IUL School of Social Sciences
Department of Social and Organizational Psychology

Experiencing and representing transsexuality: Developmental trajectories of, and social representations on, transsexual people

Nuno Emanuel Branquinho Guedes Pinto

Thesis submitted in partial fulfillment of the requirements for the degree of
Doctor in Psychology
Specialty in Clinical and Health Psychology

Supervisor:
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December, 2014

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Resumo

Em Portugal, o conhecimento acerca da transexualidade e das experiências das pessoas transexuais é ainda incipiente. Esta tese tem como objetivo central a promoção do conhecimento sobre as experiências específicas das pessoas transexuais, mas também sobre como o modo como diferentes atores sociais constroem a noção de (e, consequentemente, a realidade da) transexualidade. São apresentados três estudos empíricos. O Estudo 1 analisou as representações sociais sobre transexualidade disseminadas durante o debate público referente a uma lei inovadora em Portugal que permite às pessoas transexuais alterarem o seu nome e sexo legal. Os resultados mostram que, apesar de as representações sociais terem sido (re)produzidas com recurso a uma linguagem fortemente biológica e clínica, o debate público ancorou-se nas noções de igualdade e justiça social. A análise do discurso de diferentes atores sociais resultou na identificação de três configurações distintas. O Estudo 2 - estudo central da tese – explorou os processos através dos quais as pessoas transexuais reconhecem e lidam com a sua identidade de género. Os resultados descrevem cinco estágios de desenvolvimento, e identificam várias condições internas e externas, estratégias de (inter)ação, e consequências psicossociais típicas de cada fase. O Estudo 3 centra-se na discussão acerca da existência de diagnósticos de saúde relacionados com a transexualidade – ou seja, da chamada despatologização da transexualidade. São descritos em detalhe vários tópicos que mostram a profunda complexidade deste debate. Globalmente, os resultados dos vários estudos sugerem a necessidade de uma abordagem que permita uma compreensão mais profunda da transexualidade e do transgénero.

Keywords: transexualidade, representações sociais, trajetórias desenvolvimentais, diagnósticos de género

PsycINFO Codes:

2960 Political Processes & Political Issues

2970 Sex Roles & Women's Issues

3210 Psychological Disorders

3365 Promotion & Maintenance of Health &Wellness

Abstract

In Portugal, we still lack the understanding of the big picture on transsexuality and transsexual people. Thus, this thesis is aimed to further the understanding not only about the experiences of transsexual people, but also about how different social actors construct the notion and reality of transsexuality. Three empirical studies are presented. Study 1 examined social representations on transsexuality and transsexual people, by focusing on the public debate held during the period preceding the implementation of the innovative law on legal gender recognition in Portugal. Findings showed that, although social representations of transsexual people were being (re)produced within a discourse heavily dependent on biological and clinical language, the public debate was anchored within the broad notions of equality and social justice. Regarding the discourse of the different social actors, three distinct configurations emerged. Study 2 – this thesis core study – explored how transsexual people recognize, acknowledge, and come to terms with their gender identities. Results show the participants moving through five developmental stages, highlight various internal and external conditions, action/interaction strategies, and psychosocial consequences that participants had to cope with in each stage. Study 3 is focused on the controversies surrounding (trans)gender diagnoses. Discourses about the so-called depathologization of transsexuality have been inconclusive, filled with mixed messages and polarized opinions. We describe various topics that show the deep complexity of this debate. Altogether, our work suggests the need of a more comprehensive approach to improve the understanding of transsexuality and transgenderism.

Keywords: transsexuality, social representations, developmental trajectories, (trans)gender diagnoses

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1

GENERAL INTRODUCTION

In 2006 I was working in an outreach project in the city of Porto which provided support to street sex workers. At that time I was already engaged with LGBT (Lesbian, Gay, Bisexual and Transgender) activism. Gisberta Salce Júnior, a transsexual Brazilian woman, was a regular user of the project and I had several personal encounters with her. In February 2006, Gisberta was murdered in one of the most violent and well-known hate crimes in Portugal. In the evening of the day in which the first news about the murder appeared in the media, I participated in a gathering of LGBT activists aimed to collect information about the case. The news on the media were unclear, mentioning a "transvestite" and a "woman with a penis". During the gathering, attention was somehow turned to me since I personally knew Gisberta. Some of my fellow activists asked me questions such as: "Is she transvestite or transsexual?"; "Is she a real transsexual or she is transgender?"; "Did she made *the* surgery?" or "What is her real name?". I do not remember exactly my answers but I do remember a general feeling of confusion; not only because I had never thought of Gisberta in those terms – for me, until that moment, she was simply a woman; a visible transsexual woman, but a woman (I had never thought about her genitalia, for example). Moreover, most of us in that room were using different words to refer to the same concepts or had distinct views about transsexuality and transgenderism.

Recounting this story highlights that, just a few years ago, in Portugal and even within a group of LGBT activists, we lacked the proper language and knowledge on transsexuality, gender identity and gender expression. Furthermore, in the weeks that followed, the Portuguese press often addressed the case using incorrect and erroneous language – for instance, referring to Gisberta using masculine pronouns. Nine years after Gisberta's murder, what is the state of art in the field of transsexuality? Which are the particular experiences of transsexual men and women? And what kind of representations are being used and developed - including by the media - about transsexuality?

1. Aims and overview of the present thesis

The general purpose of this thesis is to further the understanding not only about the experiences of transsexual people, but also about how different social actors construct the notion and reality of transsexuality. In Portugal, studies on social sciences regarding the issue of transsexuality are still very scarce. Thus, in this thesis we cover a

diversity of topics, with the aim of contributing to different spheres of knowledge and levels of intervention. The specific aims are: (1) to examine how social representations and social knowledge on transsexuality are used and developed by different social actors; (2) to explore the processes by which transsexual people come to terms with their gender identities, and to describe the main intervening actions and conditions; (3) to contribute to the main current public debates related to transsexuality – including the debate on legal gender recognition and the one about the so called depathologization of transsexuality.

The present work is organized in five chapters. The present chapter starts by addressing the issues related to the use of language and to definitions in the field of transgenderism and transsexuality; and also by describing the few studies developed in this area in Portugal. Then, we review the international research on the individual, communitarian and social implications of being transsexual – including challenges to psychological, physical and social well-being. We focus in particular on the literature about the so-called stage models of identity development; and we provide a glimpse into the implications regarding legal gender recognition. Next, we describe various topics related to healthcare provision to transsexual people: historical aspects; barriers in the access to specific care; recent developments in the international guidelines for the health of transsexual and transgender people; and controversies about the existence of medical diagnoses that are specific to transsexual people. Then, we refer to depictions of transsexuality and transgenderism, including media representations and those coming from the social sciences. Finally, in the last section of this chapter, we introduce our research program, and how it aims to contribute to the current state of the art on transsexuality.

The three chapters that follow this theoretical introduction are empirical chapters in which we present three studies (Chapters 2, 3, and 4). All of these chapters are based on published or submitted articles. In Chapter 2, we present a study aimed to examine the public debate held during the period preceding the implementation of an innovative law on gender recognition in Portugal; and for which we examined several media pieces and other official documents: the debate that occurred in the Parliament, the message from the Portuguese President when he vetoed the law, and press-releases from the main LGBT rights-organization in Portugal. Chapter 3 reports an empirical study aimed to explore how transsexual people recognize, acknowledge, and come to terms with their gender identities. The results are supported by in-depth interviews of twenty-two

transsexual people, and describe an integrated and related set of concepts, illustrative of the processes through which participants managed their gender identities. In the last empirical chapter, Chapter 4, we explore specific extracts from eight of the twenty-two interviews collected for the study presented in Chapter 3. The primary goal is to better understand the concepts, main dilemmas, and possible paths related to medical diagnoses that are specific to transsexual people.

Finally, Chapter 5 presents a summary of the findings obtained in our studies, and integrates them in a general discussion, stating the contributions they give to the understanding of transsexuality. At last, we identify the main limitations of our research and avenues for future research.

2. General background

Language and concepts

Language, concepts and definitions that refer to transgenderism and transsexuality are an evolving field. Many of the terms used in the past to describe transgender and transsexual people are now considered to be outdated and even offensive - and some of the terms used nowadays did not exist a decade ago (Serano, 2007). Furthermore, individual people may use different words to describe themselves, regardless of the terms most commonly used by academics, activists and health professionals (Saleiro, 2013).

In the 1950s, transsexual people were described as those who wanted to "belong to the other sex and correct nature's anatomical 'error'" (Benjamin, 1953, p. 12). The narrative of the "wrong body" emerged and has become the defining trait of transsexuality; that is, the desire, insistence, and obsession with body modification (Lev, 2004). For decades, the term transsexual was restricted for individuals that had undergone medical procedures, including genital reassignment surgeries (Hines, 2007). In contrast, the term transgender appeared in the 1970s to describe people who lived full time as a member of the opposite sex but had not undergone medical procedures (Valentine, 2007). As explained further on, this distinction between transsexual and transgender people is not commonly accepted nowadays, and is not the one used in this thesis.

In turn, the expression gender identity was coined in the middle 1960s, and referred to one's persistent inner sense of belonging to either the male and female gender category (Money, 1994). Gender identity was seen as the private experience of gender role and gender role as the public manifestation of gender identity (Money, 1985). The concept of gender identity evolved over time to include those people who do not identify either as female or male. Nowadays, a "person's self concept of their gender (regardless of their biological sex) is called their gender identity" (Lev, 2004, p. 397). In this thesis we use this expression as described by the American Psychological Association (APA, 2009): "the person's basic sense of being male, female, or of indeterminate sex" (p. 28). The expression gender identity is nowadays commonly used both by activists and by academics and health practitioners. Nevertheless, some transsexual people may prefer other terms - such as "subconscious sex" - to refer to "the gender we subconsciously feel ourselves to be" (Serano, 2007, p. 78). Potential problems and misconceptions deriving from the usage of the expression gender identity will be addressed in the final chapter of the thesis.

Nowadays, and in contrast with the recent past, defining transsexuality is not dependent on the medical choices people may do: "[transsexual] refer[s] to anyone who lives socially as a member of the opposite sex, regardless of which, if any, medical interventions they have undergone or may desire in the future" (APA, 2009, p.28). In fact, the latest version of the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, published by The World Professional Association for Transgender Health (WAPTH; Coleman, Bockting, Botzer et al., 2012), clarified that "gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity" (p. 168). Moreover, we agree with Serano's words:

> [A]ttempts to limit the word 'transsexual' to only those who physically transition is not only classist (because of the affordability issue), but objectifying, as it reduces all trans people to the medical procedures that have been carried out on their bodies (Serano, 2007, p.31).

Accordingly, in this thesis we use the word transsexual to refer to anyone who has a gender identity incongruent with the sex assigned at birth and therefore is currently, or is working toward, living as a member of the sex other than the one they were assigned

at birth, regardless of what medical procedures they may have undergone or may desire in the future. The term cissexual is used to describe those persons whose gender identity is congruent with the assigned sex at birth.

In sum, the current notion of transsexuality is focused on gender identity (particularly on the incongruence between gender identity and sex assigned at birth) and on gender expression, rather than on medical choices. Gender expression refers "to the way in which a person acts to communicate gender within a given culture" (APA, 2008, p. 28); for example, in terms of clothing, aesthetics, communication patterns, and interests.

At the same time, the meaning assigned to the term transgender also evolved. Since the 1990's the word transgender has been used primarily as an umbrella term to describe those people who defy societal expectations and assumptions regarding gender (APA, 2008; Lev, 2004; Saleiro, 2013; Serano, 2007). In this thesis we use the term transgender with this connotation. It includes people who are transsexual and intersex, but also those who identify outside the female/male binary (and may identify as genderqueer, agender, bigender, third-gender, or gender-fluid), and those whose gender expression and behavior differs from social expectations (including crossdressers, drag performers, and even "masculine" women and "feminine" men). The term gender-variant is commonly used as a synonym of transgender. In our perspective, in a broad approach of the term, lesbian, gay and bisexual people should be spanned by these umbrella terms, since their sexual desire and conjugality defies societal expectations regarding gender – although this inclusion is not common in most academic literature. The word cisgender is used to refer to those people who are not transgender.

More recently, the expression trans – a prefix that has been transformed into a base word – is becoming popularized (Lev, 2004). Although some people (including activists and academics) use this expression (or the alternative "trans*") to refer to all transgender people (Saleiro, 2013), it is mostly used as an alternative to transsexual. For example, the main international LGBT (lesbian, gay, bisexual and transgender) organizations are changing their designation to LGBTI (lesbian, gay, bisexual, trans and intersex). By unfolding the word transgender into two words (trans and intersex), more visibility is accomplished both to transsexual and intersex people. In Chapter 4 we will intentionally use the term trans instead of transsexual: because this chapter addresses issues related to pathologization of transsexual people we find more suitable to employ

language coming from the activism rather than terms originally coined in the medical field.

In this thesis, we employ language in accordance with people's identities. Thus, the expression transsexual man refers to a person whose gender identity is male and whose assigned sex at birth was female, and the expression transsexual woman refers to the opposite situation. Occasionally, we use the expressions female-to-male (FtM) to describe transsexual men, and male-to-female (MtF) to describe transsexual women. These expressions may be seen as problematic because they relegate transsexual people to "third sex" categories and they disregard the profoundly felt gender identity of transsexuals (Serano, 2007). Nevertheless, in Chapter 3 we find the expressions FtM and MtF useful for describing the situation of those transsexual participants who are still living according the sex assigned at birth, regardless of their gender identities.

Finally, some transsexual and other transgender people may not identify with the terms used by academics, activists and health professionals (Saleiro, 2013). However, we need common language to communicate, and specific terms to refer to different situations. The issues of identity development and identification with ascribed categories will be addressed in more detail in the last chapter.

The gap of transgender and transsexual studies in Portugal

In Portugal, the interest of the social sciences for gender issues is recent. This field started to develop after the end of the Portuguese dictatorship, in the 1970s, and it was only in the 1990s that the gender perspective shaped the work of several disciplines, including social psychology (Amâncio, 2003b). However, "gender-focused analysis are still rare, and gender is more likely to be used as a statistical variable than as analytical tool" (Amâncio, 2003a, p. 186). Furthermore, the notions of sex and gender are still used in a random way, as if they were the same concept (Amâncio, 2003b). Nevertheless, and at least in social psychology, gender studies reached a point in which they are capable of raising new challenges and questions to the traditional research programs (e.g., Nogueira, 2001; Nogueira, Neves & Barbosa, 2005).

Within this scenario, studies addressing LGBT people in Portugal are still in an "embryonic stage" (Vale de Almeida, 2010, p.70). If this is true for studies regarding sexual orientation and lesbian, gay and bisexual people, it is even truer for studies regarding gender identity and transgender/transsexual people. Saleiro (2009) referred

that "in Portugal persists a 'vacuum' in sociological research, and more generally in the field of social sciences, about these phenomena" (p. 84).

In fact, Saleiro (2013) carried out the first doctoral thesis in the field of social sciences on transgenderism in Portugal. The study consisted in a contextual analysis, addressing the legal-political, medical and associative movement domains. Various self-identifications within the transgender spectrum were mapped and described: transsexual man, transsexual woman, cross-dresser, travesti, androgynous, drag king, transgender and ultra-gender. For mapping the various categories, Saleiro (2003) intersected different dimensions: gender self-identification; sex assigned at birth; expressed gender; relationship with sex assigned at birth; relation between sex assigned at birth and expressed gender; time and space of the gender expressed; medical care; body modifications; genital surgeries; relation between gender identity and sexual orientation. Among other conclusions, Saleiro (2013) mentioned the importance of addressing the distinction between the particular experiences of the people comprised in the different transgender categories. Age was identified as a major distinguishing factor in the experiences of self-identified transsexual participants: one of the big differences between younger and older people concerns the historical moment in which they came into contact with medical/psychological discourse about transsexuality. Moreover, younger and older transsexual participants had access to resources such as the internet and LGBT organizations/transsexual groups in different life stages, and that produced different life experiences. These and other findings are discussed in further detail in other sections of this chapter and in the general discussion.

Additionally, some isolated social studies on transsexuality were developed and published in Portugal. The author of this thesis participated in a study developed by the LGBT organization "Associação ILGA Portugal" in partnership with ISCTE – Lisbon University Institute (Pinto & Moleiro, 2012). The study aimed to explore the healthcare experiences of transsexual people, and several practitioners and transsexual persons were interviewed. The results showed certain competences and skills of the clinical teams that provide specific healthcare to transsexual people, but also revealed the existence of practices contrary to international guidelines (Coleman et al., 2011) – including excessive or inadequate gatekeeping. Carvalho (2010) studied the process through which transsexual people develop a "contrary identity" (p. 393), concluding that normative social parameters manage that process. Other authors (Rodrigues, Carneiro & Nogueira, 2013) studied the "pathological processes, social exclusion and

discrimination based on transsexual status" (p. 49), with a particular focus on the controversies related to the existence of medical diagnoses that are specific to transsexual people. This issue is addressed in detail in the Chapter 4 of this thesis. Additionally, Ramalho (2013) studied the particularities of a specific group within transgender people: transgender sex workers.

Moreover, and regarding the field of social sciences in Portugal, transsexuality and gender identity have been addressed in studies aimed to investigate LGBT issues altogether. For instance, in the first – and, until this moment, unique – study commissioned by the Portuguese government about discrimination on the grounds of sexual orientation and gender identity, transsexual people were found to be perceived by the general population as the most discriminated group in Portugal (Costa, Pereira, Oliveira & Nogueira, 2010).

In sum, in Portugal there is a gap of studies in the social sciences on transgenderism and transsexuality. This is most probably related to the fact that the interest of social sciences for gender is relatively recent (Amâncio, 2003b) and that the field of gender studies is still incipient (Vale de Almeida, 2010). Thus, this thesis constitutes an important contribution to the development of studies on transsexuality in Portugal.

3. Experiencing transsexuality: Individual, communitarian and social implications

There are no accurate data on the prevalence and characterization of transsexual people in Portugal. The information available is based on informal reports drafted by health professionals (Saleiro, 2009) and on data referring to the clinical processes within healthcare services (Albuquerque, 2006). Nevertheless, it is reasonable to assume that in Portugal – as in other contexts – transsexual people constitute a heterogeneous and diverse population. In fact, transsexual people may be teens, adults or elderly; may form different family configurations, with or without children, and may have any sexual orientation; they belong to all socio-economic levels, and carry out the most varied work activities; and belong to different ethnic and religious groups (Raj, 2002).

What is common to all transsexual people is precisely the fact that they are transsexual, this is, that they have a gender identity incongruent to the sex assigned at birth, and are currently - or are working toward - living as a member of the sex other

than the one they were assigned at birth. Different people may manage the incongruence between gender identity and sex assigned at birth in different ways, and the so-called transition processes may comprise individual and distinct options (Coleman et al., 2011). This topic is addressed in detail in Chapter 3. Nevertheless, being transsexual entails specific individual, communitarian, social and legal implications.

Challenges to psychological, physical and social well-being

As mentioned before, transsexual people were found to be perceived as the most discriminated group in Portugal (Costa et al., 2010). In fact, international research clearly shows that transsexual people often suffer from various forms of discrimination, including harassment, physical and psychological abuse, and economic alienation (e.g., Clements, Wilkinson, Kitano & Marx, 1999; Lombardi, Wilchins, Priesing & Malouf, 2001; Nuttbrock, Hwahng, Bockting *et al*., 2010). Experiences of discrimination and abuse may occur in the context of meaningful interpersonal relationships - such as family or work relationships (Lombardi *et al.*, 2001; Kenagy, 2005; Nuttbrock *et al.*, 2010). In Portugal, Saleiro (2013) identified significant barriers in school environment and in the access to employment.

The European Union Agency for Fundamental Rights (FRA, 2014) recently published an empirical report about the situation of trans[1] people in the European Union (EU). Findings show that "the level of perceived discrimination EU trans respondents report is alarming" (FRA, 2014, p. 21). The findings refer to the year preceding the survey. More than half of all participants (54%) felt personally discriminated against or harassed because they were perceived as trans. Young trans people, or people not in paid work or from a low social income class, were more likely to feel discriminated against. Discrimination occurred in different areas of social life: employment, education (school/university), and in healthcare and social services. Moreover, only a small number of respondents reported the discriminatory incidents. The results also show that the annual incidence rate of violence or harassment is around one incident per two participants: one in two respondents indicate that they were attacked or targeted trough violence, threats or insults in the year preceding the survey. Accordingly, the survey

[1] We decided to use here the word trans because it is the word employed in the study (FRA, 2014). It was "chosen to avoid confusion with one of the possible identity groups from which the respondents could choose" (p. 9). In the General Discussion we discuss limitations related to language in the field of studies on transsexuality and transgenderism.

found that almost one in five participants avoid being open about being trans in their own home and, for instance, six in ten avoid being open in public transport. The authors conclude:

> Stereotypes and ignorance about the reality of the daily lives and rights of trans persons perpetuate negative public attitudes and maltreatment of varying intensity; from idiotic jokes and offensive language to serious harassment and exclusion. […] Ultimately, as trans respondents noted, they are citizens who feel that they are not allowed to be themselves (FRA, 2014, pp. 10-11).

In parallel, a significant amount of studies found lower levels of mental health, psychological well-being and quality of life of transsexual people, when compared to the average population (e.g., APA, 2008; Budge, Adelson & Howard, 2013; Dean, Meyer, Robinson *et al.*, 2000; Newfield, Hart, Dibble & Kohler, 2006; Sánchez & Vilain, 2009). For example, transsexual people have been identified as being at a greater risk for developing: anxiety disorders (Hepp, Kramer, Schnyder et al., 2005; Mustanski, Garofalo & Emerson, 2010); depression (Nemoto, Bodeker & Iwamoto, 2011; Nuttbrock *et al*., 2010); social phobia and adjustment disorders (Gómez-Gil, Trilla, Salamero *et al*., 2009); substance abuse (Lawrence, 2008); or eating disorders (Vocks, Stahn, Loenser & Tegen-bauer, 2009). At the same time, data on the suicide ideation and attempts in this population are alarming: Magen and Shipherd (2010) found the percentage of attempted suicides to be as high as 40% in transsexual men and 20% in transsexual women. Nuttbrock and colleagues (2010), using a sample of 500 transsexual women, found that around 30% had already attempted suicide, around 35% had planned to do so and close to half of the participants expressed suicide ideation.

Only recently the well-being and mental health of transgender youth, particularly of transsexuals, began to be addressed in psychology research (Dean et al., 2000). Adolescence has been identified as a period of increased risk with regard to the mental health of transsexual people. This may be due to the advent of puberty and the development of secondary sexual characteristics, which is often accompanied by feelings of isolation and body distress (Korell & Lorah, 2007). However, it may also be related to the psychological and physical abuse that often characterize interpersonal relationships of transsexual people particularly in this life stage, because of gender

expressions perceived by others as non-normative (Nuttbrock et al., 2010). Thus, the data indicative of the risk to the mental health and psychological well-being of transsexual people are more solid if we focus on adolescents or young adults. For instance, Israel and Tarver (1997) indicated that between 50% and 88% of transsexual youth have considered or have attempted suicide.

In sum, research clearly shows that transsexual people are in risk for lower levels of mental health and psychological well-being. However, the idea that this is due solely to the high levels of discrimination that this group is exposed to is not consensual. In fact, decreased mental health may be a corollary of discrimination and social alienation (APA, 2008; Nuttbrock et al, 2010; Sánchez & Vilain, 2009). Nonetheless, psychological distress in transsexual people may also result from internal conflicts arising from the very experience of being transsexual (Dean et al., 2000; Newfield, et al., 2006). The incongruence between gender identity and sex assigned at birth (and the subsequent development of the body, but also the expected gender roles and expressions) may put transsexual people in risk for psychopathology. Nuttbrock and colleagues (2010), referring to their study with 571 transsexual women, stated:

> The findings of this study strongly suggest, but do not fully demonstrate, that gender-related abuse directly causes major depression and suicidality during the adolescence of MTSs. […] It should also be emphasized that gender dysphoria may itself, to some degree, be a determinant of psychopathology in this population (pp. 21-22).

In fact, transsexual people may experience, at some point of their lives, gender dysphoria – in other words, "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender roles and/or primary and secondary sex characteristics)" (Coleman et al., 2011; p. 168). This issue is closely related to the existence, or not, of medical diagnoses that are specific of transsexual people – such as the diagnoses of "gender dysphoria" and "transsexualism". Controversies and complexities of this matter are addressed in more detail in the section "Controversies on (trans)gender diagnoses" of the General Introduction, and fully addressed by the study described in Chapter 4.

Transitioning, "identity development", and intervening variables

Various studies have addressed transsexual people's identity development, focusing mainly on the so-called transition and highlighting a series of developmental stages. Before continuing we are keen to address two important questions. First, the expression "identity development" is problematic because: (1) on one hand, it may result from the assumption that there is a "transsexual identity" or, at least, that all transsexual people develop or express an identity as transsexuals – as in the case of Devor's (2004) model of transsexual identity formation; (2) on the other hand, it may imply or suggest that what we designate by gender identity (that is, one's persistent inner sense of belonging to a gender category) is a life course developmental variable – though many transsexual persons report that they know who they are, in terms of gender categories, since their early childhood (Serano, 2007). Secondly, although we use the word transition many times in this thesis, this term is also problematic. When we say that someone transitioned to the other gender (or even to the other sex), we are somehow dismissing their gender identities, by reinforcing the idea that people's gender is defined by their gender expressions and bodies - and not by who they feel to be. Alternatives for the term transition have been proposed. For instance, King (2003), from a sociological point of view, proposed the expression "gender migration":

> After all what we see as sociologists are not transsexuals or people suffering from gender dysphoria. We see people who have lived part of their lives as men living as women or vice versa. The concept of gender migration focuses attention on what is happening socially – the movement from one social position to another. (p. 190)

Hence, regardless of the way the studies described next in this section enunciated their aims, all of them examined how people manage the discrepancy between gender identity and sex assigned at birth. In other words, they studied the processes through which transsexual people come to terms with their gender identities – which is, precisely, the main objective of this thesis' core study, described in Chapter 3. And these processes may entail not only sociological variables but also individual and psychological dimensions.

Gagné, Tewksbury and McGaughey (1997) studied the coming-out experiences of "masculine-to-feminine transgenderists" (p.478) and described four main

themes of identity formation: (1) early transgender experiences – referring to the earliest recollection that individuals have of feeling that either their sex or gender was wrong or did not fit for them; (2) coming out to oneself – which involves learning that there are names for their feelings and that there are others who had similar experiences; (3) coming out to others – the sources of validation that are most important for the stabilization of identity are the significant others in one's life and the community of similar others; and (4) resolution of identity – for the transsexual participants that included "an aspiration to be seen and identified as women" (Gagné et al., p. 501). The authors conclude that "despite the policing of gender that was experienced by the transgenderists in our sample, the need to express a 'true gender' was an overwhelming urge that could not be denied" (p. 504).

Devor (2004) addressed "transsexual identity formation" (p. 41) by developing a model that shows the transsexual person moving through 14 stages. Although the model is based on "twenty years of sociological field research, personal experience, social and professional interactions with a wide range of transgendered persons" (Devor, 2004, p. 42), it is mostly inspired by previous models of homosexual identity. The model encompasses fourteen possible stages: (1) abiding anxiety; (2) identity confusion about originally assigned gender and sex; (3) identity comparisons about originally assigned gender and sex; (4) discovery of transsexualism; (5) identity confusion about transsexualism; (6) identity comparisons about transsexualism; (7) tolerance of transsexual identity; (8) delay before acceptance of transsexual identity; (9) acceptance of transsexualism identity; (10) delay before transition; (11) transition; (12) acceptance of post-transition gender and sex identities; (13) integration; and (14) pride. The author describes two processes in which the development of transsexual identity is based: witnessing (being witnessed by other for whom one is) and mirroring (being mirrored in others' eyes as one sees her or himself).

Lev (2004) presented a model of "transgender emergence" which describes in detail six developmental stages that transsexual people experience while they engage in conscious decisions regarding sex reassignment. The author outlined that the model is "not meant to 'label' people, define transgender maturity, or limit anyone to these experiences" (p. 234). Instead they are meant to "outline a general trajectory of experiences for transgendered and transsexual men and women" (p. 234), and they best describe "those who present themselves to a clinician seeking help for their transgenderism" (p. 234). Accordingly, Lev (2004) also describes a series of therapeutic

tasks that can guide therapists assisting transsexual clients in each stage. The stages described are the following six: (1) awareness (when people are often in great distress, and for which the therapeutic task is the normalization of the experiences related to transgenderism); (2) seeking information/reaching out (which involves seeking to gain education and support about transgenderism, and for which the therapeutic task is to facilitate linkages and encourage outreach); (3) disclosure to significant others (referring to coming-out to significant others, and for which the therapeutic task is to assist the person's integration in the family system); (4) exploration: identity and self-labeling (involving the exploration of various identities, and for which the therapeutic task is to support the articulation and comfort with one's gendered identity); (5) exploration: transition issues/possible body modification (involving the exploration of options for transition regarding identity, presentation, and body modifications, and whose task is the resolution of the decisions and advocacy toward their manifestation); and (6) integration: acceptance and post-transition issues (when the person is able to integrate and synthesize identity, and whose therapeutic task is to support adaptation to transition-related issues).

Morgan and Stevens (2008) examined "transgender identity development" in a group of "female-to-male transgendered adults". The authors mentioned that "participants' stories about how they came to recognize and experience their identity as transgendered displayed a similar pattern of life experience" (p. 587). The commonality was reflected in four themes: early sense of body-mind dissonance; biding time; missed opportunities; and the process of transition. More recently, Pollock and Eyre (2012) studied "identity development among female-to-male transgender youth" (p. 209) and identified three stages: (1) a growing sense of gender (school, puberty, sexuality and exposure to diverse gender options impact upon each young person's sense of his own gender); (2) recognition of transgender identity (a young person experiences a growing sense of discomfort with his female birth gender and comes to recognize himself as transgender); and (3) social adjustment (after becoming aware of himself as transgender, a young person adapts to life as a male).

These various models and findings undoubtedly have their merits and may, in fact, be significant in improving competent and effective interventions with transsexual and other transgender people – for example, in health care and support services. However, they have some limitations. First, not all of these stage models derive from bottom-up empirical research. For instance, Lev's (2004) model is based on clinical

experience, and the one proposed by Devor (2004) was built upon a previous model of homosexual identity formation and the methodological aspects of its study are not clear. Secondly, not all of these studies and proposals address the unique experience of both transsexual men and women. On the contrary, they refer to the experiences of various people who fall into the transgender spectrum. The study developed by Gagné and colleagues (1997) comprised "transsexual, fetish and nonfetishistic cross-dresser, [and] drag queen" (p.483) participants. The model proposed by Lev (2004) refers to the experience of transgendered and transsexual adults, and Pollock and Eyre's study (2012) describes the experiences of FTM individuals. Thirdly, some of these studies are not successful in defining what they intent to mean by "transsexual identity" and even "transgender identity".

Nevertheless, these and other studies highlighted various commonalities within transsexual people's experiences. As described in the previous section, many transsexuals are vulnerable to psychological distress, especially in the early stages of their paths (Devor, 2004; Gagné et al., 1997; Lev, 2004; Pollock & Eyre, 2012). For most, the exposure to accurate information on transsexuality is of vital importance to overcome the discrepancy between sex assigned at birth and gender identity (Devor, 2004; Lev, 2004). Saleiro (2013), in her Portuguese study, found that older participants had different life experiences in part because they had access to resources such as the internet in later life stages.

Several studies have also addressed the importance of social support in the lives of transsexual people, including support coming from peer-groups, transsexual support services or LGBT organizations (Budge et al., 2013; Hinnes, 2007b; Korell & Lorah, 2007; Lev, 2004, 2007). Although family is one of the support systems to which transsexual people may resort (Bethea & McCollum, 2013; Korell & Lorah, 2007; Lev, 2004), this is conditioned by the family dynamics triggered by the disclosure of one's transsexuality (Emerson & Rosenfeld, 1996; Norwood, 2012). Moreover, as mentioned before, family may be a context of discrimination and violence. Accordingly, it has been suggested that gender identity disclosure and gender role casting are more likely in achieved (e.g., friends) as compared to ascribed (e.g., family) relationships (Nuttbrock, Bockting, Hwahng, et al., 2009).

Thus, reaching out to other transsexual persons seems to be of vital importance for the development and accommodation of gender identity (Saleiro, 2013). Engagement with people in similar situations is related to less fearfulness, less

suicidality, and more comfort (Testa, Jimenez & Rankin, 2014). Participation in support groups - which can be more or less formal - is related to various dimensions (Hinnes, 2007b): the ability to be honest regarding their gender identity and to come out in public; the demand for support, not only emotional but also informational/educational support; or even the possibility of not only receiving support but of also providing it. Support groups, which often start from (or are limited to) online communities (Lev, 2007), are often identified as essential in addressing the lack of information and educational resources coming from other sources, including from the medical community (Hinnes, 2007b). In fact, transsexual people rely extensively on healthcare services and practitioners, not just for clinical and medical acts, but also for accessing information on transsexuality (Korell & Lorah, 2007). Because of their complexity, issues regarding healthcare provision to transsexual people are addressed in more detail in the following sections of this General Introduction.

Legal gender recognition

In the previous paragraphs we described various individual and social realities that are likely to be experienced by transsexual people nowadays. Nevertheless, being transsexual entails a particular legal implication that is worth to be addressed separately because of its complex intricacies and severe implications: the need for the legal recognition of their gender identities. Legal identification is required for many vital activities in daily life, such as applying for jobs, renting accommodation, opening a bank account, or voting. Thus, there are severe risks for marginalization and discrimination for transsexual people whose documents are incongruent with their gender identity and expressions (Open Society Foundations, 2014). The findings from the FRA's study (FRA, 2014) on the situation of trans people in the European Union are clear:

> The lack of identity documents that conform with one's gender identity or expression can lead to discrimination. On in three trans respondents felt discriminated against when showing their identification card or other official document that identifies their sex. Almost nine in 10 (87%) say that easier legal procedures for gender recognition in their preferred gender would help them to live a more comfortable life (p. 11).

Nevertheless, the vast majority of transsexual people around the world cannot obtain official documents under their name and sex to match their gender identity (Open Society Foundations, 2014). In this context, the need for the legal recognition of transsexual people's gender identity has been highlighted as a human rights issue (European Commission, 2012), and in the last decade various countries created or improved legislation regulating legal gender recognition and name change on official documents for transsexual people. Thus, this topic has been addressed as a political and civil rights issue, with specific legal intricacies and a worldwide scope. Activists around the world, but also politicians (e.g., Hammarberg, 2009), international organizations and medical professionals (e.g., APA, 2012; Coleman et al., 2011), have been advocating for human rights-based laws on legal gender recognition.

There is no "one size fits all" law or regulation: different countries have been producing legislation or jurisprudence that differ in the requirements that allow change of name and legal sex on official documents (Open Society Foundations, 2014). Although proof of genital surgeries tends to be privileged over other evidence (Anders, Caverly, & Johns, 2014), requirements may comprise: transition-related medical treatment, such as hormonal or gender affirming surgeries; sterilization, either explicitly or by requiring medical procedures that result in sterilization; prohibition of parenting now or the intention of having children in the future; living continuously in one's desired gender, with gender expression matching gender identity; divorce; or a medical diagnosis. In addition to the requirements, an important distinction between legal gender recognition processes is whether they are administrative or judicial (Open Society Foundations, 2014).

In Portugal, before 2011 there was no law on legal gender recognition, so transsexual people had to sue the State if they wanted to change their name and legal sex. The process could take several years, and only some people were successful in the end - since most of the above-mentioned requirements were imposed in court. In 2011, "the first European law on name change and legal gender recognition that meets the Yogyakarta Principles and the Recommendations of the Commissioner for Human Rights of the Council of Europe entered into force in Portugal" (European Commission, 2012, p. 72). With the new law, the process that allows Portuguese transsexual people to acquire legal identification that matches their gender identities is now administrative and the only requirement is the presentation in the Civil Registry of a medical diagnosis supported by a multidisciplinary team of clinicians. The process is supposed to be

expeditious: within 8 days the registrar must accept the request, ask for further information, or reject the request (Open Society Foundations, 2014).

In Chapter Two we address in detail the issues regarding legal gender recognition. Moreover, we describe an empirical study aimed to examine the public debate surrounding the new Portuguese law, including the appropriation and use of social representations related to transsexuality and transsexual people by different social actors.

4. Healthcare provision to transsexual people

Barriers in accessing (competent) healthcare provision

Transgenderism is well documented throughout human history (Lev, 2004). However, the term and notion of transsexuality only emerged in the middle of the 20th century, when hormonal and surgical treatments became obtainable. The work developed in the medical field for decades, and the clinical perspectives on transgender and transsexual people, had a major role in determining current representations of these phenomena (Hines, 2007; Saleiro, 2013). Healthcare practitioners (including psychiatrists, psychologists, physicians and sexologists) have "amassed a large body of research on the subjects of transsexuality and transgenderism that has very much shaped the way our culture views and values transgender people, as well as how transgender people come to understand themselves" (Serano, 2007, p. 116). The narrative of the "wrong body", developed within the medical field, settled: transsexuality came to be understood as the desire, insistence, and obsession with body modification (Lev, 2004).

The power of the medical perspectives on transsexuality is deeply related to the gatekeeping function. For gaining access to hormonal treatment and surgeries, transsexual persons first need to be assessed and then referred to a physician by a mental health practitioner. In this process, many people may express a personal narrative consistent with what they believe the clinicians' expectations to be (Johnson, 2007; Lev, 2004; May, 2002). Thus, in order to have access to medical treatments, transsexual people may be adapting their personal narratives and, by doing that, reinforcing the medical perspectives on transsexuality and transgenderism.

The gatekeeping function, which is regulated by the Standards of Care (SOC) of WPATH (that are described in following sections) was initially aimed to sort out the "true" transsexuals from all other transgender people. The former would have access to physical transition, and the later would be denied any medical intervention other than psychotherapy (Serano, 2007). The classic archetype of true transsexuals is founded in a profound desire for body modification (Lev, 2004), and seems to be primarily grounded in an attentiveness of the gatekeeper to eliminate sex and gender-related ambiguities (Serano, 2007). In other words, until recently, gatekeeping limited the availability of hormones and sex reassignment procedures only to those transsexual people who were seen as able to successfully blend into society as ordinary women and men. For example, body ambiguity was not allowed: those people who did not desire or had not undergone genital surgeries were not seen as true transsexual (Hines, 2007), and they were often relegated to third-sex categories – such as "she-male" (Serano, 2007). Sexual orientation was also taken into consideration for determining who was, or was not, a true transsexual. For example, those transsexual women who were homosexual (that is, attracted to women) were seen as a so-called secondary-type transsexuals, often designed as autogynephilic: biological men who are attracted to women and who seek body modifications because they were sexually aroused by the idea of having female bodies themselves (Bailey, 2003).

In sum, stereotypes, prejudices, and personal and political views of gender and sexuality shaped the way transsexuality was constructed and developed within the medical and clinical field. Instead of directing the focus of attention to the incongruence between gender identity and sex assigned at birth (and to the distress and impairment that may be associated to it), health professionals favored the exam of people's gender expressions and their ability to fit into social expectations about what it is to be a woman or a man: "by focusing so intensely on the transsexual's ability to 'pass' and conform to oppositional sexist notions of gender, the gatekeepers reduced the issue of relieving trans people's gender dissonance to a secondary, if not marginal, concern" (Serano, 2007, p. 123). Although this scenario is changing (as described in following sections), research shows that currently transsexual people still face serious challenges in accessing healthcare provision, including those related to inappropriate gatekeeping (e.g., Bauer, Hammond, Travers, et. al., 2009; Bockting, Robinson, Benner, et al., 2004). The findings of the study aimed to explore the healthcare experiences of transsexual people in which the author of this thesis participated (Pinto & Moleiro,

2012) are clear in showing that, in Portugal, the gatekeeping function still includes criteria related to the gatekeepers' perspectives on gender and sexuality. Some of the health practitioners who practice gatekeeping in Portugal may exclude transsexual people for accessing medical treatments on the grounds of the following criteria: the intention of not carrying out genital surgeries; the fact the person applying for medical treatments is a mother or a father (and, consequently, by endorsing a physical transition the gatekeepers would somehow endorse same-sex parenting); by having clinically significant psychopathology, otherwise not-incompatible with the experience of gender dysphoria; or even the fact that one's friends are mostly lesbian, gay, and bisexual people (Pinto & Moleiro, 2012).

Notwithstanding, transsexual people may resort to mental health practitioners for diverse reasons, not necessarily for gaining access to hormones and surgeries. In fact, psychotherapy may help in coping with stigma, discrimination and decreased mental health (APA, 2008). In Rachlin's study (2002), most participants reported positive life changes associated with psychotherapeutic experiences - even when they felt that the therapist had no special training in transgender and transsexual issues or even in situations where they would not recommend the therapist to a friend.

Accordingly, FRA's study (FRA, 2014) shows that 23% of the participants did not seek psychological or medical help for being trans because they were afraid of prejudice from the healthcare provider; 19% did not do it because they had no confidence in the services provided; and 30% simply because they did not "dare to". The study also shows that only 14% of trans people in Portugal are open about their gender identity in healthcare settings.

In fact, it may be challenging to find clinicians and psychotherapists with appropriate knowledge, awareness and skills on transgender and transsexual issues (Sanchez, Sanchez & Danoff, 2009; Singh, Boyd & Whitman, 2010). Several participants in Korell and Lorah's study (2007) reported that they were the first transsexual clients of their therapists, and have had to inform and educate them on these topics – which triggered feelings of frustration and anxiety, since those professionals have the power to allow (or not) access to medical treatments. Even practitioners adequately trained for clinical work with other minority clients (such as lesbian, gay and bisexual people) may not be necessarily informed and fit to work with transgender clients (Israel, 2005). Moreover, even health professionals with knowledge in this field are not necessarily free of stereotypes and prejudices (Sanchez et al., 2009). This is

reflected, for example, in the tendency to overdiagnose transsexual clients with mental health disorders (Raj, 2002). Furthermore, the gatekeeper function triggers an asymmetric dynamic of power between client and therapist and can decisively affect the development of a productive and trustworthy relationship (Bess & Stabb, 2009; Bockting et al., 2004; Raj, 2002). Thus, it has been suggested that psychological assessment and gatekeeping should be distinguished from psychotherapy (for those who need it), and that one process should not work as a substitute for the other (Rachlin, 2002).

Thus, several authors and studies strongly endorse the need for psychologists and other mental health practitioners to have competence in the effective support of transsexual clients and, therefore, endorse the need for accurate training in these matters (e.g., Carrol & Gilroy, 2002; Hendricks & Testa, 2012; Israel, Gorcheva, Walther, et al., 2008; Pinto & Moleiro, 2012; Raj, 2002; Singh et al., 2010).

Controversies on (trans)gender diagnoses

Mental health diagnoses that are specific to transsexual people are highly controversial. In the past few years there has been a vehement discussion among interested professionals, transsexual and LGBT activists, and human rights groups concerning the reform or removal of (trans)gender diagnoses from the main health diagnostic tools. However, discourses on this topic have been inconclusive, filled with mixed messages and polarized opinions (Kamens, 2011).

The discussion reached a high point during the recent revision process of the DSM – the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. In the fifth edition of the manual (American Psychiatric Association, 2013), the diagnosis of "gender identity disorder" was revised into one of "gender dysphoria". Although the changes – which included not only alterations in the nomenclature but also in the underlying criteria and in the diagnosis position within the DSM – were welcomed (e.g., DeCuypere, Knudson & Bockting, 2010; Lev, 2013), there are still voices arguing for the "ultimate removal" (Lev, 2013, p. 295) of gender dysphoria from the DSM. Nevertheless, attention is presently turned to the eleventh revision of the International Classification of Diseases (ICD), the standard diagnostic tool for epidemiology, health management and clinical purposes of the World Health Organization. Its revision process is ongoing and is expected to end by 2017. Various proposals concerning the revision of (trans)gender diagnoses within ICD have been

made, both originating from trans and human rights groups (e.g., GATE, 2011; TGEU, 2013) and the health profession community (e.g., Drescher, Cohen-Kettenis & Winter, 2012; WPATH, 2013).

Since their first appearances, these diagnostic classifications have changed various times (Drescher et al., 2012) – not only their names but also their criteria and placement within the two diagnostic guides. Despite the various revisions that occurred in the last decades, and at least for the DSM, the distress about one's assigned sex has remained the core feature of the diagnosis (Cohen-Kettenis & Pfäfflin, 2010). The changes in nomenclature from transsexualism to gender identity disorder in the DSM-IV (American Psychiatric Association, 1994), and more recently from gender identity disorder to gender dysphoria (American Psychiatric Association, 2013), line up with the assumption that (trans)gender diagnoses have to be a description of something with which a person might struggle - not a description of the person or the person's identity (Coleman et al., 2011). In contrast, the nomenclature used in ICD-10, including the diagnosis of transsexualism, still suggests that the core of the diagnosis is based on identity features. ICD-11 beta phase, a draft version of the revised classification open to input from multiple stakeholders, has already included proposals for revised (trans)gender diagnoses (GATE & STP, 2014). Regarding adolescents and adult transsexual individuals, the proposal includes two main changes: the reform of the diagnosis of transsexualism into one of "gender incongruence"; and the change of the diagnosis into a separate chapter from the one on "mental and behavioural disorders".

In Chapter 4 the controversies on, and the complexity of, (trans)gender diagnoses are addressed in detail. Notwithstanding, the complexity of this issue is well expressed by the fact that it constitutes a significant dividing line both within transsexual-related activism (e.g., Vance, Cohen-Kettenis, Drescher, et al., 2010) and within the health professionals' communities (e.g., Ehrbar, 2010). The discussion has taken place within the space between two opposite positions: (1) (trans)gender diagnoses should be removed from health classifying systems, because they promote the pathologization and stigmatization of gender diversity and enhance the medical control of trans people's identities and lives; and (2) (trans)gender diagnoses should be retained in order to ensure access to care, since health care systems rely on diagnoses to justify medical or psychological treatment.

The Standards of Care

WPATH (the World Professional Association for Transgender Health, formerly known as the Harry Benjamin International Gender Dysphoria Association) is an international association composed of professionals from different fields, whose mission is to promote evidence-based care, training, research, public policies and respect in transgender health. Since its beginning, this association has a major role in managing and defining the criteria underlining the gatekeeping function. The association issues the Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People. The overall goal of the SOC is "to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment" (Coleman et al., 2011, p. 166).

The last version of the SOC was published in 2011 (Coleman et al., 2011), and it is the seventh version of the original document released in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001. The changes between the 2001 version and the more recent one are massive – not only in terms of the language used, the definitions presented, and the depth of the discussion surrounding issues that are complex, but particularly in regard to the inclusiveness of all transgender and transsexual people. The 2011 version may be seen as a breaking point from previous versions, which were mostly grounded on dated notions about transsexuality and transgenderism. For example, in the previous version (Meyer, Bockting, Cohen-Kettenis, et al., 2001) a description about the notion of true transsexualism is presented in detail, mentioning that true transsexuals were thought to have: cross-gender identifications that were consistently expressed behaviorally in childhood, adolescence, and adulthood; minimal or no sexual arousal to cross-dressing; and no heterosexual interest, relative to their assigned sex at birth. Although the narrowing was made using the past tense (thus, suggesting that the notion of true transsexuals should belong to the past), no criticism or alternative notions were presented. On the contrary, the 2011 version clearly mention the diversity of possibilities within the transgender and transsexual spectrum, and states that "being transsexual, transgender, or gender nonconforming is a matter of diversity, not pathology" (Coleman et al., 2011, p. 168). The alternation in the name of the document also indicative of the profound changes in its content: from "Standards of

Care for Gender Identity Disorders" to "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People".

Moreover, the current SOC (Coleman et al., 2011) emphasize that treatment is always individualized: what helps a person relieve gender dysphoria can be very different from what helps others, and the process may or may not involve modifications in gender expressions or body changes. The medical options include, for example, body masculinization or feminization through hormones and/or surgical therapy - which can effectively alleviate gender dysphoria and that are medically required for many transsexual people. Nevertheless, SOC are clear in its support for diversity in gender identities and expressions, stressing that the use of hormones and surgeries are only two choices among various resources that can help people feel comfortable with their gender identity. Thus, this last version of the SOC clearly moves away from classic archetype of true transsexuals – which is grounded in a profound desire for body modification (Lev, 2004). Additionally, the SOC are clear in stating that no (trans)gender diagnosis can be cause of stigmatization or withdrawal of rights, and that the diagnosis is a description of a problem that the person deals with at a certain point, not a description of their identity.

The core principles that undergird the SOC and that can be applied for health professionals throughout the world include the following: (1) exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); (2) provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; (3) become knowledgeable about the healthcare needs of transsexual, transgender, and gender-nonconforming people, including the benefits and risks of treatment options for gender dysphoria; (4) match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; (5) facilitate access to appropriate care; seek patients' informed consent before providing treatment; (6) offer continuity of care; and (7) be prepared to support and advocate for patients within their families and communities (Coleman et al., 2011).

An ongoing paradigm shift

The traditional medical approach to transsexuality, by establishing access to hormonal and surgical treatments, has undeniably been life-saving for many transsexual people (Lev, 2004). However, as mentioned before, for decades transsexual people have

been facing various barriers when accessing healthcare provision. Accordingly, various stakeholders (including transsexual and LGBT activists, academics, and even healthcare practitioners) are arguing for a more inclusive, accurate and compassionate therapeutic understanding of transsexuality and transgenderism (e.g., Bockting, 1997; Drescher et al., 2012; GATE, 2011; Hammarberg, 2009; Lev, 2004; Serano, 2007; STP, 2012).

Already in the late 1990s, and referring to clinical management of gender dysphoria, Bockting (1997) mentioned that "a paradigm shift has occurred signified by an emerging transgender consciousness that challenges the binary conceptualization of gender" (p. 49). More recently, Drescher and colleagues (2012) mentioned that

> is now appropriate to abandon the psychopathological model of transgender people based on 1940s conceptualizations of sexual deviance and to move towards a model that is (1) more reflective of current scientific evidence and best practices; (2) more responsive to the needs, experience, and human rights of this vulnerable population; and (3) more supportive of the provision of accessible and high-quality healthcare services. (p. 575)

Lev (2004) also claimed for a paradigm shift on the "medical model's therapeutic understanding of transsexualism and transgenderism" (p. 37). However, this author argued that this paradigm shift should not deny or even minimize the seminal work of the early experts or the work they did to make hormonal and surgical treatments available to transsexual people: "the paradigm shift is not meant to invalidate the past fifty years of gender treatment. Transsexualism as Harry Benjamin defined it does exist – it is just not the only form of transgenderism that warrants access to medical treatments" (Lev, 2004, p. 37).

Two main recent accomplishments may be demonstrative of the ongoing paradigm shift: (1) the publication of the latest version of the WAPTH's Standards of Care - that may be seen as a breaking point from previous versions, which were mostly grounded on dated notions about transsexuality and transgenderism; and (2) the recent debate on (trans)gender diagnoses that resulted in the revision of the DSM's diagnosis of *gender identity disorder* into one of *gender dysphoria*. Thus, nowadays in the main medical and clinical official manuals and guidelines it is clear that: on the one hand, (trans)gender diagnoses have to be a description of something with which a person might struggle - not a description of the person or the person's identity – meaning that

being transsexual, transgender, or gender nonconforming is a matter of diversity, not pathology; and, on the other hand, what helps a person relieve gender dysphoria can be very different from what helps others, and the process may or may not involve modifications in gender expressions or body changes – meaning that the term transsexual is no longer restricted to people that desire or undergo genital surgeries.

Nevertheless, it is important to note that this paradigm shift is still a work in progress and that consensus on these topics is not likely. Both the developments in the DSM and in the WAPTH's Standards of Care are very recent. As in many other domains, the generalisation of formal norms requires time to become immanent in institutional and social practices (Castro, 2012). As mentioned before, research continues to suggest that less competent and inadequate clinical practices are still being carried out with this population (e.g., Bess & Stabb, 2009; Pinto & Moleiro, 2012). Furthermore, *transsexualism* is still a diagnostic category in the ICD - although a change is expected in the upcoming revision (GATE, 2011; TGEU, 2013).

5. Depicting transsexuality and transgenderism

(Media) representations of transgender and transsexual people

Few studies have addressed the topic of representations on transsexuality and transgenderism. Additionally, most of these studies have focused on the analysis of television and films, by examining how transsexual and other transgender characters are portrayed in popular media (e.g., Mackie, 2008; Morrison, 2010; Piganiol, 2009; Shakerifar, 2011; Siebler 2010; Siebler, 2012; Willox, 2003). One should not dismiss the impact of such representations: media facilitates transsexual people's identification processes in various and significant ways (Ringo, 2002).

It has been suggested that popular media depicts transsexual and transgender people in a way that reinforces the male/female gender binary (Willox, 2003). Siebler (2012) showed how representations codify the need or desire for surgery and hormones, claiming that transsexual and transgender people tend to be represented within a healthcare and medical framework - which the author described as a 'culture of hormones and surgery' (Siebler, 2012, p.74).

Serano (2007), on the other hand, argued that media coverage of transsexuality is intimately connected with broad notions of gender. The author suggested that media

depictions of transsexual women, whether based on fictional characters or actual people, tend to fall under one of two main archetypes: the deceptive transsexual (who tends to be perceived by the others as a "real" woman until her transsexual status is revealed in a dramatic moment of "truth" – when her female appearance is reduced to mere illusion, and her secret maleness becomes the real identity; and the pathetic transsexual (who is not successful in being perceived as a woman because of her masculine traits and mannerisms; it is the intense incongruence between her claimed gender identity and physical appearance that tends to be perceived as pathetic or funny). According to Serano (2007), unlike the deceivers, whose ability to be perceived as a cissexual woman is a threat to our culture's ideas about gender, pathetic transsexuals are generally considered harmless – precisely because they barely resemble cissexual women at all. In sum, for this author, both transsexual women's archetypes displayed in the media 'are designed to validate the popular assumption that trans women are truly men' (Serano, 2007, p. 40).

At least two studies, both in the Brazilian context and using the theoretical framework of SRT (e.g., Moscovici, 1984), addressed the issue of social representations about transsexuality in healthcare students and professionals. Matão and colleagues (Matão, Miranda, Campos, Teles, & Mesquita, 2010), in a study with nursing and medicine students, found that social representations of transsexuality in these groups are mostly based on common sense, and tend to incorporate the following features: a general confusion with homosexuality; an association to the notions of deviance and disorder; and the idea that transsexuality is an option. Batista dos Santos (2012) studied social representations of transsexuality in a sample of almost 3000 health professionals, in which 60% had assisted a transsexual patient at least once. The findings showed that: the health practitioners tended to associate transsexuality with homosexuality; transsexual people tended to be perceived as group targeted with prejudice, and that deserved "respect" and "acceptance"; representations were shaped by participants' religion; and, in the core of the representations was the expression "sex change".

Depictions of transsexuality coming from the social sciences

As described in the previous sections, the work developed for decades in the medical field has a major role in shaping current representations of transsexuality and transgenderism (e.g., Hines, 2007; Saleiro, 2013). The narrative of the wrong body - this is, the desire, insistence and obsession with body modification (Lev, 2004) – was

crucial in modeling the way the general public understands and reflects about transsexuality and transsexual people. For decades, the work of health practitioners (but also academics in the field) was to sort out the so-called true transsexuals from all other transgender people, by favoring the exam of people's gender expressions and their ability to fit into social expectations about what is to be a woman or a man (Hines, 2007; Serano, 2007). In this paradigm, those transsexual people who were seen as challenging gender norms, or understood as gender-ambiguous, were somehow penalized – for example, by not having access to medical treatments.

Not only health academics and practitioners have developed a significant body of research on transsexual and transgender people: also academics in the field of social sciences and gender studies devoted significant efforts in studying these phenomena. The social sciences accounts of transsexuality most probably do not have the same impact on the public representations as the ones coming from the medical field, but they have profoundly shaped the way in which transsexual people are discussed and considered in academia and activism (Serano, 2007). It is not within the aims of this thesis to carry out an extensive revision of this work[2]. However, bearing in mind that one of this thesis' general purposes is to contribute to our understanding about how different social actors construct the notion and reality of transsexuality, we will briefly address the two main approaches by which the social academic research in this area has been grounded.

One of the main approaches regarding transsexuality in the field of social sciences is the one in which transsexuality is seen as a medical construction, and/or transsexual people as the agents of practices that exist because of (or result in) gender stereotypes (e.g., Billings & Urban, 1982; Hausman, 1995; Jeffreys, 1997; Nanda, 2000; Raymond, 1979; Shapiro, 1991). Within a so-called "radical feminism perspective" (Hines, 2007, p. 18), Raymond's book "The Transsexual Empire" (1979) was decisive in establishing a perspective that affected significantly and for successive decades the dominant feminist and academic position on transsexuality. According to Raymond (1979), transsexuality is a medical construction, resulting from health practitioners who induce transsexual people with the promise of assimilating them into regular women and men. In the words of Hines (2007, p. 18) "Raymond locates transsexuality as a

[2] For those interested in understanding in detail the various perspectives on transsexual and transgender studies in the social sciences, we would recommend the work of Hines (2007) or Saleiro (2013).

patriarchal characteristic and the medical system as an agent of patriarchal oppression". Such as Raymond (1979), other authors that followed suggested that transsexuality is a culturally and socially derived phenomenon that would not exist if transsexual people became more conscious and involved in feminism or sexual politics (Serano, 2007). For example, in the words of Billings and Urban (1982, p. 276): "transsexual therapy […] pushes patients toward an alluring world of artificial vaginas and penises rather than toward self-understanding and sexual politics". In sum, this academic perspective has depicted transsexual people as medical inventions, condemned them for reinforcing normative sex/gender relations and, consequently, overshadowed their agency and, in particular, their profound gender identities.

The other main approach regarding transsexuality in the field of social sciences is more recent and derives from poststructuralist and postmodernist analysis of gender (eg., Missé & Coll-Planas, 2010). Butler's work (e.g., 1990, 1993, 2004) is central for this perspective, as is the academic field know as queer theory (e.g., Jagose, 1996; Vale de Almeida, 2004). Butler (1990) argued that biological sex (i.e., the female and male bodies) should be understood and theorized as independent from gender - that would create the potential for a greater diversity of masculinities and femininities, allowing a multiplicity of embodied gendered identities and expressions. This author developed the concept of performativity to refer the ways in which gender rules are repeatedly acted out to reinforce its supposed naturality; in her words: "there is no gender behind the expressions of gender […] identity is performatively constituted by the very 'expressions' that are said to be results" (1990, p.25). In this sense, the practices of cross-dressing and drag are referenced as examples of how the naturalization of gender can be challenged. In the same line of reasoning, queer theory (e.g., Jagose, 1996) argues against the representation of identity categories as authentic, and theorizes gender and sexual identities as fluid and socially constructed.

Although nowadays poststructuralist and postmodernist analysis of gender, as is queer theory, are commonly used by social sciences in the inquiry and analysis of transsexuality – including in the public discussion about the so-called depathologization (e.g., Missé & Coll-Planas, 2010) – various criticisms on its application to the reality of transsexual people have been made. Namaste (2005) mentioned that "queer theory and much transgender theory do not respect transsexuals because they do not understand transsexuality on its own terms" (p. 20). According to this author, the contributions of queer theory to the substantive issues of transsexual people's lives (e.g., access to

healthcare) are very limited, because "when we restrict ourselves to the identity of sex change, we simultaneously limit our understanding of social change" (Namaste, 2005, p. 19). In fact, transsexual people are gender-variant (and may be theoretically understood within the transgender spectrum) yet they typically identify within the gender binary. In this sense, queer theory – which conceptualizes transgender identity as a transcendence of the very notion of identity – may not be the most appropriate theoretical framework when it comes to the comprehension of transsexual people experiences and realities. As explained by Hines (2007, p. 27):

> Queer theory offers valuable insights into the ways in which some transgender cultures radically challenge normative taxonomies of gender and sexualities. However, employed in isolation, this theoretical model is limited by a lack of attention to lived experience, which often leaves non-performance-related transgender identities unaccounted for.

Not all academic work on transsexuality developed in the field of social sciences fall unambiguously in one of the two approaches we just described – as is the case of, for example, Rubin's (2003) or King's (2003) work. Nevertheless, transsexual people's depictions coming from these two main approaches significantly shape the way we think about transsexuality. Moreover, the idea that transsexuality is a medical invention and the idea that transsexual people are - or should be - a transcendence of the very notion of identity, although distinct and apparently oppositional, they share a common feature: they overshadow the profound, intrinsic and immutable nature of transsexual people's basic sense of being male or female – this is, their gender identities. This topic will be addressed in more detail in the General Discussion, in the light of our studies' findings.

6. The present research program

As mentioned before, the general goal of this thesis is to further the understanding not only about the experiences of transsexual people in Portugal, but also about how different social actors construct the notion and reality of transsexuality. The specific aims are: (1) to examine how social representations and social knowledge on

transsexuality are used and developed by different social actors; (2) to explore the processes by which transsexual people come to terms with their gender identities, and to describe the main intervening actions and conditions; (3) to contribute to the main current public debates related to transsexuality – including the debate on legal gender recognition and the one about the so called depathologization of transsexuality. In Portugal persists a "vacuum" (Saleiro, 2009, p. 84) in social research about transsexuality and transsexual people experiences. In this thesis we cover a diversity of topics, with the aim of contributing to different spheres of knowledge and distinct levels of intervention.

In the first empirical chapter **(Chapter 2)**, we present a study (Study 1) aimed to examine social representations on transsexuality and transsexual people. By focusing on the public debate held during the period preceding the implementation of the innovative law on gender recognition in Portugal, we studied how social knowledge and social representations on transsexuality were used in order to persuade the public and policy-legal spheres of what should be the next step - approving or not approving the law. Using the theoretical background of the theory of social representations (e.g., Moscovici, 1984), the representational fields made available in the Portuguese media when addressing transsexuality and/or the law on gender recognition were established. Moreover, the various ways different groups and social actors used and (re)produced social knowledge and representations, not only in the media but also through other significant channels, were characterized. Several documents were analyzed: (1) 79 articles published online on four main daily Portuguese newspapers, during 2010, which included the terms "transsexual", "transsexuality", "transgender", or the expression "sex change"; (2) an extended report on transsexuality published in a well-known Portuguese weekly magazine in June 2010; (3) the transcript of a television report on transsexuality, broadcast nationally on a Portuguese public channel in November 2010; (4) the debate that occurred in the parliament (September 2010); (5) the message from the Portuguese President when he vetoed the law (January 2011); and (6) four press-releases from the main LGBT rights-organization in Portugal (between January 2010 and February 2011).

After analyzing the social knowledge and representations about transsexuality, we focus on the lived experiences of transsexual people. The second empirical chapter **(Chapter 3)** describes the core study (Study 2) of this thesis - which main goal was to explore how transsexual people recognize, acknowledge, and come to terms with their gender identities. The study's data *corpus* was composed of in-depth interviews of

twenty-two transsexual people: 14 transsexual women and 8 transsexual men. Data collection and analysis followed the canons and procedures of grounded theory methodology (e.g., Corbin & Strauss, 1990): data collection took place between 2010 and 2012 and happened in three distinct phases: 9 participants were interviewed in the first phase, 6 in the second and 7 in the last one; analysis followed each of the three data collection periods. Proceedings from analysis resulted in an integrated and related set of concepts, illustrative of the processes through which the participants recognized, acknowledged, and came to terms with their gender identities.

Finally, the last empirical chapter (**Chapter 4**) focuses on a particular aspect: the experiences in the field of mental health – in particular, we examine the concepts, main dilemmas, and possible paths related to (trans)gender diagnoses. The study (Study 3) explored specific extracts from eight of the interviews (5 transsexual men and 3 transsexual women) carried out in Study 2. Participants' experiences of distress and impairment, their notions of mental illness and associated stigma, and their experiences in accessing transsexual-related healthcare, were analyzed. Thus, in the last empirical chapter we present a minor study, derived from this thesis core study, and which results contribute to one of the main current discussions (in the fields of activism, academia, and in the medical community) regarding healthcare provision to transsexual people.

Each one of the empirical chapters is based on an article that was either published (Chapter 3) or is under review (Chapters 2 and 4). These chapters can be read independently and in any order. Following these three chapters, **Chapter 5** presents an integrated discussion where the main contributions of our work are summarized and where we present our perspective about the directions that research in the field of transgenderism and transsexuality should take.

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2

(Trans)Gender Representations: The Public Debate on an Innovative Law for Legal Gender Recognition

This chapter is based on the paper: Pinto, N., Moleiro, C., Mouro, C., & Castro, P. (under review). Representing transsexuality and transsexual people: The public debate on an innovative law for legal gender recognition. *Culture, Health & Sexuality*.

1. Abstract

The public debate held in Portugal during the period preceding the implementation of an innovative law on gender recognition was analysed in this paper. We examined how social knowledge and representations on transsexuality and transsexual people were used, appropriated and (re)produced. The data corpus comprised media pieces and quotations from social actors extracted from various official documents. Findings showed that, although social representations of transsexual people were being (re)produced within a discourse heavily dependent on biological and clinical language, the public debate was anchored within the broad notions of equality and social justice. Regarding the discourse of the different social actors within the public debate, three configurations emerged: (1) transsexual people occupied a more conservative semantic space, focused on the idiosyncratic features of their experiences, gravitating towards the communicative modality diffusion; (2) discourses of resistance to change in the legal and/or medical procedures were mainly (re)produced by right-wing politicians and health professionals, gravitating towards the communicative modality propaganda; (3) left-wing politicians and LGBT activists were found to be the actors of a more liberal and favourable to change semantic space, characterised by features similar to the communicative modality propagation.

Keywords: transsexuality, legal gender recognition, social representations, public debate, media

2. Introduction

Legal identification is required for many vital activities in daily life, such as applying for jobs, renting accommodation, opening a bank account, or voting. What can usually be seen as mere bureaucracy encloses severe risks for marginalisation and discrimination for transsexual people whose documents are incongruent with their gender identity (Open Society Foundations, 2014). In this context, the need for the legal recognition of transsexual people's gender identity has been highlighted as a human rights issue (European Commission, 2012), and has been advocated by different stakeholders. In fact, in the last decade several countries addressed the issue by creating or improving legislation regulating legal gender recognition and name change on official documents for transsexual people.

The existence of different legal frameworks in countries that have some kind of legislation to this effect (Open Society Foundations, 2014) suggests that this is not a topic with societal consensus. In fact, it is a political field favourable to the development of resistance processes, in which clashing positions and ideological values are placed in opposition. In 2011, 'the first European law on name change and legal gender recognition that meets the Yogyakarta Principles[3] and the Recommendations of the Commissioner for Human Rights of the Council of Europe[4] entered into force in Portugal' (European Commission, 2012, p. 72). The law allows transsexual people to acquire legal identification that matches their gender identities within an administrative and expeditious process with the only requirement being a medical diagnosis. In this paper we will focus on the study of the public debate surrounding the new law, including the appropriation and use of social representations related to transsexuality and transsexual people by different social actors.

The paradigm shift on transsexuality and gender variance

Transsexual people are those whose gender identity - the 'person's basic sense of being male, female, or of indeterminate sex' (American Psychological Association,

[3] Yogykarta Principles refer to a set of principles relating to sexual orientation and gender identity, intended to apply international human rights law standards to address the abuse of the human rights of lesbian, gay, bisexual and transgender people: http://www.yogyakartaprinciples.org/

[4] Issue Paper on gender identity and human rights published by Thomas Hammarberg in 2009.

2009, p.28) - is contrary to the assigned sex at birth. The term transsexual describes 'anyone who is currently, or is working toward, living as a member of the sex other than the one they were assigned at birth, regardless of what procedures they may have had' (Serano, 2007, p.31).

Transgenderism, or gender variance, is well documented throughout human history (Lev, 2004). However, what we now call transsexuality only emerged in the middle of the 20th century, when hormonal and surgical treatments became obtainable. In the 1950s, transsexual people were described as the gender variant people who wanted to 'belong to the other sex and correct nature's anatomical "error"' (Benjamin, 1953, p. 12). In the following decades, the narrative of the "wrong body" was settled: the defining trait of transsexuality was the desire, insistence, and obsession with body modification (Lev, 2004). The term transsexual was restricted, for example, to individuals that desired or had undergone genital surgeries (Hines, 2007). By 1980, in the third edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM; American Psychiatric Association [APA], 1980) diagnoses related to transsexuality appeared in the manual for the first time, including the diagnosis of "transsexualism" (Drescher, 2010).

The traditional medical approach to transsexuality, establishing access to hormonal and surgical treatments, has undeniably been life-saving for many transsexual people (Lev, 2004). However, currently we are witnessing a paradigm shift which arises from the recognition that the traditional medical model was not inclusive of all transsexual people (Hines, 2007; Lev, 2004; Wilson, 2002). Currently the term transsexual is no longer restricted to people that desire or undergo genital surgeries. Treatment options not only deal with gender identity but also with individual life circumstances, available resources, and medical technology (Rachlin, 1999). According the last version of the Standards of Care (SOC), published by the World Professional Association for Transgender Health (WAPTH; Coleman et al., 2011), 'treatment is individualized: what helps one person alleviate gender dysphoria[5] might be very different from what helps another person. This process may or may not include a change in gender expression or body modifications' (p. 5).

[5] The expression "gender dysphoria" refers to discomfort or distress that is caused by the discrepancy between a person's gender identity and that person's sex assigned at birth (Coleman et al., 2011).

At the same time, an increasing number of people and organisations are arguing that transsexual people are not inherently disordered, and that diagnoses related to transsexuality have to be a description of something with which a person might struggle, not a description of the person or the person's identity (Coleman et al., 2011). Accordingly, in the recent publication of the DSM-5 (APA, 2013a) which includes the diagnosis of *gender dysphoria*, the authors clarified that 'gender nonconformity is not in itself a mental disorder' (APA, 2013b, p.1).

Nevertheless, it is important to note that this paradigm shift is still a work in progress and that a societal consensus on these topics is not likely. Both the developments in the DSM (APA, 2013a) and in the WAPTH's Standards of Care (Coleman et al., 2011) are very recent. As in many other domains, the generalisation of formal norms requires time to become immanent in institutional and social practices (Castro, 2012). Research continues to suggest that less competent and inadequate clinical practices are still being carried out with this population (e.g., Bess & Stabb, 2009; Pinto & Moleiro, in press). Furthermore, *transsexualism* is still a diagnostic category in the International Classification of Diseases (ICD) which is the standard diagnostic tool of the World Health Organization - although a change is expected in the upcoming ICD revision (GATE, 2011; TGEU, 2013).

Therefore, in sum, criticism against the traditional notion of transsexuality is now more consensual within the scientific sphere - including the official documents of the medical, psychiatric and psychological professions. However, could the same be said for the public and policy-legal sphere?

Legal gender recognition as a legal innovation

Even though the notion of transsexuality emerged and was settled within the medical field earlier, lately this topic has been addressed as a political and civil rights issue - with specific legal intricacies and a worldwide scope. The vast majority of transsexual people around the world cannot obtain official documents under their proper name and sex to match their gender identity (Open Society Foundations, 2014). Activists around the world, but also politicians (e.g., Hammarberg, 2009), international organisations and medical professionals (e.g., APA, 2012; Coleman et al., 2011), have been advocating for human rights-based laws on legal gender recognition.

In the international policy-legal sphere there is no consensus for gender recognition. There is no one size fits all law or regulation: different countries have been

producing legislation or jurisprudence that differ in the requirements that allow change of name and legal sex on official documents (Open Society Foundations, 2014). Although proof of genital surgeries tends to be privileged over other evidence (Anders, Caverly, & Johns, 2014), requirements may comprise: transition-related medical treatment, such as hormonal or gender affirming surgeries; sterilisation, either explicitly or by requiring medical procedures that result in sterilisation; prohibition of parenting now or the intention of having children in the future; living continuously in one's desired gender, with gender expression matching gender identity; divorce; or a medical diagnosis. In addition to the requirements, an important distinction between legal gender recognition processes is whether they are administrative or judicial (Open Society Foundations, 2014).

In Portugal, before 2011 there was no law on legal gender recognition, so transsexual people had to sue the State if they wanted to change their name and legal sex. The process could take several years, and only some people were successful in the end - since most of the above-mentioned requirements were imposed in court. In September 2010 a law was proposed by a Socialist Party government, and first approved in the parliament by a left-wing majority. Thereafter, the law was vetoed by the Portuguese President, a right-wing politician. It was reiterated again by a left-wing majority in the parliament and entered into force in March 2011.

With the new law, the process is now administrative and the only requirement is the presentation in the Civil Registry of a medical diagnosis supported by a multidisciplinary team of clinicians (Pinto & Moleiro, in press). The process is also very expeditious: within 8 days the registrar must accept the request, ask for further information, or reject the request (Open Society Foundations, 2014). The law was described as the first European human rights-based law on gender recognition (European Commission, 2012). In this paper, the public debate surrounding the law - occurring in several arenas such as the press, the parliament, and through the interventions from LGBT (lesbian, gay, bisexual and transgender) organisations - will be analysed under the social representations theory (SRT; e.g., Moscovici, 1984).

(Social) representations of transsexuality and gender variance

Few studies have addressed the topic of representations on transsexuality and transgenderism. Additionally, most of these studies have focused on the analysis of television and films, by examining how transsexual and other transgender characters are

portrayed in popular media (Mackie, 2008; Morrison, 2010; Piganiol, 2009; Shakerifar, 2011; Siebler 2010; Siebler, 2012; Willox, 2003). One should not dismiss the impact of such representations: media facilitates transsexual people's identification processes in various and significant ways (Ringo, 2002). It has been suggested that popular media depicts transsexual and transgender people in a way that reinforces the male/female gender binary (Willox, 2003), within a health care and medical framework, which Siebler (2012) described as a 'culture of hormones and surgery' (p.74). Serano (2007) argued that media coverage of transsexuality is intimately connected with broad notions of gender. For this author, transsexual women's archetypes displayed in the media 'are designed to validate the popular assumption that trans[sexual] women are truly men' (Serano, 2007, p.40).

In the Brasilian context, using the theoretical framework of SRT (e.g., Moscovici, 1984), studies have suggested that health students and professionals tend to associate transsexuality with homosexuality (Matão, Miranda, Campos, Teles, & Mesquita, 2010), and to perceive transsexual people as a discriminated group that needs to be respected (Batista dos Santos, 2012).

Social representations and social change

SRT provides a framework for the study of how knowledge on socially meaningful objects develop and circulate throughout societies (Moscovici, 1961/1976a). This approach has a dialogical epistemology; in other words, it assumes that knowledge is always historically, culturally and socially situated (Liu & Hilton, 2005; Marková, 2000). In this sense, SRT is a theory of social knowledge and, necessarily, a theory of communication. It is a social-psychological approach which stresses the agency of individuals and groups, and their active roles in the constant (re)production and transformation of social representations through communication and everyday discourse (Castro & Batel, 2008).

For dialogical approaches in general, and for SRT in particular, moments of social change are privileged occasions to study the (re)production of social knowledge (Marková, 2000). SRT has been used to analyse the processes whereby the unfamiliar becomes familiar, and the strange becomes understandable. This approach has been employed to document and analyse processes of social thought related to different types of innovation. These include innovation originating from the scientific field, such as medically assisted reproduction (Walker, Broderick, & Correia, 2007), genetically

modified organisms (Castro & Gomes, 2005), organ donation and transplantation (Moloney, Hall, & Walker, 2005), or biotechnology and health risks (Joffe, 2003). Nevertheless, change and innovation emerge not only from science, but also from other spheres, including policy-legal and public spheres (Castro, 2012; Castro, Mouro, & Gouveia, 2012; Mouro & Castro, 2012). In this paper, we will examine how various dimensions of social knowledge - including medical knowledge and political values - were used differently by various groups in order to build persuasive arguments for addressing the Portuguese public and institutions during the period in which the innovative law on gender recognition was discussed.

The reception of innovation and change usually mobilises processes of resistance (Castro, 2012; Jensen & Wagoner, 2009). Resistance to change is an expression of the agency of social beings, and societies are capable of constantly incorporating innovation while remaining remarkably stable (Castro & Batel, 2008). Plurality, diversity, conflict and consensus are central notions within SRT. Resistance may arise from different individuals and groups. However, some assume a key role in these processes, given their privileged social position in relation to the matter in question. For instance, experts have the power to offer concrete content to generic innovations, adjusting them to specific contexts and managing them with new practices (Castro & Batel, 2008; Morant, 2006). Also minorities may undertake an active role in fostering social change (Moscovici, 1976b). As mentioned, communication has a central role in the (re)production and transformation of social representations. SRT, as a theory of social knowledge, privileges the examination of public discourses in which different dialogues take place and through which they generate representations (Marková, 2007). The press is one of the privileged arenas where this "battle of words" (Castro & Gomes, 2005) can be performed and where the various positions can take form (Castro et al., 2012).

One of the concepts that refers to the process by which representations are formed, maintained and changed is the concept of anchoring (Moscovici, 1984). It involves classifying and comparing the unfamiliar with what is familiar and accessible. In other words, anchoring refers to the integration of new ideas into existing knowledge and, thus, is oriented towards stability (Marková, 2000). Another concept from SRT that addresses the role played by old categories in pushing new meanings and objects through society, and the ways the past constantly re-emerges in current communications and representations, is the concept of themata (Moscovici & Vignaux, 1994). We have a

tendency to think in oppositions: we define what is clean by reference to what is dirty, and so on. Marková (2000) defines themata as 'such oppositional categories which, in the course of history, become problematized; for one reason or another they become the focus of attention, and a source of tension and conflict'. (p. 446). Examples of themata are: normal/abnormal, nature/culture, health/disease. When an oppositional pair is brought to public attention and problematised, it can be dialogically reconstructed and have its boundaries changed. During this process it may become the basis from which social representations of new phenomena are generated (Marková, 2000).

When we communicate with each other on new phenomena we are not only constantly (re)constructing old categories, but we generally do it expressing our evaluative attitudes towards the object in question. SRT describes three systems of communication or communicative modalities (CM), which date back to Moscovici's early work (Moscovici, 1961/1976a): diffusion, propaganda and propagation. They are a privileged tool for the analysis of both the content and the structure of communication pieces, such as press articles. The CM diffusion is focused on disseminating information, and is characterised by detachment in relation to the topic in question and voicing a diversity of arguments. The aim is to give notice to the possible different opinions and positions, and not to solve any potential conflict between them, letting the message's receiver arrive at his/her own conclusions (Castro & Gomes, 2005; Moscovici, 1961/1976a). The CM propaganda is focused on creation or reinforcement of behaviour, addressing the topic in a dichotomised fashion while discarding any attempt for moderation. The complexity of the reality is reduced to two irreconcilable positions: the ones that are right - usually "we" - and the ones that are wrong - usually "they" (Castro & Gomes, 2005; Moscovici, 1961/1976a). The CM propagation is focused on attitudes and aims to disseminate a general, comprehensive and conciliatory norm. Propagation tries to articulate the various positions within a hierarchical framework, organising the conflicting beliefs around nuclear and consensual values (Castro & Gomes, 2005; Moscovici, 1961/1976a). These three systems of communication are not phenomena in themselves. Instead, they are mutually independent with social thinking: social representations shape CM and CM shape social representations (Marková, 2000). Thus, the use of each CM is necessarily and inwardly related to intergroup relations and identity dynamics (Staerklé, Clémence, & Spini, 2011). In this study, we will examine the use of CM by different social actors when an innovative law defending minorities' rights is proposed. When new phenomena emerge

in the public sphere, powerful majority groups may propagate attitudes towards them, while integrating the unfamiliar topic in the consensual beliefs of their groups. On the contrary, minorities may have to implement a vigorous position and adopt a propaganda style if they want to be successful when disseminating an alternative and minority point of view on a given topic (Moscovici, 1976b).

3. Objectives

The main goal of the present work was to examine the public debate held during the period preceding the implementation of the innovative law on gender recognition in Portugal. We examined how social knowledge and social representations on transsexuality were used in order to persuade the public and policy-legal spheres of what should be the next step - approving or not approving the law. The specific aims were:

(1) To establish the representational fields made available in the Portuguese media when addressing transsexuality and/or the law on gender recognition, during the period preceding the enforcement of the new law. For this, the main themata, the anchoring categories (hereinafter referred to as 'topics') and CM present in the media were identified.

(2) To characterise how different groups and social actors used and (re)produced social knowledge and representations, not only in the media but also through other significant channels. This implied: (2.1) examining the main topics used by different groups and social actors when discussing transsexuality and/or the law on gender recognition, (2.2) how the arguments used refer to each CM, and (2.3) to explore the possible configurations deriving from the combination of various topics with different CM, within distinct groups and social actors.

4. Method

Two datasets were used for the study. Figure 1 shows the content of each dataset. Within dataset 1, various media pieces were analysed: 79 articles published online on four main daily Portuguese newspapers, during 2010, which included the

terms “transsexual”, “transsexuality”, “transgender”, or the expression “sex change”; an extended report on transsexuality published in a well-known Portuguese weekly magazine in June 2010; and the transcript of a television report on transsexuality, broadcast nationally on a Portuguese public channel in November 2010. These 81 units of analysis were coded for three dimensions: CM, themata and topics. Each unit of analysis was coded with one of three CM. For the analysis of the themata, a list of 9 oppositional pairs was defined after reading the units several times. Each unit of analysis was coded with one themata. For the analysis of the topics, a similar process was carried out. After reading the material several times, an extensive list of possible topics was defined. A final list of 17 topics was achieved. Figure 2.1 shows the complete list of topics and guidelines for coding. Each unit of analysis was coded with as many topics as the ones found in it. In addition, for each topic identified in a unit of analysis, a score was assigned: 3 points, if the theme was highly relevant; 2 points, if the theme was moderately relevant; and 1 point, if the theme was of poor relevance.

Body | Reference to transsexual people’s body; either in an abstract manner (for example, referring to the idea of the "wrong body") or by mentioning specific physical traits, secondary sexual characteristics or biological features. If the reference is restricted to the genitalia, code with *genitalia* instead of *body*.
Conditional respect | Arguments that emphasise respect for the situation of transsexual people but not within a frame of human rights, sometimes setting a limit to their rights or requiring a counterpoint. Discourse of tolerance towards minorities, often recognising the existence of problems but minimising the need for intervention.
Criticism to gender binary | Criticism towards gender binarism; in other words, the claim that people (transsexual or not) may identify outside the duality male/female.
Diagnosis | Mention of medical diagnosis specifically related to transsexuality; for example, "gender identity disorder", "transsexualism" or "gender dysphoria"; even when the reference is not explicit (e.g., reference to transsexuality as a disease by itself).
Gender roles/expression | Reference to gender roles (social and behavioural norms considered appropriate by society for either a man or a woman), and/or gender expression (appearance, mannerisms or personal traits that people use to communicate their gender identity).
Genitalia | Allusion to the genitalia. Code with *genitalia* the use of expressions such as "sex change surgery" or "the surgery" - or whenever there is a reference, even indirect, to the genitalia.
Homosexuality | Reference to homosexuality, sexual orientation, or lesbian, gay and bisexual people.
Human rights | Reference to fundamental, civic or human rights. Discourse that frames the issue of transsexuality within the human rights field.
Irreversibility | Rhetoric arguing that the gender recognition law should guarantee the irreversibility of the

process.
Judicial vs. administrative | Arguments mentioning that gender recognition is already possible though judicial means, and that the law will simplify the process.
Medical treatments | Reference to gender affirming medical treatments, such as hormonal therapy or surgeries.
Parenting/reproductive capacities | Rhetoric arguing that transsexual people should not have to abnegate their reproductive capacities in order to obtain legal gender recognition. Or criticism towards the idea that true transsexuals are the ones that aspire to, or carried out, genital surgeries, and therefore will always abnegate their reproductive capacities. Code with *parenting/reproductive capacities* references to parenting, including mention of children.
Rigour | Rhetoric arguing that, due to the exceptional nature of transsexuality, the legal gender recognition or the medical processes need to be guided with major rigour and accuracy.
Social exclusion/discrimination | Reference to social exclusion, discrimination and stigmatisation of transsexual people. It may, or may not, include examples of specific situations.
Social integration | Reference to social integration and social inclusion of transsexual people. Code with *social integration* references to inclusion within communities, family, work, or school.
Sterilisation | Rhetoric arguing for the idea that sterilisation should be a requirement within the gender recognition law. Or reference to the idea that true transsexuals are the ones that aspire to, or carried out, genital surgeries, and therefore will always abnegate their reproductive capacities.
Suffering | Mention of suffering, sadness or psychological distress within transsexual people. Code as *suffering* references to decreased mental health, such as depression or the theme of suicide.

Figure 2.1 Description of the themes and guidelines for coding

As shown in Figure 2.2, within dataset 2 direct quotations of the various social actors who participated in the public debate were analysed. This included all quotations in the media pieces within dataset 1 spoken by transsexual people, health professionals, LGBT activists, left-wing politicians and right-wing politicians. Dataset 2 also included quotations from the debate that occurred in the parliament (September 2010), the message from the Portuguese President when he vetoed the law (January 2011), and 4 press-releases from the main LGBT rights-organisation in Portugal (between January 2010 and February 2011). All quotations from the same individual in each media piece constituted a unit of analysis (n=96 units). In the same way, all quotations from the same individual within the parliamentary debate constituted a unit of analysis (n=8 units). The President's message, and each one of the press-releases, constituted a unit of analysis. In sum, the 109 units of analysis that comprised dataset 2 were quotations extracted from the media pieces and other official documents, organised in the

following way: 34 from transsexual people; 22 from health professionals; 21 from LGBT activists[6]; 21 from left-wing politicians; and 11 from right-wing politicians.

Media Pieces Dataset 1		**Quotations from different social actors** Dataset 2	
81 units of analysis	79 newspaper articles 1 magazine report 1 television report	109 units of analysis	96 quotes extracted from the media 8 quotes extracted from the parliamentary debate 1 presidential veto 4 press-releases

Figure 2.2 Data corpus

Within dataset 2, the units of analysis were very distinct from each other regarding the length and format of the text. For example, some of the units derived from the media pieces comprised one or two brief sentences, while others – such as the press-releases, the presidential veto or the extract from the parliamentary debates - were well structured and relatively long texts. Each unit of analysis in dataset 2 was analysed according to two dimensions: topics and CM. For the analysis of the topics, we used the list of 17 categories developed within dataset 1 and a similar process was carried out: each unit of analysis was coded with as many topics as the ones present in that unit and a score of 3, 2 or 1 points was attributed to each coded topic. Since some units of analysis within dataset 2 comprised short and few structured quotations, we did not find it suitable to classify each unit with the CM themselves. Instead, and whenever possible, each unit of analysis was coded with the CM most closely tied to it.

The analysis incorporated the following features from Consensual Qualitative Research (Hill, Thompson, & Williams, 1997). The authors consisted of a team of two primary judges and two auditors. Pairwise agreement among primary judges resulted in an 82.4% agreement rate. Consensus on all units of analysis and categorisation was achieved through discussion.

[6] The quotations from transsexual people identified in the media pieces as activists or representatives of LGBT organisations were coded as such.

5. Results

Dataset 1: Media pieces

Regarding CM, the majority of the units of analysis within dataset 1 were coded as diffusion (n=73), including the magazine and television reports. Five newspaper articles were coded as propagation; this included two opinion pieces, two regular newspaper articles, and one interview with a LGBT activist. The remaining were coded as propaganda (n=3), which included two interviews with health professionals, and a regular newspaper article.

Table 2.1. Total scores of the themes within dataset 1 (media pieces)

Theme	Total score
social exclusion/discrimination	103
genitalia	83
judicial vs. administrative	78
homosexuality	61
social integration	61
diagnosis	58
medical treatment	51
gender roles/expression	37
body	33
sterilisation	32
parenting/reproductive capacities	29
suffering	29
human rights	27
rigour	23
criticism to gender binary	13
irreversibility	12
conditional respect	7

Sixty-two of the 81 units of analysis were coded with one of the following themata: equality/inequality (n=26), justice/injustice (n=24), and masculine/feminine (n=12). The remaining were classified with the following themata: normal/abnormal (n=5), health/disease (n=5), nature/culture (n=4), freedom/oppression (n=3), moral/immoral (n=1), and simplicity/complexity (n=1). Table 2.1 shows the results concerning the scores of the topics within dataset 1.

The total score of each theme resulted in the sum of scores assigned to the topics in each of the 109 units of analysis. The two topics with higher scores within dataset 1 were *social exclusion/discrimination* and *genitalia*. The following themes also achieved higher scores: *judicial vs. administrative*; *homosexuality* and *social integration*.

Dataset 2: Quotations from different social actors

Table 2.2 shows the results concerning dataset 2. For the topics, the values refer to the total score that each group achieved in each topic. For CM, the values refer to the number of units of analysis coded with the CM they shared similar features with.

All quotations from transsexual people were derived from the media pieces. The topics with higher scores in those quotations were *social exclusion/discrimination* and *social inclusion*. Although this may appear contradictory, it means that transsexual people were quoted emphasising the fact that they are a highly discriminated, excluded and stigmatised population, but at the same time they were presented in the media within their familiar routines, with their friends or in their work environments. Quotations from transsexual people also focused on topics such as *gender roles/expression*, *genitalia*, and *body*. The majority of the transsexual people's quotations were classified as having similar features with the CM diffusion (n=27).

All quotations from health professionals were derived from the media pieces. Among the topics coded in those quotations, the one that stood out was *genitalia*. The topic *medical treatments* was also highly scored. Other topics coded within this group, and highly scored, were *rigour* and *diagnosis*. Most quotations from health professionals were classified as having similar features with diffusion (n=10) and propaganda (n=10).

Quotations from the LGBT activists were derived from the media pieces and from the press-releases. The topics with higher scores within this group were *social exclusion/discrimination* and *human rights*. On the whole, activists appear in the media and press releases speaking about transsexual people as a discriminated population, framing the issue within the human rights field. The topic *judicial vs. administrative* also stood out within activists' quotations. Most of their interventions were coded as proximate to the CM propagation (n=14).

Table 2.2. Themes and communicative modalities within dataset 2

	trans people	health professionals	LGBT activists	left-wing politicians	right-wing politicians
Themes					
body	21	13	0	0	1
conditional respect	0	0	0	0	9
criticism to gender binary	8	1	2	0	0
diagnosis	0	22	2	10	3
gender roles/expression	29	8	0	0	1
genitalia	25	40	2	1	1
Homosexuality	7	5	3	0	1
human rights	0	0	29	20	4
irreversibility	0	5	0	0	14
judicial vs. administrative	2	5	11	35	1
medical treatment	6	23	5	7	1
parenting/reproductive capacities	4	4	3	6	1
Rigour	0	23	0	5	16
social exclusion/discrimination	44	5	36	21	0
social integration	43	1	5	3	1
Sterilization	0	15	0	1	18
Suffering	32	8	2	6	6
Communicative Modalities					
Diffusion	25	10	5	2	1
Propaganda	0	10	2	0	9
Propagation	7	2	14	19	1

Note. For the themes, the values refer to the total score that each group accomplished in each theme. For the communicative modalities, the values refer to the number of units of analysis coded with the communicative modality with the most similar features.

Quotations from the left-wing politicians were derived from the media pieces and the debate in the parliament.The topics with higher scores for left-wing politicians were the same as those for activists, but in a different order: *judicial vs. administrative*, *social exclusion/discrimination*, and *human rights*. Likewise, most left-wing politicians' quotations were classified as having similar features with propagation (n=19).

Quotations from the right-wing politicians were derived from the media pieces, the debate in the parliament, and the Presidential veto. The most highly scoring topic

within this group was *sterilisation*. The topics *rigour* and *irreversibility* were also vastly scored. Most of the statements from right-wing politicians were classified as having similar features with propaganda (n=9).

For obtaining a joint examination of all variables within dataset 2, a multiple correspondence analysis (MCA) was carried out[7] in order to examine the relationships between the following three variables entered as active ones: the authorship of the quotations (who), the coded topics[8] (what), and the CM sharing the most similar features with the quotations (how). The MCA yielded two first axes responsible for 48.4% of the inertia (eigenvalue for the 1st dimension = 3.617; eigenvalue for the 2nd dimension = 3.157). The projection of the two dimensions is presented in Figure 2.3.

Dimension 1 was interpreted as representing the space between two antagonist positions regarding transsexuality and gender: one more conservative that proposes clear binary distinctions between gender and sex; and the other more liberal assuming that minority experiences of gender may led to social exclusion, discrimination and human rights' violations. Dimension 2 was interpreted as representing the space between two types of discourse: one more concrete focused on individual and idiosyncratic experiences; and the other more abstract attentive on collective experiences and on the universal nature of human rights.

Three distinct configurations emerged. The first one occupies the first and the second quadrants, and shows the topics most addressed by transsexual people and also the CM to which their quotations shared similar features with: diffusion. Transsexual people spoke about their lives and referred to personal experiences and concrete situations, thereby adopting a more concrete style. In this configuration we can find topics such as *social exclusion/discrimination*, *gender roles and expressions*, *homosexuality*, *body*, and *genitalia*. All categories within this configuration scored positively for dimensions 1 and 2, except the topic *social exclusion/discrimination*, which was negative for dimension 1. Transsexual people often reinforced, in the media

[7] This procedure allows one to analyse the patterning in complex datasets. The distinctive feature of this procedure is that it describes these patterns geometrically by locating each variable or unit of analysis as a point in a low-dimensional space, allowing for the construction of complex visual maps whose structuring can be interpreted.

[8] The following topics were excluded from the analysis, because their discrimination measures were inferior to the inertia of both dimensions and they did not add substantive value to the analysis: *parenting/reproductive capacities*, *criticism to gender binary*, *conditional respect*, *suffering*, and *medical treatments*.

pieces, the idea that women and men have oppositional bodies and express themselves through distinct gender roles or expressions - in what was interpreted as a more conservative approach to gender. The following quote was extracted from a newspaper article:

> Everything was there very early, since I was born. I have a picture with my twin brother in which I can see that clearly. We were only 2 years old and we were on the beach, holding hands, with a bucket and wearing similar swimsuits. The difference is in the way I hold the bucket, with the hands to the front. My hair was all brushed, and I was with my legs closed. (dataset 2, unit of analysis 5, transsexual person)

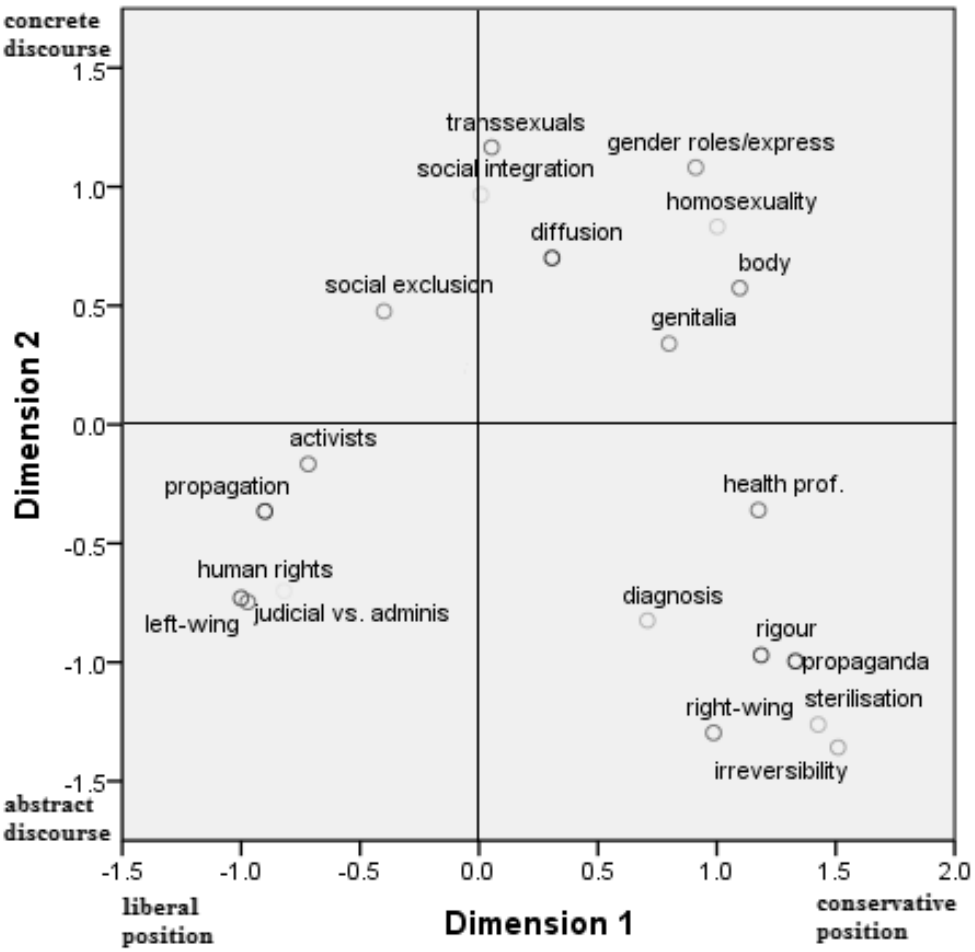

Figure 2.3. Projection of the first two dimensions yielded by the MCA

The second configuration occupies the third quadrant. It gravitates towards the CM propaganda, and puts health professionals and right-wing politicians together. Within this configuration we can find topics such as *diagnosis*, *sterilisation*, *rigour* and *irreversibility*. The fact that the two groups are positioned in the same quadrant, and interpreted as belonging to the same configuration, does not automatically mean that their discourses were exactly the same - although it suggests that they belong to the same semantic space. First, most health professionals positioned themselves in favour of the gender recognition law, while right-wing politicians were against it. Second, right-wing politicians had a more universal discourse in comparison to health professionals, as shown in Figure 2. Third, while right-wing politicians approached topics such as *rigour* and *sterilisation* within a legislative framework, health professionals did it on a clinical basis - although this only becomes clear with a detailed examination of the respective units of analysis.

For example, right-wing politicians are positioned close to the *sterilisation* topic because they argued for the inclusion of sterilisation as a requirement in the law - as illustrated in the following extract from the parliamentary debate: 'It is unreasonable to ask the community and the State that this person keeps all his female reproductive capacity when he publicly presents himself as a man' (dataset 2, unit of analysis 104, right-wing politician). Health professionals appear in the same quadrant as *sterilisation* because they frequently referred to the idea that true transsexuals are the ones that aspire to, or carried out, genital surgeries and therefore will always abnegate their reproductive capacities - as illustrated in the following extract from a newspaper article: 'What a transsexual, with the clinical diagnosis correctly done, will most want is to adapt his/her body to the gender that he/she has in the brain, and that implies a sterilisation' (dataset 2, unit of analysis 63, health professional).

The third configuration occupies the fourth quadrant, and gravitates towards the CM propagation. It puts together LGBT activists and left-wing politicians. All the categories within this configuration scored negatively on dimension 1, interpreted as a more liberal position regarding gender and transsexuality. Likewise, all the categories scored negatively for dimension 2, suggesting that the discourse of these two groups was characterised by an abstract approach - although this is truer for the politicians than for the activists. The discourse of LGBT activists also incorporated some concrete and idiosyncratic experiences of transsexual people, including those related to social exclusion and discrimination. Figure 2 shows that the link between the semantic space

occupied by transsexual people and the one occupied by activists and left-wing politicians is precisely the *social exclusion/discrimination* topic. The following quote, extracted from a press release, illustrates these features:

> The gender recognition law […] will simplify a process that requires the resource to courts, and will simultaneously tackle the social exclusion of transsexual people. Because these objectives seem to be consensual – and because the respect for Human Rights should be universal – we have been calling for the union of all the political forces to ensure the passage of this bill. (dataset 2, unit of analysis 107, LGBT activists)

The other two themes positioned within this configuration are precisely *human rights* and *judicial vs. administrative*. The former is illustrated in the following quote, extracted from the parliamentary debate: 'we are not here to trigger any type of conflict. […] Judges are called upon to fill a legislative gap. […] What we propose to you is that the legislator's silence ends through a non-judicial, simple, expeditious and fair mechanism' (dataset 2, unit of analysis 97, left-wing politician).

In sum, MCA identified three distinct configurations. Each one gravitated towards one of the three CMs and to different topics, related to particular social actors involved in the debate, and was interpreted as a particular semantic space.

6. Discussion

In this paper the public debate held in Portugal during the period preceding the implementation of the innovative law on gender recognition was analysed. We examined how social knowledge and representations on transsexuality and transsexual people were used, appropriated and (re)produced by different social actors. The study was conducted in light of SRT resorting to the concepts of anchoring, themata and CM. We examined the media coverage of transsexuality and the debate on the new law. Moreover, we scrutinised the particular features of the discourse issued by the main social actors that intervened in the debate: transsexual people, health professionals, LGBT activists, left-wing politicians, and right-wing politicians.

The media, including the press, can be a potent mediating system in the (re)production of social knowledge (e.g., Castro et al., 2012). The findings from the analysis of the media pieces - what we called dataset 1 - strongly suggest that the public debate on transsexuality and legal gender recognition was anchored within the broad notions of equality and social justice. The most frequently used themata were, respectively, *equality/inequality* and *justice/injustice*. The topic most addressed in the media was precisely *social exclusion/discrimination*. These findings are somewhat in line with the efforts of activists all around the world (e.g., GATE, 2012; TGEU, 2013), politicians (e.g., Hammarberg, 2009), and health organisations (e.g., APA, 2012; Coleman et al., 2011) in enrolling transsexual people's rights on the equality agenda. However, the approach and language used by the media was not necessarily and explicitly on civil and human rights, but rather on social exclusion and discrimination. The topic *human rights* was one of the less featured in dataset 1.

Simultaneously, the media also focused on the gender features that characterise the lives and experiences of transsexual people. *Masculine/feminine* was the third most scored themata. *Genitalia* was the second most addressed topic in the media. The sum of the scores obtained by the topics *genitalia*, *diagnosis*, *medical treatment*, *gender roles/expression*, *body* and *sterilisation* was much higher than, for example, the sum of the scores obtained by the topics *social exclusion/discrimination* and *human rights*.

It seems that, after depicting transsexual people as a highly discriminated group, the media turned the focus to the core of discrimination: gender. The so called transition processes were scrutinised, particularly in terms of biological and clinical features. The privileged position that the topic *genitalia* occupied suggests that the notion of gender was not distinct from the notion of biological sex. These results support the previous findings that social representations of transsexual people are being (re)produced within a discourse heavily dependent on biological and clinical language (Siebler, 2012), and in a way that reinforces the male/female binary (Willox, 2003). A possible consequence of the media's focus on the biological and clinical features of transsexual people's experiences, including the major focus on their genitalia, is the perpetuation of the popular assumption that a transsexual man is not truly a man, and that a transsexual woman is not truly a woman, because (s)he needs to transform him or herself into one (Serano, 2007).

Within dataset 2, transsexual people's discourse was interpreted as occupying a more conservative semantic space. This occurred not only because of the topics

addressed by this group, but also because of CM (Moscovici, 1961/1976a) to which their quotations presented the most similar feature with: diffusion. It is important to note that the reality of transsexuality is not essentially in opposition with gender binarism. Transsexuality may be understood as an experience or condition arising from the profound identification with one of the two categories that shape gender binarism, and not necessarily as an alternative identity to male and female (Pinto & Moleiro, in press; Wilson, 2002).

In general, and despite what was already said, the media coverage on transsexuality and legal gender recognition was characterised by a diversity of topics and by a general detachment in relation to the conflicts triggered in this domain. Most media pieces employed CM diffusion. Although the various opinions and positions were presented, the aim was to let the audience arrive at their own conclusions. This was somehow expected since all the media pieces analysed came from the generalist press (Moscovici, 1961/1976a). But the "battle of words" (Castro & Gomes, 2005) took place particularly in the political field involving different types of experts.

Discourses of resistance to change and innovation (Castro, 2012; Jensen & Wagoner, 2009) - in this case, contesting the change of the legal and/or medical procedures - were mainly (re)produced by right-wing politicians and health professionals. The discourse of these two groups emerged as belonging to the same semantic space. Both implemented a style with similar features to CM propaganda, and referred to topics interpreted as more conservative - that is, unfavourable to change. However, the form of the resistance of each group was unique. Right-wing politicians were against the innovative law, especially because it did not include a sterilisation requirement. On the contrary, health professionals positioned themselves, in most cases, in favour of the law. Their resistance was targeted towards the recent changes within the medical and clinical field, including the fact that the term transsexual is no longer restricted to people that desire or undergo genital surgeries (Coleman et al., 2011), and that transsexuality is not in itself a mental disorder (APA, 2013). The health professional's discourse can be understood as similar to the narrative of the wrong body, which was dominant in the medical field decades ago (Lev, 2004). This is somewhat alarming since these experts occupy a privileged position in the (re)production of social knowledge on transsexuality, through both their preponderant role in transsexual people's lives and experiences (Hines, 2007; Pinto & Moleiro, in press), and their privileged access to the public sphere and the media. However, it is

important to note that the quotations examined were the ones displayed by the media and they may not be representative of the overall discourse of these professionals. And the professionals that intervened in this debate most certainly may not be representative of all practitioners that provide health care to this population. Nevertheless, the findings are indicative of the relevance of studying how clinicians and health professionals position themselves regarding the paradigm shift on transsexuality and to understand patterns of resistance to new medical models. Moreover, further studies should focus on how the representations used by these professionals are linked to specific medical practices, as specific dynamics between representations and action can be more efficient in delaying or mining social change (Castro, 2012).

Left-wing politicians and LGBT activists were found to be the actors of a more liberal and favourable to change semantic space characterised by features similar to CM propagation. These groups adopted a more conciliatory position and articulated the conflicting positions around a nuclear and consensual notion: human rights. They addressed the gender recognition law as an evolution arising from the existing reality, and not as an absolutely new phenomenon as seen in the high score for the topic *judicial vs. administrative* within these groups. It is important to note that the style adopted by LGBT activists in the debate was not necessarily the expected one regarding intergroup conflict and identity dynamics (Staerklé et al., 2011). Although minorities often tend to implement a vigorous position and a propaganda style (Moscovici, 1976b), this was not the case for LGBT activists within this debate. Perhaps because the bill was presented by the government and its approval by the left-wing majority in the parliament was foreseeable. In fact, 'gender recognition laws around the world reflect the time periods and local contexts within which they were developed' (Open Society Foundations, 2014, p. 41).

Given the scarcity of studies on transsexuality's social representations, including the ones related to gender recognition laws, this study is pioneering. Although the findings may reflect the Portuguese context specifically, they are a significant contribution to the compression of the (re)production of social knowledge and representations on transsexuality and transsexual people. However, and precisely because of the lack of studies in this field, our results should be understood in an exploratory framework.

On the whole, the findings suggest that the analysis of the (re)production of social representations on transsexuality will always imply the examination of broad

representations of gender. As Serano (2007) points out, '[the] media coverage of transsexuals is informed by the different values our society assigns to femaleness and maleness' (p.47). There is most certainly a connection between the way we define the categories "men" and "women" and the way we produce social knowledge on transsexuality.

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3

(Trans)Gender Trajectories: Transsexual People Coming to Terms With Their Gender Identities

This chapter is based on the paper Pinto, N., & Moleiro, C. (in press). Gender Trajectories: Transsexual People Coming to Terms With Their Gender Identities. *Professional Psychology: Research & Practice.*

1. Abstract

If you are a professional psychologist, it is quite likely that you have already encountered a transsexual client, or will in the future. How confident are you in your ability to work successfully with this population? Research shows that therapists' knowledge of the specific challenges that transsexual clients have to face through the course of their lives may improve clinical care. The main goal of this study was to explore how transsexual people recognize, acknowledge, and come to terms with their gender identities. In-depth interviews were conducted with a diverse sample of 22 self-identified transsexual individuals (14 male-to-female and 8 female-to-male). The analysis conformed to the principles of grounded theory methodology. Results show the participants moving through five developmental stages: (1) Confusion and increasing sense of gender difference; (2) Finding an explanation and a label: exploring identity; (3) Deciding what to do and when: exploring options; (4) Embracing gender identity: performing a new social identity and undergoing body modifications; and (5) Identity consolidation and invisibility. Findings also highlight various internal and external conditions, action/interaction strategies, and psychosocial consequences that participants had to cope with in each stage. We also acknowledged a series of transition triggers: that is, particular events that facilitated movement from one stage to another. Implications for clinical practice are discussed.

Keywords: transsexual clients, gender trajectory, identity development, grounded theory, clinical competence

2. Introduction

Gender is probably the first feature that we notice when we meet someone new. Gender is omnipresent in our lives and defines most, if not all, social interactions. The dichotomy between women and men is a powerful one, probably one of the most powerful in western societies. Assigning the sex of a newborn, usually from a simple assessment of the genitalia, is often the first procedure after birth. However, later in life, people may realize that their sex does not match their gender identity: that is, the "person's basic sense of being male, female, or of indeterminate sex" (American Psychological Association [APA], 2009, p.28). So, what happens if the assigned sex at birth does not match someone's true sense of gender, which is the case with transsexual men and women? How can psychologists help transsexual people manage the incongruence between their sex and their gender identities? Widespread clinical knowledge about the challenges and specific events that transsexual people face throughout their lives may prove crucial for providing effective care to this population (Carrol & Gilroy, 2002; Lev, 2004; Raj, 2002). The main goal of this study is to explore how transsexual people recognize, acknowledge, and come to terms with their gender identities.

Transgender is an umbrella concept that describes different people who transcend society's traditional gender roles or expressions (Lev, 2004), such as transsexual and intersex individuals, or cross-dressers and drag queens/kings. Within the transgender spectrum, transsexual people are those whose gender identity is the opposite of the assigned sex at birth, and therefore "believe that their physiological bodies do not represent their true sex" (Lev, 2004, p.400). On the contrary, cissexuals are those whose gender identity is congruent with their assigned sex at birth. Despite the traditional medical definitions, nowadays the term transsexual is used regardless of which, if any, medical interventions one has undergone or may desire in the future (APA, 2009). Transsexual women are often referred to as male-to-female (MTF), and transsexual men as female-to-male (FTM). Even when referring specifically to transsexual people, several authors prefer to use the term transgender indiscriminately, likely for political reasons (Serano, 2007). In Portugal, the study's context, the term transsexual is broadly used, as it is in nearby countries (Platero, 2011). In this study the term transsexual describes "anyone who is currently, or is working toward, living as a member of the sex

other than the one they were assigned at birth, regardless of what procedures they may have had" (Serano, 2007, p.31).

Clinicians, and in particular psychologists, are often asked to help transsexual people who are coping with psychological distress and decreased mental health (APA, 2009). Anxiety, mood disorders, substance abuse, and suicidal behaviors (Budge, Adelson, & Howard, 2013; Maguen & Shipherd, 2010; Nuttbrock et al., 2010) can be related to internal conflicts regarding gender identity (Mizock & Fleming, 2011; Newfield, Hart, Dibble, & Kohler, 2006) and, simultaneously, to social stressors such as discrimination, violence, and stigma (Lombardi, Wilchins, Priesing, & Malouf, 2001). Therefore, clinicians may have a significant impact on the lives of transsexual people through mental health enhancement. This is even truer if we consider the therapist's role in guarding access to medical treatments, such as hormone therapy and surgery (Coleman et al., 2011). Gatekeeping can be a challenge for both clients and therapists (Bess & Stabb, 2009; Bockting, Robinson, Benner, & Scheltema, 2004). Thus, several authors and studies strongly endorse the need for psychologists to have competence in the effective support of transsexual clients, and, therefore, for accurate training in and knowledge about transsexuals' specificities (e.g., Carrol & Gilroy, 2002; Hendricks & Testa, 2012; Israel, Gorcheva, Walther, Sulzne, & Cohen, 2008; Raj, 2002).

Research on transsexual people's lives has focused on various issues and has taken different formats with different purposes in mind. Some studies have focused on particular aspects, such as mental health (e.g., Mizock & Fleming, 2011), family dynamics (e.g., Bethea & McCollum, 2013), the impact of community support (e.g., Lev, 2007), or work experiences (e.g., Budge, Tebbe, & Howard, 2010). At the same time, some studies have addressed transsexuals' identity growth through the course of life, focusing mainly on the so called "transition" and highlighting a series of developmental stages.

Transgender trajectories: Previous developmental models

Gagné, Tewksbury, and McGaughey (1997) studied the coming-out experiences of "masculine-to-feminine transgenderists" (p.478) and described four main themes of identity formation: early transgender experiences; coming out to oneself; coming out to others; and the resolution of identity. Devor (2004) studied transsexual identity formation and developed a model based on homosexual identity that shows the transsexual person moving through 14 stages, from abiding anxiety to pride. Lev (2004)

presented a model of transgender emergence which describes in detail six developmental stages that transgender people experience while they engage in conscious decisions regarding sex reassignment. The author also describes a series of therapeutic tasks that can guide therapists assisting transgender clients in each stage. More recently, Pollock and Eyre (2012) studied identity development among FTM transgender youth and identified three stages: a growing sense of gender; recognition of transgender identity; and social adjustment.

These models undoubtedly have their merits and may, in fact, be significant in improving competent and effective interventions with transsexual and other transgender people. However, not all of these proposals derive from bottom-up empirical research. Lev's (2004) model is based on clinical experience, and the one proposed by Devor (2004) was built upon a previous model of homosexual identity formation. Furthermore, not all of these studies and proposals address the unique experience of both transsexual men and women. The study developed by Gagné and colleagues (1997) comprised "transsexual, fetish and nonfetishistic cross-dresser, [and] drag queen" (p.483) participants. The model proposed by Lev (2004) refers to the experience of transgendered and transsexual adults, and Pollock and Eyre's study (2012) describes the experiences of FTM individuals. The present study focused on the specificities of transsexual men and women, and is the first of its kind developed in the Portuguese context.

3. Our Study

Context and Aim

We carried out an empirical study within a group of self-identified transsexual women and men. The study was developed and completed in Portugal, a country where research on transsexuality is still very scarce but where significant public attention has been given to transsexuality and transsexual people in recent years due to the approval of a gender identity law (Pinto & Moleiro, 2013).[9] The main goal of this study is to

[9] The new legislation allows transsexual people to change their names and legal sex in an administrative process, solely requiring the presentation of a supported clinical diagnosis by a multidisciplinary team of clinicians, including a psychologist. Actually, this means that people can change their names and legal sex without any imposed

explore how transsexual people recognize, acknowledge, and come to terms with their gender identities. Implications for clinical practice will be presented.

Participants

Twenty-two self-identified transsexual people participated in the study: 14 MTF and 8 FTM individuals. The participants' ages ranged between 16 and 55 (M = 31.81, SD = 11.81). All participants were Portuguese citizens. Most resided at the time in the two major Portuguese cities (or surrounding areas) of Lisbon and Porto, but six lived in or were from smaller towns or rural areas. Nine of the participants were working at the time in areas such as customer service, tourism, health services, data processing, or sex work; seven were unemployed; five were students in areas such as sports, psychology, or fashion; and one was a working student. The vast majority of participants presented themselves as heterosexual (i.e., they were physically and emotionally attracted to people whose gender is contrary to their self-identified gender), with the exception of two MTF participants who indicated that their sexual orientation was homosexual (i.e., they were attracted to women). Thirteen were at the time single, and nine were married or in a relationship. The group was diverse with regard to the state of transition progress: nine participants were, at the time of the study, fully living according their gender identities (and had completed some body modifications or changes in gender expressions); another nine were initiating or going through transition, and either undergoing some kind of body modification or alteration in gender expressions; and the remaining four, although identified themselves as transsexuals, were living socially according to the sex assigned at birth and had not started, during the study, any medical treatment in order to change their bodies.

Procedures: Data Collection and Analysis

Our data *corpus* was composed of in-depth interviews of 22 self-identified transsexual people. Participants were recruited through different channels. A brochure was developed and distributed to a lesbian, gay, bisexual, and transgender (LGBT) community center and also sent to public and private clinical settings where transsexual people may undergo gender oriented treatment. An electronic version of the brochure was sent to several LGBT associations and transgender support/activist groups, and

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medical treatment. This law is the "first European law on name change and legal gender recognition that meets the Yogyakarta Principles" (European Commission, 2012, p.72).

thereafter posted in their online channels. As data collection progressed, participants were also recruited through the social networks of past participants. The content of the brochure described the study's aims and procedures, and assured confidentiality. We explicitly mentioned in the brochure that the study was on transsexuality and transsexual people; nevertheless, it was specified that we recognized as a transsexual person anyone whose gender identity is not congruent with the assigned sex at birth, regardless of being in transition or not. All the interviews were conducted in person by the first author – a cissexual young adult male. Interviews took place in different locations, according to the participants' preferences: in a private office at the university, in the houses of the participants, or in public places such as malls or coffee shops. The interviewer explained the nature of the research before the formal interview, and any questions or doubts on the part of participants were answered prior to their signing a written informed consent form. Interviews lasted between 40 and 120 minutes. If necessary or appropriate, the interviewer provided participants with pamphlets from LGBT associations and transgender support groups, and the contact information of public gender health clinics at the end of the interview. All the interviews were audio recorded and transcribed later by the first author or by a research assistant. Any specific information that could lead to an easy recognition of the participant was not transcribed, in order to guarantee confidentiality. This study and all the methods employed were in line with the ethical principles of psychologists (APA, 2010; Ordem dos Psicólogos Portugueses, 2011).

Data collection and analysis followed the canons and procedures of grounded theory (GT) methodology. This research method is intended to develop an integrated set of concepts (i.e., a theory) that provide a detailed description of the social phenomenon under study (Corbin & Strauss, 1990). In GT methodology, data collection and analysis are interrelated processes: analysis must start as soon as the first piece of data is collected, precisely because it is used to direct the next data collection (Corbin & Strauss, 1990). Data collection took place between 2010 and 2012 and happened in three distinct phases: 9 participants were interviewed in the first phase, 6 in the second and 7 in the last one. Analysis followed each of the three data collection periods. Each data collection, but the first, was informed and directed by the previous analysis: while we started with broad interview guidelines, as the process of collecting/analyzing moved forward, more specific research questions emerged and directed subsequent data collection and analysis. The interview protocol was focused on the participants' current

experiences and, at the same time, on their life histories: childhood and adolescence, adulthood, family, significant others, school experiences, professional life, community support and involvement, health care, clinical transition, and legal recognition. The evolution of the analysis obeyed a core principle in GT methodology: constant comparison through processes of open, axial, and selective coding (Strauss & Corbin, 1990). We used the software MAXQDA 10 to assist the analysis. Sampling in GT proceeds on theoretical grounds: as the analysis progressed, we varied the sampling conditions in order to determine what the impact on upcoming analysis would be (e.g., in the second collection phase we intentionally tried to interview more FTM individuals, and in the third and last phase we focused on the testimony of participants who had already concluded, so to speak, their transition processes). The recruitment of participants ended when the analysis process reached saturation. Corbin and Strauss (1990, p.11) endorsed that "an important part of research is testing concepts and their relationships with colleagues who have experience in the same substantive area." We took advantage of feedback from colleagues on three occasions (respectively at the end of each analysis phase): two times with a small group of researchers working in areas related to diversity and mental health, and one time in a larger seminar with experts in transgender and transsexual experiences. When proved suitable, their comments and suggestions were incorporated in our study.

4. Results

Proceedings from analysis resulted in an integrated and related set of concepts, illustrative of the processes through which the participants recognized, acknowledged, and came to terms with their gender identities. The emergent theoretical model shows the participants moving through five developmental stages: (1) Confusion and increasing sense of gender difference; (2) Finding an explanation and a label: exploring identity; (3) Deciding what to do and when: exploring options; (4) Embracing gender identity: performing a new social identity and undergoing body modifications; and (5) Identity consolidation and invisibility. Each stage reflects a specific form of "gender identity management" the main category that emerged from analysis. Alongside the distinctive phases of these gender trajectories, we identified a set of internal and external intervening conditions, action and interaction strategies, and psychosocial

consequences (see Figure 3.1). In each stage, different conditions, actions, and consequences affected the ways in which each participant managed her or his gender identity. Action/interaction strategies (e.g., the search for clinical help) occurred under specific internal/external conditions (e.g., exposure to information on transsexuality), and were followed by psychosocial consequences (e.g., improved mental health). In their turn, these consequences could also impact conditions and action/interaction strategies.

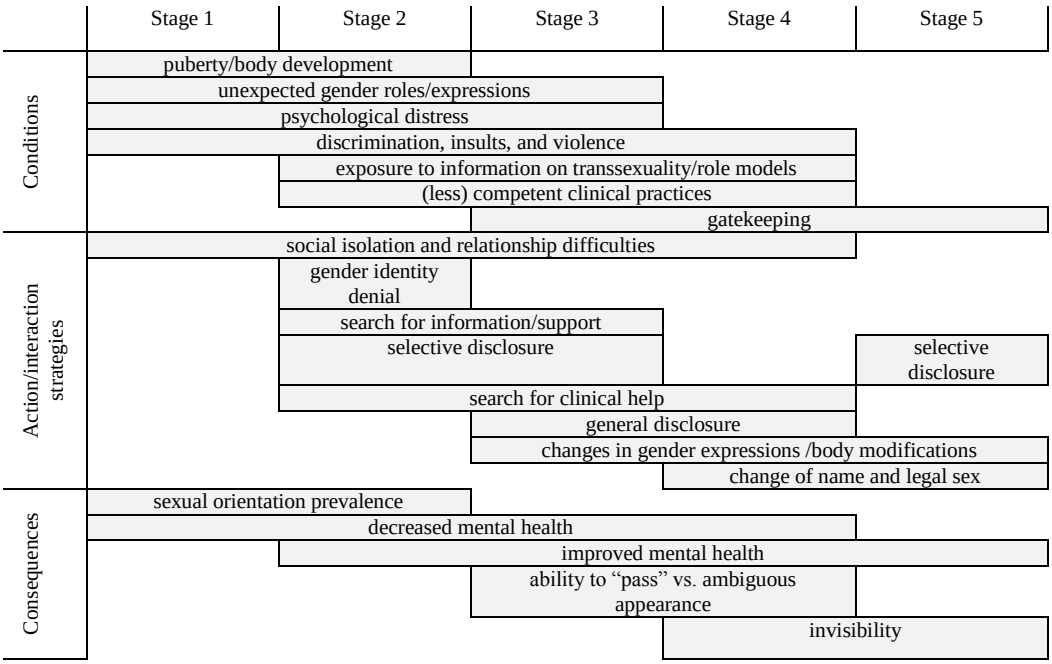

Figure 3.1. Gender trajectories: Conditions, action/interaction strategies, and consequences

We also identified transition triggers, which is to say particular events that facilitated movement from one stage to another. For example, "exposure to information on transsexuality" was found to be a possible trigger from stage 1 to stage 2. These events were not essential to progression through the stages but, when present, facilitated participants' movement to the subsequent stage. Figure 3.2 shows the main transition triggers. Naturally, participants did not imperatively move through the stages in the same way. Participants crossed the stages at different paces: some remained in the same stage for long periods of time, while others went through a particular stage very quickly.

Nevertheless, the emerged model stresses the commonalities in the participants' processes of developing an authentic self and coming to terms with their gender identities. The next section outlines the model in greater detail. All quotations include a pseudonym chosen for each participant.

Stage 1. Confusion and increasing sense of gender difference	
Transition triggers:	Exposure to information on transsexuality
	Access to internet or other information sources
Stage 2. Finding an explanation and a label: Exploring identity	
Transition triggers:	Positive transsexual role models
	Break event (e.g., divorce)
	Clinical diagnosis
	Context of acceptance (e.g., personal or clinical relationships)
Stage 3. Deciding what to do and when: Exploring options	
Transition triggers:	Break event (e.g., graduation)
	Change of context (e.g., job/city)
	Emotional breaking point
Stage 4. Embracing gender identity: Performing a new social identity and undergoing body modifications	
Transition triggers:	Constant recognition as a woman or man
	Genital surgery
	Legal sex change
Stage 5. Identity consolidation and invisibility	

Figure 3.2. Transition triggers: What facilitates movement through the stages?

Stage 1 - Confusion and Increasing Sense of Gender Difference

The first stage is about a growing sense of being different in a way not socially valued, and an increasing awareness that the difference is related to some kind of gender incongruence. This sense of difference is accompanied by a state of confusion and psychological distress: in stage 1 participants could hardly assign a satisfactory meaning to what was going on with them. The words of Andrew (FTM, age 19) concerning his childhood may synthesize the experiences of most participants in this stage: "I was sad, but I didn't know what was happening. I was not quite aware." When asked about their early phases of life, all participants described in some way a preference for gender expressions and roles socially ascribed to the opposite sex. Some alluded to personal memories or to events that parents or caretakers reported to them of their early childhood. This condition of unexpected gender roles/expressions was not necessarily

experienced as problematic by itself. Some participants lived in a relatively gender-tolerant way until their early teens, if their family dynamics and school environment were complaisant. Maria (MTF, age 19) reported that her preference for girls' toys and female playmates, and her identification with the female characters in TV shows were not a problem until the age of 10 because her parents did not make this an issue, although she later found out that her parents sought advice at the time from a psychologist. Nevertheless, for several participants, their gender expressions/roles were a source of problems in childhood, both in their school environments and families. Stories of bullying, insults, and even violence during childhood and adolescence abound in participants' life stories. Brenda (MTF, age 26) described that it was "normal" to her during childhood to play with dolls, until the day she was beaten by her dad and "began to be afraid."

For all participants, regardless of the degree of the problems they experienced in childhood, events related to body development were a challenge. The onset of puberty created or intensified the confusion about what was happening and the sense of gender incongruence. For most participants, body discomfort and gender incongruence, together with the difficulty of finding a satisfactory definition of their situation, were experienced in a dysphoric state of mind. Decreased mental health and significant psychosocial consequences were often reported, though in very different degrees. For some participants, body discomfort was particularly related to secondary sexual characteristics, such as breasts or facial hair, that explicitly announced them as female or male. However, body dysphoria could also be a serious issue. Paul (FTM, age 22) described the first experience of menstruating: "It was a very strange feeling, and so strong. That could not be happening! It was the realization that everything was wrong." Paul also mentioned that he cut himself in the face at age 16 as a consequence of his body discomfort.

For all participants, exposure to discrimination, both in school and in a family environment, intensified the sense of gender incongruence. Reproof, insults, and sometimes violence clarified that their difference was something unacceptable. Participants reported diverse consequences and coping strategies. Social isolation and difficulties in interpersonal relationships were common in participants' testimonies. Some spent much time at home, each experiencing his or her gender identity "alone, intimately, and not sharing it with anybody" in the words of Catherine (MTF, age 16). Some found partial relief by writing personal diaries, or by secretly performing

idealized gender expressions, namely through purging clothes. Stage 1 extended through adolescence or early adulthood, but rarely to later stages of life. During this phase, some participants had consultations with psychologists and other mental health practitioners (often under pressure from parents, or by referral from a teacher), but very rarely were gender identity or transsexuality issues addressed in therapy.

The vast majority of participants were physically and emotionally attracted to people whose gender is contrary to their self-identified gender. During stage 1, several participants thought of themselves and/or were perceived by others as gay or lesbian: in the absence of other plausible explanations, sexual orientation prevailed over gender identity. Some even came out as lesbian or gay to significant others; however, homosexuality failed to be a satisfactory explanation for their situation, and lesbian or gay was not a comfortable identity. In the words of Amanda (MTF, age 39), "I accepted myself as a homosexual at age 14, and I came out to my friends. I came out as homosexual at that time because, as I liked boys, I thought I was gay."

Stage 2 - Finding an Explanation and a Label: Exploring Identity

Stage 2 is essentially about finding that there is something called transsexuality and the exploration of that possibility for the self. Transition triggers from stage 1 to stage 2 were usually linked to exposure to some kind of information related to transsexuality. That happened in diverse ways for different participants. Cleo (FTM, age 20) stated that he began to put aside the assumption of being lesbian and to consider the possibility of being transsexual after seeing a series of television reports on transsexuality and the Portuguese gender identity law. Irene (MTF, age 21) described the occasion – when she was 13 years old – in which the school psychologist showed her a book about transsexual people. She referred to that day as the "day I discovered, the day I found the concept and ultimately who I was".

Seeking information and support was the main action/interaction strategy carried out by the participants in stage 2. Some plunged into internet searches, examining data on transgenderism, transsexuality, and gender identity, or exploring online narratives of other transgender people. Andrew (FTM, age 19) said that he read in an online forum "two life stories such as mine; could have been written by me." Some contacted LGBT associations or support groups in order to gain information and to encounter people in similar situations. Psychologists and mental health practitioners were also sought out at this stage by some participants. Richard (FTM, age 32) related that when he was 19

years old (and exploring the hypothesis of being a lesbian woman) he called an HIV helpline, then was forwarded to a LGBT support line, which gave him the address of a LGBT community center. Once there, he finally met a transsexual woman and "identified with everything she said."

For some participants, finding information on transsexuality and on the possibility of transitioning was an occasion of relief and mental health enhancement. They finally encountered a label for their experiences and realized that there were other people in similar situations. For those individuals, stage 2 was crossed very quickly in order to start the process that would allow them to be who they truly felt they were. On the contrary, for other participants the possibility of being transsexual appeared as something daunting. Some remained at this stage for longer periods of time, moving back and forth between engagement and avoidance of the possibility of being transsexual. This could last for days, months, or even years. During this phase, some deliberately tried to act and perform gender roles/expressions consistent with the sex assigned to them at birth. Meryl (MTF, age 51), who currently identifies as a lesbian woman, explained that she had considered being transsexual since she was a teenager, but, with no access to information, she "thought it was a crazy thing that would end." She got married with a woman and had a child, and only embraced her gender identity five years ago. Information about gender identity is currently much more widespread than it was in the past, and it is much easier to reach other transsexual people (through the internet and LGBT associations or support groups, for instance). Accordingly, younger participants crossed stage 2 in a gentler and faster way than older ones.

Stage 3 - Deciding What to Do and When: Exploring Options

In stage 3 participants had already personally accepted their transsexual situation but were evaluating strategies to manage their gender identity. Transition triggers from stage 2 to stage 3 were usually life events that allowed or endorsed that acceptance: getting to know a transsexual person perceived as a positive role model; having a significant and supportive relationship in which gender identity could be jointly addressed; being in the context of a clinical relationship that promotes acceptance; having a formal clinical diagnosis; or experiencing a break event, such as leaving the family home or a divorce. Accepting transsexuality does not automatically mean having a transsexual identity: most participants stated that they recognized themselves as women or men throughout their trajectories. For the great majority, acceptance of being

transsexual meant accepting a particular experience, not necessarily developing a transsexual identity. Stage 3 is essentially about deciding what to do (and when to do it) within that self-recognition. Lois (MTF, age 25) recognized, at the time of the interview, being a transsexual person, but was still considering options and timing. She stated: "I already know what I am. But, nowadays, I prefer to protect myself." During the interview she explained that she feared the impact that the transition would have on her mother: "It's very difficult, especially for parents, and I don't want my mother to watch such a process. I don't want to." She was considering the possibility of going abroad and transitioning in another country.

In stage 3 seeking information was still an important action strategy. However, this time the search was focused not on identity issues but on body modification possibilities, approaches for social transitioning, procuring doctors' names and contacts, or researching treatment outcomes. An important feature of this phase was selective disclosure: most participants had already come out as transsexual to carefully chosen significant others. Nevertheless, chance or the suspicion of peers or family brought others out. Maria (MTF, age 19) described how her parents found some of her hidden female clothes and read her private diary. The reactions of others to the disclosure of transsexuality was a significant factor incorporated in reflections about what to do and when.

Several participants were aware that therapists and physicians could be an important resource in the process of deciding what to do, so, for some, this was the moment to pursue clinical help. At this stage, some participants had regular contact with other transsexual people. They could have had an internet friend, or have joined a support group or an LGBT association. In any case, interaction and discussions were mainly focused on options, medical treatments, and strategies for successful transitioning. As in stage 2, exposure to positively perceived role models may have been decisive to proceed to the next stages. For some participants, the passage through stage 3 resulted in the delineation of a detailed plan, such as postponing the social transition until a graduation, or matching the adoption of a new social identity with an expected job change.

Some participants went through this third phase very quickly, especially those who spent a longer period of time in the previous stage exploring identity. Others remained in stage 3 for a considerable period of time, again moving between engagement and avoidance, but this time with regard to the possibility of transitioning.

Oliver (FTM, age 22) was in the process of struggling with these issues at the time of the interview: "I have to make a choice between going through a process of transition, and deal with all the professional, social, and familial consequences, or trying to continue living as I have done so far."

Stage 4 - Embracing Gender Identity: Performing a New Social Identity and Undergoing Body Modifications

The fourth stage of these gender trajectories was mainly about the so-called "transition." For most participants, the notion of transitioning was not necessarily related to changes or modifications of the self. Instead, it had to do with embracing who they always felt themselves to be. What changed in this stage was the way in which participants presented themselves to others (and consequently the way in which they were perceived) and, for the majority, their bodies changed as well. Transition triggers from stage 3 to stage 4 were life events that allowed or endorsed transition, such as graduation, becoming financially independent, changing jobs or schools, or relocating to another city. Also, some participants described reaching a breaking point in which it was no longer possible to live as in the past.

For those who were not already seeing a therapist, this was the ultimate moment to seek clinical help. However, to find a clinician knowledgeable in gender issues was not necessarily an easy task. Some participants made use of contacts provided by other transsexual individuals, while others resorted to their general practitioner. Andrew (FTM, age 19) went to a hospital emergency room. For some participants, encountering a clinician who was unskilled or unsupportive of their gender identity may have resulted in a halting of progress within the stage and, in some cases, in retrogression. Irene (MTF, age 21) was seen by a psychiatrist who told her that she was not transsexual and that the school psychologist who referred her was "foolish." For most participants, dealing with less competent clinical practices and undue gatekeeping was a huge barrier in this stage. Some stated that their clinical processes (which included the psychosocial assessment) were accurate and expeditious, but others described long periods of constant assessment that lasted, in some cases, for several years. This undue clinical assessment often had a negative impact on well-being and mental health. The strategy was, for some participants, to express a personal narrative consistent with what they believed the clinicians' expectations to be.

Some participants reached this phase having already done some body modifications on their own. Vera (MTF, age 33) was taking non prescribed hormones. Lois (MTF, age 25) used laser treatment to remove facial hair when she was still in stage 3. Body interventions that have a significant impact on appearance (and promote the ability to pass successfully as a man or woman) were generally the most desired ones. Hormonal treatment, both in MTF and FTM participants, and mastectomies in FTM individuals, generally resulted in improved mental health. On the other hand, dashed expectations regarding the treatment outcomes, coupled with comparisons with the achievements of others, had a negative impact on psychological well-being.

Stage 4 required a general disclosure. Those who had not yet come out as transsexuals to significant others had to do it in this phase. That represented, for some, a very painful and difficult task, postponed until the last moment. Vera (MTF, age 33) told her mother that she would have genital surgery two days before the intervention. Adapting a new social identity implied being out in all contexts, and often embracing strategies oriented to manage an ambiguous appearance. To be perceived as something in between, neither a man nor a woman, was very threatening to all. Several participants (who were already living full time according to their gender identities, independent of the treatments they had received) changed their names and legal sex in this stage. John (FTM, age 22) was in the early phases of hormonal treatment but already living socially as a man when he managed to change his documentation. He expressed his joy: "I was super happy. Oh my God, I had no words."

Stage 5 - Identity Consolidation and Invisibility

The boundary between stage 4 and stage 5 is difficult to assign. For some, living full time as a man or a woman (and being constantly perceived as that) marked the entrance into the last stage, despite the fact that they were still doing some body modifications. David (FTM, age 31) was already living full time as a man for several years, and was married and had a child at the moment of the interview, but was still considering adjustments in relation to body interventions. For others, genital surgery was essential to put an end to their gender trajectories. Although most participants desired to have, or had already had, genital surgery, their gender identities were not dependent on that decision. Meryl (MTF, age 51) decided not to have genital surgery. She explained that if gender is something defined by one's identity, she is "a woman, and had always been a woman." In stage 5 some participants who had already

transitioned in the past had to face gatekeeping again, in order to undergo the clinical diagnosis required to change their sex legally under the new law.

When asked how they identified themselves, the vast majority of participants answered "woman" or "man." Transsexuality was rarely addressed as an identity, but as a condition. In the words of Paul (FTM, age 22): "I'm a man. I never say I´m transsexual. Well, only sometimes, to explain to people. But I recognize myself as a man." Most participants struggled to pass successfully as a man or woman through their trajectories, and for several the invisibility of their transsexual experience was an achievement in stage 5. Despite the fact that few participants were out about their past (especially those who were activists for equality and civil rights), selective disclosure was again a strategy in the last phase: history of transsexuality was only revealed to a carefully chosen few.

5. Discussion

The primary goal of this study was to explore how transsexual people recognize, acknowledge, and come to terms with their gender identities. We interviewed 22 self-identified transsexual people, and reached a theoretical model through GT procedures. The model that emerged shows the participants moving through 5 developmental stages, and implementing action/interaction strategies and coping with a sequence of conditions and consequences at each stage. We also identified a series of transition triggers: that is, particular events that facilitated movement from one stage to the next. No discernable differences were found between FTM and MFT participants in relation to the 5 stages, and the respective action/interaction strategies, conditions, consequences and transition triggers. This model is not intended to be strict and prescriptive. As Cass (1998) outlined, identity development models of sexual and gender minorities are a western phenomenon. Clinicians must recall that "all human identities are impacted by the construction of particular cultural and social perspectives" (Lev, 2004, p.231). There are particular experiences that are unique to each individual, and any theoretical model would hardly capture in detail the complexity of human experience. Nevertheless, in GT the emerging theory becomes somehow predictive or transferable in the sense that if similar conditions occur it is possible that similar consequences arise (Strauss & Corbin,

1990). Thus, results of this study may inform practitioners and compel more competent and effective practices in the treatment of this population.

While most previously published models (Devor, 2004; Gagné et al., 1997; Lev, 2004) addressed the experiences of various people who fall into the transgender spectrum, our study focused on the specific experiences of transsexual men and women. Nevertheless, our results show important and various commonalities with previous studies, such as: the participants' vulnerability to psychological distress increases and mental health declines, especially in the early stages of their paths (Devor, 2004; Gagné et al., 1997; Lev, 2004; Pollock & Eyre, 2012); the exposure to accurate information on transsexuality is of vital importance (Devor, 2004; Lev, 2004), and so, too, are social support, namely the access to transsexuals' support groups and networks (Budge et al., 2013; Lev, 2004, 2007), and family support (Bethea & McCollum, 2013; Lev, 2004); and finally, physical and/or social transition has a crucial impact in the participants' lives (Devor, 2004; Gagné et al., 1997; Lev, 2004; Pollock & Eyre, 2012). In a manner similar to previous models, our results outline a general trajectory organized in developmental stages of people moving from an experience of distress and confusion to a state of (gender) congruence and identity consolidation. However, by stating a series of conditions, action/interaction strategies, and psychosocial consequences, and specifying transition triggers that are unique to each stage, our results may advance a more comprehensive overview of the experiences of transsexual people.

6. Implications and Applications

Our first and overall recommendation regards the need for accurate training in transgender and transsexual matters for clinical psychologists and mental health professionals. Results show that participants, and also their families, had consultations with psychologists and other mental health practitioners throughout their gender trajectories. However, those clinical encounters were, very often, missed opportunities both for clients and clinicians. Frequently, gender identity and transsexuality issues did not emerge in therapy or, when addressed, less competent practices were undertaken. The need for training mental health practitioners in the unique experiences of transgender and transsexual individuals is well documented by several authors (Bess & Stabb, 2009; Carrol & Gilroy, 2002; Hendricks & Testa, 2012; Israel et al., 2008).

We suggest that therapists explore a particular concept within the proposed model: the transition triggers. If adapted to the unique experiences of each individual, these particular events that facilitate movement from one stage to another may be addressed in therapy in order to promote progression. For instance, if a client is presumably in the first stage of confusion and increasing sense of gender difference, therapists should consider the client's exposure to information on transsexuality. In the next stage, related to identity exploration, therapists may consider assisting clients in finding positive role models, or in deepening significant relationships that can evolve into contexts of acceptance. If a transsexual client is already exploring options regarding social and physical transition, break events in life (such as graduation, changing jobs, or even a relationship breakdown) may be addressed in therapy as opportunities for progression in his/her gender trajectory. In the final stages, in which clients are embracing their gender identities, options regarding body modifications and, for instance, legal sex change (if that is a possibility) may be brought into therapy.

Therefore, the knowledge on the transition triggers can help therapists when working with transsexual clients. However, our results also show that each process is unique, even with the communalities identified within the participants' trajectories. Thus, and despite the fact that more advanced stages are associated to stronger psychological, physical and social wellbeing, we recommend that therapists use the transition triggers (the ones identified in this research, and others that can emerge in each individual case) with caution and respect to the unique pace of each client.

As a whole, our results strongly endorse the need for psychologists' advocacy for transsexual clients. More generally, fighting discrimination and stigma in family, school, and work environments, and spreading accurate information through mass media, may be a central role when working with the transsexual population. As Carrol and Gilroy (2002) have pointed out, therapists must "move beyond the goal of transforming the lives of transgendered clients to transforming the cultural context in which they live" (p. 240). Finally, results also align with previous findings (e.g., Bockting et al., 2004) related to how the therapist as gatekeeper may be, in fact, a significant barrier in the access to medical treatments. Some participants described several years of constant assessment and also difficulties in obtaining therapists' endorsement for legal recognition. Based on the study's results, we strongly recommend that therapists exercise the gatekeeper role with responsibility and respect for the transsexual person's autonomy.

7. Limitations

Although we interviewed a diverse sample of transsexual individuals, this sample may not be representative of all transsexual people, even within the Portuguese context. Transsexual people may be a population difficult to reach. The non-random bias of our recruitment strategy may have resulted in a sample of individuals who had generally positive attitudes toward academic research on transgender matters and, therefore, were more willing to participate. Furthermore, and despite the fact that peer consultation was done at different moments during the data analysis, it is important to consider that the main researcher and interviewer was a cissexual man. Even though there are no specific remarks to report, these interviewer statuses may have somehow conditioned the process of data collection.

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4

(Trans)Gender Diagnoses:

"I do not really see myself as someone with an illness, but I obviously need medical care"

This chapter is based on the paper: Pinto, N., & Moleiro, C. (under review). "I do not really see myself as someone with an illness, but I obviously need medical care": Addressing the complexity of (trans)gender diagnoses. *Feminism & Psychology*.

1. Abstract

This paper examines the concepts, main dilemmas, and possible paths related to (trans)gender diagnoses. Discourses about the so-called depathologization of transsexuality have been inconclusive, filled with mixed messages and polarized opinions. We first describe how controversies on this topic result mainly from: (1) the need to ensure access to health care provision for a population that has been experiencing serious challenges at this regard; and (2) the concern about reducing the stigma resulting from being diagnosed with a mental disorder - which can cause harm to this already highly stigmatized and vulnerable population. Arguments are supported by empirical data, comprising the narratives of 8 trans individuals (5 trans men/3 trans women). Participants' experiences of distress and impairment, their notions of mental illness and associated stigma, and their experiences in accessing trans related health care, were analyzed. It is argued that, for a better understanding of this debate, the following topics should be taken into consideration: (1) (trans)gender diagnoses constitute a deeply complex field, and carry with them the questioning of the very notion of mental illness; (2) limiting (trans)gender diagnoses to those who are distressed about living with a gender assignment they experience as incongruent with their gender identity may be advantageous, when compared to further options; and (3) stigma of mental illness is in itself an intervening part within this discussion, such as is a past of undue gatekeeping and difficulties in accessing medical interventions..

Keywords: transsexuality, diagnoses, depathologization, stigma, mental illness

2. Introduction

Mental health diagnoses that are specific to trans people are highly controversial. In the past few years there has been a vehement discussion among interested professionals, trans activists and human rights groups, concerning the reform or removal of (trans)gender diagnoses from the main health diagnostic tools. Such as in the case of homosexuality in the 1970s, some argue that is wrong and stigmatizing to understand expressions of gender diversity as mental health problems (Drescher, 2009). However, discourses on this topic have been inconclusive, filled with mixed messages and polarized opinions (Kamens, 2011).The complexity of the issue is well expressed by the lack of consensus both within trans-related activism (Vance, Cohen-Kettenis, Drescher, et al., 2010) and the professional community involved in trans health care (Ehrbar, 2010).

The discussion reached a high point during the recent revision process of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA). In the fifth edition of the manual (APA, 2013), the diagnosis of "gender identity disorder" was revised into one of "gender dysphoria". Although the changes – which included not only alterations in the nomenclature but also in the underlying criteria and in the diagnosis position within the DSM – were welcomed (e.g., Cuypere, Knudson & Bockting, 2010; Lev, 2013), there are voices arguing for the "ultimate removal" (Lev, 2013, p. 295) of gender dysphoria from the DSM. In fact, this diagnosis, as a psychiatric condition, is unique: it is deeply intricate with identity matters and its prevalent treatment in adulthood usually involves the hormonal and surgical alteration of a healthy body (Meyer-Bahlburg, 2010). Thus, it is highly likely that this discussion is only beginning, and that this issue will be again a hot topic in upcoming DSM revisions.

Nevertheless, attention is presently turned to the eleventh revision of the International Classification of Diseases (ICD), the standard diagnostic tool for epidemiology, health management and clinical purposes of the World Health Organization. Its revision process is ongoing and is expected to end by 2017. Various proposals concerning the revision of (trans)gender diagnoses within ICD have been made, both originating from trans and human rights groups (e.g., GATE, 2011; TGEU, 2013) and the health profession community (e.g., Drescher, Cohen-Kettenis & Winter, 2012; WPATH, 2013).

The aim of this paper is to examine the concepts, main dilemmas, and possible paths related to (trans)gender diagnoses. The analysis is supported by empirical data, which comprises the narratives of trans individuals about their gender trajectories. The focus of the discussion is on the diagnostic categories that refer to adolescent and adult trans individuals. Although the topics addressed in this paper may inform the discussion about diagnoses during childhood, that matter holds too much specificity and complexity which justifies a separate analysis (Drescher, 2013; Meyer-Bahlburg, 2010; Zucker, 2010). Likewise, this paper does not address transvestism-related diagnoses, even though these may affect people within the transgender spectrum. Transvestism entails distinct questions and is better addressed within the discussion about the conceptualization of paraphilias, and their possibility of being a type of psychopathology (Moser & Kleinplatz, 2005; Duschinsky & Chachamu, 2013).

A history of "assessing" (gender) identity rather than distress

Within the transgender[10] spectrum, transsexual people are those whose gender identity - the 'person's basic sense of being male, female, or of indeterminate sex' (American Psychological Association, 2009, p. 28) - is not congruent with the assigned sex at birth, and therefore are currently, or are working toward, living as a member of the sex other than the one they were assigned at birth, regardless of what procedures they may have had or aspire to have in the future (Serano, 2007). The term "trans", a prefix that has been transformed into a base word, has recently become popularized (Lev, 2004) as an alternative for transsexual.

Transgender people, and the possibility of transitioning between gender roles, always existed throughout human history and within distinct cultures (Lev, 2004). However, it was only in the last century that advances in medicine have offered trans people the opportunity to physically transition - via hormones, surgeries and hormone blockers more recently. In the 1950s, trans people were described as those who wanted to 'belong to the other sex and correct nature's anatomical 'error'' (Benjamin, 1953, p. 12). The term transsexual was restricted, for example, to individuals that desired or had undergone genital reassignment surgeries (Hines, 2007). The narrative of the "wrong

[10] Nowadays, "transgender" is an umbrella term which refers to behavior, appearance, or identity of persons who cross, transcend, or do not conform to culturally defined norms for persons of their biological sex (American Psychological Association, 2009).

body" emerged and has become the defining trait of transsexuality; that is, the desire, insistence, and obsession with body modification (Lev, 2004).

By 1975, the diagnosis of "trans-sexualism" (sic) was included for the first time in the ICD, within the sexual deviations category (Drescher, Cohen-Kettenis & Winter, 2012). And later, in 1980, the psychiatric diagnosis of "transsexualism" appeared in the third edition of the DSM, within psychosexual disorders (APA, 1980). Since their first appearances, these diagnostic classifications have changed various times (Drescher, Cohen-Kettenis & Winter, 2012) – not only their names – but also their criteria and placement within the two diagnostic guides. Despite the various revisions that occurred during the last decades, and at least for the DSM, the distress about one's assigned sex has remained the core feature of the diagnosis (Cohen-Kettenis & Pfäfflin, 2010). The changes in nomenclature from transsexualism to gender identity disorder in the DSM-IV (APA, 1994), and more recently from gender identity disorder to gender dysphoria (APA, 2013), line up with the assumption that (trans)gender diagnoses have to be a description of something with which a person might struggle - not a description of the person or the person's identity (Coleman, Bockting, Botzer et al., 2011). In contrast, the nomenclature used in ICD-10, including the diagnosis of transsexualism, still suggests that the core of the diagnosis is based on identity features.

Accordingly, and for decades, the mental health professionals' job was to sort out the "true" transsexuals from all other trans people. The former would have access to physical transition, and the later would be denied any medical intervention other than psychotherapy. By doing this, the professionals acted as gatekeepers and pursued to "ensure that most people who did transition would not be 'gender-ambiguous' in any way" (Serano, 2007, p. 120). Research shows that currently trans people still face serious challenges in accessing health care, including those related to inappropriate gatekeeping (Bockting, Robinson, Benner, et al., 2004; Bauer, Hammond, Travers, et. al., 2009). Some mental health professionals still focus on the assessment of attributes related to identity and gender expressions, rather than on the distress with which trans people may struggle (Lev, 2004; Hines, 2007; Serano, 2007). This is so that trans people may feel the need to express a personal narrative consistent with what they believe the clinicians' expectations to be, in order to have access to hormonal or surgical treatments (Pinto & Moleiro, in press). So, despite the various revisions of (trans)gender diagnoses within DSM, more recent diagnoses are still being used as if they were identical with the diagnosis of transsexualism – which was often used as little

else than a search for the "true transsexual" (Cohen-Kettenis & Pfäfflin, 2010). It is clear that social and cultural biases have significantly influenced – and still do – diagnostic criteria and the access to hormonal and surgical treatments for trans people.

Defining and classifying psychopathology

Consensus on the concept of psychopathology is, and has been over the years, hard to achieve. Different models and theoretical perspectives offer distinct explanations and definitions of mental disorder. For example, while the psychiatric and bio-medical model generally focuses on the underlying biological or medical causes, various psychological models tend to view psychopathology as caused primarily by psycho-social processes (Davis & Bhugra, 2004). Within the different models, distinct criteria may be used – and were used over time – to define exactly what kinds of behavior or symptoms fall within the concept of psychopathology, and therefore constitute a problem that should be considered suitable for support and treatment. Potential ways of defining psychopathology include: deviation from the statistical norm; deviation from social norms; exhibiting maladaptive behavior; and experiencing distress and impairment (Davey, 2008). Although each one of these criteria is problematic in specific and distinct ways, the latter is nowadays understood as particularly useful because describing psychopathology in terms of the degree of distress experienced by the sufferer, instead of the degree of deviation or maladjustment, is independent of the type of lifestyle chosen by the individual. In other words, defining psychopathology in terms of distress and impairment allows people – rather than mental health practitioners – to judge their own normality (Davey, 2008).

Different ways of defining and explaining psychopathology necessarily reflect different approaches for classifying it. Nevertheless, and while ICD is one of the most influential health classification systems, DSM has become the increasingly global reference for mental health diagnoses (Watters, 2010). One of the positive aspects that has been pointed to DSM is the fact that this classification system makes some attempt to rule out behaviors that are simply socially deviant, and puts the focus on distress and disability as important defining traits of psychopathology (Davey, 2008).

DSM is an evolving classification system that takes into account criticisms of previous versions and develops to incorporate recent research (Davey, 2008). In fact, during the latest revision various work groups were formed, including the Workgroup on Sexual and Gender Identity Disorders (Drescher, 2013). A vehement professional

and academic discussion on the revision of (trans)gender diagnosis within DSM took place (e.g., Cohen-Kettenis & Pfäfflin, 2010; Corneil, Eisfeld & Botzer, 2010; Cuypere, Knudson & Bockting, 2010; Ehrbar, 2010; Fraser, Karasic, Meyer & Wylie, 2010; Kamens, 2010; Knudson, DeCuypere & Bockting, 2010; Rachlin, Dhejne & Brown, 2010; Vance et al., 2010; Lev, 2013). Overall, the changes in DSM-5 addressed several of the primary concerns raised about the diagnosis of gender identity disorder as stated in the previous version, and the work group "has made a serious effort to respond to the criticism expressed over the years by both consumers and professionals in the area of transgender care" (Cuypere et al., 2010, p. 122).

Various criticisms have been directed to mental health classification systems. One of the most prominent has been about the fact that simply using DSM or ICD criteria to label people with a disorder can be stigmatizing and harmful (Link & Phelan, 2001; Davey, 2008). Being labeled with a mental health diagnosis may reduce access to the multiplicity of identity options that are available to people, because the diagnoses easily become "I am" conditions (Guilfoyle, 2013): "it is not, for example, that I experience eating related difficulties, or cut my arms, it is that 'I am' anorexic or borderline" (p. 86). Furthermore, mental disorders may be used to the detriment of diagnosed people, as it is the case of trans people: for instance, in child custody, employment, marriage and divorce, or serving in the military (Vance et al., 2010).

From a radical and anti-psychiatry position, some (e.g., Kutchins & Kirk, 1997; Szasz, 1974) have called for eradicating psychiatric diagnoses altogether, arguing that the idea of mental illness merely reflects existing social attitudes and prejudices and that classification systems are mechanisms of social control which fail to differentiate between mental illness and socially nonconforming behavior – as in the case of homosexuality until the 1970s. In fact, diagnosing mental disorders is an act of power which can be used to oppress and to engage in social control. Gender, for example, has always been a factor in mental health diagnosis and treatment, which has been used to obscure or amplify the psychological effects of sexism (Swartz, 2013; Ussher, 2013). Nevertheless, most mental health practitioners would hardly accept the line of reasoning arguing that mental illness is a myth (Drescher, 2009).

In this paper, we assume that mental health diagnoses are an important tool both for clinicians and researchers. They allow practitioners to make predictions about symptoms, treatments and outcomes. They provide a common language with which clinicians may communicate and document common problems, and researchers may

organize, conduct and communicate their efforts (Kamens, 2011). We agree with the idea that "diagnoses are neither a simple tool of oppression (although they sometimes are used oppressively), nor magical means of 'making things better' (although they sometimes are very helpful in bringing about change)" (Swartz, 2013, p. 42).

Controversies concerning (trans)gender diagnoses

As stated above, in the last years several trans activist groups and human rights organizations, and many individual stakeholders, have argued and lobbied for the reform and/or removal of (trans)gender diagnoses within DSM and ICD. For example, the international campaign Stop Trans Pathologization (STP), an international activist platform supported by groups and networks all over the world, stated in its manifesto (STP, 2012, para. 9) that "transsexuality's pathologization under the 'Gender Identity Disorder' is an extreme exercise of control and normalization'. The Global Action for Trans* Equality (GATE) claimed that "trans* people's experiences and needs have been historically pathologized, and that ongoing pathologization (…) limits trans* people's lives to dependence on a diagnosis" (GATE, 2011, p. 6). In 2009, the Council of Europe Commissioner for Human Rights (Hammarberg, 2009) argued that (trans)gender diagnoses "may become an obstacle to the full enjoyment of human rights by transgender people, especially when they are applied in a way to restrict the legal capacity or choice for medical treatment" (p. 24). The organization Transgender Europe (TGEU, 2013) stated: "the 'mental disorder' label reinforces psycho-pathologization driving stigma, making prejudice and discrimination more likely, and rendering trans people more vulnerable to social and legal marginalization" (p. 2).

Also mental health practitioners and academics in the field have been some of the most vocal in problematizing and expressing dissatisfaction with (trans)gender diagnoses (Kamens, 2011). Overall, mental health diagnoses which are specific to trans people have been criticized in large part because they enhance the stigma in a population which is already particularly stigmatized (Drescher, 2013). It has been suggested that the label mental disorder is the main factor underlying prejudice towards trans people (Winter, Chalungsooth, Teh, et al., 2009).

However, it needs to be noted that (trans)gender diagnoses constitute a significant dividing line both within trans related activism (e.g., Vance et al., 2010) and the health professionals' communities (e.g., Ehrbar, 2010). The discussion has taken place within the space between two opposite positions: (1) (trans)gender diagnoses

should be removed from health classifying systems, because they promote the pathologization and stigmatization of gender diversity and enhance the medical control of trans people's identities and lives; and (2) (trans)gender diagnoses should be retained in order to ensure access to care, since health care systems rely on diagnoses to justify medical or psychological treatment. It is also important to note that even within those who argue for the retention of the diagnoses, there is a broad consensus on the need for an overhaul of the name, criteria, and language to minimize stigmatization of trans people (Vance et al., 2010).

As described before, in the DSM's last version this question was solved by limiting the psychiatric diagnosis to those who are, in a certain moment of their lives, distressed about living with a gender assignment they experience as incongruent with their gender identity (Drescher, 2013). The change of criteria and nomenclature "is less pathologizing as it no longer implies that one's identity is disordered" (Cuypere et al., 2010, p.119). In fact, gender dysphoria is not a synonym for transsexual, nor should be used to describe trans people in general (Lev, 2004); rather, "is a clinical term used to describe the symptoms of excessive pain, agitation, restless, and malaise that gender-variant people seeking therapy often express" (Lev, 20014, pp. 9-10).

A different approach is expected within the upcoming version of the ICD. ICD-11 beta phase, a draft version of the revised classification open to input from multiple stakeholders, has already included proposals for revised (trans)gender diagnoses (GATE & STP, 2014). Regarding adolescents and adult trans individuals, the proposal includes two main changes: the reform of the diagnosis of transsexualism into one of "gender incongruence"; and the moving of the diagnosis to a separate chapter from the one on "mental and behavioural disorders". These changes were, generally speaking, welcomed by trans-related activism (GATE & STP, 2014; TGEU, 2014), in part because "not labelling trans people as mentally ill anymore will be an important step forward and will help to reduce stigma" (TGEU, 2014, para. 2).

3. The study: Trans people talking about (trans)gender diagnoses, mental health and access to medical care

The next sections explore specific extracts from eight narrative interviews with trans people. These interviews were extracted from the data corpus of a larger empirical

study, with which twenty-two trans people participated, and which aimed to explore how trans people recognize, acknowledge, and come to terms with their gender identities. The selection of the interviews to be analysed in this paper was not carried out in a random fashion. Instead, two main goals directed the selection: (1) the inclusion of participants who explicitly addressed topics related to (trans)gender diagnoses; and (2) the diversity in terms of participants' profiles and experiences, including sex assigned at birth, age, stage of transition, sexual orientation, occupation, and place of residence. The final group included 5 trans men and 3 trans women. Their ages ranged between 16 and 51 (M = 29, SD = 14.05). Six resided at the time in the two major Portuguese cities (or surrounding areas) of Lisbon and Porto, and two lived in smaller towns. Four were students, three were full-time workers, and one participant was unemployed. All but two presented themselves as heterosexuals. The group was diverse with regard to the state of transition progress: three participants were fully living as a member of the sex other than the one they were assigned at birth from some years (and had completed some body modifications or changes in gender expressions); two were going through transition, and either undergoing some kind of body modification or alteration in gender expressions; and the remaining two were living socially according to the sex assigned at birth and had not started any medical treatment in order to change their bodies.

Data collection occurred between 2010 and 2012, before the most recent changes within DSM. All the interviews were conducted in person by the first author, took place in different locations, were audio recorded and transcribed later by the interviewer or by a research assistant. Any specific information that could lead to an easy identification of the participant was not transcribed, in order to guarantee confidentiality. The study and all the methods employed were in line with the ethical principles of psychologists (APA, 2010). In order to inform the ongoing discussion in this paper, three main questions directed the analysis of the transcripts: (1) within the participants' trajectories, and regardless of the potential of these experiences fulfilling the requirements for a diagnosis on mental health, what kind of experiences can be understood as distress or impairment resulting from the incongruence between sex assigned at birth and gender identity?; (2) how did participants understand the notions of mental health and psychopathology, that is did the stigma related to mental illness shape those representations?; and (3) how did participants experience access to trans-

related health care, specifically did (trans)gender diagnoses intervene in that process? All quotations presented in the next section are attributed to fictional names.

Distress and impairment

All participants described experiences of distinguished suffering in various moments of their personal trajectories. Diana (trans woman, age 50) mentioned that she "tried to commit suicide 3 or 4 times throughout my life". In some cases, the suffering or distress was related as resulting from specific experiences of stigma, discrimination, or even violence. John (trans man, age 22) was adopted after birth and later in life he met his biological mother. He mentioned that at a certain moment his biological mother "was tired of this issue [transsexuality]. She said that it was a curse, it was this and that. The only thing she did not do was to beat me. I heard things that nobody expects to hear from a mother". John described how these experiences impacted his mental health: "after she treated me very badly, I started to cut myself". Claire (trans woman, age 16) has been a victim of bullying, including psychological and physical assault, since she was 10 years old. She described her response to bullying as "when that [the bullying] happened I became numb. It is something that really affects me. I become petrified". She also described how she became increasingly isolated at school.

However, in all the interviews we found descriptions of a specific type of distress resulting from the incongruence between sex assigned at birth and gender identity. Richard (trans man, age 20) mentioned a persistent embarrassment with his body since a very early age, consequently, he always wore loose fitting clothing in order to hide his female body. One day he decided to wear a female blouse that was a gift from his mother and "tears came to my eyes, I felt so claustrophobic inside that little blouse that did not match who I was. I do not know why I was doing that". He also described how a body that does not match his identity affected various spheres of his life, including sexuality:

> It's uncomfortable because I am not happy with the body I have. Even with masturbation it is as if I have to act. The following metaphor may help in explaining this: it is like I am in a place and my body is more or less a puppet or a doll, and that puppet is not the one I would choose for myself. Then I have to act in order to adapt that puppet in all situations. Sexuality turns out to be like this.

Claire also referred the impact that the body discomfort had in her social life: “I do not feel at ease with myself because of my body, and sometimes I have problems to get along with people in my daily life”. Adam (trans man, age 32) stated that “there are no words to describe the sensation of having a body that is not yours. A fat person may also believe that he/she has a wrong body, but in my case…I don’t know… it is more confusing”. He described a peaceful childhood which ended when his body started to develop “female shapes, [and] characteristics. Then the inner conflicts emerged. I went through a phase, when I was 15 years old, in which I thought I should die”. Charles (trans man, age 19) mentioned that his first experience of menstruating was “really bad, [because] when I told my mother and my sister they said ‘now you will become feminine’. Meanwhile, I stopped playing sports because I did not feel comfortable”. John also described his first menstruation: “It was a very strange feeling, and so strong. It could not be happening! It was the realization that everything was wrong”.

Moreover, participants detailed that the distress and impairment was not only related to body discomfort, but also to expected gender roles and expressions. George (trans man, age 22) indicated that, in his yearly teens, when he wore male clothes he “looked into the mirror and hated what I saw. I could not do it, basically”. Adam stated:

> To have a female name, having to interact socially with other people in a gender that is not mine, having to use the girls’ toilet… All that hurts. In a daily basis, it hurts a lot. It stars to hurt increasingly as you grow up. I had an inner conflict, quite depressing. I believed I should die. I never committed suicide because I had no guts.

Mental illness and stigma

Participants expressed various opinions and positions regarding the existence of (trans)gender diagnosis. John stated: “I prefer that [transsexuality] is viewed as a disorder. It is an illness. It is like any other problem for which there is a treatment; like cancer. There is a diagnosis, it is an illness”. When asked if he felt stigmatized for that, John answered “no, otherwise [transsexuality] would be only an option, a choice”. Like John, most participants did not referred to - or problematized - the distinction between diagnoses as descriptions of something with which the trans person might struggle in a certain moment, such as the distress, and diagnoses as descriptions of the person, the

person's identity, or the transsexuality itself. George, a psychology student, was the only participant that somehow made this distinction:

> If having a gender that is opposite to my biological sex makes me mentally ill? I do not think so. [But] the way I deal with that… I don't know. If it causes distress, yes. It should be treated. Absolutely, if it does not cause distress, the person is not mentally ill.

However, at the same time, he clearly stated: "I do not see myself as mentally ill" - despite the fact that he previously had described experiences of distress related to body discomfort and ascribed gender roles.

In fact, the discourse of several participants expressed a struggle with accepting the label "mentally ill" for their own selves. Some emerged into descriptions of their beliefs on the notion and causes of psychopathology – and related that with transsexuality. Richard was not sure if "transsexuality should be considered psychopathology". He mentioned that "some time ago, I read about a study, an experiment with rats, which made me think that everything is biological. If the cause [of transsexuality] is biological, it has nothing to do with mental illness". Diana referred that she believes that transsexuality has a genetic basis. Then she stated: "if a doctor can convince me, if a scientist can convince me, that a genetic alteration is a mental disorder, then I accept that I am mentally ill". She argued that the public discussion about the so-called depathologization of transsexuality should be focused on that specific argument. At the same time, she described how most people have difficulties in accepting being called mentally ill. Talking about the fact that she has been diagnosed with dyslexia in the past, Diana referred "I was never afraid of being called crazy, because I am not".

Stigma attached to mental illness shaped the narratives of several participants – even though they not always formulated that in an explicit manner. Susanne (trans woman, age 51) explained:

> Transsexualism is not a mental illness. A gender identity disorder implies that the gender identity is wrong. Gender identity is not wrong; it is the body that is wrong. It does not mean that I do not have anything… Because there are symptoms for everything; there are diseases for everything. I questioned

> myself, obviously. I reached the conclusion that all crazy people do: I'm not ill, the others are.

However, Adam addressed this question in very explicit terms:

> Illness is always connoted as a bad thing. But it does not have to be a bad thing. It is something that needs a solution, and there are medical solutions, right? I think it should be considered [a mental disorder], yes. Otherwise, we will not have access to medical care, right?

Other participants also expressed concerns related to the impact that the removal of (trans)gender diagnosis would have in access to medical care. Richard said that "after [the removal of (trans)gender diagnosis], it will not be covered by the national health care system, and this process is very expensive". For Diana, "transsexual people should not be going in a direction of which the consequence will be that only rich transsexual people will have access to treatments".

In sum, most participants resisted in accepting the label (mentally) ill for the self - although some have described experiences of severe distress. Nevertheless, the need for treatments and access to medical care was expressed by all. Claire's words summarized the struggle that various participants articulated in their discourses: "I do not really see myself as someone with an illness, but I obviously need medical care".

Access to (competent) medical care

In Portugal, the study's context, there are multidisciplinary teams that provide trans related medical care in various public hospitals. However, to have access to those clinicians, most people first need to be certified by their general practitioner. Participants described different experiences and challenges in accessing medical care. For some, the first challenge was simply to get through the primary health care providers, including their general practitioners. John expressed his concerns in having to come-out as trans to his general practitioner: "I did not want to ask my family doctor for the credential. He knows my mother, and at that time she did not know about me. And also because I know he has a lot of prejudices". He managed to get a direct appointment with a multidisciplinary trans expert team through a health professional he met in a public session about transsexuality. Charles, also because of difficulties in reaching his

general practitioner, decided to go to an emergency room. After that he was referred to a psychiatric unit.

Although we found communalities in participants' experiences as relates to health care provision, different participants experienced the provision of care by the multidisciplinary expert teams in different ways. Claire expressed satisfaction: "I think she [a mental health professional] is prepared for these cases. She really is. I was lucky with my doctor". Diana was attending a different hospital and she was also pleased with her health care providers: "Five stars. Everyone treated me very well and supports me in everything I need". However positive Diana was, at a certain moment in the interview, her words suggested difficulties related to gatekeeping. She mentioned: "even if I have to go to fifty doctors, I will find one who says 'yes, you are a woman'". Adam, in turn, explicitly related several years of continual assessment by his mental health practitioner:

> It took several years. I was going to the medical appointments and, once there, I felt I was not making any progress. I did not feel good about my psychologist. I think the encounters with her were not productive. My personal opinion is that she has some prejudices. She was repeating the same questions, appointment after appointment.

Also Susan described severe experiences of gatekeeping, in her case related to how her options on body transformations affected the clinicians' perceptions about who she was: "Rather than helping people, [health professionals] complicate. Rather than helping people in finding themselves, they are worried about knowing if you want to go through genital surgeries. If not, [they believe] you are not a transsexual". John described how he felt, at a certain moment, that his endocrinologist was intentionally hindering his access to medical care: "She was really suspicious of me, really. She scheduled the next appointment four months later. During all that time I was not feeling good but I could not start the hormones".

In sum, various participants described experiences felt as inadequate or undue gatekeeping, including the prolongation of their clinical processes during long periods of time. They often related this to practitioners' prejudices and misconceptions on transsexuality and gender dysphoria. However, no participant expressed disagreement with gatekeeping in general, rather with poor quality gatekeeping. Richard explained why he understands gatekeeping is necessary: "It is a process from which you cannot

come back. You have to be sure, right? It's irreversible, and it's an enormous responsibility to provide a treatment that involves changing the body in an irreversible way". It is important to note that, previously in the interview, this participant considered the possibility of placing (trans)gender diagnoses outside the domain of mental health. Thus, after his argument on gatekeeping, the interviewer asked who should be responsible for gatekeeping if (trans)gender diagnoses were to be revised to a medical condition other than mental disorders. Richard answered in a way that can be seen as contradictory: "I do not know if a psychologist, or some professional from psychology… I do not know if we will need a psychiatrist".

4. Discussion

The aim of this paper was to examine the concepts, main dilemmas, and possible paths related to (trans)gender diagnoses. Controversies related to the so-called depathologization of transsexuality result mainly from the need to simultaneously ensure: (1) access to health care for trans people – a population that has been experiencing for decades specific challenges when accessing health care provision; and (2) the reduction of the stigma resulting from being diagnosed with a mental disorder, which can cause harm to this already highly stigmatized and vulnerable population. Our analysis was supported by empirical data, comprising interviews to 8 trans individuals about their gender trajectories. The analysis of participants' narratives was focused on three main topics: (a) experiences of distress and impairment; (b) notions of mental illness and associated stigma; and (c) access to trans related health care.

Various stakeholders and trans organizations (e.g., GATE, 2011; STP, 2012; TGEU, 2013), but also health professionals (e.g., Lev, 2013), argued for the placement of (trans)gender diagnoses outside the field of mental health and, consequently, for its removal from DSM. Many trans people who do seek medical intervention would prefer being diagnosed with a medical condition other than a psychiatric disorder (Drescher, 2009). Our findings show that all participants experienced, at some point in their lives, distress resulting from the incongruence between sex assigned at birth and gender identity, voiced in a severe discomfort with the body and expected gender roles and expressions. The distress was associated with decreased mental health and impairment in social functioning. In other words, participants' experiences give empirical support to the existence of the concept of gender dysphoria – a clinical term used to describe the

symptoms of excessive suffering that trans people seeking treatment often express – and whose relief may be achieved through hormonal or surgical treatments (Lev, 2004).

In the course of history, the field of mental health has moved from cataloging deviant behaviors and ascribing said behaviors to historical events in people's lives, to adopting an understanding that those behaviors are not per se a hallmark of mental illness and may have organic and societal roots as well. As such the understanding of human behavior and the sources of behavior has changed, the definition of some behaviors as mental disorders was proved to be incorrect – such as in the case of homosexuality. Nowadays, it seems clear that defining homosexuality as an illness was incorrect mainly because homosexuality per se does not meet the empirical criteria for an illness (Drescher, 2009). On the contrary, the existence of gender dysphoria, a specific type of suffering that results in significant distress and impairment, that only trans people experience, and for which there are effective medical interventions, seems to be well documented (Coleman et al., 2011). Thus, why are many individuals, stakeholders, and organizations arguing for the removal of gender dysphoria from the main mental health classification system? Why would many trans people prefer being diagnosed with a medical condition other than a mental disorder – as expressed by the overall support that the upcoming diagnosis of gender incongruence within ICD is receiving? Our findings suggest that the following points may improve the understanding of the emerging dynamics and positions within (trans)gender diagnoses controversies: (1) (trans)gender diagnosis were used for decades as ways of "assessing" identity, rather than a patient's distress, and practices of undue gatekeeping are still a reality for many trans people; and (2) although one of the aims of most actors in this debate is to reduce the stigma associated with (trans)gender diagnoses, stigma of mental illness is in itself an intervening part within this discussion, such as are misconceptions about psychopathology.

First, trans people still face serious challenges in accessing health care, including undue and excessive gatekeeping (Bockting et al., 2004; Bauer et. al., 2009). Participants described experiences of inappropriate gatekeeping, including a focus on identity and gender expressions, rather than on distress. For example, the dated notion that if you do not aspire to undergo genital surgeries you are not a true transsexual person is still a reality among some gatekeepers (Coleman et al., 2011). Some mental health practitioners continue to focus on attributes related to identity and gender expressions when deciding if a trans person should have access to medical treatment

(Lev, 2004; Hines, 2007; Serano, 2007). In other words, more recent diagnoses - such as gender identity disorder or gender dysphoria – may still be used as if they were identical with the diagnosis of transsexualism (Cohen-Kettenis & Pfäfflin, 2010). By policing gender, mental health practitioners are excluding all those trans people who do not fit their personal assumptions about transsexuality from the access to medical treatments. As Serano (2007) explained, "by focusing so intensely on the transsexual's ability to 'pass' and conform to oppositional sexist notions of gender, the gatekeepers reduced the issue of relieving trans people's gender dissonance to a secondary, if not marginal, concern" (p. 123). Therefore, one should not be surprised if some trans people, activists and advocates do not see the field of psychiatry as capable of being an ally and therefore are demanding that diagnoses established on subjective distress and impairment to be placed outside the domain of mental health – even if that implies throwing out the baby with the bath water.

No participants but one referred to the distinction between diagnosis as a description of something with which the trans person might struggle with, and diagnosis as a description of the person, the person's identity, or transsexuality itself. Hence, it might not be enough to solve this debate by limiting the (trans)gender diagnoses to those who are distressed about living with a gender assignment they experience as incongruent with their gender identity – as it happened in the recent revision of DSM (Drescher, 2013). Mental health practitioners may also have to elucidate people about the meaning and the expected impact of the recent changes and, more important, to work towards building trustworthiness and credibility with trans people and their advocates. An accurate diagnosis may be a useful instrument (Swartz, 2013), but it still needs to be used carefully. Thereby, training mental health professionals on the most recent developments within (trans)gender diagnoses, and monitoring clinical practices and the gatekeeping role according the most recent international guidelines (Coleman et al., 2011) would be important steps.

Second, stigma related to mental illness is well documented (Link & Phelan, 2001; Davey, 2008), and it may be one of the main factors underlying prejudice towards trans people (Vance et al., 2010: Winter, et al., 2009). Accordingly, some intervening parts in this debate are arguing for the placement of (trans)gender diagnoses outside the field of mental health – which is the expected move within the upcoming ICD version. Nonetheless, participants' discourse also suggests that the stigma of mental illness is also an actor in this debate, shaping representations of psychopathology, and the various

arguments and positions. Even while describing experiences of severe distress - and arguing for the need for treatments and access to medical care - most participants resisted in accepting the label mentally ill for themselves. Some plunged into descriptions of their beliefs about the causes of transsexuality. As some have argued, if the cause is "biological or genetic, then we should not be talking about a mental disorder". In fact, what these participants were doing was to problematize and discuss the very notion of psychopathology. They emerged into a debate that has been going on for ages (Davey, 2008), and revealed that these diagnoses carry with them the questioning of the notion of mental illness. And it may be insufficient to argue that (trans)gender diagnoses should be placed outside the mental health field solely on the basis that people diagnosed with mental disorders are vulnerable to processes of stigmatization. In that line of reasoning, should "depressive disorders" or "trauma- and stressor- related disorder" be removed from DSM-5 because they put the diagnosed person in risk for stigmatization? Furthermore, mental health labeling practices not only expose people to stigma; they also limit people's access to alternative stories about themselves. In the words of Guilfoyle (2013, p. 91):

> Such a narrowing down of identity options should surely be questioned and problematized, but this restriction is not particular to DSM knowledge practices. This is what knowledge – not just DSM – does: it lends over to social practice by holding in place that which it describes.

Therefore, all intervening parts in the this debate should be aware that the arguments they employ may, in turn, reinforce the stigma of mental illness, and refer not only to trans people but to all people diagnosed with mental disorders.

In sum, controversies on (trans)gender diagnoses are a deeply complex field. Nevertheless, the discussion evolved into a point in which what is being questioned are the directions that the reform of the diagnoses is assuming (e.g., Cohen-Kettenis & Pfäfflin, 2010; Corneil, et al., 2010; Cuypere, et al., 2010; Ehrbar, 2010; Fraser, et al., 2010; Kamens, 2010; Knudson, et al., 2010; Rachlin, et al., 2010; Vance et al., 2010; Lev, 2013), not the existence per se of the diagnoses. Nowadays, it seems consensual that some formal categorization of people that experience conditions that require medical intervention is necessary as a prerequisite of clinical and scientific communication (Meyer-Bahlburg, 2010). Absence of diagnosis may have serious

consequences for people that need treatment (Swartz, 2013), especially in a population that has been facing serious challenges in accessing health care provision – not only in primary health care settings but also within practitioners that are experts in these matters – as showed by participants' stories.

This paper, and its arguments, may contribute to the discussion regarding the proposals for revised (trans)gender diagnoses within ICD. We argued that the changes proposed for the upcoming ICD version, which were welcomed by trans related activism (GATE & STP, 2014; TGEU 2014), may be driven by a history of undue gatekeeping and also by stigma involving mental illness. The announced changes are intended to be "more responsive to the needs, experience, and human rights of this vulnerable population" (Drescher et al., 2012. p. 575). However, there is no evidence that the diagnosis of gender incongruence will not be used in a similar way to the current diagnosis of transsexualism. In fact, because the proposed nomenclature of the new diagnosis does not focus on distress, rather on the condition of gender incongruence, the risk of regression is real: gender incongruence may be understood as an updated version of transsexualism, pathologizing people that are gender incongruent but do not experience gender dysphoria. Furthermore- as mentioned by one participant - even with the changes in ICD - gatekeeping will most probably continue to be performed by mental health practitioners. Once again, it will be crucial to train mental health professionals and to monitor clinical and gatekeeping practices according the most recent international guidelines (Coleman et al., 2011).

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5

GENERAL DISCUSSION

In Portugal, and because of the scarcity of studies in this field, we still lack an overall understanding on transsexuality and transsexual people. Accordingly, the general purpose of this thesis was to further the understanding not only about the experiences of transsexual people, but also about how different social actors construct the notion (and, consequently, the reality) of transsexuality. Three empirical studies were presented, covering a diversity of topics and therefore contributing to different spheres of knowledge and distinct levels of intervention. In this last chapter, we present an integrated and brief discussion in which the main contributions of our studies are summarized. Furthermore, possible implications of ours findings are described and linked to possible future directions when researching in the field of transsexuality and transgenderism.

1. Revisiting our research questions and the findings

This thesis was directed by the following specific aims: (1) to examine how social representations and social knowledge on transsexuality are used and developed by different social actors; (2) to explore the processes by which transsexual people come to terms with their gender identities, and to describe the main intervening actions and conditions; and (3) to contribute to the main current public debates related to transsexuality – including the debate on legal gender recognition and the one about the so-called depathologization of transsexuality.

How social representations and social knowledge on transsexuality are used and developed by different social actors?

Most of our contributions to this research question come from Study 1, in which we analysed the public debate held during the period preceding the implementation of an innovative law on gender recognition in Portugal. The findings suggest that the media depicted transsexuality and legal gender recognition within the broad notions of equality and social justice. The efforts of activists all around the world (e.g., GATE, 2011; TGEU, 2013), politicians (e.g., Hammarberg, 2009), and health organisations (e.g., Coleman et al., 2011) in describing transsexual people as a discriminated and vulnerable group, and consequently in enrolling their rights on the equality agenda, seem to be producing positive effects. A previous study in Portugal (Costa, Pereira,

Oliveira & Nogueira, 2010) found that transsexual people are perceived as a highly discriminated group. Our findings are in consonance with that claim, by showing that the media represented transsexual people as a target group of discrimination.

However, after depicting transsexual people as a discriminated group, the media turned the focus to the grounds of that discrimination: gender. The transition processes were scrutinized, particularly in terms of their biological and clinical features – and one particular aspect was central to this process: references to transsexual people's genitalia. These results support previous findings which suggest that social representations of transsexual people are being (re)produced within a discourse heavily dependent on biological and clinical language (Siebler, 2012), and in a way that reinforces the male/female binary (Willox, 2003). Moreover, a possible consequence of the media's focus on the biological and clinical aspects of transsexual people's experiences, including the major focus on their genitalia, is the reinforcement and perpetuation of the assumption that a transsexual man is not *truly* a man, and that a transsexual woman is not *truly* a woman, because (s)he needs to transform him or herself into one (Serano, 2007). This means that, while highlighting the fact that transsexual people are discriminated in several spheres of their lives, the media somehow reinforced or lined with the structural grounds of that discrimination by focusing on people's bodies (in particular on their genitalia) rather than on their gender identities or even their experiences.

References to transsexual people's genitalia also played a major role in how different groups and social actors used and (re)produced social representations of transsexuality in the public debate on legal gender recognition – and not only in the media but also in other spheres. This was particularly true for those social actors who manifested resistance to change and innovation: right-wing politicians and health professionals. For instance, right-wing politicians presented themselves against the law mainly because it did not include a sterilization requirement. In other words, right-wing politicians did not present any opposition towards legal gender recognition of those transsexual individuals who had carried out genital surgeries in the past – because those persons are necessarily sterile. Furthermore, a sterilization requirement would target mostly transsexual men: while transsexual women cannot get pregnant (although they can be biological parents when paired with cissexual women), transsexual men can – under certain conditions – get pregnant. In other words, social representations on transsexuality (re)produced by right-wing politicians were mostly grounded on

structural gender roles: if one wants to be legally recognized as a woman she may not have a penis, and/or she will not be a biological mother paired with other woman; if one wants to be legally recognized as a man he will not have a vagina, and/or he will not get pregnant. These positions may resemble the resistance towards same-sex parenting.

On the contrary, health professionals positioned themselves, in most cases, in favor of the law. However, during the public debate about the law they struggled in accepting the recent changes within the medical and clinical field, including the fact that the term transsexual is no longer restricted to people that desire or undergo genital surgeries (Coleman et al., 2011). Once again, when representing transsexuality, references to transsexual people's genitalia were favored over references to their gender identities and their personal experiences. In other words, transsexual people's identities were represented as dependent on choices regarding genital surgeries. Regarding the discourse of health professionals, one may ask the following questions: the resistance in representing people's identities and experiences is, somehow, related to power associated with gatekeeping? And, more particularly, how is this related to the change in the law – which translated in relative loss of power?

On the other hand, left-wing politicians and LGBT activists were found to be the actors of a more liberal and favourable to change semantic space. They addressed the gender recognition law as an evolution arising from the existing reality, and not as an absolutely new phenomenon. Moreover, and in contrast with right-wing politicians and health professionals, they did not claim that the access to legal gender recognition should be dependent on people's decisions regarding their bodies or parenting options. In other words, these actors did not police gender when representing transsexuality and transsexual people by making assumptions about what is the proper way to be a woman or a man. On the contrary, they disseminated social representations on transsexuality, gender, and legal gender recognition based on the notion of human rights.

Finally, transsexual people's discourse in the media was interpreted as conservative regarding gender: they spoke about their lives and referred to personal experiences, in most cases reinforcing the idea that women and men have oppositional bodies and express themselves through distinct gender roles or expressions. Thus, transsexual people were not necessarily dedicated to deconstructing gender roles and its boundaries. This finding is not necessarily unforeseen: as Wilson (2002) mentioned, transsexual people do "not want to be 'marked' by their difference and [do] not understand their gender in terms of a new category" (p. 427). Findings from Study 2

also suggested that transsexuality is rarely understood by transsexual people as an identity, but rather as a condition or an experience – which arises from the incongruence between identity and assigned sex at birth.

On the whole, our findings suggest that the analysis of the (re)production of social representations on transsexuality implies the examination of broad representations of gender. As Serano (2007) points out, '[the] media coverage of transsexuals is informed by the different values our society assigns to femaleness and maleness' (p.47).

What are the processes by which transsexual people come to terms with their gender identities, and what are the main intervening actions and conditions?

Most of our contributions to this research question come from the thesis' core study (Study 2), in which we examined how transsexual people recognize, acknowledge, and come to terms with their gender identities. In-depth interviews were conducted with a diverse sample of 22 transsexual individuals. Results show the participants moving through five developmental stages: (1) Confusion and increasing sense of gender difference; (2) Finding an explanation and a label: exploring identity; (3) Deciding what to do and when: exploring options; (4) Embracing gender identity: performing a new social identity and undergoing body modifications; and (5) Identity consolidation and invisibility. Each stage reflects a specific form of "gender identity management" - the main category that emerged from analysis. In each stage, different conditions, actions, and consequences affected the ways in which each participant managed her or his gender identity. We also identified transition triggers, which is to say particular events that facilitated movement from one stage to another.

In a manner similar to previous models (e.g., Devor, 2004; Gagné, Tewksbury & McGaughey, 1997; Lev, 2004; Morgan & Stevens, 2008), our results outline a general trajectory organized in developmental stages of people moving from an experience of distress and confusion to a state of (gender) congruence and identity consolidation. Moreover, several of the conditions, action strategies and consequences described are in consonance with findings from other studies. When referring to their childhoods, most participants described somehow a preference for gender expressions and roles socially ascribed to the opposite sex. Moreover, they referred to the onset of puberty as an overall challenge – and, for most, body discomfort and gender incongruence were experienced in a dysphoric state of mind. Decreased mental health and significant

psychosocial consequences were often reported, though in very different degrees. This is in accordance with previous studies that found lower levels of mental health, psychological well-being and quality of life of transsexual people, when compared to the average population (e.g., APA, 2008; Budge, Adelson & Howard, 2013; Dean, Meyer, Robinson et al., 2000; Newfield, Hart, Dibble & Kohler, 2006; Sánchez & Vilain, 2009).

Exposure to discrimination, insults and violence was identified as a condition crossing most of the five developmental stages. Episodes of exclusion and discrimination occurred in various contexts – including family and school. Not surprisingly, social isolation and difficulties in interpersonal relationships were common in our participants' testimonies. In fact, international research clearly shows that transsexual people are often victims of various forms of discrimination and social exclusion, including harassment, physical and psychological abuse, and economic alienation (e.g., Clements, Wilkinson, Kitano & Marx, 1999; FRA, 2014; Lombardi, Wilchins, Priesing & Malouf, 2001; Nuttbrock, Hwahng, Bockting et al., 2010). In Portugal, Saleiro (2013) identified significant barriers in school environment and in the access to employment.

Seeking information and support was one of the main action/interaction strategies carried out by participants. For some, finding accurate information on the possibility of transitioning, or getting to know other transsexual persons perceived as positive role models, was an occasion of relief and mental health enhancement. In fact, reaching out to other transsexual persons seems to be of vital importance for the development and accommodation of gender identity (Saleiro, 2013). Research shows that transsexual people's engagement with other people in similar situations is related to less fearfulness, less suicidality, and more comfort (Testa, Jimenez, & Rankin, 2014). Thus, transsexual people who are open about their transsexuality in the public sphere - including in the media - may be of vital importance for those searching for an explanation regarding their condition or for those exploring options concerning transition.

Moreover, personal engagement with other transsexual people is related to the ability to be honest regarding gender identity and to come out in public; and to the demand for support - not only emotional but also informational/educational (Hinnes, 2007b). This relationship may functions in both directions: transsexual people who are

out may be more willing to engage with other people in the same situation, and people engaged with other transsexual people may be more willing to come out.

For most participants, the notion of transitioning was not necessarily related to changes or modifications of the self. Instead, it had to do with embracing who they always felt to be: a man or a woman. Changes in gender expression and body modifications (resulting from hormonal and/or surgical treatments) resulted in improved mental health for most participants. Nevertheless, to find health practitioners knowledgeable about gender issues was not an easy task. Conversely, for some, encountering a clinician who was unskilled or unsupportive of their situation may have resulted in a halting of progress within a stage and, in some cases, in regression. In sum, for most participants, dealing with less competent clinical practices and undue gatekeeping was a huge barrier. In accordance with findings from other studies (Johnson, 2007; Lev, 2004; May, 2002), for some participants the strategy to deal with this barrier was to express a personal narrative consistent with what they believed the clinicians' expectations to be. Thus, our findings go in line with the substantial amount of research showing that currently transsexual people still face serious challenges in accessing healthcare provision, including those related to inappropriate gatekeeping (e.g., Bauer, Hammond, Travers, et. al., 2009; Bockting, Robinson, Benner, et al., 2004; Hinnes, 2007; Johnson, 2007; May, 2002; Pinto & Moleiro, 2012; Saleiro, 2013).

Most participants struggled to successfully be perceived as men or women (in accordance with their gender identities) through their trajectories, and for several the invisibility of their transsexual experience was an achievement in the last stage. In this phase, selective disclosure was a strategy implemented by most participants: history of transsexuality was only revealed to carefully chosen few. To be perceived as something in-between, neither a man nor a woman, was very threatening for all. In sum, Study 2 showed that being transsexual - this is, *experiencing* incongruence between gender identity and sex assigned at birth - does not automatically mean having a transsexual identity: most participants stated that they recognized themselves as women or men throughout their trajectories.

Besides the commonalities with previous studies and findings, our study is distinctive in various ways. While most previously published models (Devor, 2004; Gagné et al., 1997; Lev, 2004) addressed the experiences of various people who fall into the transgender spectrum, our study focused on the specific experiences of transsexual men and women. Additionally, and unlike our model, not all of these previous proposals

derive from bottom-up empirical research. Moreover, by stating a series of conditions, action/interaction strategies, and psychosocial consequences, and specifying transition triggers that are unique to each stage, our results may advance a more comprehensive overview of the experiences of transsexual people.

How our findings contribute to the public debates on (trans)gender diagnoses and on legal gender recognition?

Mental health diagnoses that are specific to transsexual people have been (and are still) highly controversial. In Study 3 we explored specific extracts from eight of the interviews (5 transsexual men and 3 transsexual women) carried out in Study 2. In order to inform the controversies and public debates on (trans)gender diagnoses, participants' experiences of distress and impairment, their notions of mental illness and associated stigma, and their experiences in accessing transsexual-related healthcare, were analyzed.

Our findings show that all participants experienced, at some point in their lives, distress resulting from the incongruence between sex assigned at birth and gender identity, voiced in a severe discomfort with their body, and expected gender roles and expressions. The distress was associated with decreased mental health and impairment in social functioning. In other words, participants' experiences give empirical support to the existence of the concept of gender dysphoria – a clinical term used to describe the symptoms of excessive suffering that trans people seeking treatment often express – and whose relief may be achieved through hormonal or surgical treatments (Lev, 2004).

Participants described experiences of inappropriate gatekeeping, including a major focus on identity and gender expressions rather than on distress. For example, the dated notion that if you do not aspire to undergo genital surgeries you are not a true transsexual person (Coleman et al., 2011) is still a reality among some gatekeepers. Some mental health practitioners continue to focus on attributes related to identity and gender expressions when deciding if a transsexual person should have access to medical treatment (Lev, 2004; Hines, 2007; Serano, 2007). Therefore, unsurprisingly, some transsexual people, activists and advocates do not see the field of psychiatry as capable of being an ally and, hence, demand that diagnoses established on subjective distress and impairment be placed outside the domain of mental health – as expected to happen in the ongoing revision of the International Classification of Diseases (ICD). At the same time, participants' discourses suggested that the stigma of mental illness is also an actor in this debate, shaping representations of psychopathology, and the various

arguments and positions. Even while describing experiences of severe distress - and arguing for the need for treatments and access to medical care - most participants resisted in accepting the label "mentally ill" for themselves.

In sum, we argued that, for a better understanding of this debate, the following topics should be taken into consideration: (1) (trans)gender diagnoses constitute a deeply complex field, and carry with them the debate on the concept of mental illness itself; (2) limiting (trans)gender diagnoses to those who are distressed about living with a gender assignment they experience as incongruent with their gender identity may be advantageous, when compared to further options; and (3) stigma of mental illness is in itself an intervening part within this discussion, such as is a past of undue gatekeeping and difficulties in accessing medical interventions.

With regards to the international public debate on legal gender recognition, findings from Study 1 suggest that processes of resistance in this field may be focused on the demand for transsexual people to abnegate their reproductive capacities or to carry out genital surgeries. As explained in previous sections, this demand is mostly grounded in structural gender roles. Thus, for those social actors who are advocating for legal changes in their national contexts (Open Society Foundation, 2014) - and in order to be successful - the main challenge may be the following: to represent transsexual people's experience as being part of the gender binary and, at the same time, to address the issue that transsexual people may in fact overpass what is socially expected - and biological possible - for cissexual men and women. For example, to explain and highlight the fact that transsexual people do identify and live as men or women and, simultaneously, address the fact that transsexual men can get pregnant and transsexual women can get cissexual women pregnant.

In this process, it may be advantageous for transsexual people's advocates to employ arguments grounded on consensual notions, such as human rights. In Portugal, LGBT activists and left-wing politicians were successful in getting an innovative law approved, by employing a conciliatory position in which they articulated the conflicting positions around a nuclear and consensual notion: human rights. Moreover, they addressed the gender recognition law as an evolution arising from the existing reality, and not as an absolutely new phenomenon.

2. General conclusions, implications and limitations

In this thesis we covered a variety of topics with the aim of contributing to different spheres of knowledge and various levels of intervention on transsexuality. The three studies that were presented are very diverse from each other. Although this diversity of topics was intentional, we recognize that it may carry some limitations and challenges – including the difficulty in laying down major, overall and integrated conclusions. Thereby, we will conclude this thesis with an exercise: to summarize in one sentence the main conclusions of our overall work. We have proposed to further our understanding not only about the experiences of transsexual people, but also about how different social actors represent transsexuality. Our findings may be summarized in the following way: transsexual people tend to be perceived and represented by others as gender transgressors, although their profound, felt and lived experience is not necessarily about transgression, but rather about achieving gender normativity. There is one topic in which social representations about transsexuality and the lived experiences of transsexual people are in accordance: the vulnerability of this population to discrimination and social exclusion. Apart from that, the combination of the findings from our different studies clearly suggests that there is incongruence between the way transsexual people are represented and their lived experiences.

Findings from Study 1 showed that the media focused on people's bodies (particularly on their genitalia) rather than on their gender identities, and that some social actors implemented processes of resistance towards the new law on legal gender recognition because the law did not include a sterilization requirement. The discourse of these social actors indicates that, for them, those transsexual persons who had not performed genital surgeries should not be recognized as real men or women. However, transsexual men and women are men and women *despite* (or even *in opposition to*) their biological bodies and sex assigned at birth (and not *because* of their bodies and sex assigned at birth). Thus, the media and some social actors were somehow pushing transsexual people to categories outside the binary female/male, this is, they were third-sexing the experiences of transsexual people – because, by focusing on people's genitalia rather than on their gender identities, some social actors reinforce the assumption that a transsexual man is not *truly* a man, and a transsexual woman is not *truly* a woman (Serano, 2007). Beyond our own findings, a closer look to the knowledge and depictions on transsexuality coming from different spheres (including the medical

field, academia/social sciences, and even activism) suggests that transsexual people tend to be perceived and represented as gender transgressor across various fields, with different consequences and implications.

As described in the various sections of this thesis, the work developed for decades in the medical field has a major role in shaping current representations of transsexuality and transgenderism (e.g., Hines, 2007; Saleiro, 2013). For decades, in this field, body ambiguity was not allowed: those people who did not desire or had not undergone genital surgeries were not seen as true transsexual (Hines, 2007), and they were often relegated to third-sex categories – such as "she-male" (Serano, 2007). Nowadays we know what helps one person relieve gender dysphoria can be very different from what helps another, and the process may or may not involve modifications in gender expressions or body changes – meaning that the term transsexual is no longer restricted to people that desire or undergo genital surgeries (Coleman et al, 2011). However, not only our findings (both from Study 1 and Study 2), but also findings from other studies (e.g., Bauer, Hammond, Travers, et. al., 2009; Pinto & Moleiro, 2012), suggest that health professionals still depict transsexuality not on the basis of people's gender identities and experiences, but on the basis of people's choices regarding medical treatments and body/gender expressions. In sum, in the health care field, transsexual people that, regardless of the reason, decide to maintain their original genitalia may still be relegated to third-sex categories, despite the fact that they identify as men or women. In fact, in the clinical field, the incongruence between representations of transsexuality and lived experiences of transsexual people is such that people may feel the need to express a personal narrative consistent with what they believe the clinicians' expectations to be – as found in Study 2. The consequences of this can be serious: by not having access to a medical diagnosis, people do not have access to medical treatment – including hormonal treatment or surgeries other than genital reconstruction. Moreover, it is important to note that accessing a diagnosis is not only crucial for accessing health care provision but, in some contexts (as is the case of Portugal), is also essential for accessing legal gender recognition.

Depictions of transsexual people as gender transgressors are not exclusive of the medical field: they are also common among social sciences. As described in the General Introduction, most academic work on transsexuality developed in the field of social sciences fall in one of the two approaches: one grounded on the idea that transsexuality is a medical invention (e.g., Billings & Urban, 1982; Hausman, 1995; Jeffreys, 1997;

Nanda, 2000; Raymond, 1979; Shapiro, 1991), and the other grounded on the idea that transsexual people are - or should be - a transcendence of the very notion of identity (e.g., Missé & Coll-Planas, 2010). In the first case, transsexual people are reprehended because their transgression is seen as a reinforcement of gender norms; in the second case, transsexuality is applauded because of the opposite reason: since it defies gender norms. Thus, although distinct and apparently oppositional, they share a common feature: they overshadow the profound, intrinsic and immutable nature of transsexual people's basic sense of being male or female – this is, their gender identities (Serano, 2007). Likewise, most studies in the field of social sciences regarding transsexuality, including the ones that are not aimed to study transsexuality in itself but specific aspects of transsexual people's lives (e.g., the impact of discrimination, the so-called transition processes, mental health, etc…), tend to represent transsexual people not as men and women who happen to have been assigned to a sex incongruent to who they are, but as people who transgress the categories men and women. When academics refer to transsexual people using expressions such as transgendered, trans* people, MTF, FTM, s/he, transgender identity, transsexual identity, or even transsexual men and women (as we do in this thesis) we are – again – overshadowing transsexual people's basic sense of being male or female. As Serano (2007, p.148) points out:

> As a Western transsexual, I may identify squarely within the male/female gender binary if I want, but once other people discover my transsexual status, they usually start slipping up on pronouns and referring to me as MTF, boy-girl, s/he, she-he, or a she-male. In other words, people try to third-gender me.

However, in contrast with this general tendency to portrait transsexual people as gender transgressors, and as described before, findings from Study 2 suggest that transsexuality is not necessarily an experience of transgression, rather an experience aimed to achieve gender normativity. To be perceived as something in-between, neither a man nor a woman (this is, to be perceived as a gender transgressor or as a third-sex category), was very distressing for all participants. Moreover, the findings suggested that being transsexual does not automatically mean having a transsexual identity: most participants stated that they recognized themselves as women or men throughout their trajectories, according to their gender identities. Moreover, in Study 1, when talking in

the media pieces about their lives and personal experiences, transsexual people often reinforced the idea that women and men have oppositional bodies and express themselves through (constructed) distinct gender roles or expressions - in what was interpreted as a more conservative approach to gender. In fact, transsexual people do not necessarily understand their gender as a new category (Wilson, 2002), regardless the choices that they may do concerning their bodies and gender expressions. As one participant in Study 2 explained (when justifying the fact that she decided not to have genital surgery), if gender is something defined by one's identity, she is "a woman, and had always been a woman".

Regarding this incongruence between transsexual people's lived experiences and the way they are represented and portrayed, some implications must be addressed – most regarding language usage. First, we need distinct terms to talk about different realities. In this thesis we are analyzing the experiences of transsexual people, so we use the expressions "transsexual women" or "transsexual men" to make it clear that we are not referring to cissexual women or cissexual men (this is, people whose gender identities are congruent with the sex assigned at birth). Other authors may do different and valid choices. Nevertheless, it is important to note that, when researching in the transgender field, we find crucial to always make it clear to whom and to which realities we are referring within the transgender spectrum. The experiences of transsexual people, intersex people, genderqueers, cross-dressers, "masculine" women and "feminine" men, may be very distinct from each other – and some of these people may, in fact, identify as gender transgressors or outside the male/female binary, although this is not necessarily the case of transsexual men and women. However, several studies fail in clarifying which particular experiences they analyze and to whom they are referring. For instance, the study of Gagné and colleagues (1997), which we mentioned in Chapter 3, analyzed the coming-out experiences of "masculine-to-feminine transgenderists". However, a closer look to the sample reveals that it enclosed "transsexuals", "fetishistic cross-dressers", "nonfetishistic cross-dressers", "radical transgenderists" and "third-gender" people. Analyzing the experiences of all these people altogether may result in portraying all as gender transgressors. Although we recommend future research to be attentive to this question, we recognize that it may be a challenge for several reasons – including the fact that people may use different terms to refer to themselves in distinct moments of their lives, and also that the terms used by academics are not always in consonance with the language that people use to describe their experiences

(Saleiro, 2013). For example, in this thesis we use repetitively the expressions "transsexual women" and "transsexual men", although most participants in Study 2 stated that they recognized themselves as "women" or "men" (according to their gender identities) throughout their trajectories. Moreover, labeling and categorizing people encompasses a risk of essencialization, this is, a risk of explaining individual differences on the grounds of inherent, biological, or "natural" characteristics shared by people within the same category.

Second, the expression "gender identity", as used repeatedly in this thesis and as in various fields (e.g., academia, activism, politics) when referring to transsexuality, is worthy of some reflection. There is an extensive amount of literature and research in the field of social sciences on identity, and we will not go into it in detail in the last reflections of the thesis. Nevertheless, an identity is something that necessarily depends on the context or, in other words, is something that is learned and socially constructed – regardless of its degree of fluidity. However, transsexual people usually refer to the fact that they are women and men in a way that can be best described in terms of intrinsic inclinations. This was clear in Study 2. For example, one of the conditions which we identified in Stage 2 was "gender identity denial", referring to the fact that some participants deliberately tried to act and perform gender roles/expressions consistent with the sex assigned to them at birth. These intrinsic inclinations are something that transsexual people can hardly escape, even if they intentionally try to do it, or, in other words, something that is given to them, or something that they do not choose. This inclinations could be better described as "gender orientation" (Williams, 2013) or, as Serano (2007, p. 27) suggests, "subconscious sex". In this perspective, gender identity would be an identity that someone develops within the space between sex assigned at birth and her or his gender orientation – and this would apply to both transsexual and cissexual people. In this sense, the title of Chapter 3 would be more accurate if formulated in the following way: "(Trans)gender trajectories: Transsexual people coming to terms with their gender orientations". To better express our point, a comparison with sexual orientation may be helpful: feeling attracted to women, men, or both is not in itself an identity, but an orientation; however, people who are attracted to same sex people, or to both sexes, may develop an identity as lesbian, gay or bisexual. In our perspective, and as a final reflection arising from the work developed in this thesis, we recommend future research on transsexuality to be attentive to this distinction between orientation/intrinsic inclinations and identity. This may be of crucial

importance within the debate that is now beginning in academia and in the clinical field regarding interventions with young transgender children (e.g., Drescher, 2013).

In brief, studies and research in this field may benefit from analyzing the overall tendency to depict and represent transsexuality in terms of gender transgression and not in terms of gender normativity. How may this incongruence result from a difficulty of most people (regardless of being health professionals, social academics, politicians and decision-makers, etc…) to accept and recognize transsexual people as real women and men? Are we ready to embrace the idea, endorsed by the ongoing paradigm shift in the medical and clinical field (Coleman et al., 2011), that one's gender depends on his/her gender identity (or, perhaps, gender orientation?) and not on body features, such as genitalia? Are we truly capable of recognizing a transsexual woman that maintains her male genitalia as a real woman? Or, are we truly capable of recognizing a pregnant man as a real man? Moreover, how do transsexual people's intrinsic inclinations challenge the common claim – including in social sciences and in feminism/LGBT activism – that gender is a social construction? Is transsexuality being addressed in a way that conveys a broad agenda regarding gender but that may not be an accurate representation of transsexual people's experiences? For instance, in our perspective, and regarding the public debate about the so-called depathologization (addressed in detail in Chapter 4), studies should reflect on to which extent the existence, or not, of (trans)gender diagnoses is being used – including within LGBT activism – to give voice to more general and broad criticisms regarding medical practices and classification systems.

In sum, research focusing in the relationship between social representations and identity (e.g., Moloney & Walker, 2007) could be extended to the field of transsexuality: how is the general tendency to represent transsexual people as gender transgressors – and not as real women and men – shaping the way people identify and express their gender orientation? Are we pushing (all) people who have a gender identity (or, gender orientation?) incongruent with the sex assigned at birth (and, therefore, could identify as transsexual men and women) to third-sex categories? For instance, the various self-identifications within the transgender spectrum that Saleiro (2013) mapped and described in Portugal may reflect the dynamics between identity and social representations and, in some cases, refer to people who, in different conditions, would identify and live as (transsexual) men and women.

To conclude, we should highlight that, besides the specific limitations indicated in each chapter, in studies 2 and 3 we used a relatively small sample and qualitative

methods. Future studies may benefit from using larger samples and quantitative methodologies – although this may be a challenge in the transgender field.

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