedures in order to trans-sex. Nonetheless, in this research, all the transmen's identities and bodily decisions were made in relation to the degree with which they disidentified with their "phenomenological bodies." The objective figurations of the body by others in the social world were revealed through random, coincidental experiences, such as meeting people in "trans spaces," "queer spaces", "sexual spaces," and "social spaces," as well as through reading literature about transitioning, and so on. The interrelational aspects of the participant's life aided and, in some instances, hindered the individual in developing a sense of their body image(s). Personal understandings of their bodies' social meanings were considered crucial, more so than normative expectations about bodily aesthetics. Participants' decisions about surgery were made based on many factors, such as self-image and the various levels of disidentification with their bodies, the social, familial, and sexual interactions of the individual transman and the access to, and knowledge about, the technologies that are available.

Hormones: masculinity from inside out and outside in

After the decision making process, usually the next stage in the "body projects" of transmen is taking, and monitoring the effects, of hormones. These are usually medically prescribed, although by no means is this always so. Some transmen consider, and then utilise, the internet as a source for obtaining hormones. In some cases hormones are administered after taking into account other health factors, such as blood pressure, and glandular functioning. Initially small doses are taken or administered to measure the positive and detrimental effects to the body. If the dangers are deemed to be less than the benefits gained, a continuation of, or an increase in, the dose will be administered. This will quicken the masculinising effects on the body. However, for transmen, the aesthetic effects which result from taking hormones are much more apparent than they are for transwomen.

Once the decision is made to transition from female to male, a speedy transition is often desired. One of the benefits that taking hormones quickly achieves is aesthetic masculinisation, which can enable transmen to pass as men. This seems to have more benefits than genital surgery. Hormonal effects also dramatically influence the sense of self as masculine, as positive readings of the body through intersubjective experiences reiterate their masculine aesthetic, which subsequently contributes to the development of self-esteem on a "phenomenological," "social" and "sexual" level.

Hormone therapy, in relation to transmen's trajectory towards possessing a male body, is widely regarded as the primary positive step in relation to transitioning. Although this step is of greater importance to the transman, compared to the transwomen in this research, it does present aesthetic and psychic challenges to them. Aesthetic benefits of taking hormones included masculine fat distribution, muscle density, facial and body hair, and, in some cases, contributed to male-pattern balding, which all created a masculine appearance very quickly. Taking hormones also incurs side-effects such as mood swings, acne, and depression, which, in this research, were considered manageable for all but one participant. Daniel suggested that there are drawbacks if hormones have to be stopped for any reason. For example, Daniel stopped twice because of problems experienced through taking high doses of testosterone He stated:

> I started to take testosterone in 2001 and perhaps not surprisingly with me; I had lots of problems with it. Basically I have tried every kind of testosterone that is on the market except for implants. I had problems with all of them in terms of side-effects. Another thing with me is that I am hyper-sensitive with substances, food, anything. So, I would react more than some people might because of that (transman Daniel).

Daniel continued:

> Sustanol that I began on masculinises people very quickly and very well if you take the maximum dose, it really works. Your voice will break, you will get facial hair, but as you can see I have very little facial hair even after five years. Then if you stop using it, well the medical professionals will say it is all irreversible, but I

> beg to differ, even the voice loses some of its depth and resonance if you stop taking it. Facial features soften out quickly, so you get a feminine looking face, even if you kept the facial hair. You would also lose masculine muscle tone and body shape would go back to female. As far as I was concerned I would lose all that I had gained by not using it anymore and that happened twice in the last five years. I would go out there and had been passing pretty well most of the time to suddenly discover that I was getting so many more "loves" and "madams" that told me that suddenly I was not passing, well passing to some people but not to others. That would have got worse and worse and worse, if I had kept the dose low or not taken testosterone. That actually drove me on to find another way of taking testosterone (transman Daniel).

In this instance, the continued use of testosterone was required to maintain [an] aesthetic appearance of maleness. The consequence of not continuing with the regime negatively affected Daniel's "social body" and his visibility as a male.

Daniel's narrative highlights the difficulties that are encountered during the processes of attaining a masculine body through hormone therapy. In addition, aesthetic hormonal changes are not foreseen in their complete entirety. That is, participants' aspirations to have a recognisably male body were thwarted by various hurdles. These hurdles affected the "social," "sexual," and "phenomenological" bodies of the transmen to varying degrees. The initial trials of hormone therapy are based on whether the body is able to cope with them in high doses. Jackson talked about his experiences alongside those of a friend, who had also taken testosterone. He said:

> He seemed to remain very calm when he had the hormones. I [on the other hand] have always been very easy going, a real softy, a pushover, [but] when I had the hormones it seemed to vamp me up a bit. I wasn't how I used to be and I used to think differently but this was only initially and I think I am back to myself now. I suppose with all that going into your body it is going to have an impact but I think I am back to myself now. I got quite touchy at times, which I never was before (transman Jackson).

Jackson's picture of taking testosterone illustrates that it was far from an easy option for him. The psychic upheaval plus the physical effects do, however, settle down in time:

> I think my body has got to the point where the hormones have stopped doing battle and I am just having top-ups now because there are no significant changes anymore in the last year or so I began noticing it was coming to an end, the transition period (transman Benjamin).

Nonetheless, other mixed emotions and problems were reported:

> It was a strange experience having mood swings and hot flushes I remember feeling happy that I was on them but also quite depressed at first (transman Benjamin).

Interestingly, for some interviewees testosterone provided a sense of relief by producing a masculine aesthetic, while simultaneously causing feelings of uncannyness and, in many cases, depression. For example, Raymond said:

> Ironically, the biggest thing I had when I had the first injection, was a really big depression. Nothing actually to do with the hormones themselves but I have been fighting so hard for this treatment, I had a doctor who struck me off because he couldn't treat "something like you," as he said, I'd had [psychiatrists] slamming me at every opportunity, [another psychiatrist] I felt had breached my confidentiality by phoning my parents, so having put in this big effort and fight about what I need, it is not a want, it is a need, I felt very suicidal at the end. I couldn't get the viola out of its case; I couldn't get myself out of the house, so I was really at that rock bottom place, where you think you have a choice, either you do something about this or you die, it is as simple as this. Because I think suicide is wrong when there is an opportunity to do something about it, you do the something else first and if it doesn't work then you kill yourself. So when I started the hormones I felt this terrible sadness because I couldn't make it work as a female, but it comes to the point when you need to say good bye to a whole load of negatives. That person has got you that far and you have to acknowledge that

> somehow, because you can not just deny the whole being, because actually, it is quite important to understand that that person has actually got you there. So that was the first response really, the psychological drop (transman Raymond).

This juxtaposition of a sense of achievement and failure was not apparent in most of the transmen's narratives. However, it was a particularly poignant moment for Raymond when he reflected upon the sheer might of his fight against the self and the clinicians he encountered.

Furthermore, "male" puberty was mentioned in most cases. Male puberty, following hormone use resulted in bodily effects that caused mixed emotions:

> I don't actually feel anything now when I take them but when I first started taking [hormones] it was strange because I was aware that I was becoming a teenager again even though I was still only eighteen but I had been through the whole teenager phase before (transman Benjamin).

The following extract illustrates the heterogeneous feelings experienced in relation to hormones. Nevertheless, both emotional and aesthetic dimensions of taking hormones amplified a sense of masculinity in various ways, for example, psychical and physical factors were highlighted by Raymond:

> The first thing that really showed up after the two injections was a massive bout of acne. I was affected on my face and it was absolutely awful. In one sense it didn't bother me because in one sense I knew it was the side effects of hormones and that it would pass but I wanted it to hurry up a bit. The only thing my parents would comment on was the fact that I had awful acne. Not the fact that my voice had started to deepen. [...] One of the first things that the testosterone does is give you a sex drive. I don't know how they measured it but a biological male will have 250mg in there body at the peak of each cycle at puberty. Transmen inject that every two weeks in the beginning so suddenly you have gone from normal female sex drive, or low female sex drive, or suppressed female sex drive, to massive [sex drive]. Your body is changing so your bodily feelings grow at the same time

> because it is becoming what you wanted it to become at the same time. So you ask: how am I going to deal with this? And you often find transmen sitting around talking about sex (transman Raymond).

Raymond's stereotypical understanding of the sex drive, which is usually associated with masculinity and testosterone in Western society, functioned here as an intrinsic indicator of masculinity and, thus, of him becoming more male. The sex drive also coincides with a "return" to a male pubescent state. The onset of acne is often noted in the narratives and, again, is a phenomenon associated more with pubescent teenage males than females. There is a developmental discourse intrinsic to these understandings, which moves from female to boy, on a journey into manhood. This reproduces widespread cultural narratives about "uncontrollable sexual urges" brought on by "raging hormones." All but one of the transmen in the research articulated heightened masculinity in stereotypical ways, in relation to the initial stages of testosterone taking. For example, one participant talked about being "able to talk about men's things with men" due to other men now regarding him as male, another about becoming more "vigorous," another about "becoming less emotional" and another about "losing empathy with people." However, after the initial hormonal "shock to the [bodily] system" and having "got to the point where the hormones have stopped doing battle," most of the transmen in the research suggested that there was a return to their normal selves and their normal temperaments, which did not come across to me as heightened masculinity (I take this analysis up in more detail in "Negotiating masculinities" below).

Producing ideal bodies

Not surprisingly, the focus of most of the younger transmen's bodily aesthetics, in relation to their ideal body, was similar to a lot of younger men's, where muscularity and toned bodies figured highly. Teenagers explicitly linked having a well-toned, muscular body with feelings of confidence and power in social situations (Grogan & Richards, 2002). Benjamin highlights that with the body hair that testosterone helped develop and some hard work at the gym he would be able to actualise his aspiration of his ideal body and express his masculinity. He said:

I think my favourite part was getting my stomach hair, I think it is because [...I] didn't have huge breasts so I could put my hands over my chest and when I looked in the mirror I had a male chest and when I would have that [mastectomy] operation the hair would help it look more male. I am aware that if I shave my stomach hair off I would still have a feminine looking belly because I am not very muscled at the moment, so the hair was really good [...] I want the lines men have. I am aware that my stomach muscles need a lot more work, more than a genetically born male would have to do to get the same sort of muscle definition, I am obsessed with it to be honest I am the sort of person who will go to the gym, anything to make me look as masculine as possible (transman Benjamin).

Benjamin "obsessed" about his male bodily aesthetic. He also checked on his bodily transformation regularly to monitor the amount of gym work that he required to attain the ideal body he envisaged. The gym also played a prominent part in masculinising for Oscar, following my question:

Zowie: *Do you have any other regimes that you do to change your body?*

Oscar: I am actually trying to build up muscle mass and I go to the gym, this is a funny thing, last year I went to the gym frequently and really trying to build up muscle and I have a really toned body and I am happy with that but more recently I have become involved with someone who is not so concerned with visual appearances, so I have stopped going to the gym so much. She has made me aware of the whole body culture and the whole fetishising of that and what you are doing to yourself or forcing yourself to have a good body, because at one point it was ridiculous as I was in the gym about four or five times a week. I was exhausting my body with weights trying to gain muscle and make it more and more male. I realised that I just need hormones for this. The pressure of all this has been lifted by having someone who sees me as having a male energy and getting my trans identity and saying that I don't need to go down this route because it is how I read you anyway. So just keeping active now, going jogging, and just getting outside much more rather than going down to the gym (transman Oscar).

Oscar's new partner influenced the way he looked at his ideal "sexual body," by suggesting that she recognised his regime to attain a muscular body as "body fascism" and by observing that this would not ultimately enhance his masculine energy for her.

Muscularity was also an important factor for Clifford, however, emphasis was placed less on the aesthetics of muscularity and more on the strength that muscles gave him prior to him stopping working-out. He stated:

> I used to go to the gym quite a lot but I feel too self conscious to go to the gym at the moment. At the moment I suppose it is the changing rooms I cannot handle, the toilets I can just about handle, but the changing rooms are too much. I do sometimes do [exercise] at home. Something I have been quite conscious about is, since Christmas, I have lost quite a lot of weight and quite a lot of strength. Like, on the [training] course, I was trying to pull the cord to get the engine started and I just couldn't, and they were saying just give it some beef. It just reminded me of me being a girl (transman Clifford).

The strength Clifford felt he had lost became a social problem for him, owing to the fact that he felt emasculated in front of his peers. He was in a double bind, being unable to endure the interaction in the changing rooms at the gym, but, at the same time, needing to build up his muscles to feel masculine.

The majority of transmen in the research mentioned height as part of an impossible ideal, which they could never fulfil. This affected them in different ways. For example, the problems with having a short body for Benjamin were both "socially" and "sexually" problematic, because it did not comply with his male ideal. However, Benjamin did acknowledge the heterogeneity of male bodies:

> Benjamin: I am obsessed with my height and I suppose if it wasn't an incredibly painful operation [...] that would be an operation that I would have just even if it added just another two or three inches on to my height. I think it's partly vanity and because other people make fun of my height, I'm not a midget, I am a short bloke.

Zowie: *Is it something to do with masculinity?*

Benjamin: Yeah I think men are supposed to be taller than women, again it causes me problems when I am meeting women because they want someone taller than them it is quite natural for a woman and a man to want a woman shorter than he is it is not essential but it is natural I think it's a protective thing, I do feel a bit stupid if I am hugging a girl and she's taller than me it doesn't feel quite as normal that's something I would like to change about myself but I can't so I'm stuck with it (transman Benjamin).

On both a "sexual" and "social" level, the expectation of males being taller than females was something that affected Benjamin's interactions as a heterosexual man.

Surgical outcomes and aesthetic conciliations in different spaces

The belief that the body can be expressed in limitless ways with the aid of technology (Baudrillard, 1987; Kroker & Kroker, 1987) available in the UK and through surgical tourism is a myth. Accordingly, at the outset, transmen's stories suggest that initially there was a "dream" of creating a body like those of biologically born males, however, this was rarely actualised. One of the themes to emerge from the interviews was what I have termed *limits on/of the body* in relation to bodily aesthetics. These limits were linked by the participants to various contexts and locations. In most of the transmen's accounts, aesthetic constraints were highlighted after surgical procedures. Phalloplasty surgery offers the transman a neophallus that takes multiple operations to construct. Body tissue is taken from the forearm or stomach area and attached to the genital area, which leaves obvious scarring, either on the forearm or the stomach. Metoidioplasty[21] is an operation through which the clitoris is extended and sculpted to give the appearance of a small penis. The decision to have phalloplasty for Benjamin, for instance, was because the "other option" (Metoidioplasty) would not be sufficient enough to make him look like a "normal male". He said:

[21] With testosterone the clitoris enlarges, over time, to an average of 4-5 cm. In a Metoidioplasty, the enlarged clitoris is released from its position and moved forward to more closely approximate the position of a penis. In some cases the urethra is lengthened to end at the tip of the neophallus.

Another option is for them to extend the clitoris which I know some people opt for. I just thought what's the point? Because it is something like half an inch long or an inch long and it is very thin to me. That is not a normal male unless there is something wrong, so yeah size did matter it does to every guy (transman Benjamin).

For some transmen, in order to have bodies that are characteristically male, such as, having a flat chest and/or a "normal" sized penis, aesthetic concessions have to be made. Benjamin continued:

> Benjamin: The first surgery was double mastectomy with nipple reattachment. I don't think they have actually made them [nipples] smaller. They were going to but they have just reattached them so they are in a better place. [...] There are several different ways of doing it. They've just taken out the whole of the tissue and gone straight across my chest. [I am] not too happy with the scaring, it's very, very big. I was happy at the time but at the moment I am not happy.
>
> Zowie: *For what reasons?*
>
> Benjamin: I think I was happy at the time because I was just happy to get rid of my breasts, and the fact that I could just wear a T-shirt and not have to do all the binding. Now a couple of years later I am still not in a position to take my top off without people noticing that there is something wrong. The scar tissue is about a centimetre thick and still very obvious and my nipples aren't quite normal. If you walked pass me in the street, if I had my top off, you would notice a huge difference, it may not be obvious what I've had done, but there is obvious surgery there, quite dramatic surgery (transman Benjamin).

A flat chest contributed to transmen's sense of maleness and, in addition, permitted participants to wear a wider choice of clothing without the nuisance of binding[22]. But drawbacks were expressed for instance restricting the removal of clothing in social spaces, such as sporting venues:

> I am happy that I don't have to bind anymore and [I can] wear a T-shirt and feel comfortable, but my dream is to go swimming and that's my ultimate goal (transman Benjamin).

The scarring that is visible on transmen's bodies is obviously due to major surgery. These scars can fade or become concealed over time with body hair. The concealment is, however, contingent on the continual taking of testosterone. All but one of the transmen interviewed indicated that in public spaces scarring constrained their behaviour because it risked heightening other's curiosity and triggering questions. It was not because people would automatically make assumptions and read the participant as a transman, in fact, most of the participants suggested that few people would recognise double mastectomy scars unless they knew them intimately or they were "in the know." In addition to the restrictive nature of public spaces, the following extract illustrates how Jackson felt constrained in private sexual spaces:

> Zowie: *How did you feel about your partner seeing your body prior to transition?*
>
> Jackson: I didn't mind before, but I don't like it so much now. I feel a bit embarrassed, a bit like a butcher's shop. I think I felt a lot more comfortable when we were supposed to be gay, as people saw us. I would often walk around with nothing on [...] I would never do it now. I always shut the bathroom door now and I think I have become more private than ever (transman Jackson).

Following chest surgery Jackson's concern was centred on the detrimental effect that the disfigurement had produced in his relationship with his partner. His negative body image affected his "sexual body" and everyday private practices and his relationship. While poor

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[22] Binding is used by transmen to flatten the chest area to make it more in-line with a male chest. This practice is often experienced as restrictive and uncomfortable.

support from the family, and other people close to the transperson, is a documented prognostic aspect of a transperson's experience of regret following "gender confirmation surgery" (Landen, 1999), in this case, the bodily aesthetic adds to the negative experience of shame.

Benjamin had started procedures for phalloplasty at the time of the interview. He was also waiting for a pump to be fitted within his prosthetic testicles, which would enable him to have an erect penis. Benjamin was also waiting for a skin graft to the tip of the penis. While he was content with the aesthetic outcome of the penis that had been constructed, Benjamin realised that the operations still had their limitations. He stated:

> At the moment I can meet someone but I still can't sleep with them, not really, fully as a man and I think that will make a big difference. Someone will still be able to tell, the surgery is brilliant, but it won't be like that you won't be able to tell, I don't think so anyway (transman Benjamin).

The potential of surgical outcomes, the dangers that are sometimes encountered, and the possible failure of the operations are all analysed by the transmen in relation to their "sexual body." Alongside the restrictions imposed by the limits of the non/pre-surgical body, these are sometimes discursively and materially challenged by the participants. In the narratives that follow, the liminal "phenomenological body" does not simply stop at the surface of the skin (liminality is a stage of change, for the period of which your usual limits to self-understanding are relaxed, opening the way to something new); in these cases the "phenomenological body" and "sexual body" schema is extended psychologically and materially with the use of prosthetics. Kenneth stated:

> Phalloplasty is an operation that doesn't work. It has a fifty per cent fail rate. Psychologically, by the time you have gone through the two years RLE, unless you have gone out and bought yourself a device that you can pee standing up, or you're not comfortable with the strap-on that you use, I personally think that it is a lot of operation. In my case, and the reason I am not looking at it [phalloplasty], is not because my body is not robust but because it has a fifty per cent fail rate and the psychological implications of that not working and being left with something

that does not function and is not aesthetically pleasing. I think you have to look at the aesthetics and it is an interesting trade-off between the FtMs and the MtFs, the FtMs pass, the MtFs struggle and get harassment but the operation is a lot smoother, the other way the operation is not. To be honest with you being able to pass allows you to achieve more. If you are going through a phase where you look wrong you get marginalised. I think [...] we are living in a materialistic world, and it is all about advertising, so when you go for a job you are advertising yourself so if you haven't got the sort of balls, or background, or confidence to carry that off you are not going to get the job. So it is about image and perception so you can be really crap but give the impression that you are great. The phalloplasty for me is not the be all and end all of life. I function with a strap-on, I have a very realistic one, I don't know if you have come across what they call a Doc Johnston, from America, it is very realistic. Being male for me is not phallocentric (transman Kenneth).

Kenneth and Oscar distinguish between the social and sexual spaces where their extended body morphology is significant. Kenneth, for instance, raises the issue of passing as socially important in order to escape prejudice and thus allows him to accomplish more in his life. Here, the penis is less of a social requirement and emphasis is placed instead on other bodily areas, along with "correct" comportment and demeanour. Kenneth suggests that it is how these characteristics are perceived by those in positions of power, which is more important because it is those people who can award material benefits. Oscar suggests that by using "packing" to give the impression of male genitals provides him with a sense of security within a social setting.

I sometimes use a sock and just that extra bit of padding helps me feel a bit more comfortable somehow (transman Oscar).

The impression of a penis, rather than actually having a penis, is significant in social spaces and thus, for the "social body". This further suggests that when these transmen considered transitioning and possible surgical procedures, it was not the genitals that were identified as the most important factor in the construction of a male body. The place, however, where the intimate bodily aesthetic is most likely to be seen by others is in sexual spaces.

Sexualised spaces, such as clubs, bars and homes, help to produce other narratives about the use of prosthetics as an extension of the body. Oscar stated:

> when I am going out and if there is more of a sexual energy, I tend to do that if I am feeling particularly playful, so I have packing or my soft dildo, which I am replacing at the moment [...] I mean sex, it is important for me. To be wearing a dildo, that is when it really matters (transman Oscar).

For Oscar the use of prosthetics contributes to his sexualised and masculine aesthetic while "going out" and procuring sexual partners. Kenneth, too, incorporates the use of a strap-on device while having sex with his partner.

> The Doc Johnston which feels real anyway, it is latex and because of the way it is worn and my clitoris is quite big it really connected and it felt as if I had a real dick. I do not like being penetrated but I don't mind my clit or dickclit as we now call it, being played with. I like to give and she likes to receive so it works very well like that (transman Kenneth).

A process of re-figuration is employed in this narrative. The clitoris, a "female" body part is discursively replaced by "dickclit," which creates a new (queer) bodily meaning. While these narratives could be interpreted as "butch" lesbian sexual practices, the reference to the "dickclit" is a decidedly queer or transgender term, which undermines that reading. Furthermore, the bodily sensation created by the prosthesis touching Kenneth's "dickclit," while he is having sex, allowed him to articulate feelings of having an authentic penis. These discursive strategies arguably remind us of Butler's (Butler, 1990) assertion of potential subversion of sexualised discourse. While Kenneth may be able to bask in the phenomenological subversion of his own (sexual) situation, by refiguring his "sexual body," his intelligibility may still be ordered through the power of "social" norms that mark him as intelligible in other situations.

The participants who use, or have used, prosthetics suggest that they can, in various contexts, extend the limits of their corporeality. The overarching claim of all members of

this group of participants is their ability to produce artful, playful, and sexual practices through discursive constructions that carve out a utopian space, which is relatively free from social determinations. In relation to the bodily aesthetics, after the union of artefact and body, the new form extends gender normative expectations and theoretical limitations. Furthermore, it is possible to understand that the union of the body and the prosthesis defies social categorisations in heteronormative discourse.

In contrast to the narratives of extended corporeality and those of normative bodies, the limits of the body were an accepted factor in a few transmen's stories. In the following narratives, participants' body modifications stopped after hormone intake, mastectomy, and, in all but one case, hysterectomy or variations therein. Like many transmen in this research, the decision not to undergo phalloplasty was taken on the basis that the potential risks of multiple operations outweighed the potential benefits, when balanced with the "social" and "phenomenological" requirements.[23] These decisions were also thought through alongside other factors, such as age and acceptance of their "sexual" bodies by significant others, especially sexual partners. This bodily acceptance was not automatic but came about through certain intersubjective and intercorporeal experiences, which then legitimated the "contradictory" body. For example, Raymond offers two diverse contexts in which his phallusless body had been phenomenologically and sexually validated, he said:

> When you go to a cruising ground, [...] I thought well, it was a really challenging thing to have to do that. The first time I did it I was absolutely petrified. By being there you are consenting in a sense, so if someone happens to suggest something and you are not happy about it, don't beat yourself up about it. The fact that you are going, take that out of the equation before if somebody wants to do something that perhaps you haven't thought about don't immediately say no. It is quite interesting how your horizons broaden. I did enjoy the fact that you could be a blank canvas. It was a nice space to be a part of that fantasy. I was open about my body. In other ways I have worked with a photographer [...] At first I went along and she said nobody is going to know that you are trans, so I ended up taking my

[23] I do not want to suggest that the penis is not important for all transmen's sense of themselves as men. The aesthetic presence of the penis is, in some cases, very important, for example, see Benjamin's accounts in this study.

clothes off. I had no intention of doing that when I went there. It led to a really, really interesting thing because there was something empowering about that. It felt more honest to do nude photographs than it did doing them with clothes on, because at least people could see the contradiction. Is it such a contradiction? Is it so bad? What is the problem? Let's see it for what it is. Let's not imagine there is a penis in there or a hand made penis (transman Raymond).

Daniel was also a non-operative transman, who worked as a sex worker. His masculinity and (masculine) bodily aesthetic were validated by his clients. Following my question:

> *You mentioned that you usually have sex with men, are you comfortable with your body in these sexual situations?*

He said:

> Generally yes, but I am a little self-conscious about the small dick and lack of testicles but these people I know accept me as a man and that is the important thing. If they didn't I would feel like I wouldn't want to get undressed in front of them. So again it is how people perceive me because we don't exist in a vacuum. There is one guy who I have sex with on an irregular basis and I have actually asked him "do you feel like you are having sex with a guy," and he said "absolutely." So you know I know he is not lying. Unless he is doing it just to please me, which I know he is not, so that makes me feel good (transman Daniel).

Gregory, a disabled transman, reiterated these sentiments in relation to how people perceived him and the importance this held to his sense of self as a man, but, at the same time, he was clearly upset at not being able to undergo surgical procedures. The probability of Gregory dying during surgery was too high. In this case, then the decision of whether or not to undergo surgery was out of his hands and was made by the medical team that he was under. I asked:

> Zowie: *Can you talk about how you feel about your body in relation to your gender identity?*

> Gregory: Absolute repulsion; not because it is not perfect, just because it is the wrong one, basically. I was approved for all surgeries, but I was told I couldn't have any because of the health risks. I expected that from the outset though because my airway was crushed when I was born, I have a high anaesthetic risk. When I have had to have surgery in the past I have actually been clinically dead on a number of occasions. I have virtually no airway and a cleft palate and damage to the vertebrae and underdeveloped jaw [...] it is not just normal risk, it is off the scale risk. It is a guaranteed killer. Well the whole point of doing this is to stay alive and what is the point in killing me in the process? However, when I first had that news I did feel suicidal, but actually to be fair I had anticipated this. So it wasn't a total shock. [...] I thought, except for a partner, the only person who will see me and who would know I hadn't had the surgery, is me. I can wear the painful chest binders, prosthetic dick, which is clearly not the same but to the outside world, they don't know, so as long as I am seen as male and seen this way, that is the whole point of it anyway. I got to the point where I thought that I am male anyway. I live by ignoring it basically, it is obviously difficult when I am getting changed, having a bath, so I take quite a disassociated approach to it really (transman Gregory).

Contemplations about having, or not having, body modifications are evaluated in relation to others and are intrinsic to the individual's sense of self.. However, the outcomes and realisations of bodily aesthetics were based on "phenomenological," "social," and "sexual" body images and contexts that were particular to each individual transman.

Negotiating masculinities

Masculinity, in this research, was varied and depended on factors, such as, age, bodily aesthetics, temperament, life histories, and relationships. Transmen negotiated masculinity through their "phenomenological" and, inescapably, through their "social" and "sexual" bodies. While most transmen said they "returned to themselves" after initial testosterone ingestion and "shots," this process was aided by the masculine bodily aesthetic that they produced. Hegemonic models of masculinity were not the only source of claims to a male gender. The shift from heightened masculinity was a result of their "social" body, which

was reflected through social and sexual interaction, which allowed a space to negotiate and redefine masculinity. Reflecting on their queer and metrosexual masculinities, Clifford and Oscar, who both live in cosmopolitan cities, said:

> Dandyism is a very big part of my self. I have often wondered where that fascination came from. Since I was a kid I have always been into ties and cravats, my dad has lots of great ties that I used to wear, and I always wanted a monocle. Which Dandy was it? I think it might have been George Brummel, an eighteenth century Dandy. He is wearing a monocle, so since I was about seven [years old] I wanted a monocle so I bought one at an auction. That is a 1920s monocle, it cost me fifteen pounds, which I was really chuffed with because it is kind of quirky, and eccentric. I do like dressing up and the dandy, the figure of the dandy is about going back to Oscar Wilde and the aesthetes of the nineteenth century, which is part of my identity and in terms of sexuality, I am attracted to gay boys as well and when my dandy image comes through I am aware that it can also be equated with a lesbian identity such as those like Radclyffe Hall and so it is all about a white upper class, aristocracy and so it is a kind of play on that (transman Oscar).

The cities where these young transmen live and socialise allowed them to explore and take-up non-traditional masculinities. These masculinities are wrapped up with sexualised spaces. Clifford, who described himself as pansexual, suggested that heightened masculinity was not important to him at all, however, being regarded as male was:

> Zowie: *So what image do you like to give out to society?*
>
> Clifford: I suppose I want to be individual, not necessarily standing out and being in the limelight, just to be me and not have to conform to a group of people and fit in the box, I prefer to just to be me. With regards to gender I prefer to be seen as male but not in a very typically masculine way that is not important to me. By the same token I do not want to be treated in a typically feminine way (transman Clifford).

Hegemonic masculinity was shunned by all of the transmen in the research. "To be *seen* as male," without being seen as "typically masculine," created grounds for negating forms of masculinity which were deemed wrong and unsuitable within the transmen's life. This is, however, tethered by outside pressures of conforming to certain aspects of masculinity. In a working environment, that is made up of predominantly male employees, Jackson suggested that he was advised by his colleagues (who knew of Jackson's trans status) to express himself in line with normative masculinity found in the construction industry. However, Jackson contemplated this and finally rejected the advice because it was not how he felt he liked to be:

> I believe, well people tell me, that I am too nice and friendly to be a man [laugh] and I am trying not to listen because it is not in my nature, I have always been smiley, I have always been friendly. People say that I should try to be more serious and even men on the [building] site say I should try to be more serious. The brickies say "you're always so nice stop doing it" but I cannot, so I am a bit lost with that really. I don't really have a good role model because I don't really like my dad very much. I had a very nice granddad, and I try to remember him and I try to be like him (transman Jackson).

Negotiations of masculinity are centred upon Jackson's "phenomenological" body. The interaction between Jackson and his work colleagues at the building site are a cause of perplexity for him because learning to fit in as masculine in this social environment requires him to base his behaviour on models of masculinity that he does not like. He likens his work colleagues' ideas about masculinity with his father's outlook that he did not respect. Jackson prefers to rely on a model of masculinity akin to that of his granddad, whom he saw as a "gentleman," which was validated by his ex-partner. Jackson demonstrated this in the following exchange:

> Zowie: *What do you think she was attracted to?*
>
> Jackson: well Fiona always said that that was what she liked about me; she said that I was an exception to the rule. She said that I was gentlemanly and quiet and that I had nice manners and treated her right.

Zowie: *What kinds of things do you do to show off your masculinity?*

Jackson: Well I don't know if I show it off. I play in a band, a jazz band, I am a trumpet player, I have always played in bands and I play the guitar, nothing else really. I don't think I am showy really.

Zowie: *What kind of masculinity do you aspire to?*

Jackson: Do you mean what I would like to be like?

Zowie: *Yes.*

Jackson: Well I suppose I would like to be like my grandpa was (transman Jackson).

The "exception to the rule" comment by his ex-partner was understood by Jackson to be a positive critique of his form of masculinity. In this respect, Jackson's masculinity is a continuation of his pre-transition temperament. He continued with his pastimes, such as music, in his distinctive way, taking his masculine cues from his grandpa. What this illustrates is the changing formulations and negotiations of masculinity in different "social" and "sexual" spheres. Moreover, there are interesting combinations of "old" and "new/queer" ideas of masculinity at play for Jackson and Oscar.

Conclusion

Childhood lived experiences often manifested as chaotic disidentifications with transmen's sense of their "phenomenological bodies" and their social roles. For most participants, these feelings were heightened during puberty, which engendered feelings of disidentification towards their pubescent bodies, which had betrayed them and caused them both psychical and physical pain, which resonates with Rubin's (2003) analysis. However, these were far from disembodied feelings. Indeed their bodies were central to their sense of disidentification.

Once the decision to transition was made, "thinking the process through," for these participants, was about weighing up their feelings about corporeal requirements in relation to their sense of self, along with personal dynamics of bodily discomfort and disidentification. Bodily aesthetics were variously desired and actualised. The ontology of transmen's "body projects" is formulated at three levels that all affect the overall body image. The first level is the personal "phenomenological body," the experiential body that lives in the world. The "social body" is gazed upon and valued by others, which incorporates both good and bad signs of acceptance. The "sexual body" is judged in more particular spaces and aesthetic validations are often given by significant others. The judgments by (significant) others about the "social" and "sexual" bodies of these participants, were also relevant in the decision making process, and impacted upon whether the participants would aesthetically alter their bodies, in the gym, hormonally, surgically, or through clothing. Most participants forsake the idea of a perfect(ed) body in its entirety and concessions are made about scarring and the possible disputability of an authentic looking penis. In some cases, the limits of the bodily aesthetic were overcome with prosthetics, which achieved a sense of unity with the self as a man psychically, socially, and sexually. In some other cases, the refashioning of genitals or having a non-operative body, and the limitations that come with that were accepted, especially when the non- or pre-surgical bodily aesthetic was validated through the gaze of, and acceptance by significant others. Being accepted as male sometimes mitigated the desire to surgically trans-sex, but could create a vicious circle when encountering people in spaces where the body is more open to the gaze of others. A central theme to emerge from these narratives is the heterogeneity of transmen's narratives. These heterogeneous narratives challenge traditional medicine's aetiology of transsexuality, because transmen are phenomenologically too diverse to capture in traditional medical models.

Chapter V: Recognising the Self: Transwomen's Body Projects

Introduction

This chapter will argue that transwomen's identities and subjectivities are constituted through a complex array of body modification, clothing, and adornment practices within discourses of choice and desire. Similarly to my consideration of transmen, I explore how transwomen's identities are experienced in relation to the complex interplay of sociological variables, different demographics, and aesthetic signifiers of gender. I aim to illustrate the broad range of trans subject positions and move beyond monolithic and universalist understandings of transwomen and explore the diversity among their narratives. I will also weigh these against the transmen's narratives explored in Chapter IV.

Using the heuristic devices employed in the previous chapter on transmen – the "social body," "sexual body," and "phenomenological body" – I will first consider the participants' childhood recollections. Following this, I will concentrate on the decision making processes and the emotional ebb and flow and ambivalence inherent in the desire to transition from male to female. The penis as a potent symbolic signifier in transwomen's narratives will then be explored. Next, I draw on the participants' understandings of the sartorial aspects of trans-sexing and the antagonistic relationship with discourses of transvestism and gender stereotypicality. I will then consider hormone therapy in relation to beauty and femininity. Finally, I will explore the various surgeries, aesthetic outcomes, and the "passing" "social," "sexual" and "phenomenological" bodies of transwomen.

Childhood re-envisions

In this research the feeling that "there was something wrong" for male-to female transsexuals was very similar to the transmen's understandings. The narratives of transwomen, on the whole, differed only slightly with this feeling that "something was wrong" starting around four or five years old instead of various ages for transmen:

> [It was] about the fourth or fifth birthday, don't ask me why I identified, well actually that was wrong I did not identify as a woman, I just knew there was something wrong (transwoman Jess).

Identification with the opposite gender was not automatic. Identification was not static and was not premised primarily in binary thinking. Like many of the transwomen, Jess' sense of difference was present when she was playing with girls. However, she did not identify as anything other than the volatile boy she had been (medically and familiarly) ascribed as. Phenomenological feelings intensified with childhood cross-dressing scenarios, nonetheless, these feelings of difference were intermittent and pleasure was derived from feminine clothing and playing with girls. Jess continued:

> I was cross-dressing in my grandmother's clothes. I was always more interested in clothes than other little boys. I was very envious of my girl cousins and I played with them at my grandmother's house and was far happier doing that than playing with boys. However, I was aware that that is not the way the game is played and I conformed. I am by nature a conformist; I am not a rebel (transwoman Jess).

There was a sense that she did not feel like an ordinary boy because she was happier to mix and play with female children rather than male children. Interestingly, though, Jess likened gender performativity to a "game." Erik Erickson (1950) claims that the games played by children act as a function of the ego, in an attempt to synchronise the body and social life with a coherent self. The theory highlights the self's need to master the various areas of social life, and especially those areas in which the individual *finds* his or herself, his or her body and their expected social roles deficient in some way. The self is not solely the "core" self in these instances, as Claudine Griggs (1998) would suggest, as a "core gender" yearning for aesthetic representation, but more of a negotiation between ambiguous feelings, re-envisioned as gendered, "with a continuity of one's meanings for others" (Erikson, 1950: 253).

In Diane's narrative, seeing the naked female body of a neighbour was a key moment, which allowed her to contrast male and female bodies:

> my second memory was seeing one of the daughters living next door and seeing her without any clothes on and instantly knowing that my body should be like that, wanting to be like that and that was at about the age of five (transwoman Diane).

This visual encounter for Diane heightened feelings of identification with the girl's bodily aesthetic.

These narratives indicate that sex differentiation was clearly understood at a young age. However, through these types of experiences Jess and Diane, like many other transwomen in this research, came to recognise themselves as boys and were willing to conform to performative ideals of male gender, which were constraining "reiterations of [gendered] norms" (Butler, 1993: 94). However, the *feelings* of difference continued. Lesley said:

> I like life too much and the single thing in a transgender life and anyone else's life is life. And if you can't do it well you got to live with it. Of course some people can't and commit suicide and all the rest of it but I couldn't let that happen to me. So that is when I started to make the effort to be a male and try to be aware of what males do and try to fit in a bit (transwoman Lesley).

Jess and Lesley both conformed to normalised notions of masculinity until they were middle aged, both marrying, and in Jess' case, having a normative family life (eight of the male-to-female participants transitioned at middle age or older and seven transitioned at aged thirty or younger). This was until, what they described as "gender issues," came to the forefront of their concerns and they decided to act upon their desires.

For Emily, the willingness to conform to a social ascription of masculinity lasted until she went to university. Prior to this, however, identification with other teenage girls added to Emily's desire to be like them:

> Emily: Well, I thought about transition vaguely since I was about 13 although I didn't really know that people could transition and I didn't really know any other transgender issues [...]. For most of my adolescence, I just tried very hard to be a young teenage boy. Yeah, when I got to about eighteen some of the more interesting teenage girls appeared. I got into them and thought I would like to be like them if I could. I still knew what I wanted, but it still didn't seem like a possibility though.

Zowie: *Can you describe these girls?*

Emily: The punk indie types, dyed hair, funky clothing.

Zowie: *Were you a part of that subculture?*

> Emily: No not then, I would say I am now. I just admired them from afar (transwoman Emily).

The connection to "the more interesting" girls had a profound affect on Emily, which suggests that she fantasised about being figuratively feminine inline with the punk/indie sub-cultural aesthetics that girls in this group conveyed. However, at this point in time, not having the cultural and gender capital to consider trans-sex technology left Emily unaware of hormonal or surgical possibilities, so she continued to "admire" feminine signifiers of her (potential) sub-culture, while retaining a sense of herself as male.

Following the transgender academic Elaine Lerner's (Lerner, 2006: 151) observation in *Crossing Sexual Boundaries* (Kane-DeMaios & Bullough, 2006):

> [m]any of the transgender I have talked with have similar early childhood memories-clomping around in mother's high heels, hiding in her closet, and feeling the soft fabric of her dresses [...]. Perhaps many little boys hide in mom's closet and put on girls' clothes sometimes; this [re-envisioning of narratives] subsequently seems more significant to transgender.

The focus on gendered aesthetics and gendered signifiers is more comprehensive in this research than in Lerner's account of gendered clothing and other signifiers are offered up in the re-envisioned narratives of the participants, as I will demonstrate. For example, feelings of difference emerged through viewing the bodies of others, during play, trying on clothing, which created identifications with the "opposite" gender. "Wanting to be like them," however, was thwarted because of cultural ascriptions of masculinity, which were adhered to primarily because of age and social pressure. As children, the transwomen in this research began to weigh-up the "rules" of play that were encouraged and validated by

society. In all the cases, conformity to cultural ascriptions of normative gender was adhered to until adulthood was reached. Whilst identification with feminine signifiers and cross-dressing scenarios continued, the lack of cultural capital about trans-sexing was identified as the most significant factor to impede their desires. Cultural capital is "gained" and situated within a person's "habitus," where conditions of knowledge, taste and judgment can engender an infinite number of patterns of behaviour, thoughts and expressions (Bourdieu, 1992). The habitus is a generative structure – rather than a deterministic structure – with objective limits (McNay, 2000). For my participants, the limit at this time was the lack of knowledge about trans-sexing. As I will explore in the next section, even in adolescence and later in life, cultural and gender capital about trans-sexing is required to give shape to transsexual embodiment and bodily aesthetics.

Decision making process

Emily, who transitioned as an adult teenager in the 1990s, said:

> I met my first long-term partner who I was with for four and half years, she was really helpful. She identified as lesbian when she met me, when I was obviously pre-op. It gave me the freedom to start wearing make-up and wearing, well not necessarily female clothes but wearing clothes in a slightly more effeminate style. So I started wearing things like vest tops, which would not have worn before, leaving my arms uncovered and things like that. Gradually with her I started making plans for transition. The interesting thing was the male friends I had, although I never told any that I was going to transition, I slotted in to this strange space. For example, in straight pubs they [the heterosexual males] would let me sit on their knees and things and it was not considered homosexual. I don't think they would have done it with other men but they did it with me. I am not sure how I managed it, maybe looking asexual. I think this gave me confidence and I would still have friends and they would be ok (transwoman Emily).

This freedom to express herself can be viewed in different ways. Firstly, university provided the space for Emily to find a partner who was complicit in her gender experimentation within punk/indie sub-cultural aesthetics that she had been fantasising about while at,, and prior to, leaving home. University was also a place where mainstream

and alternative cultures overlapped and thus lessened concerns around homophobic and transphobic encounters.

> People in our group often stated they were bisexual, even if they did not partake in sex with males and females (transwoman Emily).

During the 1990s, Britain fostered many queer sub-cultures, where rigid gender aesthetics were disrupted. For example, following on from Glam Rock of the 60s, punk in the 70s and the New Romantics of the 1980s, "gender bending" singers emerged, such as Boy George, Pete Burns and Placebo's Brian Molko, whose aesthetic was extremely visible in popular culture at the time, and who endorsed the mixing up of gendered signifiers. Similarly, the punk/indie sub-culture facilitated aesthetic styles that allowed for multiple (trans) gender figurations, as Emily illustrates in the following exchange:

> Emily: Well it is suddenly a partying phase when all your female friends are inviting you round to paint your nails and watching chick-flicks and give you reassurance, it was quite good.
>
> Zowie: *And your male friends?*
>
> Emily: I had some very open-minded male friends. I think it was the university setting and there were many bands and films and things that it was hip to be in to that had trans elements in there. I hate using this as an example but Brian Molko from Placebo was huge at the time and loads of people were going around with various make-ups and there were various levels of cross dressing. So having that in the mainstream certainly made it easier. Having things like Boys Don't Cry, although this was not at the start of my transition but certainly nearer the end, and everyone was talking about these things. It was good for talking about mainstream things and the possibility that he was trans in it. I used to look very different then, I had a shaved head, and I looked quite aggressive then, so before hormones, I didn't look particularly calm, let's say (transwoman Emily).

Similarly, Octavia suggested that being part of a Goth subculture made her experimentations far easier than she imagined it would have been in normative society. She stated:

> The S&M Goth scene is very much about playing with styles that highlight the secondary sex characteristics, which is great fun. You can also do it in an environment where people don't mind. It is a wonderfully liberating experience to play like that, in the clothes and atmosphere where that sort of behaviour is encouraged, which helps a lot. I came out of my shell a great deal because I was allowed to explore these behaviours and these styles in a way that I think a lot of people can't in everyday life. Some people might say that it has left me more balanced, some people might say not but I know it has (transwoman Octavia).

Many transwomen sought out and explored particular sub-cultures to experiment with aesthetic expressions of gender and sexuality in order to get a fuller sense of what they enjoyed and who they wanted to be. Nancy for example stated:

> Nancy: Within a few years of that, maybe six, seven, eight years ago, everything became untenable. I was no longer happy with this like up and down way of living. Then I began a search of what exactly I am. Something happened and being in a situation of no longer knowing what I am [...] so I explored, was I a gay man? Was I a bisexual man? Was I this kind of man or that kind of man? Was I a transvestite? And in the end the last thing I explored was, was I a boy who was a girl who was a boy? That didn't work either.

Zowie: *Can I ask how you explored these positions? I mean did you explore them within subcultures, for example the gay scene?*

Nancy: Yes I did I got involved with the gay scene and then I got involved with the transvestite scene. I can clearly remember the time I went out dressed as a woman since I was eighteen and I have never had anything like a femme name for myself. I was always Norman, the name given to me at birth. I remember going to

my first transvestite thing and there was this person who was meant to be mentoring me and this person introduced me to one of their friends. "This is Diane." Then they looked at me and said "this is…" and I said "I don't have a femme name," so she said "this is no-name" and I suddenly thought my name is Nancy, which was the first name that came into my mind and it has just stuck there. The name was not important to me it was being me that was important none of that was important. So I was exploring these kinds of things on the transvestite, transsexual scene. And that I was bisexual and I quickly found that I could not take a male role in these things, in these activities and it would have to be female. Even in the days that I was Norman sex was difficult for me and I would have to fantasise about it. So I found out really quickly that I wasn't gay and I found out very quickly that I wasn't transvestite because they just didn't work for me. There was me, wanting to go out on the streets and in everyday life being me, and these people just wanted to go to venues and clubs and this sort of thing. Very quickly after about six months of that sort of contact I just did everything on my own. So I would dress anyway in quite a boyish manner on the transvestite scene exploring, was I a boy who was a girl who was a boy, but in the end when I had ran out of any possibilities of what I could be I just turned round to myself and said oh shit I am a woman! I knew I needed help (transwoman Nancy).

Within Nancy's narrative the preference for a stable subjectivity was central, as it was for all the transwomen in this research, and was marked by socio-cultural and personal beliefs about masculinity and femininity, maleness and femaleness, transgender and sexuality. These narratives compliment the findings of Ekins' (1997: 87) study, in which he asserts that the primary phase of "doing femaling" – that is a building-up of a sense of femaleness through sex, sexuality and gender – what I have conceptualised as the "sexual body" image

> is not constituted in any coherent manner [, which] differentiates the self to an opposite gender. As his [*sic*] 'doing femaling' becomes more frequent the tendency to seek to 'explain' it may well become more pressing.

Prescribed modes of being gay, bisexual, and transvestite were formulated by Nancy but were not adequate identities for her, in the sense that she felt could she could not securely

fit into any one of them. Nonetheless, the journey through these various identities was required in order to dismiss them as inadequate. Whilst Nancy had an array of gendered and sexual subject positions available to her, fluidity marked by "was I a boy, who was a girl, who was a boy?" was an unliveable option, as, too, was the fluidity of the transvestite identity, because Nancy's search was for a permanently fixed and unambiguous self "in everyday life." Moreover, a presence within a secure bodily boundary considered as "woman," produced self-value as well as having social currency.

Nancy's gender conformity is negotiated through many subject positions prior to her establishing and exclaiming "shit, I am a woman" and settling on a comfortable identity and where she feels at one with her self. Nancy's feelings started to become fixed and definite in form, which also alleviated "phenomenological" feelings of "difference."

It seemed important for some participants to have some sort of support network, whether sub-cultural or closer, such as friends and/or lovers. In Nancy's, and Emily's, case these networks allowed them the space, support, and time to work "phenomenological body" issues of difference through. The intimacy and support provided by significant others lent these participants much needed clarification of thought, and added to the "gender capital" required to accomplish womanhood. These points raise the important issue that it is not the "core gender identity" of medical opinion (Griggs, 1998; Money, 1995) that somehow guides transwomen to actualise a female gender aesthetic. Body modification and/or sartorial practices are explored along with (socially constructed) gendered signifiers in supportive spaces. In addition, which is of paramount importance for these participants is the realisation that something can be done about feelings of "difference" with the aid of technology and medicine.

As the sociologist Brian Tully (1992) concluded, in his extensive study of transsexuality, what matters is that they have the "resourcefulness," that is:

> what is entailed [...] acts, intensions, judgements and justifications and so on [...] the crucial cognitive, emotional and imaginative processes necessary for the final crystallization of the transgender commitment (Tully, 1992: 16).

This, in part, is illustrated by Karen, who was middle aged and pre-operative at the time of the interview:

> [I did] the usual really, the cross-dressing, going out meeting people, talking to people, finding out about things, and obviously living in different environments. So there was lots of experimentation and the strength of feelings was very intense. I also had quite a strong relationship about ten to fifteen years ago now, with somebody who was transsexual and I helped her through her transition, I took her down to her surgery in [...]. She lived here for quite a long time while she recovered; she spent a lot of time here until we split up eventually. So there were different bits and pieces and in a way I suppose it may be a horrible way to look at it but I suppose I think I drifted into it in a lot of respects (transwoman Karen).

Courtenay suggested:

> going to get my nails done is the one trigger that eventually pushed me forward. I kind of rationalised, I sort of tricked myself into it, because once I had made one step then I thought I'd get my eyebrows shaped I had that done and eventually had my eyelashes tinted, I guess I was experimenting. I then began to transition (transwoman Courtenay).

In contrast to these personal "phenomenological body" image balancing and "social" bodily experimentations, the ebb and flow of sex and gender "testing" sometimes involved medical intervention, but it must be noted that the encounter with the medical field that followed was not the determining factor in creating a transsexual subjectivity, as some feminists suggest (Raymond, 1980). Transgender feelings come about not because of the ascription of a medical label – a theoretical error that positions transsexuals as dupes of the medical field – but because of the strong and persistent *desire* to transform the body and trans-sex. It is often stated in feminist literature that the transsexual will, in full or in part, adopt the medical discourse to secure treatment (Hausman, 1995). However, I argue that this adoption is often only rhetorical. This is because transsexualism is not a testable medico-pathological condition but rather relies on self-diagnosis by adult transsexuals in

order to actualise the *desire* to trans-sex. In this sense, the psychologist's "diagnosis," which brings institutionalised legitimacy, only follows the transsexual's own. These self and medical diagnostic events, then, tell us more about the social structure of the "gender order" and aesthetics within either a given (sub) culture or medical discourse, rather than telling us about the "nature" of *Gender Dysphoria*. For instance, Lesley observed:

> I thought I could do something about being different, so I made some enquiries and started to go down that path. I was quite clever, I thought, looking back I was keeping my options open, because I was determined not to tell my GP because then it is on your records forever. I found a sympathetic social worker at a 'people's centre.' I had a meeting with her and she referred me to a sympathetic GP who was not my own GP, who had an interest in transsexuals and other social and sexual stuff as well. I was referred to a psychiatrist. He diagnosed me with Gender Dysphoria, this was in 1974 and he prescribed an oestrogen based thing, whatever was available. When I went to the gender clinic twenty five years later all my files were still there (transwoman Lesley).

According to the majority of participants, periods of indecision can last many years, as the quotation above illustrates. Lesley, who was married and pre-operative at the time of the interview, understood her feelings within a medical context, however, she did not identify with the construction of a pathologised transsexual subjectivity and body, as Finn and Dell's (1999) study suggests. Lesley's body management was carefully arranged so that she could leave her options open. Choice and desire, then, were intrinsic to trans-sexing for some of my respondents.

Relationship factors, such as marriage and partnerships, were important considerations in decision making processes. Jess, like many late on-set transsexuals, also used a medical discourse of "remission" to account for the ebb and flow of feminine behaviours. She said:

> I went into remission for a year to save my marriage, I said "please I love you I don't want to loose you and if you just try [and] understand how I feel I will try and give you what you want and present myself as a man." So I cut my hair, which

> was kind of long, cut my nails, stopped plucking my eyebrows and went into remission for a year (transwoman Jess).

To save her marriage, Jess had to curtail her feminine practices and bodily aesthetics and present her "social" and "sexual" body as unambiguously male. This explicitly highlights the constructed "nature" of both femininity and masculinity. Whereas Diane used psychology from her degree course to work through her "gender issues" and help save her relationships:

> I spent my twenties becoming an art therapist, trying to understand myself, basically, and trying to persuade myself that I could be a normal heterosexual man. I had relationships with women but all the time I was wishing that I was them. After a series of catastrophic relationships, which always left me being left high and dry when I told my partner how I felt, I realised it was something that I was unable to get away from and that I would have to do something about. I would have to go through with it and do it. I had all the knowledge about it from when I was a student. Even though, I wasn't able to actualise it then. I had a store of information, which I was able to use and I did. So I started the medical treatment by the time I was thirty (transwoman Diane).

A Psychology degree provided academic assistance for Diane in trying to "understand" her "phenomenological body," and make her a "normal heterosexual man."

Diane's feminine aesthetic she intermittently portrayed resulted in partnership breakdowns. For many of my respondents, conformity to their ascribed gender continued for many years. This conformity, however, was not based on changing behaviour; it was based on aesthetic signifiers of gender. Being male in these instances was pursued because of significant others. This aspect of conformity is different from Emily's, whose partner supported her experimentation. This suggests that the "phenomenological," "social," and "sexual body" are adhered to differently within different social and sexual situations, due to significant others' approval of bodily aesthetics.

(Medical) information about trans-sexing was important to some of my participants while they were considering whether or not to transition. In a few cases, medical information, and its inherent authority, clarified fluctuating feelings. However, in addition to medical information, representations of transpeople in popular culture, and trans groups' publications also added to the bountiful information within which the respondents became immersed when working out their identity positions. For example, autobiographies of transwomen and magazines from various transgender groups were read, reflected upon, and digested. Sometimes these texts[24] seemed to address the respondents' sense of themselves, allowing for revelatory "eureka moments," which positioned them into an overarching transsexual narrative. For example, Penny said:

> I know Roberta Cowell was around; it was all in the papers but that all passed over my head at that stage. I think for me, in my teens, it was when we delivered the Sunday papers, a friend and I did that, and it [transsexuality] was very sensationally presented then, I felt oh, I think that's me (transwoman Penny).

The awareness of "transsexualism" planted seeds in their minds, providing the "gender capital" to investigate further. Information was gathered and stored, sometimes over many years, before transition was actualised. None of the respondents said that they were (trans) women prior to revelations brought about through the discovery of the "transsexual" concept in various texts. Moreover, "cross-dressing" did figure in interviewees' narratives. The use of this concept, by some respondents, suggests that at that point they still did not identify as (trans) women, because, if they had, they would not understand it as cross-dressing.

Penis as male signifier

The penis stood in for "man", "male", "masculinity", the "phallus" and "non-woman" for transwomen, in markedly different ways than for most of the transmen I interviewed. This study, in relation to the penis being a potent signifier of maleness, reflects Kessler and McKenna's (1978) project that was conducted thirty years ago, which also suggested that

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[24] The word 'text' here refers to the written word and the aesthetic figurations of transpeople in other popular culture mediums, such as film and art.

the presence of a "penis" on a drawn figure was a powerful enough sign to extract a gender attribution of male from ninety six percent of their participants. For example, Jess said:

> I have a theory here, not proven, no evidence, no research, but I think a man's penis is like a loaded gun being held, in a relationship with a woman. The fact that you are not going to shoot her at that time, you are still holding a gun and I think if you are pre-op even though it is not functioning it is kind of there. It [the penis] exists in the relationship and I found that when I had my penis removed through sex reassignment surgery it changed my relationship with other women; I was kind of made safe. It sounds rather stupid, this is post rationalisation, but I know my relationship with other women was different and yet I was the same person, only two months apart, the only difference they knew I had gone through surgery. I don't know if it was a rite of passage. But I think it was because I wasn't carrying a gun anymore (transwoman Jess).

To put this quotation into context, Jess had been talking about female colleagues who knew about her pre-operative trans status. She sensed that in her pre-operative bodily state, having a penis, impinged on her colleagues' ability to imagine her as a female. Jess believed that her colleagues had regarded her as "non-woman" or as "still-male." Jess also talked about the penis as a "loaded gun", which for her seemed to maintain the power of the phallus in the relationships with her colleagues, even though the penis was "not functioning." According to Jess, the non-functioning penis still had the ability to penetrate and invade the relationship with the threat of rape, without it actually being seen. As Annie Potts (2002) argues in her study, *The Vocabularies of Heterosex*, the "penis" stands in for the man and the phallus. In Lacanian terms the phallus is the transcendental signifier in the symbolic order. The phallus represents power and privilege and "the symbolic function of the phallus envelops the penis as the tangible sign of a privileged masculinity, thus in effect naturalizing male dominance" (Grosz, 1990: 123). Jess believes that the penis continues to be a potent signifier. The penis, for Jess, despite it being flaccid and "not functioning," remained symbolically powerful.

Jess also believes her feminine "social body" was re-merged into her male "sexual body" by her colleagues because of the ideological power of the (imagined) penis-phallus and it's

potency as a signifier of maleness. Jess constructs herself as a dangerous and powerful man. However, Jess' colleagues' agency is given no weight. As Foucault (1998 [1976]) suggests, "power is everywhere." According to Jess, her colleagues do not offer her closeness because of her penis and its "inherent" power; however, it is in fact her colleagues who are exerting power by refusing to grant the "phallic" "sexual body" any. In effect, they are refusing social integration on the basis of Jess' bodily aesthetic and reiterating what they think is female. Whilst this may be construed as transphobic, it can also be seen as similar to radical feminist notions of the "womyn born womyn" stance. However, there is a fundamental difference here to the stance of radical feminism in that Jess believed that SRS changed the relationship.

Emily's understanding of the penis is different and suggests that the penis is a socially "potent symbol" for both her "phenomenological body" image and her "sexual body" image:

> on good days I can be relaxed and say "oh yeah, woman with a big dick, very interesting, fantastic," but a lot of the time my gut reaction is "just get it sorted out." Also the idea of a guy with a clitoris is quite appealing [...] well I just don't like biological men and it is mostly because they have penises but if I am with a trans guy who was hairy, big and tall who had had a Metoidioplasty I would be very comfortable with that and appreciative of that (transwoman Emily).

Emily socialises in a trans/queer/lesbian community and has various contextual and political associations with the "penis." As a political queer, she is aware of the transgender discourse about transmen's bodies, which explores their gender identities without penises. While "on good days," Emily can grapple politically with the idea of "a woman with a "big dick,"" this is not always the case. Emily suggests that in sexual contexts, and as a lesbian, the penis promotes the idea of maleness for transwomen and, in relation to her own bodily aesthetic, she said:

> being lesbian, in the long run, seemed more important than being trans. The social interaction and relationships I wanted to have meant that I would have to transition (transwoman Emily).

"Transition" here refers to genital surgery. Moreover, in the past, Emily had experimented sexually with both transwomen and transmen. Transwomen with penises should "get it sorted out," according to Emily, because of her dislike of penises in sexual relationships. Nonetheless, the penis is unappealing to her on both counts. Emily equates the penis with biological men and it is the male characteristic, opposed to being hairy, "big" or "tall," she finds most displeasing. However, transmen who have Metoidioplasty to create a neophallus, it seems, do not hold the same aesthetic and imaginary power for Emily.

Octavia believes that the penis affects her phenomenological feelings and "dictates how you live your life" in many "sexual," and "social" spaces. In a similar way to both Emily and Jess, Octavia, who is bisexual and was pre-operative when she became involved in a relationship with a woman, suggested that her male genitals authoritatively signified her male "sexual body" and gender to others. She said:

> The penis and male genitals are just such an obvious pronouncement and advertisement of the gender itself and dictates how you live your life in a lot of ways, how you use the toilet, how you interact with other people. So society dealing with MtF and their gender recognition is one thing, dealing with someone who has got male genitals who is female is so much more of a difficult path to follow (transwoman Octavia).

Octavia's concern was with the "social body" and the unlikely acceptance of females with penises,[25] something she believed would be a difficult "social bodily" aesthetic for society to accept. The social pressures concerning a normative bodily aesthetic were crucial for Octavia's sense of femaleness. Transsexual bodily aesthetics are also regulated through the use of clothing and make-up, as I will now explore.

Gendered clothing and make-up

In this section, I will discuss representations and aesthetics that resonate intensely with social and material conditions of life. Arguably, it was Terry Eagleton's book *The Ideology*

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[25] I will take this point up in Chapter VII: Negotiating Authenticity and Bodily Aesthetics, with regard to the UK's Medicolegal System.

of the Aesthetic (1990), which situated the aesthetic outside the confines of philosophy in order to re-establish the body as the major site of subjectivity and aesthetic practice. This section establishes the aesthetic as an important indicator of the social power relations and ideological coercions inherent in the management of transwomen's body images. However, whilst coercion was apparent, the choices of representation were creatively and agentically actualised with reference to the transwomen's histories. As I have observed above in the chapter concerning transmen, aesthetic representations of the body are constituted with strategic agency. Relying upon "phenomenological," "social," and "sexual body" images of non-normative bodies transmen discursively and materially produced various bodily representations. In this study transwomen, too, constitute their bodily aesthetic with strategic agency but in markedly different ways.

Nearly all my transwomen respondents said clothing was a crucial indicator of their gender identification and gender expression. This was regardless of whether they had a "transvestite career" prior to transitioning or whether they had happy memories of cross-dressing as a child and throughout adolescence. Clothing as a social artefact requires an understanding of the cultural codes of masculine and feminine sartorial behaviour. As Suthrell (2004: 5-6) indicates:

> [t]he outward and visible manifestation of transvestism – of its building blocks – is the material culture of clothing but the deeper direction and inner motivation are inevitably to be found in cultural issues of sex and gender.

The "transvestite career" stood as a stark reminder for some respondents of their prior male embodiment, when they enjoyed the sensuousness and aesthetics of feminine clothing. Their male "sexual body" in feminine clothing, and the comfort and pleasure derived from cross-dressing, however, stood in an antagonistic relationship to their eventual sense of being female. This relationship was understood against a backdrop of social beliefs about "men" in feminine clothes as "perverted." For example: talking about her pre- and post-operative body, Nancy mentioned playing down her visibility whilst out and about, choosing to wear women's trousers rather than a skirt. Talking about a photograph, she said:

Nancy: I have a blouse with a tweed jacket, a pair of very light trousers, with a pair of flat trainers and a handbag. Dare I say it, some women would dress like that and you would say ooh, "she looks smart." So I like to look smart, tidy, clean, which I am sure comes from my forces days [...] Well, maybe it is self preservation.

Zowie: *Can you explain what you mean by that?*

Nancy: Well it is very dangerous out there for people such as ourselves. Not with 99.99999% of the population, it is a problem for the odd nutter [...] So it is important for me to look ok and that is where passability does become important to protect yourself from this odd nutter. Maybe dressing smartly and so on and by not dressing in a skirt maybe that is all part of it. Although I do believe dressing in trousers is much more practical (transwoman Nancy).

The threat of physical violence from the "odd nutter" was always a frightening possibility for Nancy. She had a long history of people inflicting "violence" on her for not following codes of "gender appropriate" dress. She continued:

At work I would wear women's things and then of course that would result in a job change. The job I had was a school teacher and I would go to school wearing women's clothing and the final job I had as an Air Force Officer and that of course, at the time being transsexual or transvestite, was an extremely dodgy thing and could result in having to leave (transwoman Nancy).

Nancy highlights the negotiations that take place while out and about and at work because of her cross-dressing being seen as a social stigma, a "fetishistic perversion."

The "denial" or "hiding" of the "transvestite career" was more acutely evident when the respondent desired "full transition." In order for their trajectory to be seen as legitimate, especially in the clinicians' office, but also within the research setting, and because cross-dressing was an un-deniable part of their trajectory into womanhood participants often emphasised the difference between cross-dressing as a sexual act and as an expression of

femaleness. Courtenay, tentatively opened up about her cross-dressing to me, but understood the relationship between her sense of her "phenomenological body" and clothing as a building up of a feminine identity through "non-perverse" actions of "self-discovery." "Part-time" dressing in feminine clothing for Courtenay,

> had been a kind of a stop gap it offered something, some relief that I otherwise wouldn't have. It did allow me to be in some ways myself (transwoman Courtenay).

Like all the respondents who said that they had cross-dressed or had been a transvestite, Courtenay never indicated in the research setting that she had derived sexual pleasure from wearing female clothing. Before deciding to trans-sex, she did, nonetheless, regard herself as an "old fashioned kind of transvestite":

> Courtenay: Then the transgender thing was a bit like a tide and it would come and really, really grip me and at other times it would ease down a bit.
>
> Zowie: *How would it grip you, in what sense?*
>
> Courtenay: It would sort of, well I'll have to do something about it at this period, and I was cross-dressing quite a lot, sort of, not in front of anybody, just for me. I suppose in lots of ways I would have described myself as a transvestite. It was an old fashioned transvestism harping back to the nineteenth century. It was a mixture of transvestite and transsexual because I always had had the desire to be female (transwoman Courtenay).

The polemical attack by radical lesbian feminists, Janice Raymond and Sheila Jeffreys (Jeffreys, 2005; Raymond, 1980) on (predominantly) transwomen, was on the minds of some participants during the interviews. Most of the transwomen who talked about cross-dressing and transvestism mentioned the radical lesbian stance as clichéd, suggesting that the interviewees were aware of the critical discourse and had internalised it as referring to them. In the interview with Amelia, she stated:

> I think Janice Raymond is a very sad case, she doesn't know what she is talking about, and I would tend to pigeonhole her with the likes of J. Michael Bailey and the likes of John Money who plainly are abusers of transpeople (transwoman Amelia).

As I illustrated in Chapter II, transwomen are seen as trespassers, who appropriate femininity to infiltrate women's spaces. This debate is widely known in the transgender community and so I am assuming in my analysis that this is the target of Amelia's, and the other participants, riposte.

There is a consecutive relationship between cross-dressing/transvestism and transsexualism in Courtenay's account, which Ekins (1997) also identified in his study. Cross-dressing was common among many other transwomen in the research, an investment, which offered a "stop gap" between the confusion and feelings of "difference." The clothing temporarily comforted the "phenomenological body", and allowed for private imaginings of a feminine body image.

> It all started when I was twelve [years old]. I started to cross-dress and it took me all of ten years to actually work things through in my head, to determine what I was actually going to become. I took a long time looking at websites reading up on research and the more I read about it – the more I was terrified that it might be that I am a transsexual; it has huge amounts of repercussions and problems in our life (transwoman Anna-Marie).

The comfort that occurred through dressing in feminine clothing prevailed prior to the more frightening and momentous desire to trans-sex. Feminine clothing and make-up use, however, did not come naturally to the respondents. Whilst showing photographs of herself, Amelia illustrated that femininity and the use of clothing was sometimes a difficult "thing" to do well without practice:

> This is borrowed clothing, it is not my clothing. I did not know how to relax with me. At this time I was still trying to work out who I am. In this one madam doesn't know how to wear a wig, doesn't know how to do make-up and wear clothes and it

shows. That would have been in my late twenties early thirties. Again this one, I am a bag of nerves, I really don't know what I am doing there. This [photo] is very early post transition, this is me mid thirties and I am out, out and it shows. In this I don't know how to use make-up and I still haven't got the hair right, I haven't got the look right at all [...] I am sure that's how a thirteen year old, fourteen year old, fifteen year old learns that is to have disasters and I didn't get that opportunity so you have to make mistakes on the hoof as it were (transwoman Amelia).

Anna-Marie described how she learnt her femininity from others:

> Basically a lot of observation, taking into account every girl that is walking by. I would take into account every action, ways of being, ways of talking, ways of moving and a lot of that I had drawn in my head from life, if you like what you see and it suits you, and then apply it to yourself. For example, I learned to do my walk from Beyonce's *Crazy* video, I downloaded it of the internet and you know the beginning scene when she is walking and I learned to walk like that by mimicking it then down playing it so it looked natural and it has worked very, very well. So it is all observation and application (transwoman Anna-Marie).

As I noted above, for Amelia, clothing had political implications in relation to radical feminist theorisations of transwomen's sartorial practices, which she juxtaposed with her own practices, which were unremarkable in her daily life:

> There are certainly people out there who think we want to look like 50s bouffant wearing women; I mean, who really wants to look like that now? Well, April Ashley looked like that but one must remember she looked like that because she was around at that time. People look at pictures of April Ashley and Christine Jorgensen and people like that and think we all look like that but they looked like that because it was the style. If you look at Lilly Elba she's in a little flapper's outfit with a flop hat but of course that is the era she lived in (transwoman Amelia).

Performing to counter the criticisms of being inscribed in stereotypical ways was an important element for Amelia. This required a sustained attempt to manage the meanings of some types of clothing and styles. Amelia rebukes challenges to her clothing aesthetic by understanding (in)famous transwomen's styles as merely fashions of their time. In Hausman's (1995) work she critical analyses of autobiographies of (in)famous transwomen and argues that transsexuals invest a lot of time in "mimicking" the autobiographical accounts of successfully transitioned transpeople. Whilst this may be true at a figurative level, Amelia clearly intends to be individual in her own aesthetic presentation.

Like Amelia, Bernadette said:

> Bernadette: Have you seen [the film] Transamerica?
>
> Zowie: *Not yet.*
>
> Bernadette: Oh well it is a wonderful film. If you don't cry I would be incredibly surprised. She is portrayed as being a believable person, she is not portrayed as in your face, bad clothes, the drag queen type, and it is very real. She is perceived as being a lady and I don't mean that in a derogatory sense. I have always considered myself a lady because that is my background, conservative, not in your face in terms cutting fashion style. My choice of clothes, therefore, which I hope I get right, in the colours and styles, is reflected in my perception of classic cuts and classic styles. There is nothing in my wardrobe that is going to set the world alight. I am not comfortable in wearing things like that and I think I would look ridiculous. I like stylish clothes and they tend to be more expensive, so a lot of my clothes, well I bought them in the sales, so they were theoretically more expensive clothes. They are timeless for someone of my age (transwoman Bernadette).

Clothing, for Bernadette, was only made use of for self-formation through fashionable, timely, and appropriate performances of dress and decoration, which reflects the (sub) cultural etiquette of being female in various "social" spaces:

Well I love denim and blue is my favourite colour. At home I am just relaxed but I will dress-up, if we are going somewhere like the opera, special. If we are going out for a meal, depending on what it is for, I may be casual, but if it is for somebody's birthday I would put something on that's a little dressy. I am quite happy to dress as I feel as I say I am quite happy wearing jeans and a t-shirt under the sink unblocking the pipes. I mean clothes are not the be all and end all, they are fun and they are nice to have, it's a nice thing to do but in the end I am me whatever I am wearing. If I put on a man's suit it would still be me (transwoman Amelia).

Amelia talked about her non-stereotypicality:

> [I was] riding very large motorcycles, believe it or not. I am afraid the love of the larger motorcycles has never left me but the being hairy has. Yes my bike was a Harley Davidson and I still had that when I met John (transwoman Amelia).

Amelia's complex narrative offers information that is not elucidated from her aesthetic presentation, her love of big motorbikes. For Amelia, stating her fondness for "stereotypical" masculine motorbikes and her utilisation of unremarkable "feminine" beauty regimes and clothing, illustrates her non-stereotypicality. Karen, understands that some transpeople are stereotypical, and suggested that it was transgender identities that were more stereotypical than transsexual identities, she stated:

> Well I think a lot of transpeople are very influenced by stereotypes. I think it tends to be more transvestites and those who fit into the transgender category, who seem to mimic stereotypes. I think a lot of transsexual people actually become downplayed once they have transitioned but then again I think it varies from person to person. I haven't mixed with trans people for a while, but I used to go to the Village in Manchester an awful lot and there you meet so many different people with different agendas and different needs. You do not know who you are meeting half the time and I think a full spectrum of human life is there. Some people fulfil stereotypes and other people come much downplayed and muted (transwoman Karen).

In a sub-culture that use clothing and make-up to complicate mainstream gendered signifiers, i.e. having an emphasis on androgyny, it can alert us to the subtleties of aesthetic signifiers. Interestingly in the following exchange with Octavia, she suggests that that normative femininity is not always a part of transwomen's lives:

Zowie: *You mentioned your style, you are a Goth. Can you tell me how important that is to you?*

Octavia: Well it is everything really; the average Goth defines themselves through their image and the music they listen to. So as my body image started to change I had to start thinking about the way my make-up and clothing has to change as well. So I had to get rid of the male corsets because they were male corsets and had to buy a whole load of corsets for the female body shape. My make-up style changed, I mean the Goth style is androgynous anyway so there is not a huge change but subtle changes.

Zowie: *Can you expand on that, I find this really interesting?*

Octavia: Ok, well before I changed [sex/gender] I could quite easily get away with wearing a micro skirt but afterwards I would tend to wear a long flowing one, more sort of Victorian in style. Before I changed [sex/gender] I would wear flouncy pirate shirts underneath a black corset but of course now I would wear a velvety corset over a tee-shirt. I have taken to wearing a dog collar more because it hides the Adam's apple, which is not a huge problem and ties quite nicely into my partner's aesthetic ideals for me as well. She likes me to wear it so that is fine (transwoman Octavia).

The gendered policing of sartorial and make-up styles here is obvious (which Octavia was compliant in). However, mainstream femininity does not figure in Octavia's androgynous framework and, along with Emily's queer aesthetic framework, disrupts normative and sexological understandings of female transsexuals' femininity, which I discussed in *Chapter I: Shifting the Medicolegal Construction of Transsexual Aesthetics*.

Nonetheless, clothing and make-up are intrinsic to the transsexual trajectory of trans-sexing and subjectivity. Cross-dressing and make-up are figured as practical steps and have a consecutive relationship in building up a feminine image. Nonetheless, the discursive rebuttals of perversion and stereotypicality do influence the discursive and aesthetic aspects of trans femininities. The rebuttal of stereotypicality was not observed from participants who construct feminine signifiers outside of normative femininity.

Hormones, emotionality and "beauty"

The accomplishment of womanhood is dependent on an aesthetically congruent body with more emphasis on the hair and face in social interactions. The transwoman's "social body" requires investment strategies to maintain its "beauty" and ability to "pass" in much the same way as biological women do. As Paula Black and Ursula Sharma (2001: 101) argue, men require much less maintenance to turn their bodies into cultural ones, while femininity for women, "is a state to be constantly sought." Samantha, who was one of the younger transwomen in the research, connects her maintenance of beauty with regimes associated with normative femininity. She stated:

> In a sense I am lucky because I changed so early, maintenance is easy [laugh]. Fundamentally, it is just a little maintenance. Basically it is the same as my girlfriends, who are biological [females]. Well I do my legs about once a week. Luckily my arms are not too bad. Especially in this warm weather it's the first year ever that I have got a tan on my legs. I have inherited the genes of male patterned baldness and female pattern baldness. Baldness is in both sides of my family. HRT has worked, but I am still quite thin [stroking hair]. That's natural for me but nobody can guess [about my trans status] (transwoman Samantha).

Samantha used the term HRT (Hormone Replacement Therapy) to indicate the hormone therapy used for her transition. Hormones and anti-androgens[26] featured highly in relation to beauty in this research. They enabled the transwomen various aesthetic benefits, such as softening the skin, reduction of body hair, breast formation and feminine fat deposits

[26] For an extensive review of endocrine therapy refer to Dahl et al (2006).

around the hips and, most importantly, for the majority of participants, arresting the balding that men sometimes suffer. Diane said:

> When I took the Cypretone,[27] it improved my skin virtually overnight; it certainly made my skin a lot softer and reduced body hair. It did reduce my libido, but unfortunately it made me tired, but that was a side-effect that was well worth putting up with. It didn't do everything that I wanted, it may not have feminised me but it did de-masculinise (transwoman Diane).

The age of transwomen is also important in relation to feminisation:

> What scares me a bit is when I read "I am a fifty seven year old transsexual," "I am a forty five year old," "I am fifty five and have just started hormones, or just started to see [psychiatrist]" and all these things and it terrifies me to think that I could have been like that. But I couldn't have been like that because it was so strong in me and by the time I saw thirty approaching and I thought I can't let this go on any longer. I feel sorry for these people but then feel less sorry for them when they say "I have had a good life" and they are glad to have their families, they have earnt thousands of pounds in their male jobs so that they can have their surgery and laser hair removal and stuff and "oh I am glad I waited till I was fifty five because that means I can do it more easily," or "I am more adjusted to life." I think, sorry I can not relate to that. As far as I am concerned and the way I felt about it, the sooner I can do something about it and the younger the better, because of the physical changes involved, because if you have a fifty five year old male body to feminise it is a dam site harder to do that than if it was younger. For example if you had a twenty five or a thirty or even thirty five year old masculinised body. I know I shouldn't put them down about this but I have met someone recently who had their genital surgery at sixty three and I found this person actually vaguely offensive, and I know this will sound terribly judgemental, when they said nine months into the transition, "I feel comfortable, I feel completely like a woman. I feel completely transitioned." I am sorry, I don't

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[27] Cypretone is an anti-androgen, which is prescribed to reduce masculine characteristics, such as body hair.

> believe you can live as a man until you are sixty two and then have a bit of facial surgery and then have electrolysis or laser treatment, I don't buy it basically, because it took me long enough (transwoman Diane).

According to Diane, both aesthetically and in relation to your sense of self as a woman, it is better to transition early because you can live as your preferred gender more successfully and attain a feminine body more easily without the "ravages" of testosterone on the body. To illustrate this, some older transitioning participants said that the effects of the hormonal intake were not as dramatic as had been expected. Mariza, for example, said:

> I was hoping for them to work wonders and do miracles, well actually they did, but not in the way I felt. I thought they would transform me into superwoman overnight, which of course they don't (transwoman Mariza).

Like Mariza, Amelia highlights the slow process of attaining a feminised body in the following exchange:

Zowie: C*an you tell me your experiences of taking the hormones?*

Amelia: Well there was the initial excitement of getting hold of these things. Then at first you are looking at every little change, every little thing at all to say that there is a change happening. Of course it doesn't happen particularly quickly but you persuade yourself you are a little less hairy, you persuade yourself your hair is coming back [pointing to the head] and so forth. In truth I think very little happens but as you go on you do notice the changes. I guess I noticed the emotional changes, which the hormones do. Certainly I found myself calmer, and although I have always been pretty emotional I found I was easier with my emotions, I could let go. If I wanted to cry at a silly movie, I would cry at a silly movie. If I wanted to cry at a piece of music I would do it. I no longer felt any embarrassment at doing that it was just, well that is ok to do it.

Zowie: *Do you think that was down to the hormones?*

Amelia: I do think they are partly down to the hormones, I think they give you that freedom to be who you are. I don't like stereotypes but, well I was always an emotional character, but I certainly think that they stopped me thinking I have got to control this, I have got to pretend this is not happening. I was able to say "go for it". Now it is something I just take daily and I don't really think about it, it is just a pill I take and that's it (transwoman Amelia).

Bernadette, who was sixty years old, questions the assumption that beauty and femininity are as much of a requirement for older (trans) women:

> Zowie: *Do you think as a woman you are meant to perform more with the way you look?*
>
> Bernadette: I don't think I am expected to perform more, not at the age of sixty. I think if I was someone considerably younger then yes, but at the age of sixty, what it has given me is freedom. I can dress exactly as I wish. [...] I have quite a mixed wardrobe; I buy what I like within the bounds of expense. There is no question that I do take more care of myself, in terms of beauty treatments and things like that. I do spend a little bit of money; I go for a manicure once a month, the hairdressers, where I never bothered before. I enjoy that but I enjoy it simply because I enjoy it not because I think I have to. There has certainly been a change in mental attitude; I take much more interest in fashion, clothes, make-up a little bit, although I don't wear heavy make-up or anything like that. (transwoman Bernadette).

Emily, for whom femininity was far from normative, stated:

> I think sometimes I am quite aggressively trans, I am completely out with everybody and the bars I go to I probably am known as the trans woman, "see that, that's the trans woman." Also not trying to be stealth I find so much easier than trying to pass. I am more concerned with looking good, which is slightly different, because I don't mind people looking at me and being able to work out that I am trans but I would also like them to look at me and if they work it out , look at me and think that I look OK (transwoman Emily).

Cosmetics and beauty regimes were elaborated on as body techniques, which were used to construct a range of attributes associated with the self, gender, femininity and imitation of normative femininity. Some transwomen incorporated the rhetoric of individualism. Other transwomen suggested that their body work was regulated in quite a disciplined way to produce the feminine "social body." However, Emily completely rejected normative femininity in relation to her presentation.

Genital surgery and aesthetic surgery

In contrast to most transmen in this research, genital surgery (in these cases Vaginoplasty)[28] is held up as inevitable for transwomen. As I observed above in the section, *Penis as male signifier*, the penis holds phallic power "phenomenologically," "socially" and "sexually." Without Vaginoplasty, the transwomen in this study would continue to feel incomplete. For Amelia, vaginoplasty "made [her] feel like a woman in both a physical and mental sense."

In all but two of the narratives, the transwomen mentioned their "fear" of losing their neovaginas after surgery. More positively, though, Jess described her experience of preparation, surgery and aftercare:

> Well about the surgeries as I said I found the SRS [Sex Reassignment Surgery] a joyous experience. I am pleased to say he did a wonderful job. I have a beautiful vagina. I went back after four months for a labia trim, because it was uneven, but he did explain with the swelling, anyway he did it without any problem. And it also validated my decision not to go to Thailand. How do you do that, go to Thailand for an out-patient procedure you wouldn't do it would you? I had on and off cystitis for a year due to the plumbing. Oh the joys of cranberry juice. I never had any problem dilating at all. I remember them saying, that "there is not much donor material here Jess." I said, "I am glad to hear it." He said that he's going to

[28] "The term vaginoplasty includes several procedures which transform the male external genitals into female genitals. The [medical] goals of vaginoplasty include: (a) creation of a sensate and aesthetically acceptable vulva – including clitoris, labia minora and majora, and a vaginal introitus: [...] (c) creation of a stable and sensate neovagina with adequate dimensions for penetrative sexual intercourse [...] (e) preservation of orgasmic capability" (Bowman & Goldberg, 2006: 140).

> have to use your testicles and I said, "well if you can find them you can have them [...] So he said "can you stretch it before surgery?" So for a few months I was stretching it in the bath, so I ended up with a vagina which was four and half inches in depth (transwoman Jess).

Jess illustrates the personal preparation required in order to attain a satisfactory vagina in a relaxed and joke like manner. Jess' satisfaction with the procedure had a lot to do with the surgical results. As I mentioned above, this was not always the case. For Courtenay and Diane there were problems associated with the genital surgery itself. For Nancy and Courtenay there were problems with the outcomes of the procedure(s), which led to a fear of loss and depression:

> One section of the labia on the left never healed properly even from the beginning you could see it was a darker red than the rest. And before I left [the hospital] they [nurses] were saying to me, "make sure you ask all the questions you want" (transwoman Courtenay).

Courtenay's difficulties with the surgery were quite common amongst the participants in this research where, partial necrosis of the labia and clitoris impacted on the aesthetic results of the vagina and clitoris.[29] Courtenay continued:

> Even then I had some protracted granulated skin, which was red and was not going to heal properly. I found it hard to the touch and some of it was up near the clitoris it was the size of a pea. They put some nitrate stuff on it, which burns the top away. I did not realise what it was; I did not realise what it was going to do, but it did feel a lot better. I went down to London and on the train back I thought this was a lot better, I knew I had lost some more skin but I wasn't sure if it had damaged the clitoris or not. I was crying and sometimes I was fixated that I was going to lose my clitoris. I don't know why but I did. I have a diary which I could read you bit there only tiny bits but it says "blood on the pad" "crying today" and stuff like that stuff I really did think I'd lose it (transwoman Courtenay).

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[29] For a more complete medical understanding of the potential problems associated with SRS and other secondary sex characteristic surgeries see Bowman and Goldberg (2006).

Nancy commented on how her "phenomenological body" and psychological well-being were affected through her fear of loss:

> I remember getting quite upset because I had a problem with the narrowing of my vagina and I was very worried that I might lose it, and that did affect me. I did start thinking; I would not want that to happen (transwoman Nancy).

However, Diane suggested that the vaginal aesthetic resulting from the surgery was "a mess" and "unrealistic." This was affecting her phenomenologically and affecting her "sexual body" and potential relationships:

> three years ago I realised that I had to do something, because I had not had sexual contact for years and years and years and that I needed to do something about getting corrective surgery, that was the reason I had this whole health collapse because I was too overwhelmed about what had happened and being disempowered, to cut a long story short I found my way to [hospital] and [the surgeons I] got corrective urological surgery from them. I mean it is not perfect but it is a big improvement. So perhaps this is why the physical side of it is so important to me, I think it would be anyway, I think it may have made it more important (transwoman Diane).

Samantha also had to return to the surgeon to correct some problems:

> Mine was done in [hospital] by [surgeon], I love him; I thank him to such a degree. I have had two fairly major surgeries with him and a few minor ones but even though his registrar could have done them he did them himself (transwoman Samantha).

Samantha added:

> The second [operation] wasn't too bad but it caused me to have a massive dose of depression. Instead of putting a [catheter] bag, which I have had since, they didn't,

> they put a valve in, which meant that I had to stand up and wee, which was so depressing (transwoman Samantha).

In Samantha's narrative there was an obvious appreciation of the surgeon's "work." Even after many returns to the hospital, because of medical problems, which consisted of urinary infections, blood loss, and non-healing of tissue, Samantha regarded the surgery as a success on an aesthetic level. However, Samantha had a bout of depression because she was reminded "phenomenologically" of her previous ("male") body while having to stand up to urinate. This lasted until she healed.

In contrast to the stories above, there was one respondent, Brian, who reported that although surgery was successful, both aesthetically and physically:

> I just think I am never going to be like any other woman. I know all women are different, anyway but I am never going to fit in to a lot of things. There are also a lot of things that once I had surgery, I don't relate to (Bi-Gendered Brian).

Brian was thinking about living with a more masculine aesthetic on account of him/her not fitting in to the female role as s/he wanted to or felt s/he could. While s/he had no problem "passing" in an aesthetic sense, s/he felt that there were still fundamental differences between him/her and biological women. Brian suggested that this situation was deleteriously affecting his/her self-esteem and confidence. In the following exchange Brian explained why:

> Zowie: *Is that because you are not attaining the femininity that you wanted to attain?*
>
> Brian: No I have always thought that has been there for me but I just thought and feel that it is just very difficult to be myself. Where I have conversations with people and I have never mentioned about [my trans status] there might be something I'd say or something that I'd do that they just won't relate to and I felt the subtleness of their looks of "that's a strange thing to say or do for a woman." That is one of the things that has made me think that my true self is coming out

and maybe I shouldn't have [transitioned]. This is because it was a choice and I went through the thoughts about would I go down that road. I did sacrifice a lot of things, like giving up my job, a relationship and I moved to be able to go through it. I don't have any regrets about it; it is just that I feel such a pressure socially (Bi-Gendered Brian).

Prior to transitioning, Brian's sense of his/herself as a woman was augmented through his/her positive relationship with an ex-partner. When s/he decided that s/he felt like a woman the "choice" to "sacrifice" his/her job and home was made in relation to this relationship.. After perceiving that his/her practices and bodily aesthetic and people were "saying" that is "a strange thing to say or do for a woman" through "the subtleness of their looks," Brian understood that his/her ways of being-in-the-world were not perceived as feminine and thus, by default, were masculine. This instigated his/her "reverting back" aesthetically. This reminds us of Merleau-Ponty's (2002 [1962]) assertions concerning the formation of the "self." Merleau-Ponty suggests that as intersubjective agents (ephemerally) positioned in a body-world dialectic, our perception of the perceptions of others are instrumental to our ongoing body projects and body image. Crossley (1996), following Husserl, would perhaps theorise this as us establishing subjectivity and our sense of "self" through the shared confirmation and negotiation which takes place between different and independent perspectives.

While genital surgery was important, the most striking and frequently expressed bodily aesthetic desire was the retention of, or surgery to improve, the amount of head hair. The following quotations highlight the huge benefit of having your own hair in order for the "social body" to "pass:

As far as passing goes I was worried about passing pre-op, not so much post-op but pre-op the hair transplants made an amazing difference, although there are all kinds of hair conditions that are unpleasant for people to have, I think male pattern baldness is quite debilitating for transwomen. I know one transwoman who had lost more hair than I did before she got on the hormones and that is the biggest physical challenge she has to cope with day by day. She suffers quite a lot of

> depression because of it, which it did to me, a lot of depression (transwoman Emily).

Similarly, Nancy said:

> Actually I have had some hair transplants as well and that enabled me to have my own hair. That has made the biggest difference of all (transwoman Nancy).

According to one recent report by Bockting et al. (2006: 30):

> Surgical procedures intended to reduce female or male features can reduce gender dysphoria, and are not intrinsically problematic (indeed, they are an important part of medical treatment for some transgender individuals). However, some transgender persons become obsessed with cosmetic procedures relating to discomfort with their general body image, internalized transphobia, or feelings of not being conventionally feminine/masculine, rather than gender dysphoria per se.

While in the quotation above, acquiring aesthetic surgery was interpreted as sometimes "obsessive," aesthetic procedures in my research were considered by many transwomen as a site of "phenomenological" and "social" control, and, by some, as a contestation of Western beauty ideals. Courtenay stated:

> I'm bound for Thailand in early July for some more surgery this time to the face, forehead sculpting and mandible realigning. I'm still a little in two minds about this, as it seems a bit of a sell-out, making me less noticeable as a transsexual woman. At least I hope so. Diminishing my TS presence, which I feel undermines my own radical views. But I would like to feel more safe, and a greater sense of belonging (transwoman Courtenay).

Aesthetic interventions, here, are complexly understood. Courtenay, on the one hand, sees her political transsexual body as losing its trans visibility and moving more inline with normative bi-gendered assumptions but, on the other hand, the interventions will bring a

supplementary level of social safety and security in her self because of their normative aesthetic representation. Jess, following numerous procedures to her body and face, said:

> But I must admit I feel more comfortable no one in the street looks at me or stares at me. I work [it] out on the basis that I don't pass, because experience tells me I don't. I came to terms with that because I am quite realistic, but what I could do is kind of negotiate a truce with the world as long as I did my best. I more or less fitted in and nobody is going to make a fuss about it there is a difference between that and someone passing surreptitiously. So I was going to be a transwoman with flair and style and then it didn't matter, because I wasn't going to waste my life chasing a dream and be forever dissatisfied. But if I do pass that's a bonus, but I don't expect to. It does not bother me, so whatever I do, I'll do it with style (transwoman Jess).

Jess' pragmatic approach to her (non) passing was a defence mechanism against being read as her "original" gender. Jess suggested that if you show people that you are serious about your aesthetic presentation social relations can be negotiated more easily. Nancy indicated that whilst the facial surgery was important for her, people need the "feminine" foundations for it to be truly successful, she said:

> [facial surgery] made me look younger, it made me look more pretty, which is all in the eyes of the beholder anyway. So they did not make me feel particularly better about myself. It didn't make me feel more passable, because I think passability is about acceptance than how you look. I never had much passing issues anyway [...] Well you see I was lucky with my facial features as I said earlier on, if somebody did have particularly masculine features and bone structure then I can't help feeling that their interaction with the rest of society would be improved if they'd had structural surgery on their faces, I simply can not believe that it would not be improved. But I am not saying that, well facial surgery does not turn Arnold Schwarzenegger into Bridget Bardot it just shaves the edges off (transwoman Nancy).

Facial surgery was viewed as part of the feminisation process. Participants were realistic about how much change was possible. In most cases, participants realised that the "original" facial structure could only be softened. The softening did provide a certain amount of feminine enhancement, and, as Nancy and Courtenay suggested, would alleviate some of the dangers they felt during social relations. Passing for these participants was much more contextual. The age of participants was a significant factor in whether they could attain an unambiguous feminine aesthetics because for the older transwomen hormone and surgical technology could only lessen the masculinising effects of the "ravages of testosterone."

Conclusion

In this chapter, I explored the various subjective positions of transwomen through childhood and the decision making processes in order to transition. Identification with feminine signifiers and cross-dressing scenarios were re-envisioned as important markers of being transwomen. However, these identifications were not the catalysts for the decision to trans-sex. The habitus is a generative structure, rather than a deterministic one. Trans-sexing was accomplished primarily when conditions within the transwomen's "habitus" were realised and acted upon. Identifying with medical and popular cultural discourses about trans-sexing needed to be a part of the transwomen's cultural capital in this respect. Cultural and gender capital about trans-sexing was required to give shape to transwomen's desired embodiment and bodily aesthetics. The intimacy and support provided by significant others allowed for much needed clarification of thought, and added to the "gender capital" required to accomplish womanhood. I argued that the exploration of and experimentation with (socially constructed) gendered signifiers in supportive spaces, and the realisation that something could be done about feelings of "difference" were important factors in actualising gender reassignment.

I suggested that once the decision to change sex was secure the most important aspects of transsexual subjectivities to be considered were the aesthetics, albeit in varying degrees for each respondent. Gendered aesthetics had to be negotiated within various discourses of beauty, sartorial and body modification practices. The "social," "sexual" and "phenomenological body" were the sites of these negotiations. Many transwomen rebutted the association of transpeople with perversion and stereotypicality, which influenced their

aesthetic sartorial figurations. However, most of the transwomen suggested that males and females needed "proper" "sexual bodies" and "appropriate" clothing. This "sexual body" was linked to the "social body" as it was believed in most cases that society would not accept transwomen with penises. The social pressures of a normative bodily aesthetic were adhered to by some transwomen in this research, which was a crucial difference to the transmen in this research. Whilst mainstream femininity was observed by some transwomen it was negated in other narratives. For instance, in both Octavia's androgynous framework and Emily's queer aesthetic framework, they disrupt normative and sexological understandings of femininity. The research showed how the narratives of transwomen were influenced by the aesthetics of (sub) cultural gender systems which they were a part of.

Chapter VI: Framing Bodies in Trans-Community Organisations (T-CO) in the UK

Introduction

In the previous empirical chapters I used the concepts "social," "sexual" and "phenomenological body" to analyse the "private" aspects of transpeople's embodiment. This provided a nuanced understanding of transsexuals' body projects. In this chapter I use the concept of "bodily aesthetics" – to refer to the appearance of the body that is subjected to judgments – in order to understand how three T-COs in the UK represent transsexual bodies publicly. These representations, I suggest, are a part of the political praxes each of the T-COs are engaged in. The T-COs, in effect, try to represent the "social body" of the transsexual. However, the "social body" is formulated differently by each of the T-COs I consider.

In the 1990s transgender activism[30] emerged primarily in the US aided by academic writing and grassroots activism. A pamphlet by Leslie Feinberg (1992) titled *Transgender Liberation: A Movement Whose Time has Come*, was a call to a diverse group of people who defined themselves in many ways (transgender, transsexual, intersex, queer, transboi, androgyne and so on),[31] to come together within a transgender community and transform the social and medical meanings of their existence. Similarly, Sandy Stone's (1991: 141) "call to arms" said "[p]erhaps it is time to begin laying the groundwork for the next transformation." Transformation refers to transitioning from socially expected sex roles and gender expressions based on one's ascribed birth sex and also to challenging and rewriting academic and medical literature, which constructed non-normatively gendered people as pathological or sexually deviant. Activists wanted to restructure what it meant to be transgender and transsexual (Feinberg, 1992, 1998). The term transgender replaced the medicalised term transsexual, which was an obvious change of tack in relation to self-naming. By incorporating a feminist understanding of the sex/gender divide, which illustrated gender as the socially constructed aspect of sex differences, transgender groups

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[30] More and more transpeople have identified with the term transgender and see it as an umbrella term, even though on a personal level they may identify as a specific identity, such as Butch, Drag Queen and so on. Transgender activism is not a fixed concept either, but one that has morphed in many directions from its first inscription.

[31] Rather than list the many identities I will use the widely employed concept transgender as an umbrella to capture the variation.

were able to rally support from a wider range of trans identified people who did not necessarily think of themselves as transsexual. This type of political organising was distinct from "traditional" transsexual organising, which was primarily concerned with directing its energies towards the human rights of transsexuals and their legal recognition. Transsexuals were concerned with the rights to medical intervention for their *Gender Dysphoria*, rather than critiquing psycho-medical constructions of transsexuality.

In the US, Kate Bornstein (1994) and Riki Ann Wilchins (1997) began speaking about a new type of politics for a transgender community that would be inclusive of all those who do not fit the binary sex and gender system (including those transsexuals who felt affiliated to this new type of activism). Transgender political activists were debating about identity politics as a type of "ethnic" minority, on the one hand, and the deconstruction of identity based politics, on the other (Broad, 2002). These politics were born out of queer theory's refusal of the "self" as a coherent ontological subject. However, there was an obvious fear that the subject may be deconstructed out of existence (cf A. I. Green, 2007). These deconstructionary activities and conceptualising of "new" "subjectless" politics were not uniformly accepted, and engendered much debate and consideration of the identity boundaries and goals of transgender political activism (Namaste, 1996). One inherent problem of deconstructing identity out of existence is the difficulty in pinning down minoritarian political goals for subjects. As I noted above, these debates took place in a US context, yet they did influence the debates that were going on in the UK as all theorists writing in this area cited their US forerunners (Monro, 2003).

The T-COs in the UK engage in a whole range of activism and cultural work, such as attending vigils, being visible in local, national, and international medical and legal forums and organising trans awareness campaigns. Stephen Whittle (2001), a transman, academic and political activist, has argued that the trans social movement is a "merged collective body," where personal subjective belief is suspended for the wider good of the community. Whilst this may be true of some aspects of T-COs and whilst there may be some agreement on the broader tenets of T-COs' aims, such as respect for diversity (Press for Change, 2004), it is difficult to envisage the transgender political movement as a "merged collective" due to the diverse views of the organisations and their members. Sally Hines' (2007) work considers transgender support groups in the UK and addresses the care that

these groups provide and how trans education and values are shared through giving and receiving support. However, involvement is not evenly practiced because of concerns over visibility, particularly being visibly "transsexual." Surya Monro (2003, 2005) critically explores the tensions between transgender and heteronormative models of citizenship and argues for "gender pluralism" in future models of citizenship. Monro (2005) is wary of some of the dangers she sees in identity based politics that can (re)produce new boundaries, which continue to marginalise those who do not fit. There is no research to date, about which bodies that do, or do not fit, into existing frames of activism and cultural work in the UK. Moreover, there is still a scarcity of empirical and theoretical work on UK transgender politics and activism.

Framing analysis, inspired by the work of Goffman (Benford, 1997), has contributed to an array of empirical case studies about social movements in feminism (Walby, 2005) and LGBT politics (Douglas Creed et al., 2002). Framing, according to Benford, is where activists

> seek to affect interpretations of reality among various audiences. They engage in this framing work because they assume, rightly or wrongly, that meaning is prefatory to action (Benford, 1997: 410).

Using framing analysis, Sylvia Walby understands feminist political struggles as being about "sameness," "difference" or "transformation" (Walby, 2005). If we apply these concepts to trans politics, broadly, "sameness" has been framed in transgender activism literature as "assimilationist" (MacKenzie, 1994; Raymond, 1994). Assimilation into a binary system is seen as allowing transmen and transwomen to accomplish gender normativity, which is seen as having grave consequences for all women and gender minorities who do not abide by the gender order's notions of masculinity and femininity (MacKenzie, 1994). "Difference" politics are framed as wanting acceptance and civil rights awarded to citizens, such as marriage, inheritance and equal civil liberties, whilst retaining a sense that being transgender is a worthy subject position (see Whittle, 2002). "Transformative" politics are framed as progressive and queer, and as a way to move beyond identity politics, which constructs restrictive bodily boundaries (Stryker, 2006). On a basic level, each model can be seen to apply to the three T-COs I am about to discuss.

However, Walby (2004) illustrates that political "sameness" may have a particular standard in one domain, for example, equal opportunity legislation, simultaneously with "difference" as in specific policies, such as targeted healthcare. Moreover, in Walby's (2004) formulation these standards may also become "transformative" through highlighting the visibility of issues. Therefore, Walby (2004) argues that "transformative" work is also connected to "sameness" and "difference" strategies, because there is always the possibility of "transformation" within existing gender orders. This means that we may be able to build productive bridges – rather than dichotomies – between "sameness" assimilationist politics and "difference" and "transformative" queer politics, in their respective activism and cultural work. This, however, would only be made possible by understanding that the either/or and both/neither (Roen, 2001) dichotomies of assimilationist/queer politics are not so divided. This standpoint and Walby's concepts are useful in conceptualising T-COs in the UK.

This chapter, then, will critically explore the particular political framings of (trans) bodies and the aesthetic judgments that accompany them in three prominent T-COs in the UK, the Gender Identity Research & Education Society (GIRES), Press for Change (PFC) and a "DIY" Queer collective that is based in Manchester, UK but which has links with similar collectives across the UK (see pen portraits in Chapter III *Methods, Methodology and the Research Process*). I will analyse and emphasise these political frames in relation to bodies that are absent from, or which have been reintegrated into the T-COs political considerations and ask: why might this be? And: is it to the detriment of social change? I will explore how these frames of bodies and aesthetic judgments are used within campaigns, for legal, medical, informational, and representational work. I argue that politics and cultural work theorised as "assimilationist," "difference," and "transformative politics are unproductive when seen as dichotomous "good" or "bad" practices, we often see in transgender politics literature (MacKenzie, 1994) and queer politics literature (cf Richardson, 2004). Instead I will suggest that each of the T-CO's perspective addresses its particular audience and that the framing of trans bodies is adapted to the specific context. As political praxis and cultural productions rarely invoke instantaneous social change, ongoing research questions need to be formulated, in relation to which trans bodies become assimilationist or radical, before laying blame about destructive or "unproductive" activism and cultural work. This chapter opens up the body question(s) this thesis is addressing by

illustrating three major areas – healthcare, law and cultural production – where (absent) bodies figure in changing social attitudes towards trans embodiment.

Methods

I analysed three T-CO web-sites and numerous emails related to embodiment and bodily aesthetics which had been sent out by the three organisations over a six year period and from which we can learn much about the many strands of information that have been produced by their members. Grassroots activists belonging to these groups have retrieved and subsequently redistributed petitions, academic and newspaper articles, conference calls, and so on through the various organisations' internet mailing lists and through hard copies too. The six year period was chosen in order to incorporate the period just prior to implementation of the Gender Recognition Act 2004, which I will explore in more depth in the following chapter *Negotiating Authenticity and Bodily Aesthetics within the UK's Medicolegal System*. I interweave a textual analysis of e-materials with participant accounts of activism and their involvement in T-COs.

The website material was retrieved by entering the homepage of each T-CO and systematically reading the information. I entered the hyperlinks on each page, and from the new page displayed, went on to open each hyperlink present. I did this many times on Press for Change's website due to the comprehensive range of information that was stored. The process of entering all the hyperlinks was much smaller for GIRES and Kaffequeeria due to their size. I made judgements about data collection from each webpage in relation to bodily aesthetics. I made similar judgments about the emails sent out through the mailing lists. I decided not to gather data from any hyperlinks outside of the website for various reasons, such as being unable to work with an overload of data and because I regarded this data as superfluous for understanding the T-CO's representation of transsexual "social" body and bodily aesthetics. The limitations of this website data retrieval method was on one hand, the sheer amount of hyperlinks that I needed to explore in order for me to find all the information produced about bodily aesthetics. This provided me with a huge amount of data to code and analyse. On the other hand, there were difficult ethical issues of informed consent, and privacy and confidentiality to be considered especially in relation to email list information.

The internet holds a variety of drawbacks for researchers, who can simply and inadvertently breach the privacy of individuals. For instance, even if the researcher takes out any private information about the producer of an email, it is quite easy, with the aid of a search engine to find email addresses if the quotation used in the research report/publication is written *verbatim*. Once I had decided on the emails data that were going to be used in the chapter, I contacted the producer to ask for consent. I did not deem there to be any issues about privacy and confidentiality in relation to the websites due to the public nature of the internet. Thus, I provided only correct referencing of the site. I assumed that the e-materials were for public use and, as long as it was correctly referenced, seeking publicity. I considered the possibility of not giving attribution to the authors on the website (if known), because of not having written consent, and that this would have been a misuse of another's intellectual property (see Eysenbach & Till, 2001).

Framing bodies in a biogenetic paradigm

The Gender Identity Research & Education Society (GIRES) is a registered charity. The organisation was initially set up to offer scientific and medical explanations of transsexualism, in the hope of enlightening various locally and nationally run institutional bodies, such as educational authorities, members of parliament, and medical practitioners who would not necessarily meet transsexuals or transgendered in their daily work. In addition, the information offered would be available to those who were inquisitive about the "condition," and may help employers deal with the relatively rare incidences of transsexual employees and the (policy) issues that may materialise in relation to them. It was also meant to provide up-to-date medical information for transsexuals and their families.

The most notable and consistent characteristic of GIRES, which claims to have "nearly 300 members" and whose membership "consists of trans and non-transpeople," is its concentration on the aetiology of "gender identity disorders" or "gender dysphoric" people (Gender Identity Research & Education Society, 2007). Within its virtual information it provides truncated scientific and medical evidence of transsexualism and supports a biogenetic paradigm. This biogenetic basis is intimately linked to pathological models of transsexuality and "is constituted through the logic of loss and deficit" (Blackman, 2007: 1). In the case of transpeople, the loss and deficit is of a normative bodily aesthetic.

Although there is persuasive evidence that the brains of transsexual people are programmed before birth to develop, in small but highly significant ways, *inconsistently with the rest of the body*, this difference is, and is likely to remain, *undetectable in living subjects* (Reed, 2006 emphasis added).

According to GIRES, transpeople's are placed on a cerebral continuum, which runs between male and female brains. Consequently, these differences in brain morphology apparently account for transpeople's desire to change their outer bodies to be consistent with their gendered selves.

GIRES offers other resources too, such as information for politicians. In a document called *Transsexuality – The inside story: Information for MPs* (Gender Identity Research & Education Society, : http://www.gires.org.uk/assets/inside-story.pdf) it stresses its message through a biologically reductive lens, however, here transsexuality is couched in the discourse of intersexuality:

> Transsexualism does not stand alone, but may be understood as part of a complex spectrum of related conditions, an interpretation acknowledged by Lady Butler-Sloss, (Court of Appeal, 2001): "There is, in informed medical circles, a growing momentum for the recognition of transsexual individuals for every purpose and in a manner similar to those who are intersexed (Gender Identity Research & Education Society, : http://www.gires.org.uk/assets/inside-story.pdf).

Although participants in this research did not directly refer to GIRES, five participants claimed that intersexuality was closely related to their transsexuality. For example, Amelia, who is a historian, claims that the "third"[32] is a universal phenomenon.

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[32] Ethnologists who have engaged in research into gender, sex, and sexuality and have long been interested in cultures, which recognize more than two genders (Malinowski, 1927; Mead, 1949). The most influential of these ethnologists, Herdt (1994) created the concept of the "third" to condense various sex and gender configurations from various parts of the world, such as the *Hirja* of Southern Asia, the *Berdache* of the Americas and the female husbands of Western Africa. The sexologist, Havelock Ellis (1942 [1905]), argued that the tribes reason for the inclusion of another 'gender' was probably due to congenital abnormalities, such as hermaphroditism. This, he suggests,

Well there is a historical way of looking at it and [I] began to realise that it is not as recent a phenomenon as people try to make out. It does go back a long way. It goes back to the Greeks and Romans, it goes back to Carthage. It goes back to ancient China, to India, Native America and so that opened it up for me. The third gender as some people define it is not unusual and in many societies had a lot of respect (transwoman Amelia).

This realisation, following her own research, that transgender people have been visible in various cultures, secured Amelia's understanding about her transsexualism, allowing her a sense of normality within a gender system that did not approve of her position. Amelia, like GIRES, seemed to be searching for, and finding, sources to validate the transsexual experience.

GIRES disseminates the intersex paradigm across its entire web-site, using medicolegal language, which illustrates the relationship between two highly "valued" social institutions in liberal democratic countries. In one sense, GIRES is situating biological sexed positions in relation to established sex/gender orders and, thus, could be seen as an assimilationist model. This positioning systematically augments medicalised and biological explanations of transsexualism as the "informed" "truth" and "reality" of a congenital condition. The choice of this particular body framing, if we understand it as assimilationist, is therefore a belief in the positivistic claim that science understands the phenomenon of transsexualism, and its relationship to intersexuality and to males and females. The relationship between transsexuality and intersexuality has been a longstanding issue in sexology (Diamond, 2000; H. Ellis, 1942 [1905]) and in psychological perspectives (A. Ellis, 1945) throughout transsexuality's history, albeit having different conceptualisations as I discussed in Chapter I.

This causal story of transsexualism utilises socially "legitimated" actors, who are also the "expert" social commentators in this particular arena, the biogeneticists and lawyers. Narratives that are considered valuable by society's elites, such as legal and biogenetic

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is highlighted by the tribal names for these individuals such as, *bote,* which means 'not man, not woman' and *burdash,* which means 'half man, half woman.'

accounts, are usually consistently portrayed in other areas of social life, such as popular culture and the media, for example. In the media "impoverished representations of social life" (Jackson & Rees, 2007: 917), in relation to gender and sexuality, are explained through a(n) (evolutionary) biological lens and are presented as "natural facts, given by our evolutionary heritage [...] and are assumed as the basis of all human conduct" (2007: 918). The so called biogenetic aspects of transsexualism are intimately linked with the psychological, where somehow nature has gone awry. This seems to be more appropriate for the claims and sympathies which GIRES is trying to foster, rather than the socially less convincing lifestyle choice model.

For GIRES there is a fine line between biogenetic and psychological accounts, which dialectically produce a pathological and deficient trans body, even though some doctors who have been in the "trans care business" for many years advocate the removal of the "condition" from the DSM (Burns, 2005a). For example, Walter Bockting a prominent board member of WPATH (World Professional Association of Transgender Health) remarked:

> The inclusion of gender identity disorder in the Diagnostic and Statistical Manual of Mental disorders has not resulted in broad health insurance coverage for transgender care, more and more transgender individuals perceive this diagnosis and the need to consult with a mental health provider as unnecessarily pathologising (cited in Burns, 2005a).

This quotation is aimed at healthcare systems in countries that are reluctant, or refuse, to provide trans surgery through medical insurance plans. In the UK, where free surgery is provided (albeit after a long and restrictive assessment), the context will be different. There have been debates in the UK trans community about the potential cost to transpeople if the medical classification were to be removed. The community is also debating the "cost" of pathologisation, as Christine Burns from Press for Change, remarks:

> there could be a tipping point when the trans community might decide that the benefits of accepting a degree of medical pathologisation were outweighed by the disadvantages (Burns, 2006: 53).

However, the jury is still out in the UK. However, what is striking about the virtual literature from GIRES is the picture it paints of transsexualism as pathology, albeit, one that requires compassion and understanding. Nancy understands her transsexualism in a similar way:

> Nancy: Genital surgery, as I say, it is a correction of this congenital defect, the congenital defect being the penis, although it is not a fuller correction that would be nice to have.
>
> Zowie: *What would be nice to have?*
>
> Nancy: Well as far as I know I don't have any female internal organs (transwoman Nancy).

Nancy has not been diagnosed with an intersexed condition, however, in her narrative it is purported that the transsexual as abject, is a victim of a cruel but natural aberration rather than a social, medical, and psychiatric construction. This echoes GIRES' understanding of transsexualism.

> GIRES recognises that identifying the biological determinants of gender identity and intersex conditions helps society generally to understand and accept that those they affect are naturally transgendered. The understanding that gender dysphoria is not a fantasy is especially important (Gender Identity Research & Education Society, : http://www.gires.org.uk/priorities.php).

This narrative raises a number of themes in relation to intersexuality. The transsexual is reduced to unconfirmed interior substances. There is a sense of the body as an authentic yet aberrant natural manifestation of human sexuality. This approach may mean that it is less likely to be rejected by NHS managers, policy makers, and MPs, who hold the purse strings to sex-change technology, due to "awareness" of the diversity within a binary system.

In order for GIRES to set this "natural" discourse up with any sort of coherence, the constructions of normative male and female bodies are a necessary and strategic point of departure. The transsexual body – as a congenital aberration – sits somewhere between the poles of normal male and female bodies on a continuum of human sexuality. The website states:

> We all know that boys and girls are different. They look different, they often behave differently, and they feel different. Outside appearances of the sex of our bodies - the genitals - are the indicators we all recognise, but internally too, the organs of reproduction are different, and, importantly, so are small areas of the brain. The process of developing into "male" and "female" is called "sex-differentiation". There are complicated reasons for this development. [...] in the presence of testosterone the baby will be born looking like a boy; without testosterone a baby will be born looking like a girl. Recent research suggests that, in addition to these hormonal effects, certain genes may act directly on the brain to trigger its differentiation into "male" and "female". The brain is structurally different between men and women, and appears to be "programmed" so that each experiences a strong predisposition to "feel" like one or the other. This feeling of being a boy or a girl, a man or a woman is called our "gender identity" or, sometimes, "core gender identity" (Gender Identity Research & Education Society, 2007: http://www.gires.org.uk/Web_Page_Assets/frontframeset.htm).

While this quotation suggests that there are biogenetic factors that can influence the way bodies look, which it seems cannot be denied, it further suggests that physiological factors can also influence the way people *feel* as "boys" and "girls". The environment and experiences of socialisation play no part in bodily aesthetics according to GIRES. Bodily aesthetics are constructed as basic intrinsic characteristics. They are not characterised differently through history and cross culturally and, therefore, within different political climates, rendering bodily aesthetics natural characteristics, rather than, social productions. This attempt to create the "transsexual" aetiologically is asocial and ahistorical, and based on, what GIRES, following the medical establishment's aetiology, calls "core gender identity" (Money, 1973). The often anonymous author(s) working for GIRES create a simplistic gendered analysis and leave this claim as a "common sense" statement to

encourage potential adherents to the discourse. Moreover, website posts crave no deep deconstruction due to the obvious ease of a theoretical rebuttal. This "feeling like a boy or a girl" idea has often been successfully critiqued with a more nuanced analysis within work undertaken in Women's and Gender Studies over the years, especially by feminists within psychoanalysis (Chodorow, 1978) phenomenology (de Beauvoir, 1997 [1949]; Young, 1990) and postmodern/queer accounts (Butler, 1993). It seems that GIRES uses a socially convincing narrative and commonly held social view of the binary sex system, whilst attempting to broaden the gender system's scope.

The site also states:

> Biology, through genetic and hormonal interactions, determines the structure of the brain as male or female and is a major factor in the development of gender identity from the moment of conception, through the foetal stage and postnatally. Infrequently, gender identity develops within the brain in a manner that is incongruent with the male or female characteristics of the rest of the body. It is reasonable to accept that some people may be more affected than others by this process. Consequently, not all will feel an equal degree of discomfort with the discordance between their innate gender identities and the genders that, based on their genital appearance, were assigned to them at birth. The term transgender includes this broad range of people who all experience atypical gender identity development but the way they express their gender roles may vary widely (Gender Identity Research & Education Society, 2007: http://www.gires.org.uk/Web_Page_Assets/frontframeset.htm).

The scientific explanations of transsexualism are prioritised over other dimensions of transpeople's lives as this narrative strategy assists in rationalising and justifying most of the other publications on the website. The study by Kruijver et al. (2000), that focuses on the amount of neurons in a limbic nucleus,[33] which I explored earlier, claims to add to the evidence of a sexually dimorphic brain and is appropriated by the organisation and offered

[33] I do not want to imply that this study is evidence or not of the sexually dimorphic brain paradigm that would situate transwomen and transmen in the range of their respective sex, i.e. transwomen in the range of women's and transmen in the range of men. The results in Kruijver et al's (2000) study are, as with many scientific studies, expressed with reservations.

as sound evidence in the majority of publications on the website. Other scientific references are offered in addition to undergird this line of reasoning. The adherence to medical literature in this quotation is based on a conviction that a small section of the brain, and its pre-natal "encounter" with hormones, is the instigator of a psychologically dimorphic gender identity in transsexuals and "normal" people. Albeit, non-transsexuals have outer physical bodies that have sexual characteristics, which match a "core gender identity" instigated by the cerebral and hormonal physiological factors, whereas in transsexuals these do not match with the outer physical body. Counter arguments, such as Fausto Sterling's and Pfafflin's (Fausto-Sterling, 2000; Pfafflin, 2006), which hold that there is no statistical evidence to back these claims up and that the phenomenology of transgender is too diverse to capture in these models, are never revealed for public perusal on the website.

Making a convincing argument

There is an assumption, then, that this kind of community information, comprising of both biogenetic and causal explanations, will allow transgenderism, transsexualism, and intersexuality eventually overcome the cultural stigma of the abject, as the disabled people's movement (Oliver, 1990), or as the Lesbian and Gay Movement's has partially achieved in the UK. This is as long as, to paraphrase Blackman (2007: 8), the "person can retain their dignity as a service user in the face of stigma and shame" that is still associated with "gender dysphoria."

Nevertheless, this "biological" frame allows them to call for medical intervention on behalf of the transperson. By constructing a scientifically prescribed sexuality frame based on intersexuality, the transperson, then, can reasonably request to have their "congenital defect" changed through hormonal and surgical technology. This is because aesthetic surgery is a standard clinical practice for intersexed people and generally regarded as a "medical necessity." Whilst the "medical necessity" angle seems to provide a vehicle for access to trans-sex technology, medical authorities, as a whole, do not view trans surgery as a "medical necessity."

Nonetheless, the emergence of Primary care trusts (PCTs) and patient groups has enabled transpeople to complain about health services. PCTs covering all parts of England receive budgets directly from the Department of Health. Since April 2002, PCTs have taken control

of local health care while strategic Health Authorities monitor performance and standards. Negotiation and political pressure using the intersexed narrative is often employed when confronting those who hold the medical purse strings. For example Brian said:

> it was a ten page A4 size [document] from the organization that had a page on the medical viewpoint and other topics, short paragraphs on the differences between homosexuality, transgender, transsexual and transvestite and I thought that was very compact and condensed and for me it got the information over (Bi-gendered Brian).

Surgeries and other technological interventions deemed "medical necessities" have more social and medical currency than aesthetic surgery in the UK, as I explored in Chapter I. In relation to PCTs, who are ideologically against the use of body modification practices for transsexuals, the discourse of intersexuality may help when transpeople argue for medical intervention. T-COs, who follow this line of reasoning, recreate a modernist discourse of the body that has a scientific, medical, legal, and thus "rational" empirical standpoint. Thus, GIRES' message becomes more "persuasive" to the "rational" and lay reader, because of the "findings" of science.

GIRES further fulfils its mission statement of disseminating educational and scientific studies, which are socially "valued" about the "unalterable" and, to many people, invisible cerebral aspects of bodies. The promise of this discourse is the provision of a "scientific" account of what is *wrong* with transsexuals, within a "difference" model of human sexuality, and helps qualify the "condition" as being beyond the control of the transsexual, intersexual, and transgendered. Moreover, GIRES provides an effective strategy, which is seen by a few participants in this research as a form of appropriate information, which allows the space and time for recognising themselves and understanding what trans-sexing may entail. It provides a (virtual) space to explore the best strategy for their "self-health" management.

GIRES may be read, on the one hand, as being part and parcel of the consumerist ethic that governs cultures of self-health in advanced liberal societies (Blackman, 2007), whilst, on the other hand, continuing to leave the ultimate power relations unaltered and securely in the interests of the medical field and political elites. GIRES is wary of the eugenically

motivated possibilities of medical discourse and pre-natal extermination that may materialise in relation to transsexuality, intersexuality or transgenderism, as medicine advances. The publication of Greenberg and Bailey's article, *Parental Selection of Children's Sexual Orientation* (2001), in the Archives of Sexual Behaviour may have been the catalyst for the inclusion of this warning:

> GIRES recognises the risk that research into causality may lead on to searches for ways to prevent the conditions pre-natally rather than to make life better for those they have already affected. However, it is powerless to curb the intellectual curiosity of the scientists working in this field (Gender Identity Research & Education Society, : http://www.gires.org.uk/priorities.php).

The Bailey article suggested that in the near future, when scientists have uncovered the basis of sexual orientation – which they purport is not far off – it would not be morally wrong for parents to want (heterosexual) children "like themselves" and, in effect, be able to select for the preferred sexual orientation of their child. "Parents who did not wish to have homosexual children could then abort fetuses likely to become homosexual" (A. Greenberg & Bailey, 2001:425), assuming, of course, that abortion is not deemed morally wrong by the parent/s in the first instance. This paper is known in the trans community due to what has become known as the "Bailey Affair" (Burns, 2005b), where J Michael Bailey, one of the authors of the article, came up against a worldwide protest against his representation of two "sub-types" of transsexual, "autogynephilliacs" and "homosexual transsexuals." "Autogynephilliacs" are said to be those transwomen who fantasise and become aroused when they think of themselves, and having sex, as women. "Autogynephilliacs" usually have a "transvestite career" prior to transitioning. "Homosexual transsexuals" are transwomen who have a "homosexual career" prior to transitioning (Bailey, 2003; Blanchard, 1991). Furthermore, allegations of unethical conduct were made against Bailey for using non-consented information in his book, *The Man who would be Queen* (Bailey, 2003). Transwoman, Lynn Conway, a Professor from the University of Michigan, along with other activists, initiated a campaign against Bailey's work and distributed critiques on her website of both the article and the book, which she regards as eugenically motivated (James, 2004). However, GIRES argue that anything that may help the transperson now seems a risk worth taking, because of the political and

transphobic climate transpeople must endure in the here and now. Nonetheless, this strategy is contingent upon the continued goodwill of doctors and politicians, in providing the (ever decreasing) opportunities and funding for trans-sexing. One of the most consistent types of news story and area of concern for the trans community, both during and after the implementation of the GRA, was healthcare. These concerns mainly consisted of a critique of the gender clinics. Waiting times, closure of GICs and the funding of surgeries by the Health Trusts (see West, 2004) were highlighted as being unfair in relation to transsexuals. Moreover, West argued that transpeople were being treated as unworthy recipients of surgical technologies, even though they were tax paying citizens.

By refusing all but a very narrow reading of the transgender medical literature, GIRES creates a believable medical viewpoint about transsexuality, which is persuasive and becomes, in many circumstances, framed as a congenital "condition." It is one narrative, however, that removes the dimension of "social bodily" aesthetics from transpeoples lives, which is intrinsic to transsexual embodiment. This creates a political narrative that offers only a partial understanding of transgender lived experience. In so doing the political narrative fails to reflect all the contemporary political leanings and realities of transpeople. However, GIRES may not be trying to cover all angles. GIRES is unlikely to extensively change the social sex/gender order, which may suggest that it want to be "assimilationist" in relation to the existing sex/gender order. However, on a different level, there is what Marx Ferree has termed "frame bridging" (Marx Ferree, 2004), where activism and cultural production can exercise a relationship between "assimilationist" and "transformational" politics. GIRES could be seen as trying to meld the political goals of acceptance within dominant organising structures of gender whilst extending the parameters of sex/gender possibilities and transform the binary sex system to include the position(s) of intersexuality.

Inadvertently framing bodies through a medicolegal frame?

In GIRES' political framing of trans embodiment there is little scope for capturing the diverse phenomenology of transpeople and the various "social bodies" they have. This is most aptly illustrated by a document by Stephen Whittle (first published in (Whittle, 1999)), which was awarded a cash prize by GIRES and, which perhaps paradoxically, features on its website. It states:

> a concept at the heart of the newly developed transgender activism [...] The self with its trans identity can be now experienced as an authentic self rather than as the medicalised paraphiliac, currently imposed by physicians, attached to the body and regarded as the trans sense of identity by the rest of society. Through its organisational processes the transgender community itself is being redefined, and the issues of importance are shifting. The personal recognition of the actual self; internally defined, as opposed to the medical self; which had been externally dictated, has meant a huge shift has already been undergone in transgender politics; the body or its performativity is no longer the dictator of gender. Gender has become who or what you experience through your experience of oppression as well as through a celebration of diversity of experience and life styles (Gender Identity Research & Education Society, : http://www.gires.org.uk/priorities.php).

The president of Press for Change, Stephen Whittle suggests that:

> within the community itself, as we move toward the new millennium, members no longer privilege 'passing' - the ability to hide a transsexual identity in a new gender role (Whittle, 1999).

Press for Change's gender frame of transsexual embodiment has been constructed so as not to make dogmatic claims about how a "social body" should appear when one identifies as transsexual or transgender. For example, on Press for Change's web-site it states:

> Press for Change will resist a definition of transsexual status which relies on an individual having undergone any particular medical or surgical treatment. Some transsexual people are unable to obtain treatment, are unable to receive treatment for health reasons, or do not wish to submit to unsatisfactory or expensive treatment (e.g. phalloplasty). Such persons are no less entitled to their civil rights and liberties than others (Press for Change, 2004: www.pfc.org).

The transsexual body or experience, according to PFC, thus, cannot simply be represented in a "true" or "false" dichotomy, or indeed, as having a "true" or "false" trajectory in

relation to body aesthetics, bodily transformation, or a wish for body modification. The "difference" model is further articulated by Stephen Whittle:

> I have been able to be at the forefront of a new political movement that is really challenging the issues of body fascism. If we can win the one about trans bodies, then we can win in all the other battle grounds surrounding the body whether to do with people being fat or thin, abled or disabled, black or brown, male or female (Whittle, 2007b).

What Stephen Whittle is referring to here is the Gender Recognition Bill and, eventual, Act.[34] A number of consultation exercises were set up by PFC with the expanding T-CO's networks in the UK, to understand the wishes and desires of transpeople. The findings were to be taken forward by PFC members, such as Stephen Whittle, who could draw on his legal expertise. These, however, were analysed against a backdrop of governmental directives about contemporary medical viewpoints, cross-cultural (European) precedents and human rights directives (see Home Office, 2000). Representatives from various organisations, such as PFC, GIRES, Beaumont Society, Liberty, Northern Concord and Change, collaborated with a group named *The Interdepartmental Working Group on Transsexual People*, which consisted of ministers, MPs and other social policy makers, to formulate a report that was to guide legislation in British Parliament. The "Working Group" was set up in April 1999 and was to reconvene in Easter 2000 with a report that would:

> consider, with particular reference to birth certificates, the need for appropriate legal measures to address the problems experienced by transsexual people, having due regard to scientific and societal developments, and measures undertaken in other countries to deal with this issue (Home Office, 2000).

In 2002 the "Working Group" reconvened to resolve legal intricacies and difficult technical issues involved in changing a person's legal status. Two years later, in 2004, the law was given royal assent.

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[34] On the 11th November 2003, in a Report of the Joint Committee on Human Rights from the UK government, claimed that the proposed legislation would possibly be the most progressive system of gender recognition in Europe.

The surprisingly "queer" UK Gender Recognition Act allows transsexuals to acquire full legal recognition in their acquired gender without the requirement of endocrinological or surgical intervention. Thus, in effect, trans bodies can be materially constituted in various ways. We can understand the legal gains achieved by the T-COs not simply as an assimilationist model of "sameness" but also as transformative, because it allows for bodily diversity. The legal recognition of transsexuals in their acquired gender regardless of bodily morphology was of paramount importance to PFC, and to the majority of those who participated in this research. Jess highlighted PFC and allied T-COs' political focus:

> I realised this was where we were going with the Gender Recognition Act and the medical model was being resolved as a result of human rights and legal activism not from medical rights. The NHS is not going to solve the problems. What has solved the problems is Press for Change getting the law changed. So what is happening, the way we are moving legally is actually beginning to correct the social and medical sides (transwoman Jess).

Jess believed that attending to politics solely concerned with medicine would not be enough to bring about adequate social change. In so doing, Jess promotes the legal angle as the perspective from which all other social spheres will benefit. Jess' hopes that the state and the law will remain key domains for counter hegemonic struggles. This is not because the state is a monolithic entity, which beholds a static and unified set of political structures to be broken down, but because the various state agencies create, through various avenues, opportunities to engage in critical analysis and reconfigure state and legal structures. In essence the state allows for the potential for "transformation" with equal opportunity directives and to address "difference" inequalities. Furthermore, transpeople are less afraid to be "visible" and to be a part of the emerging "transformation" of the state and civil liberty policies in relation to sexual and gender minorities.

However, within all activism there is some "social bodily" aesthetic policing going on. Some of the participants had a more problematic relationship with the PFC's difference model. For example, Diane said:

there is a wealth of disagreement within the community (transwoman Diane).

Diane illustrates the contentious relationship between transpeople and the "social bodily" requirements set out in the GRA.[35] The T-CO rather than bringing claims about a group boundary based on bodily aesthetics highlights the potential of gender diversity and the "transformation" of the states understanding of trans "social bodies." I suggest, then, that "sameness" is only possible at a basic level of transsexual identification. PFC is aiming to capture this basic level of "sameness" in the name of support whilst simultaneously promoting its "difference" model of trans bodies.

Although the deconstructed trans "social body" within PFC is without bodily aesthetic parameters, bodies continue to remain acquiescent to the binary gender system, with its symbolic codes and meanings. The gender system is ordered by the legal framework. As with GIRES, which adheres to the medical paradigm, we may assume that the social structures that the organisations are working within always pull them back toward the system, which they are trying to transform. "Right" trans bodies are confirmed by transpeople themselves on a phenomenological level, however, they are also confirmed within medico-legal parameters that the law requires "set out" by the GRP, which holds the key to defining whose bodily aesthetics count as "right" and whose do not. Whilst PFC rely in part upon the medicolegal system to gain citizenship rights for (some) transpeople, we cannot view its politics in a purely assimilationist framework, because its political praxis is contextually diverse and refuses to crystallize bodies in any specific form. Furthermore, as the meanings of trans bodily aesthetics have shifted in medicolegal circles, this displacement of trans "social bodies" in law becomes transformative.

"Get off my representation!" Aesthetic formulations of transgender

In Sandy Stone's (1991) work there was a significant "call to arms," encouraging transgender and transsexuals to tell their own stories that were not the medicalised narratives of old. "Our stories," she said, need not be the uniform medicalised narratives with well trodden tropes of "trapped in the wrong body" or "the male or female inside" (Stone, 1991), which have been conceptualised by Sally Hines as "rehearsed narratives" (S.

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[35] I will take this point up in more detail in Chapter VII: Negotiating Bodily Aesthetics in the UK's Medicolegal System.

Hines, 2007). Rather, Stone urged transpeople to tell life stories and histories about their personalised transgender trajectories. Moreover, she recommended that non-justificatory reasons should be offered and, in so doing, become the authors of new forms of self-expression. Bornstein (1994) suggests that this would constitute being "gender outlaws," who are those transpeople who wish to break down or transform the binary continuum between male and female as opposed to the "conformist" transsexuals who wish to embrace the gender system. Katrina Roen argues that they both

> seek greater societal acceptance and legal rights for transpeople. However, the former seeks acceptance for gender transition and gender ambiguity, while the latter seeks acceptance for the practice of living as "the other sex." The former seeks to destabilize and expand the categories "Woman," "Transsexual," and "man," while the latter seeks ways for "Transsexuals" to be accepted as women and as men (Roen, 2001: 502-503).

Roen's work, which was conducted in New Zealand, suggests that on occasions the divisions are not as clear cut as this and that the lines between the "transsexual camp" and the "transgender camp" are much more contextual and multidimensional in relation to political praxes. She notes that there is a conceptual continuum between the "gender outlaws" and the "conformist" transsexuals during some political praxis, which this research illustrates too. Thus, Roen's conceptualisation of the two "camps" cannot be easily placed in the assimilationist/conformist dichotomy. And, as she concedes, political praxis is contextual.

Three younger transpeople in my research were part of, and had helped formulate, other community groups (CG), which fight for political gains away from established T-COs. In the social movement literature these CGs are regarded as "DIY" queer organisations (Brown, 2007) and are growing in membership. Within these CGs are a number of transsexuals whose political allegiance is to a more "critical community" of (queer) gay and lesbian people. These groups are formulating new ideas, cultural productions, and spaces in which gender, embodiment, and sexual desire have been able to open up (Roseneil, 2002). Processes of collective experimentation, in order to build autonomous queer spaces, are seen as more personally transformative and empowering (Brown, 2007). This suggests that

the established T-COs do not fully represent the political goals, which these queer transpeople see as important. Nevertheless, there are connections between some of the political praxes that the more established T-COs cultivate on a practical level. For instance, collaborations with other T-COs are not discouraged by the "DIY" organisations on certain issues, especially when the focus is on "queerer" civil liberties. I will explore this "queerer" civil liberties concept in more detail below, following a discussion of what I observe as a shift that has occurred by older more established T-COs in relation to representations of trans bodies and the opening up of the gender system. This is, I argue, more coextensive with the rationale of the newer "DIY" groups.

For example, as I discussed above, activists from many "DIY" groups in the UK, and in a global context, staged a highly publicised e-campaign to counter the publication of the psychologist J. Michael Bailey's book *The Man who would be Queen* (2003), and the representations therein of (mainly) "paraphillic" transwomen. The email discussions within activist circles contemplated the validity of the author's ethical, methodological, and analytical stance on transwomen, gay men and ethnic minorities, who, in the book, were "predisposed to sexual deviancy" because of their genetic make-up (Roughgarden, 2004). An email was circulated with an open letter questioning Bailey's research validity, professional honesty, and personal politics:

> We would like to ask you why you have not even mentioned the biological basis of transsexualism; it's intersexual nature? Why have you disregarded the fact that, for nearly 80 years, those most actively involved in researching our condition have postulated its somatic origin? Why did you not explore the intricacies of the neurological data provided by leading researchers (Email 01/09/2003)

Whilst this could be seen as a non-queer position, I suggest that those queer activists who gave support to this political action were, in fact, fighting against Bailey and his negative representations of transpeople rather than agreeing wholeheartedly with the content of the letter. Bailey is seen as a homophobic and transphobic member of the medical establishment who needs stopping (Roughgarden, 2004). Therefore, any action to halt his work would be seen as a positive step forward. In addition to the questions directed at Bailey, the email also urged activists to engage in a letter writing campaign, with the

correspondence being sent directly to Bailey's publishing house, complete within photographs of a happy trans life, and pointing out the "well adjusted transperson" in the image. The protest had a few branches of action, and was also aimed at the LGBT Lambda literary awards, where an online petition was formulated:

> We, the undersigned, formally protest the decision by the Lambda Literary Foundation to continue listing J Michael Bailey's book, "The Man Who Would Be Queen", as a finalist in the Transgender/GenderQueer category of the 16th Annual Literary award. [...] As signatories WE DO NOT advocate that J Michael Bailey's book should be suppressed or withdrawn. Nevertheless we feel that the nature of the distress and potential harm occasioned to transsexual people by the author's actions makes this work an inappropriate candidate to be honoured by a transgender-inclusive organisation and that the book should therefore be withdrawn forthwith from the list of nominees at our collective request. (http://www.petitiononline.com/bailey/petition.html).

The political fervour that arose from the publication and the possibility that it may be honoured by an organisation that is supposed to celebrate LGBT literary pioneers was enough to engender much support, resulting in a posting on the Lambda website on March 12th 2004, stating that Bailey had been removed from the list of finalists. The book, which was publicised as a robust piece of research, was condemned globally by trans activists and non-trans allies, which ultimately led to investigations into the ethical behaviour of Bailey with regard to his "research subjects." Bailey resigned from his post as professor and chair of the psychology department at Northwestern University in the US, however, it is not known if this was as a direct result of the controversy surrounding his book.

Whilst the illustration above shows the possible effects that protest and political actions can achieve, it was not contained and pursued within a single organisation. The protest was trans-global and advocated by many prominent members of the UK trans T-COs. Moreover, it was different in focus from most of the previous political interventions. This could possibly be put down to the recent social and legal gains that have been achieved in the UK, which have allowed more time and resources to be ploughed into other areas of protest. However, it can also be seen as direct action with a theoretical underpinning of

queer theory and queer activism, which would account for the protest having a more aesthetic and representational focus. Queer activism is characterised by the generative power of oppositional "identity" constructions. As a more tolerant social climate develops and more positive views of transpeople are heard,[36] activists have more time to stage more aesthetically and culturally political actions with "in your face" non-justificatory cultural productions. Clifford suggested:

> I think that people have been living across boundaries and other things; for as long as, but it is more in the limelight now, it is more acceptable now but still controversial (transman Clifford).

The rationale for these DIY groups is derived from queer politics, which they state critiques "hierarchies, capitalism and assimilation" (Queer Mutiny, 2007: http://www.indymedia.org.uk/en/regions/manchester/2006/01/331245.html). Gamson suggests:

> serious consideration of queerness as a logic of action can force important revisions in approaches to collective identity formation and deployment and their relationship to political gains. First, it calls attention to the fact that *secure boundaries and stabilized identities are necessarily not general, but in the specific* –a point current social movement theory largely misses (Gamson, 1995:402).

Whilst the focus is not solely on transsexualism and transgenderism within these CGs, the possibility of transpeople's inclusion is never questioned. "Social bodily" aesthetics are of no importance, in relation to the notion of "right" and "wrong" bodies. However, the aesthetic and representational aspects of trans visibility and trans cultural production in a

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[36] Nadia Almada, a Portuguese transwoman, was the 2004 winner of the hugely popular Big Brother television show in the UK. Her appearance on the show was in stark contrast to the usual media representations of transwomen. She appeared on many daytime TV shows after her victory and was respected, without suffering any ridicule. Nonetheless, tabloid newspapers did continue to use transphobic language to describe her, such as "[t]he gender-bending Portugeezer who confounded her critics when she snatched the reality show" (Desborough & Myall, 2004). More recently, documentaries which have featured transpeople have been more sympathetic and less sensational about the various lived world experiences that their participants have had, in relation to their trans situation.

queer culture are encouraged and fostered equally with other concerns. Oscar articulates the difference between some (mainstream) "scenes" and the "DIY scenes" and how his trans visibility is diminished in more mainstream trans community because of its understanding of transsexualism and transgenderism:

> So I still get a little frustrated with the limited readings within some [organisations]. There is a space called Kafequeeria in Manchester, which is an activist, anarchist café and I find there my identity is taken more seriously and people are able to recognise that (transman Oscar).

The political division is much less stark between transsexuals and transgender in these queer spaces, this is illustrated more so in the younger DIY groups:

> Get Bent is a safe space for all genders and sexualities and seeks to engage with and foster the possibility of creating queer-positive spaces. [...] Get Bent follows a DIY ethic, creating wide variety of programming by supporting diverse people to create diverse events (GetBent, 2007b: http://www.get-bent-manchester.com/).

Building on the US's *Transsexual Menace*, *Transgender Nation* and *Queer Nation* political consciousnesses of being out and proud, and not necessarily "passing," queer "DIY" groups encourage the deconstruction of what constitutes a transperson in relation to bodily aesthetics. Much encouragement is given to visibility, regardless of what you look like, as long as you self-identify as politically proud. Raymond suggested:

> How can we say there is nothing wrong with being trans if we ourselves do not stand up? You have a duty to stand up in a sense and embrace the fact that there is a lot of space and there are other options but if we do not stand up we are also insinuating that there is something wrong with being trans. [...] Actually you are enforcing the things that oppress you in the first place. It doesn't make any sense; it really doesn't (transman Raymond).

Nonetheless, there is still an understanding that serious repercussions may take place because of society's transphobia and homophobia. The "DIY" groups create the space to

become aware of the wider political arena. These spaces fuse politics, culture, and sex in a spirit of inventive playfulness and offer an important "DIY" alternative to other groups in the political sphere (Brown, 2006). In one meeting

> [Organiser] introduces this open forum to discuss and debate how people approach their own body image and self image, and view their own physicality in a positive way. This is part of a larger project aiming to empower, liberate and inspire all kinds of people to reclaim, love and look after their bodies and physicality, using visual and performing arts, creative writing and holistic healthy living techniques. A founding principle of this project is to actively challenge unrealistic pressures and negative representations of gender normative "perfect bodies" and messages promoting body fascism surrounding us in the 21st Century. Everyone is welcome to get involved and there is a special invite to anyone who feels invisible, marginalised and unrepresented, such as people who self-identify as transgender or intersex or undefined/non-heterosexual, people with disabilities, people with eating disorders, people who self-harm and people who use body modification techniques (tattoos, piercings, binding, scarification, corsetry, drag, etc) (transman Oscar, email 31/08/2007).

Here, the focus is on the disruption of the established social order's representations of certain bodies having intrinsic negative meanings. This may, for example, also include challenging the social structures and the power relations in transpeople's everyday lives. The focus, then, becomes about desire and choice in using the technology available to modify the body, as Oscar explained when he talked about a group called Dimensions:

> for younger trans people, twenty five [years old] and under. Apparently you have two consultations and you can get prescribed hormones so I am just seeing what other ways are available. I have a friend in New York who set up the Sylvia Rivera Law Project, which is very much about enabling access for anyone to hormones and I know there are clinics where you don't have to pass a test or abide to guidelines in order to get the hormones, so I am looking at those routes. With the whole queer movement wanting to do away with all the system; I think we need more options (transman Oscar).

Sexing it up

The projects of representation rely on transforming spaces in which trans queers can then explore themselves. Queer and camp aesthetics are intrinsic to these explorations. An illustration of these queer and camp aesthetics was staged in Manchester, UK at a film/performance/talk and presentations festival called Get Bent 2007. Drag performances, readings, experimental film and documentaries were part of the line-up. In one session, Eliza Steinbock (2007) opened up a dialogue about trans pornography. Steinbock showed films that interrogated trans bodies and pornography alongside the film maker's comments. Steinbock's analysis questioned the idea that transsexualism and transgenderism was solely about gender as a core characteristic and argued that sexuality was part of trans subjectivity too. After many years of being silenced about sexuality and sex, for fear of being pigeon holed as sexual deviants and transvestite fetishists by the medical teams in the GICs, transsexuals have started to explore and produce their "sexual bodies" and represent them in novel ways through prose, poetry, and film. Steinbock's film explored many configurations of trans bodies in relation to pornography, which moved away from the better known "chicks with dicks" pornographic genre. The films depicted transmen on transmen, transmen on transwomen, transwomen on transmen, women on transmen, and who were using all their erogenous zones and non normative bodily make-ups. This staging not only helps reconfigure the staid ideas in the GICs, but also the staid ideas about transpeople as non sexual people, which have inadvertently been promoted by some T-COs. Therefore, these new "DIY" collectives have, what Kate Bornstein (Bornstein, 1994: 163) suggested over a decade ago, an "irreverence for the established order" and utilise an "often dizzying use of paradox." These new kinds of trans activists, who are passionate about being able to live as they wish and represent themselves as authentically as is possible, pose an ideological challenge to both the T-COs who work "within" to transform law and medicine and the ruling order itself.

By elaborating new aesthetic representations Beyond the narrow structures, Oscar suggests that queer activism questions the value of heteronormative and gender normative benefits, such as marriage and birth certificates, but it also needs to be open to others' desire of wanting normative gains made by other T-COs. Therefore, Oscar is using queer as a relational ethics of engaging with desires relating to sexual and gender differences (Brown,

2006). Moreover, Oscar's queer politics is framed as contextual in its relation to social structures and the representations of transpeople and in its relation to other T-COs which have made gains for transpeople's through normative political avenues. Oscar states:

> I think we need more options and possible coalitions between these options, between the Gender Recognition Act, civil partnerships, but at the same time would it reinforce it? It is tricky (transman Oscar)

As Oscar illustrates, activism is not simply an either/or problem. Queer aesthetic activism can be both transformative and empathetic to others who choose not to be so defiantly separatist. Therefore, it seems that there is something more at stake in considering techniques and practices of queer self-production than whether it is assimilationist or transformative. More importantly, queer politics must allow for a contextual space for difference and a space for collaboration amongst different political actors. As Terry Eagleton (1990) suggests, the test of a truly radical aesthetics will be its ability to manoeuvre as a social critique without simultaneously providing the grounds of its own political ratification.

Conclusion

"Sameness" (assimilationist politics), "difference" (different but equal politics) and "transformative" (queer politics) in their respective activism and cultural work cannot simply be conceptualised as "sameness," "difference" or "transformative" politics. The types of political and cultural productions and political activism concerning trans bodies that each T-CO fights for, poses a challenge to the system in some way by offering a critique of the dominant understandings of trans bodies in the specific areas that the organisations work. Discursive cultural work and activism strategies, I observed, were aimed at different areas of concern. The T-COs I focussed on adapted the most effective discourses in relation to the audiences they were addressing. Transgender political communities largely exist as smaller marginal sub cultures doing specific work (S. Hines, 2007) rather than merged collectives (Whittle, 2001). In this sense, trans "social bodies," which are subjected to aesthetic judgements, will always be contextually driven. Nonetheless, I showed how particular political actions work to change dominant

representations of trans "social bodies." Thus, this research suggests that politics, in relation to trans bodily aesthetics have some form of "transformative" power.

Chapter VII: Negotiating Authenticity and Bodily Aesthetics within the UK's Medicolegal System

Introduction

In this chapter I look at the complex encounters transpeople have with the ontological claims made by experts within medical and legal institutions, and how transpeople negotiate them. Following Butler (1993, 2004), I will be using the term "medicolegal," to conceptualise the relationship between medical and legal regulatory norms, which function to constitute "authentic" transmen and "authentic" transwomen in society. Transpeople often foster relationships with medicine in order to negotiate access to aesthetic technologies, and to receive legal recognition in their acquired gender. During these negotiations, both transpeople and medicolegal representatives construct, deconstruct, and reconstruct various narratives of (trans) authenticity.' This chapter addresses my participants' narratives phenomenologically – that is, a study of experiences, actions and practices, and their meanings (Heinamaa, 1997) – moreover it explores how participants understand and negotiate their "authentic" subject positions when seeking body modification and legal recognition. The aim of this chapter, then, is firstly to refrain from falling into the trap of reducing authenticity to essentialism, which rests on biological notions of "sex" as the natural basis for "gender." Secondly, I do not want to reduce inauthenticity to poststructuralist understandings of gender, in which subjects are often seen as passive and culturally determined by the coercive forces, which constitute their mental and behavioural characteristics. I argue that we should regard transsexual subjectivities as intentionally "situational" (H. Rubin, 2003) and understand the agentic negotiations that are intrinsic to them, in order to access a deeper understanding of how the medicolegal fields are navigated.

In providing a complex assortment of transsexual narratives as situational, I aim to incorporate transsexual subjectivities into an agentic framework. The narratives show how transsexuals' desire for body modification requires them to negotiate the medical discourses that constitute them and also requires them to work "with" doctors and psychiatrists when approaching services in relation to bodily modification. Transsexuals acknowledge that the medicolegal discourses are interpreted by the doctors and psychiatrists that use them, which then requires savvy manipulation in order to situate

themselves, actualise their desired bodily aesthetics and guarantee legal recognition. Thus, transsexual discourses have both subjective and subjugating elements, which participants utilise and/or rework at a discursive level as well as at a phenomenological level.

In the first part of the chapter, I discuss the negotiations between general practitioners (GPs) and transpeople at the initial stages of transition, and look at how these encounters are experienced and at any problems which arise around the notion of "authenticity." I then explore the experiences of transpeople's treatment on the NHS and in the private healthcare sector, which uncovers inequalities based on age and economic and cultural capital. I move on to include a temporal dimension, considering successive policy implementations and how they may have affected the treatment of Gender Identity Disorder. Finally, I assess how the Gender Recognition Act 2004 influences the "medicolegal alliance" (Butler, 1993) and affects transsexual subjectivities and bodily aesthetics in the UK. In this research, nine participants had various body modification technologies as NHS patients. Gregory, who could not have any surgeries, was prescribed hormones on the NHS, and two other transmen had not decided to undertake body modification procedures at the time of the interviews. There were ten private patients, who had all undergone various body modifications.

Gender recognition through the medical gaze(s)

Diagnosis of Gender Dysphoria by the medical authorities is required not only to actualise the body modifications required by a transperson, but to actualise legal recognition of their acquired gender. The processes of referrals to Gender Clinics begin with participants presenting their narratives to their General Practitioner (GP), a psychiatrist or a counsellor. In my research, a GP was usually the first port of call for participants experiencing "gender issues" and in these meetings recipients were often confronted with problems of ignorance, which resonates with the findings of Hines (2007). Some GPs had very little experience of trans issues while some had none at all. Participants attempted to pre-empt or overcome GPs lack of knowledge about "gender disorders" and sought medical knowledge themselves. For example, Daniel suggested:

> if you are a T person, she [psychiatrist] tells you to get these books published in the States by Dr. Sheila Kirk. They are very good books about testosterone and

> oestrogen for transpeople and they tell you far more than you would ever find out from the doctors I have come across here [...] That helped me a lot and it all came from me, it didn't come from medical professionals because they didn't really know (transman Daniel).

Half of the respondents were referred to counsellors, who did not necessarily work in Gender Clinics. Gregory said:

> I found out that my counsellor was actually a trainee counsellor. She wasn't judgmental at all but I just freaked her out, because she thought I was a freak, she had no frame of reference. She couldn't handle it (transman Gregory).

Rather than being straightforwardly inflexible gatekeepers to transsex treatments, Daniel's and Gregory's experiences reflect GPs,' and counsellors,' lack of training and authoritative knowledge about "gender issues."

Both the GPs and the psychiatrists at the Gender Identity Clinic (GIC) need to cooperate in the treatment of transsexuality. The cooperation will enable a smoother transition to the primary trans-sexing stage of hormone therapy and the Real Life Test. Services did not always offer the support necessary, according to this research. Sometimes the GPs were at fault and sometimes it was the psychiatrists at the GIC, according to the participants' narratives. GPs often did not know about the "Standards of Care" for transsexuals (Harry Benjamin International Gender Dysphoria Association, 2001), which have been modified five times since the original version 1 in 1979 and which standardise professional key principles and treatments in the area of transgender and transsexualism. There was very little correspondence about treatment protocol between the clinics and the GPs, if any at all. In a few cases this was because the GPs were reluctant to treat the "condition," for example, Raymond said:

> I had a doctor who struck me off because he couldn't treat something like me because he was a good catholic (transman Raymond).

In Raymond's narrative, the GP's religious convictions seemed to outweigh professional codes and medical diagnoses, such as the DSM classification of Gender Identity Disorder. The refusal of treatment also suggests that this GP did not accept the psychiatric diagnosis as an authentic medical condition, but rather conceptualised it as "sinful" because of his faith.

Many of the participants who related negative experiences of GPs suggested that they were not taken seriously and that their requests for treatment were seen as absurd. Regular visits to their GP, or to different GPs, were required to either demonstrate their determination to transition or to find a sympathetic GP who would prescribe hormones and provide regular health checks. For example, Courtenay suggested that at first she was put off talking about how she was feeling about her "gender issues," because of not knowing the GP well enough and not knowing his professional position on transsexualism. She said:

> Why I had not gone earlier was because this new doctor didn't really know me, I hadn't seen him more than two or three times. I think he did say to me, "how has this come out of the blue," and I said "I don't think it has come out of the blue" and had to explain this. I kind of left it a while after that (transwoman Courtenay)

Following this encounter with her GP, Courtenay consulted an experienced and well known psychiatrist in the field of GID who subsequently diagnosed her with Gender Identity Disorder. However, Courtenay continued to have problems with her GP, she stated:

> I went to my GP and [my psychiatrist] had given me a letter. So I gave him [the GP] the letter and I said "would you prescribe hormones for me" and he said to me "well how would your relatives feel if you drop down dead" and this sort of thing and I said "well I would hope that they would be upset" and then he basically said "no." I thought he would be nice about saying no but he was adamant about it. I think he thought I was mad taking this health risk which he felt I did not need to take (transwoman Courtenay).

According to Speer and Parsons (2006), in the clinical setting psychiatrists ask a number of hypothetical questions like the one addressed to Courtenay. These have been understood by

Speer and Parsons' as an attempt to "obtain a spontaneous response which will provide a valid diagnostic test of the patient's commitment to their aspired-for gender role" (Speer & Parsons, 2006: 801-802). Speer and Parsons concluded that these hypothetical questions are not hypothetical at all, because the scenario is premised on a "situation" that the psychiatrist (as with Courtenay's GP) has power over. To be precise, a hypothetical question is asked only when the answer will have no effect on the situation. Because of the power relations inherent in the gatekeeper/client relationship the response will certainly involve power relations through which the transperson must negotiate. In this case, Courtenay needed to respond strategically, in a way that reduced the chances of her being denied hormone therapy. Thus, the GP "influence[s] whether or not the proposed hypothetical future scenario come[s] about [and acts] as gatekeeper to hormones" (2006: 796). For Courtenay, the hypothetical question from her GP was unrelated to her diagnosis and contradicted what the gender identity specialist had written in the letter. No matter what Courtenay had said at this meeting, she would have been denied hormone treatment. There was no correct response that Courtenay could have offered, which suggests that her GP, like Raymond's, was not influenced by the experts diagnosis nor convinced of the authenticity of Gender Identity Disorder. Furthermore, the question both undermined Courtenay's phenomenological experiences and the psychiatrist's diagnosis and rendered them both inauthentic.

Courtenay subsequently approached a different GP in the same medical practice, where she was approved for prescription hormones. Here we witness different approaches from GPs, arising from their different opinions about Gender Identity Disorder and the hormone therapy required for transition. These procedural differences, far from being grounded in medical diagnoses, may be subject to non-medical influences like religious beliefs. Each GP asserted their beliefs in relation to the patient presenting to them, however, the second GP accepted Gender Identity Disorder as authentic and treatable, unlike the first.

Other GPs, who worked with both the GICs and patients, were more accommodating during the referral process and the administering of hormones and this led to a smoother transition and RLT for transpeople. For example, Anna-Marie said:

I had no problem whatsoever with any of the staff, they were all very helpful and never gave me a cause for concern. We always hear so much about the badness of NHS staff and how someone was unjustly treated; you never hear anything about the successes, perhaps because it is not news if everything is going well. The problem with only the bad news making it to press is that it perpetuates a negative stereotype (transwoman Anna-Marie).

Anna-Marie's account was very positive. Similarly, Samantha was pleased with her GP's understanding of her:

> I was living a dual life as it were. So living a dual life was a literal hell. I was lucky that I found my GP; she helped me deal with a lot of stuff. Anything I needed I got.
>
> *So the support from the GP was very good?*
>
> It was brilliant the two GPs I normally see have been very good one had just come back off maternity leave; she always asks how I am and refers to me by my first name, which is very surprising. Well I went to see her once because my asthma was driving me nuts and she said to me "well, Samantha what's up with you" and that is how she referred to me, they're great, I can't thank them enough. I was originally going to have my GRS [gender reassignment surgery] privately and she just said to me do you want it on the NHS or not (transwoman Samantha).

The GP's use of Samantha's first name and recognition of her economic status led to a situation of mutual respect. In this research, it is worth drawing on the possibility that Samantha and Anna-Marie were treated better than others because of their age and ability to "pass" successfully as attractive women, allowing them a sense that they are recognised as authentic candidates for body modification technology.

Consumer rights and NHS provision: authentic vs. cosmetic

Medical services were demanded even though some participants were sceptical about the psychiatric process within the NHS. The processes involved in persuading their

psychiatrist/gatekeeper that they were legitimate candidates for hormonal and surgical intervention were viewed as ritualistic, lengthy, and patronising. For example Benjamin said:

> The positives are only that you get what you need from them. The negatives were lack of clinics so long travel involved, and very generalised and out of date questioning which resulted in standard answers (transman Benjamin).

Therefore, Benjamin and a few other participants provided a "standard" narrative response, which is performed out of obligation rather than believed in wholeheartedly. Benjamin is both a passive recipient of clinical determinations, by responding to questions in such a way as to acquiesce to clinical protocol, but, simultaneously, agentic in his securing of body modification by stage-managing the system in which he found himself. As with the majority of participants in this research, both Benjamin and Mariza understood that taxonomic legitimacy and a diagnosis are required to actualise the transformation of their bodies.

Mariza rationalised her request for treatment as pragmatic, a run of the mill solution. She thought that her surgical and hormonal interventions should be provided in the same way as other treatments are offered for medical "conditions":

> People with physical problems they do help, but the mental and any other problems are just as valid and are as much a contribution to the happiness of a person as getting rid of diphtheria or anything else. I remember the doctor telling me one time about hypochondria who really thinks they suffer with a disease, but I don't think I suffer from a disease I was just born with the wrong bits. These needed sorting out. However, a medical health service can't be called a medical health service unless there is a service and they sort them out. They can not be selective about who does and who does not need services (transwoman Mariza).

According to Mariza, the NHS works hierarchically in relation to Gender Identity Disorder, which is deemed less significant than other conditions and which thus affects the funding for surgery. In the mid 1990s, when some participants, like Mariza, were waiting for SRS,

NHS budgets were tightened. The NHS reformed their accountability structures in relation to health care provision, and were further constrained by "clinical audit" mechanisms (Hughes Tuohy, 1999). Health authorities radically changed the way they purchased health care from providers (1999). Decisions to buy and then provide healthcare services to patients were made by managers and, in some health authorities, SRS and hormone therapy was reduced or cut. This is illustrated in a document that came to light in the court case, Regina v North West Lancashire Health Authority, 21st December 1998. In 1995 this health authority introduced a policy entitled "Medical procedure of no beneficial health gain or proven benefit," in which it stated:

> [I]nterventions on the human body are not always related to ill-health but may be related to a desire to achieve an ideal body image or a bodily function that cannot currently be achieved. That is complicated by the fact that its supporters often describe the desire for intervention in medical terminology and indeed point out that the lack of complete well-being may itself be a health problem (cited in Press for Change, 1998a).

Then followed a section specifically addressing transsexualism:

> Persons wishing to adopt the role of the opposite gender (male to female or female to male) have access to the general psychiatric or psychological services available within the contract portfolio. However no service will be commissioned extra contractually. The Heath Authority will not commission drug treatment or surgery that is intended to give patients the physical characteristics of the opposite gender (cited in Press for Change, 1998a).

The plaintiffs' case was based on the argument that health authorities did not regard Gender Identity Disorder as authentic and, therefore, they de-prioritised treatment. The health officials conflated a "superficial" perception of transsexualism with other body image cases, such as breast augmentation or rhinoplasty, viewing them all as cosmetic. According to the ruling, Gender Identity Disorder consists of both a psychological and a physical dimension, but the health service focused solely on the "cosmetic" body image aspect, downplaying Gender Identity Disorder and rendering transsexualism imaginary and, thus,

"inauthentic."[37] This health authority's stance on transsexualism was ruled unlawful by Mr Justice Hidden (Press for Change, 1998a).

The following quote from Octavia provides a critique of depictions of sex change surgery as cosmetic:

> Octavia: I don't think it is necessarily fair to spend public money on cosmetic surgeries; fair enough the sex change should be paid for by the public money because it saves a lot of money in the long run and stops a lot of suffering. If I can afford to pay for things myself I do not see why I should burden the tax payer.
>
> Zowie: *Is cosmetic surgery just that cosmetic for you?*
>
> Octavia: Well I know I can live with my nose if I have to, I don't have to have it chopped about and mashed up. I would like to but things I can live without I consider cosmetic but the actual change no. If I hadn't had had that [sex change] done it would have finished me off (transwoman Octavia).

Another interviewee, Jess, was not an NHS patient, but she had learned much anecdotal evidence from other transpeople receiving NHS services and treatments. Jess claimed to have mentored quite a few transwomen through transition surgery in an attempt to turn this "scary" and "harrowing" process into something positive. Jess visited or phoned the transwomen daily for the first month and then every week thereafter. In response to my questions about psychiatrists' and surgeons' attitudes in the clinical setting, by email Jess wrote:

> The psychiatrists have focussed on justifying the controversial provision of expensive medical resources to PCTs by bringing about a resolution of a

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[37] Evidence of hierarchies in relation to doctors' perception of disease affects the decision making within a health service. As Album and Westin (2008: 188) suggest in their study in Norway "medical activities are organized, [by] categorizing patients, planning and allocating work, setting priorities at all levels, pricing services, and teaching and developing medical knowledge. A widespread, and at the same time tacit, prestige ordering of diseases may influence many understandings and decisions in the medical community and beyond."

> psychological 'disorder'. The surgeons don't really care beyond doing an acceptable job of genital reconstruction and both, understandably, wish to avoid post-treatment legal claims and keeping people off their backs (transwoman Jess).

Jess sees the psychiatrists as "justifying" surgical interventions in the treatment of Gender Identity Disorder to health authorities who must provide the funding. Jess suggests that there is pressure from PCTs to justify spending and to curb any possible lawsuits for negligent treatment.[38] Furthermore, Jess states that the treatment offered by the NHS is minimal and that surgical intervention is not about alleviating Gender Identity Disorder through transformational bodily aesthetics per se, but about doing just enough to keep both PCTs and patients "off their backs." This interpretation compliments the findings of West's (2004: 14) research, which held that:

> those who continued to [have the] operation with Charing Cross [gender identity clinic] report patronising attitudes, insensitivity and no sense of caring. The operative results, I have seen so far, are far inferior to those from other countries and invariably give problems post-op. Local psychiatrists can vary widely in their knowledge about GID and seem at times to be unsympathetic and unable to empathise.

Diane, who became extremely distraught during this part of the interview, expressed her dissatisfaction with her genital surgery and the subsequent response of the surgeon:

> [my vagina] was ugly, it was not realistic at all, there was far too much tissue. I actually got really badly treated about it because I said, "look, this is not realistic, this is just a mess." The way I was treated was "well it looks alright to me, what else, do you want me to do?" He actually said at one point, "well I have cut off your penis, what else, do you want me to do?" (transwoman Diane).

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[38] Many participants spoke of one psychiatrist who faced a General Medical Council disciplinary hearing into allegations that, between October 1984 and August 2003, he breached standards of care by prescribing patients sex-changing hormones and referring them for genital surgery without adequately assessing them. Two of the patients told the inquiry they regretted changing sex and were suing Russell Reid for wrongfully diagnosing them with Gender Identity Disorder.

Diane's rendition of the follow-up meeting between her and the surgeon, when the surgeon said "I have cut off your penis, what else, do you want me to do?" demonstrates an insensitive and uncaring attitude towards her. Diane's comments, here, illustrate the way this particular surgeon did not accommodate her in an ethical sense.[39] There was a lack of an "ethics of care," which should have allowed her to act authentically and with autonomy (Cardol, De Jong, & Ward, 2002). According to Diane, her questioning of the surgeon's "authority" was received negatively.

This "questioning" attitude is further evidenced by psychiatrists writing in the medical literature, who often characterise attitudes of transsexuals in the clinical setting as "adversarial" (Newman, 2000) or resentful toward them (Green in Speer & Parsons, 2006). What is seen as adversarial by psychiatrists, however, is simply read as assertive by transsexuals. Kenneth said:

> Historically we have looked to the medical profession as gods. In fact these people have strong opinion and do not treat people impartially. To do these professions you must have a very strong belief in yourself, and what you're doing and where you are going. When you get to that point where you are a leader in that profession, even though it is a microcosm of society, to change your opinion it takes a big man or big woman to do that. So as somebody who is trans it is down to me to have a responsibility in my own treatment [...] I think in doing that it is educating people. I think people should be allowed to have a dialogue with the medical profession, allow them to change their theories (transman Kenneth).

What Kenneth was attending to here was the hierarchal relationship between the psychiatrist and patient. Historically this meant absolute respect for the doctor and her/his "wisdom." But Kenneth's narrative spoke of the fallibility of doctors' theories which made him question their judgement and be more proactive and research his own treatment. These treatment dynamics were expressed by a few participants in this research, which may

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[39] While definitions of accommodation may vary across jurisdictions, clinical staff are chiefly mandated to respect autonomy, respect comfort, self esteem and confidentiality. For a more extensive review of the guidelines for transgender clinical and legal care, White-Holman and Goldberg (2006) provide a contemporary overview.

account for the psychiatrists' reports about difficult encounters with transpeople. Likewise, Karen was able to challenge her psychiatrist when he used male pronouns with her:

> "you are in a professional capacity where you give a service to people like me and you have just said something that is so unacceptable and so unprofessional." People could have gone out after that and done something to themselves, after that very simple statement. So I think it is a question of training and I see this across the system at every level. And we all know that psychiatrists are a bunch of dysfunctional people, they are more dysfunctional than we are (transwoman Karen).

Over the last few years the government has worked with the Sexual Orientation and Gender Identity Advisory Group, which is an umbrella group of stakeholder individuals and organizations, (such as Press For Change, for example) to assist the Department of Health with the development and delivery of a programme to eliminate discrimination of Lesbian, Gay, Bisexual and Transgender (LGBT) people in health and social care. This healthcare strategy covers both service users and employees. The group has four work streams: (1) Reducing Health Inequalities, (2) Better Employment, (3) Improving Services and (4) Transgender Health (Department of Health, 2007). The discourse of "providing a service" was often used by participants in the context of their own treatment. They describe this changing climate within healthcare as user/provider framework which has the potential to help them negotiate their sex-change demands. Perhaps this enabled Karen to understand the power dynamics between "client" and "psychiatrist" and feel able to demand more consumer rights in relation to her treatment. This may seem "adversarial" or "resentful" to the psychiatrists,[40] however, it could also be seen as appropriate behaviour enabled by the service provider/service user policy initiatives within the NHS.[41]

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[40] A study in the US by Street Jr. et al., (2007: 594) suggests that physicians were more likely to be "patient-centred" if they judged that the patient was "more satisfied with care and more likely to adhere to treatment."

[41] Although the policy initiatives are published, there is still much disappointment with healthcare delivery amongst the UK trans population, as the following petition to the government in 2008 suggests: "We the undersigned petition the Prime Minister to ensure equity of access to NHS treatment for Gender Identity Disorder. Currently, there is a postcode lottery over access to treatment of Gender Identity Disorder. With the creation of the Gender Recognition Act, transsexual people for the first time were able to become legally recognised in their true gender. However, with the process of getting one's true gender legally recognised depending heavily on

Hormones as a diagnostic tool in private care

In this research there was also a strong financial factor determining the kind of treatment some transsexual patients received. Quality of treatment in many cases was dependent upon whether the participant was a private patient or a NHS patient. In most private practice cases, both the younger and older participants claimed that they were lucky not to have to go through the process as a NHS patient. Private practices, nonetheless, have their own criteria of assessment.

There is a school of thought that believes hormones reduce the intensity of Gender Identity Disorder in transwomen by producing a more feminised body shape (Harry Benjamin International Gender Dysphoria Association, 2001; Reid, 1998). For example, "[h]ormone therapy can provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so. In some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross-living or surgery" (Harry Benjamin International Gender Dysphoria Association, 2001: 20-21). According to the "Standards of Care" (Harry Benjamin International Gender Dysphoria Association, 2001) hormones can be administered to people, who are over the age of eighteen, *show a demonstrable knowledge of their effects and limitations* and who have attended psychotherapy session for at least three months, however, in some cases, if the patient intends to obtain hormones from "black market" sources, provision can be brought forward to facilitate monitored therapy.

It seems from this research that in private practice, hormones also act as a diagnostic test for transsexualism, by virtue of their anti-libidinal effects (Reid, 1998). Anti-libidinal effects can take place between one and six months after having begun taking hormones, according to the medical literature (Dahl et al., 2006). Very little is mentioned in the literature about hormones as a diagnostic test for transmen. As I illustrated in chapter IV, in

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medical evidence by specialist doctors, a number of transsexual people are unable to make use of the process within a reasonable timescale, if at all, due to inequity in healthcare provision by the NHS. This is discrimination by the back door. We call on the Prime Minister to ensure that transsexual people receive consistent treatment across all NHS areas in a timely manner and in line with treatment timescales set for other significant health affecting conditions. It is unacceptable for treatments to be managed and rationed in such a way that transsexual people must often wait many years for even a first appointment" (Pearse Rhiamon, 2008).

most cases, hormones heightened the libido of transmen. Nonetheless, the effects of hormones are assumed by some psychiatrists to have negative effects on male cross-dressers and male "fetishistic transvestites." Feinbloom suggests that hormones reduce the libido and render transpeople incapable of erections (Feinbloom, 1976). The hormonal "diagnostic" tool is employed to sort "fetishistic transvestites" from the "true transsexual." Furthermore, an "authentic" diagnosis can be gained through an admission by the "fetishistic transvestite" or the "true transsexual" of the suitability of hormone therapy. For instance, if the hormones are refused the prognosis would probably be that the person is a "fetishistic transvestite," and if they were requested this would suggest that they are a "true transsexual." The refusal of hormone therapy was considered as admittance to being gender dysphoric for sexually motivated reasons and consequently unsuitable for further trans-sexing technology. Many of the transwomen who had private treatment in this research understood that hormones were initially prescribed for these reasons. For example, Christina said:

> I went on hormones diagnostically with [my psychiatrist] (Christina transwoman).

Christina agreed with [the psychiatrist's] reasons for prescribing hormones and sees hormones as being able to determine, as much for her as for the psychiatrist, transsexuality. Similarly, Lesley said:

> I went to [a different psychiatrist] to get a second opinion, he wrote to my doctor with a slightly changed hormone regime. [...] it is necessary because there are people out there who are kidding themselves and I do think with so much easy access on the internet people can be persuaded by people that they are what they are not. In essence we are presenting to them [doctors] our own diagnosis, saying I am transsexual, give me the drugs, and help me (transwoman Lesley).

Lesley sees the hormones as a way of establishing who is an authentic transsexual and who is not. Bernadette agrees:

> I went to see [a psychiatrist] in February 1999, he gave me hormones as I thought he probably would, I knew that from friends that he probably would. I don't

> quarrel with his method as there are some people, transvestites who find that the hormones have a very negative effect on them and they don't go further. I think that is a good thing (transwoman Bernadette).

In most cases, the possible side effects of hormones are discussed in the clinical consultation in order to inform and aid the patient in monitoring their health risks. However, for Daniel, who was forty-nine at the time of transition, his medical care seemed to be simply about facilitating his treatment. He said:

> I went to a Harley Street endocrinologist who basically only knew about MtF people. So I went and said "I would like to try this," and he would say "OK, jolly good, off you go." So I was paying him fortunes, for a twenty minute consultation, for him to rubber stamp what I [had] decided to do. That is the way I see the medical professions, but I have had the money to pay them. God help me if I was on the NHS (transman Daniel).

Money, treatment and agency

Patients who could afford to have private care found the process allowed them a certain amount of agency with their treatment schedule, which was very important to them. Amelia, who transitioned in her early thirties, said:

> I was fortunate to be treated privately by [a psychiatrist]. The positives were that he did not attempt to stereotype or steer me and there really were no negatives. [...] I am aware of "experts" out there who do attempt to steer, lead and stereotype (transwoman Amelia).

Amelia was referring to NHS psychiatrists who attempt to control what the transsexual process should be like. For Penny, agency was being able to plan the transition in relation to her work commitments.

> I appreciated being allowed to go at my own pace and being given hormones diagnostically at the first visit. I did ask at that time if I could begin with hormone patches, rather than tablets, bearing in mind my age, forty eight at that point.

> Given that it took a year and a half before I was able to change documents because of work and begin the RLT (transwoman Penny).

For Jess, who transitioned in 2000, agency was about gaining the respect of medical professionals. She stated:

> The positives were that they all respected my position and intelligence. Nobody treated me like a fool or as incompetent to understand the issues and consequences of transition and surgery. As a private patient I was able, within reason and the standards of care, to set my own timescale and support team. The negatives included the lack of knowledge of GPs, this continues. I was ok because I guided them, and still do, but if I hadn't had the information and resources things might have been problematic. The biggest negative of course was the cost. Because I had no confidence in the NHS treatment of transsexual people at that time, I believe it has since improved. And because the NHS was never going to fund what I considered necessary to a successful gender transition and for an acceptable post transition quality of life, I paid over £60,000 in transition and surgery costs. It was worth it but I do resent that after years of paying higher-rate tax and NI contributions, even when most of my life I was a private patient and non NHS user, I could not get the treatment I felt I needed funded, at least in part by the NHS (transwoman Jess).

Jess sees respect for her intelligence as an important element in the relationship between her and her private GIC, which made transitioning a mutually supportive arrangement. The arrangement seemed to give Jess agency and allowed her license to control her transition. Her body modification was not compromised by the shortfall in service from her GP, but this did come at a price. Jess continued:

> So what I decided to do was not go to the [NHS] Gender Identity Clinic, I had heard too much, and lets face it I had come from a privileged position of a managing director and I had the money and it was the most important thing in my life. I wanted to go 1st class, I wanted to enjoy it, I didn't want to come out of it

> bruised and saddened and battered I wanted to come out of it singing (transwoman Jess).

A significant shift has to occur in the NHS if the diagnosis of Gender Identity Disorder is to be treated uniformly by both public and private healthcare providers. Nonetheless, there seems to be a broader move in provision of healthcare generally that is marked by dynamic customer led negotiations within both the NHS and private healthcare sector.

There are also more options to commence transition outside the medical profession. With the growth in internet companies and commercial and illegal outlets selling hormones (BBC News 24, 2008), it seems there is less of a need for medical intervention in the early stages. This was the case for Oscar, who was considering taking hormones unsupervised by a doctor or endocrinologist. He said:

> The whole NHS route [...] I don't want to be part of that [...] The black market does seem quite appealing to me. What other options are available to me? (transman Oscar).

Oscar was the only participant in my study who suggested that he may initiate his body modification through non-medical sources. He was weighing up the possibilities of hormone ingestion without supervision by medical experts. Most of the literature about this situation is from the US, and focuses on how expensive treatment there forces transgendered people to utilise black-market sources (Israel & Tarver, 1997) and how HIV infection can be reduced (Bockting et al., 2005; Hook, 2005), by providing hypodermically administered hormones. Providing hormones to reduce the risks of black market hormone taking is also a recommendation in the HBIGDA Standards of Care (Harry Benjamin International Gender Dysphoria Association, 2001). There are very few studies in the UK, however, one recent UK study by Vardi et al, follows the HBIGDA recommendation:

> [i]n a harm reduction model (e.g., to prevent the use of black market hormones or decrease psychiatric consequences of denying the hormones), it can be appropriate to prescribe hormones with very minimal or no exam (Vardi et al., 2008)..

The medical discourses about transpeople taking "black market" hormones can be understood in a couple of ways. On the one hand, it could be seen as reducing the risk to the transperson, through careful monitoring. On the other, by reducing adversarial guidelines in relation to hormone therapy it may suggest medical practitioners safeguarding their authority over "gender issues" and deterring transpeople from going elsewhere for treatments.

NHS gender clinics past and present and the age factor

Most of the participants who had started the transition process from 2002 onwards reported that they were treated quite well by the NHS. Participants who had begun transitioning before 2002 suggested that GPs and clinical and psychiatric staff in the NHS GICs were not so sympathetic. Interestingly, although Lesley went to "sort out her gender issues" in 1974, when she was in her twenties, her experiences of social services and the doctors were straightforward. Lesley did not continue to transition at that time, but when she did go back to the doctor's, thirty years later, she had an altogether more negative experience:

> I hate them all! They spend a prolonged period assessing whether we are mad, in any definition of that term, or that we suffer from any major personality disorders. Their diagnosis of Gender Identity Disorder is based clearly on the clinical perception that we are not mentally dysfunctional. But they continue to treat us in a one size fits all situations. There is no concept of patient choice, and their prevailing attitude is one of veiled hostility and contempt within an atmosphere of fear. We are expected to show blind compliance to their rules and procedures, no matter how bizarre or restrictive some of these rules are (transwoman Lesley).

The younger transmen and transwomen, such as Samantha, Anna-Marie, and Benjamin, whose ages ranged from twenty one years old to twenty six years old, and who had transitioned in the last five years, mentioned very few problems associated with their psychiatrists. Instead, their problems were associated with the length of time before surgery dates was offered. The NHS patients, such as Anna-Marie, suggested that they had a relatively easy time in the consultations and in being referred for surgery, whereas older transwomen in particular reported NHS appointments and referrals as laden with difficulties, like Lesley's narrative mentioned above.

Whilst it is difficult to draw any firm conclusions from the analysis presented here, it does suggest that the inferior treatment received by these particular participants at the NHS clinics they attended might be dependent on their age. However, for those who were financially able to access private healthcare, age seemed not to be a barrier. Some older participants started their initial hormone treatment on the NHS and then had surgery privately overseas. Many participants who accessed private treatment went overseas.

> I started off in the NHS, but I thought I would go private because if I went to Charing Cross [GIC] they would either put the clock back, I heard that they may do that, or they could have a long waiting list. Where I thought if work were going to give me that time off, I would negotiate that with them and then negotiate it with Thailand and book it. So that is why I did it like that (transwoman Penny).

Penny's story was very similar to most of the older transwomen's in the research. Often, if they could afford it, the older transwomen sought treatment away from the NHS system. This awarded them greater agency in relation to body modification technologies. Getting a private referral for surgery was necessary, but private psychiatrists were often more accommodating. My research adds weight to that of West (2004), who conducted an extensive study in the south of England. West concluded that many transpeople in the UK were forced to become medical tourists and preferred to have private treatment abroad, rather than wait for NHS treatment or pay the high prices of UK surgeons. The positive aspects of medical tourism have become a common "news thread" in internet discussion groups and self-help forums. Transsexuals often state that they have had a:

> positive experience, where they were treated with respect, kindness and great professionalism, [where] operative results [were] excellent and [there were] very few post-op problems (West, 2004: 13).

Authenticity and authentication

In order to trans-sex both physically and legally requires authentication by a qualified doctor. The participants spoke about this authentication process in different ways. Anna-Marie believed that her psychiatrist asked her clandestine questions in relation to her

childhood experiences to see her reaction and to search out the truth about her transsexuality. She said:

> I believe all they are looking for is someone who is balanced in what they are doing, what risks are involved and what is ahead of them. To know that along with knowing what role you will play in life afterwards. If you go in with the notion of changing sex for pleasure, let's say, or sexual gratification, they will be able to tell that immediately. [The psychiatrist] asked me a typical trap question, he asked me if I played with girls' toys when I was younger, girls may not play with girls' toys, if I was to say yeah, yeah, yeah, he would know that I was trying to guide his opinion. When I go in I am honest with him, he is going to know that I am honest and dedicated to what I want to do (transwoman Anna-Marie).

More important for Anna-Marie was the clinician's expertise in differentiating sexually motivated sex-changing from that of the "balanced" type, who understands the situation they are getting themselves into and who is "dedicated" to the social role that they will perform once they have transitioned. Anna-Marie's authentication is provided by the psychiatrist on the basis that she would pass the RLT and is committed to live in an authentic "woman's" role.

Anna-Marie sees the questions that the psychiatrist asked her as establishing authentic markers which differentiate transsexualism from other diagnoses of "gender deviancy," such as Autogynephilia (Blanchard, 1991) or transvestism. For Anna-Marie, a "true transsexual" (Benjamin, 1966) woman's authenticity is established by moving as far away as possible from the idea that she wants a sex change for "sexual gratification" and closer to the notion that it is because she wants to *express* her gender identity.

Samantha was authenticated as a transwoman before going to the GIC. She stated:

> I saw a psychiatrist who had dealt with a transsexual before, I was suffering with a bit of depression and she spotted me within ten minutes and said yes you're TS. I mean I was hiding it (transwoman Samantha).

Samantha's psychiatrist, "who spotted" her, set in motion the process of Samantha seeing herself as a transwoman. It was a turning point. Prior to this, Samantha had not admitted to herself that she was transsexual and only afterwards realised that she had been keeping her authentic self concealed. It seems that Samantha had a problematic entry into the discourse of transsexuality. Samantha was unique in this research insofar as she was the only participant who suggested that did not "self-diagnose" prior to attending the GIC.

The participants who suggested that the authentication process "was a matter of course" were only concerned about the psychiatrist seeing them as their "gender of choice" at a superficial level. The strategy for getting through the RLT and the appointments needed to secure the "diagnosis" and subsequent surgery, if it was sought, was guided by "rehearsed narratives" (S. Hines, 2007). These patients offered stereotypical answers to questions that the psychiatrist asked. For example, Benjamin said:

> It was very generalised and out of date questioning which resulted in standard answers. So if you are like me a male with a feminine, sensitive side you would not show that side or even lie for fear of them thinking it meant you didn't truly want to change (transman Benjamin).

Amongst younger participants, clinical authentication is seen as pliable to a certain extent. Similarly to Benjamin, Oscar suggested that his personal requirements and his queer political affiliations put him in a position that made him consider how his narrative could be tailored to NHS medical definitions. Later in the interview, Oscar clarified that he wanted primarily to look "trans," because he was concerned about the effect transitioning would have on his relationship with his parents. Oscar suggested that he needed to transition slowly in order for his parents to get used to the physical changes.

> Oscar: I do not want to take hormones in order to pass as male yet [...], but want the hormones to be more physically trans and less female. I am trying to weigh up at the moment through discussions with friends that this is first and foremost a personal decision and I am not doing it to please anybody else. The struggle I am having with this is that I am aware of the affects that the hormones are going to have on other people.

Zowie: *Do you think you will be able to be prescribed hormones telling them this?*

Oscar: That is another thing, the whole NHS route, I don't want to lie but I am quite keen on manipulating the system in order to get what I want. Pretty much nearly everyone does that. I am just wondering though how much impact I can have because I don't want to be just another statistic that they cite in the medicalised narrative. I don't want to be part of that and I do want to challenge that (transman Oscar).

Oscar believed that by telling the clinician that he wanted to have hormone therapy to look "more physically trans" would hinder, if not stop, his transitioning. In addition, both Benjamin's and Oscar's concerns centred on hegemonic masculinities (Connell, 1995). Nonetheless, both participants understood that they needed to be careful not to disclose any form of femininity, because they knew that the psychiatrist had the power to halt the process of transition despite it being part of their authentic self. Benjamin's fear stemmed from the fear of being read as inauthentic by the psychiatrist and Oscar's fear stemmed from fear of being drawn into a medical discourse.

Authenticity, then, is an unstable concept. Brian initially transitioned from Male-to-Female and had SRS in 2000. Brian had been living as Alison for a number of years, but during the times I interviewed him/her, s/he transitioned from appearing feminine to being more masculine. Brian does not identify as male or female now and prefers to see him/herself as Cross-Gendered or Bi-Gendered. This case is similar to St Jacques' (2007) "Post-Transsexual" position, where the "second" transition does not necessarily mean a reversion to an "original" sex, but, as in Brian's case, a transition to an identity outside the medicolegal framework. Consultations with the psychiatrists for both Brian's first and second transition were fairly routine. He said:

> I found that most of my consultations were just a matter of course: Go along to appointment, talk about what's been happening since last appointment, doctor takes notes, says goodbye until next appointment (Bi-gendered Brian).

Brian was authenticated as female by the first psychiatrist and unauthenticated as female by the second. He continued:

> This doctor suggested indirectly that I should sue my original consultant if I intend to go for reverse surgery, as I had only ever received one recommendation for my initial surgery when I should have had two (Bi-gendered Brian).

While there was no pressure from the "consultant" "to go for reverse surgery," Brian believed that the clinician thought that the only option was to have surgery that would try to rebuild a penis and allow "him" to live "fully" as a male. This suggests that the psychiatrist assumed that the initial diagnosis was a mistake and that if Brian was not a transsexual woman then "he" must have been a man all along. The "mistake" was understood within a binary system of gender, as opposed to Brian's identification as "bi-gendered." Brian, however, did not believe the initial diagnosis to be a mistake and referred to his/her situation as his/her "choice" that became untenable whilst living as Alison.

The final set of authentication narratives, articulated by a few of the private patients, referred to the psychiatrist as simply rubber stamping their own decision to become transsexual. Jess' narrative illustrated this:

> I phoned [the psychiatrist] to make an appointment and I have nothing but respect for [him] we had a long discussion and he said that I am "definitely Gender Dysphoric," which I knew, but it was nice for someone else to tell me that. He said as to whether you are a transsexual person or not it is up to you, you are going to have to work that out, it is your decision (transwoman Jess).

Gender recognition and the "medicolegal alliance"

Prior to the Gender Recognition Act 2004 (GRA), transpeople were able to change their names by deed poll, and have passports, driving licences, and bank accounts in their new name and corresponding gender preceding any surgery or hormonal intervention. Sex/gender could not, however, be changed on national insurance records or on birth certificates. When the GRA was passed in 2004, it was heralded as a huge advance for the rights of transpeople (Press for Change, 2005), after more than thirty years of having only

partial legal recognition (Sharpe, 2007a, 2007b; Whittle, 2007a). However, amongst respondents in this research, the GRA provoked mixed reactions. Three significant themes emerged from the interviews, "authentication," "agency" and "ambivalence." In their current situations, some interviewees viewed the GRA ambivalently. Emily suggested:

> I haven't applied for the Gender Recognition Certificate, even though I could have. I will, but because I have been trans for so long, for about seven years it doesn't seem particularly urgent and it doesn't actually affect my day to day life. I will get around to do it at some point especially when, although I am not satisfied with civil partnerships, I would like to marry a woman one day. I would like to be recognised as a woman when I do, do that (transwoman Emily).

At this point, to be recognised by the law is of little consequence to Emily's identity as a transwoman. Emily's practices in day to day life and her bodily aesthetic, which I explored in Chapter V, are sufficient confirmation of her gender and sexual identity. Emily is aware that her legal status may change, however, she is prepared to use her legal recognition only if she needs to in some future contractual scenario, such as having a civil partnership. Similarly, Clifford said in response to my question:

> Zowie: *How has the Gender Recognition Act affected your life?*
>
> Clifford: I suppose at the moment getting a Gender Recognition Certificate is not really important to me so it has not influenced it that much. If the Act said that anybody who has not had treatments would not be considered then it might have had some influence in the long term (transman Clifford).

Clifford raises a number of issues about how trans bodies are (not) situated in law. The law, as it stands, allows Clifford the freedom to reflect on his body project without its mandates forcing surgical intervention upon transpeople for legal recognition. Clifford continued:

> the Act is good for people who wish to be recognised as either male or female but in the long run I think I would rather see either three boxes or no boxes (transman Clifford).

In addition, Clifford highlights the growing "transgender phenomenon" (Ekins & King, 2006) in the UK and his ambivalence with the binary logic of the law. Clifford suggests that the GRA cannot accommodate those who do not identify with the male and female options and, in effect, therefore, misrecognises many transpeople. Similarly, Oscar recognises the positive aspects for those transpeople who want "equal access" to citizenship rights in the binary system, but fears the underlying ideology on which sexed identity is premised.

> It is important for the recognition of trans identities and status in terms of transsexual peoples' financial privileges and in terms of citizenship and equal access, but I am sceptical about the basis of this and the reliance on certain medicalised narratives. The status of the transsexual and the hierarchy being created through that and reinforcing, the "true" the "real" and the "authentic." [At the point of saying "true, real and authentic" Oscar indicated that he wanted to use quotation marks around the words by gesturing with his fingers]. Also not recognising genderqueer and still only having two options to choose from. It is an important step but there is many flaws in it and should just be seen as the first step. I hope we can build on it (transman Oscar).

Interestingly, but not surprising, it was the younger transpeople – Oscar, Emily and Clifford – who belonged to queer activist organisations, and who were ambivalent about institutional recognition. Oscar was grappling with different notions of authenticity within frameworks of socio-legal authenticity and personal authenticity. In Sartre's (1966) existentialist philosophical discourse about authenticity, he suggests that a person who has made their decisions based on pre-established codes of civil life – which the GRA would be seen as – is inauthentic. The decisions were made in "bad faith," which is the primary obstacle to authenticity (1966). In a Sartrean sense, the pre-established codes of male and female which are enshrined in the GRA, foreclose the possibility of gender queerness and restrain freedom, the freedom which Oscar is striving for. In Clifford's narrative he highlighted how "bad faith" and inauthenticity may act empirically:

In terms of doctors and psychiatrists and having to prove and actually going out of their way to, in the case of transwomen who are overtly feminine beyond what she might feel comfortable with just to prove a point. So there are always transpeople going out of their way, beyond what they want, just to not leave doubt in peoples' minds. If you can not show to prove it then you are going to have to do something to prove it (transman Clifford).

Nonetheless, transsexuals with non-normative bodies, can be constituted in law may also be seen as symbolic critiques of the binary sex/gender system. These bodies can contest the naturalness of sexed bodies and undermine the once dogmatic sex/gender binary. All transpeople who contest the symbolic understanding of "natural" or normative bodies undermines the notion that "bad faith" in civil codes, such as the GRA, can never overcome and challenge the social conditions of their production. As Lois McNay (2000) contends, the scope to re-enact social codes in new social contexts is always a possibility, because of individual agency.

Medicine and the GRA are "new social contexts" that allow for agentic action in relation to how far people can go in realising their (non-normative) bodily aesthetic in relation to their gendered bodies. Sartre's (1966) dichotomous assertion, that civil life suppresses authentic subjects and that "the desire to maintain distance from those structures, to call them into question and to change them" (Sartre cited in Zane Charme, 1991: 253) is more authentic, is witnessed in relation to trans bodily aesthetics. As I illustrated in Chapter VI, transsexuals are re-writing the civil codes themselves, and, thus, overcoming what it means to have normative bodies and a normative civil life and are staking claims about their own authenticity in various ways.

The medicolegal alliance in the UK has, in many ways, reduced the institutional constraints regarding legal recognition of trans-sexed people in comparison to many other countries. This recognition by state institutions, on the one hand, has been a positive, forward looking regulative ideal. A new birth certificate, Gregory suggested, gave him both recognition and the feeling of authenticity:

> The first thing I thought, when the law was first passed, was at last I am a real person. I exist. When I got my birth certificate at the age of thirty nine, I exist. Before, I felt like a part person in the eyes of the law but now I feel three dimensional (transman Gregory).

Additionally, for Benjamin, Gender Recognition (GR) allowed him freedom to actualise dreams and plans that up until then he had put off due to the sex on his original birth certificate.

> I am funny about sending my original birth certificate away and also when I am putting my previous name on forms as it is a different identity. Just paperwork-wise it's a completely different identity. So I think it [GR] will make me do things. I am going to learn to drive this year, but I might apply for that [GRC] first, because it will make me feel a bit better about sending my stuff off, that then will make quite a big difference (transman Benjamin).

According to Gregory and Benjamin, the reification of transsexuality, through the regulatory practices of the GRA, establishes authentic transsexuals. Thus, it seems that Gregory and Benjamin accept that their authenticity is, in part, awarded by the "medicolegal alliance." Gregory, as you may remember, was unable to have any body modification surgery due to the physical impairments he sustained during childbirth. Gregory was approved for surgery, but not operated on, giving him the necessary paperwork in order for the GRP to approve his new birth certificate. This recognition is seen by these participants as authenticating their citizenship.

For the participants in this research the discourse of authenticity was key to their social recognition, their claims of embodiment and to their self-understanding within the structural parameters of medicolegal relations. Authenticity was qualified in various ways in relation to the medicolegal system. Rather than essentialising "authenticity," participants used it as an ontological category within their lived relations.

Concluding remarks

The participants' narratives in this chapter suggest that the experiences of these transpeople when accessing body modification technologies can be both good and bad and are contingent upon whether they and their diagnoses were taken seriously. It was a "postcode lottery" as to how they were treated and also when they had medical treatments. The gamble was often replaced with agency, and respect, if the participant was fortunate enough to have the capital to fund their body modifications privately. Notions of agency and authenticity were complicated by intersubjective negotiations with those who act as gatekeepers to body modification technologies. According to some participants, there does seem to be a shift in the provision of treatment, which is marked by dynamic customer led negotiations, especially within the private healthcare sector. Nonetheless, new NHS healthcare policies gave some transpeople the confidence to challenge what they saw as unreasonable or unethical treatment. These situations and experiences, within the NHS or in private practice, fed into complex embodiment stories of authenticity and agency. Agency was not seen in terms of voluntarism, where identity can be negotiated without constraints, but was seen as consciousness about the social relations between them and those in positions of power. Therefore, the situation the participants found themselves in generated reflexive agency about how best to secure body modification if so desired, and legal recognition.

The GRA has created novel parameters in which assorted trans bodily aesthetics are recognised. Bodily aesthetics, which are now permitted in law, creates socio-legal relations that allow participants to understand authenticity outside of essentialised notions of realness. Authenticity in legal terms is an altogether different ontological claim and is seen as enabling the autonomy and agency, which is required for transpeople to live their desired lives. Those participants, who embraced a more pluralistic outlook regarding trans embodiment and bodily aesthetics, had some reservations about the underlying ideology of the GRA. However, these participants also empathised with those transpeople who identified as either male or female and who did wish for the citizenship rights awarded by the GRA. The GRA was welcomed as a step in the right direction in relation to socially integrating transpeople. Moreover, what these diverse views help illustrate is the phenomenological diversity within the trans population which was studied. Such an understanding is important because it shows that stereotypes are far from the norm in

transpeople's narratives and, thus may continue to generate knowledge about the situational and agentic aspects of trans-sexing. Furthermore, the phenomenological, discursive, and bodily diversity of transsexuals in relation to the medicolegal alliance poses a critique of the pervasive binaries, good/bad; natural/constructed, beautiful/ugly that often inform theories of the transsexual subject. I hope that this analysis will move the theoretical debate about transsexuality towards a less deterministic understanding and embrace more openly the agentic aspects of trans embodiment and bodily aesthetics.

Conclusion: A Springboard from which to Leap

From aetiology to management

This thesis has taken transpeoples' embodiment and bodily aesthetics as a point of departure, rather than gender identity per se. I felt that a return to trans bodies was required because of the changing social and political contexts that transpeople in the UK were party to. The introduction of the Gender Recognition Act, and the influence of transgender politics in its implementation, offered fresh frameworks for developing analyses about trans bodies. A range of questions concerned with embodiment and bodily aesthetics, in relation to transsexuals' lives, were the central foci of the research. The thesis explored the different personal and public considerations and experiences of transpeople's embodiment and bodily aesthetics. I also investigated transpeople's imaginatively anticipated bodies and body modification desires and to what degree bodily aesthetics are constituted as a commitment to a gender identity for transsexuals themselves and within emergent medicolegal and political contexts.

In the first part of the thesis I reviewed, through phenomenological descriptions, the ephemeral medical landscape where the terms, "diagnosis" and "cure," have "progressed" in tandem with wider academic and cultural narratives, which have clearly orientated their development. I have argued that traditional models of transsexualism preserve a "sex" dimension, upon which a psychical "gender" dimension is constructed, using cultural notions of masculinity and femininity, which are couched within heteronormativity. I suggested that traditional medical models have yet to find a credible account of the aetiology of transsexualism and that they continue to rely on cultural manifestations of "masculine" and "feminine" bodily aesthetics to support their theories. In 1990 "transsexualism" was removed from the DSM (American Psychiatric Association, 1994) and in its place a broader category of "Gender Identity Disorder" was inserted. This shifted the medical emphasis from a single to a double pronged approach where aetiology and the management of Gender Identity Disorder encompassed many more facets of transgendering. Alongside other critics (Billings & Urban, 1996), I argued that this shift was an attempt to control the sex-change industry, whose qualified clinicians provide diagnoses after a lengthy time span (recommended in the "Standards of Care"), and the surgical "cure" for adult transpeople. Moreover, this shift safeguarded the authority of

medicine in the construction of "deviant" gender identities and their underlying theories. More recently, those doctors and theorists interested in discovering the aetiology of the "condition," Gender Identity Disorder (Gender Dysphoria), have incorporated topical neurochemical models with brain size studies to help refocus their theories through a biological lens. Rather than furthering theories, I argued instead that these adaptations still retain an aesthetic dimension, where visual markers of hormonal activity or sizes of parts of the brain relied upon ahistorical and culturally specific notions of masculinity and femininity. These theories are based on scant empirical evidence and have been critiqued by feminist biologists and psychologists. Moreover, I suggested that because the diverse phenomenology of transpeople could not be fully encapsulated in the theories, this also challenges the assumptions undergirding these models. In tandem with wider academic debates, feminist, queer, and postmodern theorists and clinicians' understandings of masculinity and femininity in the clinical context have incorporated these challenges to traditional models of transsexuality. These novel explanations, whilst not denying the ontological claims that there are transmen and transwomen, have challenged gender essentialism and shifted emphasis from a biological model of bodily aesthetics to a psychosocial one.

I provided a brief history of the relationship between intersexed and transsexualism in relation to the law. I suggested that prior to the Gender Recognition Act, UK law differentiated between intersexed bodies and trans bodies. UK law separated biological markers and psychological markers to differentiate the transsexual from intersexed. This differentiation continued even though the same types of surgeries were used to "correct" the "anomalies." The intentions behind surgical interventions were seen differently, one was deemed a "necessity" (for intersexed people) while the other was seen as a "choice" (for transsexuals). I then looked at the relationship between medicine and law in contemporary Britain and showed how the medicolegal alliance constitutes ontological claims through the diagnosis of gender dysphoria. This new framework is now used for the purposes of legally defining transpeople. I illustrated that new legal prccedents have recently come into force, through the implementation of the Gender Recognition Act 2004. I suggested that the Act allows for *queer* gender recognition through non-normative bodily aesthetics. However, this queer recognition is restricted to pathologised transpeople, who wish to change their sex socially and legally, rather than allowing for the dismantling of the

binary system all together. Thus, the clinicians still retain authority even though the criteria of bodily aesthetics in law have changed. However, this legal change, I suggested, contests the diagnosis and cure model based on traditional formulations of Gender Identity Disorder, because it is now possible that the "true transsexual" (Benjamin, 1966) in law may not correspond to the "true transsexual" in medicine. It was within this context that I situated my research, from which I could understand contemporary embodiment narratives and bodily aesthetics of transpeople in the UK.

Moving beyond dichotomies

I then moved on to consider how transpeople's embodiment and bodily aesthetics have been theorised in feminist, socio-philosophical, and key transgender approaches. The purpose of this was to highlight my analytical approach in the thesis. Radical feminist work about beauty and trans embodiment and bodily aesthetics often ended up as dichotomous moral polemics, based on what they understand as "good" and "bad" practices. In the rest of the review I suggested that feminist and non-feminist work that drew on poststructuralism also fell into similar, problematic dichotomies, such as docile versus subversive action, good versus bad politics, mind and body, right and wrong bodies. The transgender (as opposed to transsexual) body projects represented in some of the literature were heralded as subversive, and as acting out against the oppressive gender system. Transgendered people, here, it seemed had unrestrained choice to be who they wanted to be. Transsexuals, however, were represented as the docile recipients of a medical discourse of "distress." Transsexuals were constrained by a wish to pass as a member of a particular gender. I suggested that the transgender/transsexual distinction was in fact not an easy one to draw and, moreover, I argued that this dichotomy becomes divisive and unproductive for theorising the diverse phenomenology of transpeople. What is more, to posit that transsexuals do not have intentionality and agency halts questions about how transpeople do navigate, and help rewrite, the material and ideological constraints within the social fields of medicine and law, which I illustrated. I have taken a different position, which has assumed that transpeople have agency, and which has asked questions concerning the tactics employed in attaining, assessing, and subverting bodily aesthetics. I argue that this position enabled me to develop a fuller conceptualisation of transpeople and their bodily aesthetic desires. This also enabled me to move away from dichotomous and theoretically limited analyses of transpeople's embodiment and bodily aesthetics, which often suggested

that transpeople were dupes or behaved stereotypically. Thus, I have offered a more nuanced understanding of how transpeople are (re)writing cultural scripts, and thereby situating their own authentic desires.

I have argued that feminists who use poststructuralist approaches emphasise the structure/agency aspects of beauty, aesthetic surgery, and bodies as lived experiences, which are also important for this research. However, I suggested that their conclusions were too neat. I have illustrated that much of this work was restrictive and could only show how bodies are duped into conforming to the structural guidelines, which constitute normative bodily aesthetics. Theorised through the "negative paradigm" (McNay, 2000), social discourses, which support social structures that correspondingly affect the aesthetic criteria of social, sexual, and phenomenological body image, situate the subject as pervaded by ideology and subsumed by symbolic social norms. This, I suggested forecloses agency for transpeople. Similarly, whilst I identified some aspects of symbolic interactionism, which are able to account for a social analysis of trans embodiment and bodily aesthetics, I have argued that a more conducive framework for this research can be drawn from phenomenology. Phenomenology can attend to the inner conflicts and tensions arising from the construction of body images, and attend to limits of the body, limits of technology, as well as intersubjective negotiations. The concept of intentionality – someone who has an attitude toward the world – enables an analysis of divergent bodies in various personal and public situations; furthermore, it allows us to understand how the bodily aesthetics of transpeople are situated contextually. I observed that there is greater scope for a broader, inclusive understanding of transpeople's differences if we refuse to judge "good" and "bad" transgender practices and instead incorporate phenomenological notions of asymmetry (difference) as both an ethical and methodological necessity. Thus, starting from this standpoint is valuable, because, not only does it allow us to recognise difference within broader categories of transmen and transwomen, but it also allows us to understand that the various habituses of transpeople have historically divergent aspects, which need addressing.

The (diverse) phenomenology of trans bodily aesthetics

The research suggests that acknowledgement of sex/gender differences is not a singular realisation for transpeople, but are understood through ongoing sensations of identification and disidentification. Feelings of difference were common to all the participants but were

experienced in various ways. The decision making process to transition is not a simple one and can, but does not always, take many years to decide upon. Various sub-cultures are prominent in the lives and decision making processes of the participants, which influence the contextual parameters of gender capital and knowledge about transgendering. Hines (2007) discusses how recognising the self as trans happens in complex contexts, where self-help groups, intimate partners, and kinship networks all affect and produce non-normative spaces in which transpeople transition. Similar conclusions were drawn in this research, where decisions were reflexively negotiated with significant others, in the context of intimate relationships and in favoured sub-cultures. The "eureka moment" of becoming positioned in an overarching transsexual narrative is premised upon connections to other transpeople, and transgender literature. Moreover, reflections on participants' own corporeal agendas within significant relationships are also important aspects of trans-sexing. This challenges the medical accounts which suggest that there are predictable signs of Gender Identity Disorder that can be "captured" and averted.

The thesis addressed important questions about the embodiment and bodily aesthetics of transpeople in contemporary UK contexts. The research addressed transmen and transwomen in different chapters. I suggested that transmen and transwomen considered their "body projects" through their particular lenses. This, I proposed, highlights the ways in which aesthetic judgements operate within different social, sexual and phenomenological contexts and with different intentions toward the world. This is a significant insight which will broaden both medicolegal understandings of trans difference, but also to broaden transgender studies' approaches to politicised trans bodies and bodily aesthetics.

I have argued that drawing on some of the insights of phenomenology can bring a contextual understanding to trans bodily aesthetics and embodiment. I suggested that transpeople understand their bodies through various body images that I heuristically divided into "social," "sexual" and "phenomenological bodies." Phenomenology is often seen as a voluntarist account of "I can" (cf Heinamaa, 2003). "I can" discursively represent my body, "I can" materially change my body, "I can" perceive my body in numerous ways. However, accusations of voluntarism are misplaced, because, as this research has illustrated, in harmony with Merleau-Ponty (1968, 2002 [1962]), participants' agency and desire are imaginatively adapted through intersubjective validation by others. There is a

relationship between the body that is objectified and the gaze of significant others, which is instrumental to the phenomenological comprehension of the social and sexual body image. Furthermore, the habitus of divergently situated subjects guides these intersubjective evaluations of body images. The transperson's habitus informs them of their own physical limits and the possibilities of technology. However, the habitus is not deterministic in transpeople's body image formation. Transpeople recognised the limits of the technological and surgical procedures and that concessions also had to be made with regard to their non-normative bodies after transitioning. In some transmen's narratives these concessions were discursively and materially overcome with the use of prosthetics. The transmen understood the use of prosthetics as an extension of their corporeal limits in particular social and sexual spaces. In other participants' narratives, a revaluation of their intentionality towards their own bodies was required in order to accept their non-perfect(ed) bodies. For some transwomen, passing was seen as a benefit if it happened, but was not always the expected outcome for some. In these narratives emphasis was placed on securing a mutual understanding with others about their non-normative bodies. Most of the transwomen, however, suggested that they, and other transwomen, needed "proper" sexual bodies. The notion of "females with penises," in most cases, was considered a difficult bodily aesthetic for the majority of society to accept. This conception was coupled with the fear of violent retribution. This was a crucial difference to the narratives of most of the transmen in this research. Not surprisingly, younger, queer respondents wanted to move beyond normative understandings of bodies.

Whilst mainstream femininity and masculinity was actualised by some transpeople in this research, they do not figure in all participants' narratives. The research showed that the narratives of transwomen were influenced by the bodily and material aesthetics of (sub) cultural gender systems of which they were a part. Gendered aesthetics had to be negotiated within various discourses of "beauty, and sartorial and body modification practices. Octavia's androgyny, Emily's queer aesthetic, Oscar's Dandyism, and Benjamin's metrosexuality illustrated how normative and sexological understandings of femininity and masculinity were disrupted by participants. A central theme, then, to emerge from these narratives is heterogeneity, highlighting that the aetiology of transsexuality purported by traditional medicine is being challenged by transmen and queer participants, due to their insistence upon what is right for them in relation to their bodily aesthetic. Participants are

aesthetically and phenomenologically too diverse to be completely captured by traditional medical models.

Building bridges over the political ravine

Following my argument for the need for an understanding of the diversity of trans embodiment, I then picked up the theme of dichotomies again and considered how trans politics often assumes either an assimilationist stance or a transformative one. I used T-CO literature and participants' narratives to analyse political actions. From what, on the surface, looked like three major differences in political standpoint, I argued for a more nuanced analysis of the three T-COs political praxes. I suggested that the website data I discussed cannot simply be placed into either a "sameness" (assimilationist) or "difference" (transformative) dichotomy of political activism. Political actions were formulated in relation to the audiences they were addressing, through offering several critiques. I showed how particular political praxes and cultural productions worked to change the dominance of normative bodily aesthetics in various ways; I have suggested that (absent) bodily aesthetics used through normative channels of action is strategic. These (absent) bodily aesthetics are also evident in queer groups; however, here more emphasis is placed on providing space for producing an array of bodily aesthetics and subjectivities. I also illustrated that queers sometimes work in collaboration with more mainstream trans organisations and, thus, that queer politics is contextually driven. This lends support to Brown's (2006) argument that queer politics can be theorised as having a "relational ethics" in its politics and cultural productions. Thus, a key finding of this research is that trans politics, in general, needs to be open to diverse interpretations of bodily aesthetics as well as to future collaborations. This, I suggest, can only be done by understanding that political dichotomies only creates divisions, whereas accepting difference may start to build bridges.

Agency and authenticity in context

This thesis also addressed the medicolegal contexts that participants had or were experiencing. A number of questions were asked about the contemporary situation of being recognised through medicolegal institutions in order to gain civil rights. I suggest that these were timely to pose due to the changing perspectives of some clinicians and the implementation of the Gender Recognition Act. My research suggests that for my participants being recognised as trans was the "luck of the draw" or a postcode lottery, with

both GPs and psychiatrists alike as to how they were treated. I argued that (trans) identities are complicated by these structural and intersubjective negotiations, which showed that transsexuals are neither purely a product of the medical establishment nor purely product of self determination. However, I did suggest that in most adult cases "self-diagnosis" of transsexualism took place prior to entering the negotiations with medicolegal authorities, where social and personal authenticity was sought. Authenticity, I argued, was a concept that had numerous meanings. Rather than being situated as straightforwardly essentialist in participants' narratives, the notion of authenticity was utilised to secure treatment and diagnosis, and validate their position from which to request body modification. In most cases, it also legitimated a social position for posing demands for equal civil liberties. Thus, a key finding in this research is that transpeople are agentic in their approach to trans-sexing and that they need to be savvy in their negotiations with those who have the ability to stop them actualising their imaginatively anticipated bodily aesthetics. The luck of the draw was often replaced by agency if the participant was fortunate enough to have the capital to fund their body modification privately.

I suggested that the GRA has created new spaces in which trans bodily aesthetics may be constructed. Moreover, these spaces were, in part, constructed by the document that was carried through parliamentary sessions during the passing of the law. The policing of bodily aesthetics is not, as much of the (anti) trans literature suggests (Billings & Urban, 1996; Hausman, 1995; Raymond, 1980), solely an attempt by transsexuals and medicine to maintain a gender order, but is also related to the personal projection of bodily aesthetics that the transperson feels they can live with in relation to their phenomenological, sexual, and social selves. The contemporary context of queer gender recognition is borne out within the law. I argued that by understanding this contribution by transpeople neither as dupes nor as transcendent agents in their own aesthetic construction offers a more nuanced consideration of the various agentic negotiations transpeople partake in.

Where to now?

This thesis represents a return to trans bodies in order to empirically understand trans embodiment and bodily aesthetics in contemporary Britain. The research, as I mentioned above, is timely due to the changing medicolegal contexts of transpeople in Britain. I suggested that by arguing for the importance of understanding difference in the personal

and public representations of trans bodily aesthetics a richer analysis of the aesthetic judgments that are made about the trans subject's body will result. I argued that aesthetics were not the problem for (trans) gender theory per se. I understand trans embodiment and bodily aesthetics, in this research, as an agentic aspect of subjectivity. However, I suggested that the mechanisms which support judgements about aesthetic bodies do need to be exposed and scrutinised, some of which I have achieved in this thesis.

What of future research in this area and what might this entail? I hope to have broadened the debate about trans (bodily) aesthetics by bringing the notions of intentionality, difference, and agency to the attention of different fields of research. Questions may be posed to the main players in the gender recognition panel about their aesthetic criteria for judging trans bodies especially because there is no research to date. What are the implications for transpeople when subjective aesthetic criteria are applied in relation to civil rights? We may ask: how do postmodern and queer aesthetics create questions for the emerging field of transgender studies? Do queer aesthetics possess a truly radical relativism or are they confined by the fields they work in? Who has the resources to create cultural productions and to what effect are they utilised politically? By addressing judgements of (bodily) aesthetics in a number of research fields, it may raise issues particular to transpeople. This is due to the aesthetic judgements from the self and others that transpeople constantly face.

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Appendices

Transpeople and our bodies.
Research on transpeople's experiences of and feelings about our bodies.

Aims:
I am a (trans) PhD student at the University of Leeds. I am looking for transpeople who are willing to be interviewed for my research. The interviews will last about 1 ½ hours, and can be arranged at a time and place that suits you.

The research:
The research will explore how transpeople change their everyday lives and how we experience our bodies, including what changing our bodies (if we do) means to us. I am interested in the styles, fashions and images that are important to transpeople. I am keen to talk to a wide range of transpeople, so that the diversity of transpeople's experiences can be represented.

The research will also investigate the impact of the Gender Recognition Act on transpeople. As the act does not require genital sex reassignment surgery, I will explore how transpeople and doctors understand gender identity.

Aim of research
One of the aims is to inform future social policies by developing a framework of common values in the 'treatment' of transsexual people in relation to body modification, which respects the diversity of transpeople's practices and beliefs.

All participants' information will be held in the strictest of confidence, names and places will be changed, and I will work within the framework of the British Sociological Association's ethical guidelines.

If you would like more information about this research, please contact: Ms. Zowie Davy. Tel. No. 0113 3437614 email **zowie.davy@ntlworld.com** or research supervisors, Prof. Sasha Roseneil Tel. No. 0113 3434409 email **S.Roseneil@leeds.ac.uk** or Dr. Ruth Holliday Tel. No. 01133431868 email **R.Holliday@leeds.ac.uk**

Zowie Davy
Centre For Interdisciplinary Gender Studies
University of Leeds
Leeds
LS2 9JT

PARTICIPANT INFORMATION SHEET

All the information supplied will be held in strict confidence

CONTACT DETAILS

Name
(of choice)

Address

Post Code

Tel. No.

Email Address

Date of Birth

Gender
(self definition)

EMPLOYMENT
What best describes your current employment situation?

- □ **Self-employed**
- □ **In paid employment (full-time or part-time)**
- □ **Unemployed**
- □ **Retired**
- □ **Looking after home, family or partner**
- □ **Student**
- □ **Long term sick or disabled**
- □ **Training scheme**
- □ **Other**

ETHNICITY
How would you describe your ethnicity?

RELATIONSHIP STATUS

Are you currently in a relationship **yes / no**

Are you currently married **yes / no**

SEXUALITY

How would you describe your sexuality (e.g. gay, lesbian, heterosexual etc.)

TRANS STATUS

Please indicate how you would like to be described

Would you be willing to discuss some personal photographs that you have of yourself?

Have you or plan to apply for gender recognition?

Please feel free to add any further information that you think is important and has not been covered by the above questions.

Thank you very much for completing this form and for your offer of participation.