A PHILOSOPHICAL EXPLORATION OF TRANSSEXUALITY

by

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ABSTRACT

This thesis has two aims: First, to demonstrate that there is in the current medical model of transsexuality conceptual incoherence. Second, to establish an alternative model for understanding transsexuality: the model of authenticity.

The current medical model is based on an assumption that the sexed body and gender identity are distinct, so that gender is different to sex, which forms the basis of transsexuality. The tension in transsexuality between sex and gender gives rise to suffering. Surgery unifies sex and gender and is offered as the humane response.

It is this move from separation to unification of sex and gender that constitutes the conceptual incoherence in the current medical model.

Suffering is then explored as a potential justification for surgery. It is argued that it is not obvious that suffering must be alleviated. Indeed, suffering may be valuable, and where this is the case there is no moral imperative to remove it. So, whilst there is a serious moral duty to respond to suffering there is no absolute duty to alleviate it.

An alternative model is then explored. A model of authenticity, which can replace the medical model, better enables the freely chosen identity and goals of the transsexual to be respected, without compromising the ends of medicine.

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INTRODUCTION

The Problem

In the current medical model of Transsexuality (TS), (also known as Gender Dysphoria (GD) or Gender Identity Disorder (GID)), a distinction is made between sex and gender. This is necessary for the condition to be a rational possibility. At the same time TS is resolved by means of sex and gender alignment. This is seen as the proper end of treatment by both the medical and transsexual communities.

The first aim of this thesis is to argue that a model founded on a sex/gender distinction and terminating in sex/gender alignment is conceptually incoherent. The second aim is to demonstrate an alternative model, the model of authenticity, and to work out its implications. In order to establish both aims the thesis will be laid out in the following way.

This Introduction will provide both an outline of the condition, focussing on the current classification of TS and on its clinical history, and provide a list of the current guidelines, codes of conduct and practices as defined by The World Professional Association for Transgender Health Inc (WPATH), formerly known as The Harry Benjamin International Gender Dysphoria Association (HBGDA). WPATH has formal responsibility both for the current medical understanding of TS and for professional regulation. A sixth version of their Standards of Care (SOC) was produced in 1998 and replaced all previous standards. The Association's philosophy of care aims:

> to provide flexible directions for the treatment of gender identity disorders.[1]

Chapter One will locate TS within current models of sex/sexuality and gender before discussing in greater detail the problem with that model as outlined above. Chapter Two will apply those models to TS ending with an interim conclusion that they are an inadequate justification for the current therapeutic management of TS. In Chapter Three an alternative justification for the existing treatment regime will be sought, that focuses on the suffering of the transsexual individual. It will address whether suffering alone can be thought to justify the current medical management of transsexual people. It is argued that suffering cannot be regarded as sufficient justification. An alternative model of Authenticity will be proposed in Chapter Four, which seeks both to meet the objections raised in the discussion of existing models and to provide a coherent justification for treatment, principally that it respects autonomy. Chapter Five will explore some implications of this model, both for medicine and the person who has transitioned. Finally it is concluded that the authenticity model is more coherent and consistent than the medical model.

1. The Condition of TS

According to Benjamin TS has four characteristics:

1. A strong and persistent cross-gender identification…manifested by symptoms such as a stated desire to be the other sex…or that he/she has the typical feelings of the other sex.
2. Persistent discomfort with his/her sex or inappropriateness in the gender role of that sex…the belief that he/she was born in the wrong sex.
3. This disturbance is not concurrent with a physical intersex condition.
4. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.[2]

Benjamin distinguishes between two types or experiences of TS; Primary and Secondary. The former begins in early life and the individual tends to seek help whilst fairly young. In the latter gender identity becomes a prevailing concern later on in life, often after the individual has led an apparently successful life in the assigned gender both in marriage and parenting.

He coined the term TS in 1953 following the successful Gender Reassignment Surgery (GReS) of Christine Jorgensen in Denmark[3]. He developed the Sex Orientation Scale (SOS) in order to distinguish between various expressions of TS, ranging from mild to severe.

Benjamin distinguishes TS from both transvestism and homosexuality. In The Transsexual Phenomenon[4], whilst acknowledging a continuum theory of sexual behaviour ranging from transvestism to transsexuality, he meticulously differentiates

between them on two accounts. The first is related to the experience of happiness[5]. In transvestism the male dresses up in female clothing for reasons of sexual gratification. This is the motivating factor and the transvestite is secure in his sense of male identity. The wearing of female clothing does not indicate distress over gender identity but is a means of sexual satisfaction. Benjamin argued that in fact transvestism is a celebration of masculinity because the man involved in able to reach orgasm despite the fact that he is wearing female clothing and so his masculinity has triumphed over possible female domination. By contrast the transsexual experiences profound gender distress. The second differentiation is spatial: transvestism is expressed of privately whereas TS leads the individual to seek public help, which puts the feeling into the public domain.

Accordingly:

> The transsexual puts all his faith and future into the hands of the doctor, particularly the surgeon. These patients want to undergo corrective surgery, a so-called 'conversion operation' so that their bodies at least resemble those of the sex which they feel they belong and to which they ardently wish to belong.[6]

Seeking medical attention apparently becomes a symptom of TS. This creates something of a circular justification both for his model and for the treatment he prescribes and this circularity is one of the problems with his model to be discussed in Chapter One.

Benjamin discusses homosexuality as a matter of the nature and orientation of sexual desire and not of gender identity. He concludes:

> The transvestite has a social problem,
> The transsexual has a gender problem,
> The homosexual has a sex problem.[7]

On his definition TS has three discrete yet related elements: (i) gender identification, (ii) gender desire and (iii) gender dysphoria.

(I) GENDER IDENTIFICATION

The Benjamin/medical model of TS distinguishes between the subjective sense of gender and the objective sexed body. The latter is thought of as separate to and distinct from the former and the sexed body does not give rise to the individual's gender identity. The sexed body is that which is part of the person's original given-ness or mode of being at birth, whilst gender identity is that which a person adapts as a result of personal development. Stoller refers to the latter as a person's 'gender core'[8].

Whilst a distinction can be made between sex and gender it is thought that most people develop with a sense of harmony or concurrence between the two in so that an individual who has a female sexed body will develop a female gender identity and an individual with a male sexed body will develop a male gender identity. Whether this development is either desirable or normal is challenged by the trans-gendered community. This challenge will be explored in Chapter Five.

In TS however this harmony or concurrence between sex and gender has not taken place. A transsexual develops a gender identity that is opposite to her/his sexed identity.

Gender identity develops early in life before the transsexual realises the reality and significance of her/his sexed body and it is only gradually that she/he comes to understand the problem that is posed by the sexed body.

Throughout this thesis reference will be made to the stories of three transsexual persons: Christine Jorgensen[9], Jan Morris[10] and Mark Rees[11]. Jorgensen and Morris are designated as Male to Female (M-F) transsexuals whereas Rees is Female to Male (F-M). Their narratives will act as source material for both the experience of TS and for the way that medicine seeks to assist and treat transsexuals. Jorgensen expresses her gender identity in the following way:

> I have the physical characteristics of a very immature male but as far back as I can remember I've always had the feelings… the emotions of a girl.[12]

Similarly Morris, in the opening words of her autobiography writes:

> I was three or four years old when I realised that I had been born in the wrong body, and should really be a girl. I remember the moment well and it is the earliest memory of my life.[13]

Morris expresses the way that TS is most commonly understood; that of a person being 'trapped in the wrong body'. Here a person is understood to be the gendered self who ought to have been 'placed in' or 'rightly belongs to' the correct body. The correct body is the one which correlates to the gendered self and this conviction about sex/gender correlation remains despite the sex/gender distinction previously noted. A mistake is thought to have occurred which is either the fault of nature or of God, depending upon

individual belief systems, but is not the responsibility of the individual concerned. The transsexual is a victim who deserves a remedy from those who are in a position to help.

At the 20th WPATH International Symposium in 2007 Olyslager and Conway presented an assessment of the prevalence of both M-F and F-M TS in the general population[i]. The number of M-F transsexuals in relation to F-M currently stands at 3: 1.

The gendered self is regarded as the true representation of the self with the sexed body representing what the transsexual is not. The body is rejected by the transsexual being, in any sense, a real aspect of the self. This rejection extends to the way that the body represents the self to others. That the gendered self is the real self is accepted by both the transsexual and the medical community.

(II) GENDER DESIRE

Within the Benjamin medical model, gender desire refers to the desire for the transsexual's gender identity to be seen and ideally understood by others. It is a desire for recognition and often great importance is attached to achieving this. Recognition is thought to lead to acceptance, which in turn brings a sense of fullness or completion to the gendered self. In order for others to recognise a transsexual's gender she/he often

[i] M-F TS is between the ranges of 1: 1,000 – 1: 4,500 and F-M TS 1: 5, 500 – 1: 8000. This figure puts the prevalence of TS at much higher in the general population than previously thought. Olyslager and Conway "On the Calculation of the Prevalence of Transsexualism" presented at the 20th Symposium of WPATH Chicago, Illinois September 5th -8th 2007 and submitted for publication in the International Journal of Transgenderism (IJT)

identifies with the insignia of that gender, which can function as a means of communication. Jorgensen describes her attraction to items that belonged to her grandmother and felt that her grandmother would have been sympathetic to her had she known. She regretted not having told her of her desires:

> Had I told her of my childish prayer one Christmas when I was five asking God for a pretty doll with long, golden hair Grandma might have helped answer that prayer.[14]

Jorgensen goes on to describe how her attraction to sewing lead to public ridicule by a class teacher. She knew both the shame of being a boy who was attracted to an activity associated with girls and of having that attraction discovered by others who responded with ridicule. Her own shame led her to keep her sewing hidden in her school desk but was not strong enough to cause her to give it up. If, however, she had been either alone in the world, or in a world that viewed her desire sympathetically, then she would not have experienced shame. Shame is a response to the effects upon and response of others. It is a significant element of gender distress.

For many transsexuals recognition is achieved through surgery. Gender Reassignment Surgery (GReS), otherwise known as Sex Reassignment Surgery (SReS), is standard. The original secondary sex characteristics of the transsexual are altered to match those that correspond to the gender asserted. Vaginoplasty is the procedure in which the secondary sex characteristics of a female are constructed and Phalloplasty is the male equivalent.

Surgery is performed as the final stage of treatment in a process that is known as 'transitioning': beginning when the transsexual seeks medical help and moves through psychiatric assessment, hormone therapy and a period of time when the transsexual lives out the gender role in public in an activity known as 'passing'. The requirements for surgery include the presence of TS for at least two years, followed by a two year period of psychiatric supervision and a successful one year period of living in the chosen gender role.

(III) GENDER DYSPHORIA

The distress that is associated with TS can be understood both subjectively and relationally.

Subjective distress refers to that which the transsexual feels about his/her gender, specifically in light of his/her sexed body. Distress is experienced at a number of levels including the tension experienced between assigned and felt gender, and difficulty in understanding oneself as a result, and powerfully negative feelings towards the sexed body[15]. The tension between assigned and felt gender identity can itself be experienced in a number of different ways. For example a pre-operative male transsexual (M-F) may have desires that are apparently consistent with the assigned gender, such as playing football, which he rejects or views negatively because he may perceive these as inconsistent with his valued female gender identity. He may fear that to express his interest in football may compromise his claims to a female gender identity, especially if he is at the early stage in the transitioning process. Similarly a female transsexual may

abandon her strongly held desire to work with children in order to train as a car mechanic as this is perceived to be more consistent with a masculine gender role. The rejection of that which is associated with the assigned gender may also be a cause of distress.

This type of gender distress is linked to the assumption that certain activities are gendered. This assumption has, on the one hand, increasingly been challenged whilst, on the other, traditional gender role constructions remain in place both in the general and transsexual communities. This challenge has given TS its plausibility whilst traditional gender constructions seem to figure in the transsexual's experience. The latter appear to be rejected if they are associated with the assigned gender role but desired if associated with the chosen gender role. It also seems that very traditional gender characteristics are both desired and exhibited if they are thought to be consistent with the valued gender role. Male transsexuals' often choose traditional feminine names for the female gender identity and express that identity in overtly feminine ways[16]. It seems to be similar for female transsexuals[17].

Descriptions of gender distress have been well documented in recent transsexual autobiographical narratives[ii]. Jorgensen gives a detailed account of her distress prior to transitioning. She relates how she was aware at a young age that she was fundamentally different from other boys. This was exacerbated by the comments to of her sister Dolly:

> I remember I was about eleven or twelve years old when my sister Dolly began to notice my outstanding feminine mannerisms[18].

[ii] See list p 6.

As a result Dolly described such mannerisms as ‘silly’ and encouraged her to become more masculine. This caused Jorgensen to wonder why certain activities such as carrying books home from school should be considered as either ‘boyish’ or ‘girlish’ and why because of the way that she carried them she should be considered as a ‘sissy’.

Jorgensen claims that gender distress was the central feature of her life prior to transitioning and it lead to her considering suicide. This was ultimately rejected and Jorgensen turned to friends and doctors for help.

Both Morris and Rees describe similar gender distress which was expressed differently for them both. Morris recalls her prayers to God to make her a girl whilst Rees describes his inner conflict.

Gender distress is generated by being perceived and treated by others in a way that is not consistent with how the transsexual understands him/herself. It can be discussed in terms of absence and presence. Absence refers to the ‘hidden’ nature of the transsexual’s gender identity whilst presence refers to the way that others respond to how the transsexual presents his/her chosen gender identity. Absence occurs when a person relates to the transsexual on the basis of his/her body and insists that he/she behaves in a way that is believed to be consistent with it and presence occurs when a transsexual seeks to display his/her gender identity and other people respond negatively. Absence can lead to a transsexual feeling unknown by others and this in turn leads to a sense of isolation

and social withdrawal. Presence can lead to open conflict with others in which the transsexual can face hostility, ridicule and rejection.

Jorgensen describes this relational aspect to her distress in the account of her interview with a doctor from whom she sought support for GReS[19]. The doctor challenged the strength of her gender identity convictions by referring her to God and the need to submit to His will. She countered:

> I don't believe that God would want me to go on being unhappy, unable to present the best part of my life to the world, when there is the possibility of developing into a whole person.

Here Jorgensen not only makes a claim about God, she also questions why she should continue to suffer when medical and surgical treatment is available.

The transsexual's distress may lead to any number of behaviours and experiences that are of concern, such as social withdrawal, social dysfunction, substance abuse, self harming, suicide attempts that are occasionally successful, and difficulty in forming meaningful and lasting relationship and successful employment. The total experience of distress is often described as being both unbearable and intolerable. It is such distress that leads a transsexual to seek medical help, most frequently specifically psychiatric help.

2. History of TS

Although the publicity surrounding Jorgensen in 1952 brought the subject of TS to public attention it had already been of considerable interest to medicine for nearly fifty years beginning with the work of Hirschfeld and Ellis.

In 1910 Hirschfeld produced his formative work on the subject of sexual identity.[20]He reviewed sixteen male, and one female, cross-dressers along with interviewing female impersonators. He noticed the variety of sexual expression amongst his interviewees and his major conclusion was the development of the concept of 'intermediaries'. Here he argued that the then current dimorphic understanding of the sexes was too simplistic. Some men and women did not fit into such categories but fitted somewhere in between. Hence the need for a third category which he classified as 'intermediary' He also referred to such people as transvestite if they thought, felt or acted like a member of the opposite sex for sexual purposes.

In 1913 Ellis coined the term 'sexo-aesthetic inversion'[21]. This term came to replace Hirschfeld's concept of the 'intermediary'. Ellis distinguished sexual attraction from gender identity and life-style choice. Many of his clinical subjects showed little or no interest in sexual activity but were concerned with gender identity and its external expression. He later came to regard the word 'inversion' as inappropriate as it may suggest homosexuality in those to whom it was applied and so he replaced the whole designation with that of "Eonism" after the name of an eighteenth century French cross-dresser , the Chevalier d'Eon.

Hirschfeld's and Ellis's medical interest in TS was continued by doctors specialising in the then new science of psychiatry, of which the most important is Freud. His theories of sexual development were applied to the experience of cross-dressing and cross-sex identification. His treatment of Fetishism was seen as one possible way of understanding the condition along with Castration Anxiety and flight from the realisation of the genital condition of the mother.

Following on, researchers were concerned to distinguish what is now called TS from other conditions that had been identified and confused with it. TS was separated from homosexuality, cross dressing for reasons of sexual arousal and relief, the inter-sex condition of Hermaphrodism, Pseudo-Hermaphrodism and conditions that were classified as psychosis. Medical, psychoanalytical and sociological views competed to explain TS.

Benjamin's major contribution to the medical understanding of TS has already been noted in this introduction. Later researchers sought to categorise TS in different ways. With regard to M-F TS Blanchard argues for two distinct categories[22]: 1) those who from a very early age are effeminate in nature and are sexually attracted to men and 2) those who are not overtly effeminate either as children or adults and who are either incapable of sexual arousal or who show little or no interest in sex. Blanchard refers to the former as homosexual M-F transsexuals or Trans-homosexuals with the latter referred to as non-homosexual M-F transsexuals. This categorisation differs in an important sense from Benjamin in that he ruled out homosexuality in the experience of the transsexual. He

took sexual attraction to a member of the same genetic sex to be part of the experience of TS itself whereas Blanchard recognised that a M-F transsexual could be sexually attracted to women both pre and post-operatively. Both Blanchard and Benjamin seemed to concentrate on male transsexuals rather than female.

Lawrence later argued that non-homosexual M-F TS has close clinical resemblance to Apotemnophilia[23]. She was aware of the report by Dyer of the two Scottish surgeons who amputated the limbs of an apotemnophiliac man in 1997, the report of which generated renewed interest in the condition[24]. She argues that both reflect issues of identity rather than sexuality.

An example of the psychoanalytical contribution to the classification and demarcation of TS is found in the work of Person and Ovesey[25] who offered a dual explanation for sexual neurosis: 1) that which inhibits pleasure and 2) that which facilitates it. TS is an example of the former due to the sexual difficulties a transsexual person often experiences due to gender dysphoria.

The sociological explanation for TS posed a major challenge to the dominance of the medical model. This was largely due to the widespread adoption of Money's concept of gender which will be introduced in Chapter One of this thesis and discussed along with both the medical and body-image model in Chapter Two.

3. Current Guidelines

WPATH is the professional body overseeing the diagnosis and treatment of TS. Five stages in the treatment process have been identified[26]: diagnosis, psychotherapy, the Real Life Experiment (RLE) otherwise known as the Real Life Test (RLT), hormonal therapy and surgery. It is a mental health professional, usually a psychiatrist, who has overall responsibility for the management of the transsexual beginning with the initial assessment, continuing through transitioning with therapeutic support offered for the early stages of life in the chosen gender role. The role of the psychiatrist provides a psychiatric framework both for the construction of TS and its treatment. As will be seen in Chapter One the APA DSM 1V offers a psychiatric codification of TS. Yet TS is not thought to be a mental illness. The psychiatrist's function seems to be to filter out other conditions that may give rise to the experience of gender dysphoria, such as schizophrenia and mania where a person may experience delusions centring on her/his identity and then to establish the validity of the transsexual's claim. Once this has been done then the transsexual's eligibility for surgery has been established.

The SOC covers: 1) the criteria that are required for the referral of individuals to the psychiatric services; 2) the different approach required for the treatment of children, adolescents and adults with what it refers to as GID, which therefore becomes the main medical designation of TS; and 3) the criteria that need to be met for the transsexual to be eligible for the various stages of treatment.

In describing GID as a psychiatric condition WPATH offers the following justification:

> This designation is not a license for stigmatization nor for the deprivation of gender patients civil rights. The use of a formal diagnosis is an important step in the offering of relief, providing health insurance coverage and in generating research to provide more effective future treatments.[27]

This justification of a psychiatric classification of TS warrants further comment which will be provided in Chapter One. However, it seems appropriate at this point to note that WPATH seems to be offering several pragmatic reasons for this, including the possibility that both insurance cover and future medical research will be threatened if the psychiatric classification were removed. This could be understood to mean that it is in the best interests of transsexuals to have a psychiatric diagnosis which, though distressing, is far better than the alternative of no recognised designation and therefore no insurance cover or future medical advances.

The SOC discuss the nature and purpose of the RLE and this will be further examined in Chapter Five where the implications of the model of Authenticity that is developed in Chapter Four are explored.

In the sections dealing with reconstructive surgery the guidelines state that:

> (surgery) has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary.[28]

The section discusses the ethical concerns of performing surgery on what it describes as 'anatomically normal structures' including one of the fundamental medical principles of 'first do no harm'. Many of those who oppose GReS often do so on the basis that this principle is breached, even if surgery is carried out at the request of a competent transsexual person. It may be further argued that a person can be harmed even when she/he may not know that she/he is being harmed. This issue of harm will be discussed in greater detail in Chapter Five where it will be proposed that a transsexual might be harmed by surgery performed at his/her request and with his/her consent.

The guidelines respond to such criticism by stating that direct conversation with a transsexual person, especially when listening to an account of the suffering that transsexual has experienced, is disarming. WPATH is particularly concerned to sway any clinician who may be critical of both TS and GReS:

> The resistance to performing surgery on the ethical basis of 'above all do no harm' should be respected , discussed and met with the opportunity to learn from patients themselves about the psychological distress of having profound GID.[29]

WPATH entreats the doubting physician to reflect upon the transsexual's life in order to be in a position to help. Surgery is justified on the basis of suffering and the doctor's ethical concerns should be assuaged by the prospect of alleviating suffering, understood better by attempting to identify with the transsexual.

I will call this the suffering justification for surgery. This priority to alleviate suffering supersedes medical ethical concerns about harming healthy organs. The suffering justification will be critiqued in Chapter Three of this thesis.

4. Practice of Certification

The Department for Constitutional Affairs (DCA) of the UK government has legal responsibility for transsexual people[30]. It estimates that one man in every 12,000 has feminine gender feelings with a smaller proportion of women feeling themselves to be male. It identifies a number of specialist centres that cater for GID in England[iii].

The Gender Recognition Act (2004) was introduced to provide a basis for the legal recognition of trans-gendered people. The Act resulted from a ruling by the European Court of Human Rights (2002) which found that the UK was in breach of Article 8 and Article 12 of the European Convention on Human Rights (the right to respect for private life and the right to marry).[iv] The Act provides for gender recognition certificates to be issued by a Gender Recognition Panel. Applications are made to the Panel for legal status, with the aim of:

> ensure(ing) that transsexual people can enjoy the rights and responsibilities appropriate to their acquired gender[31].

[iii] Caring Cross Gender Identity Clinic, London; The London Gender Clinic; The Tavistock Clinic, London; The Albany Gender Identity Clinic, Manchester; Newton Abbot Hospital, Devon with other clinics at Leeds, Newcastle, Nottingham, Newcastle, Sheffield and Bristol.

[iv] The case of Goodwin –v- The United Kingdom and I-v-The United Kingdom. An Interdepartmental Working Group reported to Minister on 1st Nov 2002 which prepared the way for the GRA 2004.

The Panel has eleven members, six of whom have medical expertise and three legal. There are three criteria to be satisfied before a Gender Recognition Certificate (GRC) is issued: 1) a diagnosis of Gender Dysphoria; 2) having lived fully in the acquired gender role for at least two years; and, 3) intention to live permanently in that gender role. If a transsexual person is married at the time of transitioning then an interim GRC is issued which allows for the marriage to be dissolved. This has to be done before a full GRC can be issued. The GRC accords the full rights and responsibilities of the acquired gender including the right to marry or to form a civil partnership, and to retire and receive state pension at the age appropriate to the acquired gender. A new birth certificate is issued showing the recognised legal gender.

The transgender pressure group Press for Change (PFC) estimates that there are around 6,500 post-operative transsexuals living in the UK with around 400 operations performed each year[32].

The Aggressive Research Intelligence Facility (ARIF) of the University of Birmingham was asked in 2004 (original request in 1997 updated in 2004) to investigate:

> What are the effects of gender reassignment surgery, and does the balance of positive and negative effects suggest that this procedure is clinically effective overall?[33]

Having identified problems with the available research literature its conclusion was:

> the degree of uncertainty about any of the effects of gender

> reassignment is such that it is impossible to make a judgement about whether the procedure is clinically effective[34].

ARIF recommends more rigorous research using randomly assigned control group and blind independent assessment of outcomes (Abramowitz SI, 1986)[35v].

Professor Louis Appelby, the mental health czar of the UK government, has stated that at present there are no NICE guidelines on transsexuality. He has considered referring the matter to NICE but considers that there is insufficient data at this stage to do so. He appears to be satisfied with the current guidelines offered by The Royal College of Psychiatrists[vi].

Conclusion

This Introduction has sought to lay the ground for the discussion of TS that will follow in the main body of the thesis.

[v] When contacted ARIF were not able to disclose neither who commissioned the original research nor whether their recommendations were followed up. Their policy of confidentiality would not allow them to do so.

[vi] See Appendix 2 of personal correspondence.

CHAPTER ONE MODELS OF SEX/SEXUALITY AND GENDER

Introduction

The purpose of this chapter is two-fold. First (Section One) to locate TS in current constructions of sex/sexuality and gender which will prepare the ground for the discussion in Chapter Two of three models of gender, medicine and body image. Second, (Section Two), the conceptual incoherence and logical contradiction of the way that TS is currently constructed will be discussed. This is done as preparation for a more detailed examination of the three models discussed in Chapter Two

1. Models of Sex and Sexuality

TRADITIONAL MODEL: SEX AS BODY.

Traditionally 'sex' has been determined by the body of an individual. 'Sex' referred to physical characteristics, the social role that a person was expected to fulfil and sexual orientation, with heterosexuality considered to be the norm. Men and women were thought to be distinct from one another because male and female bodies showed obvious differences. Male bodies shared certain physical features and so the conclusion was drawn that men shared the characteristics that were thought to arise from the body. Physical strength was one feature and this give rise to the idea that men were stronger than women with this becoming one source of men's dominance over women. Likewise women's bodies give rise to characteristics that were believed to be common to women. Because her body was the place where new human life began and was nurtured it became

customary to think of a woman's role as that of nurturing and caring. This often resulted in her being assigned a secondary and subservient place in society.

Two stages of this construction of female/male can be found. The first, and oldest, stage regarded the difference as one of *degree* with the second positing the difference as one of *kind.*

The first view expounded by among others Galen[36] maintained that the human condition is fundamentally male and the observable physical differences a matter of spatial location. The sex characteristics of men are external whereas those of women are internal. These sex organs were thought to be the same in terms of structure and make-up but different with regard to the place within the human body. The possession of 'heat' gave rise to the external location of the male sex organs, as well as providing the source of the energy that enables men to possess the characteristics that are usually associated with them. In this construction men were thought to be more perfect than women, because they were further along an idea of human perfection. This became the justification, or rationalization, for the social advantage and prestige that was traditionally enjoyed by men. This view remained dominant until the nineteenth century with the arrival of both the industrial revolution and modern medicine. In this view the body signifies both human unity and difference.

The sexed body was the source of an individual's identity. There were two sexes, male and female, with a whole system of what was thought to be appropriate ways of behaving

built upon the understanding of the body. To be masculine, therefore, was to act in accordance with the nature of the male body, with femininity dictated by the female body. Bodies were the source of sexual desire with the male body fitted both to desire and experience the female body. Its apparent design to penetrate the female body gave an additional justification for man's dominance over women. The male body was believed to be the origin of human seed with the female body, as a result of experiencing regular loss of blood due to her menstrual cycle, thought to be both weak and unstable. Both of these observations fitted into the existing and emerging constructions of masculinity and femininity.

The second view, difference of *kind*, was first articulated in 1803 by Moreau[37] who claimed that the two sexes were 'a series of opposites and contrasts'[38]. The notion of the incommensurability of the sexes developed, which was believed to be firmly anchored in the 'facts' of science. Laqueur describes how this view replaced the older one of Galen and others with what he describes as:

> a new model of radical dimorphism, of biological divergence. An anatomy and physiology of incommensurability replaced a metaphysics of hierarchy in the representation of women in relation to man.[39]

This is a 'two-sex model' grounded in nature with the cultural and social division between man and women merely the outworking of a natural or God-ordained order. Moreau was building on the work of Enlightenment thinkers such as Rousseau who by

appealing to nature sought a rational explanation for the difference between the sexes. For instance discussing Sophie as a wife for Emile Rousseau wrote:

> All we know for certain is that everything in common between men and women must come form their species and everything different must come from their sex. From this double point of view we find so many relations and so many oppositions that perhaps one of nature's greatest marvels is to have been able to make two beings so similar whilst constituting then so differently.[40]

Mosher describes this modern view as *dimorphic sexual essentialism*[41]. The two sexes were no longer thought to be one, differing in degree, but two distinct categories with that distinction being located in and defined by the body. Like the older view, in this 'two-sex' model, the character of men and women centred on the body. Proper behaviour reflected the nature of the body and if the body was either sick or improperly functioning the character of that person reflected such dysfunction. It was primarily the sex characteristics of the body that both defined men and women and determined appropriate behaviour.

A graphic example of how this theory worked in practice in the Nineteenth Century can be seen in the way that female ovaries were thought to influence behaviour. Indeed, ovaries were thought to determine the female character. Chereau wrote, 'it is only because of the ovary that a woman is what she is'[42]. If she demonstrated behaviour that became of concern both to herself or to others, such as hysteria, melancholia or anxiety then it was assumed that a woman's ovaries were malfunctioning. By the 1870's ovariotomy was widely practiced as a cure for 'problem' female behaviour and, in spite

of the fact that it was frequently observed upon removal that the organs themselves were healthy, many women reported themselves to be improved. Improvement not only consisted in the removal of the symptoms described earlier but also in the fact that women were thought to be made more 'feminine', in the sense of more docile and more malleable.

In this view sex is an ontological phenomenon. It refers to the being or to the nature of an individual. Men and women are different from one another in terms of their sex and their individual character and mode of being is referred to as their 'sex' identity or role. Sexuality refers to the whole area of a person's life concerned with attraction to another person. Although the idea of human character being defined by the sex characteristics of the body is no longer a majority view in this model of sex, the 'two-sex' model itself continues to be used. For instance Nadeau claims:

> the sex specific human brain…impacts all aspects of the human sensorium…and the differences in the brains of men and women have behavioural consequences.[43]

The bodily locus for the difference between men and women has here changed from the sex characteristics to brain structure and organization. Nadeau argues that even though the similarities in the brains of men and women are greater then the differences, the latter are of significance. The human brain is organized differently in men and women during foetal development as a result of the hormonal functioning of the mother. Nurture then builds on these inherent differences in terms of character, expectation and role within society. Nadeau calls for this basic difference between men and women to be recognized

in contemporary society as a means to achieving equality. Equality is not to be achieved by arguing that men and women are the same but by recognizing difference in an atmosphere of mutual respect.

Similarly Tiger and Fox[44] call for recognition of the differences between the sexes along biological lines. Garret discusses how they argue that differences such as menstruation, physical strength, reproduction, brain size and the nature of sexual desire are of ontological significance and constitute what they refer to as 'biogrammers'.[45] These are the biological programmers that set a course of action for the person concerned. Whilst this may be resisted or overcome, nevertheless the biological programmers are significant features of a person's life exerting an influence over the person.

Garret claim's that 'biogrammers' are genetically based programmes that predispose men and women both to develop certain characteristics and to exhibit certain patterns of behaviour. The genetic codes originate in the early days of human history and Garret maintains that they change very slowly over time. In fact they prove resistant to ideological challenges from within any particular society. Ideologies may have an influence over the thinking of individuals within society but behaviour is rooted in the biogrammers and as such is more difficult to change. It is for this reason that Garret is critical of much of the feminist movement with its critique of patriarchy. He thinks that it ignores basic biological reality: different roles exist for men and women based upon different modes of being which are in turn based upon different biological programmers.

Garret argues that this is the reason why women are often thought of as possessing a nature that is characterized by caring and nurturing whereas a man's nature is to provide and to protect for his family and to forge links between them and the outside world. The origins of this lie in the early human 'hunter-gatherer' societies where much of the human genetic coding, he concludes, took place. Changes in the ordering of human society have occurred over the generations but the basic genetic coding remains in place. This may prove to be one of the reasons why so many human societies demonstrate similarity of roles for men and women and if the basis for this is genetic then our duty is to recognize this and to build an understanding of the sexes upon it.

Anzieu[46], with his concept of the 'skin-ego', focuses attention on the surface of the body, on the skin, in terms of the development of the self. It is this that matters most in the development of personal identity. It is the skin that forms an interface between the self and the outside world (in which there are others who are like/unlike the self) and between the biological and psychic self. Individual identity is the result of the internalization of the experience of the surface of the body. Anzieu draws on the work of Freud, specifically his concept of the unconscious as made up of actual experiences of the body, to offer a biological explanation for the development of the self[47].

Prosser[48] relates the notion of embodiment to transsexuality. He argues that for a transsexual, becoming a gendered self takes place at those moments when the body is surgically constructed:

> In that s/he seeks to align sex with gender identification; in that the somatic progression toward these goals of sexed embodiment constitutes the transsexual narrative, the transsexual does not approach the body as an immaterial provisional surround but, on the contrary, as the very 'seat' of the self. For if the body were but a costume, consider: why the life quest to alter its contours?[49]

Prosser argues that the transsexual re-figuring of the sexed body is along psychic and symbolic as well as corporeal lines. What happens to the body during surgery matches what is happening both psychically and in terms of gender signifiers. Gender identity, therefore, is bound up with the body.

MODERN MODEL: SEX AS CONSTRUCT

Foucault argues that sex and sexuality should not be thought of as something fixed or biologically determined, nor that heterosexuality is the norm with homosexuality as deviation. Rather:

> (it) is the name given to a historical construct; not a furtive reality that is difficult to grasp, but a great surface network in which bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges, the strengthening of controls and resistances, are linked to one another, in accordance with a few strategies of knowledge and power.[50]

Foucault claims that far from living in an age that has liberated sexuality, sexuality is the subject of control and power in human relationships. Sexuality is a site of power in society, as a result of paying attention to the bodies of women as the source of emotional disturbance in the nineteenth century, the growth of the expert in sexuality within medicine and the way that so-called perverse sexualities are the subject of psychiatric

labelling. He argues that alternative sexualities can be a means of resistance to power and thought that homosexuality was able to function to this end.

He draws a distinction between sex and sexuality. The former is fixed and biological with the latter constructed as something which is fluid and developmental and is relative to the person concerned.

CONCLUSION

Sex, in the traditional model, is a category definition: Male and Female. It is a matter of corporate identity. Sex has referred to either one category of being in which there was a difference of degree or as two categories of being in which there exists a difference kind. This two-sex model has sought to locate the difference in different ways; secondary sexual characteristics, brain organisation and functioning, genetic coding or the differences in experiencing the surface of the body.

However, at this point in the thesis it is important to note that, in spite of what is popularly thought, Trans*sexuality* is not a matter of sexuality or of anatomical sex. Because the term 'sexuality' appears in the term, ideas of sexuality have been popularly associated with it. This is a case of the misleading nature of the classification.

2. Models of Gender

THE INTERPERSONAL MODEL

In this model gender refers to the most obvious difference between people: some are men and others women. A person is thought to belong to either the category of masculine or feminine on the basis of physical (sex) characteristics. Masculinity and femininity are equated with maleness and femaleness and a whole series of roles, behaviours, characteristics and responsibilities are assigned to a person.

This model of gender is closely associated with the traditional model of sex discussed earlier in the previous section. This is to be expected as sex and gender are co-terminus.

THE INTRA-PERSONAL MODEL

Following what has been described as the second wave of feminism[vii] a concept of gender was developed that sought to make a distinction between the body and the subjective sense of identity. The latter was thought to be distinct from both sex and sexuality. This view was first articulated by Money in 1955[51]. He applied the idea of gender as it is used in linguistic discourse to designate the nouns 'masculine', 'feminine' and 'neuter' to human experience in order to distinguish between maleness and masculinity and femaleness and femininity. Money was researching Hermaphrodism and sought to distinguish between the qualifying criteria of sex and the way that a person both understood him/herself and subsequently behaved. He used the idea of gender in order to bring clarification to such statements as:

[vii] Second wave feminism was the result of post Second World War discontent felt by some to the pressures to return to social roles that were the norm before the war. It was during the 1960's that feminist concerns were expressed both politically and culturally in the USA and in Europe.

> John has a male sex role except that his sex organs are not male and his genetic sex is female.[52]

He applied the idea of gender to the sex role with the term 'sex' being restricted to biology. Gender came to refer to a person's social identity and this was defined by Money as 'gender role'.

Money's idea of gender followed on from the anthropological work of Mead[53] who had asked in 1950:

> How are men and women to think about their maleness and their femaleness in this twentieth century, in which so many of our old ideas must be made new?.[54]

Working with seven Pacific peoples, Mead recorded the differences she encountered in terms of the relationships and social functioning between men and women. The different peoples had different customs, roles and responsibilities for men and women and Mead sought to apply her findings to contemporary American culture and the way that men and women were understood there. Her major conclusion is that both masculinity and femininity ought to be understood as relative concepts and not as fixed identities across cultures.

Uncoupled from sex, gender is no longer thought to be a matter of essence but as something that is acquired through personal development, social identification and social interaction. Gender is concerned with the acquisition and social display of personal

characteristics. These may still be characterised as masculine and feminine. Gender was understood to be fundamental to the core of self identity, experienced subjectively, and existing with little or no reference to the body. It became possible to talk about both a 'gendered self' that possesses certain characteristics and traits *and* the body that the self inhabits.

This construction of gender is predicated on a difference *within* the individual rather than differences *between* individuals. The difference is between the body and the sense of self. The former may still be thought of as male or female and the latter may or may not accord with the sex designation. Both the body and the sense of self are considered to reveal 'truth' about the individual but it is the inner reality or the subjectivity that is considered to be the ultimate truth or the truth about the person. This true self can develop without being defined by the body with its body acting as the medium through which the gendered self interacts with the world.

This model suggests that many of the behaviours that have been traditionally associated with the roles of men and women may be cultural or sociological constructs and not fixed realities that determine the place of men and women. The idea of fixed realities may have served the purpose of 'fixing' the relationship between men and women played out to the benefit of the former and dis-benefit of the latter. The intra-personal model challenges the idea of 'fixed-ness' and by extension the traditional relationship between men and women.

Simone de Beauvoir[55] asserted that 'One is not born, but rather becomes a woman'[56] and concludes:

> woman feels- and often detests- the domination of the male; but this is no reason to conclude that her ovaries condemn her to live forever on her knees.[57]

It is clear that de Beauvoir recognises that it is usual for a human being to be sexed as either male or female but that this does not cause or determine the gender of the individual. Gender is a human characterisation that is acquired as a result of the development of traits, dispositions, attitudes and desires that all operate in both a person-specific matrix of space and time and a context-specific cultural location. The upshot is as Butler[58] points out:

> Gender ought not to be constructed as a stable identity or locus of agency from which various acts follow; rather gender is an identity tenuously constituted in time, instituted in an exterior space through *a stylised repetition of acts*.[59]

Butler argues that gender should be understood as a matter of performance. She places emphasis not upon the visibility of the body but on the visibility of action, particularly interaction with others. Gender is a creation achieved by means of interaction and as such cannot be understood as a fixed identity. It is one that changes in relation to the demands and expectations of social interaction.

This construction emphasises human freedom and responsibility and places onus on human choice. However, it is not true to say that this idea of gender allows for total freedom as Butler recognises that forces operating within society impacts upon a person's freedom to choose. As Weight and Beach[60] point out discussing social identity in Britain between the years 1930-1960, identity itself:

> is conceptualised as a social meaning constructed like other meanings, but with the uniquely existential dimension of being anchored in an individual's body.[61]

Whilst the primary reference here is to identity as a whole it includes gender in its view. The emphasis is upon the construction of gender by specific individuals.

If the inter-personal model of gender can be understood in reference to the Enlightenment's paradigm of essence preceding existence then this intra-personal model belongs to the existential paradigm of existence preceding essence. Existentialism makes the idea of a human nature inappropriate. All there is is human existence. The specific shape of a particular human existent is a matter of personal construction. A particular person or society determines how to construct identity free from any external or objective reference point, whether this is the body itself or a set of religious or scientific beliefs or laws constructed around the body. Individual identity is established as a result of struggle or anguish. The building of identity is a difficult or costly activity with individual desires and preferences the basic buildings blocks. A person can choose to identify themselves as male/female and masculine/feminine in either absolute or relative terms as part of the process of self understanding and relating to others.

Gender is the subjective sense of self that is thought in some way to 'inhabit' the body with the result that the body is thought of both as that which 'is' and 'is not' the person. It 'is' the person to the extent that it encases the body and is the vehicle through which the self is known and 'is not' the person in terms of self-definition and self-determination. It may be that this view is one expression of Cartesian dualism but with the distinction not between the thinking self and the self of extended substances but between the gendered self and the self of sexed substance. As with Cartesian dualism the 'true' self is the subjective self and, central to this view of gender, this subjective self has a gendered identity. Personhood is a matter of sentience or of consciousness and as this is incorporeal then corporality is not defining of human existence. Merleau-Ponty states:

> I am the absolute source, my existence does not stem from my antecedents, from my physical and social environment; instead it moves outwards towards them and sustains them, for I alone bring into being for myself the tradition which I elect to carry on.[62]

Gender is a matter of individual identity or ontology. Emphasis has shifted from the idea of group or category identity to the individual who constructs an identity within a social context.

THE PAN-PERSONAL MODEL OF GENDER

This third model combines the previous two. Here gender incorporates bodily reality whilst maintaining that it does not determine it but can, if chosen, significantly contribute to it. The contribution a body makes to gender identity may be, for example, a matter of

physical strength in relation to masculinity or female reproductivity in relation to femininity. It may also serve as a means of self expression in relation to others. It is through the body that a self comes to learn of the world it inhabits and then is in turn known by others. Differences between selves can also be experienced by means of the body. Such differences can exist as much between members of the same sex as between those of different sexes.

A person therefore consists of her/his gender identity *plus* body. The latter is an extension of the gendered self with the subjective experience at the centre of identity. In turn identity is an ongoing creative dynamic and is a unique personal construction which can consist of any combination of, or none of, the characterisations known historically as 'male' or 'female'. Persons are able to group together not as a result of biological fundamental nature but as a result of preference or of lifestyle choice. Gender is here thought of as 'a multidimensional category of personhood'[63]. It is this understanding of gender that will be incorporated into the model of authenticity.

This presentation of the self is done with a view to recognition. The self seeks recognition from those who stand in significant relation to it. This seems to reflect the social nature of human existence[viii] and consists in the desire to be 'seen' by another. What is desired is a sympathetic 'seeing' as this would be indicative of positive qualities within the one who sees towards the one being observed. A critical seeing would be

[viii] As examples of authors who have treated this subject the following can be thought of as representative: Tim Ingold "The Appropriation of Nature: Essays on Human Ecology and Social Relations" 1986, Reinhold Neibuhr "Man's Nature and his Communities: essays on the dynamics and enigmas of Man" 1966, Paul Heyer, "Nature, Human Nature and Society: Marx, Darwin, biology and the human sciences" 1982 and John Lofland, "Doing Social Life: the qualitative study of human interaction" 1976.

considered negative and much has been written on this subject but it is not within the purposes if this thesis to pursue this[ix]. A sympathetic seeing may be the result of the recognition of similarity or of the ability of the one doing to seeing to empathise with the other. It is also possible to sympathetically 'see' another where a measure of difference exists as long as the point of contact between individuals is perceived to be of greater importance than difference[x].

The pan-personal model enables identity to be conceived as that which transcends traditional masculine/feminine and male/female binaries with the result that importance is attached to the notions of choice, freedom and voluntariness. It is a model that allows for the blurring of the boundaries between persons that were previously thought to be determined whilst at the same time attaching significance to the body. Kessler[64] writes:

> Biological differences contribute to gender differences but are mediated through an interaction with the environment according to a person's mental concepts.[65]

Loren Cameron[66]., a F-M transsexual, seeks to challenge the binary nature of much thinking about masculinity/femininity and maleness/femaleness through his work both as a social commentator and photographer. Whilst constructing a body that is deliberately and visibly male he does so without constructing a penis, as it is an object that is considered by some to be the essence of maleness/masculinity. In his self-portraits he

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[ix] See, David Gauntlett, "Media, gender and identity (electronic resource) an introduction Taylor and Francis e-library 2004, Judith Butler, "Gender Trouble: Feminism and the Subversion of Identity" 1990,

[x] Of interest here are the wives of transsexual men who facilitate the cross-dressing and socialising of their male partners. A wife may often be the one who offers advice on clothing, make-up and posture as well as being the one who accompanies her husband on his/her first appearance in public in the desired gender role.

challenges the spectator's understanding of the categories by which gender is usually assigned. His most celebrated self-portrait is on the cover of his book *Body Alchemy*[67] and it is in the visible maleness of the image that the challenge is found.

This model of gender is achieved by the blending together of gender constructions in academic feminism and in popular culture as well as in the application of philosophical concepts to the issues of human ontology. This third model of gender can be understood to be an example of Hegelian dialectic[xi] in terms of the following formulation: thesis (gender is body/inter-personal model) leading to antithesis (gender is not body/intra-personal model) leading to synthesis (gender is body plus/pan-personal model).

CONCLUSION

Elements of all three models can be found in contemporary debate about TS. The particular model used often depends upon the context. In medicine the inter-personal model pre-dominates, which is unsurprising given the biological paradigm of western medicine. It is the intra-personal model that is often found in feminist discussions perhaps because it most usefully serves one of the aims of feminism which is to challenge the twin notions of patriarchy and phallocentrism[xii] .

[xi] This thesis is not the place for a debate on the correctness of attributing this formulation to Hegel himself. Rather I wish to make the general point on the three way process that ideas can develop

[xii] Patriarchy is the notion that men both generate and exercise power within society for the benefit of men and that this power is predicated on the male body. It is the male body that gives rise to notions of male superiority due to the fact that it is generally stronger than the female body. Coupled to this are the limitations placed on women by the demands of menstruation and child-bearing and rearing. Phallocentrism is the privileging of the male phallus in social relations. The male genitals become the

Many participants in the feminist debates seek to challenge the idea of male dominance. One way of doing this is to re-orientate the idea of gender identity so that it is no longer sourced in the body. Personal identity is therefore freed from the constraints of the body and becomes a matter of development and acquisition rather than endowment. Accordingly everyone can acquire the same personal characteristics and therefore attain power in society. The result is a levelling of relationships between people and the possibility of social equality.

3. Defending the First aim of the thesis

The first aim of the thesis is to demonstrate that there is conceptual incoherence in the current construction of TS. The current conceptualisation of TS draws on an intra-personal model of gender (i.e. sex and gender are not the same) but treatment by means of GReS assumes an inter-personal model (i.e. sex defines gender). The move from one model to the other is neither recognised nor, therefore, defended. I will argue that this leads to conceptual confusion because the two models make very different presumptions about how gender is derived. Indeed, the models are so different that there is not only confusion but contradiction: either gender is not implied by sex (as the diagnosis of TS implies) or it is (as the use of GReS suggests) in which case it is difficult to see how TS can be justified as a condition. I will now explain each of these claims in greater detail.

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prime source and significance of power between men and women. Women are thought to envy the man his penis whilst the man 'glories' in the possession of it. He feels it to be the source of his identity. The penis is both passively experienced in the way that the man is conscious of it and is actively expressed in his relationships with women, primarily through domination.

3:1 The distinction between sex and gender is required in order for TS to be a rational possibility because it assumes that sex and gender can be separated. The traditional model of sex as defined by the body cannot accommodate the possibility of TS and anyone claiming not to be the gender of the sexed body would be regarded as being irrational. Accordingly, the concept of being transsexual was only made possible by the challenges to this traditional model that separates sex from gender.

Throughout human history there have been individuals who have not fitted the usual models of maleness and femaleness and non-transsexual explanations have been offered to account for them. For example in Native American culture, particularly before the coming of European culture, the *berdache* were men who were known as 'half-men/half-women' to whom shamanistic powers were attributed.[xiii] The *berdache* was seen as a 'two-spirit' person who was able to enter the perspective of either a man or a woman in a specific context and by doing so to bring insight and reconciliation to situations of conflict. Similarly in India the *hijras* were (and remain) men who lived and functioned as women who attended weddings in order to bless the marrying couple. *Hijras* occupied an ambivalent place in Indian society being seen both as a source of bringing the blessing of the gods and as a threat to the existing social order. They were/are both revered and reviled[xiv].

[xiii] For a discussion on this subject and specifically of the way that the *berdache* is used as a model for the historicity of homosexuality by American Queer Theorists see Califia "Sex Changes: The Politics of Transgenderism" p 123-158.

[xiv] See: Peoples Union of Civil Liberties (Karnataka) Report on Human Rights Violations Against the Transgender Community, released in September 2003. http://www.countercurrents.org/gen-narrain141003.htm

Perhaps modern transsexual people are in the fortunate position of experiencing 'proper' recognition and help to resolve their difficulties. The medical model arguably offers a way of understanding TS that seeks to remove the stigma that may attend the condition. By making TS a *medical* problem accusations of immorality or deviancy that have often been associated with sexuality and gender are negated by the removal of room for any choice in the matter.

3:2 The sex and gender alignment is both that which is desired by the transsexual and seen as the proper end of medical and psychiatric treatment. Jorgensen wanted surgery in order to 'present the best part of myself to the world'.[68] The medical model of TS is the dominant model and as a result it is unsurprising that its treatment is physical. Being unable at the present time to directly act upon the brain, where the origins of TS are thought to lie, it acts instead upon the body by seeking to 'align' it with the brain. Hence surgery to the body is thought to be the proper treatment goal.

Having been predicated on the separation of sex and gender, however, current models of TS seeks fulfilment in their alignment by use of the inter-personal model. Accordingly, surgery that re-aligns the sexed body with the claimed gender alignment appears to be at odds with both the basic presupposition of TS.

I argue that a model that is founded on a sex/gender distinction and then terminated in sex/gender alignment, and does so without reconciling the different gender presuppositions involved is both conceptually incoherent and contradictory.

3:3 GReS is discussed in terms of its effectiveness but not in terms of its conceptual coherence. For instance, WPATH SOC guidelines discuss surgery in the following terms:

> Sex reassignment is not 'experimental', 'investigational', 'elective', 'cosmetic', or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID (Gender Identity Disorder).[69]

The guidelines suggest a 'triadic' sequence of therapy: hormonal therapy, the Real Life Experience, and surgery. Whilst acknowledging that not every person wishes to follow this therapeutic triad, and increasingly many clinicians are aware of this, the guidelines state that should a person not want medical treatment then this is a matter of choice and not a comment on the coherence on the treatment itself. There appears to be no discussion on the sex/gender concepts themselves or that the treatment goal appears to be at odds with the foundational premise.[xv]

[xv] Interestingly the same guidelines make the observation that without medical intervention most boys and girls with GID would outgrow the desire for surgery (see ref 35). In the section Natural History of Gender Identity Disorders the section states that all clinical decisions ought to be made in the light of data about the 'natural history' of GID i.e. the experience of GID prior to medical involvement. However, the data appears to be lacking apart from that about the majority of boys and girls outgrowing the desire for surgery. It is the intervention of medicine that seems to secure the desire for surgery. It would be interesting to discover both how it is known that most would outgrow the desire for surgery without the intervention of medicine and whether it is that intervention itself which gives rise to TS as formally understood.

The conceptual incoherence and contradiction remains whatever terminology is used. Gender reassignment, sex reassignment or even the term *re*-assignment do not remove the incoherence. Gender is not being reassigned in surgery, because the central claim made by a transsexual person is that his/her true gender identity is unchanged. Sex is not being reassigned as *gender* as opposed to sexed identity is what is being asserted by the transsexual individual.

It is the body of the transsexual that is the object of attention and treatment consists in the sexing of the body so that it reflects the idea that sex and gender are the same. Sex and gender are co-ordinated as a result of surgery and often both the surgeon and the transsexual wish to construct a sexed body that accords with traditional gender identities. M-F transsexuals often appear to want a sexed body that conforms to notions of femininity that are closely associated with the body, such as breast size and body mass. In turn, an overtly feminised body is then augmented with other insignia such as hair length, make-up and jewellery as well as choice of female name. All appears designed to bring the M-F into line with ideas of gender that are build upon the 'body as gender' model.

In the letters column of an on-line support group for transsexual persons, one correspondent asks for advice on ideal feminine proportions and gets the reply that biological markers for femininity include wide hips and breasts[70]. Whilst the advice giver rejects the notion of ideal feminine proportions it is worth noting that it refers to biological markers of femininity and not to biological markers of femaleness.

It is the discrepancy between the two concepts of gender (gender is sexed body, gender is no sexed body) that establishes the first aim of this thesis. If the sex and gender distinction is correct then it is necessary for it to be applied across the board in a consistent manner. At the present time this distinction is being observed in many areas of human activity, such as in employment law and practice where sex discrimination legislation is based upon the idea of equality of gender and not on the distinctiveness of biological sex. Similarly equal rights law is predicated upon notions of gender equality divorced from biology. This being the case, surgery as the proper goal of treatment for TS may be called into question. It appears to run counter to prevailing social sex/gender constructions.

Alternatively if sex/gender alignment is to be kept as a legitimate therapeutic goal then a new formulation of TS is required. The challenge is to explain TS in such a way that coherence is maintained.

One solution may be to redefine TS not as a gender or sex problem at all but as a brain, and therefore a medical, problem. As already indicated Chapter Two will examine the medical model. Briefly, this model locates TS within the BSTc region of the hypothalamus. It is thought that this region of the brain gives rise to a gender identity and that this normally accords with a person's sexed body. Post-mortem examinations of the brains of a number of M-F transsexuals reveal a BSTc region of comparable size to

that of the average for women (See ref in Chapter Two). The conclusion being that M-F transsexuals have a BSTc region like that of women.

If TS is a brain problem then because it is not currently possible to work directly on the living human brain then the next best thing is to work upon the body. GReS then becomes a coherent treatment goal. A broader problem remains, however. Whilst such a redefinition of TS may keep surgery as a coherent option, it would result in TS being out of step with the way that gender is understood more generally. As well as the distinction between sex and gender already noted, gender is thought to be that which is acquired and developed rather than that which is the result of brain function. Characteristics that were once thought to be a matter of biology are now understood to be characteristics that both genders can develop.

My argument in this thesis is that the sex and gender distinction, which is so widely adopted within society, needs to be maintained but both the medical model and the treatment goal needs to be replaced and redefined. In Chapter Four, I will argue that the medical model should be replaced with the model of authenticity and that whilst surgery is an option, it should fit within the model of authenticity. Surgery is regarded as the inevitable end of a medical conveyor-belt and it is this sense of inevitability and 'appropriate-ness' that the authenticity model challenges.

3:4 The transsexual's experience of alienation and isolation is reported to be almost unbearable. It is a direct result of the inability to be perceived correctly in terms of

gender. This experience is the justification for medical and surgical intervention. The WPATH guidelines clearly link the distress of the transsexual with the ethical urgency for surgery (ref 26 in the Introduction). However, this assumption is open to question in at least three ways:

1. There is a need to examine why the desires of transsexuals are medically recognised and not those of other groups such as apotemnophiliacs who request the surgical removal of limbs or other body parts for reasons other than suffering.
2. It begs the question about the legitimate scope of medicine in relation to issues of physical appearance, sexual pleasure, personal relationships, lifestyle choices and leisure pursuits and
3. It leaves unclear the status of those who do not seek medical help in order to resolve their crisis in gender identity.

In terms of 1), in 1997 and 1999 operations were carried out on two men who desired the surgical removal of limbs in order to fulfil sexual desires. Due to the subsequent furore the surgeon was subsequently asked to suspend further operations whilst the ethics committee of the Primary Trust met to discuss the issue[xvi].

Presumably, if surgery is no longer a viable alternative, people seeking surgery amputation are now referred to psychiatrists for the assessment and treatment of a mental disorder. Lawrence discusses the similarities between autogynophilia and TS and noted the difference in clinical approach[71]. She concludes that just as surgery seems to bring

[xvi] http://news.bbc.co.uk/1/hi/scotland/625680.stm 23/02/2009.gives details of this controversy, including the reaction of both the NHS Trust and members of the Scottish Parliament.

fulfilment in TS so it may to do so in autogynophilia. If she is right then autogynophilia ought to be as legitimate a concern for medicine as TS.

In relation to 2) the issue of the legitimate scope of medicine will be addressed briefly in Chapter Five.

In relation to 3) according to Benjamin the seeking of medical and surgical help is a symptom of TS, creating something of a circular justification[xvii]. People whose gender identity differs from their sexed identity *yet who do not seek medical help in order to resolve that difference* cannot, therefore, be regarded as transsexual. In which case how are such people to understand themselves and be understood by others? This is especially important for an individual who wants to think of her/himself as transsexual in order to belong to the transsexual community where she/he feels that help and support can be found. To have the designation of TS taken away from such a person solely because of the absence of the desire for surgery would seem to deny him/her a means of self and community identification. This seems odd primarily because TS does appear to be a matter of self-designation even within the medical model. Self-designation, it seems, only works if it leads someone to seek medical help but not if it leads someone else, with

[xvii] Benjamin writes: "The transsexual, however, puts all his faith and future into the hands of the doctor, particularly the surgeon. These patients want to undergo corrective surgery, a so-called 'conversion operation' so that their bodies would at least resemble those of the sex which they feel they belong and to which they ardently want to belong" and "True transsexuals…for them…their sex organs are disgusting deformities that must be changed by the surgeon's knife. This attitude appears to be the chief differential diagnostic point between the two conditions…that is between transvestism and transsexuality" **The Transsexual Phenomenon** The Julian Press Inc, New York, 1966 p 12.

a similar set of experiences, *not* to seek it. WPATH guidelines seek to keep the DSM 1V designation to avoid this kind of problem.

Conclusion

This chapter outlines the claims of conceptual incoherence and contradiction that lie at the heart of the medical model of TS. This consists in the way that the medical model justifies both the condition and treatment of TS in relation to two mutually exclusive models of gender (the inter-personal and intra-personal models).

CHAPTER TWO APPLICATION OF GENDER MODELS, BODY IMAGE MODEL AND MEDICAL MODELS TO TRANSSEXUALITY

Introduction

There are three sections in this chapter: In the first brief section the three models of gender discussed in Chapter One will be applied to TS; in the second both the medical model and the body image model will be discussed in relation to TS; and the third consists of an interim conclusion.

1. Application of the gender models to TS

All three models of gender are concerned with the way that human characteristics can either be thought of as belonging to the categories of masculinity or femininity or as characteristics that are available to everyone and freely chosen.

INTER-PERSONAL MODEL

This model ties the experience of gender to that of the sexed body.
Here the body is defining: genes, chromosomes, hormones, secondary sexual characteristics and internal and external bodily organisation are the sources of gender identity. Though each individual is also the result of his/her interaction with his/her environment, this interaction is based solely on bodily foundation. What is ideal for any

person is that gender identity is in harmony with those physical attributes and personal constructions that are associated with the sexed body.

When applied to TS a major issue arises. The body of the transsexual is of the sex that does not match the gender she/he considers to be correct. This does not seem to be a rational consideration if the body is the source of human ontology. If the body gives rise to the sense of self as well as to specific characteristics such as tenderness, compassion and courage then what has occurred within the body to give the transsexual person the sense of gender that is distinct from the body? A medical answer might be that nothing has occurred within the extended substance of the body itself, rather it is within the mind that the problem is to be found. TS may be a psychiatric condition. This seems to be the view of Dr. Barrett, head of the Gender Identity Clinic at the Tavistock Clinic, London who Christine Burns regards as having:

> distinct contempt for trans people as a whole (and trans campaigners in particular). He dismisses the modern day self-descriptive language of the trans-community, angrily asserts that transsexualism is a mental illness.[72]

Dr Barrett (see Appendix1) argues for a mental illness definition for TS partly because it has a psychiatric classification internationally but also for potentially instrumental reasons. He notes that in certain Islamic countries TS is linked with homosexuality. As a result the protection that is afforded to TS on the grounds of mental illness is extended to homosexuals. If TS were to have its psychiatric classification removed then, by default, so would homosexuality with the result that homosexual individuals, in such countries would no longer enjoy any form of protection:

> Were any country (including this one) to take a unilateral decision to remove a particular diagnosis it would open the door for other countries psychiatric bodies to do the same, or possibly to add things as diagnoses, including homosexuality. Thus, there may be a very gravely bad unintended consequence of rather parochial libertarian thinking[73].

He argues that the medical establishment has a duty to act internationally and so to avoid any pre-emptive action which would have a possible detrimental effect upon patients in non-liberal cultures. Barrett concludes with the observation that to access medical and surgical treatments it is necessary to have a medical diagnosis. These observations will be further examined in Chapter Five of this thesis in a discussion on the implications for medicine of the model that I am proposing in this thesis (p. 286).

A psychiatric understanding of TS would, however, be consistent with an interpersonal model of gender. If the body gives rise to gender identity then gender ought to reflect the sexed body and so a transsexual must be mistaken in believing her/his gender to be different from the reality of the sexed body. The belief must be a delusion because of its fixed and false nature. If TS is a psychiatric condition then the participation of non-psychiatric doctors and health care professionals in the current treatment regime should be called into question[xviii]. A justification for the medical and surgical treatment of a psychiatric condition would be required, one that demonstrates the rightness of a therapeutic goal that seek to align a person's physical reality to that which is generated by

[xviii] A full compliment of endocrinologists, surgeons, speech therapists and behaviour therapist, for example, work at the Tavistock Clinic participating in the transitioning of the transsexual to full gender status.

his/her mental illness and including the mutilation of healthy organs. Such a justification is unlikely to be forthcoming.

Likewise the transsexual who has physically transitioned and is now living out her/his life in the desired way is living with an unrecognised and untreated psychiatric/psychotic illness. This would be unacceptable in relation to any other delusional condition: medicine would be colluding with the delusions of its patients.

Alternatively, the designation of psychiatric illness may reflect the idea that TS is a matter of brain dysfunction. If so then perhaps because of the limitations of present day technology- it is not possible to work directly on the brain- the body must be brought into line with the brain condition, *everything else being equal.* This could provide a possible justification for the medical and surgical treatment of a delusional condition. This possibility will be discussed in the next section of this chapter which deals with the medical model.

THE INTRA-PERSONAL MODEL

In this model the categories of masculinity and femininity are anomalous modes of reference. Certain character traits are referred to as either masculine or feminine for no other than historical reasons and it is open to us all to develop personal identity as a matter of choice. A male is able to become tender, caring, gentle and nurturing and a woman could choose to develop traits of boldness, daring, risk-taking and recklessness.

The relationship with the sexed body is important but not defining and neither would it be deviant to pursue characteristics that have not been traditionally associated with the sexed body.

This model of gender offers a different way of understanding the sex/gender dichotomy in TS. The transsexual is able to define her/himself apart from, and even in opposition to, the body. This generates at least two tensions. First, a gender identity that bears no relation to the sexed body necessitates a justification for both the desire for, and treatment with, GReS. This point is linked to the discussion in Chapter One where the crossing of models was noted in relation to the construction of TS. Second, again related to earlier discussions, the TS narrative begins with the intra-personal model and ends with the inter-personal following GReS.

This movement across models is arguably an unacknowledged conceptual incoherence and logical contradiction, as concluded in the previous chapter. This potential incoherence is found both in the desire of the transsexual and in those who seek to help her/him. This does not mean, however, that the desire itself is not real nor that no genuine suffering is associated with the discordance experienced between sex and gender. Neither is it necessary to argue that the transsexual should not be seeking to transition. Rather I am arguing at this point that this incoherence should be acknowledged. I am making the conceptual point that the current constructions of TS are inadequate and invalid and that a new and more coherent model is required that does not move across concepts nor collapse into confusion. In Chapter Four of this thesis Authenticity will be

offered as both an alternative model for understanding TS and as an appropriate model for a person seeking to transition and to re-sex the body.

This conceptual incoherence is found in the designation GReS. This appears to state that it is gender that is being reassigned by means of surgery yet it is the fundamental position of TS that gender is that which a person 'has' and it is the body that is the locus of the problem. This is why the body is brought into line with gender identity. The designation GReS may be used in order to cohere with other terms such as Gender Identity Disorder and Gender Identity Clinics and there seems to be a reluctance to use the designation Sex Reassignment Surgery (SRS). There are two possible explanations for this. The first is that it is gender claims that prompt medical and surgical interventions and not sex claims, and the second is that the conceptual incoherence itself is difficult to resolve because its justification is based on gender dysphoria rather than bodily dysfunction.

The designation SRS or sex change surgery is problematic both because it is not possible to change chromosomal sex and because some inter-sexed conditions require surgery and a distinction needs to be made between this and surgery for TS. SRS suggests that the sex function of the body is the reason for surgery not that surgery is of instrumental value to the needs of gender. This is the main reason why this designation is not preferred. People within the transsexual community criticise the 'reassignment' component of the designation because it is felt that gender is not being assigned but rather freely chosen.

GReS is not concerned with gender at all but with the surgical alteration of a healthy and properly functioning body not for the sake of that body but for the sake of an immaterial and subjective notion of gender. This latter issue is not solely a matter of conceptual confusion, however. Even if a coherent model of TS is found it would still be the case that healthy organs are surgically removed for a reason beyond that of the body.

THE PAN-PERSONAL MODEL

This model offers a way of resolving the problems of the previous two models. Significance is attached both to the body and to the development of personal characteristics through the exercise of choice. This model acknowledges both the similarities and differences between people with the body functioning as both a source of sameness and difference. This is the model that is to be used in Authenticity Model for TS to be developed in Chapter Four

It is, however, the other two models that dominate medical discourse at the present time. The Pan-personal model is found mainly within the trans-gendered community.

2. Medical Model

This section will: look briefly at the nature of health and disease[xix]; consider why TS should be thought of as disease and to trace the way that medicine seeks to explain TS.

[xix] This is not the place for a full discussion on the vast literature that deals with the subject of health and disease. For a representative sample of authors who deal with this subject the following may be considered

HEALTH AND DISEASE

Trimble points out that: 'Our concepts of disease are not immutable, and various models have been proposed'[74]. The models that are used to classify phenomena as diseases generally fall into two categories: welfare or functionalist. The main welfare model is that used by the World Health Organisation (WHO) which states that health is:

> …a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity[75].

Here health is seen as synonymous with well-being and this model emphasises the subjective element of happiness in human experience. As a result it is thought to be a positive model of health. The functionalist model of health has been articulated by Boorse:

> The state of an organism is theoretically healthy i.e. free from disease, in so far as its mode of functioning conforms to the natural design of that kind of organism.[76]

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as representative: A Caplan "Health, Disease and Illness: Concepts in Medicine" Georgetown UP 2004, "Making Sense of Health, Illness and Disease" Ed P Tuohig and V Kalitzkus Rodopi 2004, "Making Sense of Illness-the social psychology and Health and Disease" A Radley Sage 1994, "Worlds of Illness-biographical and cultural perspectives on Health and Disease" A Radley Routledge 1993, "Concepts of Health, Illness and Disease-a comparative perspective" C Currer and M Stacey Leamington Spa- Berg 1986, RM Hare Journal of Medical ethics 12 (4): 174-181 Dec 1986, W M Brown "On Defining Disease" Journal of Medicine and Philosophy 10 (4) 311-328 1985 Nov and Steve Taylor "Approaches to Health and Illness" BMC Public Health (1471-2458) De Allegro 2001 Vol7.

As long as a person functions according to the norms for humanity as a whole then she/he is to be considered as healthy. Functioning refers both to bodily systems and social interaction. If a human heart works as it is believed that is should then it is healthy. Similarly if a person is able to work and form relationships then she/he is healthy. No reference is made to the subjective condition of the individual. If a person is unhappy but able to function both in terms of body and by holding down a job then he/she is considered healthy. Also if a person is happy but her/his body is not working properly then she/he is considered unhealthy. Boorse claims that diseases are 'deviations from the natural functional organisations of the species' which are in turn determinable objectively.[77]

This functionalist theory of health calls for a description of what is normal human functioning, one that is universally recognised and that sets a minimum standard of functioning achievable by all. To fall below this constitutes a state of ill health. Such a model of health can be understood to be performative or mechanistic, with the mechanism of performance as the object of interest. Boorse aims for a value free definition of health and to achieve this he makes a distinction between theoretical health and practical health.[78] The latter consists of that which ought to be treated by medicine because it fails to reach normal standards. No personal judgement is required in order to determine the presence of an illness as normal standards are objectively determined.

McDonald[79] offers a critique of both Boorse and functional models in general in terms of their inherent teleological goals. She argues that instead of being based solely on

observation of that which is natural to a species, functional models actually choose between potential options. She gives the examples of survival and reproduction and states:

> It is simply not the case that all species pursue the goals of survival and reproduction as individuals. Many species have a majority of members who are effectively infertile, and many species pursue reproduction only in a manner that ensures the death of individuals.[80]

She continues by discussing ageing, which Boorse referred to as 'an inherent defect of the organism'. McDonald argues that to be consistent aging would have to be viewed as a disease as it is not consistent with the normal functioning of a species. This view would result in all beings considered as unhealthy as they age. She concludes by suggesting that both concepts of health and the delivery of health care be based on a multiplicity of models.

However, it is not the purpose of this thesis to offer a detailed critique of Boorse's or MacDonald's models. It is sufficient to note that different models of health exist and that TS falls within the remits of both functional and well-being models. A more details critique is offered in my thesis for the MSc Health Care Ethics (2002) Body Dysmorphic Disorder.

TS WITHIN DISEASE MODELS

Medicine defines TS as a disease for at least three reasons: TS is concerned with the functioning of the human body; it manifests as social dysfunction with increasing inability due to the tension between the body and sense of gender as a result of which the

transsexual may withdraw from social engagements and personal relationships; and it is accompanied by the subjective experience of unhappiness. Unhappiness is often articulated as overwhelming and provides a major justification for both a medical explanation of the condition and for treatment and surgery. The experience of suffering is so central to TS that Chapter Three of this thesis is devoted to an exploration of it.

HISTORY

This section maps out the well documented course that medicine has taken in order to explain TS as a subject of legitimate medical interest.

Benjamin devoted a chapter of his definitive work to the subject of the aetiology of TS.[81] He reviewed the then existing literature that grouped TS into the two categories: the biological and the psychological. Of the former Benjamin examined genetic and endocrine dysfunction as possible causes. Whilst acknowledging that at his time of writing genetic science was at an early stage Benjamin cites the work of Hoenig and Torr[82] and Melicow and Uson[83] to argue for the possibility of the sex identification gene as a possible cause for TS:

> A theory such as this would explain much better than psychological 'conditioning' the astonishing depth and the intensity with which a transsexual identifies with the opposite sex. Incidentally, it would also explain the resistance to treatment.[84]

Benjamin then discusses the possibility that TS is cause by endocrine dysfunction. He begins by examining the possibility that the foetus may be influenced by the hormonal condition of the mother, specifically that a male foetus may be influenced by high levels of oestrogen. This might occur as a result of the woman experiencing stress during pregnancy or if she has consumed certain chemicals whilst pregnant. He discusses normal foetal development and how this may be influenced by stresses that the mother experiences. He wonders if this may be why there are more M-F transsexuals than F-M and then examines the work of Stoller et al[85] in relation to the possibility that M-F transsexuals may produce abnormally high levels of oestrogen themselves.

Benjamin speculates whether this finding in relation to inter-sexed men and women may also apply to the transsexual. Benjamin also examines the role played by the brain itself. He again reviews the existing literature, paying attention to that which examines cerebro-neural functioning along with research into the effects of lobotomy upon sexual functioning and brain effects produced by the use of electrodes. He focuses attention on the work of Gorsky[86] who identified the hypothalamus region of the brain as of central importance and argued that this is inherently female and must be masculinised in the womb for male identity to occur:

> Unless there is testicular tissue secreting testosterone during this period of development to organise this portion of the brain along masculine lines then it remains forever female.[87]

Benjamin completes his discussion of aetiology with an examination of the possible psychological causes for TS paying particular attention to imprinting, which is the impression made upon a developing mind from its surroundings.

The identification of the hypothalamus as an important area for an organic explanation for TS was later taken up by Zhou et al[88], who identified the BSTc region as potentially decisive. Having studied the brains, post mortem, of six M-F transsexuals they conclude:

> Here we show that the volume of the central subdivision of the bed nucleus of the stria terminalis (BSTc), a brain area that is essential for sexual behaviour is larger in men than in women. A female sized BSTc was found in M-F transsexuals.[89]

They concluded that, following experiments with the brains of rats, this area of the brain may be responsible for masculine identity and that this finding can be applied to human beings. They speculated that it is the absence of androgens in the womb that may be responsible for the size of the BSTc. By 'sexual behaviour' it appears that they mean both gender identity and behaviour that has traditionally been understood as falling within the gender-as- body model discussed earlier. The BSTc region is of similar size in both non-transsexual men and women regardless of sexual orientation[90]. The conclusion is, therefore, that this region of the brain is linked to the subjective sense of gender identity that forms an essential element in personal identity.

This work was later taken up by Chung, De Vries and Swab[91], who sought to determine when the BSTc region becomes sexually dimorphic. They concluded that this region

showed more neurons in men than in women from midgestation onwards and that this only becomes significant in adulthood. In fact the difference between men and women may extend into adulthood. They report:

> Alternatively, it must also be taken into consideration that changes in BSTc volume in M-F transsexuals may be the result of a failure to develop a male-like gender identity[92].

This conclusion raises the possibility that the failure for a male sexed individual to develop a subjective male identity may have an effect on the area of the brain that is associated with gender identity. It may be the case that the functioning of the will in some way alters the brain. This reverses the organic explanation for TS that is formative in the medical model.

The BSTc region remains the focus of research into organic causes for TS. The medical model itself provides the justification for such research and medical explanations continue to be sought.

In its most recent formulation TS is now known as Harry Benjamin Syndrome (HBS)[93]. This designation is used to reflect the neurological understanding of the causes of TS. The claim is now made that Harry Benjamin Syndrome is not an illness, either physical or mental, but should be thought of in the same way as inter-sexed conditions. Goair asserts in her on-line information site that: 'experts now consider that HBS is not a mental disorder, but rather a natural and biological variation of human sexual identity'[94]. Her claim is that HBS is as normal an expression of gender and sexual identity as any

other, yet one that requires medical and surgical interventions in order for the person concerned to realise her/his identity.

A transsexual is now considered to be 'born' a member of the opposite sex (this is the term used by those proponents of the designation HBS) who requires 'corrective surgery on physical structures'[95]. There is no 'trans' element in this construction. The idea of 'trans' or of moving across boundaries in the older model had overtones of fault and instability and is no longer considered to be an appropriate construction within the transsexual community.

However, the medical model remains the primary model for contemporary reflection and treatment of TS both within scientific/academic and popular discourse. Accordingly the medical model warrants greater discussion within this thesis (see Chapter Four).

3. The Body Image Model

The third model that can be used in order to explain TS is the Body Image Model.

DEFINITION

Merleau-Ponty holds that the primary purpose of body image is to provide an individual with 'a global, practical and implicit notion of the relation between our body and things, and of our hold on them'[96].

Body image is an internal awareness of the appearance, shape, nature, position in space and time and identity of one's body that informs a person from moment to moment of her/his position in the world relative both to others and to the world of things. Head[97] identified two characteristics of the postural body image: plasticity and equilibrium. Plasticity refers to the body image's adaptability and flexibility whilst equilibrium refers to the body image's role as setting a standard against which both bodily and other changes are measured in order to promote stability.

Plasticity means that the body image can change not only in relation to actual changes in the body due to age, illness and injury but also as a result of psychical and social changes such as the role of imagination focusing upon present and future possibilities. Schilder[98] claims that each individual possesses an unlimited number of body images that need to be held together in tension. This multiplicity of images is made up on an ideal body image, and both masculine and feminine images as well as distorted body image all compete in the mind for attention. These images relate to one another in conflict and this in turn prevents any one image from achieving hegemony. This conflict and lack of dominance can be thought of as a good thing because it enables a person to cope with change over time.

DEVELOPMENT OF THE BODY IMAGE

All body image theorists recognise the importance of perception in the development of the body image. Perception here is a cognitive or conscious process by which an individual develops a sense of bodily identity as a result of self-awareness, the world

around the self and the reciprocity between that self and the world. This develops gradually and the crucial stage has been identified by Lacan[99] as the 'Mirror Stage':

> (T)he Mirror Stage is a phenomenon to which I assign a two-fold value. In the first place it marks a decisive turning point in the mental development of the child. In the second place it, it typifies an essential libidinal relationship with the body image.[100]

The 'Mirror Stage' is the child's awareness of its body from 'outside', what is called the specular image, in competition with its view of itself and its body from the inside. These two perspectives are seemingly disparate experiences and the challenge is for the individual is to develop a coherent image out of the two. This problem is not faced consciously but seems to be a task undertaken by the non-conscious mind. Two difficulties need to be overcome in order for cohesion to be achieved. First a person needs to realise that the specular image is *not* the self even though it may be one image or one representation of the self. Second s/he must realise that the person is not located in the mirror but instead is located where he/she feels him/herself to be introspectively. This last term means the awareness of bodily position in space and time as a separate object.

An individual has therefore to reconcile two forms of awareness: she/he feels him/herself to exist in an introspective sense yet she/he can also be seen by an external witness at the very same moment. A space opens up between these two forms of awareness with a sense of alienation and fragmentation the result.

Merleau-Ponty[101] suggests that the developing self has to incorporate the specular image into its own self image and this process involves active participation rather that passive acceptance of what is seen from the outside. It is not only the mirror image that needs incorporation but also the perspective that others have of 'my' body and how they respond to it;

> The specular image, given visually, participates globally in the existence of the body itself and leads to a 'phantom' life in the mirror, which 'participates' in the life of the child himself. What is true pf his body, for the child, is also true of the other's body. The child himself feels that he is in the other's body, just as he feels himself to be in his visual image.[102]

This incorporation allows for sympathetic identification with others later on in life and debate focuses on the place and role of deception in the development of the body image. Deception here refers to the role of dress and techniques of making the self attractive to others. (Deception as a moral possibility will be discussed in Chapter Five in relation to both self deception and the deceiving of others in the context of intimate relationships).

Body image continues to develop through the narcissistic stage when a person can be sexually aroused in response to their own bodily sensations. This is linked to the experience of the self in relation to the world and the finer aspects of the body image are dependent upon life experiences, training and emotional attitudes.

The self strives to achieve bodily equilibrium by means of establishing a stable body image. This can never be achieved fully because a constant process of construction/deconstruction and reconstruction of the body image occurs. Schilder

maintains that it is possible to be 'tied down' to one's body image, meaning that one image becomes dominant with the result that it does not take account of changes to the body over time. To avoid this, the body image can be 'played with' or experimented with by means of clothing, jewellery or even self mutilation. Butler writes:

> This desire for a kind of radical remaking of the body is obviously out there in the public sphere.[103]

She argues that a desire exists to transform the physical limits of the body and so it is necessary to think of one self as not being tied down to its present physicality. This desire can be expressed through admiration both for sportsmen and women and for fashion models and those who are recognised as physically beautiful.

ABJECTION

This is the psychical process by which various physical phenomena are excluded from the sense of self and therefore from the body image itself. This is done in order to sustain a healthy and functioning sense of self thereby enabling one person to relate to others.

A self refuses to recognise any of its defiling or uncontrollable and impure bodily functions as part of the body image. A person knows what it is to produce waste products as part of the functioning of the body. These substances originate within the body but are then passed out of it, as that which is harmful to it. As we have seen the body image is constructed in relation to the experience of the body and as waste products are part of bodily experience a way has to be found of not incorporating these into the image itself

otherwise the image would be built on a foundation that is unstable and toxic. To prevent the incorporation of waste products in the body image a boundary needs to be established between the sense of self and that which is being abjected. On one side of this boundary is the self and on the other are all those substances and functioning of the body that can be thought of as damaging to the sense of self. Abjection is the process of expulsion from the one side of this boundary to the other. This leads to a solid sense of self as that which is a substantial and idiosyncratic entity.

Abjection, however, is problematic. That which is abjected is necessary for the healthy functioning of the body. Waste products are the result of food consumption, which in turn is necessary for life. So there is awareness within the self that what is abjected is at one point necessary for life itself. This is further complicated by the knowledge that food may be a source of threat as every time an individual eats he/she may be taking into the body a substance that has the potential to destroy it, as in the example of food poisoning. Abjection therefore is not a clear cut or straightforward activity. It is not an activity in which a person performs consciously.

Kristeva[104] describes abjection as a process of letting go of that which one desires to keep. This arises from the knowledge that what is rejected was once part of the self. Abjection can be experienced by the feeling of horror and disgust experienced when one sees vomit, blood or even a dead body. The abject is to be distinguished from both subject and object. Subject refers to the self who experiences abjection and object refers

to that which has never been part of the subject's experience. The abject lies between both and abjection is the process of removing it from within oneself to a place outside.

One effect of the problematic nature of abjection is that the experience of the body can be at odds with the body image. A body continues to function by utilising the very substances that are abjected. The abject is therefore necessary in some sense to the body and ambivalence exists between the self and the abject. Furthermore that which is abjected has the potential to seep back into the body image and so threatens it. One possible outcome of this is that the body image can be distorted.

Weiss[105] has considered the way that abjection can threaten the body image. She finds evidence of this in anorexia nervosa. She argues that an individual with anorexia sees bodily processes that lead to the development of fatty areas as abject and therefore as being rejected from the sense of self. This is the result of an over-identification with one particular body image, which she identifies as the culturally desirable female body image that has been constructed in patriarchal western societies. As seen earlier, a person requires a multiplicity of body images in order to adapt to the changes in the body over time. This is called *destablisiation.* Weiss argues that an anorexic may identify exclusively with one body image to the exclusion of others and the one that she identifies with is the ideal:

> By contrast, I am claiming that it is precisely the lack of *destabilisation* in the anorexic's body image that is the source of its deadly destructiveness…I am claiming that she is *too* coherent [106].

Weiss' analysis of anorexia differs from many accounts in relation to the place occupied by the body image. She argues that it is not a case of distorted body image, which is the popular view, but of too clear a view. In the popular view it is believed that there is a disconnection between the way that an anorexic sees herself and her actual bodily appearance. Weiss argues that there is not a contradiction between the two but a dominance of one image. She argues that what is required is that other body images be created:

> (there is a) need to respond *corporeally* to these contradictions through the creation of multiple body images.[107]

3. Body Image and TS

The application of the body image model to TS is something that I consider to be of value both in terms of the 'mirror stage' and in relation to abjection. Prosser[108] devotes a section of Chapter Two to a discussion of body image and TS from the perspective of 'being trapped in the wrong body'. He describes body image as an internal sense of sexed identity which is 'radically split for the material body' body and leads to a rejection of the sexed body. Prosser states that this is sufficiently powerful as to:

> feel sufficiently substantial as to persuade the transsexual to alter his or her body to conform to it.[109]

Citing the work of Anzieu and Sacks, Prosser discusses how the body image of the transsexual leads to a sense of loss of the sexed body. GReS seeks to restore what has been lost so that the transsexual can live normally. Body image, therefore, is the conviction that the internal sense of the self is the real self

What I suggest is that it may be useful to explore how this disconnection between the body image and the sexed identity occurs within TS.

MIRROR STAGE.

TS could be associated with the disjunction between the body image of the transsexual which, as we have seen, is known 'introceptively' and the image of the self that is perceived specularly. This is the difference between the way that a transsexual 'sees' him/herself subjectively or mentally and what he/she sees when looking in a mirror. A transsexual may have 'seen' him/herself as having a body that belongs to the opposite sex and only realises that this is not the case at that point in human development designated by Lacan as the 'mirror stage'. As well as the usual disconnection experienced when confronted with the specular image the transsexual has the added distress of a total failure to recognise the self in the image in the mirror. This may come slightly later than the actual mirror stage, when the child has both the mirror stage itself and the knowledge that men and women are different.

The distress of the transsexual may be greater than that which is normally experienced in the development of the body image. One outcome of this may be not just a failure to recognise the self in what is seen but to have no point of contact with the image at all. This may result in a total rejection of the image in the belief that what is seen is not true: rather the truth lies in the introceptive image. This image is the more familiar one, one that has been 'with' the transsexual longer than the specular image. It is the familiarity of

the introceptive image than may lead the transsexual to believe that it represents the truth about him/herself. This may explain why he/she holds on to this image, for which there is no objective evidence, instead of the specular image, for which there is.

The transsexual may not receive the specular image as representing the self or as showing some form of truth about the self. Instead he/she sees it as that which denies his/her own self, as that which is a contradiction and will lead others to the wrong conclusions about who he/she really is. The specular image is rejected. The 'usual' course of events is that a person 'comes to terms' with the image that she/he sees in the mirror. However, in TS there seems to be a failure to adjust or to integrate this image with the result that a transsexual disconnects totally from that image that she/he sees.

ABJECTION

The process by which a transsexual may come to disconnect from the specular body image may be abjection. Prior to the mirror stage a transsexual may have developed a body image in which the sexed characteristics of the body have been abjected. A body image has been gradually developed which is that of the opposite sex. If the idea of a multiplicity of competing body images is adopted, as discussed earlier in terms of *destabilisation*, then as with anorexia, it may be that the transsexual develops a dominant image with which he/she identifies exclusively. So instead of seeking to integrate a whole number of competing and contradictory body images by means of a creative tension, a transsexual has one dominant image.

The secondary sexual characteristics of the actual body are moved outside of the boundaries that form the self and are placed 'outside'. All the characteristics of abjection may be present. The secondary sexual characteristics, the abject, are associated with the body and so at some level are associated with the self in the same way that bodily fluids are. Also, just as bodily fluids, they have the potential to threaten the existence of the self. Secondary sexual characteristics do so because it is the gender that is associated with them that is 'seen' by others and is that which forms the basis on which others relate to the transsexual.

The initial experience of abjection lies in the way that a body image of the 'opposite' sex is set up. This continues when the transsexual 'abjects' the specular image. This may be the first occasion for suffering in her/his experience. At least if not the first experience of suffering then it may be the first experience of significant and internally generated suffering. Abjection continues for as long as the specular image exists and is experienced whenever that image forces itself upon the attention of the transsexual.

Surgery may be interpreted as the ultimate abjection. Surgery both removes the threat to, and promotes the actual survival of, the self in accord with its introceptive image. Understood in terms of threat and survival the sense of urgency in relation to surgery becomes more comprehensible. Abjection is closely related to the positive desires that are present within the experience of TS and this will be discussed further in Chapter Four.

I have sought to include body image into the discussion of TS as a potentially useful means of exploring how a transsexual arrives at the conviction that she/he 'inhabits' the wrong body. I have demonstrated that the notion of abjection appears to offer fertile ground both for an understanding of TS itself and as an alternative perspective to the medical model. More work yet needs to be done to apply the insights of body image theory to the transsexual debate. In this thesis I wish to direct attention to the importance of body image and the need to explore the way that this develops in the experience of the transsexual.

Conclusion

TS has been discussed in this chapter in relation to the models of gender, medicine and body image. Within the transsexual community there is a move away from the medical model in favour of the gender model. Bornstein[110], a M-F transsexual, as well as rejecting a medico-surgical-psychiatric interpretation of TS, challenges the whole notion of gender categories and calls for them to be rejected. She challenges the idea that surgery is necessary and that there exists biological factors that account for gender identity and by extension for TS:

> By focusing on the so-called 'inherent differences' between men and women we ignore and deny the existence of the gender system itself and so we in fact hold it in place. But it's the…idea of gender itself that needs to be done away with. The differences will then fall aside of their own accord.[111]

She is aware that she is subject to criticism at this point as someone who has transitioned in the accepted medical way. She acknowledges that she may be thought to be closing a door to others that she was able to walk through. Her defence is that she has only come to realise after transitioning that by following the medical route she actually maintained gender constructions.

Even some of those within the transsexual community who advocate surgery have difficulty with the medical model and its psychiatric classification. For instance, O'Hartigan[112], disagrees with the idea of trans-genderism[113] and also claimed that surgery saved her life:

> Receiving surgery allowed me to aspire to what most take for granted… a normal life![114]

For O'Hartigan the issue is not whether TS should be understood as psychiatric or biological in origin but rather that surgery works. Hers is a pragmatic approach although she does seem to be willing to discuss the conceptualisation of TS itself. For others[115] it is the psychiatric gate keeping role that is seen as problematic and there exists a desire to move away from any psychiatric classification. Califia[116] wonders, however, if the medical and psychiatric justifications for surgery were to be removed what justification could then be found for the treatments that so many transsexuals seem to desire:

> The desire to be free from the stigma of having been diagnosed with a mental disorder is understandable. But if sex change surgery is going to continue to be in its most complete and fullest sense. They are challenging the imaginary assumptions through their own imaginations.

All three models discussed in this chapter are to a greater or lesser degree found in contemporary transsexual debate. All three need to be critiqued both in terms of validity and in comparison to one another. It appears, however, that for a number of reasons such a critique has been difficult to pursue up to the present time. These reasons form the interim conclusion of this thesis which will be discussed next.

INTERIM ASSESSMENT

This interim assessment seeks to do two things. First, to examine my claim that insufficient critical attention has been paid to the three models and second to discover whether or not, because of the difficulties with the three models, there are any other grounds for offering medical treatment and GReS to those with TS. There is not the same difficulty with the body image model as there is with the other two; the only difficulty appears to be the lack of development and application of it to TS. Suffering will be explored in Chapter Three as an alternative justification for treatment.

Insufficient critical attention seems to have been paid both to TS and to the three models because of certain cultural trends and preoccupations. Writers such as Raymond[117] and Millot[118] have attempted a critical analysis of TS with the former offering an anti-transsexual analysis. Raymond argues against the medical construction of TS claiming that: 'transsexuals (M-F) are not women. They are deviant males'[119].

Raymond, a lesbian feminist, sees the creation of transsexual women as an attempt by male patriarchy to invade one of the last spaces occupied exclusively by women. This space is the female body and the subsequent relationships between women in which the nature and experience of being a woman is discussed and worked out. TS is a way for men to equip themselves with what they have always desired, which is the acceptance by women as being one of their own. Raymond argues that M-F transsexuals ought not to be accepted by women as women but as men who are seeking to invade the space of women.

She has created a division of opinion amongst lesbian feminists with this claim and has provoked strong reaction from M-F transsexual writers and advocates. Stone[120] argues that transsexuals are 'embodied voices' whose individual stories need to be heard and she rejects Raymond's claim that M-F transsexual's 'rape' women's bodies and belong 'outside of normal gender structures;

> I suggest constituting transsexuals not as a class or problematic "third gender", but rather as a genre-- a set of embodied texts whose potential for productive disruption of structured sexualities and spectra of desire has yet to be explored[121].

It may be that this kind of critical assessment of TS has had the unintended consequence of hampering further analysis. Doctors, for example, may fear being considered anti-transsexual and, in turn, this may inhibit them from undertaking critical reflection on TS. This may be a reason for the failure of medicine, up to the present time, to identify the problem with the use of two mutually exclusive models of gender (as identified in the first aim of this thesis).

It is certainly the case that some within the transsexual community have written about the caution that is required when non-transsexuals seek to write about, and comment upon, TS. Hale[122] offers fifteen guidelines for non-transsexuals who wish to express an opinion on TS, the first of which is:

> "1. Approach your topic with a sense of humility. You are not the experts about transsexuals, transsexuality or transsexualism or trans…anything. Transsexuals are!"

This claim to be the experts on the basis of experience rather than on knowledge and skill may be seen as an 'anti-expert' perspective which sees expertise as the preserve of white middle class males. Suspicion of this class of people and the guilt that the class itself may be experiencing will be discussed in the next chapter in the work of Amato[123].

Other trends and values that may have hindered critical attention of TS include the value that is currently placed within society upon sex and sexuality. Human sexuality is understood both as procreation and recreation and it is the value placed on the latter that is in focus here. This value is seen both in the way that recreational sex is increasingly prominent and acceptable within society and in the belief that a full and satisfying recreational sex life is a basic human right[xx]. Linked to this is the belief that any failure to have and enjoy recreational sex is problematic and unacceptable. TS, in a general way, is associated with sex and so the way that sex is viewed influences the way that TS is thought of.

Szasz[124], documents the value that is placed on recreational sex:

> Next to the need for sleep, water and food the sexual urge is our most powerful biological drive.

He is deeply critical of the way that medicine has constructed medical difficulties around sexual functioning. Medicine uses disease constructions in its discussion of sexual

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[xx] Staff at The Douglas House Hospice, Oxford, UK recently helped a resident with Duchenne Muscular Dystrophy to have sex with a prostitute after consulting lawyers, clergy and doctors. A human rights justification was used. The Daily Telegraph carried the story on 31st January 2007.

dysfunction in a way that it does not do in relation to other bodily functions such as eating and enjoying food. Medicine promises treatment to those who experience difficulties in relation to sex. Szasz argues that sexual problems may not be medical problems at all but rather matters of taste or preference. Medicine has constructed the idea of 'normal' sexual behaviour, with the corresponding notion of dysfunction when that norm is not realised, so that people now consider themselves to be ill when in fact they are not. Medicine offers a range of treatments for those who wish to improve their own sexual performance. As well as medicine reflecting the general value placed on recreational sex Szasz argues that constructing sexual dysfunction as a medical problem may be a way for medicine to increase its own prestige and mechanism for controlling human behaviour.

The acceptance of something akin to the right to recreational sex is seen in a number of ways: pornography being given to prisoners[xxi], lowering of the age of consensual sex to sixteen[xxii], the 'Right to Say No' campaign for women[125], sex being offered as therapy in some medical contexts[126] and claims that the State has a duty to provide sexual fulfilment to those who through disability or other factors are unable to do so for themselves[xxiii].

[xxi] Reports from a number of countries describe the way that pornography is offered to prisoners and the way that this is justified cf The Daily Telegraphy June 02 2008, The Supreme Administrative Court in Stockholm in June 2007 ruled that the prison service has no right to withhold pornographic magazines from prisoners and The American Civil Liberties Union in 2006 sue for the right of prisoners in Indiana, USA to have access to pornographic material. They argues that any prison ban on such material could be extended to a ban on personal correspondence as well as on the 'great classical literature'.

[xxii] Guardian February 11 2000 reported on Parliament's decision to lower the age for gay sex to 16 on Thursday 10th February 2000.

[xxiii] Asta Philpot travelled to Spain to a state sponsored brothel in order to loose his virginity. He felt that his medical condition arthogryposis inhibits him from normal sexual practice. Disability Now website in 2005 suggested that 75% of disabled people believed in the legalisation of prostitution, with 62.5% of men and 19.2% of women saying they would use trained sex workers.

The value placed on recreational sex may have two effects; first in an unwillingness to criticise any form of consensual sexual behaviour amongst adults and second, as discussed above, in the medicalisation of both sexual failure and the desire for better sexual performance.

Applied to TS the value placed on recreational sex may work in this way. TS is associated with sex. This may either be as a result of a lack of clear thinking on the part of those who are not called to theorise about it but who may be involved in some way, or because of the continued conflation of ideas of sex and gender. This may be because TS has the designation 'sex' in its construction. If this is the case then just as it is felt to be inappropriate to express a critical opinion of a person's sexual practice or performance then it is inappropriate to question a transsexual's claim to GReS.

Szasz targets this medicalised response to TS. He further reflects on the fact that TS is not a matter of either sex or medicine yet values and attitudes towards sex are applied to it. He describes TS as 'a condition tailor-made for our surgical-technological age'.[127] This may apply equally to medical practitioners as it does to the general population.

A further cultural norm that may contribute to unwillingness to critically engage with TS is the way suffering is regarded. Claims to be suffering tend to go unchallenged. Indeed suffering individuals tend to be admired by others. Transsexuals claim to be suffering, and so the way that suffering is viewed in general may be extended to them with the

result that the claim to be suffering is accepted at face value. Having admired the person who is suffering, there is an assumption that suffering is to be alleviated. I will demonstrate in Chapter Three that there is no absolute duty to alleviate suffering because suffering has potential value.

The second thing for this interim assessment to do is to ask whether given the problems discussed in relation to the three models any other justification for GReS can be found. One possible justification of GReS is the suffering that a transsexual person experiences as a result of gender dysphoria. As seen earlier such suffering has a profound effect upon the individual and this leads her/him to seek medical and professional help. Surgery is often that which the transsexual desires both in order to bring suffering to an end and to make visible gender identity. Therefore it may be that suffering alone is a justification for surgery. The next chapter will examine this claim by firstly offering a specific definition of suffering in order to exclude this experience from other forms of unhappiness, secondly by examining the moral duty to alleviate suffering and, finally by examining the possible value of suffering. The conclusion to be reached in Chapter Three is that suffering does not form a sufficient justification for surgery.

A final issue is the value placed on medical knowledge and technology. Both the necessary skills and technology exist to achieve GReS. As well as contributing to the concept itself, medical technology may be thought of as driving forward the practice of GReS. Meyerowitz[128] offers a history of TS that includes a medical analysis. She details the way that advances in technology enables the desires of transsexual people. A

comparison can be made with other bio-medical practises such as In Vitro Fertilisation. The recent example[129] of a woman giving birth to octuplets raised questions about the ethics of IVF treatment. The existence of the technology to perform a task may result in that task being performed without too much critical reflection. The question in ethics centres on the relation between availability of technology and its rightful use. Because the technology exists it does not mean that it is right to use it.

If, therefore, the current models do not form a logical and coherent justification for surgery and suffering does not either then the question to be asked is: Is there any other possible justification for surgery and therefore for the fulfilment of the desires of many transsexual people? In Chapter Four a new model will be offered which both resolves the difficulties with the existing models and does not rely on the notion of suffering. That model is Authenticity.

CHAPTER THREE SUFFERING

Introduction

This chapter will begin by constructing a specific definition of suffering. This definition will distinguish suffering from other experiences of human pain, misery and unhappiness in order to be clear about the kind of negative human experience that have the potential to be of benefit. This definition will then be applied to TS in order to establish whether TS can be thought of as suffering in this specific sense. The next section will discuss the moral duty to alleviate suffering with the third examining ways in which value can be found in the experience of suffering.

The central argument of this chapter is that even if the transsexual can be thought of as suffering it does not necessarily follow that there is an absolute moral duty to alleviate this suffering. I will offer two reasons in support of this view:

1. A duty to alleviate suffering is problematic both at the motivational and consequential level.
2. Value can be found in the experience of suffering. Value may be found both by the sufferer and those who are related to her/him. This value may be lost if the experience of suffering is removed.

The chapter will end with an application of all that has been discussed to TS.

1. A Definition of Suffering

Contrasting views of the human condition can be found in the theological, philosophical and literary tradition of western thought that are both optimistic and pessimistic. Leibniz[130]is an example of optimism with his belief in a controlling benevolent Deity and Hobbes[131] an example of pessimism. For Hobbes the three principles of competition, diffidence and glory contribute to the basic human condition. Describing human existence in terms of a series of negatives Hobbes concludes with his well known description of the life of man as:

> worst of all, continual fear, and danger of violent death; and the life of man, solitary, poor, nasty, brutish and short.[132].

There is a longstanding theological and philosophical tradition that holds to the futility and vanity of human existence. Christian theology has reflected upon the insight of Job in the Hebrew Scriptures who concluded that:

> Man, who is born of woman, is of few days and full of trouble. He comes forth Like a flower and fades away; he flees like a shadow and does not continue.[133].

Such reflection has resulted in the belief that human life is fundamentally a negative experience. The cause is believed to be the wrath of God provoked by human sin and no-one is exempt from experiencing this because, in the words of St. Paul:

> All have sinned and have fallen short of the glory of God[134].

Christian theology teaches that whilst God is essentially good and gives good gifts to all people the basic condition of humanity is one of misery. It is from this that Humanity needs to be delivered and deliverance can only be found in God Himself and His redemptive purposes in the person of His Son Jesus Christ. Men and women are unable to deliver themselves both because of their sinful nature and because of an unwillingness to recognise this nature with its inherent hostility towards God. God has to take the initiative in delivering people from their misery and seeks to reconcile humanity to Himself by offering a place in Heaven. Reconciliation takes place when an individual embraces the promises of God and as a result experiences divine grace[135].

Christianity's answer to human misery lies in a relationship with God through Jesus Christ. This relationship begins in human experience and finds fulfilment in eternity. The relationship does not guarantee exemption from the ordinary misery of life but seeks to utilise unhappiness to achieve a fuller and deeper knowledge and experience of God. It is in through these means that a Christian believer can live with the harsh realities of life.

Philosophy has also been engaged with the problem of human misery. Philosophers have reflected on such experiences as ill-health[136], natural disasters[137], war[138], misery[139], and the daily disappointments of life[140]. A history of this engagement can be found in Amato[141].

A modern philosopher who sought to engage with the subject of human misery is Schopenhauer[142]. He maintained that human life is characterised by vanity which is found both in the way that the world itself is constructed and in the nature of men and women themselves. In terms of human nature Schopenhauer argued that we are so constituted that:

> we do not feel the health of our whole body, but only the small spot where the shoe pinches, so we do not think of all our affairs that are going on perfectly well but only of some insignificant trifle that annoys us[143].

His contention is that the only experiences that seem to register in human consciousness are negative ones such as the awareness of pain or distress. This results in negativity being the only experiences we feel. Happiness and pleasure are to be thought of as absence rather than presence. Schopenhauer states that happiness is:

> the elimination of a desire and the ending of a pain[144].

Happiness consists of cessation which soon gives rise to the experience of boredom and frustration. It is nothing more than a void which leaves the individual wondering what to do next. No one is able to stay long in this condition and soon new desires being to take shape and new goals are formed and so a person begins to experience again all the

anguish of unfulfilled desire. Effort is then expended in order to satisfy these new desires and to achieve the new goals. To add to the experience of human misery Schopenhauer factors in the consciousness that each person has about the passage of time and the inevitable experience of death. Self-awareness is the hallmark of the human condition yet this proves to be the very grounds for the experience of misery:

> the enhanced power of knowledge renders the life of a man more woe-begone than that of an animal[145].

For him to be human is to be aware of one's own life in the light of the imminent and inevitable approach of death. Such knowledge reduces the living of life to that of:

> a task to be worked off…the world is just hell and in it human beings are the tortured souls on the one hand, and the devil on the other[146].

The awareness of death is the greatest reason for the experience of vanity but not the only one. Men and women are also tortured by the awareness that the future could hold things that could prove far worse than anything yet experienced. Present happiness (or the cessation of pain) can be lost as it submerges into a generalised fear of the future. Fear of the future causes men and women to re-orientate themselves to the present moment and to maximise the benefits of the now. One way of doing this is by elevating basic human needs to a higher order of significance. For instance the need for food becomes a desire to find pleasure in the eating of a meal either on an aesthetic or a social level. For this to be achieved a great deal of effort now needs to be expended and this too can lead to

anxiety and the experience of disappointment. The attempt to be orientated to the present proves to be a further occasion for the experience of misery.

In the philosophy of Schopenhauer the fact of misery or vanity does not prevent men and women from searching for meaning and purpose in life nor from seeking happiness. Inactivity is impossible so people are thrust forward into an endless searching which will always fail to be satisfied. Humanity is condemned to be future orientated, constantly pursuing gaols and dreams. Thoughts about the future dominate to such an extent that the present cannot be appreciated on its own terms. Every one is pulled from the present time into the future with the result that all live with anxiety and restlessness.

Schopenhauer's conclusion is that true happiness is impossible. Happiness is nothing more than an illusion. If a person claims to be happy then she/he is merely indulging in a form of self deception:

> No one is happy, but everyone throughout his life strives only for an alleged happiness that is rarely attained, and even then only to disappoint him.[147]

That human existence is like this ought to come as no surprise, according to Schopenhauer. He sees it as proof that 'human existence is some kind of error".[148]

Other thinkers argue that such views are unnecessarily pessimistic and point out that happiness is not always as transitory and as elusive as Schopenhauer argues. Some people do seem to experience happiness in a profound way and to enjoy it in the present

moment free from any worries about the future. Similarly there are those for whom the achievement of a personal ambition brings lasting satisfaction and does not appear to lead to boredom and frustration. Such people even seem to be able to revisit the achievement of an ambition and to recapture at least a vestige of the original pleasure.

Nevertheless, it appears that, from the point of view of ordinary human experience, unhappiness seems to be that which is both known more extensively and for longer periods of time then happiness. Unhappiness is talked about more often than happiness and there seems to be a greater willingness to hear stories about sorrow than of joy. This is often reflected at a popular level in radio phone-ins[xxiv]. Perhaps we are curious about how people overcome sorrow and difficulties. Sorrow provides an occasion for virtues such as courage and determination to be demonstrated. A tale of how a person overcomes suffering commands greater interest than one of someone who has experienced unalloyed joy and pleasure. The universal resonance of suffering, and the challenge of behaving virtuously, may account for the willingness to hear stories about suffering.

For the purposes of this chapter it is important to distinguish the type of misery that seems to be part of ordinary human experience from that which can be thought of as unusual and of potential value to the sufferer. This distinction enables us to determine

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[xxiv] A recent example of this is the audio diaries of Nick Clarke, the former radio presenter at the BBC. Having been diagnosed with a rare form of cancer that necessitated the surgical removal of his left leg Clarke kept an audio diary recording his ordeal that would be broadcast on the radio when treatment had been completed[xxiv]. He records the reactions of his sons to the amputation of his leg and also documented his slow recovery. He was eventually able to return to work before a relapse of his condition that eventually led to his death

that which ought to be alleviated, because no good can come out of it, from that which, perhaps, ought to be left alone because of the value it produces. The latter will be denoted as *suffering* and I will argue that because of its potential value there is not necessarily a duty to alleviate it.

First, the concept of suffering needs further clarification. Weil[149] distinguishes between suffering and what she calls 'mere'[150] pain and she argues that for an experience to be considered an example of suffering it needs to contain the following three elements: physical, psychological and social factors. Any negative experience that affects a person in only one or two of these areas cannot be considered to be suffering because it is relatively easy to overcome, to forget and fails to leave lasting scars upon a human psyche. For Weil it is scarring that forms the essential element in an experience of suffering. Tooth ache, for instance, is an experience that ought not to be thought of as suffering because when it is over it is as if it never happened.

Similarly she argues that a purely mental experience such as a cognitive interpretation of an event ought not to be thought of as suffering because the mind has developed ways of escaping from and dealing with any trauma it may have known. An example of this is the mind's ability to re-write or to re-interpret past experiences: the psychological defence mechanism.

Weil lays particular importance upon the third element in her classification of suffering; the social:

> There is not really affliction unless there is social degradation or the fear of it in some form or another[151].

Affliction is a term that she uses along with suffering and social degradation with reference to the response of others to the sufferer. By social degradation Weil is referring to the way that a non-sufferer seeks to put distance between him/herself and a sufferer. This in turn exacerbates suffering. She argues that this is a mechanism that permits the non-sufferer space and distance to pursue his/her gaols rather than becoming overwhelmed by the experiences of the sufferer. This distance denies the sufferer comfort and support.

Freud[152] constructs a similar three-fold definition of suffering. Suffering threatens the individual from three sides:

> from our own body which cannot dispense with pain and anxiety, from the external world and finally from our relations with others.[153].

He maintains that because life is hard for everyone to bear humanity has developed a system of palliatives in order to survive. These consist of three distinct strategies: powerful distractions such as scholarly activity (which helps to make light of suffering), substitutive satisfactions (which act to minimise suffering) and intoxicants (that act to anaesthetize it).

Weil uses the term ‘affliction’ as a synonym for suffering but this terminology will not be adopted in this thesis as the term ‘affliction’ is now understood to refer to chronic

physical impairment or disability. Downs Syndrome or Cleft Palate, for instance, are regarded as 'afflictions'. These conditions certainly impact upon an individual's life and may be one of its outstanding features but they may or may not cause suffering.

Suffering, on the other hand, is regarded as a deviation from normal experience. It is associated with the absence of justice, fairness and equality. Where suffering occurs the hope is that it will be short lived either as a result of a change in circumstances or because help has been offered and received. In contrast to affliction suffering is thought to impact upon the whole of the person and it is usually obvious to even the casual observer.

A distinction can also be drawn between suffering and unhappiness: unhappiness is not as multidimensional as suffering. For example, I might be unhappy that a shop sells out of the brand of jeans that I want, but my disappointment can hardly be described as suffering.

So far suffering has been defined as an experience that impacts on a person in three ways simultaneously; physically, psychologically and socially. This definition stresses the objective nature of suffering. It is also important to examine the subjective experience of suffering to achieve an overall definition. One place to begin an examination of the subjective nature of suffering is Epicurus[154] and the importance he attached to the need to fulfil natural and necessary human desires.

Epicurus constructed a threefold classification of human desires: those that are both natural and necessary for the attainment of pleasure; those that are natural but not necessary for it; and, those that are both unnatural and unnecessary.[155] Natural and necessary desires are those that are common to all people because of their shared humanity. Examples include the desire to be loved, to be valued within a particular social context and to set personal goals that are both worthwhile to the individual and achievable.

For Epicurus, that which is natural is common and morally valuable. To fulfil them is to advance both the welfare of the individual her/himself and of humanity itself.

The presumption of commonality assumes a human nature either in terms of essence- being born with a nature that is inherent and which then reveals itself in development- or as a matter of existence. In the latter human nature is not a given but is acquired: character and personality is developed and then regarded as a person's nature. Commonality here would mean that all moral people would freely choose to acquire certain desires because they are universally regarded as right and good. This distinction between essence and existence will be further examined in Chapter Four and the discussion of Authenticity.

Epicurean necessity refers to basic human needs such as that for food, shelter, sleep, safety and community. The fulfilment of needs is a basic requirement for human happiness. Epicurus differentiates between desires that are necessary for life and those

that are necessary for pleasure. The latter are a higher order type desire such as the desire to pursue knowledge, wisdom or the virtues of self reliance and fortitude over and against reliance upon the gods or good fortune. We will return to the distinction between higher and lower pleasures later in this chapter. Once these needs are fulfilled we are in a position to attain pleasure that is not dependent upon circumstances and is therefore not easily lost. The Epicurean term 'tranquillity' describes the person who has fulfilled the natural and necessary desires for pleasure. Based on the Greek 'ataraxia' Ferguson states that tranquillity is:

> freedom from being shaken.[156]

An example of a desire that is natural but not necessary for pleasure, or what could be styled as true happiness, is the desire for wealth, success or for immortality through fame with fame itself as the end goal. Such desires are natural to the extent that they are common in human experience but are not necessary both because happiness can be achieved without them and because when they are fulfilled happiness is not guaranteed.

Unnatural and unnecessary desires are those that are orientated to the achievement of immoral ends for the benefit of the individual or others *or* to the disbenefit of self or others. These desires are unnatural to the extent that they seem to be particular to the individual and not shared by the rest of humanity.

Suffering occurs when a natural and necessary desire is frustrated in some way and so it becomes difficult to achieve happiness. Frustration can be sourced to factors within the

individual, outside of her/him or both. This frustration results in the experience of the opposite of ataraxia.

Mayerfeld[157] discusses the nature of suffering and its relation to the satisfaction and frustration of personal desire. He considers the claim that happiness depends upon the satisfaction of desires whatever their nature. He points out that happiness ultimately depends upon the cognitive awareness of satisfaction, the subjective experience of satisfaction rather than the nature of the desire itself. It is possible either to focus attention upon the desire, and to discuss which desires ought to be fulfilled and why, or to focus attention upon the fulfilment of desires. Mayerfeld's claim is that happiness is a matter of the latter rather than of the former.

It is possible for a morally acceptable desire to be fulfilled but for this not to lead to an experience of happiness, however, because the person disvalues the fulfilment for other reasons. For example a PhD student may successfully complete her studies but fail to achieve happiness because her marriage fails because of the strain imposed upon it by the demands of study. For a fulfilled desire to lead to happiness it must be experienced subjectively. This subjective experience must be in relation to a desire that has remained current. Mayerfeld writes:

> happiness is correlated with the experienced satisfaction of an existing desire.[158]

If this is what Epicurus and Mayerfeld mean by happiness then unhappiness must be understood to be its antithesis: the conscious experience of the failure to satisfy an existing desire, one that is both natural and necessary. This failure is one of the components of suffering.

An example of the frustration of a natural and necessary desire is that of a man who has formulated his first order preferences according to his understanding of the ideals of the Christian religion. This is not to say that religious belief is a natural and necessary desire but the desire to build one's life according to ideals and then to live in accord with them is. For him, then, such ideals include the belief in the Scriptures as the inspired Word of God and as authoritative in all matters of belief and practice. He also experiences homosexual desires which continually seem to frustrate his attempts to live in a way that he would wish. He experiences a conflict between his 'higher' and 'lower' natures and if the lower desires are more keenly felt and are subsequently satisfied, he may feel unable to live up to the standards he has adopted for himself. The result of this is that he suffers.

Of course it is possible for this example to work the other way around. A man who regards his homosexual orientation as an acceptable aspect of his personality and who regards heterosexuality as a patriarchal social construction may yet be unable to live a fulfilling and 'out' life because of acquired guilt. His traditional religious upbringing with its teaching regarding the wrongness of homosexuality may dominate his character and even though he wishes to live as a gay man, he may be unable to deal with this guilt: these competing ideals prove to be irreconcilable. Both are held with equal sincerity and

neither can be given up without a feeling of compromise or insincerity. Suffering here results from holding competing and mutually exclusive ideals.

Ideals seem to form part of what constitutes a necessary and natural desire and are tied to notions of common morality. This consideration is important because it is possible to have ideals that are contrary to traditional standards of morality. For example a white supremacist may have as an ideal a natural world order that consists of nations made up of pure races. His happiness may depend upon the fulfilment of his desires to achieve such an order. Both the ideal itself and the world that would come into being if the ideal became a reality, however, would be one that is morally undesirable because it would compromise equality.

This discussion of the subjective nature of suffering has focused upon the awareness of frustrated desire. This frustration can lead to a person experiencing the cessation of all desire. This consists of a lack of concern to form first order preferences which leads to numbness. This suffering is not the subjectively experienced frustration of personal desire but is rather the absence of any natural and necessary desire. This absence is a long term consequence of continual and profound frustration of desire.

So far in this discussion suffering has been distinguished from the ordinary experience of human misery and constructed in terms of the frustration of deeply held and autonomously chosen desires and preferences. This frustration has the impact noted earlier. Further considerations need to be added for the definition to be complete.

Portman[159] argues that:

> suffering is not only the absence of pleasure but…(is) also a disruption of personal identity[160].

He uses the term 'personal identity' to mean the beliefs that people have about themselves, their self worth, their place in the world and the principles by which they live. Suffering occurs whenever these beliefs are found to be inadequate or insufficient and are then subject to re-evaluation. Bodily pain does not normally cause such re-evaluation but experiences of shame, failure or rejection can. This may result in a person abandoning a set of beliefs and the estimation of self that was based upon them in favour of a new set that may or may not lead to happiness. The need to establish a new set of beliefs is a further occasion for suffering.

This re-evaluation process is not necessarily a bad thing particularly if the first evaluation was either unrealistically optimistic or pessimistic. What is of importance in Portman's remark is not the rightness or wrongness of the beliefs upon which personal identity is based but the suffering that is experienced when those beliefs are found to be inadequate and in the need to create a new set of beliefs with the consequent reordering of personal identity.

Portman sites Scarry who makes an observation similar to his own:

> the annihilating power of pain to utterly nullify the claims of the world.[161]

Scarry makes her comments on the context of physical pain but the devastation that results is equally true in the context of personal identity. This quote from her is included because 'pain' in her terms is the same as suffering in ours.

Cassell[162] in defining suffering, draws attention to its impact on the person:

> Suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some way..it extends beyond the physical… (it is) the state of severe distress associated with events that threaten the intactness of person[163].

He sees suffering as something that impacts upon the whole of a person. It cannot be confined to a person's physical pain, but suffering may include physical pain if it is of sufficient intensity and duration. He carefully defines what he considers a 'person' and lays stress on social context; subjectivity, in terms of beliefs, desires, hopes, fears and aspirations; the past, present and future of the individual and the inter-relationship between the mind and the body.

Cassell also emphasises the subjective nature of suffering and engages with the question of medicine's interest in suffering. He argues that medicine regards itself as an objective science. Medicine demonstrates this by the way that it aligns itself with the natural sciences that seek to operate according to physical laws. As an objective science medicine can legitimately concern itself with the functioning of the body, as the body is

an objective phenomenon. The problem arises when medicine seeks to concern itself with an issue that is basically subjective. Suffering is such an issue.

Cassell argues that suffering has a problematic place within medicine. It seems obvious that medicine should concern itself with people's suffering as one of its stated goals is to promote well-being. Yet, at the same time, suffering cannot be verified objectively with the result that medicine has to set aside its objective methodologies in order to engage with it. Cassell concludes that medicine does concern itself with suffering but that it has difficulty accommodating it as suffering is a subjective experience.

For the purpose of this thesis Cassell's theory of suffering (that it threatens the integrity of the self, that it is both intense and of significant duration), helps to build the definition of suffering that I am seeking to establish.

Two further considerations need to be added before the definition of suffering is complete.

First, is the importance of both longevity and intensity. For an experience to be considered one of suffering it needs to be experienced either for more than a fleeting moment or it needs to have a certain degree of intensity. The latter is a variable criteria but the experience needs to register on the scale of intensity. Mayerfeld discusses various measures by which the intensity of suffering can be measured. He argues that methods of

measurement need to include more than the expressions of suffering made by the sufferer as this may not always be an accurate reflection of what is going on. He says that:

> the intensity of suffering may be rather less than what the alleged victim represents to himself…claims to having suffered may not always be authentic.[164]

Mayerfeld's method of measuring suffering include the Ordinal and Cardinal Measures of intensity which rate the experience on a scale of 1-10. Ordinal refers to the points 1-10 whilst Cardinal measures differences between those points. Cardinal measures have four levels of intensity:

1) The Intuitive measure which seeks to measure suffering in accordance with the expressed hurt of the sufferer.
2) The Preferential measure which establishes a ranking system of personal preferences of happiness and suffering
3) A Global Evaluation measure to assess the overall nature of a person's experience
4) A Local Evaluation measure which is similar to the above but focuses attention on one particular experience of suffering.

These measures are useful to the extent that they focus attention on the need to recognise intensity as a valid criterion in the recognition of suffering. It is not, however, straightforward to determine how a subjective experience of suffering can be measured in objective terms. It may be the case that because it is difficult to measure subjectivity the

reports of intensity by the sufferer should be accepted at face value, all things being equal.

Second, a definition of suffering needs to take cognizance of notions of innocence and desert. Innocence suggests that a person has not wilfully and deliberately brought suffering upon her/himself by acting in an immoral or irresponsible manner. Desert suggests the opposite. A common moral intuition would be suffering resulting from acting irresponsibly does not deserve sympathy. Sympathy is linked to desert. Undeserved suffering evokes the sympathy of others, and the sufferer regards the absence of desert as an entitlement to sympathy. There is therefore suffering that invites a sympathetic response and that which does not.

An example of deserved suffering is a justly imposed punishment. Such punishment fulfils the criteria of Epicurus, Weil, Portman and Mayerfeld in that it is distressing. Deprivation and incarceration will cause distress, which may even threaten a prisoner's well being, but it would not ordinarily be regarded as suffering that merits sympathy.

On the other hand, it is possible to feel sympathy for a prisoner without simultaneously seeking to repeal the sentence and put an end to his/her suffering. This demonstrates that suffering can be acknowledged without this acknowledgement prompting a duty to alleviate it.

The relationship between happiness and suffering is constructed as a polarisation with people being categorised as either happy or sad. This dualism does not seem to allow for

the possibility that someone can be both happy and sad/suffering at the same time. Yet we do experience things that bring both happiness and suffering simultaneously with the result that our overall condition is not one or the other but both. It is, perhaps, unnecessary for anyone to reach a global conclusion about his/her overall state. For example the father whose wife or partner dies whilst giving birth knows the happiness, not pleasure in this case, of the birth of a child whilst at the same time knowing the sadness of losing a partner and fellow parent. The latter is likely to amount to an experience of suffering even though the happiness is real. The birth of a child is an occasion for happiness rather than pleasure because pleasure is understood to be 'in' something which may or may not last. The 'in' nature of pleasure usually consists of events or happenings that are of importance to an individual who takes pleasure in their fruition. It is therefore inappropriate to talk about the pleasure that the birth of a child brings and it may be more appropriate to talk about happiness.

Another example of how happiness and sadness can be experienced simultaneously is found in the case of parents of conjoined twins who realize that one twin is to be sacrificed for the sake of the other. There is sadness at the loss of one twin and happiness at the continued and improved survival prospects of the other, and perhaps even that the loss of both has been averted.

Accordingly, it is possible to be *suffering* in the sense developed in this chapter whilst also having reasons to be happy. It is not necessary for a polarised or a one dimensional perspective to be taken. If an overall judgement is considered desirable then the decisive

issue may be the way in which the individual comes to think about him/herself. One person may think of himself as a sufferer whilst another may think of herself as fundamentally happy, even when there are comparable measures of both in the two lives. The difference may lie in the way that the individual thinks of him/herself. The woman considers herself to be happy because she places value upon her experience of happiness and not upon sadness. Happiness is given a greater meaning or significance by her and is held to be more characteristic and representative of the nature and quality of her life. This mindset enables her to think of herself as essentially happy even though to an observer it seems as if her life consists more of sadness than of happiness. Similarly, the man understands himself to be a sufferer because he gives more significance, and pays greater attention, to his suffering that he does to the occasions in his life for happiness. To the woman he may seem to have every reason to be happy yet he maintains that he is not and this insistence may be a cause of both puzzlement and incomprehension to the observer.

Two things are clear in this discussion about the relationship between happiness and sadness/suffering. First, both can be present in the current experience of an individual and it is not necessary for an overall judgement to be made about which one is truer. Second, the subjective judgement of the person is necessary for a qualifying decision to be reached. Ultimately a person can be thought of as a suffering *iff* this is what they claim for themselves and it is the strength of this claim and its relation to the three elements mentioned earlier that is of importance; physical, psychological and social.

Accordingly, regarding oneself as a sufferer may be a matter of personal choice. One chooses to think of oneself as a sufferer and this choice may or may not be a conscious one. It may be a response to what seems to be the overwhelming nature of the experience of suffering and once established this view remains in one's psyche and becomes a perspective from which one's whole life is then interpreted. This view may persist after the occasion for suffering is past and happier experiences predominate.

For example, consider a daughter who has suffered years of physical abuse at the hands of her father. Her distress as a child was real, objectively verifiable and fulfils all the criteria of suffering. As an adult she continues to define herself by her childhood experiences. Regardless of all the good things that fill her adult life, she continues to think of herself as a sufferer. This may be because she wants her childhood experiences to be acknowledged by those around her and fears that these may be forgotten if she allows herself to embrace the good things that are happening in the present. This acknowledgement is only possible if she keeps the memory of her early years alive by, so she believes, often thinking about her past and talking about it with others. She may believe that if she were to forget and to allow others to forget then she would in some way be doing a disservice to her past self and all that this past self endured. The trauma of her past self becomes more significant than her potentially happier present self.

This analysis suggests that suffering is not only a matter of what is claimed in relation to others but also a matter of self-definition. Being a sufferer depends on the way that

person understands themselves. Both the claim and the self definition are matters of choice. Choice reflects the importance a person gives to suffering:

> It is our attitudes towards events, not events themselves, which we can control. nothing is by its own nature calamitous…even death is terrible only if we fear it.[165]

SUMMARY

Therefore an experience can be considered to be suffering if it is a negative personal experience that: impacts upon an individual physically, psychologically and socially; causes significant frustration of personal goals and natural and necessary desires so that self integrity is threatened; that it is undeserved and would normally evoke a sympathetic response from others; is both intense and prolonged *and* if the person considers it to be a matter of suffering both in terms of claim making and self definition. When these criteria are fulfilled then suffering can be said to be experienced. For the purposes of this chapter it is this definition that will be used from here on in and to make this clear it will be referred to as *suffering*. It is this understanding of *suffering* that will be used in the discussion about the duty to alleviate it, the possible value of such an experience and about TS.

2. The Duty to Alleviate Suffering

Mayerfeld distinguishes between *suffering* that is psychological in its nature and that which is objective. The former is subjectively experienced whilst the latter consists in

events such as famines, wars and other calamities. He argues that a prima facie duty exists to alleviate the former type of *suffering*- because it is avoidable-whilst it would be desirable to alleviate the latter but this may or may not be achievable due to the nature of the world.

The duty to alleviate *suffering* is not primarily grounded on the need to eliminate the effects of it but in the fact that it exists at all. Mayerfeld claims that it is so inherently catastrophic that the only possible moral response is to seek to alleviate it. *Suffering* calls out for 'moral condemnation'.[166] What matters to him is not how an individual *sufferer* feels about the experience but the fact that the experience exists at all. It is objectively undesirable even though the experience itself is a subjective one. As an example he discusses a person who has lost the ability to care whether or not she is unhappy due to the fact that she has been unhappy for so long. She may not be able to express a preference if asked about whether or not she wishes her *suffering* to come to an end. Nonetheless a duty exists to relieve her even though she is not in a position to ask for help. Similarly whole populations have suffered under tyrannical regimes and are unable to hope for anything better. They may be unable to conceive of any other way of existing as a society. The same duty to help exists. Mayerfeld argues:

> As suffering increases in intensity the degree to which it is worth avoiding outpaces the degree to which it feels bad.[167]

For Mayerfeld the most intense form of *suffering* can be that which is not felt at all. It fails to register in the realm of feeling because of its familiarity. He links intensity of *suffering* with urgency and argues that the greater the intensity the more urgent is the

need to act on the absolute duty to help. Help is to be given even where and when it may not be sought. Failure to intervene is failure to act morally and he lays the initiative with the helper.

One danger with Mayerfeld's construction of the duty to alleviate *suffering* is that it runs the risk of being both paternalistic and possibly tyrannical. It seems paternalistic to argue that one person is in a better position to judge what is and is not good for someone else. It also seems potentially tyrannical to intervene in a person's life when they have not requested help on the grounds that it is for that person's good. Intervention may involve force, the deprivation of rights or liberties and be contrary to the wishes of the *sufferer*. In a society that both values and has respect for autonomy people should be free from interference unless the interference is invited. Uninvited interference is justified only when there is doubt about capacity.

Mayerfeld moves his argument forward to claim that *suffering* makes the world a worse place to live and that it 'cries out' for its own abolition. This cry is instinctively heard by everyone and is not directly related to the merits or otherwise of the one who is *suffering*. He says that *suffering* has objective disvalue and that an 'agent neutral' consideration exists to eliminate it. Even in a materialistic world that fails to acknowledge meaning it is still possible for everyone to agree that *suffering* is of no value and that the moral condition of the *sufferer* are irrelevant.

He couples his arguments about the duty to alleviate *suffering* to the fact that human beings are naturally attracted to the idea of happiness. He claims that happiness is essentially a matter of feeling and that to feel happy is what everyone would naturally choose.

In relation to happiness Mayerfeld argues that every human being is capable of evaluating her/his feelings and that this can be done without reference to any other consideration or circumstance. The person concerned is best placed to know whether or not she/he is happy. Mayerfeld sets great store upon this capacity to feel which he describes as:

> an introspectively discernable feature of consciousness…which is found desirable.[168]

It is difficult to know what he means by the term 'desirable'. He may be saying that it is a good thing that human beings are able to feel and to register this fact within consciousness. Alternatively, he may mean that some feelings are pleasurable and when they are it is a good thing. It seems clear that he links feelings to both cognitive and volitional functioning. Feelings are known in the conscious realm, and perhaps evoked by cognitive activity, which then cause a person to set both personal goals and the means to achieve them. Such goals can be the result of an introspective reflection upon feelings and serve as a means of either achieving again or maintaining the experience of happiness.

So far, then, the duty to alleviate *suffering* has been constructed both as the moral duty to remove from the world something that is undesirable in and of itself and because it militates against the natural human orientation towards an introspective awareness of happiness.

Happiness is not the only thing that can be known as a result of introspection. *Suffering* is also known introspectively and has a place in the realm of feeling. As we have seen this capacity to feel *suffering* can be lost and when this is the case Mayerfeld argues that some form of objective measurement like those referred to in the first section of this chapter are required. His method of measurement seeks to distinguish *suffering* from other forms of negativity and to correlate it with the desire to be happy. Also, Mayerfeld would acknowledge that some people may be *suffering* without realising it. They may even describe themselves as happy, though this would be an error in Mayerfeld's view. An objective perspective is therefore necessary.

The natural human orientation towards happiness is the foundational principle of the moral theory known as Utilitarianism. This theory as formulated by Mill[169] provides Mayerfeld with further support for his claim regarding the duty to alleviate suffering.

Mill developed his Utilitarian theory in the mid-nineteenth century by building on the work of Bentham[170]. Mill's concern was to establish a scientific basis for morality and to do this he believed he needed to put forward one central and guiding principle which could be empirically provable. For him this principle was the universal human concern

with happiness and so he made this his theoretical basis and called it the Greatest Happiness Principle (GHP). Mill argues that:

> Actions are right as they tend to promote happiness, wrong as they tend to promote the opposite of happiness.[171]

Mill's claim is that happiness can either be thought of as a positive experience of pleasure or in terms of the absence of pain. Unhappiness is either a positive or actual experience of pain or a deliberate and wilful privation of pleasure. Pleasure is the only thing that is desired as an end in itself whilst all other things in life are desired as means to this end. Pleasure has to be understood as that which is appropriate to-in Mill's terminology 'harmonious with'- human nature and is thereby the fulfilment of human ontological potential or 'the gratification of human faculties'.

He developed his argument to include the notion of higher and lower pleasures. The former has greater intrinsic worth than the latter and is therefore both more valuable and more desirable. A higher pleasure is more difficult to achieve but this difficulty is not only linked to the value of the pleasure itself but is considered to be an appropriate price that needs to be paid in order for the pleasure to be experienced. A lower pleasure is more attainable and so is less desirable and less valuable. Less effort is required in order to experience it and is thought not to be sourced in the highest human ideals and aspirations but in the commoner human concerns. A higher pleasure is linked to the aspiration of truth, beauty, nobility and goodness whilst a lower pleasure is concerned with that which is physical, sensual, base or temporal. In considerations of utility

preference is to be given to the higher pleasures even though the attainment of them is filled with difficulty. Mill states:

> if one of the two (pleasures) is…placed so far above the other that they prefer it, even though knowing it to be attended with a greater amount of discontent, we are justified in ascribing to the preferred enjoyment superiority in quality.[172]

Again he writes:

> A being of higher faculties requires more to make him happy, is capable probably of more acute suffering and is certainly accessible to it at more points, than one of inferior type.[173]

Mill here introduces the idea that difficulty and hardship (what he calls suffering) is inherent in the attainment of pleasure. It becomes impossible to achieve the one without knowing the other. In fact it seems as if the one becomes the means for achieving the other. The goals that a person sets for her/himself and which reflect the highest aspirations are to be pursued either in spite of the difficulties or as a result of embracing them in the knowledge that this is what is necessary in order to experience the higher pleasures. A 'superior' type person will always value the higher pleasures and will recognise that, to paraphrase Bentham, 'poetry is to be promoted over pushpin'. An 'inferior' type of person will either pursue the lower pleasures due to a lack of awareness of the higher pleasures or because he or she prefers not to pay the costs that are necessary in order for them to be experienced. Such an individual may express a preference for the lower pleasures but Mill would argue that he or she is mistaken to do so and if only he/she could know a higher pleasure then the difference between the two would become clear. Mill maintained that the fact that the lower pleasures are more commonly

experienced and more frequently favoured by so many does not invalidate his opinion about the superior nature of the higher pleasures.

Whilst recognising that the best expression of human nature is found in the choosing of the higher pleasures Mill also recognised that people may choose the lower pleasures either for reasons within themselves or because of the character and moral climate of a particular culture. It is possible for a society to be so organised that the lower pleasures are promoted as the most desirable and instead of aspiring to greater heights it favours the lowest common denominator. This may occur in a society where ideas of human improvement are disvalued and the higher pleasures are considered to be elitist. Mill would argue that every good society ought to promote not only the idea of happiness but specifically the valuing and attaining of the higher pleasures.

He argued that the GHP is primarily concerned with:

> not the agents own happiness but the greatest amount of happiness altogether.[174]

It is the total sum of happiness in the world that is of ultimate importance. Mill's position is that there is a duty to seek to put the interests of others before narrower personal concerns. Humanity has chosen to organise itself into social groupings and for this to be successful each member of that community must seek to promote its general well-being whilst at the same time acknowledging that there is utility to be found in pursuing individual happiness. He writes:

> Society between equals can only exist on the understanding that the interests

> of all are to be consulted…the good of others becomes a thing naturally and necessarily attended to, like any of the physical conditions of our existence.[175]

Mill developed his argument in the context of his principle of utility. Not only is it grounded in individual human nature but in terms of the social nature also. Therefore the duty to alleviate suffering has a broader reference. It becomes not only a matter of relieving the suffering of one particular person at any given time but is also a matter of thinking abstractly about the nature of society. Society itself is a better place if the quantity of happiness exceeds the quantity of unhappiness. There needs to be a surplus of the right kind of happiness over unhappiness for the right conditions to be established for human beings to flourish.

Mill next established reasons why any one individual ought to put the general happiness before his/her own. He gives two reasons to this general duty. The first is an objective rule which is binding for all and is to be constructed according to the belief systems of a particular community. A community that believes in God might formulate the idea that it is the will of God that the needs of the whole group should take priority over those of the individual. An atheistic society might formulate the maxim in terms of the laws of the state which can be enforced by the power of that state. The second has reference to the subjective moral feeling, known as conscience. The conscience consists of an innate feeling of concern for the well being of others, as well as for the rightness of individual behaviour, and it appears to operate intuitively. This feeling of concern is the basis of human moral functioning and is a natural outgrowth of human nature. Mill discusses

both the way that the moral nature is capable of flourishing spontaneously and how the need exists for it to be cultivated and developed.

Mill finally stresses the need for the principle of utility to be taught to all due to this universal nature of the moral concern to alleviate unhappiness and to promote happiness. He recognises the difference between alleviating unhappiness and promoting happiness and argues that both can be achieved by making everyone familiar with the GHP. He says:

> the principle of utility should be taught as a religion and the whole force of education, of institutions and of opinions ought to be directed to make every person grow up from infancy surrounded on all sides both by the profession and practice of it[176].

Mayerfeld draws on these theories to justify the duty to alleviate suffering. He incorporates beliefs concerning human nature and the natural orientation to happiness to add strength to this duty. The need to alleviate *suffering* is not just to do with the experience of it but is also a matter of what is in the best interests of human beings. The idea of best interests gives priority to the interests of society as a whole over those of the individual.

The contribution of Mill to the duty to alleviate suffering can be constructed as a duty in relation to what is considered best in human nature. Higher pleasures are a formulation of the human ideal and attaining the higher pleasures offers the best opportunity for the fulfilment of the highest human good. Unhappiness is therefore the lowest level of human experience and is to be considered as that which works against the highest human

good. If unhappiness can therefore be removed men and women are more likely to achieve the best in human experience.

One further source of this duty needs to be discussed within the context of this chapter. This is the subject of human sympathy.

Schopenhauer[177] argues that our psychological make-up provides us with a natural affinity for moral action and the fundamental moral motivation is sympathy or compassion. All human action can be traced to the three source of egoism, malice or sympathy and it is the latter which is the basis for morality. He discusses the way sympathy functions, the expression of which gives moral worth both to an action and to an individual. On this point he differs from Kant who, whilst recognising the worth of a sympathetic disposition, felt that moral worth was to be found in the activity of the human will in accordance with the demands of reason. Kant maintained that the ultimate principle for moral action was the Categorical Imperative, of which one formulation is:

> I ought never to act except in such a way that I could also will that my maxim for action should become a universal law.[178]

For Kant sympathy may be lost under certain circumstances and if the duty to help is based on sympathy then that duty is lost too. Kant would maintain that because the duty is not based on sympathy the duty can be considered as universal and, therefore, not in danger of being lost. Kant illustrates this point with the example of a philanthropist

whose capacity for sympathy has been extinguished as a result of his own misfortune. Nonetheless:

> he nevertheless tears himself out of his deadly insensibility and does the action without any inclination, simply from duty.[179]

This thesis is not the place for a discussion on which perspective on morality is correct. It is sufficient to note that different views exist on the nature of the duty to act morally.

Schopenhauer argues that sympathy is instinctive to human beings and remains operative no matter what a person may experience. Even those who are numbed to their own misery have the capacity to feel for the misfortune of others. The capacity to feel is the result of social attachment and this in turn is linked to emotional well-being. Portmann notes this discussion in his work[180] and cites Schopenhauer's contention that the way sympathy functions is analogous to the activity of a virus, contagion or infection.

Schopenhauer states that the person who takes pleasure in the misery or misfortune of others will pay the price for doing so in the 'pangs' or 'stings' of his own conscience.[181] Social discourse by its very nature elicits a sympathetic response. An unwillingness to participate in such a response requires an act of will and therefore renders a person immoral.

The importance of sympathy is also discussed by Scheler[182]. He agrees with the importance of sympathy and argues that an ethic of response to the suffering of others should be based on sympathy.

This ethic of sympathy is to be derived from the attitude of the person who witnesses the misery of others. It consists of an emotional response to the experience of the sufferer but the unhappiness must be undeserved. It is inappropriate to sympathize with a person who has acted immorally and Scheler is making an observation here that is similar to the one made earlier in the chapter in the discussion on the definition of suffering. Similarly a fellow feeling in response to another's pleasure can only be viewed as moral if the sources of that pleasure are in themselves moral. He writes:

> It is certainly not moral to sympathize with someone's pleasure in evil…the sharing of another's pleasure can only be moral when the latter is itself moral and warranted by the value situation which evokes it.[183]

Scheler argues that sympathy functions as an appropriate response to both the moral pleasures and sufferings of others. He places emphasis upon morality and states that both the occasions for pleasure and the context of sufferings has to be moral if the sympathetic response of others is to be legitimate. Sympathy can be offered at individual and communal levels and, as with Schopenhauer, its expression has the effect of causing or encouraging others to do the same. As well as noting the infectious nature of sympathy he notes the way it identifies with suffering on an emotional level.

In conclusion the moral duty to alleviate suffering can be said to be based upon; the undesirable subjective/objective nature of suffering; the desirable subjective/objective nature of happiness, and the moral importance of sympathy. Sympathy is concerned with

the relationship between the sufferer and the non-sufferer and this relationship seems to be predicated upon two considerations. The first is concerned with ideas of mutuality or community and predicates a connection or bond between all people that acts as an instrument of obligation and co-operation. The primary focus of this bond is upon those who are in near relation to the individual but it is wide enough to encompass those who are more distant. The second consideration is an acknowledgement that the sufferer/non-sufferer relationship could exist the other way around if the situation were reversed. Reversal is a real possibility and so the non-sufferer offers sympathy in the knowledge that if it were the other way around then she/he would want to be sympathised with.

3. Critique of the Duty to Alleviate Suffering

This section of the chapter will offer a critique of the duty to alleviate *suffering*. It will do so in three ways: at the conceptual or intrinsic level, at the motivational level and at the consequential level.

CONCEPTUAL/INTRINSIC CRITIQUE

Mayerfeld laid out an absolute duty to alleviate *suffering.* An absolute duty is one that has a universal application and claims universal obedience. It is not conceptually concerned with the condition of the person or of the one whose duty it is *per se* but is rather an analytic duty. This is to say that it is concerned with the nature of the idea of absoluteness and seeks to analyse the ideas that are inherent in that concept. On this basis at least two criticisms can be made.

The first is in relation to autonomy. Autonomy derives from the two Greek words 'autos' (self) and 'nomos' (law/rule) and refers to the self-determining nature of human existence and action. Each individual is endowed with reason which enables him/her to determine the course of his/her life as a result of setting goals and the means to achieve them. It is by the exercise of the will that these goals are to be realised and everyone ought to be free from any arbitrary and inhibiting external forces in order to pursue them.

Kant formulated the idea of autonomy in the following way:

> (autonomy) is the concept of every rational human being…who must regard himself as giving universal law through all the maxims of his will so as to appraise himself and his actions form his point of view.[184]

Each person is considered as king of their own destiny with the right to rule the kingdom of their own lives. When every autonomous individual acts in this manner then a desirable state of affairs has been brought about which Kant refers to as: The Kingdom of Ends[185]. This is:

> a systematic union of various rational beings through common laws.

In such a kingdom each rational being is to be thought of as a subject as well as a king. Kingship consists in the establishing of universal laws to govern action whilst being a subject is a matter of subjecting the will to the demands of those laws.

Autonomy is one formulation of self-determination. Placing an absolute duty to alleviate *suffering* may conflict with this concept and therefore with self-determination in at least two ways.

First, as discussed earlier, with regard to law making Kant constructed the Categorical Imperative. Laws were only to be established by an individual if she/he were able to universalize them. If the duty to alleviate suffering were universalised in this way so that the formula became 'wherever *suffering* is to be found I have an absolute duty to alleviate it' then the law maker would know that others would be bound by this duty in relation to her/him, too. This law would be binding regardless of the situation or of other considerations that may feature at the time. It may be that the law maker may not always want others to respond to her/him in that way nor to always be under a law to act in that way. S/he must be aware, however, that everyone is to be under the law so if s/he does not want this then the law itself is in question.

For instance, it is possible that a person chooses *suffering* as a means to an end. This idea was glimpsed in the earlier discussion concerning Mill's formulation of the difficulties that attend the attaining of higher pleasures. If *suffering* is always to be removed then this may mean that the ends to which it would have led may be lost. Mill may not have meant that higher pleasures are accompanied by *suffering* as defined in this chapter but the idea of it as a means to an end can be true both if that difficulty is not great enough to be styled *suffering* and if it is. The removal of *suffering* could be thought of as interference especially if value is attached to it. Even where there is no value attached a

person may still feel that the most important thing is that they are asked whether or not they wish to be helped as such an enquiry demonstrates that he/she is still being regarded by others as an autonomous being. *Suffering* need not render a person unable to express a preference nor to allow another to disregard autonomy. This remains true in the case of numbing. A person may no longer feel any pain and it is left to others to recognise its extent but that person can still be asked whether or not they would like to be helped. The answer to that question would still need to be respected and only disregarded in the most extreme of circumstances. Persuasion may be legitimate and time may need to be given for the *sufferer* to consider the request but it remains important throughout not to rush in citing an absolute duty to alleviate *suffering*.

Second, it needs to be recognised that there are occasions when pain must be inflicted upon others and if an absolute duty to alleviate *suffering* is in place then this is not possible. This may even be morally necessary in certain circumstances. Examples of this can range from the trivial to the important: a surgeon inflicts pain in the pursuit of a beneficial treatment and the negative effects of the surgery may last a lifetime; a parent imposes discipline upon a child; the State inflicts punishment upon a wrongdoer as an expression both of moral outrage and as a deterrent to others; one nation goes to war against another to defend its sovereignty and independence; and a person defends herself from the physical aggression of another and has to use force to do so. In all these cases those involved would wish to limit the pain and distress caused to that which was absolutely necessary to achieve the ends in sight but the fact remains that pain and distress has to be caused for those ends to be achieved. In all the examples given the ends

are considered morally justifiable and so the means have to be in moral accord with them. In these cases the means are considered legitimate as they are recognised as appropriate to the ends themselves.

Whilst a very strong duty to relieve *suffering* may exist it is not necessarily an absolute one. Perhaps the correct thing to say is that the duty exists *unless there is a good reason to suppose otherwise*. Respect for autonomy appears to be one and the need to sometimes inflict suffering upon others may be another.

MOTIVATIONAL CRITIQUE

An absolute duty may have an unintended effect upon the motivation of those upon whom the duty lays. It is generally recognised that some form of duty exists but if it is constructed in absolute terms then the result may be that people will feel overwhelmed. This in turn may then diminish a person's capacity to respond to the needs of others.

Lifton[186] describes his feelings whilst working in Hiroshima following the dropping of the Atom bomb by the USA which brought WW2 to an end. The scale of the *suffering* he encountered plus his own feelings of inadequacy led him to experience what he called the phenomenon of numbing. Linked to the experience of not being able to recognize one's own *suffering*, numbing is the inability to respond to that of others due to the enormity of what is being faced. Lifton recognised that what he saw called for a response but he became increasingly unable to respond. Eventually he became unable to offer any

emotional response and what he saw even failed to make a continued impression upon his consciousness. He writes that numbing is:

> a diminished capacity to feel…what I came to call psychic numbing, or in its most acute form psychic closing off.[187]

He thought of his own numbing as the response to *suffering* that existed on a catastrophic scale. He argued that it was also possible to experience numbing in other ways. It can be a response to the everyday *suffering* that a member of a family may feel and can be experienced by professional carers such as doctors. Lifton describes the latter as a form of desensitisation which may be necessary for optimal technological functioning. He classified the three forms of numbing (catastrophic, ordinary and professional) as an 'Anatomy of Numbing'.

It is ordinary numbing that is more important for this chapter because whilst the *suffering* of the transsexual is of supreme importance to her/him it is 'ordinary' in its nature: only one person is affected and this in the context of health and disease in ordinary life. For *suffering* to be considered catastrophic then many people need to be affected in extraordinary circumstances. Because the *suffering* of the transsexual is ordinary so is the response to it.

For example, the person who is in a relationship with a transsexual which would normally be characterised by sympathy to *suffering* may feel unable to sympathise if he/she has been exposed to that *suffering* in an unabated way. She/he may feel they do not possess the personal resources that are required in order to respond in the way which the duty

demands. Alleviation becomes impossible because the person is numbed to feeling and it is feeling that has provided the motivation to enable the duty to be performed. Feeling has dissipated due to constant exposure. The resource which is lacked is the ability always to sympathise.

Another example here may help. Imagine a woman who has a partner who is depressed and this has led him to seek help from a psychotherapist. He experiences constant difficulty and perpetually seeks reassurance. Work is a struggle for him as he is unsure of what others think of him. He worries about whether or not he is accepted at work and if he does a good job. Every night after work he talks about his day and expresses his fears and worries to his partner. She hears his fears and complaints at the end of each day whether or not she wants to. At first she offers sympathy and tries to be supportive. She encourages him with his therapy and seeks to reinforce what the therapist has said. The two of them are in this situation for over a year before she begins to realise that she is not as sympathetic as she once was. He does not seem to be improving in any tangible way. Every day closes with a discussion of his difficulties and she increasingly feels unable to respond. This is coupled with what is happening to her in her own work and the demands that she has to face in her own life. She grows numb to his *suffering.* If the duty to alleviate his *sufferings* is in place then she is morally at fault to feel as she does and she needs to overcome her feelings and to continue the daily conversations about his distress as this is her contribution to alleviating it. She did once consider that she was under an absolute duty to alleviate the *suffering* of her partner but this prove so difficult to do and

the demands upon her proved so great that she is now numb and wondering about her ability to continue in the relationship.

A counter-argument is possible: her attempts to listen to him every day were ineffective in helping him and she is therefore not under a duty to continue to listen. If listening did help but she grew tired and weary and so stopped then she may be at fault. A duty to help exists if help is effective but not if the intervention fails to help.

If the duty is absolute then it is in place at all times and such a duty in its turn may lead to the numbing of sympathy with consequences not just for the *sufferer* but for the person who is expected to offer sympathy. One possible consequence is the creation of distance between the non-sufferer and the *sufferer*. This distance is both a reaction to the feelings of inadequacy and a means of allowing the non-sufferer space in order not to be overwhelmed by the *sufferer* and so to retain a sense of separateness and independent existence.

Soelle[188] discusses the way that Western societies have since the time of the Enlightenment looked to science to eradicate both the causes and the experience of *suffering*. One of the unintended and unforeseen consequences of this search she describes as Apathea[189]. This is the dynamic that allows a person to pursue his/her gaols of happiness and fulfilment against the demands to seek to relieve the misery and anguish of others. If all of a person's time were spend in alleviating the *suffering* of others, which an absolute duty requires, then there may be no time to pursue their own goals. Therefore

a person has to develop a form of immunity or indifference to others which can in time develop into an aversion to *suffering* itself. Soelle's claim is that it is a small step from this to the avoiding of other people completely in order to avoid any contact with *suffering*. She writes:

> Apathea is a social condition in which people are so dominated by the goal of avoiding suffering that it becomes a goal to avoid human relationships altogether.

Her argument is that the determination to pursue personal goals can lead to both an avoidance of *suffering* and of those who are *suffering* so that relationships deteriorate and men and women become increasingly individualised. *Suffering* is avoided in order to avoid the absolute duty to alleviate it. Happiness is sought in isolation from the *suffering* and the overall result is a diminution in the quality of life for all. Because the non-sufferer has lost contact with the *sufferer* both lose out and both fail to benefit from each other and so there is an all round lessening in the richness of human experience. She writes:

> a suffering free state (experiences loss)…so that even joy and happiness can no longer be experienced intensely. A consequence of apathy is the desensitization that freedom from suffering involves-the inability to perceive reality.[190]

Her conclusion is that an absolute duty to alleviate *suffering* results in a social reality of increased individualism and the concentration upon happiness to the exclusion of the one who is *suffering*. A type of disengagement has occurred between *sufferers* and non-sufferers with the result that the situation is worse for the former then was ever intended.

Perhaps, therefore, we should regard the duty to alleviate *suffering* as very serious but not an absolute one. If the onus were put upon the judgement of the non-sufferer as to when, where and how she/he was able to help without interference with his/her personal goals then continued and effective motivation will be maintained. As help is offered so the life of the one who is doing so is enriched both as a result of doing good and of the contact between the two, i.e. an imperfect duty in Kantian terms.

CONSEQUENTIAL CRITIQUE

Soelle argues that one consequence of this duty is an actual increase in the total amount of unhappiness that is experienced. The overall quality of life declines because the apathy that is necessary in order for people to feel immune to the misery of others leaves those same people immune to the pleasures of life. A loss of the capacity to feel has occurred. This loss is a direct consequence of the concern to only experience happiness which in turn leads to avoiding both personal distress and that of others. Soelle seems to suggest that a certain amount of distress is necessary in order to retain the capacity to feel pleasure and therefore to be happy.

The idea that the duty to alleviate *suffering* leads to further *suffering* can be found in the work both of Nietzsche[191] and Freud[192] as well as in their critique of Schopenhauer[193].

Schopenhauer urged the universal need to sympathize with the *sufferings* of others. In the earlier discussion it was seen that he understood sympathy to be universally required and that it ought not to take account of the individual sufferer. However, if sympathy is

to be given to all indiscriminately its value may be diminished. Expressed to all sympathy either becomes too thinly spread or is exhausted. For sympathy to retain its value it needs to be discriminating in its operation. Objects of sympathy need to be appropriately identified and expressions of it based upon desert.

Therefore in relation to Schopenhauer's view there will be insufficient sympathy to go around if the duty to alleviate *suffering* is regarded as absolute. Stocks need to be preserved and one way of doing this is to ensure that it is given in appropriate ways. If this does not occur then when someone deserves to be sympathised with she/he may find that sympathy is not forthcoming. This is a first possible consequence of the absolute duty

It is possible to argue that it does not matter where sympathy comes from all that matters is that it is to be found in a time of need. A stranger's sympathy can be welcomed as much as anyone else. The *sufferer* expects sympathy to be given because it is a matter of duty and not of fellow-feeling and so it is the duty that is important and not the feeling.

However, if sympathy is offered to a *sufferer* merely on the grounds of duty with no importance attached to fellow-feeling then this may appear to be cold and not to reflect the ideas that are inherent in the nature of human relationships. Relationships are an expression of mutual regard and concern and part of this is the notion that when one *suffers* the other cares about this fact and shares in that *suffering* through fellow-feeling. The closer the relationship then the greater the expectation of fellow-feeling and in this

case if sympathy were to be offered on the grounds of duty then the sufferer may conclude that the relationship is not what he/she thought it to be. Duty exists between strangers precisely because there is no bond of intimacy and so some mechanism is required to ensure that help is available. Duty is one example of such a mechanism. The nature of relationships in terms of obligations, duties and intimacy will be explored in Chapter Five.

Schopenhauer, then, maintains the need for universal sympathy but he also acknowledges that attempts to alleviate *suffering* may result in its appearance in another form even within the same life. *Suffering* in his view is impossible to eradicate successfully. It is a weed in the sympathiser's garden. This weed has deep and unreachable roots and only its above ground flowering can be seen. The gardener deals with what can be seen but soon discovers that the weed re-appears elsewhere. Attempts to remove it are relentless:

> The ceaseless efforts to banish suffering achieve nothing more than a change in its form. If we have succeeded in removing pain in this form…it at once appears on the scene in a thousand others.[194]

Nietzsche [195] argued that sympathy has reduced western civilisation to a level of weakness and powerlessness robbing us of the life force that is required to achieve great goals and at the same time denying us the will to live.

He regarded Christianity as the greatest expression of the perverse nature of sympathy and thought that it had given rise to what he described as 'slave morality'. With its

emphasis on the underdog and the need to attend the weak and the marginalised, Christianity has succeeded on elevating the slave, who is a contemptible individual, to a position of power. Those who are strong have been emasculated by a morality of sympathy and are bound by feelings of guilt to defer to those who are less.

Nietzsche argued that the weak envy the strong and that Christianity is for them the only way of emulating the strong and to attain prominence. The strong have been forced to embrace the morality of slaves due to the fact that the slaves cause guilt feelings in the strong. The latter then give up what is natural to them which is the will to power. Guilt in turn leads the strong to feel that a duty is owed to the weak but by focusing energy upon helping them the strong forget their main task which is to affirm their will and in so doing to affirm life:

> One should not embellish or dress up Christianity: it has waged a war to the death against the higher type of man…it has taken the side of everything weak, base…it has made an ideal out of opposition to the preservative instincts of strong life.[196]

Guilt is the basis upon which sympathy operates. The duty to alleviate *suffering* is predicated upon an ignoble motive. It does not affirm life. The sympathetic motive behind the duty is ultimately harmful to the best interests of human aspiration. Anything that proceeds from guilt cannot be good. It gives a false shape to the conscience of the strong.

This is a further example of the way that this absolute duty can have detrimental consequences this time not in relation to sympathy itself but in the effects that it can have on the sympathiser. Negative emotions are both necessary in order for sympathy to be possible and as a consequence of it. Sympathisers are weakened and debilitated by its demands and are marginalised as a result of the needs of the *suffering* taking centre stage. This is a second consequence of the absolute duty.

Amato[197] devotes a great deal of attention to the subject of collective guilt and how this lies behind much of the action to alleviate *suffering*. He collates two phenomena of twentieth century western society: post imperialism and the Second World War. He argues that both of these have resulted in a sense of responsibility on the part of the west for the *sufferings* of the world as a whole. Western aggression has occasioned much *suffering* one result of which is the proliferation of what he calls the 'cult of the victim'. Whole classes of people are now learning to think of themselves as the victims of the past actions of others who therefore have a duty to help them.

Amato dwells on the effects of past guilt. One society believes that it owes an obligation to another because of the way its past members treated those of the other society. The past treatment may even have occurred century's ago but both present day societies believe that a duty exists. Amato writes:

> The post war world abounded in accusations about the west, in the form of colonialist, missionary, capitalist and white man, as the primary cause of innocent suffering[198].

This post-imperial guilt is that which was indicated in the interim conclusion in Chapter Two as one of the reasons for a failure to critically examine the models of transsexuality.

Amato seems to be arguing that an uncritical acceptance of the duty will lead to the setting up of a victim mentality and the creation of people who consider themselves as victims. Instead of taking personal responsibility and refusing to identify with either past or present suffering people may become preoccupied with suffering and seek recompense and recognition for it. This preoccupation may be motivated by justice concerns and sympathy may be desired and given but the ultimate result may be an increase in the actual experience of *suffering* due to the keeping alive of issues that have long since been inactive.

Potential example's include: Afro-Americans who in the present gain a sense of injustice from the slave trade of the eighteenth and nineteenth century; present day Jews who think of themselves as victims of the Holocaust and followers of Islam who seek recognition for the injustice of the medieval crusades called for by the Papacy in its attempts to reclaim the Holy Land. Victim status is problematic because it is unclear how a group of people in the present day can legitimately be thought of as *suffering* because of past events, especially if those events do not have direct and continuing effects. Questions cluster about the issue of distance between past and present and of the nature of the duty a present day group have for the actions and their consequences of a past group. A further example of the present day *suffering* that can arise out of past actions and their consequences is the Arab-Israeli conflict in the Middle East. Claim and counter claim are

made in relation to who has *suffered* the most and who is owed the most and by whom, but the result is that suffering continues to be experienced.

Victim status and the suffering that follows is a possible third example of the consequences of the duty to alleviate *suffering.* An absolute duty would include all people for all of their *sufferings* as long as they consider such *sufferings* to be relevant. As we have seen, relevance can extend backwards to include past events. If a culture of sympathising for *suffering* as identified by the *sufferer* is created then this may lead to a victim mentality.

Ignatieff[199] discusses victim status and mentality and argues that this is so extensive now that everyone is a potential victim. This awareness has itself increased both the personal and overall sense of vulnerability and so *suffering* results.

Freud[200] offers a further consequential critique of the duty to alleviate *suffering.* He discusses the so called golden rule of Christianity which states 'Thou shall love thy neighbour as thyself'[201] and claims that a universal application of the rule not only devalues the love that is supposed to lie at the heart of the duty but increases the *suffering* of the one who seeks to fulfil it. He argues that the demands of the duty are beyond anyone's capacities and the striving to do what cannot be done can only increase a person's distress. Blind obedience to a rule will in this case have the opposite effect to that intended.

In summary this consequential critique of the duty argues that it carries a cost to both the nature and functioning of sympathy and to the experience of *suffering*. The latter is the result of guilt feeling that motivates action, the formation of a victim culture and the distress caused by trying to perform an impossible duty. Added to this is the financial burden which the demands of the duty might make upon both the individual and society in general. This burden may prove unsustainable in the long term.

To conclude this section, an absolute duty to alleviate *suffering* is problematic. A very strong duty may well exist, one that is generally recognised in moral discourse. It is a duty that is generally applicable but can be waived either because of the reasons discussed or because of the idea that value can be found in *suffering.* This last idea leads to the next section of the chapter.

4. The Value of Suffering

The value of *suffering* is to be discussed within the context of a fourfold structure. Examples of value will be discussed.

The fourfold analysis of value is as follows:

1. I value my *suffering* for my sake.
2. I value my *suffering* for your sake.
3. I value your *suffering* for your sake in the context of a shared goal.

4. I value your *suffering* for my sake. The idea of Schadenfreude is of importance here.

I VALUE MY SUFFERING FOR MY SAKE

In this analysis *suffering* can be thought to possess a value that is either intrinsic or instrumental for the person experiencing it. An example of the former is sadomasochism, especially if this is thought of as a life-style choice which includes the setting up of a social network with whom the person spends as much time as possible. Sadomasochistic interests can define the person who comes to value the practice. The latter is found where a person believes that *suffering* leads to the fulfilment of a goal or an end that is valued and has been autonomously chosen. Examples of the instrumental value of *suffering* include the following:

First, *suffering* as a means by which a person experiences penance or atonement. In this example one feels that one has committed a wrong for which one should be punished. One acknowledges that the wrong should be put right and that the harm that was done should in some way be neutralised or negated by accepting punishment. The desire to atone seems to be a legitimate desire as it demonstrates awareness of the ill-effects of the original wrong-doing, an acceptance of culpability and a wish to make up for the wrong. Atonement has to be freely chosen and one may have the right to insist on making it even if others may wish to spare one the *suffering* that is involved. Atonement may be made by someone on behalf of another. An innocent person may wish to atone for the actions of someone with whom she/he is in close relation and who may be either unable or

unwilling to make atonement themselves. Christian theology is predicated upon the idea of vicarious atonement in the person of Christ. If *suffering* is denied to a person in this context then she/he may feel that the wrong that was done lingers without anything taking place to put things right. Atonement is a way of putting things right and for this to be the case then *suffering* is necessary.

Second, *suffering* can provide a context in which virtues can be exercised. It is important here both that *suffering* has not been chosen in order for virtue to be exercised and that such virtue is already part of the character of the individual otherwise such virtue could appear as a false display for an appreciative audience. Virtue can be an indication of moral character and where this is genuine it can act as both inspiration and example to others. Virtue can be that which enables a person to endure *suffering* as well as be the means by which life as a whole is lived in. Courage, commitment to principle, resolve, optimism and determination are some of the virtues that are required at times of trouble. It is also possible that virtues can be learned in a time of *suffering* with the result that the sufferer's character develops. Patience and the ability to empathise with others are examples here.

An example of this can be found in the history of classical Greece. The circumstances surrounding the death of Socrates are well known[202]. On the morning before his execution Crito tells us that Socrates was being prevailed upon by his friends to escape from prison. Escape would prove a relatively easy matter and may even be what the Athenian fathers wanted. It seemed obvious to all that Socrates should go on living and

so be able to continue teaching and influencing others. The death penalty imposed upon him for blasphemy was felt to be unjust and that he would be justified in doing all he could to escape it.

Socrates thought otherwise and claimed that whatever the rightness and wrongness of the judgement it would be wrong to disregard it and to set aside the demands of the law. This would be the case even for personal or worthy motives and goals:

> Whatever the popular view is, the fact remains that to do wrong is in every sense bad and dishonourable for the person who does it. Is that our view or not?.[203]

Socrates maintains that he always has sought both to keep the laws of the state and to teach others to do the same. Laws are to be kept even if they prove onerous to the one whose duty it is to keep them. He now demonstrates his own determination to keep the law even if this results in his death. He values consistency and integrity more than his own life. To escape would be to repudiate all that he has stood for.

Socrates argues that obedience is required even if laws are considered bad and unnecessary and *suffering* is the result. Any refusal to obey on the grounds of private judgement concerning the legitimacy or otherwise of the law will result in an undermining of the state itself. He argues that just as men and women enjoy the benefits provided by the state they have a duty to obey its laws and meet its demands. He believes that he is able to demonstrate his commitment to this principle by accepting the death penalty.

By accepting this judgement Socrates knew that his life would end. This knowledge would undoubtedly be an occasion for *suffering*. Yet he seems to regard this as a price worth paying and one that shows his deep attachment to his beliefs. If there was another way to demonstrate his attachment then he may have chosen it and in doing so spared his own life. No other way seemed possible and so to remain faithful to himself he accepts his own death. Crito is left feeling admiration for his friend whilst disagreeing with him. Socrates' *suffering* may not have lasted long but it may have been intense and with a possibility to threaten his understanding of himself if he failed to respond to it on a way that met with his own satisfaction.

Martyrdom seems to be related to the example of Socrates. Here men and women accept their own death as a price worth paying in order to demonstrate fidelity to beliefs and values. Martyrs appear to believe that some things are of more value and importance than continued personal existence and that one way of demonstrating this is to adhere to them even if the cost is one's own life.

Rule-keeping may be a further occasion when *suffering* can be of value to the individual. Some rules can be considered to be so important that to keep them causes *suffering* which then become the measure by which commitment to the rule is judged. Two examples can be considered.

First, a Muslim homosexual man may choose a life of celibacy in order to conform to the demands of his faith. His faith matters more to him than sexual fulfilment. Given the nature of some Islamic cultures no one else knows of his decision. Only he does but the knowledge he gains from his adherence to his faith and the consequent *suffering* this causes him sexually, socially and personally is viewed as indicating his faithfulness. There may be moments when he longs for sexual fulfilment as well as facing the embarrassment of explaining why he is not married. Others may misunderstand him and think him selfish or overly fussy and criticise him as a result. He knows his true motivation and regards *suffering* as a means of measurement.

Second, in a society that values marriage two unhappily married people who share that value determine to remain married to each other. Both recognise the importance of promise-keeping and that this may require one to put aside personal feeling. Promises that have been freely entered into ought to be kept in order to preserve trust and to make social relationships possible. If a person breaks a promise then his/her integrity may be open to question. Recognition is given to the fact that sometimes it is impossible to keep a promise but this is usually understood to occur for reasons beyond an individual's control, such as unforeseen circumstances and the actions of other people. In a marriage where both parties value promise-keeping then, in spite of any unhappiness in the relationship, it is possible for both to keep their original commitment to each other. *Suffering* occurs because both are reminded daily of unmet needs and the failure of the hopes and expectations which were present at the outset but the *suffering* is again viewed as a way of measuring the value of promise-keeping. Marriage vows are often considered

to be taken in the presence of God and such vows are often believed to be even more binding. *Suffering* can then be viewed as a demonstration of loyalty to God.

Rules are worth keeping whether they are difficult or easy but some rules are of more importance than others. Those that are considered the highest value often have the most difficulty associated with them and keeping them may result in *suffering.* To try to love in the way that, for instance, the golden rule of Christianity requires, would daily oblige one to put one's considerations to one side, to suppress personal desires and goals and to consistently put the wellbeing of others first. It is in the denial of personal considerations that *suffering* is experienced.

The self control of the athlete who puts aside all other considerations in order to train for a sporting competition is a further example. Whilst competing she reaches the limits of physical endurance but continues in order to win. She considers *suffering* to be a test of her physical condition and to be able to win having exerted so much is more valuable than wining as a result of little effort.

Some people find pleasure in the experience of *suffering* as Sackville-West records in her account of unrequited love:

> It is painful but also rather pleasant if you know what I mean. It is good to have so keen and persistent a feeling about somebody. It is a sign of vitality.[204]

She is describing the pleasure that can be found in the experience of *suffering*. Of the two, pleasure is more highly valued but this particular pleasure is not possible without the experience of *suffering*. Pleasure seems to 'piggy-back' the *suffering* and is dependent upon it and so to this extent *suffering* is valued.

Suffering can also lead a person to reflect upon the course that life has taken and provides an opportunity to re-evaluate personal goals and their chances of fulfilment. As a result of reflection and re-evaluation a person can reassess life and achieve greater insight both of themselves and of life in general. A person can seek to positively engage with *suffering* and as a result emerge with greater wisdom. *Suffering* has a transcendent effect and engaging with it may be a means of achieving authenticity. Authenticity will be discussed in Chapter Four where it will be presented as a new framework for thinking both about TS and GReS.

For the purposes of this section of this chapter an example of *suffering* leading to authenticity can be given. A sportswoman believes that she has sufficient talent and is hard-working enough to become a champion at her chosen sport. She has been encouraged in this belief by her family, friends and coach. All tell her that hard work will bring its own rewards. She enters as many tournaments as she is able but consistently fails to achieve the success that both she and others believe she is capable of. At first she explains this away but eventually she re-evaluates her chances of success following a defeat to an opponent she considers to be far less talented. The process of re-evaluation proves painful. She has to give up her belief in her ability to become a champion and to

change the way that others see her. They have encouraged her in the belief that positive thinking is a means of achieving results but she now realises that she was mistaken to think so highly of her attributes and to have set for herself unrealistic goals. She is now in a position to set for herself more realistic goals which may or may not be in the sporting arena and along with this has come to a new understanding of herself. She feels more settled and under less pressure to achieve. She feels more able to enjoy what she is doing and to find pleasure in her achievements. She has experienced the *suffering* of failure through which she learned truth about herself and her potential in life. She has achieved a greater measure of authenticity.

A final example of the way that *suffering* can be of value to an individual for his/her own sake is in the way that it can prove to be a basis for personal identity. The previous example of the woman who was abused as a child and keeps the memory of it alive in adulthood is instructive here. There are dangers, as was noted earlier, but if the *suffering* is incorporated into personal identity, rather than being a way to define identity, then it may prove to be of value. For instance, she may choose to work with abused children as a result of her own experience and as long as she does not think of herself as a victim, then she may value what she experienced as a child.

It has long been understood in religion that *suffering* can be of value to an individual. It may be found in various forms such as self-denial, the ability to withstand temptation, flagellation and the wearing of coarse garments next to the skin all of which are believed to be of value in bringing a person closer to God and in ridding the body of its sinful

thoughts and desires. *Suffering* is chosen in the belief that it may prove to be the only way to achieve greater spiritual awareness and is therefore valuable to the person whose goal it is to become spiritual.

I VALUE MY SUFFERING FOR YOUR SAKE

One person's *suffering* may be of benefit to another person who matters to her/him. *Suffering* may be either one means of benefit or the only means available in a particular context. For instance, Captain Oates, when he realised that the lives of all involved, and the very expedition itself was in danger, sacrificed himself for the sake of the others[205]. Oates sacrificed himself voluntarily for the benefit of the group and did so without discussing with his intentions with them. He merely announced his intention to go outside of the tent for a while.

Oates *suffering* can be understood to consist in both the intense moments of physical distress, with its consequent impact upon his consciousness in his final moments, and that he sacrificed the chance of future life. Had he made his intentions known they may have sought to dissuade him with the idea that good things could be anticipated in the future. This may then inspire hope and courage in their present extremity. Oates may have reasoned in this way himself and, if he did then, he seemed to choose to disregard it. He made the judgment that a future life would be more likely for others if he sacrificed himself. For Oates however he found value in his *suffering* knowing that it would be of benefit to others.

Notions of sacrifice can be understood as central to this particular value of *suffering.* Sacrifice can range from that which a parent makes for the benefit of a child, to a person offering to give her/himself up for the release of another being held hostage. The act of sacrifice itself may or may not be painful. If it is then the act can be thought of as an experience of *suffering*. In either case a person who sacrifices themselves can be said to be *suffering* in the sense that he/she is losing the possibility of a future life that will hopefully contain good things. Not all sacrifice is done for the sake of others, as in the case of Sister Luke (Gabrielle van der Mal) in the Nun's Story who was asked deliberately to fail at her examinations in order to learn the virtue of humility, but always involves an element of *suffering.* When undertaken for the sake of others it is a demonstration of the value placed by the one making the sacrifice for the one for whom the sacrifice is made.

Sacrifice may not be valued by the one doing the sacrificing if it is forced upon her/him by a powerful outside agency. A well-known example of this is William's discussion of integrity in the context of Utilitarianism[206]. He imagines a western tourist being asked by a group of terrorists to kill one Amazon Indian in order to save twenty others. Williams focuses his discussion on the tourist but for the sake of this chapter the focus can be on the one Amazon Indian. If the tourist consented to the demands of the terrorists and shot him then his life would have been sacrificed for the sake of the other twenty. The Amazonian may or may not find comfort in the fact that the others are being spared as a result but because he did not choose to sacrifice himself, his *suffering* cannot be thought

of as valued by him for the sake of others. Sacrifice needs to be freely chosen by the one making it if the attendant *suffering* is to be valued.

I VALUE YOUR SUFFERING FOR YOUR SAKE

In this formulation a person who has a positive relationship with a *sufferer* and at the same time shares a specific goal with him/her may come to believe that the *suffering* is a means of achieving that goal.

An example of this is the university tutor who encourages her student to work hard whilst knowing that it is burdensome to him. The student may experience *suffering* comparable to the sportswoman. The student may question his ability as he constantly evaluates talents and diligence. The tutor may deafen herself to the agonies of the student in the knowledge that she cannot do the work for him. *Suffering* is a means to an end for the student, who may consider his *suffering* as an indication of commitment to the study project. The tutor may also share this view of his *suffering* in this way and places value on the experience of the student. Both share the goal of the project but for different reasons. The student desires a degree whilst the tutor desires a good outcome both for the student and for his/her own academic reputation. The tutor knows that a degree may not be achieved without an experience of *suffering* for some people but values that element of it which consists of determination, self-understanding, courage and grit.

I VALUE YOUR SUFFERING FOR MY SAKE

This value focuses upon the idea of Schadendfreude as discussed in Portman's treatment of both Schopenhauer and Nietzsche[207].

Schadenfreude describes the pleasure a person feels when witnessing the *sufferings* of others, especially if those others have demonstrated undesirable or unattractive characteristics. Subjectively it results in an observer feeling better about himself and his life whilst objectively the observer feels that something appropriate has happened to the sufferer. Many philosophers believe that the pleasurable feelings are based either on considerations of justice or belief in the actions of a God who will not let the wicked prosper for too long.

One example of Schadenfreude is the following: Two teachers of similar ability and social standing work in the same school. Both were appointed to their positions at the same time. One is more adept at putting herself forward and at self promotion. The other feels unable to promote himself as he feels this would be to run counter to his idea of humility, which he values highly. The first teacher appears to reap rewards from her self-promoting behaviour, whilst the second works quietly away in his classroom. The first is seen as a dynamic individual whose reputation stands high with the educational authorities but not with her colleagues whilst the second is overlooked by the authorities but held in high esteem by those who work in the school. If the first teacher falls from grace in some way, perhaps as a result of poor exam results or a parent's complaint, the

second teacher may experience pleasure in her fall even though he may know that the first teacher is *suffering* as a result.

For this pleasure to be considered as an example of Schadendfreude then it must stand in a relation of symmetry with the character of the *sufferer*. The *sufferer* has benefited from some unattractive trait in her character and the benefits reaped as a result are thereby illegitimate. Her *sufferings* are not thought to be deserved in the sense that she has deliberately brought it upon herself in the way that a smoker is said to bring lung cancer upon himself or obese people are said to bring health problems upon themselves. Rather her *suffering* is resulting from some force at work that seeks to put right things that are wrong in the world. Pleasure is linked to ideas of balance and justice. One wrong thing has been put right and a sense of harmony and equality achieved. In the case of the two teachers the downfall of the one is seen as an example of pride coming before a fall.

Schopenhauer considers Schadendfreude to be immoral and is therefore never justified.[208] He believes that feelings of pleasure in the *sufferings* of others are wicked and ought not to be countenanced. Furthermore he argues that to appeal to notions of justice in order to rationalise Schadenfreude is a mistake because there is no force at work in the world that seeks to put things right and punish wrongdoers. To believe that justice is an objective reality is to believe in an illusion and so to be deceived

Nietzsche[209] had no such objections to Schadenfreude. For him it is pity or sympathy that he considered immoral. He believed Schadenfreude to be a universal human reaction that

was not necessarily linked to ideas of justice. It may be nothing more than an experience of pleasure in the face of *suffering*. Nietzsche argues that it is important that this laughter comes from a clear conscience and it is then something that is life affirming:

> If the gods know how to philosophize…they also know how to laugh in a new and superhuman way…and at the expense of all serious things. Gods are fond of mockery.[210]

It is a celebration of both the good in, and the continuance of, life. The *suffering* of one person causes the other to reaffirm his own life in a 'count your blessings' formulation as he makes a comparison between his experiences and that of the *sufferer*.

SUMMARY

I have discussed four examples of the value that can be found in the experience of *suffering.* For many, *suffering* may prove valuable as an occasion for reflection. This may lead to new attainments of wisdom and insight from which not only the *sufferer* may benefit but so may those who come into contact with him/her.

In the final section of the chapter I want to tie the discussion about *suffering* to TS. This will be done briefly here before expanding on it in Chapter Four and the subject of authenticity.

5. Suffering and TS

> A transsexual person is aware of being of a gender opposite to that (of their) physical sex. This conflict, between gender identity and physical sex, is always manifest from earliest awareness, and is the cause of enormous suffering. It is

> common for transsexuals to be aware of their condition at preschool ages. This agony can and does lead to self destruction unless treated.[211]

The intense suffering that this quotation tries to capture is reflected elsewhere in the narrative accounts already referred to in this thesis. If these are true, then undoubtedly a transsexual may experiences *suffering* in a way that satisfies the definition established in this chapter. This *suffering* appears to affect the sufferer physically (in the rejection of the sexed body) socially (in terms of withdrawal from social interaction and relationships) and emotionally (in terms of psychological instability, depression and suicidal ideation). As required by my definition of *suffering* it is fundamentally subjective in its nature, is of sufficient intensity to threaten the integrity of the self and results in the frustration of the natural and necessary desires for wholeness and integration of self. Moreover, no blame can be attached to the *sufferer* as TS is an accident of birth and their misery is all consuming.

Suffering is not, however, the only subjective element to the transition from being an unhappy and miserable individual to a *suffering* transsexual. Autobiographical accounts, medical case studies and stories in the mass media suggest that a person comes to think of himself/herself as transsexual by mapping their own experience of *suffering* onto the accounts they in turn have read of other people's experience of TS. In this respect, TS is self-diagnosed: the transsexual him/herself makes the connection between his/her *suffering* and that described by others. Indeed, this may be experienced as a form of self-realisation or self-understanding, which is then present this to a doctor or therapist for 'official' verification. As outlined in Chapter Two, this process of verification takes the

form on making a judgement about the patient's sincerity, strength of feeling, and lack of any other medical condition. And, according to some transsexual literature, on whether the physical appearance of the transsexual is compatible with 'moulding' into the desired gender.[212]

Returning to Cassell's theory of suffering – but taking it a step further - this process of self-diagnosis presents something of a double challenge to medicine. Not only must the clinician take at face-value the transsexuals claim to be suffering, but there is no objectively verifiable means of 'testing' for TS. The clinician must themselves make a subjective judgement based on their own impression of the patient's sincerity or strength of belief. The only blood tests or similar tools that may be available are those employed to discount other conditions. In other words, the suffering is subjective, the diagnosis is self made on the basis of how the patient feels and the clinician's own subjective judgement is used to confirm the accuracy of this subjective impression.

The lack of objective criteria, both to recognise *suffering* and to identify TS, is a matter of concern within the transsexual community and attempts are being made to construct an objective test for diagnosis. Reitz[213], for instance, has created the Combined Gender Identity and Transsexuality Inventory or COGIATI test which consists of sixty five questions concerned with issues such as memory, spatial awareness and powers of recall. The test seems to seek a biological basis for the differences between men and women and it is Reitz's hope that the medical profession will take up her work and develop a more scientific model for establishing objective criteria.

The Statistical Manual of Mental Disorders[214] (DSM-1V 302.85) of the American Psychiatric Association states that the diagnostic criteria for gender identity disorder in both adolescents and adults should take note of the measure of distress:

> "This disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning".

Referring to her pre-operative self Jorgensen recounts how she felt upon being perceived as a male homosexual. This seemed to sum up for her all that she was then feeling due to her TS:

> I sat alone in the darkness, drained and limp, devoid of any feeling at all, watching the lights on the opposite shore, though that night they afforded me no comfort…slowly an idea began to take form in my mind and I remember thinking that beneath the surface of the water I could blot out the revulsion and horror I felt. It would be easy to end years of loneliness, of hoping and searching by slipping quietly into oblivion.[215]

It seems reasonable, therefore, to maintain that the experience of the transsexual is one of *suffering* in the sense defined in this chapter. It is this experience that is the basis upon which the transsexual seeks help, and the request for help is often expressed in absolute terms. The transsexual's request is often constructed on an either/or basis such as 'either I am helped or I'll end my life as I can't stand it any more'. It is possible to argue that this formulation indicates that *suffering* may possess a certain currency. It is that which 'gains' the transsexual the treatment which she/he desires and the greater the claim to

suffering then the greater is the duty to respond to it. For a significant number of transsexuals surgery is sought in the belief that it is the only means of resolving *suffering* and therefore the medical community has a moral duty to grant it.

6. The duty to alleviate the suffering of transsexual persons

I want to argue that there is no an absolute medical duty to alleviate the *suffering* of the transsexual. I want to offer a critique of the duty to alleviate *suffering* structured in the same way as the general duty to alleviate *suffering* discussed earlier in this chapter.

INTRINSIC OR CONCEPTUAL CRITIQUE

The intrinsic critique of this duty will focus on two issues: causation and medicalisation.

In relation to causation at present there does not seem to be a consensus in medicine about the cause of TS as demonstrated in Chapter Two. Research continues and at present a biological explanation is favoured as the underlying causation with psychological and environmental factors contributing to the final condition.

Due to this uncertainty to alleviate *suffering* using surgery may prove to be inappropriate. If, for example, future research proves that TS is a psychotic condition or that the binary categories of masculine and feminine are false constructs and all that matters are individual personalities, then a surgical response to TS will be viewed as a mistake. There may be a need to respond in some way to the current *suffering* of the transsexual but to make that response a moral duty to alleviate it surgically is to assume that the

current medical construction is the only and correct one and that it requires no further reflection.

The medical construction of TS is problematic and is an example of the present trend to medicalise an increasing number of human experiences. This trend has been in evidence since the beginning of the twentieth century and has been noted by a number of commentators both inside and outside the medical community. Szasz[216], for instance has noted the interest of medicine in such diverse areas of human experience as sexual performance, criminality, insanity, drug and alcohol consumption and emotional well-being.

Human experiences such as these are brought into the compass of medicine for benevolent reasons. The hope is that by so doing such experiences can be both normalised and de-stigmatised. If they are medical problems then the person who is experiencing difficulties in these areas are not responsible for them and can also be helped with them. This attempt to normalise and de-stigmatise is an expression of the humanitarian concern that has been in evidence both since the Enlightenment and the decline of religion with its emphasis on sin, guilt, blame and punishment.

The medicalisation of TS is problematic within the transsexual community itself. This will be discussed in Chapter Five as the implications of the central idea of this thesis, authenticity, is worked out. It will be postulated that transsexual *suffering* is currently considered to be a medical problem because of the interest that medicine has in the

subject. As was seen in Chapter One, medicine began to take an interest in human sexuality and sexual identity with the work of the Edwardian sexologists. Doctors are seen as experts in matters of both mind and body and as experts who offer an explanation for TS which has gained currency at the present time. Szasz argues that medicine has replaced the Church in terms of authority and doctors now function as priests once did. He regards the idea that there is only one explanation for human phenomena as problematic:

> The belief that there is only one right way to live, only one right way to regulate religious, political, sexual and medical affairs is the root cause of the greatest threat to man: members of its own species bent on ensuring his salvation, security and sanity.[217]

Szasz recognises that the motives behind this single-mindedness are benevolent but argues that they are intrinsically harmful to human well-being. The harm consists both in the paternalism of those who propound the view and in the damage done to those on the receiving end.

MOTIVATIONAL CRITIQUE

The desire on the part of medicine to alleviate the *suffering* of the transsexual may well be an expression of the way that post-imperial, post Second World War guilt functions within western institutions as noted earlier in the work of Amato. He argues that western, white, male and middle class awareness is suffused with guilt which in turn leads to an assuming of responsibility for and a desire to help those who are needy.

Amato argues that this awareness includes the idea that the western white male class are responsible for the *sufferings* of others and have not always responded well to it. Once such sufferings would have been dismissed as irrelevant and no concern showed to those who are experiencing it. Now there is a desire to make up for this earlier failure and so responsibility is assumed for present *suffering* and attempts made to alleviate it.

In relation to TS it is possible to argue that the predominantly white, western and male medical community have assumed a responsibility for the *suffering* of the transsexual on the basis that there would have been a time when it would not have been recognised and the transsexual person left alone in her/his misery or given advice that is now regarded as paternalistic. Evidence of this can be found in most transsexual autobiographies such as those of Jorgensen, Morris, and Rees et al. This awareness is coupled with other examples of the way that medicine once mistreated or mishandled people in need such as those who sought help for such 'problems' as masturbation, hysteria and psychiatric conditions. It is the publication of such autobiographies and the work of both the medical and activist transsexual pioneers that has raised awareness of the way that medicine once failed to help. It can now be argued that medicine has sought to reverse its previous approach.

The *suffering* of the transsexual is now taken seriously, but sometimes uncritically. Some doctors may be aware of the way that medicine previously failed to help people with what would have been then regarded as trivial or irrational problems. A climate of taking

seriously the concerns of minority groups especially in relation to issues of sex and sexuality is now the result (see Chapter Two and interim conclusion).

A motivation that is both unwilling to engage critically and that incorporates feelings of guilt and responsibility for past actions is a problematic motivation for action. It can be argued that this motivation is fundamentally negative and as a result is wrong both for the one who feels the need to act and for the one for whose sake the action is undertaken. What medicine may need to learn from its past mistakes is not to seek to rectify them by uncritically accepting *suffering* claims but to discriminate between those claims that are the legitimate concern of medicine and those which are not. Added to this is the need of medicine to measure *suffering* claims against its own skills and resources.

CONSEQUENTIAL CRITIQUE

One possible consequence of an uncritical acceptance of the duty to alleviate *suffering* is that it may reinforce the bipolar or dimorphic sexual essentialist views of gender. It was seen in Chapter One that in the discussion on gender there is a contradiction at the centre of the current construction of TS. The condition is predicated upon the separation of sex and gender yet treatment aims to reunify the two. Without the separation of sex and gender TS would not be a logical and rational possibility yet by seeking a correlation or realignment between the two through surgery it reverses the very conditions upon which its existence depends.

The separation of sex and gender, discussed earlier in the work of Money, is part of the legacy of feminist theory. Feminism sought to question the assumption that masculinity and femininity are essentialist categories determined by biology and fixed through all cultures and for all times. It offered the view that they were social constructs concerned with power between the two groups, constructed by men on order to subjugate women and ensure the continuation of masculine dominance. The idea of immutable categories of masculine and feminine was part of the attempt by men to maintain power and was accomplished by means of patriarchy.

For instance Butler[218] argues that gender ought to be viewed as a cultural construction that serves the interest of men:

> the distinction between sex and gender serves the argument that whatever biological intractability sex appears to have, gender is culturally constructed.[219]

Butler recognised that there are biological differences between the bodies of men and women and that there may be differences between the two in terms of physical strength and certain functions such as menstruation, pregnancy, lactation and child birth but denied that these either naturally do, or in some moral sense ought to, give rise characteristics that define the ontological possibilities of men and women. Sex is therefore not to be understood as that which defines gender or as that which determines ontological realities.

The separation of sex and gender has contributed to the shift away from the idea of the inequality of women. Traditional ideas of female inequality was predicated upon the notion that character is determined by body and as the body of the woman was thought to be inferior to that of the man then her character and her possibilities were also inferior. With this uncoupling of sex from gender then the latter became the limitless possibility of all people. Characteristics could now be universally experienced and along with this came the possibility of equality between the sexes.

It is possible, therefore, to argue that the idea of gender as distinct from sex is a gain in terms of the equality of women. By making the realignment of sex and gender the therapeutic goal in the treatment of TS medicine can be seen as working against this gain. This is not only out of step with those who regard sex and gender as distinct realities but may also ultimately harm the equality that has been gained as a result of the distinction.

At some popular levels sex and gender are still understood as being one and the same. This is seen in the both the popular media and in ordinary and everyday conversations. Medicine may be aligning itself with these popular views with its current treatment goals for TS. To do so may prove to be inconsistent with the insights regarding the difference between sex and gender. On the one hand medicine recognises this distinction thereby allowing TS to be seen as a legitimate construct and, on the other hand, by its treatment approach denies it through presenting a transsexual person in whom sex and gender is one.

This consequential critique of the current duty to alleviate *suffering* argues that medicine's current response is both incoherent and may possibly impact negatively on the gains that have been achieved by the separation of gender from sex. This does not mean that medicine ought not to respond at all to the *suffering* of the transsexual but to do so by seeking to once again cohere ideas of sex and gender is not only incoherent with its own construction of TS but may also reinforce popular ideas that are at odds with academic discourse.

7. The Possible Value of Transsexual Suffering

In this section I want to argue that the chief reason why it may be inappropriate to adopt an absolute duty to alleviate the *suffering* of the transsexual is because of the potential value of *suffering*.

It can be argued that there at least two possible ways that the *suffering* of the transsexual may be of value: the first is that it may benefit the person who is *suffering* and the second is that TS may be of benefit to humanity as a whole.

The *suffering* that is experienced by a transsexual may be of personal value in existential terms. This *suffering* is centred upon the nature of personal identity and the way this is understood both subjectively and objectively. It is specifically related to the way that personal identity relates to issues of masculinity and femininity. The transsexual is in a unique position to reflect upon this. In a sense she/he has been forced to so reflect and

the experience of *suffering* that may be an opportunity to reflect upon why it is that some aspects of personality are seen as masculine whilst others as feminine.

If a male transsexual believes that he is in reality a female and *suffers* as a result then rather than seek to do nothing other than alleviate this *suffering* he may embrace it and through it reflect on why it is that he can feel female. He may be able to reflect on what femininity is and how it is possible for him to access this knowledge. This in turn may lead him to address the broader issue of what both categories are. He may well conclude that to construct them as opposites is a mistake the answer to which is to embrace the totality of his life experience and not seek an either/or solution but to seek one that is both/and. Through reflecting upon his *suffering* he may learn to think of himself as neither male/female nor masculine/feminine but as himself. He is a totality of a being which incorporates both his objective status and his subjective awareness. He may be led to increased sincerity and authenticity as a result of his reflections and this latter possibility will be discussed in greater detail in the next chapter.

The potential benefit that is gained from this reflection upon *suffering* may be lost if an absolute duty to alleviate it is in place. An absolute duty disvalues *suffering*: it is to be removed as quickly as possible. Removal of *suffering* may involve *suffering* for the transsexual in terms of all that is required in the treatment process. A transsexual's willingness to experience *suffering* in order for it to be alleviated is not only necessary but is also seen as evidence of commitment to therapeutic goals. This commitment appears to be a prerequisite for the granting of the treatment itself.

Suffering may prove to be of value then if it proves to be an occasion for reflection in the way described. A transsexual is no more under an obligation to reflect upon *suffering* than anyone else in similar circumstances. Whilst it may not be possible to maintain that there is a duty to reflect upon *suffering* it seems reasonable to argue that the *option* to reflect in the way discussed above ought to be available. An absolute duty leaves little or no room for such a possibility.

The second possible value of transsexual *suffering* is that it may prove an occasion for general reflection upon constructions of maleness/femaleness and masculinity/femininity. This may result in a rethinking of current understandings which may lead either to a reordering of the categories themselves or to an abolition of separate categories.

Califia[220] documents how Bornstein calls for such reflection in the hope that the whole idea of gender will be abolished. Bornstein claims:

> I know I'm not a man…and I've come to the conclusion that I'm probably not a woman either, at least not according to a lot of people's rules on this sort of thing. The trouble is, we're living in a world that insists we be one or the other.. a world that doesn't bother to tell us exactly what one or the other is.[221]

It is Bornstein's own experience as a M-F post-operative transsexual that seems to have enabled her to come to this conclusion. If she had been encouraged to reflect before treatment began then she may or may not have transitioned. This is something that she recognises herself and Califia documents[222]. Bornstein regards gender as an expression of

suppression and classifies it along with racism and sexism. Califia reports that Bornstein came to her conclusions as a result of reflection:

> Bornstein makes it clear that she did not come to a place of being neither male nor female until she had done considerable growth and soul searching.[223]

Bornstein's reflection was after the event and it lead her to question the medicalisation of TS and to wonder whether or not the desire for GReS can be reconciled to a non-medical construction of TS. As indicated in the discussion in Chapter Two, authenticity may be a possible answer to this question. If *suffering* were to be valued, as I am proposing here, then it may be that reflection can be done before the event of transitioning both by the individual and in society as a whole.

There may be two beneficial consequences to making gender categories redundant. First, the grounds for the *suffering* of the transsexual would be removed as it is the conflict between masculinity and femininity that causes the *suffering.* If there is no conflict or no polarity of view then there may be no reason for the *suffering.* A person may still be aware of traits that may once have been considered as exclusively masculine or feminine, but would not experience this as a contradiction. Second, society as a whole may be freer in its understanding of the possibilities for personal development. Gender polarity may be replaced as a concept with the view that identity is more free and more fluid an idea than was once thought.

Conclusion

In this Chapter I have argued that there is a negative human experience that can be understood as *suffering* and which is distinguishable from other negative experiences by its multidimensionality. The importance of this experience is the way that the person concerned thinks about it. There is a very strong, but not an absolute, duty to respond to this *suffering*. *Suffering* is potentially of value both to the *sufferer* and to society in general. The absolute duty to alleviate *suffering* is problematic and so a prima facie duty may not exist.

Should a person who is *suffering* express the wish to be helped then this ought to be respected. It would, however, still be legitimate to point out the potential value of *suffering* and if, on the basis of informed choice, someone then sought this benefit, it would be legitimate to offer support and to enable them to do so. Counselling or other forms of talking therapy may be a means of enabling a person to benefit from the experience of *suffering.*

The alleviation of suffering can not be thought, therefore, to be a sufficient justification for GReS to be prescribed as the treatment goal for all transsexual people. *Suffering* may be a necessary condition for surgery to be offered but for the reasons laid out in this chapter it does not provide sufficient grounds for treatment. A serious duty to respond to *suffering* exists but the shape of that response may depend upon the requests and the desires of the one who is *suffering.* There is also an important role for the one who is

seeking to respond apart from that of alleviation. The responder may have the role of encouraging the *sufferer* to positively engage with their *suffering*.

If *suffering* is not a sufficient justification for surgery and the three models are also problematic, as was seen in Chapter Two, then an alternative justification for GReS is necessary. Chapter Four will offer such an alternative justification, in the form of authenticity.

CHAPTER FOUR AUTHENTICITY

Introduction

In this chapter I will argue for a specific definition of authenticity and authentic TS. The definition will be an Existential one which lays emphasis upon personal freedom and responsibility recognising the importance of choice and autonomous functioning.

As we have seen, the current understanding of TS is essentialist in its construction, an understanding that is overwhelmingly medical. Many transsexuals think about TS in this medical sense[xxv], one result of which is that their sense of self is defined by TS. Self-identity is conceived in terms of TS with the belief that because the condition was not chosen there is no control over it and therefore no choice about how it is experienced and how it will impact upon one's life.

In Existentialism freedom is the fundamental truth of human existence and each individual has to recognise themselves as undetermined free agents. Failure to do so results in what Sartre coins 'bad faith', a species of inauthenticity[224]. Bad faith results from the failure to take responsibility for oneself, one example of which is the claim that because a person did not originally choose a condition or an experience there is therefore neither choice in how it is worked out nor responsibility for its implications.

[xxv] See the autobiographies mentioned in this thesis e.g. Jorgensen and Morris.

In this chapter I will argue that an essentialist construction of TS results in inauthentic living. An inauthentic life has elements of deception, both self-deception and of deception of others. To think that a person's essence or original condition is an immutable factor that determines behaviour is to be in bad faith as it ignores personal responsibility which is a core feature of morality.

Authentic existence consists in taking personal responsibility for one's whole of life and then living that life in freedom and choice. In order to develop the argument of authenticity in relation to TS this chapter will be organised in the following way. It will begin by giving some background for Essentialism which, for the purposes of this chapter, will be understood as the idea that a person is defined by his/her essence. Essentialism relates to the original 'given-ness' of an individual. Determinism is the idea that a person is defined, controlled, operates upon or shaped by factors outside of his/her conscious experience. A person's decisions and actions are 'determined' by antecedent events. In relation to TS, then, this can be understood in the following way: the 'essence' of TS is found in the size of the BSTc region of the hypothalamus whilst 'determinism' is the view that gender identity arises inexorably from its functioning.

This background will prepare the way for an analysis of the medical model of TS. This model is essentialist in nature and offers a form of determinism that states a transsexual individual is not freely choosing a gender identity but is 'determined' by the functioning of the BSTc region of the hypothalamus. It is predictable, given the nature of the hypothalamus that the transsexual person behaves in the way that she/he does.

There then follows an Existential analysis of TS leading to an existential account of authenticity and TS with counter arguments to this existentialist construction. I will then address the question of what is gained by replacing an essentialist account with an existential one. I will conclude that essentialist accounts of TS are both problematic and incoherent. Such accounts are the product of the 'first wave' of thinking about TS in a medical context where doctors are considered experts, able to rationalise, codify, manage and act as gatekeepers for GReS. Within the transsexual community a 'second wave' of thinking about TS is taking place in which the medical model is being challenged and an anti-essentialist perspective emerging.

My thesis is that both essentialism and suffering per se are bogus justifications for GReS. Instead GReS is a means by which a transsexual may either achieve or work towards personal authenticity.

1. Essentialism

Essentialism is the view that the nature of a particular life form is determined by its inherent nature that gives a life its shape and in turn governs how a life is lived. It is based in the physical nature of the life form, which in the case of human beings tends ultimately to mean the structure, organisation and functioning of the brain. The whole body is seen as that which is given and it is the brain that endows a person with those capacities that mark him/her out both as unique as an individual and also as a member of the human species. It is the capacity for reason that is the hallmark of human persons. An

essentialist would hold that a person is a product of physical endowment and therefore ought to live in accordance with this. Accordingly, morality is based on the belief that good action accords with human reason. The capacity for reason is viewed as the highest human capacity.

Philosophical essentialism is found in the works of Plato[225], the French encyclopaedists Diderot[226] and Voltaire[227] and Kant[228]. Aristotle writes:

> Now we take the human's function to be a certain kind of life, and take this life to be the soul's activity and actions that express reason. Hence the excellent man's function is to do this finely and well. Each function is completed well when its completion expresses the proper virtue. Therefore the human good turns out to be the soul's activity that expresses virtue.[229]

Aristotle argued for a *hylomorphic* understanding of all objects; they consist of an irreducible minimum of element, the sum total of which gives to an object its form and nature.[230] Aristotle further identified this irreducible minimum as the *material cause* with the *formal cause* understood as the pattern used to assemble the basic materials into an object. A human being consists of the basic material of humanness and is 'assembled' according to the idea or form of humanity. The end of human life is to function according to its human nature.

The concept of formal cause has been subject to much scrutiny since the time of Aristotle and has largely been replaced in modern secular philosophy with the idea that the only

element of design in nature is that provided by biological evolution. Attention has become focussed upon biological functioning as the basis for human living.

In modern secular philosophy one form of essentialism is the view that human consciousness is the result of the neuro-chemical activity of the brain making human consciousness ostensibly a physical activity. Searle[231]. discusses human consciousness in the context of the 'mind/brain' problem and regards self consciousness as that which is distinctive about humanity. He argues for an essentialist understanding of mind that maintains that human consciousness is the result of the physical workings of the brain:

> As far as we know anything about how the world works, variable rates of neuron firings in different neuronal architectures cause all the enormous variety of our conscious life. These variable rates of neuron firings cause all the colour and variety of our conscious life …the smell of the flower, the sound of the symphony and the thoughts of the theorems in Euclidian geometry-all are caused by lower level biological processes in the brain[232].

For Searle there is no duality between physical and mental things. All mental activity- including higher consciousness- is the result if the workings of neurological processes. Lower level physical functioning gives rise to higher level consciousness, which is experienced both subjectively and in a manner that gives to the self an appearance of separation between brain/body and mind. (It is the appearance of consciousness to the self as well as consciousness itself that is known as the mind). Brain processes are the cause mental states and it is in the latter that a sense of self is formed. This includes the knowledge that one is a self as well as the awareness of what it is to engage with the

external world including other selves. Both the essence of a self and the expression of that self can be traced back to the neuronal activity of the brain.

Searle suggests that all the aspects of personality results from neuronal activity. Talents, tendencies, abilities and characteristics are all inherent features of the self that come to expression in the way that a life is lived out. Also linked to this, not necessarily in Searle but in a general sense, is genetic determinism.

Other philosophers working in philosophy of mind have offered alternative models to that of Searle. In Popper and Eccles[233] for instance, the goal of essentialist thinking is:

> to formulate a theory that can in principle provide a complete explanation of all the behaviour of animals and man, including man's verbal behaviour.[234]

They argue for 'interactionism', which claims that mental states are as real as physical objects and that the brain, rather than being the origin, location and causation of mental states is the place where the mental and physical interact. Both authors claim that the problem in philosophy of mind is to explain how interactionism works.

This brief account of both the arguments and counter arguments in the realm of essentialism are provided in order to pave the way for a discussion of essentialism and TS

2. Essentialist Explanation for TS

We are by now familiar with the fact that the majority view on TS is both essential and medical. Hoenig[235] produced a review of all the research into the biological basis for TS in 1985 and offered the following conclusion:

> (the claim that) psychological factors determine gender identity cannot be regarded as being established. The search for constitutional factors has brought to light interesting conclusions.[236]

Hoenig developed the work of Benjamin by looking for biological explanations for TS and to further conceptualise it as a matter of a person's essence. Initial attention was focussed on hormonal abnormalities but this was soon superseded by interest in the brain. In Chapter Two the work of Zhou et al in relation to the BSTc region of the hypothalamus was noted. They offer the following conclusion to their research:

> Our observations suggest the small size of the BSTc in M-F transsexuals cannot be explained by differences in adult sex hormone levels, but is established during development by an organising action of sex hormones, an idea supported by the fact that neonatal gonadectomy of male rats and androgenitization of the female rats indeed induce significant changes in the number of neurons of the BSTc and suppressed its sexual dimorphism[237].

The difference in the size of the BSTc region of the hypothalamus between M-F transsexuals and non-transsexual men is thought to be the result of abnormal foetal development. The brain of the foetus is thought to be organised as a result of hormonal 'washings' from the mother and the foetus. Such washings organise the sexual characteristics of the foetus all of which are female in initial formation. After week fourteen a foetus may develop as male as a result of hormonal influence. If the brain and the secondary sexual characteristics are masculinised then the brain will show differences

in organisation from the female. One such difference is the size of the BSTc which appears smaller in females. This region is believed by essentialists to be the source of gender identity and so if a M-F transsexual has the same brain organization as a female then she can be thought of as essentially female.

Zhou et al collaborated with Krujiver and Pool[238] in 2000 to produce an article which stated that M-F transsexuals have female-like neurons in the Limbic Nucleus:

> In line with the hypothesis that in transsexuals sexual differentiation of the brain contrasts with that of the genetic and physical characteristics of sex, our group has recently found that the size of the central subdivision of the BSTc was within the female range in genetically M-F transsexuals.[239]

The researchers sought to establish whether this difference is due to the neuronal organisation within the region itself or as a result of the organisation of the amygdale itself. To do this they focussed attention on the somatostatin expressing neurons in the BSTc region. Niedermayer[240], reporting on the findings of Sapolski, comments:

> The research suggests something new about the source of TS: your pattern of chromosomes, gonads, genitals, secondary sexual characteristics, the hormones of your blood stream and the way you are treated by your parents, teachers and society at large may all be in agreement that you are a certain sex. But, something as hard-nosed and biological as the number of neurons in a part of your brain may be telling you that no, that's not who you are: You are the opposite sex. Imprisoned. The bodies transsexuals are born into actually are the opposite gender of who they really are because prenatally established brain structures determine innate gender feelings and gender identity.

Niedermayer concludes by quoting Sapolski's response to these findings:

> These are dramatic, unprecedented, undeniable observations…the implications are far reaching, especially for those who suffer from cross-gender identities. Instead of those gender feelings being considered 'psychological' they can now be understood as being 'neuro-biological' in nature.[241]

These findings are thought to indicate that TS results from the brain being 'wired' in a particular way. Other factors may contribute to the total picture but the essence is due to the structure and functioning of the BSTc region of the hypothalamus. This essentialist construction gives rise to the idea that TS is an unalterable condition which in turn determines the experience of the transsexual individual.

This essentialist construction is reflected in the way that many transsexuals learn to think about themselves as evidenced in autobiographical accounts. As was seen earlier; the first transsexual to have a wide and popular readership was Jorgensen who was offered the following explanation of her condition by her doctor:

> I think that the trouble is deep rooted in the cells of your body. Outwardly you have many of the sex characteristics of a man, yet it is quite possible that you are a woman. Your body chemistry and all of your body cells, including your brain cells, may be female.[242]

She likened her response to this news to receiving an 'electric volt [243] and it was this consultation which provided her with the medical support she needed to pursue reassignment.

A similar essentialist self understanding is found in Morris's autobiography. In her first encounter with Benjamin he acknowledged the limited understanding of TS at that time but maintained that it should be thought of as something which is fixed and unalterable. She records him as saying:

> It (TS) is an immutable state. So I ask myself in mercy or in common sense if we cannot alter the conviction to fit the body, should we not in certain circumstances, alter the body to fit the conviction?[244].

As a result Morris's dream of changing her body to reflect the way she saw herself became a real possibility.

Both narratives suggest that transsexuals are experiencing the dissonance between sex and gender and as a result put themselves on the path to alignment using medical and surgical interventions. The dissonance seems to be experienced as something that is fixed partly because it has been present from earliest memories. A mistake of nature or of God is often the belief that a transsexual offers with the claim that it has 'happened' to them. As a result of this sense of permanence a transsexual may think that she/he has no choice but to *be* a transsexual and that TS is somehow defining.

As the two passages show it is often when an essentialist, medical explanation of TS is offered by a physician that an individual comes to think about themselves as transsexual. The explanation of the doctor becomes a moment of insight and transcendence which both liberates and offers hope. Also, as the recent 'Between Ourselves' programme

broadcast on the BBC Radio4 suggested the internet is also a source of information and insight[xxvi].

The on-line transsexual discussion forum Gendertalk contains many accounts of many people for whom the medical explanation of their experience was important and who learned to think about themselves as transsexual as a result.[245] The moment of 'revelation' from the doctor becomes a moment of self-understanding. This suggests that the transsexual may buy into the medico-essentialist construction as that which explains her/his experience. Not only does it seem to fit with the facts of experience but it also comes with the authority and weight of science and medicine. The permanence TS and the medical explanation combine to form the understanding of the condition.

The combination of subjective (as experienced by the person) and objective (found in scientific 'evidence') fixedness is often reinforced by contact with other transsexuals whether this takes place within the hospital setting or the transsexual community. Contact with others has the effect of consolidating self understanding.

3. Essentialism and TS

[xxvi] Transmitted on the 17th July 2008 two partners of transsexual people discuss their experiences. Both talk about how they understood their partners transsexuality and, amongst other things, how their partners found information about their transsexuality.

The inability to function has been identified by Boorse[246] as one of the elements that constitute a disease. Boorse argues that health corresponds to ideas of what is normal for a species in order for it to function:

> the state of an organism is theoretically healthy, i.e. free from disease in so far as its mode of functioning conforms to the natural design of that kind of organism. (Diseases are) deviations from the natural functional organization of the species.[247]

This view fits within the Natural Law Paradigm and within medicine it gives rise to the belief that the health of an individual is proportionate to the ability to function according to norms of human experience. Boorse argues that health is a value neutral concept which can be thought of in three ways: as a matter of individual potential, species potential and as an unlimited view. The first of these consists in an individual's ability to achieve maximum functional potential, the second is concerned with the maximum potential of the species as a whole and the third is the idea that any increase in functional ability benefits the whole species. Anything that interferes with this functional ability has to be considered as a matter of disease with illness being the subjective experience of interference with normal functioning:

> diseases are internal states that depress a functional ability below species-typical levels.[248]

Boorse maintains that health need not be thought of as a practical judgement made in relation to patients, nor as a commitment to what he describes as 'positive health'. Health is merely a description of what is the normal functioning of a species.[xxvii]

According to this definition TS can be thought of as a disease as it results in a failure to function according to ideas of what is normal for men and women. The dysfunction is rooted in the sex/gender dissonance and so it may be inferred from this that sex/gender congruency is both normal in human experience and necessary for human functioning. If TS is a disease then transsexuals may be unable to live successfully or function normally so that she/he is unable to experience personal happiness.

The sex organs of the transsexual are not diseased. They function as Boorse suggests they should (to promote survival and reproduction). One component of the 'disease' is in the perception of these organs and this may make TS partly a mental as well as a physical disease.

If TS is a disease then medical treatment, if it can be found, is appropriate. Without treatment both the condition and the *suffering* will remain: TS is a fixed condition. There is also a relationship between frustration at the lack of access to treatment and *suffering.* Where it is difficult to access treatment there is often an increase in the experience of *suffering.* The knowledge that treatment is available but not a possibility for a specific

[xxvii] In Chapter Two a footnote sets out an example of the vast literature on health/illness definitions. Catherine McDonald has offered a critique of Boorse's account of health (1V Annual Symposium on Biomedicine, ethics and Society 2004 Uppsala University Sweden).

individual (perhaps due to economic considerations) may intensify a person's *suffering*[xxviii]. The elements of hope, desire and possibility are frustrated when treatment is denied and this leads to *suffering.*

When no treatment is available a transsexual may adjust and accept that surgery is not a possibility for her/him. This, in turn, may lead to a diminution of *suffering*.

The essentialist belief about the fixedness of TS drives medical and surgical management:

1. The G.P is the first point of contact who would normally refer the individual to:
2. A psychiatrist for initial assessment whose first task is to test the strength of the belief in sex/gender dissonance coupled with an understanding of the strength and duration of the *suffering* claim. The psychiatrist attempts to rule out other conditions that cause sex/gender dissonance, such as some form of psychosis, before accepting the claims of the transsexual and beginning the treatment process. The psychiatrist has a gate keeping role in relation to the whole treatment process.

3. Once the individual's claim has been accepted by the psychiatrist then the process of transitioning can begin. The first step is the taking of hormones and leads to

[xxviii] There has been a great deal of publicity in recent times about so called 'patient protests' in relation to cancer treatment e.g. http://www.bio-medicine.org/medicine-news/Cancer-Patient-Protests-Before-Assembly-7513-1/. It is the *suffering* that this causes in addition to the experience of cancer that is often highlighted in these cases.

the transsexual ‘passing’ in the desired gender role within the community. This is seen as an essential indicator of the success or otherwise of reassignment surgery.

4. Surgery (GReS) is the ultimate goal of medical intervention.

No guidelines from NICE are currently available on the management of TS. The Harry Benjamin organisation remains the body that governs the medical management of TS.

Because of the importance attached to transitioning a few comments are necessary at this point. First, it is possible for a person to live in a desired gender role without medical and surgical intervention. This is known within the transsexual community as ‘living out’ and is thought of as a matter of personal choice. Transitioning, strictly defined, is a medicalised process containing the idea of moving from one mode of being to another by means of technically and permanently altering the body. A subjective decision is made by the individual between ‘living out’ and transitioning. The former emphasises gender role and is a matter of what a person can ‘put on’ in terms of gender signifiers whilst the latter is a physical remodelling of the body. ‘Living out’ is a matter of display and performance and transitioning a matter of re-orientating the sexed body.

Second, successful ‘passing’ seems to be a matter of convincing others of gender performance. Reitz argues:

> To the transsexual it [the ability to pass] can make the difference between forever being an object or living a comfortable life..[249]

Transsexual's are encouraged to study the characteristics of the desired gender and to incorporate then into his/her own life. By transitioning a transsexual is encouraged to choose a construction of gender that is often stereotypical. A M-F transsexual may seek to 'pass' as a very feminine woman whilst a F-M may seek to become a readily identifiable man. This may be due to a desire to make sure that the act of passing is successful. As ambiguity during this process may harm the prospects of being accepted for surgery, a transsexual may be under pressure to construct a gender presentation that conforms to stereotypical ideas as these are unambiguous. It remains true, however, that such gender presentations often coincide with the wishes of the transsexual him/herself who may visualise their own gender identity in such terms.

Lawrence suggests:

> The importance of the Real-Life Experience (passing) is probably the closet thing to a 'sacred cow' that exists in the world of transsexual care. But there is surprisingly little empirical evidence that a one year real-life experience, or indeed that any real life experience, is either a necessary or a sufficient condition for achieving favourable outcomes after GReS.[250]

Her comments cast doubt on the connection between the ability to pass and satisfactory post-surgical outcomes. Nevertheless it remains a pre-condition for surgery and is something that is generally considered to be an important element in the treatment process. WPATH lays stress on both aspects in its standards of care.[251]

The goal of medical intervention in TS is a happy and adjusted individual. In order to achieve this various medical specialists are engaged: urology, endocrinology and

dermatology as well as those already identified. Psychiatry formally recognises TS according to its diagnostic standards and controls transitioning by referring transsexuals to the appropriate disciplines and exercising a supervisory role[252].

Psychiatry has, therefore, a central role in the construction and organisation of TS yet TS itself is not considered to be a mental illness. As we have seen in the work of Zhou[253] et al TS is thought to be due to brain disorder in the same way as epilepsy or Tourettes syndrome. This would make TS a neurological matter rather than a psychiatric one and so a psychiatric classification of TS is problematic. Even more problematic, then, is a surgical resolution to a neurological problem.

4. Critique of Essentialism

This critique will consist first of a general critique within the parameters of this chapter and second of the essentialist understanding of TS itself.

GENERAL CRITIQUE

Haldane[254] offers the following general critique:

> If materialism is true, it seems to me that we cannot know that it is true. If my convictions are the result of the chemical processes going on in my brain, they are determined by the laws of chemistry and not of logic.[255]

Haldane's argument is that materialism reduces the whole of human experience to both the organisation and functioning of the brain. He is critical of this view. However, Haldane seems to conflate materialism with both essentialism and determinism. For him materialism seems to refer to both the essence of a person and to the subsequent effect of that essence upon the person (determinism). Materialism includes both conceptualisations. It reduces the whole of human experience to physical processes. Brain structures account for a person's essence, whilst neuro-chemical functioning of the brain determines human behaviour.

However, contrary to Haldane, materialism need not coincide with essentialism or determinism. It is also possible to think of materialism as referring to the view that the physical world is the only world that exists and that ideas of an immaterial or spiritual world are mistaken. In this sense materialism is the view that it is only physical and visible substances that can be thought of as existing beyond doubt or as 'real'. Haldane seems to be using the term 'materialism' to refer to the scientific view that discounts a 'mind' as opposed to brain explanation for human behaviour or as the opposite view to Cartesian dualism.

Working with his definition of materialism he points out that this concept must also be the result of the firing of brain chemicals and not a 'pure' thought. The concept cannot be considered as a logical deduction about the nature of brain functioning but as a further example of brain functioning.

Materialism, in the sense critiqued by Haldane, attributes all human behaviour and experience to a combination of essence and determinism. This would include the functioning of reason. It is a matter of brain organisation and functioning. A person is able to reason if she/he has the correct brain organisation that, in turn, functions accordingly. There is no room, in this view, for the subjective life of the individual, for the idea that subjectivity is a 'real' area of experience and for the subjective choice of choosing whether or not to act rationally.

Outside of materialism, reason is classified as a mental capacity linked to the will and is regarded as the highest good in human experience[xxix]. A person can freely choose whether or not to act rationally and be held morally accountable for doing so. Haldane's materialism undermines this understanding of both rationality and morality: moral categories such as goodness/badness are replaced by neurological function/dysfunction. Accordingly it is increasingly difficult to have notions of responsibility, moral worth and commendable behaviour.

Robertson[256] adds a further argument against essentialism. She argues that an essentialist position would not allow for variation if the same original material is used. Using Ship of Theseus[xxx] type arguments she explores ideas of continuity and difference and argues that difference is in fact possible even where similar type building materials are used.

[xxix] This thesis is not the place for a full discussion of the work of Aristotle or Kant who emphasise the importance of rationality as the highest good and rational functioning. It is sufficient here to note that this is the case.

[xxx] The Ship of Theseus is a Greek legend told by Plutarch. Overtime the ship in which Theseus returned to Athens was replaced piece by piece in order for it to be kept as a memorial. Plutarch questioned if the fully replaced ship could be understood as the same ship which returned Theseus in the first place.

Applied to human experience if essentialism is true then it becomes difficult to explain human variety in terms of abilities, character and social presentation. Human brains are similarly configured and operational yet the differences between people are incalculable. Robertson questions how this is possible if origins are determinative.

She is concerned both to identify attributes that 'make-up' a thing and those which are present but not determinative and with how this distinction is to be made. She makes a distinction between attributes that are essential and those that are accidental. She does not consider essentialism an unintelligible theoretical position but questions the basis on which it distinguishes between essentials and accidents:

> I do not mean to suggest that it [essentialism] is without its perplexities. Chief amongst these is the obscurity of the grounds on which ratings of attributes as essential or accidental are made[257].

A slight variation in the essential make-up could greatly impact upon a finished object, so that it is difficult to distinguish the essential from the accidental. This may be sufficient reason to be careful about the way that the original condition of a thing is constructed.

Whilst essentialism recognises the importance of the original nature of an object or a person in terms of its nature it cannot be thought to be a complete explanation. First, it does not allow for the possibility of variation or difference and second, in relation to human thought, if all thought is reducible to neurological firing then principles or concepts are nothing more than neurological activity. Common intuitions regarding morality are redundant and so a new construction becomes necessary.

CRITIQUE OF THE ESSENTIALIST CONSTRUCTION OF TS

In this section I want to make four criticisms of the essentialist construction of TS.

The first criticism is in relation to the current willingness of medicine to offer transition and reassignment as a solution. This may be inconsistent with an essentialist understanding. If essentialism is the basis for the experience of TS (in terms of brain organisation) then, at the same time and in order to be consistent, the *suffering* of the transsexual needs to be understood in the same way. All human experience is traced back to brain function/dysfunction. *Suffering* would be viewed as neurological dysfunction affecting those areas of the brain thought to be responsible for emotional experience. Chemical imbalances would be the reason for *suffering* and its alleviation would consist in controlling these imbalances with the appropriate drugs rather than through the current practices of transitioning and surgery.

Yet, within TS, *suffering* is not understood in this way. It is considered to be the direct result of the dissonance between sex and gender. It is thought to arise within the mind of the transsexual and then to be experienced by the self. It is the most 'real' element of TS as well as the most morally significant element in her/his experience. It forms the basis for the present medical justification for treatment.

TS *suffering* is understood to be different from the medical understanding of depression. In the latter a person is thought to be experiencing negative emotions as a result of brain dysfunction and treatment consists in attempting to restore the chemical balance. An

essentialist construction defines both the formulation and treatment of depression with the result that it is viewed as an illness.

TS is not seen as an illness even though it has a medical construction and treatment. This is the case for those who seek to identify and treat illness even though TS has illness identifying markers and treatment modalities. Instead TS is thought to lead to malfunction or impairment with the problems of the transsexual understood to be emotional and social. The transsexual does not claim to be ill nor does the doctor think of the transsexual as an ill person.

To be consistent therefore the present medical model of TS would need to think of the whole of the experience of the transsexual, including the experience of *suffering*, as a matter of the operation of the brain. Then, this essence would be understood to arise from a dysfunction of that essence with treatment being focused upon restoring or treating that dysfunction. It would be the brain that would be acted on, primarily by means of drugs that would act on the chemical functioning of the brain.

However, as things stand medicine explains the condition of TS as a matter of essence with *suffering* understood as a matter of experience. Hormones and surgery reflect the essentialist understanding whilst the respect for and the conceptualising of *suffering* reflect an existentialist approach. There seems to be a failure to be consistent here. An essentialist approach would call for treatment that acts on the essence in order to restore it to proper functioning. Alternatively an existential account would call for both the

condition itself, the role of the person and the way that the person is to be helped to be a matter of personal choice and responsibility.

The essentialist understanding of TS is given by Morris in her account of the interview she had with Benjamin. In refuting an existentialist understanding of TS she recalled him saying:

> No true transsexual has yet been persuaded, bullied, drugged, analysed, shamed, ridiculed or electronically shocked into an acceptance of his physique.[258]

This statement reveals several things about Benjamin's view of TS. First it implies that the difference between true and false transsexuals is that true transsexuals find that only surgery works. The true transsexual's experience is so bound to the body that it can only be remedied by treatments that affect the body: hormones and surgery. Next it claims that because true TS is a matter of essence the related *suffering* cannot be resolved directly but only by means of treating the underlying condition, with a medico-surgical intervention. The implication, then, is if anything else works then the person was not a true transsexual. Benjamin is appealing to medical practitioners to see TS as a matter of essence and to give up all attempts both to see it and treat it as a matter of the person. Yet the transsexual presents as a *person who is suffering*.

To make the distinction between essence and experience clearer a comparison can be made between the *suffering* of a transsexual and that of a person with a broken wrist. In the former case *suffering* is understood to engulf the totality of the person, both

objectively and subjectively, whereas with the latter the pain is associated with the body. The pain of the broken wrist arises from the broken bone; it is experienced as pain and loss of function and disappears when the bone mends. By contrast the *suffering* of the transsexual is not a matter of a broken BSTc region or broken hypothalamus, nor is it experienced as such. *Suffering* is not experienced as a broken body at all. It is entirely subjective in nature with no attempt made by the sufferer to locate the *suffering* in the body. It is not just that the transsexual is unable to point to the origin of the pain and say that it hurts here; pain is not located in the body at all even though it is linked with the body. Currently the brain is not the target of surgery but the body is and this is altered in order to alleviate the *suffering* of the transsexual.

A second criticism of the essentialist construction of TS I will call the 'I have therefore I am' criticism. A claim is made that a given element determines the character and the experience of the person in such a way that they are unable to exercise choice in this matter. The person is not, therefore, responsible for either the given element or for its subsequent effect. Also a person is not thought to have a condition called TS but *to be* a transsexual. Jorgensen's reading of de Kruif's 'The Male Hormone'(New York 1945) is an instance of this.[259]

Claims about identity are necessarily and causally related claims that are simultaneously made about the body. An identity claim is something that forms the basis for personal identity and is offered by the person concerned as a justification for that identity. Being a transsexual follows inevitably from either the subjective awareness of sex/gender

dissonance or from claims made about the body itself (that the genitals are not the correct one for the individual for example). This may be articulated by the transsexual person as being trapped in the wrong body.

A transsexual identity is added to the subjective awareness of the person as if the former both explains and accounts for the latter. The identity is thought to be the explanation of the condition of the person. The person concerned learns to think about him/herself in terms of this identity. It is 'added on to' the experience of dissonance in order to make sense of it e.g. as a result of conversations with family, friends, professional people or with others who share the experience.

But making an identity claim from a body or fundamental nature is a false move. The latter does not necessarily follow from the former. All that can be claimed as a result of fundamental nature is that fundamental nature exists. Identity claims require an additional premise (such as choice or desire) and as such cannot be thought to be supported by a fundamental nature claim. The two claims cannot be thought to prove anything other than the fact that the fundamental nature claim is true whilst the identity claim may or may not be true. Any attempt to draw a conclusion about identity from a fundamental nature claim is invalid. In relation to TS all that can reasonably be claimed as a result of the awareness of sex/gender dissonance is that sex/gender dissonance exists within the experience of the person.

One consequence of establishing an identity on the basis of fundamental nature is that this becomes the only possible identity: TS is the only explanation for people with sex/gender dissonance. It is then difficult for someone experiencing gender dissonance to construct an identity as anything other than transsexual. Indeed, any attempt to do so may be viewed as 'denial'.

The force of my point is obvious when applied to other claims that people make, or try to make, about their identity. For example, claims that a person is criminal solely because he possesses an extra X chromosome (I am a criminal *because* I have an extra X chromosome) or that a person is a homosexual because she is sexually attracted to people of her own sex (I am sexually attracted to people of my own sex *therefore* I am a homosexual) show the spurious nature of such claims.

The analogy with homosexuality is worth pursuing further. Norton[260]., in order to establish the legitimacy of the idea of homosexual identity, disagrees with those who argue that it is modern idea. He maintains that the concept is as old as Western civilisation itself. Citing literary and historical sources he demonstrates that every Western culture has had people with homosexual desires which he argues then formed the basis for personal identity. His position is that sexual desires form the basis for identity claims. This identity is then maintained over a lifetime and may be expressed by means of belonging to distinct groups that make up subcultures within society.

Norton contends that such identity was and still is a matter of *being* rather than of *doing* and to qualify as a defining desire it has to pervade the consciousness of the individual. Therefore the sexual desire of the person becomes the identifying marker for that person *as a person* in relation both to himself and to others. This sexual desire is not something that has been chosen, and therefore needs to be understood as part of a person's fundamental nature and because sexual desire is a fundamental element in personal experience, the desire is to be understood as something which determines the identity of the person.

Norton seeks to challenge the medical construction of homosexuality which sees it as a matter of genetic make-up, brain structure, hormonal functioning during foetal development all of which is influenced by psychological factors in early childhood and adolescence. It may be that medicine is able to explain what was not previously understood but he argues that this explanation does not create the idea of homosexual identity as this identity preceded explanation.

Norton cites the work of Ulrich[261] in order to strengthen his position. Ulrich was a non-medical journalist and campaigner for equality in mid-Victorian Germany and is thought to be the first person to coin the term homosexuality. He argued for the idea of male homosexuality as 'a female mind in a male body'.

Ulrich argued that it is immoral to discriminate against homosexual men and women because their homosexuality is part of who they are. It is natural to them and therefore

equality ought to be extended to them. His ideas were slow to find acceptance both within the medical community and within society at large due to what Norton claims to be the prejudice that existed at the time. As a result of the work of the early twentieth century sexologists[xxxi] Ulrich's views were eventually accepted (after homosexuality was firstly viewed as a matter of mental illness) and have become the norm today.

Ulrich is cited by Norton because he was a non-medical person who thought of homosexuality in terms of identity. For Norton it is legitimate to cite Ulrich in order to establish a non-medical view of homosexual identity. Medicine adopted Ulrich's idea of identity and then sought to find a medical explanation for it. However the idea of identity came before medicine's interest in it. Norton's position is that it has always been the case that identity claims have been based upon other claims that seem to be experienced before an idea of an identity. A person is first aware of sexual attraction and what follows from this is a sense of who the person is as a person. Personal identity is based upon their nature and the identity that follows from this is shaped by it. Same sex desire therefore becomes the basis for a sense of personal identity which in turn gives rise to a whole mode of existence. Essence in terms of sexual desire precedes existence and then shapes and controls it.

Part of Norton's critique is against those who argue that prior to the medicalised view of homosexuality same sex desire was viewed in terms of action and not in terms of identity. Same sex *acts* were seen as aberrations of a person's identity. Everyone was essentially

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[xxxi] See Chapter One

heterosexual with same sex acts constituting a derivation from this norm which could be accounted for either on the grounds of morality or situational pressure. Norton argues that whilst it may have been the case that the heterosexual majority viewed same sex acts as deviant, for those who experienced them such acts were expressions of their nature and not deviations from it.

Norton clearly bases homosexual identity on ideas of nature. It is the nature of the person to be homosexual. He does not want to credit this concept to medicine yet at the same time he seeks a medical explanation for it.

Yet both the medical construction of homosexuality and Norton's views are problematic. It does not necessarily follow that sexual desire is a sufficient basis upon which to assert identity as a given. Identity is constructed here in the following way: "I am a person who is sexually attracted to members of my own sex *therefore* I am homosexual". An idea of possession leads to ideas of identity with the latter as an inevitable consequence of the former.

Essentialist constructions of identity proceed in a "A *therefore* B" manner which does not seem to allow for choice, variation, freedom or alternative identities. In the essentialist formulation 'A' refers to fundamental nature whilst 'B' refers to the identity that is believed to necessarily follow. To criticise this formulation is not to argue that 'A' does not exist or is not a given but is rather to argue that it is not an inevitable identity. Cystic Fibrosis (CF) is genetically determined but a person with CF may well object to the idea

that she/he is defined by it. An individual could think of her/himself as much more that a person with a specific genetic condition and would want others to do the same. Here essence is not thought to determine identity yet this seems to occur in the case of both homosexuality and TS.

If a contrast between TS/homosexuality and heterosexuality is made at this point then the logical gap between "I have" and "I am" becomes clearer. It is not inevitable that someone who is sexually attracted to people of the same sex is defined by this attraction, any more than someone who is sexually attracted to the opposite sex feels defined by their desires. Yet individuals are more likely to be identified as being homosexual than heterosexual.

Same sex desire seems to be the basis for a whole way of life that can be recognised by and promoted to others by means of specific symbols, cultural activities and discourse all of which is known as 'pinkness'[xxxii]. This cultural expression is not merely a protest against perceived heterosexual dominance but is a positive celebration of homosexual identity as stated by Altman:

> Gay liberation is a process whereby homosexuals seek to come to terms with themselves and through self affirmation commence the path towards human liberation.[262]

Heterosexual desire does not seem to require self-affirmation leading to liberation in the same way. A heterosexual person does not need to come to terms with her/his own

[xxxii] Ironically adapted by gay man because pink is traditionally and stereotypically a female colour.

heterosexuality in the same way that Altman argues a homosexual person does. This may be because it already is the dominant culture even if this is not always consciously expressed.

TS and homosexuality, therefore, seem to be essentialist constructions in ways that do not appear to be the same for heterosexuality. Transsexuals and homosexuals seem to assert their identities far more frequently and in a more essentialist way than those who are 'straight'. In the former two cases essence is linked to identity. Heterosexual identity claims may also be made in terms of essence. For example, if a straight man is asked why he is only attracted to women may answer that 'it's just the way I am'. It does seem to be the case, however, that both homosexual and transsexual identities are claimed for more often than other identities appear to be in terms of essence, as was seen in the transsexual narratives identified earlier and in many homosexual biographies[xxxiii].

If identity follows from a fundamental nature this negates the need to seek any other form of identity: the way to live is in accordance with ones nature.

This discussion of TS, homosexuality and heterosexuality highlights the inconsistency in both the models that are employed and in the way that discourse is conducted. Models of TS and homosexuality seem to employ essentialist notions of identity in a way that those of heterosexuality do not and both also use a subjective state in order to build notions of identity in a way that heterosexuality does not. It could be argued that a consistent model

[xxxiii] See: "Science, Identity and the Construction of the Gay Political Narrative" Nancy J. Knauer Law and Sexuality Vol 12 p1 2003.

for all three would be desirable as all three are concerned with subjective awareness, personal identity and social relation. If a consistent model is employed then two outcomes are possible. An essentialist understanding could be employed for all three states of being with the result that heterosexual desire becomes a basis for identity in the same way as the other two. Alternatively, the essentialist model could be completely abandoned so that the original nature of all three states of being is not seen as a basis for personal identity. Choice and freedom would be considered to be of greater importance than an idea of a fixed and determining characteristic.

The Sartrean notion of Bad Faith throws additional light on the essentialist notion of TS. This is the idea that living one's life according to notions of fixed identities is inherently deceptive. A person begins with an idea of what a thing or a role or a nature is and then lives out that idea as if there is no choice in the matter or as if behaviour is prescribed by the identity. Sartre offers the example of the waiter to illustrate his point. This man has a certain idea of what a waiter is, of how a waiter ought to conduct himself whilst at work and of what a customer requires a waiter to be. He then conforms himself to these ideas and behaves accordingly:

> He knows well what it means (to be a waiter): the obligation of getting up at five o'clock, of sweeping the floor of the shop before the restaurant opens, of starting the coffee pot going etc…his movement is quick and forward, a little too precise, a little too rapid. He comes towards the patrons with a step a little too quick. He bends forward a little too eagerly; his voice, his eyes express an interest a little too solicitous for the order of the customer.[263]

Sartre's argument is that the man conforms himself to the idea of what both he and others have of what a waiter is. This image controls what he does. Yet Sartre argues that the man is much more than a waiter. He is actually free and can choose how to live. He can choose how to be a waiter and does not need to conform to any idea. Instead of acknowledging his freedom he tells himself he is bound to conform to this fixed notion of 'being' a waiter:

> It is a 'representation' for others and for myself, which means that I can only be in representation. But if I represent myself as him, I am not he; I am separated from him as the object from the subject, separated by nothing. I cannot be he, I can only play at being he.[264]

To play at being is to negate the self. As such it is a form of in-authenticity. To play in this way is to propel oneself towards nothingness.

Bad Faith can be used to understand the 'I have therefore I am' process in both TS and homosexuality. A person with gender dysphoria 'fits' him/herself to the idea of a TS. The 'I have' of gender dysphoria becomes the 'I am' of TS and he/she is then limited and restricted to this idea.

In conclusion then, this second critique of the essentialist position argues that essentialism does not allow for freedom, choice and authenticity. A person is reduced to his/her essence and all that can be hoped for is that nature fulfils itself. This is Bad Faith.

A third critique centres on how a transsexual is to be understood post-operatively. A claim is made that a person 'is' a transsexual. Once a person has undergone surgery the issue becomes whether he/she is to be understood as someone who remains a transsexual or as someone who is now a man or a woman. If the latter is the case then the issue becomes what has 'happened' to the TS. Because TS has been constructed as a matter of the essence of a person then, following surgery, how is that essence to be understood? If TS has been surgically removed then in some way the essence has been altered. However, it is problematic to claim that an essence can be altered. If it could then it becomes difficult to conceive of it as *essence*. Also, a distinction between ex- transsexual men and women and other men and women becomes illegitimate. It appears that some wish for this distinction to remain[xxxiv].

If, however, a person remains a transsexual following surgery, because she/he remains a transsexual, then the issue is what has been gained by surgery. A person may have a surgically altered body but because TS remains then she/he is not a 'man' or a 'woman' in the way that has been desired.

Szasz refers to post-operative transsexuals as 'fake' men and women[265] whilst Raymond uses the phrase 'male to constructed female'[266]. The phrase 'Gennys'[267] is commonly used in order to distinguish between men and women who have received GReS and those who have not.

[xxxiv] Raymond is critical of this idea and does not want post-operative transsexuals to be viewed in the same way as non-transitioned men and women. Yet if TS has been 'cured' by surgery then that person must now be thought of the same way as anyone else

One solution to this criticism is to argue that TS *is* the experience of the dissonance between sex and gender. TS is then located in subjective experience. Once a person has undergone surgery then TS has been removed because the experience of dissonance has been removed. A person is then free to be the gender that she/he has always felt themselves to be.

For this to be accepted, however, then a rethink, along essentialist lines, is required in the way that TS is currently constructed. First, the BSTc region would be understood to give rise to the experience of dissonance and not to be the 'location' of TS. Second, TS would not be a matter of the essence of the person but rather as something that he/she is experiencing (suffering?) as a dissonance in the same way as other dissonances are experienced, as for example that between first order preferences and second order desires. Third, it would need to be established why the dissonance between sex and gender is to be a matter of medical concern.

This rethink of TS may prove unacceptable to many because of the way in which it re-categorised TS as the experience of dissonance rather than essence. Also it may be felt to weaken the transsexuals claim to medical and surgical interventions.

A fourth and final critique of essentialism and TS focuses on the way in which it seems to be predicated on the notion of a self divided against itself. Currently TS allows for the gendered self to be understood to be the true self with the sexed self seen as false. The

former is valued and accepted whilst the latter is disvalued and therefore is rejected. The result of this accepting/rejecting dynamic is that drastic surgery is undergone in order to remove that which is disvalued.

One problem with the way that the gendered self is accepted but the sexed self is not is that this leads a person not to accept him/herself as a whole. Both the sexed and gendered aspects of the person can be thought as 'true'. They are at least to the extent that a person 'has' or 'is' both before coming to disvalue the one and rejecting the other. One further problem is the relative nature in which the gendered self is valued. At the moment gender seems to be valued over against the sexed body in some cultures and TS reflects this. Were this value system to be overturned, however, and the sexed body became that which was valued, then TS as it is currently understood may be threatened. This would suggest that TS is a culturally determined condition and not something that exists as an objective fact of human experience.

Following on from this, if gender is the valued element in a transsexuals experience then to surgically alter the body suggests that it is the body that is being valued and not gender identity. Gender is predicated on the idea that it is distinct from the sexed body yet it is the sexed body that is the object of concern and attention,

In reference to the accepting/rejecting dynamic that lays at the heart of the current TS construction it could be argued that *all* of a self ought to be accepted. In TS this would

include the sexed body as much as gender identity. This would result in a transsexual accepting him/herself as a whole and therefore avoiding a divided self.

Both theologically and philosophically men and women are often understood to be divided selves. Divisions are variously constructed between minds and bodies or between the God-ward nature and the sinful nature. Such divisions are often thought to be true of all people and can furthermore be understood to lead to tension within the person. In order to resolve this tension one aspect of the person is valued over the other. That which is valued then becomes of first importance to the person who then seeks to ignore or to limit that aspect of the self which has been disvalued. In relation to TS a further division of the self has been brought in, that between the gendered self and the sexed body.

It can be argued, however, that instead of the idea that divisions are to be accepted in the experience of what it means to be a person, the whole of a person's nature is to be accepted. Specifically for the transsexual this would mean that instead of a division between sex and gender, both would be accepted as they are. Being transsexual would mean accepting what one is. This would require living with the tension between sex and gender. Others would also be required to accept this to.

5. An Existential Analysis of TS

In this section I will argue that the essentialist, or medical, account of TS should be replaced with an existentialist one because an existential account resolves the difficulties noted above and provides a more coherent model.

This existential construction draws on phenomenology. Mainly systematised and developed by Husserl[268] and later employed by Heidegger[269], Merleau-Ponty[270] and Sartre[271], phenomenology is a method of investigation that seeks to eliminate all presuppositions from the subject under investigation in order that the 'in itself-ness' is revealed and can be examined.

Heidegger applies the phenomenological method to the study of being itself and to that of the nature of human 'being'. After exploring the linguistic meaning of the term 'being' he states that an application of the phenomenological method will result in the:

> letting everyone see (the subject under investigation) in its Being. Thus the term 'phenomenology' expresses a maxim which can be formulated as 'To the things themselves'.[272]

The subject under investigation is, as a result, brought to a place of brightness and clarity and shows itself as it really is. This is vital if the phenomena are to be rightly understood. The investigation reveals new insights to the subject. This newness may be a matter of bringing to light ideas that were previously known only intuitively. The result is both clarity and certainty.

This approach allows the investigator to move beyond contemplating the subject as mere appearance, semblance, symptom, distortion, myth or any other generally accepted view as all may prove not to be true. A particular culture may have view of a thing at any one time as a result of forces at work other than objective and rational factors, such as prejudice or expediency. It is this that can provide the lens through which a thing is viewed, understood and discussed with the result that the truth is hidden. Phenomenological investigation seeks to remove the cultural accretions in order to look at that which lies underneath. Such accretions can range from existing theoretical underpinnings to the ignorance of the investigator that leads to the inquiry in the first place. It is this 'thing-in-itself-ness" that is sought because it is believed that this reveals the true nature of the phenomena.

Criticism of the phenomenological method has been made by, among others, Todres[273] who states:

> It's (phenomenology) findings are experientially intelligible insights about the life-world that are transferable as ways of understanding different life-world phenomena in relation to the phenomena studied. It's findings are not necessarily final ways or best ways of articulating these insights…Whether this is the same phenomenon studied as that of another study is always to be examined as an open question, and the transferability of insights is always a reflectively

critical process[274]

Todres' point is that the phenomenological method of investigation can offer clearer views of any phenomenon but care must be taken not to think that these views are of necessity the whole truth about that phenomenon. Neither are insights to be considered *de facto* as objective truths. The removal of 'coverings' does not necessarily mean that all biases have been removed. The result is still a matter of interpretation. The individual perception of the investigator, linked to his/her belief systems, world-view and motivation, exercise an influence over the findings. The investigator needs to be aware of this and not to naively think that her/his investigation has revealed 'truth'.

The benefit of a phenomenological approach is found in the use of reductionism. The 'bare bones', or essential features, of a phenomenon have been sought. The use of the idea of essentials does not imply that an essentialist philosophy is at work but is concerned with seeking to identify those features of a phenomenon that can be expected to invariably belong to it.

So when applied to any investigation, including an investigation of TS, phenomenological findings seek to establish the 'invariants' that belong to the phenomenon and these would then be held by the investigator along with the knowledge that objectivity cannot necessarily be thought to have been achieved.

A phenomenological investigation into TS, therefore, would seek to filter out all existing presuppositions in order to see the "thing-in-itself-ness". It would seek to examine the

phenomenon in a way that is as free as possible from its current cultural construction. This in turn may reveal with fresh force both the inherent nature of the experience of TS and certain intuitions of non-transsexuals about claims made by transsexuals.

One such claim is the ontological claim that the individual is the same person after surgery that he/she was prior to it. One anonymous correspondent writing in the on-line support group 'Susan's Place' says following surgery:

> I am the same individual you have come to know…I have only begun to remove a shell.[275]

Intuitively this claim seems not to be straightforward. The transsexual person has sought to change the way that she/he is represented before others. This change is a radical change achieved by re-sexing the body. This was undertaken because she/he felt that the 'truth' of her/his gender was not seen by others. The 'real' person was unseen and surgery becomes the way to make the invisible visible. A transformation has occurred. What was 'true' before surgery is no longer 'true'. To claim to be the same person following this transformation seems both to diminish the impact of what has taken place and to negate the claim that what she/he was before surgery was not the 'true' self.

The claim to be the same person requires that temporal and spatial continuity is demonstrated. Williams[276] argues that three criteria are required for this claim to be met: historical enquiry, memory and proximity. The first validates a claim and needs to be conducted by someone other than the individual concerned so that an objective

perspective is achieved; the second requires that both the claimant and the observer have recourse to shared memory, whilst for the third it is necessary for the successive stages of the individual's life to have occurred in the closet manner possible. Disruption in any of these, particularly in the latter, may bring the claim into doubt. Williams argues that the body is the vehicle for continued personal existence. Whilst a body may alter and a personality may change if a body can be recognised as the same body it has always been then a claim to be the same person can be thought of as reasonable.

Williams moves his argument along by giving the example of Charles who claims to be Guy Fawkes. Charles appears to have all the memories of Guy Fawkes but Williams maintains that it is not the make-up of the inner life that proves identity but the possession of the body:

> For the memory claim of an event to be proved as true there needs to be a witness to the event. In identification this witness will point to the body doing the event for verification[277].

Applied to TS Williams argument would focus attention on the body. To validate the claim to be the same person *post-operatively* both the claimant and the observer would need to satisfy historical, memory and proximity requirements by means of the transsexual's body. The post-operative body would need to do this to the degree that is necessary for an identity claim to be made. The closest connection between the claimant and the idea of identity through time is necessary with the body providing the connection. It is the body of the transsexual that is the object of focus both because it undergoes the

most extensive alteration and because Williams claims that the body is the most important factor in identity.

It is possible to establish this in at least two ways. First, by demonstrating that the post-operative person stands in the closest possible relation to the pre-operative person, which can be done by videoing the surgery and then showing the video to anyone doubting that the transsexual is the same person. Second, if the transsexual individual argues that it is the same body following surgery, but that it has undergone changes. The post-operative transsexual does not have a different body. Neither has her/his body been replaced. Rather things have happened to it, but not enough to make it no longer the same person. The fact of the same body could be established by resorting to DNA testing and fingerprinting but it is not the claim that it is the same body that is problematic here but that the same *person* is present.

The upshot of this discussion is that there may be problems with the transsexual's claim to be the same person before and after surgery. It may be going too far to claim that a new person has emerged following surgery but it also may seem to be saying too little to say that it is the same person. The transsexual her/himself wants to emerge in a new way. Others also recognise that a transformation has taken place. The UK Government has sought to recognise this 'new' identity. The Gender Recognition Bill (2004) gives legal recognition of this new identity by means of the replacing the legal documents of the pre-operative individual. All legal identifiers are now in place for the recognition of the status of the transitioned person. There is no straight forward legal continuity between

the pre and post operative individual. It would be possible to conduct a paper trail and to discover the previous identity in the same way as divorce certificates could provide evidence of previous marriage. However the law may be understood to demonstrate that spatial/temporal continuity has been broken and the individual emerges with a new status.

Transsexuals, however, often wish at the same time, to claim continuity. To do both may be problematic. As things stand some transsexuals want at once to be understood as both the same *and* a new individual. The new individual is the one whom the transsexual has always both understood themselves to be and wanted to be seen by others to be. The same individual continues to exist and this seems to be important in order both to reassure others and to establish a legitimate claim to the identity and rights belonging to that (previous) person. One solution to this would be to claim that following surgery the transsexual could say to others that what they are now seeing is the person that the transsexual has always been.

The result of this problem over continued or new identity is that both the condition of TS itself and the way it is experienced needs to be examined. The former examination is not concerned with correctness of diagnosis as applied to an individual experiencing distress in relation to gender, or with the aetiology of the condition but with the issue of whether or not the current construction is the most appropriate explanation for the experience[xxxv].

[xxxv] To do this it is important to note that both medical and literary sources provide evidence that medicine has constructed notions of illness and disease that were thought correct at the time but subsequently were discredited. An example of this is Ovariotosis and is discussed by Laqueur. A woman's emotional difficulties were thought to be the result of problems with her ovaries and the treatment consisted in their removal by surgery (ovariotomy). It was thought that a woman was defined by her body and that it was the

A phenomenological approach, therefore, would begin by removing the assumption that current models are correct with the result that there is the need to strip away this assumption in order to look at the phenomena itself.

The initial stage of an investigation is concerned with the removal of what Heidegger terms 'coverings'. These can be understood to be models and labels and they have the effect of either distorting or determining perception. A phenomenon is seen through the prism of a label/model and in turn the way that it is understood reinforces the label/model. Once this has been realised and the label/model removed then it becomes possible to see the phenomenon as it is and a clearer understanding is achieved.

The discussion so far has centred on the need to remove the conceptual coverings that surround TS. Once this has done it is the experience of TS that can be investigated, particularly how an individual consciously experiences it. Presuppositions can then be removed.

The first pre-supposition to remove is the correctness of the interpretation of the conscious experience. Currently a transsexual is believed to be correct in her/his claim to know the true nature of her/his gender identity. This is not challenged even though it is not clear how a transsexual arrives at this understanding of his/her gender. Individual's

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specifically female parts of that body that were responsible for uniquely female behaviour. Many women experienced this operation with some even reporting benefit. However, both the connection between body and emotional distress and of women being defined by their bodies lost ground and this view and procedure lost its place in medicine.

making the claim may be challenged on the grounds of its strength or appropriateness of their claim, but the conceptual possibility itself is not challenged. The claim is accepted at face value even though a gender identity is in part the result of how a person is both perceived and treated by others. A transsexual is perceived and treated as belonging to her/his sexed body yet comes to think of her/himself and the opposite of this. How this is possible is not considered.

The removal of presuppositions allow for this claim to be examined. The claim to be a gender that is distinct from sexed identity, when examined in this way, may be proof not of the existence of TS but discomfort with traditionally understood and culturally constructed notions of masculinity and femininity. The dissonance may be with constructions and not with categorisation.

For example, a boy who develops a liking for reading books and playing musical instruments may come to think of these activities as unmanly. This view may be reinforced by members of his family who understand masculinity to be a matter of playing sport and the free use of sexually referenced language. If he believes what his family tell him then he may come to doubt the fact that he is masculine. If he cannot think of himself as masculine then the only option he has is to think of himself as feminine. This may be reinforced by the idea that reading and playing musical instruments are 'girly' occupations. He may also be concerned to become a tolerant and kind individual and again this is traditionally associated as feminine behaviour. He may

soon identify himself as being in some way feminine. This in turn may lead over time to the idea that he is transsexual.

Upon examining this claim it becomes possible to argue that what he is experiencing is not TS, but discomfort with culturally constructed notions of masculinity and femininity. It is one specific and local expression of gender identity that he has difficulty with and not the masculine gender as a whole. To think that he is transsexual may be a mistake but without a willingness to examine his experience free from presuppositions it could be a mistake that would easily happen. He could be asked to explore his preferences from a different point of view as to whether he actually does prefer them.

A second presupposition centres on the correctness not of interpretation but of identification. When a girl claims to 'feel' herself to be a boy this claim is accepted even though the knowledge of maleness or masculinity is outside of her cultural experience. Her claim rests on the idea that there is such a thing as 'maleness/masculinity' existing independently into which an individual can place himself. The girl feels that she belongs to this class of 'maleness/masculinity' as a result of attraction/dissatisfaction. This in turn leads to self-identification. This is not just problematic in TS but is problematic generally. How any person comes to an understanding of themselves as masculine or feminine is questionable.

The use of a phenomenological approach may challenge the idea that there is such a thing as a gender category into which an individual places him/herself as a means of self-

identification. The idea of two discrete and binary gender groupings may appear to be false. A phenomenological investigation may offer this insight and then proceed to state that gender characteristics are available to all persons *as persons* and are not fixed by the sexed body. A person conducting such an investigation could offer this view. This view would be in line with the current conceptualisation of TS.

Alternatively, a different person conducting a similar investigation into gender may come to the conclusion that gender is fixed by the sexed body. The point I am making here is that it is not phenomenology itself that has a view about gender; rather it is that the view is the interpretation of the person conducting the investigation. Phenomenological investigation leads to a subjective interpretation by the investigator. The gain is found, not in a claim to objective truth, but in achieving closer scrutiny.

What I am suggesting is that if this method of investigation were done into TS, then it might reveal that what a transsexual experiences is not a mistake of nature, nor a medico-psychiatric illness, nor something which is the result of faulty wiring in the brain but is a matter of desire. It is desire that is being identified as the crucial element and not notions of illness or physical dysfunction. A transsexual may be experiencing the desire to breakout of traditional gender constructions. As we have seen the sexed body has defined gender identity and TS may be one way in which a person experiences discomfort with this.

This desire to be a certain gender appears to have at least two elements to it: one negative and the other positive. The former consists in the desire not to be the assigned gender whilst the latter is the desire *to be* in the fullest sense of this term. This is formulated as a rejection/grasping towards dynamic.

The negative element of the desire does not appear to centre in feelings about the body *as a body* but rather on the representation of that body. The negativity is a matter of the association of gender and sexed body. The male body of a M-F transsexual may conform to notions of beauty, desirability and performance that it normally associated with maleness but is rejected because it represents a gender to which the M-F person does not feel she belongs. This negative attitude to her male body is a subjective reaction of the transsexual which leads her to totally reject her male body.

The positive element of the desire is a longing to be able to present to others by means of a sexed body what is believed to be the true gender identity.

As has been already seen in the discussion of Primary TS this positive desire presents itself both solidly and immutably within the perception of the individual. A transsexual comes to the conclusion that it is impossible to remove, alter or ignore it. It comes to dominate the individual to the extent that it gives shape to a sense of personal identity. The desire is thought to reveal some fundamental truth about the nature of this person's identity. This solidity of belief is coupled with imaginative functioning where the transsexual fantasises about what it would be like to 'live in' the appropriate body and so

be able to live out the gender role. This fantasy often focuses on the fulfilment of sex and gender congruency and if this appears a real possibility to the transsexual then ideas of happiness are attached to it.

Before Jorgensen transitioned she confessed to two friends her gender desire:

> Yes…I have the physical characteristics of a very immature male
> but as far back as I can remember I've always had the feelings…
> the emotions of a girl.[278]

This was the first time she had told anyone of her distress and because it proved to be a positive experience she felt encouraged to seek medical help.

In Secondary TS the desire becomes increasingly prominent over time. It presses itself on the consciousness of the individual until it can no longer be ignored. Here desire is coupled with the experience a transsexual has of living in the sexed role. This can be done successfully as with e.g. Morris or unsuccessfully as with e.g. Rees[279]. who continued to experience distress following surgery.

The medical explanation offered by Zhou et al[280] is that the BSTc region of the brain is responsible for TS. This may make sense in relation to Primary TS. In Secondary TS however, the need to transition comes later on in life after a significant period of time lived out in the original role. The question is how this is possible in relation to claims made both about the BSTc region and the experience of *suffering.* On the one hand is the claim that due to the effects of the BSTc region a person has early knowledge of gender

identity which causes clinically significant distress resulting in significant inability to function, whilst on the other hand it is possible for a person to live for some time, perhaps successfully, in the original role before coming to doubt their true identity. Conceptually it can be argued that either TS is a matter of brain dysfunction that leads to *suffering* that makes life impossible so that treatment becomes a priority, or it is a matter of awareness that can be lived with until the person reaches a point when she/he decides no longer to do so. At the moment the medical model seems to allow for both. This may therefore be a matter of conceptual inconsistency and this then becomes a further reason to question the current essentialist constructions and the claims made for it.

Alternatively the difference between Primary and Secondary TS may demonstrate that people's pain and suffering thresholds are different. Suppose I am in what I regard as an unhappy marriage. I remain married either because I think it's best to do so for the children or because I believe that I should keep the promises that I've made. Eventually, however, either the reasons to bear the suffering disappear, or the suffering grows to an unbearable level or I meet someone else and this gives me the impetus to act. Any of these reasons do not mean that the marriage was happy until I chose to leave, or that it was ever happy. Rather it shows that it was bearable for a while.[xxxvi]

If this is what happens in Secondary TS then the experience of *suffering* needs to be understood alongside a person's coping mechanisms and belief systems.

[xxxvi] This was demonstrated in the "Between Ourselves" radio programme. One man was able to cope with his suffering up to a point but when other sources of distress were added it become too much for him to bear. This does not mean, however, that he was not suffering before.

A third presupposition focuses on the correctness of the belief that it is only by transitioning that a person can experience happiness and fulfilment. This belief is a correlation of the disvalue that seems to be attached to the experience of *suffering* (see Chapter Three). This disvaluing of *suffering* is often accompanied by the idea that a condition of happiness exists which is achieved once a barrier has been crossed or a significant point has been reached. Happiness is thought to be achieved when certain conditions are fulfilled. This can be styled as a "Land of Canaan" perspective[xxxvii]

This view sees happiness as an all or nothing construct depending on the fulfilment of certain criteria. Until the criteria are fulfilled then happiness is impossible and life is on hold. When Canaan is entered happiness will be achieved with no further effort.

In TS the "Land of Canaan" is life beyond transitioning where *suffering* will be over. Until this time life is on hold. The whole of life appears to be negative and a transsexual often claims to be sustained by the hope that transitioning will bring the happiness that she/he has longed for. Happiness is not, however, guaranteed as the case of Sam Hashimi/Samantha Kane demonstrates[281].

[xxxvii] Based on the Biblical story of the deliverance of the Hebrew slaves from ancient Egypt and their journey to inhabit the land of Canaan as recorded in the Book of Exodus, the "Land of Canaan" syndrome occurs when happiness is held to be a future and permanent prospect. However, the history of the Hebrews should that their original hopes were not realised. During the difficulties of slavery it is easy to see how they hoped for future happiness in their own land. This sustained them in Egypt but subsequent disappointment may be due in part to unrealistic expectations.

Kane is a M-F transsexual who believed that the decision to transition from male gender to female was a mistake. This conclusion was reached as a result of her continued experience of unhappiness plus her continued family difficulties. She laid the blame on her treating physician and has taken an action against him for professional misconduct[282]. She has returned to living in the male gender and is now known by the first name of Charles and is seeking further GReS.

The idea that happiness is achieved by means of transitioning would therefore need to be carefully examined. Presently it appears to be the case that both the transsexual and those around her/him too easily accept this claim about happiness/suffering and therefore may be setting up a possibility of further *suffering*. If this presupposition is removed then the transsexual may be in a position to make more realistic assessments of what surgery may achieve and what degree of happiness is attainable. This is more than an issue of informed consent as it is concerned with the whole direction of a person's life and not just with the imminence of a decision.

A fourth presupposition that a phenomenological analysis would examine is the response of medicine to TS *suffering.* The current one is that medicine has a duty to alleviate it (Chapter Three). This will be discussed further in the next chapter and the discussion of the implications of the model of authenticity for medicine.

6. Authenticity and transsexuality

Heidegger[283] styled the human being who is concerned with the subject of her/his own being as Dasein and as such us able to reflect upon its existence in the world. The term means "Being-there":

> This entity which each of us has is himself and which includes inquiring as one of the possibilities of its Being, we shall denote by the term Dasein.[284]

When all else is right Dasein will seek to construct a life that is consistent with its own nature. Existence occurs in a context which Heidegger describes as arbitrary, without order or system. Dasein must therefore take responsibility for its own existence and to establish a life built upon freedom, choice and personal responsibility. Dasein seeks to understand its own existence in the light of the world in which it finds itself. This world is full both of objects that are ready to hand and other beings that are both like and unlike itself. Heidegger argues that the one characteristic of the individual Dasein is "mine-ness". Authentic existence is the result of reflection upon this "mine-ness" of the individual Dasein.

Heidegger comments upon authentic existence in the following way:

> Is there not a definite ontological way of taking authentic existence, a factical ideal of Dasein, underlying our ontological interpretation of Dasein's existence? That is indeed so. But not only is this fact one which must not be denied and which we are forced to grant; it must

> also be conceived in its *positive necessity*.[285]

Dasein seeks to realise its potentiality for being and to engage with the fact that existence is to be lived out against both the realities of time and nothingness. Dasein can either chose authenticity or lose it by its absorption in average everydayness. Both are possible modes of existence but it is the choice of authenticity that is to be regarded as the proper telos of human existence because of its moral significance. Morality is freely exercising choice as part of engaging with the world.

Heidegger's concern with authenticity is characteristic of Existentialism; it denies that there is a pre-established pattern for human existence and states that a person is to establish his/her own existence as a result of living. For Sartre:

> (it is) necessary that a man be for himself only what he is…Good Faith seeks to flee the inner disintegration of my being in the direction of the in-itself which it should be and is not.[286]

For Taylor self-determining freedom…

> demands that I break the hold of all such external impositions and decide for myself alone.[287]

Taylor argues that authentic existence recognises both individual uniqueness and the need for self-determination. This is why a 'one size fits all' approach either in terms of labels or of a fixed human nature is mistaken. Emphasis should be placed not upon that which

is common to all men and women but on what sets an individual apart from the rest. Authenticity is the realisation of unique potential.

Trilling[288] traces the development of the concept of authenticity in literature and philosophy. He maintains that it is possible to sum up the concept with the popular phrase 'to thine own self be true'.

Authentic TS would therefore have to recognise that all constructions of human experience that see one thing as true and another false are inauthentic. The whole of human existence must be accepted. For the transsexual this would mean an acceptance of the sexed body, of the gendered self, of the discordance between the two and of the way that society presently constructs gender identities. This willingness to accept is a rejection of value systems that categorise certain human characteristics as desirable/undesirable. Such a system of classification is inauthentic because it is regarded as objectively true and therefore as something which is to be accepted and lived out. A total acceptance of the self rejects such value systems and maintains that truth is to be found in the whole of personal experience. Equal value is to be placed on all human nature.

This does not mean, however, that it is possible to reconcile those elements of personal experience that appear contradictory. Neither is it desirable to place them into a hierarchical system. Rather it can be argued that authentic existence is one that seeks to

hold together, sometimes in tension, all aspects of experience even if to do so seems to be an impossible task that generates great anxiety.

Authenticity in TS means holding the experience of gender in tension with the experience of the sexed body because both are 'true' of the transsexual. There is no necessity to reconcile the two, or to reconcile the subjective experience of gender with its objective cultural constructions. So, a male transsexual (a male sexed individual) who is subjectively drawn to ideas of femaleness must hold both these ideas together and choose a way of engaging with them to construct his personal identity. He may be helped to learn how to engage with both aspects of his experience but this help would be aimed at enabling him engage with both rather than to promote one at the expense of the other. The *suffering* of the transsexual is also part of the totality of his experience and needs to be embraced. This may be achieved by seeing it as something that reveals a personal truth about the transsexual, or as a means to achieve virtues such as empathy and patience.

Authenticity can only be acquired by effort. It demands that one thinks about oneself and the world in a way that is free from labels, constructs and ready-made explanations. Authenticity places value upon personal responsibility. Fear of criticism may result in a reluctance to take personal responsibility and leads us to hide behind the claim to have no control over certain of our characteristics or dysfunctions. Personal responsibility assumes a willingness to be honest about ones choices, decisions and actions and then to defend against disagreement or to accept that one was mistaken.

Authenticity is difficult to achieve. It involves a struggle with both oneself and with the world. Failure to engage in this struggle results in conformity to the established and existing norms. Authenticity may only be achieved through *suffering*, and a transsexual who is already *suffering* due to sex/gender dissonance may not have the same reluctance to engage with *suffering* that a non-suffer may have. Because of the familiarity with *suffering* a transsexual may be more willing to engage with authenticity and it is then a matter of achieving a unique and freely chosen existence. As outlined above a transsexual may choose to incorporate *suffering* into a life goal.

Authenticity is, however, compatible with radical surgery if this is necessary to achieve a goal that has been autonomously chosen. For example, a woman may wish to become a father[xxxviii]. She already has a masculine gender identity and in relation to this wishes to know what it is to be a father to a child. It may be that ideas of fatherhood have for a long time been part of her masculine imaginings. She may decide that the best way for her to be a father is to align her body with her gender identity.

This decision is not made out of regard for cultural norms but from what she considers to be the best interests of the future child, especially in its earliest years. She may be attracted to the cultural constructions of fatherhood and wishes to engage in this way.

[xxxviii] Or alternatively a F-M transsexual wishing to become a father decides to have a baby by keeping her womb intact. This is the experience of Thomas Beatie who transitioned ten years ago and gave birth on Friday 4th July 2008. http://www.guardian.co.uk/world/2008/jul/04/usa.gender

She is working against the idea that to be a father is exclusively the privilege of those born with a particular anatomy.

This may pan out in the following way: a woman wishes to become a Royal Marine. Only men are accepted and so she may decide to align her sexed body with the gender that she both recognises in herself and seeks to become in order to achieve this life goal. She has to conform to an external and irrational requirement over which she has no control in order to become her authentic self.

In authentic TS *suffering* is not a justification for surgery. Neither is it a matter of inevitability or necessity. Rather it is the means by which an individual is able to accomplish her freely chosen goals

Surgery is an authentic response to sex/gender dissonance provided it is freely and responsibly chosen as a means to an end. The authentic transsexual would not believe that she/he had no choice but to proceed. S/he would seek to be rid of the coercive influence of an idea. Surgery is not the solution to a medical problem but the means of facilitating authentic living. The need for a medical explanation for sex/gender dissonance disappears. Authenticity accepts gender dissonance and does not seek to explain it. To regard TS as a disease is inauthentic because it relies on a construction of a 'normal' relationship between sex and gender. The disease model values sex and gender congruence above divergence and thereby constructs an artificial normative dimension to the experience of divergence. The role of medicine in the light of authenticity will be

discussed in the next chapter, but essentially surgery ought only to be offered in response to autonomous decision-making.

Autonomy for the transsexual is to be understood in the same way as it is for any other individual. Authentic existence is a matter of developing the idea of what sort of person she/he wishes to be and then pursuing the characteristics and attainments that make that possible.

7. Critique of Authenticity

Taylor[289] offers two criticisms of authenticity. The first is directed at the concept itself and the second is a discussion of the value placed upon authenticity in contemporary society.

From a conceptual point of view authenticity is open to the charge that it is a celebration of subjectivity, especially in relation to morality. The good is determined by the individual rather than according to objective standards. Subjectivism can not accommodate commonly accepted norms that are binding within a culture. Individuals, within authenticity, are free to choose a moral system for themselves and so it becomes possible to choose behaviours that others regard as immoral.

Taylor answers this criticism by arguing that an authentic individual *will* choose those things that have traditionally been understood as morally good and will do so not because

of tradition but because she/he will see them as the means by which personal goals can be achieved. He argues for a 'horizon of significance'[290] which brings into view ideas of morality and then acts as a perspective along which an authentic individual can plot the course of her/his life. This horizon prevents a slide into subjectivism and as well as charting a path to authenticity. It facilitates communal living with its requirements of co-operation and mutual assistance.

A counter-criticism here is to challenge Taylor's idea of 'horizons of significance'. If such a horizon exists then how is this different from the notion of an accepted moral code that defines any given society? The answer to this counter-criticism is that the element of choice makes it different. Authenticity requires that a person thinks about his moral compass and then owns it at a personal level. Moral behaviour is justified on the basis of that choice and not with reference to codes or impositions. These choices are also justified in as much as they accord with morality.

A further counter-criticism can be levelled. If both an authentic and an inauthentic individual behave in the same way then what has been achieved by the one acting authentically? One possible answer to this is that for an action to be considered moral then the choice that lay behind it must be a real choice: the person could have chosen to behave differently. Choice must be free if it is to qualify as choice and so it is the authentic person who is behaving morally because her behaviour has been freely chosen and is not the result of conformity to rules that have been handed down to her.

Taylor's second criticism of authenticity is that it is a celebration of individualism over collectivism. This is problematic because of the social nature of men and women. Authenticity's emphasis upon the individual may lead to a loss of a sense of community with the result that, as society becomes increasingly atomised, it becomes more difficult to pursue common goals. Taylor notes:

> A fragmented society is one whose members find it harder and harder to identify with their political society as a community.[291]

A fragmented society loses cohesion and becomes less able to look after its most vulnerable members. The emphasis on the worth of the individual is a recent one and may be seen as a corrective to the view which held the individual to be unimportant because society, or rather the elite within it, were more valuable. The worth and value of the individual was given special prominence during the Enlightenment and has been enshrined in moral and legislative programmes since.

It may be that there has been too much emphasis on individual and that what is now required is a move towards the middle ground where both the individual and society are equally valued. The danger of social atomisation has been recognised by writers in the existentialist tradition such as Houllelbecq[292] who chronicles the way that individualism leads to a diminution of the traditional support structures such as the family and neighbourhood communities. The result of this can be isolation, a failure to achieve fulfilment and a reluctance to admit to difficulties because of the value that society puts on individual freedom as a means of achieving happiness. Houllebecq reflects on the

popularity of psychotherapy and wonders whether this is an expression of, and has added to, the individualisation of society. Its emphasis on the self and the need for self-fulfilment downplays the needs of others in favour of the individual.

Authenticity begins, therefore, with an acceptance of the essence of the person but is not a matter of a person identifying that essence and then living in accordance with it. Authenticity requires engagement with that essence in a way that reflects the establishment of goals and preferences. This may also involve living in tension with a person's essence. Authenticity is distinct from essentialism because it incorporates the transsexual's present desires. It is not a 'backwards' looking way of understanding a self. The essence can be understood as a springboard for the present self.

However, neither is authenticity a 'forward looking' way of constructing a self. If a transsexual person has a mental picture or mental ideal of what she/he is or is to become, then she/he is no longer acting authentically. To match actual living to a mental ideal is to act, in Sartrean terms, in 'Bad Faith'. No such mental picture can fit into an account of authenticity. A mental picture of the self would function as a form of 'essence', this time as a future essence to which a person seeks to conform rather than a past essence exerting its influence in the present.

Authentic living is a matter of present engagement with life. To live authentically means to live in the moment, to take responsibility for the whole of oneself as one is in any given moment. Present engagement is the focus of authentic living.

8. The gains of an authentic account of transsexuality

At least two potential gains from an existential account of TS can be identified; the first is respect for autonomy and the second is the removal of the current medico-psychiatric classification.

Respect for autonomy is described by Beauchamp and Childress in the following way:

> To respect an autonomous agent is, at minimum, to acknowledge that person's right to hold views , to make choices, and to take actions based on personal values and beliefs. Such respect involves respectful actions, not merely a respectful attitude. Respect involves treating persons to enable them to act autonomously.[293]

An existential account of TS recognises both the autonomous choices of the individual and respect for the transsexual's autonomy. It frees the transsexual from the ontological constraints of the current transsexual label enabling autonomous functioning. With no label to define his/her possibilities the person with sex/gender dissonance is free to construct an identity for him/herself in a way that is both unique and in accord with his/her own preferences and desires. This is consistent with the Sartrean idea of Good Faith or authenticity.

Also, by recognising choice in relation to both gender/sex dissonance and to GReS, respect for autonomy is served. Respect for autonomy recognises the other person's right to live according to his/her values and choices free from any constraint or coercion.

In relation to TS this principle both prevents the coercive or constraining effect of the current construction and ensures that any decision that the transsexual makes in relation to surgery is be respected. It may not be appropriate, therefore, for a surgeon to disagree with the reasons why a transsexual wants surgery or to withhold his skills. As long as the person is acting rationally, then the surgeon places his skills at his/her service.

A comparison can be made here with Body Dysmorphic Disorder, where a person requests the surgical amputation of healthy limbs. Levy and Bayne[294] suggest that this request should be honoured out of respect for autonomy. They argue that there are no compelling reasons to refuse surgery as long as those making the request are capable to do so. A doctor ought not to impose his will over against that of the patient, using her/his expertise as a justification. A similar rational can be applied to TS.

Clearly, this view of the surgeon's role may undermine both the need for clinical judgement and the duty to act in the patient's best interests. Surgeons are mechanics rather than as clinicians[295]. One solution may be to align the authentic model of TS with cosmetic surgery, where clinical judgement is a means to successful treatment rather than a barrier to surgery. Surgeons could therefore regard GReS as a matter of personal choice, in the same way that cosmetic surgery is regarded. Clinical judgement then

becomes a matter of determining the correctness of procedure and not a matter of correctness of person for surgery. Objective standards, such as ruling out psychosis and determining capacity, would remain in place to safeguard the patient's interests.

The current medico-psychiatric classification of TS has the inevitable consequence of making it a psychiatric condition[xxxix]. The preferred designation is 'disorder'. Barrett offers a pragmatic justification for this and regards it as a means of treating disabling symptoms. It is rare for a transsexual to be told that she/he is mentally ill but nonetheless it is a psychiatrist who confirms the diagnosis of TS and who co-ordinates the treatment/transitioning process.

Within some transsexual communities there are attempts to de-classify TS as a psychiatric condition. One such is offered by the non-governmental organisation (NGO) Gender Identity Reform, (GIR), who describe themselves as:

> medical professionals, caregivers, scholars, researchers, students, human rights advocates and members of the transgender, bisexual, lesbian and gay communities and their allies who advocate reform of the psychiatric classification of gender diversity as mental disorder.[296]

GIR argues that because it is now generally recognised that gender identity is a matter of fluidity, this awareness ought to be recognised within the experience of TS itself. People who experience difficulties with masculinity and femininity, therefore, need not be

[xxxix] See earlier references in the Introduction

regarded as psychiatrically ill, but rather as those occupying a place at the extreme end of the sex/gender spectrum.

GIR draws attention to the history of homosexuality as a psychiatric classification. As recently as 1984 in the APA *DSM III* classification system homosexuality was considered to be a mental illness[xl], but as a result of the campaigning by the gay community then this classification was entirely removed form the DSM in 1986, a decision endorsed by the American Psychiatric Association. GIR hopes that the same could be achieved for the current classification of TS (DSM 1V 302.85).

This attempt by GIR to de-classify TS as a psychiatric condition does not deal with the issue of what will replace the current medical model or with how GReS can be justified if the medical model is abandoned. Califia[297] wonders how a transsexual will be able to obtain GReS without the current psychiatric justification:

> The transactivists who are trying to eliminate GID from the *DSM-IV* have not come up with any credible replacement for the diagnosis, which is the prerequisite for sex reassignment.[298]

My thesis is that an account of authentic TS is a credible replacement for the current medico-psychiatric one and as such it is an alternative model that justifies GReS for those who construct it as a means to achieve personal goals. It is not free of problems, but is more coherent and less contradictory than the medical model as it does not cross between

[xl] Ego-dystonic homosexuality, a persistent lack of heterosexual arousal leading to interference in opposite sex relationships.

two concepts of gender, as is the case with the current construction of TS. Also, the model of authenticity removes the stigma of psychiatric classification.

Authenticity can be both encouraged and substantiated in the following way. Medicine would need to engage with the narrative of authenticity that the transsexual (if this term is in fact to be used) has constructed for him/herself. The purpose of this is not to judge its sincerity but to validate or affirm it. The General Practitioner may be the most appropriate person to do this. Her/his involvement is not to detect the presence of illness, particularly mental illness, but to act as gatekeeper to those services that are necessary in order for the person concerned to achieve his/her goals. It is the psychiatrist who 'authorises' other medical specialist for the sake of the transsexual, some of whom, as we have seen, desire surgery. A transsexual's current narrative of suffering is therefore replaced with one of authenticity and just as medicine currently engages with the former so it can engage with the latter.

The model of Authentic TS has the following benefits. First it recognises the whole of the fundamental nature of the transsexual individual and affords her/him the freedom to respond to that fundamental nature in the way that fits best into her/his own value system. He/she is able to construct a life that is pleasing to him/her. There is no division within the self, no accepting/rejecting mechanism at work in relation to the self. Second, he/she is not labelled as ill, diseased or as experiencing a disorder and so does not need to think of him/herself as 'deviating from the norm' in any way. The transsexual has a fundamental nature in the same way as any other individual. Every fundamental nature is

unique with none being thought of as better/worse or healthy/unhealthy than any other. Each person has the responsibility to 'own' one's fundamental nature and to engage with it in order to construct an authentic existence. Third, as discussed earlier in relation to the principle of respect for autonomy, doctors and surgeons can offer GReS to those who choose it in relation to their value systems. Califia's observation can now be answered. The model of authenticity is a credible replacement for the medical diagnosis and so becomes the prerequisite for sex reassignment. Califia's criticism can now be answered; a model that both removes psychiatric classification *and* provides a framework for surgery is found in authenticity.

The authentic model removes TS from that which currently stigmatises it both as a deviation from that which is normal and as a psychiatric condition. This may achieve what the transsexual desires, both in terms of understanding their experience and in terms of a rational for seeking medical treatment. A model of authenticity 'normalises' both TS and the process by which an individual responds to it. It is no longer necessary for the transsexual to view her/himself as ill or deviant or marginalised from the rest of society. It is a matter of personal choice what she/he does in response to the normalising of his/her experience in exactly the same way as it is for anyone else in relation to her/his own fundamental nature. The element of *suffering* that is now integral to TS may either be engaged with for its own sake or alleviated by the pursuit of freely chosen goals. Indeed *suffering* may be prevented if TS is no longer thought of as deviant or a matter of disease but regarded as just another personal characteristic. If a person then chooses to

construct a life in which sex and gender are to be aligned then GReS can be offered out of respect for their autonomy.

On an authentic model, the transsexual need present not to satisfy the psychiatrist that her/his gender identity is real nor that her/his *suffering* is so extreme that unless treatment is given she/he may seek to end her/his life because it is so unbearable. Instead it becomes a matter of articulating autonomous choices and as the transsexual seeks to live as a rational being like any other. The psychiatrist is assessing capacity to consent and ensuring all information is given and understood.

The authenticity model can not only replace the medical model but could also make the designation 'transsexual' obsolete. No designation would be necessary to explain why a person has a gender identity that is not the same as his/her sexed identity. This would just be seen as something that *is* the case for the person concerned in the same way as, for instance, sexuality is regarded. No medical or moral explanation is required. Certainly designations such as 'gender dysphoria' or 'gender identity disorder' would be obsolete as these are specifically designed to reflect a medical understanding of the experience.

The medical designation, 'transsexuality' would no longer be thought of as a condition or as an experience. A person would simply, from the time that self awareness emerges, begin with an awareness of his/her own body and develop an understanding of his/her gender identity. Where society regards sex and gender as one and the same then the individual will need to think for her/himself how to respond. She/he needs help to do this

and to work out a response to that society's view. If a society sees sex and gender as distinct categories, then it may be easier for the individual to choose how to begin to live authentically.

Sex and gender identities need not be thought of as dissonant or discordant, or at odds with each other, or that they need necessarily to be in agreement with each other. It is up to the individual concerned to choose how and in what way she/he relates his/her experience of sex and gender together.

There are a set of virtues that are generally recognised as being associated with authenticity. These are honesty, prudence, integrity, truthfulness, freedom and responsibility and form, as we have seen, what Taylor refers to as 'an horizon of significance'. These virtues provide the moral imperative to pursue an authentic existence. In addition, authenticity may be regarded as a manifestation of autonomy. There is some debate over whether people are obliged to be autonomous. Moral agency certainly seems to require this[299]. On the other hand, a distinction can be drawn between respect for, and even promotion of, autonomy and a requirement that an individual must maximise autonomy in their own person. It may not be the case that a person is obliged to act autonomously but it seems obvious to argue that respect for autonomy is a universal obligation. Respect for autonomy is one justification for a moral imperative to make autonomous existence possible.

Conclusion

In this Chapter, I have argued for a re-thinking of the phenomena of TS. In the 'first wave' of thinking about TS the medical scientist has taken the lead and the transsexual community has fallen in with the scientific construction. A 'second wave' is now building from within the transsexual community, which seeks to remove TS from the medical context and place it within the broader context that recognises both gender fluidity and that binary modalities of gender are out dated. This thesis reflects this 'second wave' of thinking.

Authenticity can replace essentialism as the justification for surgery. It requires, however, the medical profession to reflect seriously on what TS means and how it reflects artificial norms related to sex and gender that have been abandoned in other contexts. The profession ought to reflect upon the incoherence of, and inconsistencies with, the current medical model.

CHAPTER FIVE THE MODEL OF AUTHENTICITY IN PRACTICE

Introduction

This chapter, consisting of four sections and a conclusion, details how the model of authenticity will work out in practice in relation to TS. It will first examine its advantages over the medical model; second, explore the idea that authenticity reveals the possibility of deception in the current taxonomy of TS both in terms of straightforward deception and self-deception; third consider the activity known as 'passing' from the point of view of the medical model to see if it is inherently deceptive; and finally to examine whether authenticity requires a fully transitioned individual to reveal that she/he has transitioned to those with whom she/he seeks an intimate relationship. The duty to disclose will be balanced against both the right to privacy and the right to self definition.

1. Advantages of the Authenticity Model over the Medical Model

If the model of authenticity is adopted then there are at least four advantages over the medical model:

The first is that the transsexual need no longer be defined by his/her essence. An authenticity model removes the need for TS to be constructed along essentialist lines without at the same time calling into question the gender identity of the person

concerned. It can be accepted that a person genuinely experiences a gender identity that is distinct from the sexed body without the recourse to an essentialist position.

The move away from an essentialist understanding to the view that identity is a matter of construction places TS within mainstream views on the nature of personal identity. It is generally accepted that individuals achieve an identity over time as a result of interacting with the world in order to realise freely chosen goals. These goals reflect the importance placed on desires and a person exercises freedom of choice and bears the responsibility for doing so[xli].

It is not the purpose of this section of the chapter to offer a full treatment of the philosophical problem of personal identity, or how a person acquires identity or how it is possible for this to exist as the same identity over time in tension with change and continuity. An example of the philosophical treatment of this subject is found in the work of Sider.[300] Nor is it the purpose of this section to explore the debate over the way in which a sense of gender is acquired either as a matter of essence or existence. Wesselius[301] offers such an analysis. Rather the purpose at this point is simply to argue that ordinarily personal identity is thought to be that which is constructed over time. The way that a person constructs a masculine or feminine identity is a matter of choice and not of fundamental nature.

[xli] Cf Archer, M.S. (2000) "Being Human: The Problem of Agency" Cambridge University Press: Glover, J. (1988) "The Philosophy and Psychology of Personal Identity" London; Allen Lane; The Penguin Press: Perry, J. (2002) "Identity, personal identity and the self" Cambridge Hackett Publishing.

The second advantage over the medical model focuses on gender identity. The medical model posits gender identity as a matter of brain organisation (Chapter Two) but feminist theorists such as Raymond[302] argue that it is much more than this. She claims that the identity of a woman flows from the fact of being born as a woman into a community that is known as 'women' with all its history and struggle. This does mean that she begins life with a certain genetic/organic fundamental nature but this is not that which defines her. It merely brings the possibility of gender. The realisation of gender is a matter of development. She begins a gender narrative at the point of origin and then works this out during the course of a lifetime:

> Women take on self-definition…not only from the fact of being born XX but also from the whole history of what being born with those chromosomes mean in this society.[303]

To be a woman is to identify oneself as a woman by placing oneself into a stream of existence that is known as 'woman'. This stream has an identifiable history, cultural place, collective experience and collective hopes and fears. A person becomes part of this at birth and then actively participates in it throughout the course of a life. Raymond places particular stress on the notion of history which she applies on two levels: first, at the personal level and second, at the corporate level. The former is concerned with a woman's personal history as a woman and goes back to the issue of fundamental nature. She argues that a M-F transsexual cannot be thought of as a woman because she lacks this history. GReS cannot give a person this history and so cannot be thought to enable a person to become a woman.

Authenticity accepts that gender identity is a matter of choice in which a person places her/himself into a stream of existence. This is because of the emphasis authenticity places upon human freedom. The essentialist model of gender would be redundant. However, it is possible to hold this position and disagree with Raymond regarding TS. For her a post-operative M-F transsexual cannot be thought of as a woman because of the lack of a woman's history. Entry to this history occurs at birth. It could be argued that entry does not have to be restricted by birth but could be a matter of the possession of the gender identity that is part of a person's fundamental nature. To be born with a certain sense of gender could qualify that person as a member of that gender and GReS could then be thought of as similar to other ways in which the possibility of gender can become a reality. Birth is one means of entry whilst gender awareness is another. Both require that what is possible becomes actualised through the exercise of choice.

The third advantage over the medical model is concerned with the gender claim. Under current guidelines the transsexual's gender claim is evaluated for sincerity and genuineness by using criteria such as duration of the conviction and the level of identification with the gender classification. This evaluation is done to establish whether or not the person making the claim can be understood to be 'suffering' from TS. Benjamin[304] adds to this the persistence of the experience of gender dysphoria, the intensity of the desire for surgery and the amount of disgust a person feels towards the sex organ. With reference to the employment of the Sex Orientation Scale (SOS) he writes:

> As a working hypothesis, but with good practical uses, the SOS

> should illustrate six different types of the transvestism-transsexualism syndrome as clinical observations seem to reveal them.[305]

Benjamin's six types are; active/passive transvestism, mild, moderate and severe TS which can be thought of as either primary or secondary in its manifestation. Other illnesses such as the inter-sexed condition and mental illnesses are to be ruled out whilst evaluating the gender claim. He argues that the SOS provides an objective means of evaluating the claim itself because at the present time it is impossible to directly measure the BSTc region of the brain of a living person. The SOS is also thought to provide an objective model for determining the nature of gender experience. Testing seems to serve the purpose of assessing a person's sincerity in making the claim. Sincerity here needs to be understood to be both a matter of morality and correctness. The former is concerned with whether or not the person is making the gender claim for reasons other than the presence of TS whilst the latter is concerned with whether or not the person may be mistaken in thinking that she/he is a transsexual.

However, no such evaluation is required by the model of authenticity as it proceeds from the basis that a person's given experience is to be accepted not just by themselves but by others. It is sufficient that the person making a statement about her/his gender identity is thought to be competent to do so and provided all the relevant information has been given to her/him and understood, the person should be allowed to proceed with the realisation of personal life goals (Chapter Four).

The medical model, by locating TS in the essence of the person, needs to locate that essence by means of evaluation. Once it is believed that the essence has been identified then it is thought that the person is correct in making a gender claim. The words and experience of the individual is not thought to provide sufficient proof. Something greater, which is beyond the immediacy of the person, is required if the claim is to be accepted. This is believed to be found in the measuring tools of which the SOS is an example.

The authentic model does not seek to locate TS within the essence of the person as it is not concerned with essences but with the 'lived-outness' of a person's life. The model accepts an individual's fundamental nature and is concerned with the way in which a person seeks to live. Therefore the gender claim of the transsexual can be accepted at face value providing all else is equal.

A fourth advantage over the medical model is concerned with the way that at present a transsexual 'buys into' the medical model as a way of making sense of the experience of gender. The model of authenticity does not require a person to 'buy into' a model. By contrast the medical model provides a framework of meaning for the transsexual. Once this framework has been accepted then the individual filters a sense of identity through it. If he/she uses a conceptually confused model in order to achieve this sense of personal identity then he/she can be thought of as being harmed as a result of thinking that one thing is true when in fact it may not be. This may be the case even if he/she is unaware of this.

The possibility of being harmed even when unaware of it is well understood in the area of personal relationships. Take, for example a married man, a father of two children, apparently happy with the life he is living but who is conducting a secret affair with a male prostitute. As far as his wife is concerned, life is as it appears to be. She believes one thing whilst not knowing the falsity of her beliefs. Harm consists in the discordance between what she thinks is true and what is actually true but unknown to her.

Those caring for the transsexual may inadvertently harm her/him by applying the medical model as if it is the only model and as if it is the whole truth about TS. This may be done when someone fails either to think through the limitations of the favoured model or to pro-actively question traditional practice. I am not suggesting that doctors and others deliberately seek to mislead the transsexual but by passing on medical orthodoxy in an uncritical way they may be failing to give the transsexual the opportunity to think differently about her/his experience.

These advantages stress the importance of conceptual consistency. As has been pointed out, the medical model is predicated on the separation of gender and sex with the former being understood as both essence and non-essence. It is essence to the extent that gender is a matter of TS and non-essence in the sense that it is generally thought not to be a matter of fundamental nature or tied to the sexed body. This confusion with regard to the way that gender is to be understood is at the heart of the medical model and by removing

the requirement that gender in relation to TS be thought of as a matter of essence then the authenticity model removes this conceptual confusion.

What is required by both the TS and medical communities is a willingness to engage with the medical model at the conceptual level in order to see the problematic nature of its essentialist construction. As long as it is constructed along essentialist lines then the value of the gender reconstruction is open to question. Similarly if an essentialist model is jettisoned on conceptual grounds then an alternative justification for medical treatment and for GReS is required. The current justification is that of treating an essence. Treatment is offered in the belief that personal happiness consists in living in accordance with one's personal essence and if this belief is rejected then time and effort must be spent in making it possible for that person to live as much as is possible in accord with his/her existence.

2. Deception in the Medical Model

In this section of the Chapter I wish to discuss the way that deception is at work in the medical model of TS, both in a general sense and in relation to self deception

GENERAL DECEPTION

Mele[306] discusses deception as "to cause another to believe what is false". Causing someone to believe what is false can be a matter of either intentional or unintentional activity. The latter happens when a simple mistake in the passing on of information takes

place; Mele gives an example of one person inadvertently misreading a newspaper article to another causing him to believe something that is not true. Due to the lack of intention to deceive the reader has not deceived the listener only misled him. Deception requires an intention to deceive. A deceiver is a person who knows one thing to be true but intends another person to believe that either the true thing is false or that the false thing is true. The motivation for doing this can be either benevolent or malevolent but the motivation is irrelevant to the definition of deception.

Deception occurs as a result of the use of words, actions or omissions and it is the intention behind the deception that gives rise to moral issues. Deception that is intentionally malevolent is generally regarded as unacceptable whilst intentionally benevolent deception is more problematic. Jackson[307], for instance, weighs up the moral merits of intentional benevolent deception in the context of health care. She argues for both a broad concept of benevolent deception and for its use to be regarded as acceptable in the context of health care because it can be beneficial for patients. For instance, it enables a patient to maintain morale in the face of a poor or terminal prognosis. Lying, on the other hand, has the potential to destroy the trust between a patient and those caring for her and if this was to happen then the patient may no longer be able to believe the advice or the explanations that are being offered. Jackson concludes:

> The teaching that I am advocating would allow you to conceal information and even to use deceptive tricks-telling half truths and the like. It would not allow you to lie-not even as a last resort.[308]

Jackson refers to health care practitioners who are willing to conceal or to deceive as 'caring pragmatists'[309]. She argues that openness is incompatible with the duties of doctors and nurses, particularly in relation to the issue of confidentiality[310]. She wonders whether increased openness on the part of doctors has led to both deterioration in the public trust of doctors and an increase in legal action against them[311]. She finally engages with the subject of paternalism and with reference to Kant suggests that there are times when medical paternalism is still necessary, especially where the circumstances are not ideal:

> A tree that was tall and straight but has suffered an injury may need a temporary support if it is to recover and not become permanently misshapen[312].

However, Jackson's defence of paternalism is problematic. It assumes an inequality between the patient and the health care professional and envisages a situation in which the professional is in a superior position to the patient, not only in terms of their immediate health problem but also of their long-term interest. This assumption is questionable. Patient's need their doctor because they are not able to help themselves. They do not need the doctor to decide for him them what they are able to know. Hence Jackson's defence of paternalism is problematic.

Deception operates in the medical construction of TS in two ways: in the way that doctors sometimes talk about TS and in the way that a transsexual may use his/her *suffering*.

One way in which medicine makes sense of the *suffering* of transsexuals is to compare TS to other diseases. For example Benjamin compares TS to diabetes and reasons that just as a failure to treat the diabetes can lead to death so to can a failure to treat TS:

> What both treatments (insulin for diabetes and surgery for TS) accomplish is the preservation of the life of the patient. Otherwise many of these people would commit suicide. There is no doubt, in my mind, that sex-reassignment surgery can be life saving and frequently is just that.[313]

This demonstrates the faulty reasoning at work in the current TS medical narrative. In both cases Benjamin maintains that death is something that happens to a person because of dysfunctional body systems that operates independently of the person. The person, therefore, has no choice or control over whether they live or die as a result. Having drawn a parallel between the two conditions Benjamin then likens the death of a transsexual by 'suicide' to death resulting from diabetes and argues that in both cases treatment has the moral imperative of saving life.

It is, however, false to claim that TS is a life threatening condition like diabetes. Whilst a diabetic may die if insulin is not administered a transsexual will not die if left untreated. Rather they will continue to suffer and even though this *suffering* may be both profound and debilitating it is not sufficient to bring about death. Something further is necessary for death to occur and it is disingenuous to regard a suicide as being the result of TS as though TS has 'killed' them. By committing suicide, the transsexual chooses death. Death is not the result of a disease processes. Suicide, or even the threat of suicide, is a significantly different type of threat of death than that which results from organic causes.

> The transsexual cannot die of his disease. Out of despair like anyone else the transsexual may kill himself; or like anyone else he may threaten suicide to extort something he wants from family, friends or physician.[314]

The threat of death endows action to prevent death with a moral imperative: death is the ultimate harm. It is, however, a misuse of this imperative to apply it to TS. The medical profession must find an alternative means of enduing itself with a sense of moral urgency in relation to TS.

The knowing adoption of this faulty logic is a form of deception: deception of the public about the justification for action. These 'psychologically reassuring fallacies', as Giordano[315] discusses them, enable disease labels to be used to *explain* human behaviour when all they do is to *describe* them. She argues that this reasoning is prevalent in psychiatric nosology and occurs as a result of seeking to offer explanations that reassure without being true explanations. It is the patient who is the object of such reassurance:

> These sorts of apparent explanations also make it easier for the sufferers to tolerate their own experiences and the scarce control they have over them…they are not real *explanations* …they are *psychologically reassuring fallacies.*[316]

Giordano argues that such fallacies are also logical mistakes and as such are an insufficient basis for approaching human experience. What she says about anorexia may be equally applicable to this discussion about the way that medicine seeks to make parallels between diabetes and TS.

The second way that deception operates in the medical model of TS is the claim that a transsexual may make about death. She/he states that death will be inevitable unless surgery is granted. The threat of death, and the existence of suffering are used as tools to obtain surgery and in turn becomes a measure of the sincerity of the transsexual. This often occurs in the first meeting between the transsexual and the TS specialist.

Jorgensen, for instance, describes her first meeting with Dr. Angelo as an occasion when he sought to put obstacles in her way to transitioning. These were both technological and moral. His attempts to dissuade her continued in subsequent meetings until in their last interview she referred to her sufferings as her reason for wanting surgery. She writes that his attempts to dissuade her by referring to what could go wrong during surgery met with this reply:

> Yes I've considered that but how could any future life be worse than the past twenty three years.[317]

In relation to the risk of surgery Jorgensen seems to be saying that if anything went wrong then she would be no worse off than she has been for twenty three years. In relation to a future without transitioning she implies that suicide is the only option for her because life cannot get any worse. She presents death as something which is the natural end point in her experience of TS and only surgery can prevent this from happening.

This view was subsequently adopted by her treating physician and has become the standard view since. Benjamin states:

> Some of them (transsexuals) probably languished in mental institutions, some in prisons and the majority as miserable, unhappy members of the community, unless they committed suicide.[318]

This ignores the logical space between the experience of suffering and suicide as a response to it. Suffering alone does not cause the death of the transsexual. Suicide is but one choice and this needs to be recognised. Recognising suicide as a possible response is not to minimize the transsexuals suffering but is important both as a matter of fact and as a matter of personal morality and responsibility.

Empty suicide threats are also a form of deception when used as a means of extortion, for instance to obtain GReS.

An anonymous correspondent writing to an agony aunt working for an on-line transsexual advice journal admitted exaggerating suicide threats when soliciting letters of recommendation for surgery:

> My therapist didn't want me to get Sex Reassignment Surgery (SReS) at that time. I just went there and told her what she wanted to hear just to try to get letters (of recommendation).[319]

This is a straightforward example of deception. The correspondent deceived her therapist into writing letters of recommendation for surgery on the strength of exaggerated suffering claims. She says that she deliberately overplayed the extent and nature of her sufferings because she believed this was the way to obtain what she desired. Her

exaggerated suffering was used as a means to an end and as such as instrumental to her purposes. This does not mean that her suffering was not real: suffering may be both real *and* to be used and exaggerated as a means to an end.

This correspondent subsequently wished to take action against her surgeon as she came to believe that she was not a fit subject for surgery and that the surgeon ought to have realised this at the time. What she had previously wanted strongly enough to gain by extortion, she now regarded as a mistake for which the surgeon, and not she, was responsible. Put another way, first she lied and then she complained that her surgeon should have realised that she was lying. Now she wants compensation for his failure to see through her lies.

To conclude the argument in this section of the chapter, authenticity requires that a distinction be made between the claim that TS leads to suicide if left untreated and the sincerity of the suicide claim itself. Suicide is a matter of choice. However, sincerity of belief and sincerity of suffering does not prove the rightness of the belief that suffering leads to death. Deception would occur if this distinction between sincerity and rightness were understood and then discounted either by the transsexual or the medical practitioners.

SELF- DECEPTION

The subject of self-deception is of interest to some philosophers because of its apparently paradoxical nature. It is predicated on the notion that a self is able to deceive itself. Deception normally requires both a deceiver and a deceived with the latter being unaware of what the former is seeking to do. If the latter becomes aware of this then she/he is no longer deceived. Self-deception suggests that in order to deceive oneself a single consciousness must be both doing the deceiving and being deceived whilst knowing that this process is going on. Philosophical debate focuses on both how this is possible and on the apparent rationality of the idea that a consciousness can be divided against itself in this way. It is because of this paradox that some argue that self-deception is not possible.

Philosophers such as Mele[320], Barnes[321], Haight[322], Davidson[323], Lazar[324], Fingarette[325] and Sartre[326] engage with self-deception and offer various explanations for how they think that it is possible. For example Fingarette argues that it is possible because the self-deceiver develops a skill which he calls 'spelling-out'[327]. This is the ability to tell oneself a narrative of what one wants to believe and to keep this uppermost in one's mind. Anything that contradicts this is deliberately not retained in conscious awareness but is pushed into the margins of the mind. Consciousness selects that which accords with the personal narrative and Fingarette argues that the Freudian concept of the Ego needs to be

restructured into the idea of the Ego proper and the Ego defence with the latter acting as a filtering mechanism which does not allow any contradictions to enter into awareness.

By contrast Haight argues that self-deception is nothing more than a matter of straightforward lying, not to oneself but to others about oneself and what it is that one truly believes. He maintains that the idea of self-deception is used due to the difficulty of calling someone a liar. It is the apparent sincerity of the liar that makes someone hesitate to call her/him a liar and so the less offensive term is used.

Davidson offers a third explanation. His position is that the mind of the self-deceiver must be partitioned rather than fully integrated. The partition permits no cross traffic. The largest portioned area determines the main narrative that is developed and maintained with the contradictory elements being consigned to the smaller partitioned area. Lazar talks of beliefs being formed under the influence of emotion and contradictory beliefs can be explained by the conflicting nature of a person's emotional life. Mele makes a distinction between a deceptive belief that can be motivated but not intended. A person, as a result of powerful desires, may be motivated towards a belief that is known to be untrue but may not intend to hold such beliefs alongside others that are known to be true. It is the presence of beliefs that a person both intends to hold and doesn't intend to hold that explains the paradoxical nature of self-deception.

For Sartre self-deception is bad faith and is 'a certain art of forming contradictory concepts which unite in themselves both an idea and the negation of an idea'[328].

Sartre discusses the twin ideas of 'facticity'[329] and 'transcendence'[330] which he argues are the double properties of all human beings and ought to be the subject of valid co-ordination. By facticity Sartre appears to mean the fact of a particular individual's existence as a definite and objective reality in relation to others who are the same. Transcendence is the subjective reality of such an individual. It is the sum of a person's hopes, beliefs, desires and meanings. Sartre's position is that these two features of human existence ought to be held together in a way that has integrity and harmony. Self-deception or bad faith occurs where there is either not the wish to have co-ordination or where there is a failure to achieve something greater as a result of surmounting them: "Bad faith seeks to affirm their identity whilst preserving their differences"[331].

To be in a condition of bad faith is a matter of inauthenticity and Sartre maintains that a person is required by the claims of authenticity to move out from bad faith into knowledge and freedom. Authentic human experience is held out by Existentialism as the ultimate human good and therefore as something to which men and women ought to aspire.

Authenticity requires self-deception to be examined wherever it occurs. Here self-deception will be explored as it appears to arise within the current construction of TS.

Taking Fingarette's analysis a transsexual may be engaged in the practice of 'spelling-out' in relation to gender awareness. In M-F TS a male 'spells-out' to himself a narrative of being female and to maintain this he deselects anything which suggests otherwise. This would include the evidence of the sexed body, the idea that gender is a cultural construction and is not a fixed identity determined by inheritance and that all claims to self-knowledge by means of reflection are problematic. Anything that would threaten the female gender narrative is marginalised in the male transsexual's consciousness as the female identity is kept uppermost in his mind.

Similarly, self-deception may be linked to the presence or absence of desire. An individual may positively desire to belong to one particular gender or may have negative desires in relation to the gender in which she/he belongs as a matter of birth. Desire can then give rise to belief as described by Lazar and may exist without relation to any facts of bodily or conceptual existence. Desires function here as both the origins and sustainers of belief systems and such systems are not dependent for existence upon objective facts. Truth is subjectively generated and the desires themselves may be related to the way in which a person has sought to make sense of early experience.

Alternatively self-deception may be the result of misinterpretation. A female transsexual may have interpreted her discomfort with the way that femininity has been constructed by those around her as evidence that she is in fact not female and therefore must be male. For her to do may well be a mistake and the self-deceptive aspect is found in the way that this mistake is seen to reveal a fundamental truth about her. This belief is elevated above

others. Counter-beliefs are not considered because they would contradict the narrative of masculinity that the F-M transsexual is telling herself. This could be a case of 'spelling-out' in the way that Fingarette describes. It may also work in terms of attraction. The same M-F may interpret her attraction to male symbolism and culturally identity factors as evidence of an inherent masculinity. This may be based on, or a reaction to, discomfort with the cultural symbolisation of femininity.

Linked to this is the idea of selective focussing/attending and selective evidence gathering. This is concerned with the possibility that the transsexual is only focussing on those elements or aspects of the self that 'fit' the transgender narrative that has been established. A F-M transsexual would fail to give serious attention to anything that speaks of her femininity whilst focussing on that which tells her she is male. Not to acknowledge this selectivity may constitute self-deception.

Another possible instance of self-deception is related to future claims. In mind here are those claims that are made in relation to personal happiness. Happiness is said to be dependent upon successful transitioning and is not possible until this has been achieved. Present happiness is suspended and only future happiness is a possibility. Happiness is made dependent upon one thing which, when absent, makes happiness impossible and when present makes it certain. Happiness is most often identified as GReS. Once this has been achieved then happiness will be permanent, or so it is believed. Any other opportunity for happiness may be discounted, discarded or ignored.

This idea is found in many transsexual narratives where also there is virtually no acknowledgement that human happiness is difficult for anyone to achieve, that it is a matter of personal endeavour and not a result of what others may or may not do for us, and that once achieved it is difficult to hold on to and may easily disappear. Thoughts about future happiness appear to function in the same way as suffering in the exchange between a transsexual and his/her medical advisers; as a means to the end of GReS. Both are accepted by both parties.

It is here that suffering can become a matter of self-deception. The transsexual attributes all suffering to the conflict between gender identity and sexed body. Present suffering is caused by this and future happiness is ensured when it is resolved. Other potential sources of unhappiness are discounted. This process is illustrated by the case of Mr D[332]. He attributed his suffering to his facial disfigurement. This consisted of an enlarged and protruding lower jaw. His sufferings consisted in experiencing difficulty in forming personal relationships and failing to gain promotion at work. He found it particularly difficult to form successful relationships with women. His sufferings caused him to withdraw and to lead a life of increasing isolation. He came to the conclusion that he needed surgery on his jaw both to end his suffering and to ensure his happiness. Surgery was the only answer to his problems. He sought medical help and was given the surgery.

Following surgery Mr D discovered that his hopes were not fulfilled. The surgery itself was successful but his personal difficulties continued as before. He was unable to explain to himself way this should be the case as he had consistently believed that surgery would

prove to be the answer because he believed his jaw was the reason for both his difficulties at work and with relationships.

Perhaps Mr D was mistaken in his belief that his suffering was caused by his physical deformity and that the reasons for his problems were more complex. His problems may have resulted from the kind of person that he had become and to his lack of personal and professional skills. In attributing his problems to his disfigurement he managed to avoid the need for personal reflection and change. He thought the cause was to be found not in himself but in his body. His difficulties were projected onto his disfigurement which he then disassociated from himself. It was not his responsibility. His chin became both the location for his sufferings as well as its reason. Therefore it had also to be the focus of intervention. Once this was put right then he would function appropriately and his sufferings would end and happiness begin.

This was arguably a form of self-deception. To pin-point his jaw as the reason for his sufferings may have been the easier option for Mr D. Self-examination both in terms of work performance and personal relationships may have been too threatening to his sense of personal integrity. What may have happened here is that he chose to believe a narrative of disfigurement rather than one of personal inadequacy both at the social and professional levels.

Similarly a transsexual may claim that all his/her suffering is the result of gender/sex conflict and that this will end and happiness be achieved when this conflict is resolved by

means of surgery. Both suffering and happiness are caused by the body of the transsexual. The body is thought of as 'not' the person. Rather the person is handicapped and held back by the body. Were it not for the body then the transsexual would be without suffering and be experiencing happiness in the same way as everyone else. An artificial space is created between the person of the transsexual and the body as cause of her/his suffering. This allows for the transsexual to disown the body as it is the locus of suffering. However this space will be closed down once the body has been surgically altered and ownership of it then taken up. Then the body will be thought of as belonging to the person in a way that it did not do so before.

This locating of suffering and happiness in the body of the transsexual so that both are thought of as not being her/his personal responsibility may be more tolerable than an examination of the possibility that the reasons for suffering and the hopes of personal happiness are more complex. To attribute all suffering to one cause and to pin all future hopes of happiness on one event may prove to be a matter of self-deception.

Other person deception is discussed at this point in terms of the subject of Passing. This features prominently in current constructions of TS and therefore requires considerable and detailed attention in the next section.

3. Authenticity and 'Passing'

PRINCIPLE AND LAW

Passing, alternatively known as the Real Life Experience (RLE), consists of a lengthy period of time in which the transsexual presents him/herself in public as a member of the desired gender before GReS. The transsexual would normally have taken male or female hormones so that the body will have taken on some of the characteristics of the desired gender. Help would also have been given in relation to mannerisms, voice production and other gender symbols. Successful passing leads to the decision to proceed to surgery, the final stage of gender transition.

Passing is thought to serve at least two purposes. Medical practitioners consider that it provides an experience of what it means to live as a member of the desired gender. This experience is both informative and serves to test the resolve and nature of the gender desire. In the official guidelines of the Harry Benjamin International Gender Dysphoria Association (HBGDA) the RLE is discussed in the following way:

> Since changing one's gender presentation has immediate profound, personal and social consequences, the decision to do so should be preceded by an awareness of what the familial, vocational, interpersonal, educational, economic and legal consequences are likely to be. The Real-life experience tests the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic and psychological supports.[333]

The quality and success of the RLE is judged on the transsexual's ability to do a job of work, to form successful relationships and to be able to fit into the community as a whole. Acceptance of the transsexual by others as a member of the preferred gender community is crucial. The RLE functions as a way of measuring this idea of belonging to a recognisable gender community. It is the opportunity for desire and belief to be

measured against reality. Reality may prove to be what the transsexual imagined it to be or to reveal things that were not anticipated. If this is the case then the decision to transition generally follows; if not the transsexual may reconsider the option of surgery. She/he may then decide against it.

The second purpose of Passing as understood from the perspective of the transsexual community itself is; "the act of successfully appearing as a desired definition of a person in the world".[334]

The on-line support organisation www.Transsexuality.org define gender identity as determined by two things; one is the sum total of behaviours linked to gender and the other is physical appearance. What is required is that the transsexual 'fits' on both counts and the aim of Passing is; "to be accepted as the correct sex".[335]

The transsexual is, therefore, advised to seek acceptance as a member of the desired gender. All whom the transsexual comes into contact with are to be convinced that she/he belongs to the preferred gender. The support group advise that Passing needs to be successful in order for the transsexual to live safely given the human capacity for cruelty and ridicule. The ideal in Passing is to live in conformity to existing ideas of masculinity and femininity:

> In every way, it is safer, easier and less filled with suffering to fit neatly within one of the twin accepted poles of the current definition of gender: male or female.[336]

Transsexuality.org appears to be advocating a policy of conformity to gender stereotypes as a pragmatic measure. It does caution against a too rigid adherence to stereotypes but nonetheless advises a measure of conformity as the above quote shows.

Two distinct rationales are offered for the activity of Passing. The medical one is therapeutic in aim and orientated towards testing the personal resolve of the transsexual whereas the rationale from within the transsexual community appears to be orientated towards establishing the likelihood of surviving in society in the chosen gender role. Passing is orientated in both cases towards the individual being able to live out permanently and visibly in the gender role as a member of the community. This is the stated desire of many transsexuals.

The Gender Recognition Act has set up a Gender Recognition Panel whose responsibility it is to oversee in law the recognition of men and women who have transitioned from one gender to another[337]. This panel has responsibility for all the documentation that is necessary in order to establish legal status. Transsexuals will be placed on a Transsexual Person's Register which will be a means of overseeing the issuing of birth and marriage certificates. The result will be that transsexuals will have the legal rights and entitlements of a person of the acquired gender. This will include the right to marry and to pension and property rights. The Act does away with the Corbett Sex Test (1970) which was used to determine the sex of an individual and which laid down legal definitions of sex and gender and replaces it with a fourfold inquiry about the experience of the transsexual:

1. Has a person taken decisive steps to live in the gender which they believe to be more appropriate? (section 1.4b).
2. Do they intend to live in that gender until they die? (section 1.4c)
3. Have they had Gender Dysphoria? (section 2).
4. Have they undergone medical treatment? (section 2).

Following this inquiry the transsexual person is responsible for submitting medical reports to the panel that substantiate the existence of Gender Dysphoria as well as confirming that she/he has lived in the preferred gender role for at least two years. Successful application to the panel results in the granting of a Gender Recognition Certificate which can either be partial or full and when it is the latter then the Registrar General is informed and a new birth certificate can be issued. Recognition can be refused but the person concerned can apply again within six months.

Once it has been established that the criteria for gender recognition have been fulfilled then gender status is recognised in law. Evidence of previous gender status is legally removed and outstanding matters such as pension contributions and other financial matters are adjusted into the new gender role. In law the transsexual now has the same legal gender status as a person born with that gender.

PASSING AS DECEPTION

An alternative interpretation of Passing, and its recognition in law, is that it is as a straightforward matter of deception. Deception can be thought of as taking place in at least three ways.

First, to appear in public as a member of a particular gender whilst either belonging to, or having once belonged to, the other gender is inherently deceptive. Raymond for instance writes:

> to not acknowledge the fact that one is a transsexual in a women's space is indeed deception.[338]

As seen in my Interim Conclusion, Raymond's central argument is that inherent in TS are men seeking to invade the space of women by means of the deception. M-F TS is a way for patriarchy to continue its dominance of women and is a rearguard action to the attempts of women to liberate themselves. Part of the deceptive nature of M-F TS is found in the way that men seek to appear as women without acknowledging their original masculinity. She argues that:

> no man can have the history of being born and located in this culture as a woman. He can have the history of *wishing* to be a woman and of *acting* like a woman but this gender experience is that of a transsexual and not of a woman.[339]

For Raymond the very claim to *be a woman* as a result of surgery is deceitful and ought to be recognised as such by 'real' women. She claims that the whole issue of TS is a moral one that centres on the question of when it is *right* to use medical technologies and not on when it is possible to do so because the skills are available:

> The question (of GReS) is a moral one; which asks basically about the rightness of choice and not the possibility of it.[340]

Rightness does not consist in the fulfilment of human desire but in the addressing of a genuine and recognisable health need. In Raymond's opinion medicine has placed a therapeutic model on matters that are inherently moral and as a result makes therapy a way of life. To turn moral matters into therapeutic ones is to damage the individual concerned and contributes to the continuance in society of classifications and groupings that are harmful:

> The present counselling and treatment of transsexuals, based on the medical model I have described, give the transsexual no real moral options. Failing to analyze our society's definitions of masculinity and femininity, such therapy offers little encouragement and advice to help the transsexual live beyond both these containers of personhood.[341]

Raymond argues that TS ought to be understood as a quest for transcendence in which the individual seeks to go beyond current limits of the self in both bodily and gender categorisations. She appeals to Tillich's notion in *The Courage to Be*[342] and argues for an ethic of integrity that is a rejection of both sex and gender roles into a Being of

integrity[343]. For Raymond the act of simply appearing as a woman when a person has once lived as a man is straightforwardly deceptive.

A second way in which Passing can be understood to be deceptive centres around the way in which one term can be understood in two different ways. This issue is raised by both Raymond's views and the action of the UK Parliament and is concerned with whether or not gender identity is subjectively established or objectively determined. The term 'gender' is used in both senses by different groups within society, with Raymond giving it an objective meaning whilst the UK Parliament gives it a subjective one. Deception results when one group gives the term one meaning in the full knowledge that the other party is using the other. Not only this but one group must use the term differently in different contexts without acknowledging that this is being done. So, for instance, one group would use the term 'gender' objectively whilst another does so subjectively, with the first group doing so knowing that the opposite view is held by the second.

An analogy can be made at this point with the way in which the term 'law' is used. Two people discuss a theoretical case of an adulterous woman. One claims that the law demands that she be stoned to death and by law he understands the law of the Hebrew Scriptures, especially the Book of Leviticus with its code of immoral behaviours and punishments[344]. The other person hears the word 'law' and understands it to mean the actual law of the land and thinks that the first person is claiming that the law of the land demands that an adulterous woman be stoned to death. For this to be a matter of deception rather than misunderstanding then the first person must be aware of the fact

that the second person has a contemporary concept of law and not a Biblical one. Knowing this he fails to make his own position clear and encourages the second to comply with the 'law' by participation in the stoning.

The UK Parliament's view of gender is that it is subjective in nature but needing an objective validation. Raymond views gender as a matter of fact (a fact which is tied to the sexed body) but in its form gender is a matter of cultural construction and expression. She states:

> masculinity and femininity are social constructs and stereotypes of behaviour that are culturally prescribed for male and female bodies respectively.[345]

Such constructs do not allow for a person with a male sexed body to claim to be a woman or *vice versa.* Sexed bodies determine gender but its shape is a matter of cultural expectation. These are predicated on particular understandings of the sexed body and can vary from culture to culture and from one time to another. If gender was equated only with the body then it would be as fixed as the sex of the body itself and so no variation in content would be possible. The parameters of gender for Raymond are established by the sexed body but its content is fluid because the idea of a fixed content is a cultural construct.

This examination of both Raymond's and the UK Parliaments view of gender focuses attention on the way that one term can be used in different ways and that deception occurs where this is not acknowledged. Two paradigms of gender exist, the objective and

the subjective, with the subjective being the one upon which the definition of TS depends and as the one used by both medical professionals and transsexual in any discussion of TS between themselves. However the objective definition of gender is used when a transsexual seeks to pass before others. In Passing a transsexual moves from a subjective paradigm of gender into an objective one and does so because it is believed that this is the view of gender that is held by those before whom she/he is seeking to pass. The transsexual presents him/herself through an objective view of gender whilst he/she actually has a subjective view, a view which makes possible his/her gender desire in the first place. He /she knows that he/she is not a member of the desired gender in the same way as others are from birth, and that he/she does not regard gender as tied to the sexed body as others may do but proceeds to act according to the objective view of gender-as-sexed-body by behaving like a stereotypical member of that gender.

What is necessary for successful Passing is that a transsexual acts in ways that are believed to be in keeping with the mannerisms of a person who belongs to the gender that she/he is seeking to convince others that she/he belongs. She/he both seeks and is encouraged to seek to act in ways that conform with what can be understood as cultural stereotypes of masculinity and femininity in order to convince others that such stereotypes are ideal gender identities linked to a sexed body. Both the transsexual and those who consider that Passing is an important element of the treatment process can be thought of as moving between these two paradigms of gender and to fail to acknowledge that they are doing so. Both transsexuals who seek to Pass in this way and doctors and others who are involved in Passing process may be employing a construct of gender

which is not necessarily the one that would be generally accepted by the audience for this Passing. If Passing is successful then the transsexual will live full time in that gender role and is then living out an objective paradigm of gender whilst still prioritising a subjective one that made the transitioning possible. Deception can be understood to continue after the initial period of Passing and into the transitioned life.

A third way in which Passing can be understood to be deceptive is perhaps the most significant. To knowingly believe in the separation of sex and gender, which as we have seen is a pre-requisite for TS to be seen as a rational possibility, and then for a person to *act as if* sex and gender are one and the same thing is deceptive. This is what seems to be happening in Passing in the case of both the transsexual and the professional.

Considerations of authenticity may require that a transsexual openly acknowledges the purpose of Passing and that she/he tries not to present a gender identity in such a way as to make it appear that this identity is a matter of birth. It may be thought to be desirable to ask openly and freely whether or not they consider the transsexual to present a gender identity in such a way that it is consistent with an understanding of how gender is thought to relate to the sexed body. In this way the transsexual is seeking to be as open as possible about what it is he/she is seeking to do in Passing and other people are being treated not as a means to an end but as ends in themselves and are afforded the respect that is due to them as autonomous beings.

These three forms of deception may be thought to be inauthentic. Authenticity requires both that the concepts and ideas involved are consistent and clear and that those who are taking action do so in a way which is honest and respectful of others. The former requirement means that the current unacknowledged paradigm shifts between subjective/objective understandings of gender that occurs in the transsexual narrative be acknowledged and replaced with a consistent approach. The latter requires that openness and straightforwardness should characterise the activity of Passing if Passing is to remain an intrinsic part of treatment.

Two counter examples may be thought of here. A person who is a smoker but sincerely trying to give up is about to attend a conference where no one knows her and where some socialising at the bar is certain to happen. As this is pre July 07 there is also likely to be lots of smoking at the bar. She wants to make this a real test of her resolve to quit smoking. She therefore acts as if she is a non-smoker. She behaves like the non-smoker she wishes to become. Can this be thought of as a matter of deception in the same way as Passing? Similarly a trainee learning disabilities nurse, wanting to see what it is like to be confined to a wheelchair, pretends to be confided himself. He visits the local shops and receives help from others. He does not really need the help yet he accepts it. If someone else were to dash in front of a lorry risking death to push him out of the way (should the need arise), *and he lets them do it*, this would be unacceptable, but to receive lesser forms of help fits in with his original experiment. He, too, faces the problem of whether he is acting deceptively.

Both examples can be answered in terms of authenticity. In the first example the ex-smoker is seeking to test the authenticity of her intention to quit smoking. She knows herself well enough to realise the difference between an intention to quit and acting on that intention in a pressurised setting. To test herself she acts in the way described above. The trainee nurse seeks to be authentic in his caring for those confined to a wheelchair. This is why he conducts his experiment and why he does not tell others what he is doing. In order for his experience to be of value then he needs others to respond to him *as if he were disabled.* For the person who is engaging with his/her sex and gender identities *authentically* the deception involved in Passing is problematic. This is because it is predicated on notions of gender that are out-dated. Both the non-smoker and the student nurse are pursuing goals of authenticity whereas the transsexual is pursuing the goal of displaying sex/gender congruence whilst holding to sex/gender dissonance which, as we have seen, is the fundamental concept that allows for TS to be a rational possibility.

Authenticity requires that Passing be given up in favour of an open and acknowledged activity in which a transsexual does not seek to hide the original gender identity but is seeking both to test personal resolve and to gain insight into the actual bodily experience of a person with a particular gender. This activity could be renamed 'Testing' or 'Resolving', the aim of which is not to establish gender identity (as this is established subjectively as a claim) but to determine whether or not a person wishes to transition to a gender identity that is tied to a sexed identity in order to achieve sex/gender congruency. This is done for reasons of authentic existence. 'Passing' as a construct seems to be inherently deceptive.

4. Authenticity and Personal Responsibility

In this fourth and final section of the chapter I want to argue that a post-operative transsexual, living authentically, has a duty to disclose the fact that she/he has transitioned to any person with whom she/he seeks a relationship of intimacy, particularly romantic intimacy for at least three reasons: first, the right to privacy cannot be constructed as an absolute right; second, in specific contexts others have a right to know and third because of considerations of the duty to oneself. These three reasons will be explored in this section of the Chapter. Finally, disclosure will be discussed in relation to achieving intimacy.

THE DUTY TO DISCLOSE

I am not arguing that there is a general duty to disclose, as this may undermine the very purpose that transitioning serves, rather that it is a specific duty to the person with whom the transsexual seeks to establish a life partnership.

The issue of disclosure is explored in a series of rhetorical questions that Mason asks:

> Is it better to conceal the past from potential employers than to 'tell all' even if this means evasion or outright lies on an application form? Do they really want to know that I have been in the WRNS and have had a total hysterectomy? Wouldn't such disclosures make life difficult all round? At what point does one tell a girlfriend of the situation?[346]

Such questions highlight what Mason describes as 'the transsexuals dilemma'. He is reflecting on the tension between a transsexual's right to privacy and the right that other people have in relation to their own interests. With regard to privacy a transsexual has both desired and worked for a considerable time to be the person that she/he now is, and has experienced great difficulty in order to do so. The right to privacy can enable her/him to live in the desired gender role. On the other hand, a transsexual's right to privacy can come into conflict with the rights of those with those she/he is in an intimate relationship. Where this occurs I argue that a transsexual has a duty to disclose the fact of her/his transitioning.

This is not to diminish the importance of the right to privacy. This right is well known as a good that is valued by most people. Nyberg comments:[347]

> Every important right needs a social system to protect it. The right to privacy is no exception. It is protected by laws, by ethical codes, skills of concealment and deception…we need privacy to survive just as surely as we need communal civility.[348]

Nyberg argues it is impossible to avoid deception completely but this ought not to be a matter of moral concern because such deception is often innocently done. He argues that relationships would not survive the experience of pure truth telling and so innocent or non-malicious deception is often necessary. Absolute honesty may have a negative impact on intimacy:

> An atmosphere of pure truth telling is no more fit to sustain relationships than the atmosphere of pure oxygen is fit to support biological life. Social life without deception to keep it going is a fantasy, and even if it were possible it would be undesirable.[349]

Nyberg's argument about the right to privacy centres on the need to shield our thoughts about ourselves and other people from others; for instance how we think another person looks or what we feel about another person's character or achievements. If all such thoughts were disclosed then relationships may break down and social relationships become impossible. Privacy actually facilitates good relationships and creates social cohesion.

Thomson[350] argues that no-one has a clear idea of what a right to privacy is. She thinks that it consists of a cluster of rights that are related to other rights such as the right not to be harmed. A right to privacy is related to 'the right over a person' and after examining various possibilities she argues that a person's right to privacy may be violated in various ways but not as a result of someone else knowing a fact about oneself:

> There is no such thing as violating a man's right to privacy by simply knowing something about him.[351]

Thomson's position is that whilst a person has the right not to be coerced to reveal something and the right to be protected from other people taking steps to find things out about him/her the right to privacy can be undermined by other rights. Harm does occur when privacy is invaded, but this has to be explained in terms of other rights.

Lever[352] agrees that the right to privacy is a cluster or a bundle of rights amongst which are the rights to solitude, intimacy and confidentiality. Lever is concerned to work out a

political justification for the right to privacy and makes a distinction between the private and the public realm. In the former Lever argues that the equality and freedom of individuals need to be protected and that the right to privacy has often been a justification for the political exclusion of women. Like Thomson she agrees that the concept of the right to privacy is problematic;

> At present there is an unresolved debate amongst moral philosophers about the best way to understand the content and justification of privacy rights..[353]

Her main concern is that equality and freedom between persons is maintained and that as long as this is the case then specific matters or concerns are of less significance.

Both agree that an important element of the right to privacy is concealment. The right entitles a person to keep to themselves certain facts that are considered to be of importance and that others do not have the right to this information as a matter of course. Concealment may be important both in order for an individual to pursue his/her goals and to protect him/her from the inquisitiveness and prurience of others.

Nonetheless, whilst acknowledging the importance of the right to privacy, I argue that a transsexual has the duty, under some circumstances, to disclose that she/he has transitioned for the following three reasons; first, because the right to privacy is not an absolute right, second that in certain situations others have a right to know and third that the transsexuals duty to disclose can be formulated as a duty to the self. This third point can be broken down into a discussion on respect and pragmatic considerations

First, then, the right to privacy is not an absolute right. Article 8 of the Human Rights Act 1998 codifies the right to private and family life but states that this is qualified by the duty of the State to protect the lives of all its citizens. Individual rights can be over-ridden in the interests of the State, as long as those interests represent the interests of the general population. This legislation sets the right to privacy in a public context. In the private realm the right to privacy may also be thought not to be an absolute right. It needs to be weighed against other rights, both of the individual concerned and of those around her/him.

On an individual level it may be necessary to weigh the right to privacy against other rights, such as the right to health care, the right to education and the rights to public services, all of which involve the disclosure of some personal information to those who supply the services that ensure that the rights are met. If an individual values such services then she/he waives the right to keep secret personal information, such as the nature of a particular illness.

Similarly on the inter-personal level an individual may waive the right to privacy in favour of his/her other rights, such as the right to safety. Barilan and Brusa[354] discuss the way that the right to privacy is often seen as a:

> 'super-master concept, as a trump card even more powerful than other trump cards…the right to privacy…trumps all other moral considerations and rights.[355]

They question why the right to privacy should have such prominence in ethical deliberation before concluding that:

> The reign of privacy is more of a legal tyranny threatening to silence interpersonal deliberations on issues that are so much part of human identity and existence.[356]

This conclusion suggests that there is scope for increasing the number of occasions when the right to privacy can be trumped by other rights, as an insistence on the right to privacy may interfere with more basic human concerns. One example is the way that national interests often over-ride privacy. In the so-called 'War on Terror' governments often attempt to justify breaches of personal privacy on the grounds that they are concerned with national security. Attempts are made to access mobile 'phone conversations and e-mail traffic in order to police the activities of those whom they suspect of terrorism.

A broader justification for privacy being trumped by interests of national security is that a trade in benefits is taking place. The benefit of privacy is being traded for the benefit of security. Security is considered here to be of greater benefit than privacy. Without security it would be difficult to achieve privacy and therefore security is a means to privacy.

It is not just in relation to national security that privacy can be traded for other benefits. This can also be the case at a personal level. An example of this is the 'fly on the wall' type documentary, where a family invites a film crew into their home to film either the way that they bring up their children or cope with poverty and unemployment.

Supernanny[357] is an example of the former, where a professional Nanny gives advice to parents who are in difficulties in relation to their children. In this programme the behaviour of both parents and children are brought under scrutiny. The right to privacy has been traded for advice and help. Furthermore, the public element of experiencing family difficulties broadcast on mainstream television is justified from a didactic perspective. It is thought that parents watching the programme may be experiencing similar difficulties and so may benefit form the programme. Here, the right to privacy has been traded for public benefit. The parents who have agreed to be filmed may value this trade-off and incorporate this into their rationale for agreeing to be filmed.

The idea of trading benefits can then be applied to TS, as will be discussed later in this section of the chapter (p 279 *para* 3).

A second reason why a transsexual has a duty to disclose is that there are certain situations in which other people have a right to know. Personal intimacy creates an atmosphere in which there exists a duty to disclose certain information. Baier[358] argues that it is the nature of a context that gives shape to both duties and expectations:

> a right to get straight answers to questions (that) one has a right in certain circumstances to pose.[359]

Baier argues that social contexts both create expectations and place duties upon those who are engaged in them. Both can be thought of as rights. Contexts can be understood either as weak, as when a person enquires about another's health in a social gathering and

strong, as with long standing intimate relationships. Weak contexts place both a duty and an expectation, for example to be asked about one's health with a positive answer being given. Strong contexts create both a duty and an expectation of high levels of disclosure and truthfulness.

In a strong context of intimacy a non-transsexual can be understood to have an interest in knowing the history of the transsexual based on other interests, such as the interest in founding a family, the interest in enjoying family life and the interest in having an informed sexual relationship. In such a relationship it is unlikely that a non-transsexual partner would ask a transsexual about his/her gender history. Where surgery has been successful, there may be no signs which prompt even an intimate partner to question the history of their transsexual partner. The interests out-lined above may then provide compelling reasons why the right to privacy can be over-ridden. Further argument may help at this point.

Tension exists between the need to take people at face value *and* the need to be aware enough in order to protect oneself. For instance, both the prevalence of, the prominence given to and danger of HIV mean that people need, in general, to protect themselves when engaging in sexual intercourse[360]. Therefore, anyone engaging in a sexual relationship without safeguarding themselves and doing so *just on the word of the other person,* can be thought to be acting irresponsibly. It is the attention given to HIV, in the media and from both governments and health organisations, that creates the conditions in which people need to act with awareness. However, TS does not have the same attention

or prominence. It is less common[361], even though evidence presented at the LGBT Health summit 2008 shows that the age at which requests for surgery is rising[362]. It is less reasonable, therefore, to expect people to have an awareness of TS.

An important out-working of this lack of awareness of TS can be seen in the matter of what people can expect when meeting others with whom they seek romantic relationships. Meeting a person in a heterosexual context would lead a person to believe that she/he is meeting someone of the opposite sex. Expectations are in play, determined both by the desires of the person and the context in which that person operates. So, both desiring and expecting to meet a person of the opposite sex, a person is likely to think that this is exactly what has happened when she/he meets someone to whom they are attracted. She/he has no reason to suppose otherwise and cannot be expected to be aware that the person to whom they are attracted may be transsexual, because of the general lack of awareness that exist in relation to TS.

The movie *The Crying Game* (1992)[363] provides an example of someone who ought not to have been surprised to find that his partner was a pre-operative transsexual, because they met in a LGBT bar. It could be argued that he has no reason to feel that he has been deceived because of the circumstances in which he met his partner. This demonstrates that expectations ought to be linked to contexts and a heterosexual context gives rise to a heterosexual expectation.

It is not justified to argue, therefore, that an onus is placed on a person to realise that the one to whom they are attracted may once have had a different gender. Often, transsexuals desire to meet potential partners in a heterosexual context. Jorgensen thought in terms of heterosexual marriage when thinking about romantic relationships[364]. Her desire was to have a heterosexual relationship. Her public profile as a transsexual made is impossible for her to keep her past gender a secret, and so she was not faced with a duty to disclose. She is being quoted here to demonstrate that a post-operative transsexual may have a heterosexual romantic aspiration. Where this is the case, and the past gender identity cannot be expected to have been known, then the onus, is with the transsexual to disclose.

Similarly a woman who looks white, but has black ancestry (of which she is aware), is in a relationship with a man whom she discovers to be a member of the British National Party. The issue here is not the rightness or wrongness of either belonging to such a political party or whether she thinks it is acceptable or not. Rather it is that he has certain beliefs and values which he may assume are not threatened by his relationship with her. He cannot know the full facts of the situation because he cannot see them. What he can see seems to affirm what he thinks. If he wants children then there is a real possibility that their black ancestry may be made visible.

These examples are not used in order to argue that the transsexual has a shameful past which she/he must confess to a partner. Rather they are used in order to demonstrate that there is a connection between what a person can see and what she/he may then believe.

Seeing and believing is associated with evidence. A person believes on the evidence that is available. Sometimes a person ought not to believe what she/he sees or is told, as in the example of HIV where a person claims to be free of the condition and asks for unprotected sex. Here, the other person ought not to just act on this claim because she/he knows that the risk of HIV infection is real and that using condoms is the safest thing to do. At other times a person cannot be expected to doubt what he/she sees (as in the case of the white woman) because knowledge to the contrary is not available.

Lerner[365] argues that a distinction ought to be made between truth telling, which is beneficial for relationships, and the need to deceive. For example, a women needs to pretend to have a virtue because this can be the route to acquiring it. In terms of relationships, however, truth telling is an occasion for joy and authenticity. Her distinction seems to be between good secrets and bad. A good secret would be pretending to have a virtue and a bad secret would be hiding something that has the potential to harm another. This harm exists where the other person has an interest in knowing the secret. Where such an interest is legitimate then a duty exists to disclose.

TS, in a context of heterosexuality, is an occasion where such a duty is found. The non-transsexual has an interest in knowing about the past gender identity because he/she assumes that what she/he sees has always been the case. This seems to be a reasonable assumption because of the heterosexual context. The transsexual has a duty to disclose because of the same heterosexual context.

The third reason for a duty to disclose can be formulated in terms of a duty to oneself; first in terms of respect and second from a pragmatic point of view.

First, then, the right to privacy needs to be offset against the duty the transsexual owes to him/herself in terms of self-respect. The duty is not to harm oneself and this is achieved by being respectful of oneself. This duty would not in and of itself preclude surgery as surgery is a means to and end.

Kant[366] argues that every human being has a duty of respect to the self. Amongst other things this duty demands that a person ought not to lie or to deceive others as this harms oneself. A transsexual sees the post-operative gender as the truth about him/herself so the lie does not consist in the present presentation of gender but in the unspoken or unacknowledged claim that this gender is the gender that has always been presented.

Kant argues that lying or deceiving is:

> more a violation of duty to oneself than of one's duty to others.[367] [for]
>
> by a lie a man throws away and, as it were, annihilates his dignity as a man.[368]

From a Kantian perspective, then, it is possible to view a transsexual who does not disclose the fact of transitioning, in the specific context being explored in this Chapter, as someone who may be actively harming themselves. Harm consists in disrespecting ones rationality. It is not primarily a matter of the consequences that may follow acts of

concealment but of a failure to act rationally, which Kant formulates as the highest human good. To afford primacy to the right to privacy may involve the transsexual failing to act rationally.

Second, a transsexual has a duty to disclose as this may be in her/his own best interest. To fail to do so may lead to problems in the future such as other people picking up on gaps in her/his personal history, chance encounters with people from the pre-GReS past, the need to draw on knowledge and experience gained from life lived in the previous gender and which cannot be explained without reference to that life, and the desire to relate to others in a way that would reveal the past gender life. Such circumstances may lead to forced disclosure, exposure or to the possibility of either being misunderstood or loosing access to valuable past knowledge and experience.

A partner who discovers a transsexual's transitioning by means other than personal disclosure may believe that the transsexual has been both duplicitous and untrustworthy. This may then threaten the relationship itself with a partner experiencing a sense of being let down or lied to. To avoid this possibility then it may be in the best interests of the transsexual to be open about her/his transitioning. A partner may think that she/he had not been considered trustworthy enough by her/his transsexual partner to be entrusted with the knowledge about her/his past life.

Such pragmatic considerations may not give a transsexual a moral duty to disclose but is concerned with what works and what does not. A judgement needs to be made about the

tension between the desire for privacy and considerations about the consequences of someone finding out. A transsexual may come to the conclusion that though she/he has a strong desire to keep the fact of transitioning secret in order to live in the desired gender role, or it may be both more valuable and beneficial to tell her/his partner.

Not to disclose runs the risk of being found out. To prevent this, a transsexual may need to develop skills of concealment in order not to give away the fact that he/she was once differently sexed. Linked to this he/she may have to offer reasons that are not strictly true to explain his/her infertility, for example. Skills of concealment focus on not giving oneself away; not feeling uncomfortable when giving false reasons for something and not feeling uncomfortable when causing others to believe something that is not strictly true. A certain amount of concealment has already been seen to be necessary in order to pursue private goals such as ambition in work, but in the context of intimacy concealment at the level of not revealing transitioning may prove to be detrimental. A transsexual may also be harmed to the extent that concealment may be the result of fear or prejudice and by keeping transitioning secret she/he is either confirming fear or prejudice to him/herself or in society as a whole.

In a similar way a social climber from a poor background may regard himself as a socially superior person, and therefore as someone who is better than others. He may try to achieve this by means of accent, mannerisms, and false claims and by constructing a false past of public schools and domestic servants. He assumes that the possession of a posh accent means certain things in terms of status, education and wealth and when this

assumption is shared then he may successfully pass himself off as socially superior. His ability to convince others about his/her social status does not make the claim itself true. What he is doing is conforming behaviour to social stereotypes, which may be inherently harmful. He is concealing his past in order to be the sort of person that he desires. However, for this to be achieved both concealment is necessary and socially harmful stereotypes are being maintained. Both can be understood to be harmful.

Authenticity would require that both the transsexual and the social climber seek to relate their present lives to their past selves in a way that emphasizes continuity and wholeness as well as challenging social stereotypes. Present and past selves are integrated so that the whole of a person's life is owned in the recognition that all his/her life has been a unique event. To disconnect from a past life is to disvalue past experience and to act as if it never was. This may be an example of bad faith. Authenticity would require that all people respond in this way.

DISCLOSURE AND INTIMACY

A final consideration about disclosure can be thought about in the context of creating intimacy. A relationship with a partner is by definition a relationship of intimacy. Intimacy is both achieved and maintained by disclosure. Derlega and Chaikin ask:

> What is probably the most important function of disclosure? The creation of an intimate, caring relationship with another person.[369]

They offer a supplementary reason for disclosure which is that it aids personal insight and can relieve neurosis. Nevertheless, they argue that what must be recognised is that the primary function of disclosure is the establishment of intimacy. Both authors state that they agree with the position of the psychologist Mowrer which is that:

> concealment of self occurs out of fear of the consequences of self-disclosure, from a person's belief that if people knew his real self they would find it ugly and unworthy of love and respect.[370]

Jourard[371] refers to the reciprocal nature of disclosure as the 'dyadic effect', which is crucial in creating intimacy. Intimacy begins when one person 'risks' disclosure. Risk consists in the possibility of the other person either misunderstanding or disliking the discloser's comments or becoming suspicion of his/her motivation. If a negative response follows disclosure then the relationship itself may be threatened. However, when there is a positive response to disclosure there is often an accompanying deepening of intimacy. A dynamic of mutual disclosure can be created with the relationship deepening as a result. When a relationship begins it is usual for relatively safe matters to be disclosed and as the relationship continues for disclosures that are more revealing to be shared. Often a point of climax is reached when a person has fully (or as fully as she/he is conscious of) revealed him/herself to another. This is often thought to be the moment when deepest intimacy has been achieved.

Derlega and Chaikin discuss the way that candour can increase closeness between people and conclude:

> The aspects of ourselves that we hide may actually improve the chances of a successful relationship if we reveal them.[372]

Goffman[373] offers a set of guidelines for people who are seeking to achieve intimacy by means of disclosure. He advises that disclosure is appropriate if it is in the context of an on-going relationship; it is not an isolated or random act; it develops out of the good experience of the person involved; it is mutual; the discloser monitors the effects of each revelation on the other and each act is appropriate to the current state of the relationship.

It is Goffman's contention that for intimacy to be achieved the discloser needs to be more concerned about intimacy than she/he is about privacy, secrecy, personal anxiety and self-protection. Such a person would both need to value intimacy above other values such as privacy in order to be willing to risk disclosure and realise that disclosure is a means by which intimacy is achieved.

Derlega and Chaikin argue that disclosure leading to intimacy needs to be done on a basis of equality. Some types of disclosure are inappropriate, if they cross the boundaries that are traditionally thought to exist between people. For example, doctors disclosing to patients or priests to members of the congregation:

> disclosure by a low status individual (for example an elevator operator) to a high status individual (such as a business executive) is more appropriate than disclosure in the reverse direction.[374]

The importance of this observation lies in their recognition of mutuality. There are exceptions to this rule and times when one-off disclosures that ignore normal social conventions may be beneficial (disclosing to a stranger on a train, for example). Derlega and Chaikin are pointing out that intimacy is usually understood to be between people who share a measure of equality and that disclosure is a means of achieving this.

In terms of TS this suggests that if a transsexual wants intimacy she/he may need to begin a relationship of self-disclosure. As stated above, this would begin at a relatively safe yet significant level with someone with whom she/he desires intimacy. As the relationship develops further disclosures take place in a risk/being well received dynamic. Greater disclosure leads to deeper intimacy. Ultimate intimacy may be achieved by the disclosing of the fact of transitioning. It is also the case that the greatest risk may attend disclosing this but along with this is the greatest potential for intimacy.

The consideration of intimacy does not give a transsexual an imperative to disclose but is part of a wider prudential mechanism. The benefits that a transsexual gains from disclosure may outweigh both the attendant risks and other considerations such as privacy in the context of intimacy.

Conclusion

This chapter has sought to establish that the model of authenticity developed in Chapter Four requires a number of things. Firstly that the existing models be examined because

of the conceptual confusion that appears to be inherent in them and that they be replaced with the new model of authenticity. Secondly that TS be seen part of the original or early inheritance of the transsexual but not as something which is a matter of personal essence which cannot be changed or thought of as something for which the transsexual is not responsible. Thirdly that a transsexual may or may not decide to move from this inheritance towards the establishment of gender/sex harmony if this forms part of the larger autonomously chosen goals of the individual.

If this choice is made then the medical profession can be thought to have a duty to assist in the process of reassignment. This duty flows from the position of respect for autonomy. GReS ought not to be considered as a form of cosmetic surgery as sex/gender harmony is related in a fundamental sense to the matter of personal identity and therefore of individual functioning. If harmony is pursued then a transsexual would need to be made aware of the difficulties inherent in Passing and so may decide to either forgo this activity completely or to conduct it in an open a way as possible. This may prove to be a difficult thing to do but it has already been acknowledged that authenticity is a difficult thing to achieve.

Different transsexuals may decide to pursue authenticity differently. Some may choose to live with sex/gender dichotomy and to do so in order to challenge the traditional binary notions of masculinity and femininity. It may be that some would think of themselves as gender non-conformists and so see their own sex/gender incongruence as a means of

embodying a challenge to the way that society constructs gender identities. The Authenticity model permits a variety of responses to TS

Fourthly that for a post-operative transsexual authenticity requires that disclosure takes place in a context of intimacy. An intimate context can be that of the family, friendships or especially where a long-term sexual or romantic relationship is being experienced. Disclosure is owed both for the sake of the partner, the relationship and for the transsexual. There is no duty to disclose to others with whom she/he has a non-intimate relationship, such as an employer, casual friends or new neighbours or colleagues that have been made post-operatively.

Fifthly and lastly the medical profession needs to recognise the conceptual confusion inherent in the current models employed in transsexual narrative and so be willing to replace them with more coherent models. The duty of medicine is then to rend assistance to a transsexual who is seeking to achieve autonomous goals in order to establish personal identity. One result of this may be that those who perform surgery are viewed as practitioners standing outside of traditional medicine, in a way that is analogous to cosmetic surgery, operating within a context of commercial medicine.

Sullivan offers a sociological analysis of the commercialisation of medicine in the USA, particularly in relation to cosmetic surgery[375]. She likens cosmetic surgery to attempts in other cultures to achieve personal identity by means of altering the body, such as the binding of feet in Chinese culture and the marking of the face in Maori culture. She is

critical of the fact that beauty has become a concern of medicine and worries about the implication of commercialism within medicine, such as advertising services (which she refers to as promotion) and the possible consequences of deregulation.
Shepherd[376] reviews Sullivan and argues that cosmetic surgery is an example of medicine seeking to improve the quality of life. She argues that not all medicine needs to save life, as improving the quality of life is a legitimate medical goal. She compares cosmetic surgery with hormone replacement therapy. The latter is seen as a legitimate function of medicine, yet is not a matter of saving life but of improving quality of life. Shepherd further argues that what Sullivan regards as promotion may be a matter of patient education.

In relation to TS practitioners would operate in a context similar to surgeons performing cosmetic surgery. Concerns around the safety of both patients and practitioners and the need to guard against the dangers of commercialism in relation to the latter can then be applied to the former.

CONCLUSION TO THESIS

In this thesis I had two aims. First I aimed to demonstrate the conceptual incoherence and logical contradiction that lies at the heart of the current medical model of transsexuality and the provision of gender reassignment surgery. This aim was achieved in chapters 1-3. My second was to develop an alternative model that avoided these inconsistencies and incoherence. In Chapter 4 I proposed a model based on authenticity and in Chapter 5 I discussed how this model could be made to work in practice in order to demonstrate that the model was more than merely theoretical.

To understand the conceptual incoherence and logical contradiction of the current model it is necessary to understand the current therapeutic guidelines. These were examined in the Introduction. In Section One of Chapter One TS was located within current constructions of sex/sexuality and gender before, in Section Two, its conceptual incoherence and logical contradiction was outlined. Here I argued that the contradiction arises because the model sex/gender distinction dissolves into sex/gender alignment, by means of GReS. If sex and gender are to be regarded distinct constructs, and this I argued is the proper way to understand them, then this distinction must have some place in the justification for surgery and for the post-surgical understanding of what the transsexual has achieved. Instead, what I showed was that the rational for GReS is that sex and gender are dependent: to be 'truly' female one must have female sex organs and to be 'truly' male one must have male ones.

Further problems with TS were uncovered in Chapter Two. In the first Section the models of gender, medicine and body-image were applied to TS. These were critically examined. In relation to gender TS was seen to start out with the intra-personal model before dissolving into an inter-personal model. But this collapse is not acknowledged. The medical model depends upon accommodating TS within disease models, specifically psychiatric disease models, but at the same time avoiding regarding the transsexual as mentally ill. This is necessary because if the transsexual is reporting a mental illness rather than some dysfunction of the brain this would cast doubt on the capacity of the transsexual to be reporting accurately or being able to consent to – or even insist upon - surgery.

The application of a body image model raised fewer problems. Here it was seen that the model had potential to be of benefit in the understanding of TS, particularly if the way that a transsexual 'sees' her/himself is explored. Yet the body image model is not used to understand transsexuality. I therefore concluded that further research is needed into the potential benefit of the relationship between body image development and TS.

Having established the conceptual incoherence and logical contradiction of the current medical model of transsexuality, and having argued for the potential benefit of substituting a body-image model in its place, I then offered a number of reasons why, to date, there has not been a great deal of critical attention given to the conceptual underpinning of TS. These were that first; there has been a pre-occupation in popular

discourse with sex; second, there seems to be a reluctance for those who are not transsexual to comment upon TS and third there is also a reluctance to critically engage with the suffering of others.

I then turned to the view that the alleviation of suffering is the best and most appropriate response to the experience of transsexuals. The argument turns on the belief that suffering should be addressed wherever possible. Given that surgery and hormonal drugs will alleviate this suffering, and granted that both fall into the remit of medicine, clearly clinicians have an obligation to address the needs of those suffering from transsexuality. In Chapter Three I argue that the first premise of this argument from suffering is flawed – namely that there is no absolute duty to relieve every kind of suffering just because one can. I first sought to define what I understood suffering to mean. I offered a specific definition of suffering: *suffering* was differentiated from other forms of human misery in order to be clear about what kind of human misery merited a surgical response of the nature of GReS. *Suffering* was defined as: something that impacts on a person physically, psychologically and socially; causes significant frustration to a person's goals and desires with the result that the self is threatened. If it is undeserved, intense and prolonged and is considered to be *suffering* by the person concerned then the criteria are met.

I then argued that *suffering* can be of benefit. For instance it can be of value both to the sufferer and to others who are connected to him. Accordingly, the duty to alleviate *suffering* cannot be an absolute one. This is not to say that there is no duty: the duty

remains important but the automatic response shouldn't be one of seeking to remove it. *Suffering* per se cannot, therefore, provide a sufficient justification for GReS because we can imagine an individual who values such *suffering*, not for its own sake but because of what it may lead to, or the way that it is engaged with.

This conclusion left the way clear for me to propose a new way of understanding – or model of - TS and possible justifications for a surgical response: the model of authenticity.

In Chapter Four I show that this model must be articulated from within an existentialist framework. Authenticity recognises personal freedom and responsibility and as such does not regard TS as a medical condition. It seeks to empower the person both to regard all aspects of his/her experience as that which can be owned and to be free to construct an identity according to her/his own goals and desires. The precepts of this model echo and address concerns from within the transsexual community, where there is growing dissatisfaction with the medical model, and particularly its psychiatric classification. At the same time there is recognition that medicine has a gate-keeping role in relation to surgery, which is only accessible from within a therapeutic framework.

My model of authenticity provides an alternative justification for surgery that avoids both a medical under-pinning and a psychiatric diagnosis and therefore addresses the discomfort of this group. The justification is that a transsexual needs medical help to enable him/her to pursue an authentic existence. A doctor (or other kind of helper) is

putting his/her skills at the service of the transsexual in much the same way as those with body dysmorphia seeking the amputation of healthy limbs are (a condition discussed in Chapter Two). The transsexual is an autonomous individual and as such is best placed to know what his/her best interests are. On my model those who offer help recognise this autonomy, and that TS and the response to it are in large measure based on personal choice rather an illness or condition that leaves the afflicted helpless, with no choice but to seek surgery or continue to suffer.

My final Chapter demonstrates the advantages of this model over the medical model and also discusses the implication of authenticity for both the individual and for those who offer help. The advantages are that a transsexual is no longer viewed as someone with a mental illness, and that his/her autonomy is respected in keeping with authenticity. These choices, however, bring with them responsibilities particularly related to the avoidance of deception and in relation to disclosure. I argue that the usual practice of transitioning is inherently deceptive and also reintroduces some of the incoherencies of the old medical model. For this reason I suggest a more open and, I argue, honest process of 'Resolving' or 'Testing', I also argue that the transsexual has obligations to disclose his/her history to those who have a legitimate interest in knowing. I argue that whilst the right to privacy offers some scope for concealment, this right can be outweighed by others' interests. This duty is both principled and pragmatic. It is pragmatic because it will better facilitate the circumstances of intimacy which it is prudent for those seeking intimate relationships to cultivate.

The model of authenticity frees an individual to think of her/himself not as ill or as deviant in any way but as a person who is in a position to challenge still further the concepts of masculinity and femininity that are already being challenged from within feminism.

In the model of authenticity sex and gender remain distinct, so both logical and coherent inconsistency is avoided, yet GReS remain an option, not for reasons of cure or treatment but for reasons of authentic living. Where GReS is chosen sex and gender remain distinct, separate and vital elements of the person- not necessarily held in tension (though this could be the case if a person chooses to live in tension).

The model of authenticity has value on the conceptual level and on the personal level. It is conceptually clearer and more coherent because it retains the sex and gender distinction that is vital for transsexuality to be conceived of at all. At a personal level it avoids the use of labels and frees a transsexual to think of her/himself in ways that avoid the stigma of mental illness and psychiatric treatment.

The model requires both transsexuals and those who seek to help them to think in different ways. The model has personal responsibility at its core. The transsexual must, therefore, accept responsibility both for the initial experience of sex/gender dissonance. The individual is also responsible for deciding how to respond to their experiences. In current transsexual narratives the notion of responsibility is avoided by focussing on suffering, which – it is believed - must be addressed so urgently that the individual has no

choice but to seek surgery. Authenticity is based on the notion that a transsexual, like everyone else, is a person who is responsible for his/her own existence (all things being equal).

In this thesis I challenge the medical model of TS. My conclusion does not, however, challenge the provision of GReS, though it is radical, expensive and time consuming. Nor is GReS always effective. The case of Samantha Kane illustrates the lengths to which individuals are prepared to go to get their surgery reversed. Instead, I argue that surgery is an option; one option amongst others. Its provision is neither justified with reference to the proper function of medicine in response to a disease, nor by the *suffering* experienced by the transsexual. Rather it is justified as a response to the value of authenticity, and proper respect for the autonomous choices of those who aim to live authentically.

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APPENDICIES

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