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Article

The banality of evil: crystallised structures of cisnormativity and tactics of resistance in a Brazilian gender clinic

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Abstract

The aim of this article is to unveil how cisnormativity is institutionalised in a Brazilian gender clinic, creating an emotionally charged local regime of doctor/patient interactions. Our interest is not only in illustrating how the clinic's institutionalised normatitivies about transbodies are the result of the crystallisation of particular transnational medical discourses, but also in showing how such a normative framework creates specific conditions for trans people's acts of resistance. In order to capture this dual perspective on norms and resistance to them, we draw upon three important but somewhat neglected perspectives in sociolinguistic and discourse analytical research, which may bring some fresh insights to the study of language and discrimination more broadly: Hannah Arendt's (1994) reflections on the 'banality of evil'; Michel de Certeau's (1984) ideas about the no less banal ways in which social actors speak back to power via a plethora of 'tactics of resistance'; and transfeminism's critique of language and the banalisation of hegemonic systems of oppression.

KEYWORDS: BANALITY OF EVIL; CISNORMATIVITY; DISCRIMINATION; RESISTANCE; TACTICS

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Introduction

As we write this article, news of the torture and assassination of a trans woman is causing uproar on Brazilian social media. A video, recorded by one of her attackers, shows Dandara dos Santos covered in dust and blood, being kicked in the face and beaten with a plank of wood while sitting on the ground. She is then forced into a wheelbarrow, taken into a backstreet, and shot twice in the face. In a harrowing banalisation of violence and death, her torturers laughed and cheered while she pleaded for her life. This is a gruesome example of the hardships of gender nonconformity in a country like Brazil, where translives do *not* matter.

According to the non-governmental organisation Transgender Europe,[1] Brazil tops the world ranking of transphobic countries, with a record of 802 trans people murdered between 2008 and 2016.[2] Such figures, however, may underestimate the actual occurrences of transphobic murders in the country, because the offence is not frequently reported to the police, and, even when it is, it is often classified as a crime against homosexual men.

That homophobic and transphobic acts are conflated in Brazilian official discourses emerges in the report *Violência Homofóbica no Brasil: ano 2013* (Homophobic Violence in Brazil: 2013) published by the Human Rights Commission of the federal government. The report indicates that more than five people a day are victims of attacks motivated by their sexual orientation and/or non-conforming gender identification. Here, homophobia is employed as an umbrella term for violence perpetrated against gay men, lesbians, trans people and *travestis* (see also Borba and Ostermann 2007; Kulick 1998), which in turn makes it difficult to single out the degree of specifically transphobic acts in the country.

According to the Brazilian transfeminist scholar Jaqueline Gomes de Jesus (2015), equating homophobia conceptually and statistically with transphobia is problematic because it homogenises distinct processes and dynamics. While homophobia refers to hatred of non-heterosexuality, transphobia targets individuals' non-conformity with available gender norms. The suffix '-phobia' is itself misleading as, whether directed against sexual or gender non-normativities, linguistic and bodily aggression 'is not due to an "irrational" fear, nor can it be understood from a purely psychological framework, that is, as a fear or hatred that resides in an individual's psyche […] [but] it is a socially produced form of discrimination located within relations of inequality' (Murray 2009:3).

It is with a view to moving away from a mentalist view that some scholars prefer the concepts of heterosexism and cissexism[3] which, analogous to other -isms, seek to capture the *structural* dimensions of hatred against

sexual and gender variance. However, as Don Kulick cautions, '[a] problem with terms like *sexism* and *racism* (or the alternative often proposed for *homophobia, heterosexism*) is that while they do indeed lead us to pay attention to social structure, they background an exploration of the emotional investment that people come to have in those structures' (2009:25).

How is it possible then to capture the social production of hatred in relation to local regimes of difference without losing sight of the deeply affective layering involved in such processes? Rather than focusing on blatant forms of anti-homosexual or anti-trans discourses and behaviours, we argue in this article for the importance of considering apparently subtler and more mundane forms of *institutionalised normativities*. To this end, we investigate a gender identity clinic in Brazil in order to unearth a set of unsaid but pervasive norms that regulate patient/doctor interactions as well as enable, legitimate and even incite emotional investments around specific bodies in the Brazilian trans-specific healthcare environment. Such investments are not only limited to emotions directed *against* sexually and gender diverse individuals, but also encompass the affective loading mobilised in support and in defence of them.

At this junction, it is important to clarify that just as heteronormativity can be defined as 'those structures, institutions, relations and actions that promote and produce heterosexuality as natural, self-evident, desirable, privileged and necessary' (Cameron and Kulick 2003:55), so is cisnormativity 'a series of sociocultural and institutional forces that discursively produce cisgender as "natural"' (Vergueiro 2015:68). According to transfeminist activist Viviane Vergueiro (2015), this, in turn, is supported by three ideological dimensions of cisgender 'naturalness': its *pre-discursivity* – the belief that sex is a biological fact; its *binarity* – the idea that 'normal' bodies have only two alternatives for gender identification: penis/man, vagina/woman; and its *durability* – the ideology according to which gender identification is consistent and unshakable throughout one's life (see also Brubaker 2016).

Against this backdrop, the aim of this article is to unveil how cisnormativity is institutionalised in a Brazilian gender clinic and creates an emotionally charged local regime of doctor/patient interactions. Our interest is twofold: first we want to illustrate how the clinic's *institutionalised normativities* about transbodies are the result of the crystallisation of particular transnational medical discourses entextualised in the *Diagnostic and Statistical Manual of Mental Disorders* (henceforth DSM) published by the American Psychiatric Association (APA); and second, we want to show how such a normative framework creates specific conditions for trans people's acts of resistance in the clinic. In order to capture this bifocal

perspective on the discursive creation of norms, and resistance to them, we draw upon three important but somewhat neglected perspectives in sociolinguistic and discourse analytical research, which may bring some fresh air to the study of language and discrimination more broadly, namely Hannah Arendt's (1994) reflections on the 'banality of evil', Michel de Certeau's (1984) ideas about the no less banal ways in which social actors speak back to power via a plethora of 'tactics of resistance', and transfeminism's critique of language and the banalisation of hegemonic systems of oppression.

Although the study of transgender and language has been of interest to sociolinguists (Besnier 2003; Hall and O'Donovan 1996; Kulick 1998), trans people's voices have largely been silent in the epistemological canon of the field (see, however, Edelman 2014; Edelman and Zimman 2014; Zimman 2009, 2014). We believe that the epistemological and political disruptions transfeminists such as Koyama (2003), Enke (2012), Vergueiro (2015) and Gomes de Jesus (2012) bring to current understandings of the relations between gender, language and power structures cannot be overlooked if language and gender scholars want to produce politically engaged knowledge that questions processes of normalisation, exclusion and hierarchisation.

This analytical apparatus will allow us to deconstruct two textual sets: (1) some sections of the DSM, and (2) excerpts taken from a thirteen-month period of ethnographic fieldwork conducted by the first author of this article in 2009–2010 at the *Programa de Atenção Integral à Saúde Transexual* (PAIST), which offers free-of-charge comprehensive healthcare for trans people. From this corpus of data, which comprises 75 consultations with the professionals of the clinic – a psychiatrist, a psychologist and a urologist – we have chosen here a series of interactions between the trans woman Estela and two physicians – the psychiatrist Fernando and the urologist Carlos. According to the Brazilian documents that regulate trans-specific healthcare in the public health system, it is the psychiatrist's duty to diagnose whether clients of the clinic fit the criteria for Gender Identity Disorder (GID) established by the DSM (see also Borba 2015, 2016, 2017). Such a diagnosis is required by the Ministry of Health and by the Federal Board of Medicine in order for hormone therapy and sex reassignment surgeries to be subsidised by the state. In light of this, the interactions between Estela and Fernando have been chosen because they encapsulate most clearly the ways in which psychiatry's 'therapeutic and disciplining power' (Foucault 2006:451) tries to pathologise non-conforming genders according to cisgender aesthetic and moral norms,

and, in doing so, simultaneously provides trans people with the discursive resources with which to resist their own pathologisation.

Before delving into a detailed deconstruction of relevant excerpts, however, we first want to briefly present the theoretical scaffolding that informs the analysis, followed by a discussion of transnational medical discourses and their impact on the processes leading to sex reassignment in the Brazilian context.

The banality of evil – mundane acts of resistance

In a famous report on the trial of the Nazi official Adolph Eichmann and his responsibility in the Jewish *shoah*, Hannah Arendt (1994) provocatively concluded that there was nothing monstrous or exceptional in Eichmann's behaviour – he was instead 'terrifyingly normal' (Arendt 1994:276) and 'what he fervently believed in was success, the chief standard of "good society"' (Arendt 1994:126). While many detractors read these views on what Arendt powerfully called the 'banality of evil' as potentially excusing Eichmann or downplaying his responsibility for his actions, others have highlighted how Arendt is making a much subtler point: that the pursuit of evil actions is not 'the product of some deep, inner or innate impulse. Rather, evil [has] become *institutionalized*, *depersonalized* and *mundane*' (Swift 2009:132, emphasis added). And it is this banality that is most dangerous, because it can have a tremendous social impact without people immediately recognising it. Arendt cogently writes:

> It is indeed my opinion now that evil is never 'radical', that it is only extreme, and that it possesses neither depth nor any demonic dimension. It can overgrow and lay waste the whole world precisely because it spreads like a fungus on the surface. It is 'thought-defying', as I said, because thought tries to reach some depth, to go to the roots, and the moment it concerns itself with evil, it is frustrated because there is nothing. That is its 'banality'. (Arendt 1994:471)

Of course, we are aware that Arendt's theorisation of the 'banality of evil' emerges from an attempt to understand, and put words to, the attempted extermination of the Jews by the Nazis. Proposing analogies to cisnormativity may be seen as problematic.[4] Nevertheless, the depersonalisation of evil described by Arendt, together with the clear focus on the mundane aspect of its implementation, resonate well with our interest in the capillarity of cisnormativity, and its production of emotional investments around specific bodies. As we will show in more detail in the next section, the DSM's pathologised understanding of transsexuality has itself 'spread like a fungus' – to use Arendt's words – that curtails trans people's wellbeing

across a variety of contexts outside the USA, including Brazil. And, like Arendt, we do not mean to downplay psychiatrists' responsibility for harm done to transbodies; what we do, however, want to highlight is how the psychiatrist's comments in the gender clinic under investigation here are not expressions of individual evil, but instead the manifestation of what Arendt would call a 'crystallised structure' (Arendt 1958) of medical discourses that prevent doctors from 'think[ing] from the standpoint of somebody else' (Arendt 1994:49). How does this 'crystallised structure' work discursively? And how can it be countered?

It is at this juncture that Arendt's reflections on the banality of evil can be productively brought into dialogue with de Certeau's (1984) distinction between *strategy* and *tactics* as discursive moves through which a structure not only becomes crystallised, but also can be subverted. As de Certeau (1984:xix) forcefully puts it,

> I call a 'strategy' the calculus of force-relationships which becomes possible when a subject of will and power (a proprietor, an enterprise, a city, a scientific institution) can be isolated from an 'environment'. A strategy assumes a place that can be circumscribed as proper (*propre*) and thus serve as the basis for generating relations with an exterior distinct from it (competitors, adversaries, 'clienteles', 'targets', or 'objects' of research). Political, economic, and scientific rationality has been constructed on this strategic model.

Crystallised structures then emerge from the solidification of strategies linked to hegemonic power – not only intimidation of the weak by the strong but also medical discourses' allegedly rational taxonomies of what should be felt and experienced in order to count as 'authentically' transgender. We will illustrate in our analysis that medical discourses act on transbodies, subjectivities and lives by establishing hierarchies of authenticity and intelligibility that are based on *cis*gender norms.

Still, as Foucault famously said, 'where there is power, there is resistance' (Foucault 2003:91). Or, as de Certeau would likely rephrase it, where there is a strategy, there are tactics. When powerful institutions such as 'the clinic' and medical discourses more broadly attempt to appease 'a world bewitched by the invisible powers of the Other' (de Certeau 1984:36), individuals develop forms of moral and political resistance. While a strategy is the weapon of hegemonic power, a tactic is its nemesis; it is a 'maneuver within the "enemy's field of vision" […] within the enemy territory […] it operates in isolated actions, blow by blow. It takes advantage of opportunities and depends on them' (de Certeau 1984:37). Tactics, thus, sneak furtively into the enemy's plans, carrying the potential to challenge the hegemonic strategy and twist it to one's own benefit.

To sum up, cisnormativity might indeed be a crystallised structure curtailing bodies that do not easily fit in the gender binary, but every norm provides individuals with the tools for its own contestation, and every strategy of domination contains in itself the basis for the tactics that challenge it. This slippery interplay between cisnormative strategy as a crystallised structure on the one hand, and grassroots tactics of resistance on the other, is what this article seeks to illustrate.

Crystallised structures of cisnormativity in trans-specific healthcare

According to Koyama (2003:245), the principles that guide transfeminist thought and action are the following:

> First, it is our belief that each individual has the right to define her or his own identity and to expect society to respect it. This also includes the right to express our gender without fear of discrimination or violence. Second, we hold that we have the sole right to make decisions regarding our own bodies, and that no political, medical or religious authority shall violate the integrity of our bodies against our will or impede our decisions regarding what we do with them.

As Koyama makes clear, transfeminism demands trans people be given the right to speak about themselves in their own terms – a linguistic politics of autonomy. Language, therefore, is central to the development of tactics that challenge cisnormativity. Serano (2007) explains that discourses about transsexuality have historically contained language and concepts coined by physicians and researchers who treated trans people as lab rats, and established their authority to name trans experiences as pathological (see also Stone 1992). In this scenario, cispeople's experiences have been constructed as pre-discursive, natural and normal, thus avoiding detailed scrutiny (Vergueiro 2015). In this section, we offer a transfeminist critique of the language used in the documents that regulate trans-specific healthcare in Brazil. This analysis aims to investigate how language helps to crystallise structures of cisnormativity that eclipse trans people's voices in decisions about their bodies and health.

In Brazilian trans-specific healthcare settings, sex reassignment surgeries and hormone therapy may be subsidised by the state once clients of the few gender clinics available in the country are diagnosed as suffering from Gender Identity Disorder (GID). The diagnosis is spelled out in the many documents from the Ministry of Health and the Federal Board of Medicine, which quote the assessment criteria detailed by the World Health Organization in its *International Code of Diseases and Related*

Health Problems (ICD), and by the American Psychiatric Association (APA) in its *Diagnostic and Statistical Manual of Mental Disorders* (DSM). In the ICD-10, 'transsexualism' is viewed as a personality disorder of adult behaviour, while the DSM-IV lists it in the chapter on sexual identity disorders. Traces of these medical positions can be found in the Brazilian regulations for trans-specific healthcare practices, e.g. the Ministry of Health Ordinance 2.803/2013, and the Federal Board of Medicine Resolutions 1.652/2002 and 1.955/2010, which holds that 'the transsexual patient has a permanent identity disorder and tends to reject his phenotype and to self-mutilate and/or suicide' (Brasil 2010:110). These documents impose psychiatric treatment as mandatory for at least two years, during which a health professional must evaluate, against the criteria listed in the ICD and the DSM, if the client is indeed a 'true' transsexual.

The DSM establishes the diagnostic criteria for what it classifies as mental disorders. It includes descriptive and diagnostic elements as well as treatment procedures, and is therefore considered the 'Bible of psychiatry' (Bento 2006; Sarbin 1997). Its influence all over the world contributes to the circulation and crystallisation of specific medical epistemologies (Borba 2017; Briggs 2005). A new edition of this manual – the DSM-5 – was published in 2012; there, transsexuality was re-classified as gender dysphoria. In psychiatric jargon, dysphoria would be the antonym of euphoria, i.e. severe sadness that causes mental suffering. Although the DSM-5 is currently in use, we analyse in this article its previous edition – DSM-IV – because it was the reference text during the fieldwork period. Moreover, since the publication of the DSM-5 is relatively recent, it has not had a major impact on the Brazilian public health system. For example, the more recent ordinance 2.803 published by the Ministry of Health in 2013 did not incorporate the changes introduced in DSM-5 about gender dysphoria. Hence, the text of DSM-IV still plays a key role in the medical imaginary and in trans-specific healthcare practices in Brazil (and elsewhere).

The main objective of the DSM is to 'provide a helpful guide for clinical practice [by offering] brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria' (APA 1994:xv). In spite of the many criticisms about the lack of reliability of diagnostic criteria, and the paucity of attention given to issues of diagnostic validity, each new edition of the manual increases the number of observable behaviours worthy of psychiatric attention. The DSM-I, published in 1952, listed 106 diagnostic criteria. This figure increased to 182 in the second edition of the manual and grew over subsequent years, reaching a peak of 390 diagnostic categories in DSM-IV, which consequently decreased to 250 categories in DSM-5.

The fluctuation in the number of observable disorders listed in each edition itself testifies to the fact that the healthcare epistemologies encoded in DSM are a social product (Russo 2004), a result of negotiations and renegotiations among different committees of experts who strive to reach consensus about the diagnostic basis for each psychiatric condition they are creating. The many editions of the DSM are textual manifestations of a crystallised structure (Arendt 1958), consisting of strategies (de Certeau 1984) through which psychiatry legitimates its control of social life through the creation of scientific patterns and taxonomies of (ab)normality.

The manual indicates that there are two main elements in Gender Identity Disorder (henceforth GID) cases. Both must be present for the diagnosis of transsexuality to be valid:

> There must be evidence of a *strong and persistent cross-gender identification*, which is the desire to be, or the insistence that one is, of the other sex (Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). (APA 1994:532–3, our emphasis).

We can see here how cisnormativity – with its dyadic treatment of two genders – is taken as a measure for diagnostic assessment. In order to prove that there is 'strong and persistent cross-gender identification', as the DSM establishes, trans people must demonstrate the *durability* of their gender identity; anything that transcends such a dichotomous binary would irrevocably result in not being deemed to fit in the category 'transsexual'. During the fieldwork, it was not uncommon to hear trans clients at PAIST utter sentences such as 'I was born this way' or 'I found out I was a transsexual when I was three years old'. In Brazilian trans-specific healthcare, gender durability is used as a measure to evaluate the legitimacy and authenticity of trans people's gender identity. However, as transfeminist and queer activists have demonstrated, gender exceeds any dichotomy. With their radical criticism of the man/woman binary, transfeminists argue that gender refers to someone's psychosocial identification with masculinity, femininity or both (Enke 2012; Gomes de Jesus and Alves 2010). There are, thus, a plethora of gendered possibilities. For example, in 2016 the City of New York started to recognise thirty-one different genders. This decision legitimates one of transfeminism's central demands, namely, respecting people's gender self-identification (Gomes de Jesus 2015; Koyama 2003). Conversely, the DSM and psychiatry seem not to recognise that social life exceeds 'scientific' attempts to homogenise and stabilise gender.

After defining the basic diagnostic criteria for GID, the DSM-IV goes on to discuss elements of the 'disorder' in each stage of life from infancy to adulthood. In boys, for example, GID may be identified when

> […] the cross-gender identification is manifested by a marked preoccupation with *traditionally feminine activities*. They may have a *preference for dressing in girls' or women's clothes or may improvise such items from available materials* when genuine articles are unavailable. […] There is a strong attraction for the *stereotypical games and pastimes of girls*. They particularly enjoy *playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. Stereotypical female-type dolls, such as Barbie*, are often their favorite toys […] They *avoid rough-and-tumble play and competitive sports* and have little interest in cars and trucks or other nonaggressive but stereotypical boy's toys (APA 1994:533, our emphasis).

In turn, girls with GID

> […] display intense *negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire*. […] They prefer *boy's clothing and short hair*, are often misidentified by strangers as boys […] Their fantasy heroes are most often *powerful male figures*, such as Batman or Superman. These girls prefer boys as playmates, with whom they share *interests in contact sports, rough-and-tumble play, and traditional boyhood games*. They show *little interest in dolls or any form of feminine dress up or role-play activity*. A girl with this disorder may occasionally *refuse to urinate in a sitting position* (APA 1994:533, our emphasis).

In the DSM, childhood plays a significant role for diagnosing GID in adults. In the clinical practice, these criteria take discursive shape in the frequent questions health professionals ask about the moment when the clients first felt different from the others around them. In this scenario, the DSM-IV has a retroactive performative force (Hacking 2007): it causes childhood to be read post hoc in the terms of the disorder. During the fieldwork, it was common to hear trans people tell their doctors that they had felt out of place since very early on in their lives. Gregory told his doctor that when he was two years of age he tried to remove the earrings his mother tried to make him wear. The psychiatrist sarcastically complimented his memory; after all, 'virtually no one can remember details of facts that happened when one was two years old'. Gregory replied that he did not remember this fact himself, but his mother told him this story, which, according to him, confirms his authenticity as a 'true transsexual'.

We saw earlier that binarity is an important component of cisnormativity (Vergueiro 2015). Here, the use of opposing pairs of activities and bodily practices not only describes the 'disorder' but, most importantly, also performatively juxtaposes two separate sets of gendered ideals which are not

so clear-cut in social life. Research has demonstrated that even highly conventionally gendered children cross-gender (Eckert and McConnell-Ginet 2003). Boys may play with Barbie dolls and have long hair, girls may have short hair and their recreational activities may involve cars and trucks. The DSM thus gives scientific support to gendered idealisations that hardly exist outside the doctor's office.

After giving centrality to childhood for the GID diagnosis, the DSM-IV goes on to performatively produce gender variance as a psychiatric problem in adulthood:

> Adults with Gender Identity Disorder are preoccupied with their *wish to live as a member of the other sex*. This preoccupation may be manifested as an intense desire to *adopt the social role of the other sex* or to *acquire the physical appearance of the other sex* through hormonal or surgical manipulation. Adults with this *disorder are uncomfortable being regarded by others as, or functioning in society as, a member of their designated sex*. To varying degrees, they *adopt the behavior, dress, and mannerisms of the other sex*. […] The sexual activity of these individuals with same-sex partners is generally constrained by the preference that their partners neither see nor touch their genitals (APA 1994:533, our emphasis).

Once again strict binarity seems to be the main principle on which to determine who counts as a transsexual. The DSM-IV makes its diagnostic premises explicit in its text: if an individual has a penis, he must engage with stereotypically masculine activities; if an individual has a vagina, her interests must be conventionally feminine. Any detour from this route, which is established by one's genitals, must be seen as a symptom of the disorder (Bento 2006; Borba 2015). In this sense, the DSM takes as a diagnostic assumption another element of cisnormativity, namely its prediscursivity, i.e. 'the sociocultural understanding […] that it is possible to define sex and gender […] based on certain body parts and certain bodily characteristics' (Vergueiro 2015:63; see also Koyama 2003; Stone 1992). Transfeminist scholarship and activism demonstrates that viewing gender as pre-discursive obscures the intense discursive work that is involved in the construction of what is legitimately regarded as sex and gender.[5]

The GID description in the DSM-IV also includes a section entitled 'Associated Features and Disorders' in which it is stated that:

> Many individuals with Gender Identity Disorder *become socially isolated. Isolation and ostracism contribute to low self-esteem and may lead to school aversion or dropping out of school.* […] *The disturbance can be so pervasive that the mental lives of some individuals revolve only around those activities that lessen gender distress*. They are often preoccupied with appearance, especially early in the transition to living in the opposite sex role. *Relationships with one*

> *or both parents also may be seriously impaired.* […] Especially in urban centers, some males with the disorder *may engage in prostitution*, which places them at high risk for human immunodeficiency virus (HIV) infection. *Suicide attempts and Substance-Related Disorders are commonly associated* (APA 1994:534–5 our emphasis).

In the DSM-IV, any problems related with trans people's social lives are explained *as a result of* their 'disorder'. Observe in particular how the relational verb 'become' in the first sentence of the extract above conveys that trans people themselves are actually responsible for their own 'isolation'. In this way, the responsibility is shifted away from society while transphobia and cisnormativity are erased. In the DSM, it is the 'disorder' that makes trans people suffer, not the societal oppositions they face on a daily basis. What is also not said is that social isolation may not necessarily be a choice, but a necessity. Since trans people's bodies question hegemonic discourses about gender, they are constantly subject to prejudice and violence (physical or otherwise), and isolating oneself might be the only available tactic of survival. However, the tactics that trans people carefully design are considered by the DSM as the result of the 'disorder' and not the product of social forces. For the DSM, these tactics are motivated by the fact that the 'disturbance [is] so pervasive that the mental lives of some individuals revolve only around those activities that lessen gender distress' (APA 1994:535) and not by necessities created in a society that grapples with gender variance. It is also this social context that can impair trans people's relationships with their parents, and lead them to engage in sex work and develop substance-related disorders. Instead, per the DSM-IV, trans people are expelled from home by their parents, are subject to physical violence, drop out of school and engage in commercial sex as a result of their 'disorder'.

Overall, the DSM creates a 'crystallised structure' in which cisgender norms of binarity, pre-discursivity and durability, as well as aesthetic judgements about childhood behaviour, underpin the diagnostic criteria for who counts as a 'true' transsexual. And, since power's most insidious trait is to disguise its own operations (Foucault 1980), cisnormativity conceals itself in the DSM by suggesting that trans people's psychic and social problems derive from their own 'disorder', rather than from the cisnormative social structure which fails to acknowledge any gender variance. Most crucially, the 'crystallised structure' of cisnormativity in the DSM shapes health professionals' 'field of vision' (de Certeau 1984:37) in making specific evaluations that have a real impact on trans people's lives.

The following section scrutinises the micro details of the mundane clinical gaze (Foucault 2001) by investigating how the PAIST's psychiatrist uses appearance attributions (Speer and Green 2007) in order to test clients'

gender authenticity. Most importantly, our analysis also focuses on how PAIST's clients manoeuvre within physicians' 'field of vision' (de Certeau 1984), and creatively design tactics of resistance to the institutionalised cisnormativity in this trans-specific healthcare setting. For such an analysis, we investigate the consultation Estela had with PAIST's psychiatrist Fernando and the one she had on the following day with Carlos, the clinic's urologist.

The banality of evil in (inter)action

When Estela had her meeting with Fernando on 30 March 2010 she wore clothes which in her view could be seen as unisex: baggy dark green jeans, a black large T-shirt and running shoes. She had not grown her hair long because she was afraid of bullying at school. Although Estela did not wear conventionally feminine clothes, her gestures and voice could be read as stereotypically feminine. The psychiatrist, however, seems to pay less attention to gesture and voice and focuses more on Estela's attire, which, in his view, are conventionally masculine.[6, 7]

Excerpt 1

285	Estela:	não::: o::: sabia sim, >pode falá< desculpa
286		(0.3)
287	Fernando:	Estela <você ta muito feminina demais viu>
288		>com essa aparência masculina< cria uma
289		situação difícil, as pessoas ficam meio
290		<espantadas com você>=
291	Estela:	=>muito feminina?<
292	Fernando:	ta >ta muito feminina< a sua gesticulação
293		[você ta-]
294	Estela:	[no::ssa] mas eu nunca tomei hormônio,
295	Fernando:	mas cê- não:: não é- não é na aparência
296		[física]
297	Estela:	[não sim,] entendi, entendi=
298	Fernando:	na gesticulação, >maneira de falá< (XXX) eu
299		posso até usá uma palavra vulgar >posso
300		usá?<=
301	Estela:	=po::de,
302	Fernando:	ta mu- cê ta muito <aviadado> demais,
303	Estela:	HHHh ° @[@@°]
304	Fernando:	[daí] as pessoas olham você::>acham
305		que vo[cê é viado<]
306	Estela:	[não:::: escu]ta=
307	Fernando:	=bi::cha, via::do ete[cetera né]

308	Estela:	[sim:: sim] sim=
309	Fernando:	=ta muito a- cheio de coisa assim, de
310		trejeitos, muito
311		(.)

285	Estela:	no::: o::: I knew it, >speak please< pardon
286		(0.3)
287	Fernando:	Estela <you look too feminine indeed, you see>
288		with >this masculine appearance< you create a
289		difficult situation, people will get
290		shocked at at you=
291	Estela:	=>too feminine?<
292	Fernando:	yes, >you're too feminine indeed<, your
293		gestures you[look re-]
294	Estela:	[wo::::w] but I've never taken hormones,
295	Fernando:	but you- no:: it's not- it's not your physical
296		appea[rance]
297	Estela:	[no- al]right, I see, I see=
298	Fernando:	=your gestures, >your way of talking< (XXX) I
299		can even use a vulgar word
300		>can I?<=
301	Estela:	=you ca:n,
302	Fernando:	you ar- you are very <faggish> indeed,
303	Estela:	HHHh ° @[@@°]
304	Fernando:	[s o] people look at you::: they >think
305		that you [are a fag<]
306	Estela:	[no:::: lis]ten=
307	Fernando:	=a mad queen, a queer etcetera [right]
308	Estela:	[ye::s yes] yes=
309	Fernando:	=you are real- you have these gestures like
310		like this, you're really
311		(.)

The psychiatrist's turn between lines 287 and 290 could be paraphrased as follows: you say you are a transsexual woman, but your masculine appearance is not evidence of a strong and persistent identification with the other sex. Crucially, this specific doctor's utterance is not idiosyncratic, but rather a manifestation of the depersonalised, institutionalised, and mundane nature of cisnormative evil – the 'crystallised structure' (Ahrendt 1958) of the DSM (see section above) and more specifically of criterion A, i.e. 'There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other

sex'. Interestingly, here, its sequential position seems to cause misunderstanding between the interlocutors. At first, Estela indicates she does not understand and requests further clarification (line 291).

This communicative misalignment emerges from the fact that Fernando's turn may be linked to diverging discourses. It may be understood as an 'appearance attribution' (Speer and Green 2007) or as 'criticism' (Pomerantz 1984). Speer and Green (2007) call 'appearance attributions' the comments physicians and/or trans clients make about their physical appearance and their ability to 'pass' as women or men. These attributions have a positive evaluative role in the interaction, and are typically made by trans people by using terms such as 'adorable' and 'pretty'. Less frequent are the attributions made by psychiatrists who, according to Speer and Green, only use them 'objectively' as a clinical observation about the client's self-presentation: 'You look like a man/woman'. In other words, a psychiatrist's appearance attribution testifies to the fact that the client meets the diagnostic protocols. In this context, as a preferred response, this kind of attribution requires a downgraded agreement with the medical assessment by the trans client. In contrast, as Pomerantz (1984) demonstrates, criticisms require a refusal as a preferred response, and an absence of reply, or acceptance, as dispreferred responses.

Since Estela does not know how to reply to Fernando's turn, she asks him to explain its aim at line 291. The psychiatrist retakes the floor and repeats what he just said in the previous turn. This repetition reinforces the diagnostic function of the psychiatrist, which is not ratified by Estela (line 291). However, Fernando's intonation changes in the course of his turn (line 292). Here, falling intonation in a lower tone of voice works as a contextualisation cue and indexes a transition relevance place. In line 294, in overlapping talk, Estela demonstrates her understanding of what Fernando previously said. The exclamation '[wo::::w] but I've never taken hormones' suggests that Estela understands the psychiatrist's turn as an appearance attribution which positively evaluates her gender performance. Having a feminine presentation without ever taking hormones would confirm that she naturally meets the diagnostic criteria without any chemical intervention. This would place her at the top of the authenticity hierarchy established by the DSM. In line 294, Estela then adopts a different discursive position from the one Fernando's turn projects. The self-compliment frame she orients to prevent the psychiatrist from delegitimising her identity as a transperson.

In this context, Fernando's crystallised strategy is not ratified by his interlocutor, and a new interactional frame would possibly emerge, one in which Estela would be in a positive position with regard to the DSM's

transsexual model. In the face of such a possibility, in line 295 Fernando disqualifies Estela's understanding of what is happening in this interaction. The first half of the turn seems to indicate that he would hold on to his diagnostic function as he uses the discursive marker 'but' as a liaison to what he said in the turn in lines 292–3, when he was interrupted by Estela. Nevertheless, the psychiatrist aborts the repetition, and explains the function of his turn – 'it's not your physical appea[rance]' – and thus makes his diagnostic strategy clear. Estela, then, understands what Fernando had been trying to do all along: he criticises her gender performance on the basis of her self-presentation, which does not meet the DSM's standards for GID. In line 297, Estela finally ratifies Fernando's diagnostic position ('al]right, I see, I see'), consolidating his function as a judge of her gender identity.

Having secured the diagnostic/evaluative frame he had been trying to establish since his turn at lines 287–9, Fernando repeats his criticism for the third time and asks Estela if she would allow him to evaluate her with an expletive (line 299). Through this request, the psychiatrist is aware of, and thereby pre-empts, the problematic discourse he is about to invoke. In a situation of unequal power relations like doctor/patient interactions (Wodak 1996), Estela would not dare counter Fernando's request (line 301). In line 302, the psychiatrist criticises Estela's gender performance. This criticism is shaped as an 'extreme case formulation' (Pomerantz 1986). In this kind of turn, an interactant qualifies their interlocutor's actions/attributes in such an exaggerated form that it may be heard as untrue.

In his criticism, the doctor not only uses a category that delegitimises Estela's performance as a trans woman (i.e. 'faggy') by positioning her as a feminine homosexual man, but also qualifies this adjective in an extreme form by using the intensifiers 'very' (*muito*) and 'indeed' (*demais*).[8] Interestingly, this turn structure has already been used at lines 287 and 292 in the psychiatrist's negative evaluations of Estela's performance as 'too feminine indeed'. The indexical links that the category 'fag' brings to this consultation have interactional and identity effects. On the interactional level, this category will be frequently repeated by the psychiatrist in interactional frames he designs in order to diagnose Estela's GID, evaluate her appearance, and verify her commitment to undergo sex reassignment surgeries. In such frames, the category 'fag' is used as a challenge to the client's gender self-identification and her seriousness about the transition.

In his repeated refusals to accept Estela's identification as a transperson, Fernando uses the cisnormative crytallised structure established by the DSM as diagnostic criteria which obviously have interactive and intersubjective outcomes. On the identity level, the evaluative category 'fag'

disqualifies Estela's performance as a transsexual woman because it performatively excludes her from the DSM's diagnostic standards for GID and prevents her from receiving the document the Brazilian Ministry of Health requires to subsidise the surgeries. Moreover, Fernando's turn in line 302 entangles homophobia/heterosexism and transphobia/cisnormativity in one single action. For the psychiatrist, the overlap of 'mannerisms' he sees as 'too feminine indeed' with bodily forms and conventionally masculine clothes is not a 'symptom' of a mental disorder. As he himself explains later in this consultation, such an overlap points to other identity models (i.e. homosexuality) which are not legitimated by the Federal Board of Medicine, and which prevent healthcare from being provided by the state. The usage of locally meaningful and highly emotionally charged words such as the qualifier 'faggy' (*aveadado*), and the nouns 'mad queen' (*bicha*) and 'queer' (*viado*) are linguistic traces of the ways in which the DSM is re-entextualised locally, creating difficult emotional investments for Estela. If by 'evil' we mean anything that goes against a person's wellbeing, then we can see here one of its most mundane and institutionalised manifestations: the way in which the 'crystallised' DSM structures the doctor's framing of a gender and sexuality identity model – homosexual man – with which a transperson does not identify, disrespecting her self-identification as a heterosexual trans woman and ultimately deeming her unsuited to undergo sex reassignment.

Tactics of resistance

The interaction above illustrates how the psychiatrist and his client locally negotiate intersubjective relations within the evaluative and diagnostic position imposed by the DSM and by the Brazilian documents that regulate trans-specific healthcare. However, with regard to the subjective and practical effects produced by the legal requirement of the GID diagnosis, the consultation Estela had on the following day (31 March) with one of PAIST's urologists is revealing. As we will argue, in her interaction with Carlos, Estela's actions give us ways to understand some tactics of resistance trans people at PAIST design to navigate the crystallised cisnormative structure that (in)forms and is in turn (in)formed by the physicians' clinical gaze.

On 31 March, although Estela wore the same pair of baggy dark green jeans she had during her consultation with Fernando, her bodily presentation had undergone some changes. She wore a tight pink blouse over which she wore a large flowery scarf; she had also put on make-up. Fernando's injurious comments the day before may not have annihilated Estela's social

existence, but they clearly had material effects on her body (see excerpt 2 below). However, as we will see in the analysis that follows, we should not understand such an aesthetic change in Estela's gender performance as a simple and straightforward acceptance of Fernando's diagnostic strategies. As de Certeau (1984) argues, tactics are not easily discernible to the naked eye. They work in more insidious ways by manipulating 'commonplaces and the inevitability of events in such a way as to make them habitable' (de Certeau 1984:xxii). In other words, if Fernando's diagnostic strategies are like sedimented crystals of the cisnormative structure that regulates trans-specific healthcare practices in Brazil, Estela's tactics manoeuvre within this regulatory framework, twist it to her advantage, and make it possible for her to use cisnormativity to her own benefit. Excerpt 2 below shows part of her consultation with Carlos during which Estela refers back to the meeting she had with the psychiatrist on the day before.

Excerpt 2

179	Carlos:	=se tivé outra consulta em outra área alguma
180		[outra co]isa, fora- fora aqui né=
181	Estela:	[não: não] =não↓ se
182		precisá eu faço outro, pode ficá:: HHhh
183	Carlos:	°ta bom°
184		(7.9)
185	Estela:	não então daí::- é:: >acho que eu falei até
186		lembro que o doutor Fernando não gostô<
187		eu só quero começá- é:: eu só vô me senti
188		se↑gura de me ves↑ti é::: de menina é: quan-
189		é:: <quando> começá a to- >começá a tomá os
190		hormônios< pra::: [>não chamá muita atenção=
191	Carlos:	[então olha quanta coisa=
192	Estela:	=não ficá muito-<]
193	Carlos:	=p o d e a con te]cê em seis meses=
194	Estela:	=é:::↓ >pra não ficá ambíguo<=
195	Carlos:	=é uai,
196		(9.2)
197	Estela:	você vai me falá como que eu devo tomá o
198		hormô::nio? de quanto em quanto tempo?=
199	Carlos:	=vô te ensiná aqui

179	Carlos:	=if you have another consultation in another
180		area, [other thi]ng, out outside here=
181	Estela:	[n o: n o] =no. If

182		I need it I'll make another, you kee::p it HHhh
183	Carlos:	°OK°
184		(7.9)
185	Estela:	no. So the::n- a:: >I think I told you that
186		I remember Doctor Fernando didn't like it<
187		I only want to start- a:: I will only feel
188		safe to dress a::: as a girl a:: whe-
189		a:: <when> I start a to- >start to take the
190		hormones< no:::t [>not to call much attention=
191	Carlos:	[so look how many things=
192	Estela:	=not to look very-<]
193	Carlos:	=c a n h a p p e n] in six months=
194	Estela:	=a:::, >not to look ambiguous<=
195	Carlos:	=of course
196		(9.2)
197	Estela:	will you tell me how I should take the
198		hormo::ne? how often?=
199	Carlos:	=I'll explain here

This excerpt is taken from the moment in the consultation when Carlos is writing the prescription for the hormones Estela should use. Carlos and Estela are talking about the blood tests she took for the consultation (lines 179–83), and Carlos tells her it is advisable for her to leave the results of the tests at the PAIST for them to be included in her medical records. He says this is not mandatory; she may take the results back home in case she needs them for another consultation. Estela replies that she will leave the results with Carlos because if necessary she could have other tests conducted. While the physician writes the prescription (in the time lapse of 7.9 seconds), Estela comments about the fact that Fernando does not agree with her decision to only start dressing 'as a girl' after the hormones have had visible effects (lines 185–9). She tactically, however, does not call Carlos' attention to the conventionally feminine items of clothes she is wearing in the consultation with him, during which her hormone therapy is to be prescribed. As we can see, the doctor does not orient to her comment about Fernando, nor even to her new sartorial aesthetic. Nevertheless, before handing Estela the prescription, Carlos leaves the room to consult with the PAIST's coordinator in his office. While Carlos was away, Estela talked to the first author of this article about the meeting she had with the psychiatrist the day before.

Excerpt 3

215	Carlos:	só vô confirmá aqui quanto é que- que ele
216		vai- >a gente vai fazê do gel ta?<=

217	Estela:	=oquei
218	Carlos:	°°(só um minutinho)°°
219		(9.1)
220	Estela:	°to bem menos ansiosa que ontem ta vendo?°
221	Rodrigo:	@@[@@@@@]
222	Estela:	[é que]ontem o doutor Fernando [me-]
223	Rodrigo:	[ele] tava
224		inspirado ontem=
225	Estela:	=po(h)i(h)s é(h)::(h)=
226	Rodrigo:	=cê tá bonita Estela, >curti do lenço<
227	Estela:	a::(hh)i: obrigada:: tava em dúvida se- se
228		usava esse. acho muito colorido >cê acha que
229		combi[na?<]
230	Rodrigo:	[cla::]::ro
231		(0.7)
232	Rodrigo:	.hh pensei que tu ia- tinha receio de sair
233		mais assim femini[n a >n a r u a<]
234	Estela:	[po(h)i(hh)s é::]:(h): °eu
235		tenho muito°
236		(2.5)
237	Estela:	mas só entre a gente tá, >>por favor não diz
238		nada tá<<, eu me ma(hh)quie(h)i a(h)qui no
239		banhe(h)[iro]
240	Rodrigo:	[@@@@]@@=
241	Estela:	=@@@@ de(h)po(h)is de ontem >não queria
242		corrê ris[co né<]
243	Rodrigo:	[@@@ ta] cer(hh)ta=
244	Estela:	=°°shi::::, não fala na[da°°]
245	Rodrigo:	[f i]ca tranquila.
246		(0.8) ((Carlos retorna à sala))
247	Carlos:	pronto, já resolvi >é esse remédio<=
248	Estela:	=ã?
249		(0.3)
250	Carlos:	um é comprimido e o outro é gel
251	Estela:	uhum=

215	Carlos:	I'll go check how much is it that- that he
216		will- >we'll prescribe of the gel, OK?<
217	Estela:	=alright
218	Carlos:	°°(just a moment)°°
219		(9.1)
220	Estela:	°I'm less anxious than yesterday, you see?°

221	Rodrigo:	@@[@@@@@]
222	Estela:	[the thi]ng is that yesterday doctor Fernando [me-]
223	Rodrigo:	[he]
224		was inspired yesterday=
225	Estela:	=I co(h)ul(h)d te(h)ll=
226	Rodrigo:	=you look pretty Estela, >I like the scarf<
227	Estela:	a:(h):: thank you:: I was in doubt if- if I
228		wore this. I think it's too colorful >do you
229		think it suits [me?<]
230	Rodrigo:	[o::b]vi::oously
231		(0.7)
232	Rodrigo:	.hh I thought you we- were afraid of going out in
233		feminine cloth [es >in public<]
234	Estela:	[s (h) o (h) ::] I am, °very much so
235		actually°
236		(2.5)
237	Estela:	but only between us right? >>please don't tell
238		anyone right?<<, I put on ma(h)ke(h)up here in
239		the ba(h)thro[(h)om]
240	Rodrigo:	[@@@@]@@=
241	Estela:	=@@@@ af(h)te(h)r the consultation yesterday > I didn't
242		want to run risks [right<]
243	Rodrigo:	[@@ yo]u di(h)d well=
244	Estela:	=°°shoo::::, don't say a [word°°]
245	Rodrigo:	[don't] you worry.
246		(0.8) ((Carlos returns))
247	Carlos:	alright, I solved the issue. >this is the medicine<=
248	Estela:	=pardon?
249		(0.3)
250	Carlos:	one of them is a pill, the other is gel
251	Estela:	uhum=

Notwithstanding the fact that Carlos does not orient to Estela's new bodily aesthetics, her (temporary) use of indices of femininity in this consultation emerges as a tactic of resistance against the transsexual model that guided Fernando's criticisms the day before. Since Estela did not leave her home wearing the clothes and make-up she wore at Carlos' office, she clearly did not follow Fernando's advice. In this context, the change in self-presentation she made in the restroom presents itself as one of the tactics she uses to manoeuvre within the demands of the GID diagnosis in the DSM's terms. In fact, Estela had stuck to her decision to only wear conventionally feminine clothes *after* the bodily changes that would result from the

hormone therapy course Carlos prescribed her on 31 March, in order not to look ambiguous, as she repeatedly told Fernando.

The fact that Estela changed clothes in the restroom of the hospital, within the doctors' 'field of vision', indicates that the emotionally charged remarks Fernando made the day before did in fact have material effects on her body and subjectivity. One might be tempted to interpret this style change as the direct result of the diagnosis, and as an example of Estela's compliance with the institutionalised cisnormativity found in Brazilian trans-specific healthcare. Nevertheless, to paraphrase Frantz Fanon, the cis-mask with which Estela adorned her trans-skin is actually an instance of the tactics of simulation that PAIST's trans clients use. Such a simulation tactically emulates the authenticity model produced by the DSM and challenges it from within itself. When Rodrigo met Estela at the bus stop moments after her meeting with Carlos, she had erased any traces of the cis-aesthetics she had carefully designed in the restroom before entering the doctor's office.

Conclusion

In this article, we have illustrated how the transnational medical discourses entextualised in the DSM operate as a 'crystallised structure' of evil (Ahrendt 1958) in which cisgender norms of binarity, pre-discursivity and durability are taken as the diagnostic benchmark of 'true' transsexuality. This crystallised structure, in turn, takes locally meaningful discursive shapes, framing health professionals' 'field of vision' (de Certeau 1984) and guiding them to make specific evaluations that have a real impact on trans people's lives. Trans people who most clearly stylise their bodies and subjectivities according to cisgender aesthetics are seen as more legitimately trans than those whose bodily presentation does not appropriate such cisgender discourses. Thus, as a *strategy* in de Certeau's usage of the term, cisnormative medical discourse delegitimises and misrecognises trans people's various gender identifications and embodiments. As such, evil manifests itself in its most subtle forms – not as directly harming one's existence, but as an institutionalised and mundane form of discriminatory misrecognition. Yet, as Estela's case makes clear, trans people may manipulate the terms of the diagnosis and thus tactically play with the DSM's own traps. In this matrix of truths and lies, we see that although 'the terms by which we are hailed are rarely the ones we choose […] these terms we may never really choose are the occasion for something we might still call agency, the repetition of an originary subordination for another purpose, one whose future is partially open' (Butler 1997:38). In contexts of crystallised cisnormativity

such as Brazilian trans-specific healthcare, simulation thus emerges as a tactic of resistance with which clients may contest oppressive discourses and practices and reinvent the terms that hail them.

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Appendix: transcription conventions

Symbol	Function
.	falling intonation
?	rising intonation
,	continuing intonation
::::	sound elongation
-	abrupt stop
talk=	
=talk	latched talk
talk	emphasis
TALK	louder volume
°talk°	lower volume
>talk<	faster speed at talk
<talk>	slower speed at talk
ta[lk]	
[ta]lk	overlapping talk
.hhhhh	in-breath
hhhh	out-breath
ta(hhh)lk(hh)	smiley talk
@@@@@@	laughing
(3.5)	silence in seconds
XXXXXX	inaudible talk
(talk)	uncertain transcription
((comments))	transcription comments.

Adapted from Jefferson (2004).

Notes

1 The Transrespect vs. Transphobia Worldwide report is available at http://transrespect.org/wp-content/uploads/2015/08/TvT_research-report.pdf (accessed on 23 February 2017).

2 The Trans Muder Monitoring map is available at http://transrespect.org/wp-content/uploads/2015/08/TvT_research-report.pdf (accessed on 23 February 2017).

3 The English term 'cisgender' was first used in 1994 in an online forum by the biologist Dana Leland Defosse, who coined the term on the basis of the usage of the prefix 'cis-' in molecular biology to describe processes in which organic substituents or groups are oriented towards the same direction (see also Enke 2012, 2013). In transfeminist thought and practice, when the prefix 'cis-' modifies the noun gender, it 'refers to people who identify with the gender that was assigned at birth' (Gomes de Jesus 2012:14).

4 However, due to their frequency and ferocity, Gomes de Jesus (2013) classifies transmurders in Brazil as a kind of genocide. Bento (2016) prefers the term 'transfemicide'.

5 According to biologist Anne Fausto-Sterling (2000), neither chromosomic nor genital sex is obviously binary. There are individuals who are born with anatomic variations that are not clearly a penis or a vagina. The Intersex Society of America estimates that one in every 2,000 babies is born with morphological variations. Chromosomes are also not simply XX or XY. There are multiple possibilities such as XXY, XYY, XO and XXX, among others. In other words, not even on the biological level can individuals be easily divided into binary pairs (see King 2016). Such a division and its naturalisation demand much discursive investment into people's bodies and subjectivities.

6 Transcription conventions can be found in the appendix.

7 The research was approved by the hospital's Ethics Committee. All participants who agreed to participate in the study signed an informed consent document. Estela, however, only allowed the use of her recordings and their transcriptions for publication after her reassignment surgery, which was performed in the first semester of 2016.

8 Fernando's turn is difficult to translate into English. In Brazilian Portuguese, he uses the adjective *aveadado* (roughly translated as 'effeminate' or 'faggy') and the intensifiers *muito* ('very') and *demais* ('too much'), which are respectively pre- and post-positioned in relation to the qualifier, i.e. *muito aveadado demais*.

References

American Psychiatric Association (1994) *Statistical and Diagnostic Manual of Mental Disorders* (4th edn). Washington DC: APA.

Arendt, H. (1958) Totalitarianism. The Meridian 2(2), reprinted in H. Arendt (2004) *The Origins of Totalitarianism*. New York: Schocken Books.

Arendt, H. (1994) *Eichmann in Jerusalem: A Report on the Banality of Evil*. Harmondsworth: Penguin.

Bento, B. (2006) *A Invenção do Corpo: Sexualidade e Gênero na Experiência Transexual*. Rio de Janeiro: Garamond.

Bento, B. (2016) Transfeminicídio: violência de gênero e o gênero da violência. In L.

Colling (ed.) *Dissidências sexuais e de gênero* 43–67. Salvador: EdUFBA.
Besnier, N. (2003) Crossing gender, mixing languages: the linguistic construction of transgenderism in Tonga. In J. Holmes and M. Meyerhoff (eds) *The Handbook of Language and Gender* 279–301. Oxford: Wiley Blackwell. https://doi.org/10.1002/9780470756942.ch12
Borba, R. (2015) How an individual becomes a subject: discourse, interaction and subjectification at a Brazilian gender identity clinic. *Working Papers in Urban Languages and Literacies*. King's College London.
Borba, R. (2016) *O (des)aprendizado de si: transexualidades, interação e cuidado em saúde.* Rio de Janeiro: Editora Fiocruz.
Borba, R. (2017) Ex-centric textualities and rehearsed narratives at a gender identity clinic in Brazil: challenging discursive colonization. *Journal of Sociolinguistics* 21(3): 320–47. https://doi.org/10.1111/josl.12236
Borba, R. and Ostermann, A. (2007) Do bodies matter? Travestis' embodiment of transgender identity through the manipulation of the Brazilian Portuguese grammatical gender system. *Gender and Language* 1(1): 131–47. https://doi.org/10.1558/genl.2007.1.1.131
Brasil (2010) Conselho Federal de Medicina. Resolução 1.955 de 18 de agosto de 2010. Dispõe sobre a cirurgia de transgenitalismo. *Diário Oficial da União*, n. 170, seção 1, pp. 109–10.
Briggs, C. (2005) Communicability, racial discourse and disease. *Annual Review of Anthropology* 34: 269–91. https://doi.org/10.1146/annurev.anthro.34.081804.120618
Brubaker, R. (2016) *Trans: Gender and Race in an Age of Unsettled Identities*. Princeton: Princeton University Press. https://doi.org/10.1515/9781400883233
Butler, J. (1997) *Excitable Speech: A Politics of the Performative.* New York: Routledge.
Butler, J. (2004) *Undoing Gender*. New York: Routledge.
Cameron, D. and Kulick, D. (2003) *Language and Sexuality*. Cambridge: Cambridge University Press. https://doi.org/10.1017/CBO9780511791178
De Certeau, M. (1984) *The Practice of Everyday Life.* Berkeley: University of California Press.
Eckert, P. and McConnell-Ginet, S. (2003) *Language and Gender*. Cambridge: Cambridge University Press. https://doi.org/10.1017/CBO9780511791147
Edelman, E. A. (2014) Neither in nor out: taking the 't' out of the closet. In L. Zimman, J. Davis and J. Raclaw (eds) *Queer Excursions: Retheorizing Binaries in Language, Gender, and Sexuality* 150–69. Oxford: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199937295.003.0008
Edelman, E. A. and Zimman, L. (2014). Boycunts and bonus holes: trans men's bodies, neoliberalism, and the sexual productivity of genitals. *Journal of Homosexuality* 61(5): 673–90. https://doi.org/10.1080/00918369.2014.870438
Enke, A. (2012) *Transfeminist Perspectives in and beyond Transgender and Gender Studies.* Philadelphia: Temple University Press.
Enke, A. (2013) The education of little cis: cisgender and the discipline of opposing bodies. In S. Stryker and A. Z. Aizura (eds) *The Transgender Studies Reader 2* 234–47. New York: Routledge.
Fausto-Sterling, A. (2000) *Sexing the Body: Gender Politics and the Construction of Sexuality*. New York: Basic Books.
Foucault, M. (1980) *Power/Knowledge*. New York: Pantheon.
Foucault, M. (2001) *O nascimento da clínica* (7th edn). Rio de Janeiro: Forense

Universitária.
Foucault, M. (2003) *História da sexualidade*: a vontade de saber vol. I. Rio de Janeiro: Graal.
Foucault, M. (2006) *O poder psiquiátrico*. São Paulo: Martins Fontes.
Gomes de Jesus, J. (2012) *Orientações sobre identidade de gênero: Conceitos e termos* (1st edn). Goiânia: Ser-tão – Núcleo de estudos e pesquisas em gênero e sexualidade/UFG.
Gomes de Jesus, J. (2013) Transfobia e crimes de ódio: assassinatos de pessoas transgênero como genocídio. *História Agora* 16(2): 101–23.
Gomes de Jesus, J. (2015) *Homofobia: identificar e prevenir*. Rio de Janeiro: Metanóia.
Gomes de Jesus, J. and Alves, H. (2010) Feminismo transgênero e movimentos de mulheres transexuais. *Chronos* 11(2): 8–19.
Hacking, I. (2007) Kinds of people: moving targets. *Proceedings of the British Academy* 151: 285–318. https://doi.org/10.5871/bacad/9780197264249.003.0010
Hall, K. and O'Donovan, V. (1996) Shifting gender positions among Hindi-speaking hijras. In V. Bergvall, J. Bing and A. Freed (eds) *Rethinking Gender, Language and Research: Theory and Practice* 228–66. London: Longman.
Jefferson, G. (2004) Glossary of transcript symbols with an introduction. In G. Lerner (ed.) *Conversation Analysis: Studies from the First Generation* 13–32. Amsterdam: John Benjamins. https://doi.org/10.1075/pbns.125.02jef
King, B. W. (2016) Becoming the intelligible other: speaking intersex bodies against the grain. *Critical Discourse Studies* 13(4): 1–20. https://doi.org/10.1080/17405904.2015.1113190
Koyama, E. (2003) The transfeminist manifesto. In R. Dicker and A. Piepmeier (eds) *Catching a Wave: Reclaiming Feminism in the 21st Century* 244–59. Boston: Northeastern University Press.
Kulick, D. (1998) *Travesti: Sex, Gender and Culture among Brazilian Transgendered Prostitutes.* Chicago: University of Chicago Press. https://doi.org/10.7208/chicago/9780226461014.001.0001
Kulick, D. (2009) Can there be an anthropology of homophobia? In D. A. B. Murray (ed.) *Homophobias: Lust and Loathing across Time and Space* 19–33. Durham: Duke University Press. https://doi.org/10.1215/9780822391395-002
Murray, D. A. B. (2009) Introduction. In D. A. B. Murray (ed.) *Homophobias: Lust and Loathing across Time and Space* 1–15. Durham: Duke University Press.
Pomerantz, A. (1984) Agreeing and disagreeing with assessments: some features of preferred/dispreferred turn shapes. In J. M. Atkinson and J. Heritage (eds) *Structures of Social Action: Studies in Conversation Analysis* 57–101. Cambridge: Cambridge University Press.
Pomerantz, A. (1986) Extreme case formulations: A way of legitimizing claims. *Human Studies* 9: 219–29. https://doi.org/10.1007/BF00148128
Russo, J. (2004) Do desvio ao transtorno: a medicalização da sexualidade na nosografia psiquiátrica contemporânea. In A. Piscitelli, M. F. Gregori and S. Carrara (eds) *Sexualidades e saberes: convenções e fronteiras* 95–109. Rio de Janeiro: Garamond.
Sarbin, T. (1997) On the futility of psychiatric diagnostic manuals (DSMs) and the return of personal agency. *Applied and Preventive Psychology* 6: 233–43. https://doi.org/10.1016/S0962-1849(97)80012-1
Serano, J. (2007) *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity.* Emeryville: Seal Press.

Speer, S. and Green, R. (2007) On passing: the interactional organization of appearance attributions in the psychiatric assessment of transsexual patients. In V. Clarke and E. Peel (eds) *Out in Psychology: Lesbian, Gay, Bisexual, Trans and Queer Perspectives* 335–68. Chichester: Wiley. https://doi.org/10.1002/9780470713099.ch16

Stone, S. (1992) *The Empire Strikes Back: A Posttranssexual Manifesto*. http://sandystone.com/empire-strikes-back.pdf

Swift, S. (2009) *Hannah Arendt*. London: Routledge.

Vergueiro, V. (2015) *Por inflexões decoloniais de corpos e identidades de gênero inconformes: uma análise autoetnográfica da cisgeneridade como normatividade*. Dissertação de Mestrado. Bahia: Universidade Federal da Bahia.

Wodak, R. (1996) *Disorders of Discourse: Speech Barriers and Sociolinguistics*. London: Longman.

Zimman, L. (2009) 'The other kind of coming out': Transpeople and the coming out narrative genre. *Gender and Language* 3(1): 53–80. https://doi.org/10.1558/genl.v3i1.53

Zimman, L. (2014) The discursive construction of sex: remaking and reclaiming the gendered body in talk about genitals among trans men. In L. Zimman, J. Davis and J. Raclaw (eds) *Queer Excursions: Retheorizing Binaries in Language, Gender, and Sexuality* 13–34. Oxford: Oxford University Press.