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The interactional making of a "true transsexual": Language and (dis)identification in trans-specific healthcare

https://doi.org/10.1515/ijsl-2018-2011

Abstract: Can the transsexual subject speak in their own terms? This is the question this article addresses. Grounded on a Foucauldian genealogical approach to discourse analysis and on Goffmanian-inspired interactional analysis, it investigates how knowledge systems that pathologise transsexuality as a mental disorder get gradually embodied (and spoken) in consultations at a Brazilian gender identity clinic. The analysis follows the interactional history a trans woman had with the clinic's psychologist and traces the intertextual links that connect various consultations in time. This series of encounters constitutes a socialisation trajectory during which the trans client is led to speak a language that is not hers in order to frame an identity performance within the diagnostic criteria for the identification of "true transsexuals". The article, thus, contributes to three areas for the study of transgender and language: (1) it investigates how transsexual people are led to speak a language that is not their own (the problems of agency and trans-autonomy); (2) it points to the centrality of studying how others speak to transsexual people – a gap identified by Don Kulick but which remains under-investigated; and (3) it highlights the importance of language use for the design of trans-positive and trans-affirmative healthcare practices.

Keywords: trans-specific healthcare, agency, interactional analysis, socialisation trajectories, depathologisation

1 Introduction

This article tackles the problem of whose voice is recognised as legitimate when a transsexual person[1] requires the State to subsidise their healthcare needs in

1 For the purposes of this article, I use "transsexual people" and similar collocations (i.e. transsexual subjects, users etc.) to refer to individuals (1) who engage in gender identification which contradicts the sex assigned at birth; (2) who self-identity as "transsexual"; and (3) who,

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Brazil. At first glance, this seems a platitudinous matter: after all, it is the trans client who makes their demands to health professionals so that sex reassignment surgery and/or hormone therapy, two central healthcare needs, be offered for free by the Brazilian healthcare system (*Sistema Único de Saúde*, SUS henceforth). As I argue, nonetheless, due to the pathologised status of transsexuality, the speaking subject is constrained by discursive forces beyond their control. Hence, this discussion contributes to three relevant areas in the study of transgender and language: (1) it investigates how transsexual people are led to speak a language that is not their own (the problems of agency and trans-autonomy – or the lack thereof); (2) it points to the centrality of studying how others speak to transsexual people (i.e. how trans individuals are addressed) – a gap Kulick (2000) indicated almost 20 years ago but which remains under-investigated; and (3) it highlights the importance of language use in the design of trans-positive and trans-affirmative healthcare practices.

In Brazil, one must be granted a psychiatric diagnosis which legitimates the authenticity of one's transsexuality in order for surgeries and hormone therapy to be offered in premises of the SUS. This diagnosis is based on the evaluative criteria imposed by the World Health Organization in its International Statistical Classification of Diseases and Related Health Problems (ICD), by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and by the Brazilian Federal Board of Medicine's Resolutions on the trans-specific healthcare program. The necessity of a psychiatric diagnosis imposes interactional tensions, as has been noted in the available literature (Newman 2000; Butler 2004; Bento 2006; Stone 2007 [1991]; Teixeira 2013; Borba 2014; Borba 2016, Borba 2017). Louise Newman (2000: 400), for example, proposes that the question guiding healthcare professionals is "how can I be sure that this patient is a true transsexual and is not saying what she/he thinks I want to hear in order to get treatment?" Transsexual people, on the other hand, are guided by the question: "how can I convince this sceptical doctor that I am a true transsexual and have the right to surgeries?" In this scenario, worried that they will be denied access to the clinic services, transsexual clients rapidly learn "the necessary life-history required for successful 'passing'" (Hird 2002: 583).

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for various reasons, participate in a gender identity clinic although this is not a requisite for such an identification (see also Zimman [2009, 2012, 2014] for a similar position). These phrases avoid the essentialisation of such an experience implied in the use of "transsexual" as a noun. Identifying with one form of transsexuality or another is but one quality of these individuals; it is not the only one. In this sense, Brazilian trans-feminist activist Jaqueline Gomes de Jesus (2012: 15) explains that the use of the term "transsexual" as a noun "sounds offensive" because it reduces the complexity of the experience.

Although the learning and the telling of an adequate diagnostic narrative is frequently referred to in the research literature, showing how little resonance such diagnostic criteria have in transsexual people's lives (Butler 2004; Bento 2006; Stone 2007 [1991]; Teixeira 2013), these analyses are largely based on second-hand, retrospective accounts of transsexual people about their experiences with doctors. Because of this, we know little of the interactional *in situ* instantiation of such discourse, let alone the learning process that leads to its shape and to dynamics of disidentification from the "worldly" forms of living one's transsexuality that it entails.[2] This article seeks to understand the micro-interactional phenomena that lead to the materialisation of diagnostically driven language of this kind, along with the subjectification processes it engenders. How does an individual actually become a legitimate (transsexual) subject for the institutional purposes of the Brazilian trans-specific healthcare program?

To address this question, I draw on thirteen months of ethnographic fieldwork at the *Programa de Atenção Integral à Saúde Transexual* (PAIST, hereafter), one of the busiest gender clinics in Brazil.[3] During fieldwork, the PAIST had three main health professionals, a surgeon, a psychologist, and a psychiatrist, and two visiting physicians who were specialising in urological surgeries. For the purposes of this article, I analyse a corpus of five consultations between Verônica, a new client of the clinic, and Inês, a PAIST's psychologist. Verônica had her first consultation with Inês in February 2010 and in the following months several other meetings occurred (five of them were audio-recorded and transcribed). In these consultations, Inês' therapeutic focus was on the apparent mismatch between Verônica's life narratives and bodily presentation on the one hand, and the "true transsexual" identity model on the other (Zimman 2012; Borba 2016, Borba 2017).[4] As I argue, this series of consultations constitutes a trajectory of socialisation (Wortham 2006), i.e. a

2 But see Speer (2009, 2010, 2011, 2013) for accounts of interactions between psychiatrists and trans clients. However, Speer's allegiance to the conversation analytic understanding of context as co-text (Billig 1999), and her focus on what members explicitly orient to, impel her to take the status of transsexuality as a mental disorder for granted. As such, her CA studies overlook the centrality of pathologising discourses to the relationships within the gender clinic that she investigates.

3 Pseudonyms are used to refer to the clinic, its clients and its professionals.

4 I use the term "true transsexual" between quotation marks to point to its origins in systems of knowledge/power which produce transsexuality as a mental disorder (see also Zimman 2012). In this sense, the use of the concept in this format aims to highlight its diagnostic character, which is based on idealisations of what constitutes an allegedly authentic transsexuality. In addition, the use of quotation marks is intended to index the mismatch between the "true transsexual", as devised by medical knowledge systems, and the multiple contingent ways transsexual people experience their bodies and subjectivities in their daily lives.

complex of related communicative events in time, through which an individual becomes an institutionally recognisable type of (trans) subject. The article, thus, presents a case study of the experiences of one trans woman in the clinic and her interactional struggles not to be mistaken as a *travesti* (see Kulick 1998; Borba and Ostermann 2007) – an identity category with which Verônica does not identify and which would delegitimate her plight for specialised healthcare. Although I investigate the interactional history of a trans woman, my ethnographical experience indicates that trans men seem to face similar obstacles since they also have to deal with biomedical gender ideologies which crystallise physicians' understandings of transsexuality and universalise trans people's subjectivities.

In order to track the multitude of phenomena that comprise this learning trajectory, I draw on Foucauldian discourse analysis and Goffmanian-inspired interactional analysis, which are discussed in the following section.

2 On how an individual becomes a subject: Discourse and interaction

To a great extent, Foucault's work focuses on the dynamics through which individuals become – or are forced to become (i.e. are docilised in his philosophical jargon) – institutionally recognisable types of subjects. In this endeavour, Foucault traces the historical emergence and the material effects of a multitude of discourses, which he understands broadly as "practices that systematically form the objects of which they speak" (Foucault 1972: 49). Discourse, thus, is not only language in use, as linguists claim. It involves, besides language, a complex of knowledge systems, scientific categories, institutions, laws, architecture, philosophical propositions, moral standards, etc. (see Foucault 2013 [1979]). Such discourses interlace individuals in a web of knowledge systems which, when put into practice in institutions, produce dynamics of governmentality that end up transforming them into subjects. Governmentality, a concept Foucault developed in the later phase of his work (Foucault 1982, Foucault 1988, Foucault 2009), refers to "all endeavours to shape, guide, direct the conduct of others [...] Practices of government are deliberate attempts to shape the conduct in certain ways in relation to certain objectives" (Rose 1999: 3–5; see also Foucault 2003 [1978]). Through the insidiousness of such practices in daily life, human beings gradually become institutionally recognisable types of subjects.

Foucault's understanding of a subject is two-fold: "subject to someone else by control or dependence; and tied to his [sic.] own identity by a conscience of

self-knowledge" (Foucault 1982: 781). Both senses are central to understanding how trans individuals are socialised to becoming "true transsexuals" for the purposes of the Brazilian health system. As will become clear in the analyses that follow, the dependence on a health professional's classification of one's identity and the interactional processes through which one learns how to speak as a "true transsexual" are intertwined discursive phenomena. Conjoined, they engender dynamics of unlearning how one understands oneself in order to adopt the adequate diagnostic language imposed by powerful pathologising knowledge systems (Borba 2016, Borba 2017).

With his genealogy of the "different modes by which human beings are made subjects" (Foucault 1982: 777), Foucault delineates a historical shift which marked the development of disciplinary societies. He traces a move from the identification of people based on their "natural" behaviour to the categorisation and docilisation of their mental and spiritual dispositions (Foucault 1976, Foucault 1977). In this scenario, the philosopher explains how the social and medical sciences and the development of scientific categories simultaneously allowed for the emergence of new forms of knowledge and new forms of power. A central tenet of this historical change is the proliferation of taxonomies and practices for institutionally classifying people in places such as prisons (Foucault 1977) and hospitals (Foucault 1976). The bureaucratisation of such taxonomies allowed governments and their institutions to identify such individuals and foresee and/or prescribe how they (should) behave in ways that were theretofore unavailable. Hence, according to Foucault, the new systems of classification permitted individuals to be identified as specific kinds of subjects and made possible the development of institutional techniques of discipline and surveillance. Techniques for governing others (Foucault 2009) were installed which, in turn, would engender practices of self-surveillance and control (i.e. government of self). In this way, institutions such as hospitals and prisons would entangle the individual, progressively and by themselves, in webs of knowledge/power. Webs of this kind gradually produce certain technologies of the self (Foucault 1988), which transform an individual into a subject dependent on others and on the available knowledge about the category to which they allegedly belong.

The documents that pathologise transsexuality (i.e. ICD, DSM and the Brazilian legislation) are but a cog in the discursive machinery that produces individuals who disidentify with the gender they were assigned at birth as specific types of subjects. These texts entextualize (Silverstein and Urban 1996) biomedical knowledge systems which are based on the identification of a disease, its aetiology and temporal progression within a relatively fixed constellation of observable and interpretable signs and symptoms (Foucault 1976). Within

trans-specific healthcare contexts, such pathologisation is materialised in the institutional imposition of a psychiatric diagnosis which allows for surgical and hormonal intervention. As described above, Foucault's work is useful to our understanding of how such knowledge systems have emerged. But we know little of how they are embodied in the consultation rooms of gender clinics and their effects on trans clients' health needs and identities. For this, we need a more situated gaze on the details of what happens when health professionals and transsexual clients meet to do business together. In this context, a Goffmanian lens on interaction proves useful.

Whereas Foucault was interested in analysing the emergence of broad knowledge systems, Goffman focused on how individuals interact with each other on the ground, as it were, and within the institutions of which they are part. Foucault's research was "top-down, directed at entire systems of thought" (Hacking 2004: 278), while in contrast, Goffman's focus is said to be "bottom-up – always concerned with individuals in specific locations entering into or declining social relations with other people" (Hacking 2004: 278). In Brazil, most research on transsexuality has followed a Foucauldian perspective on discourse and has mapped the emergence of discourses that pathologise transsexual people's gendered experiences (Bento 2006; Lima 2011, Lima 2017; Teixeira 2013). With its focus on how people negotiate intersubjective relations in their ordinary interactions, Goffmanian interactional analysis can contribute to our understanding of how the classification of transsexuality as a mental disorder is embodied in the institutional practices of the Brazilian trans-specific health program. Analytically speaking, as Rampton (2016) notes, a focus on the micro-details of the moment-to-moment development of situated interaction provides the Foucauldian enterprise with a microscope, as it were, since it offers a more focused attention on "how power reaches into the grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourse, learning processes, and everyday lives" (Foucault 1980: 39).

In this sense, according to Hacking (2004) and Rampton (2016), both Foucault and Goffman are relevant for an investigation of how individuals are transformed into subjects, i.e. conjoined, they may provide the analyst with an avenue into the macro and micro dynamics of governmentality. Foucault's top-down genealogy of discourses provides an understanding of how certain individuals become of interest to sciences; Goffman's bottom-up approach to situated interaction helps us study how discourse in the Foucauldian sense becomes institutionalised and embodied in people's day-to-day lives. These two approaches to discourse analysis are central to understanding the constitution of knowledge systems and their solidification in techniques of surveillance and control. In this sense, both are useful for studying the development of practices

of other and self-government, which cumulatively produce docile subjects for the purposes of institutions. Having this in perspective, the following section provides a genealogical précis of the pathologisation of transsexuality. Analyses of the interactional history of Verônica and Inês at the SUS follow.

3 The pathologisation of transsexuality and the "true transsexual" model of identity

According to the Brazilian Federal Board of Medicine (FBM), "the transsexual patient has a permanent psychological disorder and [because of this] rejects his/her phenotype and tends to self-mutilate and/or commit suicide" (Brasil 2010, my translation). Due to their pathologised status, transsexual people who wish to have their healthcare subsidised by the State must be diagnosed as suffering from a Gender Identity Disorder (GID) – a term coined by the APA in the 4th edition of its DSM.[5] Therefore, it is a psychiatric diagnosis which guides Brazilian trans-specific healthcare policies and, as a consequence, informs the interactions between transsexual people and their physicians. Interestingly, however, the Brazilian legislation never actually mentions the DSM as a diagnostic resource,[6] but fieldwork in one of the Brazilian gender clinics has shown that it is the APA's diagnostic criteria which guide doctors' clinical gaze (Foucault 1976) when talking to a transsexual person.

Bento (2006) explains that the individuals whom the APA considers to be suffering from a gender disorder were at the epicentre of epistemological conflicts between the 1950s and 1970s: different fields of medicine tried to explain the characteristics and the origin of transsexuality through their own scientific lenses. In fact, Bento argues that these epistemological conflicts have produced diverging explanations of this "disorder": separate biological and psychoanalytical fields of definition were established. But despite the contradictions between them, the apparent scientific objectivity of these theories made the inclusion of

5 The APA frequently revises the manual. The latest version, DSM-V, was published in 2012. However, I use the DSM-VR as a reference because it was the version available during the period of fieldwork in 2009–2010, and it was that version that was used as a resource for the interactional construction of the diagnosis.

6 The pathologisation of transsexuality is also present in the text of the International Code of Diseases and Health-related problems (ICD) of the World Health Organization (WHO). For the purposes of this article, however, I focus exclusively on the DSM text for two main reasons: (i) it is the DSM which regulates these diagnostic encounters; and (ii) space constraints prohibit discussion of the details of the ICD and its production.

transsexuality in the APA manual possible.[7] The history of the APA's interest in gender transition is a complex one which space constraints prevent me from exploring in detail. However, it is important to note the centrality that two diverging medical explanations have in the current institutional standards of textuality which regulate transsexual people's and physicians' lives in gender clinics around the globe. These explanations are those of the endocrinologist Harry Benjamin and the psychoanalyst Robert Stoller. Benjamin's and Stoller's theories contradict each other due to their scientific allegiances, but surprisingly, both shape what the APA – and consequently, what the Brazilian FBM – understands about who counts as a "true transsexual" (Benjamin 1999 [1966]).

In his book *The transsexual phenomenon* (1999 [1966]), Benjamin argues as an endocrinologist that transsexuality is a matter of biological determination. He proposes that human sex is comprised of eight different "sexes": genetic, gonadal, germinal, endocrinological, phenotypical, psychological, legal and social sex. Due to unnamed biological processes, according to Benjamin, transsexuality is the result of a radical dissociation of psychological sex from the other ones. This dissociation produces a gender identity that is not in accordance with the more biologically based sexes of the body (i.e. genetic, gonadal, germinal, endocrinological, and phenotypical). Benjamin explains, however, that this separation of the psychological sex may have different intensities, and that there are six degrees of transsexuality. Only those who presented the most severe manifestations of the disorder (types V and VI) should be classified as "true transsexuals" and should be considered for sex reassignment surgeries.

In Benjamin's view, "true transsexuals" "feel that they *belong* to the other sex, they want to *be* and *function* as members of the opposite sex, not only to appear as such. For them, their sex organs, the primary (testes) as well as the secondary (penis and others) are disgusting deformities that must be changed by the surgeon's knife" (Benjamin 1999 [1966]: 11, emphasis in the original). Viewing transsexuality in these terms, Benjamin has always supported the necessity of sex reassignment surgeries because, in his view, psychological sex cannot be changed. Since psychological sex is more ingrained, one should modify the morphology of the body, which, due to technological advances, can be transformed.

Benjamin's theories, however, did not go unchallenged. The psychoanalyst Robert Stoller was a prominent opponent of sex reassignment surgeries and viewed transsexuality as the product of dysfunctional socialisation within

7 "Transsexualism" first appeared in the DSM in its third version, published in 1980, the same year the APA depathologised homosexuality. Now in its fifth edition, the DSM classifies transsexuality as Gender Dysphoria. Dysphoria is the antonym of euphoria.

gender roles in the family. Stoller focussed his efforts on analysing the socialisation processes that would supposedly lead to gender non-conforming behaviours in adulthood. To this end, he worked with young boys whose parents were concerned about their sons being "effeminate". In his book *The transsexual experience* (Stoller 1982 [1975]), he proposes that the origin of gender non-conforming behaviour in boys (which could lead to the desire to undergo sex reassignment in adulthood) is the product not of behaviours and preferences *per se*, but of traumatic psychosocial dynamics imposed by the boys' relationship with their parents, especially their mothers.

In this most Freudian vein, Stoller suggests that the mother of a prospective transsexual is a masculine woman whose penis envy is so strong that she transfers her unfulfilled desires onto her son. This produces family dynamics in which the mother is powerful and dominating, and the father is absent and emotionally unavailable. In this context, the father cannot establish himself as a masculinity model and the Oedipus complex is interrupted by, among other things, the excess of physical contact between mother and child. Stoller believed that it was possible to inculcate gender-conformity in these boys via what he termed the "therapeutically motivated Oedipus complex" (Stoller 1982 [1975]: 101), in which the (male) therapist must serve as a "representative of society, health and of conformity with the external reality" (Stoller 1982 [1975]: 80), providing the child with a model of masculinity. In his clinical practice, Stoller attempted to lead the boy to disidentify with his envious mother, which was supposed to turn the child's attention to stereotypically masculine activities, games and clothing preferences.[8]

Although the term "true transsexual" is almost exclusively used to refer to trans women by Benjamin and Stoller, in the Brazilian trans-specific healthcare program (and in the DSM more broadly), the concept has been expanded to include trans men regardless of their distinct subjective and bodily experiences with transitioning. As such, the DSM-IV definition of Gender Identity Disorder reentextualises these contradictory discourses on transsexuality and produces a Benjamin-Stoller hybrid. This diagnostic manual establishes the set of "symptoms" individuals desiring to undergo sex reassignment surgeries must demonstrate in order to be diagnosed as "true transsexuals" in the APA's terms. As such, the text imposes certain narrative demands (Coupland et al. 2005) which must be fulfilled if one is to be granted institutional authorisation to have one's

8 Space constraints prevent me from going any deeper in the discussion of the historical and epistemological construction of the APA's view on transsexuality. For more detailed discussions, see Heath (2006). For a critical discussion of what Brazilian sociologist Berenice Bento (2006) calls the "dispositive of transsexuality", see Bento (2006) and Lima (2011).

healthcare needs covered. According to the DSM, there are four main symptom areas that a mental health professional must pay attention to in order to diagnose someone as a "true transsexual":

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
   In children, the disturbance is manifested by four (or more) of the following:
   1. Repeatedly stated desire to be, or insistence that he or she is, the other sex;
   2. In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing;
   3. Strong and persistence preference for cross-sex role in make-believe play or persistent fantasies of being the other sex;
   4. Intense desire to participate in the stereotypical games of the other sex;
   5. Strong preference for playmates of the other sex [...]
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex [...]
C. The disturbance is not concurrent with a physical intersex condition;
D. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

(American Psychiatric Association 1994: 537–538)

In this text, stereotypical gender behaviours make possible the reentextualization (Silverstein and Urban 1996) of Benjamin's and Stoller's theories in the DSM. The symptoms of Gender Identity Disorder do not merely materialise the medicalisation of transsexuality – in a broader sense, their entextualization medicalises gender and, more significantly, the non-linearity between sex and gender. As such, the DSM text is a vector of social control that attempts to maintain the current matrix of gender intelligibility (Butler 2004; Bento 2006). By pathologising gender transition through the supposed neutrality and objectivity of scientific language (Martínez-Guzmán and Íñiguez-Rueda 2010) and by producing it as a medical fact, this text homogenises transsexual experiences and effaces the idiosyncrasies of alternative context-specific forms of transsexuality.

Although the APA published a new version of the DSM in 2012 in which the GID category has been replaced by the concept of Gender Dysphoria, also slightly modifying the diagnostic criteria, the history of the emergence of the "true transsexual" concept still finds its way into contemporary gender clinics in Brazil. As such, the "true transsexual" acts as a metapragmatic model of identity (Wortham 2006), for this has been ingrained in the medical and social imagination through its history of repetition in "objective" scientific knowledge systems. A metapragmatic model is one that includes "recognizable kinds of people (e.g. inappropriately resistant students) participating in a recognizable kind of interaction (e.g. refusing to participate in class)" (Wortham 2006: 32). Analytically, linguistic signs used in

situated interaction (cf. Goffman) can only make sense when, in amalgam, they indexically point to a history of discourses (cf. Foucault) that produces the framework to understand the metapragmatic model in action.

According to Wortham (2006) however, one must not see the relations between linguistic signs and models of identity as static and a-historical. The brief genealogy above of medical discourses on transsexuality considers how the "true transsexual" model has emerged from constellations of knowledge/power within medical fields from endocrinology to psychoanalysis. This discursive construction has established the fields of action "true transsexuals" may engage, i.e. they must want to undergo surgeries as well as hate their genital organs and tell narratives of the type "I'm a man/woman trapped in the wrong body". Such a history of use constrains the effect of the linguistic sign locally. Thus, "the metapragmatic model 'regiments' the sign (i.e. it makes it clear which aspects of the context are relevant to interpreting of the sign in this case) from among the various contextual aspects that might be relevant. Such regimentation [...] limits the possible meanings of the sign, making it easier for people to interpret it or react to it" (Wortham 2006: 33). In this sense, becoming an institutionally recognisable type of subject implies the situated contextualisation of a sign in fields of meaning that extrapolate its local use. It is this process that the following section discusses. After all, how are the discourses of the "true transsexual" identity model embodied in gender identity clinics? What are their effects on the identity performances of trans clients and on the language that they speak within trans-specific healthcare contexts?

4 Unlearning what one is: Language and (dis) identification at a Brazilian gender clinic

The previous section briefly tracked the emergence of the "true transsexual" as a model of identity by critically analysing the discourses that have produced transsexuality as a mental disorder in different systems of knowledge. This section now focuses on how these discourses (in the Foucauldian sense) become materialised in a situated series of interactions between Verônica, a new client at the PAIST at the time of fieldwork, and Inês, the clinic's psychologist. According to my fieldnotes, between February and June 2010, Verônica met Inês at least ten times. Five of these consultations were audio-recorded. Analytically, this series of consultations allows me to track the micro-details of the interactional trajectory through which Verônica gradually learned the language of the "true transsexual" model. In this way, the analysis problematises

the issues of agency and trans-autonomy. After all, can transsexual people speak in their own terms in trans-specific healthcare settings?

To address this matter, I focus on the question-answer adjacency pair, given its centrality in doctor-patient communication (Heritage 2010). In conversation analytical jargon, an adjacency-pair consists of two sequenced utterances, produced by different speakers, in which the first turn establishes a range of possible second actions (e.g. questions project answers; an invitation expects a refusal or acceptance). As will become clear, the adjacency-pair is a powerful milieu for developing dynamics of other and self-government since, as Foucault (1982: 221) explains, "to govern [...] is to structure the possible field of action of others". In this sense, according to Rampton (2016), the adjacency-pair provides an analytical view into the investigation of Foucault's "capillary micro-physics of power" (Foucault 2013 [1979]). More specifically, I investigate the discursive positions (Kendal 2008) produced by Inês' questions and their subjectification effects on Verônica's actions. Such effects can only be studied as the cumulative result of a series of intertextual links that connect each of the consultations over time. As space constraints prevent a full account of the complexities of the interactional history between Verônica and Inês, I shall focus on the changes in Verônica's understanding of her genitals as a feature that is relevant for her to be classified as a "true transsexual".

On 24 February, in her first consultation with Inês, Verônica was exposed to the diagnostic centrality of her relation to her penis. The talk about what she thought of her genitals was parallel to the broader agenda of this consultation, namely the difference between a transsexual person and a *travesti*. Grossly speaking, *travestis* are male-bodied individuals who identify as gay men, dress in women's clothes and drastically modify their bodies by ingesting female hormones and injecting (industrial) silicone in order to look more attractive to "heterosexual" men (see Kulick 1998; Borba and Ostermann 2007). Due to their body modification practices, *travestis* and transsexual people share a very close social space in Brazilian culture and gender imaginary. Commonsense has it, however, that the defining characteristic setting these two groups apart is that *travestis* do not wish to undergo sex reassignment surgeries since their penises may be a source of pleasure (and income for those who work as sex professionals). In contrast, "true transsexuals", as we saw earlier, must demonstrate hatred of their bodies and more specifically of their genitals.[9] In this first

9 As researchers and transsexual activists have been arguing in their political fight against the pathologisation of transsexuality, not all transsexual people hate their genitals as propounded by the diagnostic manuals. Transsexual people's relation to their genitals is complex and multifaceted, ranging from total disgust to nonchalance.

consultation, in the design and sequencing of her questions, Inês discursively positioned herself as a psychotherapist, as a teacher and as a judge of Verônica's performance of transsexuality.[10]

(1) Verônica's first consultation: 24 February 2010

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1  Inês:      Verônica >vô pedi pra você< me falá- me
2             explicá qual é a diferença entre transexual
3             <e travesti>.
4             (4.2)
5  Verônica:  °ô:: como é° que vô explicá isso,
6  Inês:      >não precisa-< ↑fala com seu coração Verônica
7  Verônica:  que que eu a::cho?
8             (.)
9  Verônica:  ah eu acho que são::- são pessoas diferentes
10            que tem a- pensa da maneira diferente né=
11 Inês:      =>exatamente< sentem diferente=
12 Verônica:  =é. [se sentem-]
13 Inês:          [tem a<sexua]lidade> [diferen-]
14 Verônica:                           [diferen]te uma da
15            outra=
16 Inês:      =i:::sso mesmo. esses suas- >seus amigos<
((11 linhas omitidas))
28 Inês:      <o transexual> ele- na grande maioria ele
29            não tem relação (sexual) °com pênis°
30            (0.7)
31 Inês:      entendeu?=
32 Verônica:  =uhum
33 Inês:      já o travesti não. eles são- tanto eles são
34            ativos quanto eles são [passivos]
35 Verônica:                         [passivo] isso eu sei,
36            [são os dois]
37 Inês:      [então eles] U::sam o pênis,
38 Verônica:  uhum
39            (0.6)
40 Inês:      >entendeu< a diferença?
41 Verônica:  °entendi°=
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10 Transcription conventions were adapted from Jefferson (2004) and can be found in the Appendix. Here I first present the transcription in Brazilian Portuguese, the language in which consultations originally happened, followed by a translation into English.

[English translation]

Inês: Verônica>I'll ask you< to tell me- to explain to me
the difference between a transsexual <and a
travesti>.
(4.2)
Verônica: °a:: how can° I explain this,
Inês: >you don't need-< open up your heart Verônica
Verônica: what do I thi::nk?
(.)
Verônica: ah I think they are:::- they are different people who
have the- they think in different ways right=
Inês: =>exactly<, they feel different things=
Verônica: =right. [they feel-]
Inês: [their <sexua]lity> is di[fferen-]
Verônica: [different] one from the
other=
Inês: =tha:::ts right. these friends->your friends< who say
((11 lines omitted))
Inês: <the transsexual> he- the great majority they
don't have (sexual) relations °with the penis°
(0.7)
Inês: get it?=
Verônica: =uhum
Inês: but the travesti don't. they are- they are
both top and [bottom]
Verônica: [bottom] this I know,
[they do both]
Inês: [so they] U:::se the penis,
Verônica: uhum
(0.6)
Inês: >understand< the difference?
Verônica: °I do°=

The question Inês poses in lines 1–3 positions her as having less epistemic access (Heritage 2010) to the matter that she is asking about than Verônica – she positions herself as knowing less than Verônica about the difference between transsexual people and *travestis*. At the same time, Inês is an institutional representative in a gender identity clinic, a place where professionals are expected to be knowledgeable about the issues on which, in this consultation, she seemed to know less than her interlocutor. Her job, in other words,

contradicts the discursive position articulated in her question, and it may be this mismatch that produces the delay in line 4 before Verônica replies. Instead of seeing it as a legitimate inquiry about something that the psychologist was less knowledgeable about, this delay may indicate that Verônica sees Inês' question as actually doing just the opposite: testing the client's knowledge about the matter. With this interpretation in mind, Inês' question resembles what conversation analysts call a "known information question" (Mehan 1979; Koshik 2010), which is commonly used by teachers in conventional lessons or, in Foucault's jargon, panoptical classrooms (Fabrício 2007). In such contexts, the teacher has the power to reproduce knowledge and test their students with questions for which they already have a pre-established agenda. This allows them to correct answers they consider wrong. Such a dynamic imposes a panoptical structure on the teacher-student interaction: the teacher knows and sees all. In Foucauldian terms, we may say that this type of question works as a disciplinary device in which "the subjects of education, their relations amongst themselves and with others and their attitudes to knowledge are regulated and transformed" (Fabrício 2007: 127, my translation). So Inês' question projects a complex footing (Goffman 1981): she acts not only as a psychotherapist but also as a judge of Verônica's identity.

Verônica's reaction to this footing could have consequences for her access to the clinic's body modification services, and a wrong answer could provide the clinic with reasons to refuse her participation in the program. So Inês' question puts Verônica in a difficult position, and this is indicated in the repair sequence (Schegloff et al. 1977) she initiates in line 5. In line 6, faced with her interlocutor's difficulty to address the agenda of her question, Inês launches an utterance typical of psychotherapeutic discourse: "open up your heart Verônica". According to Vehvilainen (2011), turns that try to motivate their interlocutors to speak freely, "from their heart", without the constraints of concepts of right and wrong, are sequentially inserted in contexts where therapists encounter clients' resistance to tackling a problem that the therapists advance. So "open up your heart" seems to indicate that there is no correct answer, and that Verônica may say whatever comes to mind. This is what she does in lines 7–10: for her, transsexual people and *travestis* "are different people who have the-they think in different ways". Although Verônica's answer is very broad and vague with regard to Inês' agenda, the psychologist seems satisfied with it (line 11). At the same time, Inês' turn in line 11 consolidates her discursive position as teacher and evaluator by closing the interactional sequence, a move that is infamous among students of classroom discourse. If we analyse the series of turns in lines 1–3, 7–10, and 11 (temporarily disregarding the repair sequence in 4–6), we find a standard Initiation – Response – Evaluation (IRE) sequence

(Sinclair and Coulthard 1975; Mehan 1979). In a sequence of this kind, the teacher, who knows all, produces a question whose answer they know in advance, the student answers and then gets feedback from the teacher in terms of right or wrong.

Importantly, in Verônica's first consultation with Inês, the evaluative character of this sequence is disguised by the repair in lines 5–6, when Inês positions herself as a therapist, inciting Verônica to open up her heart. The psychologist's turn in line 6 has at least three effects for the development of intersubjective relations between these interlocutors. First, it forces the client to abandon the repair she initiated in line 5, which did not meet the psychologist's agenda in line 1. Second, it disguises the evaluative stance Inês took up with her question. Third, it frames the sequence within psychotherapeutic discourses, in this way effacing the possibility of moral judgment. Produced like this, the repair tones down the pedagogical character of the interaction, so that Inês can receive answers that are not constrained by the agenda for the consultation set by her question in line 1. In other words, Inês' turn in line 6 masks the pedagogical-disciplinary effect of the IRE sequence in which it is embedded.

The presence of the IRE sequence in the trans-specific healthcare program indicates that the institutional function of mental health professionals involves more than just providing psychotherapeutic follow-up to clients' emotional issues, as the FBM Resolutions require. These professionals, in fact, act as evaluators of clients' identities. In this context, the IRE materialises the discursive conflict between different models of identity – specifically, the "true transsexual" model, which pathologises trans subjectivities, and the multiple forms of experiencing gender variance that clients bring with them to the clinic. The latter are not ratified by the knowledge systems that produced transsexuality as a medical problem and must, thus, be superseded in this context by more "legitimate" models. So here the IRE sequence and the pedagogical discursive position it projects seem to act as an interactional device to inculcate pathologising medical discourses in clients' linguistic performances, and this will become clearer as the analysis of Verônica and Inês' interactional history proceeds.

In line 11, the psychologist completes the trajectory of the IRE sequence by making a slight but enormously consequential correction to Verônica's answer in lines 9 and 10. Verônica says transsexual people and *travestis* are different because they *think* differently, but Inês says that "they feel different things". With this substitution of "think" by "feel", Inês frames her turn as an evaluation by using a lexical item that is common in the diagnostic criteria of the DSM (see above). In line 12, Verônica orients herself toward this correction and

rephrases her answer, this time repeating Inês' lexical offer. The psychologist elaborates on her evaluation and adds that transsexual people and *travestis* do not simply feel different things, but, more importantly, have different sexualities (line 13). Verônica's turn after that – "different one from the other" – may have different functions: it either complements, in overlap, Inês' prior turn, or it continues Verônica's own turn in line 12, which was interrupted by Ines' overlap. But the health professional favours the first interpretation and, once more, takes an evaluative position, judging Verônica's turn as agreement with what she has been saying ("=tha:::ts right."). Having made sure that Verônica understands that transsexual people and *travestis* have different sexualities, Inês goes on to explain what she means by this. According to her, the great majority of transsexual people "don't have (sexual) relations °with the penis°", whereas *travestis* do as they are "both top and [bottom]" (lines 28–34) so they "U:::se the penis" (line 37 – note the emphasis given with vowel elongation). With this explanation, Inês not only maintains her discursive stance as "teacher", but also echoes the epistemological position of the medical discourses that the DSM reentextualizes. This first pedagogical sequence is closed with Inês certifying that her interlocutor understands this central diagnostic criterion: ">understand< the difference?" (line 40), to which Verônica replies bluntly and without the hesitations, delays and hedges displayed in her previous turns: "°I do°=".

As this analysis indicates, Verônica was exposed to linguistic signs reentextualizing the pathologising discourses of the "true transsexual" metapragmatic model of identity right at the beginning of her first consultation at the PAIST. Through the design of her questions, their sequencing and the discursive positions they constructed, Inês acted not only as a therapist but, more importantly, as a judge of Verônica's identity. These turn-design and sequencing features indicate that Inês' aim in this consultation was to make sure her interlocutor knew the correct answers. Later in the same consultation (24 February), Inês brought up the issue of how "true transsexuals" relate to their genital organs, making clear what she meant by "different sexualities". The interactional context, however, differed. This time she did not refer broadly to the difference between transsexual people and *travestis*; instead, she funnelled the issue down to how Verônica herself saw her body morphology. As we saw in the previous section, one of the central criteria for identifying "true transsexuals" is their disgust to their genitals, which, in turn, frames the transsexual experience as averse to sex. The insertion of this diagnostic element set up a new discursive structure for the interaction, moving it from pedagogical talk to diagnosis, also introducing a new position for Inês (i.e. diagnostician rather than teacher/evaluator).

(2) Verônica's first consultation: 24 February 2010

```
210 Inês:      bom e quando você tem- tem relação você:::
211            <prefere> que você fique
212            (.)
213 Inês:      totalmen[te nu:::a,]
214 Verônica:          [totalmente]::- totalmente assim à
215            vontade, >por exemplo< numa ca::ma né melhor
216            [na rua-]
217 Inês:      [sim mas] não te incomoda de vê assim o
218            pê::nis?
219            (1.5)
220 Inês:      o SEU pênis.
221            (0.9)
222 Verônica:  se não me incomo::da?
223            (.)
224 Verônica:  ↑n::ão:: até que não
225 Inês:      cê não se incomoda com ele,
226 Verônica:  não:::
227            (0.3)
```

[English translation]

```
210 Inês:      right and when you have- have intercourse you:::
211            <prefer> to stay
212            (.)
213 Inês:      total[ly na:::ked,]
214 Verônica:       [totally]:::- totally like at ease,
215            >for example< on a be::::d right that's better
216            [on the street-]
217 Inês:      [alright but] doesn't it bother you to see like
218            the pe::nis?
219            (1.5)
220 Inês:      YOUR penis.
221            (0.9)
222 Verônica:  if it doesn't bo::ther me?
223            (.)
224 Verônica:  n::o:: not really
225 Inês:      you don't care about it,
226 Verônica:  no:::
227            (0.3)
```

In lines 210–211, Inês introduces a question which aims to check the quality of Verônica's relation with her penis. The design and content of this turn implicitly presuppose a fact that Stoller (1982 [1975], see above) had observed in his psychoanalytical approach to transsexuality: in order to disguise the genitals in sexual intercourse (which is rare), transsexual people make use of artifices such as underwear and towels (see Heath 2006). But Verônica does not orient to this element of the "true transsexual" model (after all, this is her first consultation) and she answers, as requested by the psychologist, from her heart. Inês rephrases her question (lines 217–218) and makes its diagnostic function clear, i.e. being uncomfortable with her penis will insert Verônica in the metapragmatic model the question presupposes. The client does not take the turn Inês offers her (line 219), so the psychologist retakes the conversational floor and increments her question by making it clear that she is referring to Verônica's penis and not her partner's (line 220). Although Inês has already explained the differences between transsexual people and *travestis* (see above), Verônica's answer does not reentextualize the diagnostic criterion that would confirm her participation in the identity model which frames the function of Inês' question. The client affirms that her penis does not bother her: "n::o:: not really" (line 224). Faced with a negative answer to this central diagnostic element, Inês repeats the question as a formulation (Heritage and Watson 1979), which summarises her interpretation of what her interlocutor has just said – "you don't care about it" (line 225). Verônica then repeats she does not care about her penis.

Although Inês provided Verônica with linguistic signs for her to understand the differences between transsexual people and *travestis*, as is supported in the biomedical knowledge systems of the DSM, in her answers Verônica was not able to reentextualize the diagnostic criterion to which she had been exposed in her first consultation with Inês, namely aversion to genitals. The absence of this element in Verônica's identity performance seems to have produced a classificatory hiatus: could Verônica be a *travesti* despite her claims to being a "true transsexual"? It is this categorisation problem that Inês addressed in the consultation of 9 March 2010.

(3) Verônica's second consultation: 9 March 2010

```
289 Inês:     então me explica o que é transexual,
290           (0.4)
291 Verônica: ah:: >não sei< acho que o tran [sexual t-]
292 Inês:                                   [fa:::la com]
293           seu coração, >o que você entende<=
294 Verônica: =sei lá:::: acho- acho que transexual acho
295           que gosta das duas coisa, tanto de mulher
```

296 como com::- com- com ho::mem=
297 Inês: =ah::::: en[tendi]
298 Verônica: [não é?]
299 (1.2)
300 Inês: será que isso que você está falando não-
301 não é::<tra::vesti>=
302 Verônica: =é, travesti então,
303 Inês: então não=
304 Verônica: =transexual é trave- mas travesti gosta-
305 (0.3)
306 Verônica: o travesti- o travesti mesmo gosta de::::
307 tanto homem quanto mulher.
308 Inês: i::::sso=

[English translation]

289 Inês: so explain what is a transsexual,
290 (0.4)
291 Verônica: ah:: >don't know< I think that the trans [sexual t-]
292 Inês: [o:::pen up]
293 your heart, >what do you understand<=
294 Verônica: =not su::::re I think- I think that the transsexual I
295 think likes both things, both women as- as- as-
296 as well as me::n=
297 Inês: ah::: I [got it]
298 Verônica: [isn't it?]
299 (1.2)
300 Inês: isn't it you're talking about, isn't it-
301 isn't i::t <tra::vesti>=
302 Verônica: yes, travesti right,
303 Inês: so isn't=
304 Verônica: =transsexual is trave- but travestis like-
305 (0.3)
306 Verônica: travestis- the real travesti likes bo:::th
307 men and women.
308 Inês: right=

As we saw earlier, in her consultation on February 24, Verônica was offered discursive tools to produce a linguistic performance of "true transsexual" via the design and sequencing of Inês' questions. On 9 March, Verônica and Inês met again. Two weeks after her first consultation, Verônica was still not able to speak the diagnostic language that Inês had tried to teach her. Due to the lack of

production of this language, Inês framed her second consultation with Verônica so that the client's classificatory difficulties could be solved. Once again, the PAIST's psychologist asked her interlocutor to "explain what is a transsexual". The proper answer to this question had been repeatedly offered to Verônica on 24 February: a "true transsexual" hates their genitals. Even so, Verônica could not show that she had indeed learned the lesson. Most importantly, in her second consultation, she seemed to be confused with the categories "transsexual" and *travesti*, as she imputed to the former attributes that, on 24 February, had been explained as characteristics of the latter (lines 294–296). Inês noticed this categorial confusion, and in line 300, she produced a question aimed at repairing her interlocutor's answer – after all, she had already told Verônica what the difference was. Verônica promptly corrected her answer and gave the answer Inês was looking for (line 308).

On 9 March, Inês limited her efforts to helping Verônica define identity boundaries to similar but conflicting categories. As Verônica's answers demonstrate, by then she seemed to have mastered the differences between *travestis* and transsexual people by adopting footings which supported Inês' discursive positions as evaluator and teacher. In fact, Inês recycled this topic in the opening of her third meeting with Verônica on 5 May: ">I remember< when we started talking you had- you had a certain- you said you were a *travesti*". Interestingly, though, Verônica never self-identified as a *travesti* in her first consultation. But she did say this on 9 March, due to the categorial confusion she still had then, which was swiftly solved, as the excerpt above illustrates. On 5 May, following her own understanding of what it means to be a transsexual person, Verônica contradicted what Inês told her in the first consultation, namely that "true transsexuals" feel they are women, and affirmed that she did not feel "completely as a woman because of her genital organ" (excerpt not shown). Note that she did not say her penis disgusted her, but that it prevented her from being a "complete woman". So Inês addressed this issue by once again drawing on the diagnostic discourses that constitute the "true transsexual". The consultation on 5 May, then, followed very similar steps to the two previous meetings: Inês and Verônica spent the entire time discussing what it means to be a "transsexual". Even so, this consultation represented an important point in Verônica's trajectory of being socialised into the "true transsexual" model, thereby unlearning her understanding of her own body and subjectivity. As we can see below, on 5 May, Verônica started to adopt some of the linguistic signs Inês had been providing her, and started to demonstrate she had indeed learned some of the lessons her psychologist taught her in the previous consultations.

(4) Verônica's third consultation: 5 May 2010

539 Inês: =essa é Uma ou é a única maneira de
540 dife[renciá-]
541 Verônica: [não é u]:::ma
542 (0.4)
543 Inês: e qual a se- qual você acha que seria a
544 <outra>?
545 (8.1)
546 Verônica: .hhh bom geralme- o travesti:::::
547 (0.3)
548 Verônica: >geralmente travesti< é o que eu fiquei já
549 sabendo né, não::::: tem vontade de fazê
550 essa cirurgia,
551 (0.7)
552 Verônica: agora eu acredito- >>sei lá<< a trans- a
553 <transexual> já:::::
554 (0.4)
555 Verônica: já tem vontade de fazê a ci[rurgia]
556 Inês: [então] começando
557 por essa maneira de pensá, é::::: porque será
558 que o transexual qué fazê: >a cirurgia< e o
559 travesti não qué?
560 (.)
561 Inês: pois se <<aparentemente>> >eles são iguais<
562 (4.2)
563 Verônica: sei lá::: XXXX=
564 Inês: =pensa Verônica, [pensa]
565 Verônica: [às ve(hhh)]zes- @@@ às
566 vezes é::::::
567 (0.5)
568 Verônica: não sei:::, não- não vô dizê todos > mas às
569 vezes< tem algum transexual que não se sente
570 bem::
571 (.)
572 Verônica: né?
573 (0.6)
574 Inês: °°(como?)°°
575 Verônica: ah sei lá, não se sente bem,
576 (0.7)

577 Verônica: <<em sê:::>> >>em- em- em-<< em sê do jeito
578 que é,
579 (0.3)
580 Verônica: né?
581 (0.4)
582 Inês: °°.hh ta bom°°

[English translation]

539 Inês: =is this ONE or the ONly way to set
540 them [apart-]
541 Verônica: [no, it's] o:::ne
542 (0.4)
543 Inês: and what do- which do you think would be
544 <the other>?
545 (8.1)
546 Verônica: .hhh well general- the travesti:::::
547 (0.3)
548 Verônica: >generally travestis< that's what I heard right,
549 they do::::n't have the wish to undergo
550 this surgery,
551 (0.7)
552 Verônica: now I believe- >>don't know<< the trans- the
553 <transsexual> do:::::es
554 (0.4)
555 Verônica: they have the wish to have the sur[gery]
556 Inês: [so] starting
557 from this way of thinking, a:::: why is it that
558 the transsexual wants to ha:ve >the surgery< and the
559 travesti doesn't want it?
560 (.)
561 Inês: if <<apparently>> >they are similar<<
562 (4.2)
563 Verônica: don't kno:::w XXXX=
564 Inês: =think Verônica, [think]
565 Verônica: [some(hh)ti]mes- @@@ sometimes
566 a::::::
567 (0.5)
568 Verônica: don't kno:::w, I can't- I can't say all of them >but
569 sometimes< there are some transsexuals that don't
570 feel we::ll

```
571            (.)
572 Verônica:  right?
573            (0.6)
574 Inês:      °°(how?)°°
575 Verônica:  ah I don't know, they don't feel well,
576            (0.7)
577 Verônica:  <<to be:::>> >>vto- to- to-<< to be the way
578            they are,
579            (0.3)
580 Verônica:  right?
581            (0.4)
582 Inês:      °°.hh ok that's good°°
```

Moments before Inês' question in line 539, Verônica had been telling her that in contrast to transsexual people, *travestis* usually work in the sex industry (see Kulick 1998). So Inês inquires whether this would be the only way to draw differences between the two groups. Verônica recognises that this is but one feature that sets *travestis* apart from transsexual people,[11] and then claims that travestis do not usually wish to undergo sex reassignment surgeries whereas transsexual people do (lines 546–555). Compared with the consultation on 24 February, Verônica's answers now echo the identity models Inês had constructed in the previous meetings. The repetition of linguistic items that constitute these models intertextually contribute to building this series of consultations as a socialisation trajectory during which, as a speaking subject, Verônica learns how to ventriloquise the metapragmatic model of "true transsexual". Note, however, that Verônica's turn has several hedging strategies – prefaces (">generally travestis< that's what I heard right") as well as disturbances such as truncated words ("well general-"), inhalations (".hhh well"), and vowel elongations ("the travesti::::"). Such phenomena indicate that (i) this is still an interactionally delicate topic (Silverman and Peräkylä 1990) and (ii) that she epistemically distances herself from the information being conveyed. Although Verônica does not cite the source of her knowledge ("that's what I heard"), analysis of her interactional history with Inês shows that this element of differentiation has been used repeatedly by the psychologist in previous consultations. The interactional patterns of previous appointments also happen in this one: Inês repeatedly projects

11 Inês, however, does not challenge this view, which reflects common sense understandings of *travesti* life in Brazil. As a matter of fact, many *travestis* work in the sex industry, but others have a multitude of ways to earn a living, prostitution being but one alternative (see Kulick and Klein 2010).

discursive positions and footings as teacher and judge of Verônica's identity performance via the design and content of her questions and their sequencing. For example, in line 564, Inês closes an IRE sequence by motivating her interlocutor with "think Verônica, [think]".

In May, then, the client started to reentextualize the identity signs to which she had been exposed since her first consultation at the PAIST. But Inês is not satisfied with Verônica's answer and goes deeper into the matter of what makes *travestis* and transsexual people different (at least for the purposes of the Brazilian trans-specific health program). Between lines 556 and 561, the psychologist inquires about the reasons why *travestis* do not want to have the surgery while transsexual people do "if <<apparently>> >they are similar<<". This question presupposes the category differentiation Inês made on 24 February and repeated on 9 March: According to the psychologist *travestis* use their penises and do not reject their body morphology whereas "true transsexuals" do not identify with this part of their bodies and need to extirpate it surgically. In her turn in lines 568–570, Verônica repeats the kind of epistemic distance she had produced before: "I can't say all of them >but sometimes< there are some transsexuals that don't feel we::ll". Although Verônica now repeats signs of identity she did not use in her previous consultations, her answer does not meet the psychologist's diagnostic agenda, and in line 574, Inês incites her to elaborate. So Verônica has not reentextualized one of the central discourses that Inês has been teaching her – she has not done her homework, as it were. But even though she does not use the appropriate diagnostic language, Inês accepts her answer (line 582). Using at least some of the identity signs the psychologist has socialised her into (lines 546–555), Verônica shows in this third consultation that her understanding of different identity categories has begun to be challenged by the medical discourses that the psychologist has been exposing her to.

On 9 June, the changes in Verônica's language use and identification as a trans person become more drastic. It is in this consultation that we can clearly see her own understanding of her body and subjectivity getting eclipsed by the medical discourses that pathologise transsexuality. Not only does Verônica reentextualize the DSM diagnostic criteria for GID, but, most importantly, she also applies them to herself. This adoption of a language she did not use in her consultation on 24 February is proof of the efficiency of her interactional socialisation into the metapragmatic model of "true transsexual", which shapes the trans-specific healthcare practices currently in use in Brazil.

(5) Verônica's fourth consultation: 9 June 2010

123 Inês: o transexual >não é travesti<=
124 Verônica: =não
125 Inês: preste bem atenção, o transexual é diferente
126 de travesti,
127 (0.3)
128 Inês: <travesti> ele s:::- ele- ele- é:::: ele tem
129 um corpo de ho::::mem, ele gosta de homem no
130 caso MAS gosta de vesti de mulher, porque
131 vestir se de mulher é:::: faz com que eles
132 se sintam diferentes [dá um:::-]
133 Verônica: [mas tem] muitos
134 transexuais também [que-]
135 Inês: [tran]sexual não,travesti
((7 linhas omitidas))
144 Inês: já o <transexual> é::: u- uma pessoa que
145 a:::cha- que sente >acha não< SENTE que
146 nasceu no corpo errado,<se sente mulher>
147 e- >não é só porque se veste de mulher< mas
148 se sente mulher e não gosta do corpo que
149 tem.
150 (.)
151 Inês: no caso com o pênis, diferente do travesti,
152 o travesti nem pensa de fazê uma cirurgia de
153 tirá o pênis,
154 Verônica: mas então o caso é o meu caso.
155 Inês: qual é o seu caso?=
156 Verônica: =esse que a senhora falô, que::- é::- assim
157 eu gosto de meu corpo eu só não gosto do::-
158 é::- >no caso< do órgão genital que eu tenho
159 (.)
160 Verônica: por quê? porque isso me incomo::da e além de
161 me incomodá::: muitas vezes me prejudica
162 de eu ficá com o ca::::ra >entendeu?<
163 Inês: entendi

[English translation]

123 Inês: a transsexual >is not like a travesti<=
124 Verônica: =nope
125 Inês: pay close attention, a transsexual is different

126 from a travesti,
127 (0.3)
128 Inês: <travestis> they s- they- they- a::: they have a
129 ma:::le body, they like men in this case
130 BUT they like to dress up as women, because
131 dressing as women a::: makes them to
132 feel different [it gives them-]
133 Verônica: [but there are] many
134 transsexuals also [who-]
135 Inês: [not] transsexuals, travestis
((7 lines omitted))
144 Inês: yet the <transsexual>> i:::e a- a person who
145 thi:::ks- who feels >they don't think< they FEEL
146 they were born in the wrong body, <they feel like
147 women> and- >not only because they dress up as women<
148 but they feel they are women and they dislike the
149 body they have.
150 (.)
151 Inês: in this case the penis, differently from travestis,
152 travestis don't even think of having the surgery to
153 take the penis off,
155 Verônica: but so this is my case.
156 Inês: which is your case?=
157 Verônica: =this is just mentioned, tha::t- a:: like
158 I like my body I just don't like the::-
159 a::- >in this case< the genital organ I have
160 (.)
161 Verônica: why? Because it bo::thers me and besides
162 bothering me many times it spoils my dates, get it?
163 Inês: I get it

At the very beginning of this excerpt (and of the consultation, for that matter), Inês reviews what has been discussed so far with regards to the differences between *travestis* and transsexual people. Note that before, on 5 May, Verônica had only partially replicated this discourse, and in lines 125–126, Inês projects the discursive position of a teacher whose pupil still needs some clarification about the subject matter: "pay close attention, a transsexual is different from a *travesti*". So in this consultation, the psychologist reentextualizes the pedagogical-disciplinary discursive structure that has coloured her interactional history with Verônica so far. Her explanation of identity boundaries between *travestis*

and transsexual people repeats the identity signs she has already established as valid to account for the difference. Combining commonsense knowledge about *travestis* with the pathologising knowledge systems about transsexuality, Inês' turns in lines 128–132 and 144–149 set the background to Verônica's self-identification in lines 157–162. According to the psychologist, the defining element differentiating *travestis* and "true transsexuals" is the way they psychologically experience their body morphology: *travestis* are homosexual men who fashion their self-presentation to attract other men's sexual attention and do not wish to undergo sex reassignment surgery; "true transsexuals", on the other hand, "FEEL they were born in the wrong body, <they feel like women> and- >not only because they dress up as women < but they feel they are women and they dislike the body they have in this case the penis".

By reviewing these elements of the identity models that she has been exposing Verônica to, acting as a teacher Inês sets the ground for Verônica to take the turn and self-identify with either of these categories, and this is what she does in line 155, affirming that "so this is my case". As the psychologist has just discussed two different identity models, she asks for clarification: "which is your case?". It is in Verônica's turn in lines 157–159 that we can see the solidification of the metapragmatic model of "true transsexual" starting to eclipse her understanding of her identity. Here Verônica finally replicates the discourses that Inês has been teaching her since February and that until this moment, she has been unable to reproduce: "I like my body I just don't like the::- a::->in this case< the genital organ I have". Nonetheless, in her first consultation at the PAIST, Verônica had used a different language to describe her relationship with her penis:

(6) Verônica's first consultation: 24 February 2010

217	Inês:	[alright but] doesn't it bother you to see like
218		the pe::nis?
219		(1.5)
220	Inês:	YOUR penis.
221		(0.9)
222	Verônica:	if it doesn't bo::ther me?
223		(.)
224	Verônica:	n::o:: not really
225	Inês:	you don't care about it,
226	Verônica:	no:::
227		(0.3)

By comparing Verônica's identity performances on 24 February and 9 June, the interactional analysis in this section shows how she has gradually and

cumulatively learned to speak as a "true transsexual". In her interactional history with the psychologist, Verônica's language of the lifeworld – her own ways of understanding and describing her trans experience – has been slowly replaced by the discourse of medicine (Mishler 1984). This process of socialisation into pathologising discourses happens through intertextual links among a multitude of interactional events over many months. Via the identity signs that link these consultations to one another, Verônica becomes familiar with the language she is expected to use in order to project an identity performance which can meet the Federal Board of Medicine's requirements to diagnose "true transsexuals". In this scenario, the institutional demand for a diagnosis is an obstacle to agency. To gain access to trans-specific healthcare, trans speaking subjects must adopt a language that is not theirs, and as such they become subjugated to knowledge systems that homogenise the complexity of trans experiences. In this way, the need for a psychiatric diagnosis forces trans people to speak the language of medical institutions in order to have their gender identity legitimised and have their healthcare needs attended. In Goffmanian terms, the transsexual speaker is in this context the animator of a language that supports ontological and epistemological stances which do not necessarily reflect their lived bodily and subjective experiences. The *author* of the words lies elsewhere but is still omnipresent in the consultations, constraining the clients' possibilities for social action.

5 Final remarks: Can the transsexual subject speak?

The case study of Verônica's trajectory into "true transsexuality" illustrates how the imposition of a diagnosis in the Brazilian trans-specific healthcare program delegitimises the multitude of voices trans clients bring with them to the clinic. Such a demand imposes interactional structures and discursive positions on the interactions between health professionals and trans people in which such professionals act as judges of clients' identity performances. In the consultations, by acting as they are institutionally forced to do, health professionals provide their interlocutors with a language that may fulfil the FBM's demands. The process of unlearning non-ratified forms of transsexuality within the SUS is the result of health professionals' question designs and sequencing, and, most importantly, the lexical items they offer their interlocutors in the IRE sequence. The interactional making of "true transsexuals", thus, emerges cumulatively in a

series of interactions as clients of gender clinics are socialised into this metapragmatic model and learn to govern their tiniest actions so that they may fit the diagnostic criteria. The dynamics of subjectification Foucault discussed in his work, thus, take place in the micro-details of clients' daily interactions (see Rampton [2016] in this regard): little by little the systems of knowledge that produced the "true transsexual" model become embodied in clients' identity performances, constraining, thus, their possibilities of action. In this sense, gender clinic professionals end up speaking by/for their trans interlocutors, which diminishes their clients' chances at agency and empowerment.

The demand for a diagnosis frames the Brazilian trans-specific healthcare program within institutional practices of disciplinary panoptism (Foucault 1977). In other words, gender clinics discipline (and punish) performances that contradict the "true transsexual" model; health professionals, thus, know all, see all, hear all. In the micro-details of their talk, they impose "legitimate" forms of performing transsexuality on clients who must learn what to say and how to say it in order to be classified as "true transsexuals" and have their healthcare provided. In this sense, the institutional requirement of a diagnosis engenders interactional processes, which intertwine the government of the others and the government of self (Foucault 1997). Health professionals shape clients' understandings of their bodies and identities; clients, in turn, are led to monitoring their identity performances so that they may be diagnosed as "true transsexuals". By merging Foucault's genealogical approach to the emergence of knowledge systems and the categorisation practices they make possible with Goffmanian-inspired interactional analysis, the discussion in this article contributes to our understanding of how macrosociological phenomena (i.e. the pathologisation of transsexuality) constrain the micro-details of intersubjective relations.

The interactional analyses in this article indicate that in contexts where transsexuality is pathologised and, as a consequence, homogenised by biomedical discourses, transsexual people cannot speak. Who speaks, instead, is the DSM since trans clients are expected to reiterate the knowledge systems that made the emergence of this diagnostic manual possible. The possibility for agency, however, may be glimpsed in the attempts to depathologise transsexuality (see Misé and Coll-Planas 2010). The international movement Stop Transpathologization aims at debunking the necessity of a diagnosis in order for trans people to have their healthcare needs attended to.[12] To depathologise implies valuing trans people's multiple ways of understanding their lived bodily

12 For a more detailed account of the movement's agenda see http://www.stp2012.info/old/en (accessed 21 January 2019).

and subjective experiences. Clinically, this would allow for the "circulation of transsexual narratives that make other experiences of transsexuality visible" (Red Latinoamericana de Hombres Trans en el Activismo 2009: n.p). As the analysis of Verônica's trajectory into "true transsexuality" suggests, the current model of trans-specific healthcare in Brazil is trans-oppressive in that it obliterates alternative ways of living one's identity. The depathologisation of transsexuality would, in contrast, foster more trans-positive and trans-affirmative healthcare practices in which the client's voice may be heard for what it stands for. By not framing trans-specific healthcare within pathologising knowledge systems, gender clinics would hear clients speak their own language, which would allow for health policies which treat them as autonomous subjects, not as voiceless patients.

Appendix

Transcription conventions have been adapted from Jefferson (2004).

.	Falling intonation
?	Rising intonation
,	Continuous intonation
::::	Sound elongation
-	Abrupt interruption of talk
talk=	Latched talk
=talk	
talk	Emphasis
TALK	Louder voice
°talk°	Lower voice
>talk<	Faster talk
<talk>	Slower talk
ta[lk]	Overlapping talk
[ta]lk	
.hhhhh	Audible inhalation
hhhh	Audible exhalation
tal(hhh)k(hh)	Laugh while talking
@@@@@@	Laughing
(3.5)	Lapse of time in which no speaker takes the turn
XXXXXX	Inaudible speech
(talk)	Dubious transcription
((comments))	Transcriber's comments

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