Authenticity, Intersubjectivity and the Ethics of Changing Sex

Introduction

This paper examines how specific concepts of the self shape discussions about the ethics of changing sex. Specifically, it argues that much of the debate surrounding sex change has assumed a model of the self as authentic and / or atomistic, as demonstrated by both contemporary medical discourses and the recent work of Rubin (2003). This leads to a problematic account of the ethical issues involved in the decision to change sex. It is suggested that by shifting to a properly intersubjective and performative model of the self we can better understand (a) the diagnosis of transsexuality; and (b) issues of success, failure and regret with regard to changing sex. I also reveal the important implications this shift has for how the relationship between medical practitioners and trans individuals is understood. The paper concludes by showing how the model of the self as authentic can individualise identity and downplay or overlook the tight intertwinement between self and other. A properly intersubjective, performative concept of the gendered self places other people at the centre of both an individual's attempt at self-transformation and the ethical issues that arise during this process.

The Role of Authenticity in Debates about Transsexuality

The trope of "authenticity" is a common means for making sense of and relating to one's identity. As Taylor has documented, the "inward turn" of Western subjectivity has led to the modern idea that self-fulfilment or self-realisation amounts to 'being true to myself… being true to my own originality, and that is something only I can articulate and discover' (Taylor, 1991, p. 31; cf. Taylor, 1989). This idea of an authentic identity is prevalent in many accounts of transsexuality. For example, the autobiographical accounts and self-narratives of transsexuals often invoke the idea of a "true self" or "authentic selfhood" in making sense of their embodied experiences and attempts at self-transformation (e.g. Bolin, 1988; Brown and Rounsley, 1996; Ekins, 1997; Gagne et al. 1997; Mason-Schrock, 1996; Morris, 1974). The gendered self is often presented as something inner, fixed and persisting, which connects with the widespread idea that the transsexual's identity has been fixed within them from birth.

Identifying and realising this authentic self is often seen as central to becoming a "whole" or fully "real" person (Morris, 1974).

The notion of an authentic sex/gender identity also underpins dominant medico-legal models of transsexuality. For example, the UK's Gender Recognition Act (GRA), which grants applicants official recognition of their desired gender, contains the requirement that the applicant 'intends to live in the acquired gender until death' (GRA, 2004). This assumes that one's sex/gender identity is fixed and stable, which supports the idea of an authentic self. Relatedly, Sharpe (2002) notes that many court cases which involve establishing the sex of an individual have reverted to a "present from birth" narrative. This narrative assumes the existence of an "authentic" sex, which is determined chromosomally and/or hormonally and deemed to be fixed and stable throughout one's life. Similarly, when dealing with transsexual or intersex individuals, it is often assumed that the role of medical clinicians is to establish what the "true" sex/gender of the individual actually is (Hird, 2002; Karkazis, 2008). The result is that the idea of authenticity generates and/or reinforces 'the one fundamental belief of most transsexual subjects – that the sense of being the other sex is an inborn and therefore irrefutable and unchangeable aspect of self' (Hausman, 1995, p. 153). Within this narrative of the self, transitioning to one's desired sex/gender is a matter of become the person one always really was / truly are.

Such a belief is identifiable in the guidance offered by the Gender Identity Research and Education Society (GIRES), which states that 'the issue of one's gender identification… is rooted in the brain, and is… largely determined pre-birth and more or less stable thereafter' (GIRES, 2008, p. 4). This statement also reflects the tendency to search for a biological cause and explanation of transsexuality, wherein certain individuals are inescapably "hard wired" to be transsexuals (e.g. Bailey, 2003; Ramachandran and McGeoch, 2008).[1] Biological determinism can underpins a model of "authentic" transsexuality in which "true" transsexuals are those who are neurobiologically destined to be so. GIRES (2008: 4) asserts that the latest medical and scientific evidence is that transsexuality is 'strongly associated with unusual neurodevelopment of the brain at the fetal stage'.[2] Owing to the inescapable demands of one's brain/body, transitioning 'to live in the gender role dictated by the brain may be the

[1] See Elliot (2010) for a compelling critique of such theories.

[2] It is noteworthy that transsexuality is here cast as something "unusual". This reflects the common but problematic assumption that there is something fundamentally "wrong" or "mistaken" about transsexuality, and that transsexuals have not developed "properly".

only way forward if they [transsexuals] are to avoid a life of psychological torment' (ibid: 5). Not only should we be worried at the implication that a life of gender ambiguity or dissonance is necessarily one of "psychological torment", the statement also implies a notion of sex/gender identity as fixed and persistent throughout one's life, which generates the inescapable need for sex change.

The idea of an authentic sex/gender identity can be valuable insofar as it allows one to explain the dissonance between one's sexed body and one's sense of sex/gender identity. Specifically, the experience of false embodiment can be rendered intelligible by invoking an authentic inner gender identity that is misaligned with one's physical body. This sense of an inner authentic sex/gender identity can then be used to justify the demand for hormone treatment and sex reassignment surgery (SRS) on the basis that they will allow one to realise / manifest one's authentic identity. However, a number of theorists have cogently argued that the idea of an inner, authentic sex/gender identity is problematic and that an alternative model for making sense of one's embodied existence is required (e.g. Butler, 1990; Shapiro, 1991; Stone, 1991; Sullivan, 2003). Indeed, despite the importance of authenticity within many transsexual narratives, Hird (2002) has suggested that the idea of authenticity has been undermined by the increasing dominance of a model of the gendered self as performative. In particular, the idea that sex/gender identity is an unstable, performative construct undermines the idea of an authentic, core gendered self (Butler, 1990).

In response to the scepticism within feminist and queer theory about the concept of authenticity, Rubin (2003) has offered a nuanced defence of the concept for understanding and justifying the lives and self-transformations of FTM (female-to-male) transsexuals. Rubin (ibid, p. 15) argues that 'authenticity is a leading principle behind an FTM's life. FTM lives are a search for recognition of the innermost self. What FTMs realize is that their innermost selves are authentically male. Once they make this realization, they modify their bodies to express this authentic identity'. Not only does authenticity ground one's self-understanding, it also provides the political impetus for justifying sex change: 'By mobilizing the cultural connections between identity and embodiment, FTM men address the misrecognition of their authentic selves. This "authenticated" self provides the moral foundation for securing the democratic rights and obligations these men deserve' (ibid).

As noted above, the concept of authenticity implies that one's sex/gender identity is something inner, fixed and stable. This idea is echoed by the participants in Rubin's study, many of whom 'believe they have always been men, despite their female bodies' (ibid, p. 143). Consequently, 'Their transitions are only a means of making their core identities visible and recognizable to the public. This points to the importance of expressive identities. An expressive identity is a core gender that is situated inside oneself, a gendered soul. Bodies are an expression of that core self' (ibid, p. 145). The result of this understanding of the gendered self is that the transsexuals in Rubin's study believe that 'they are becoming the men they always already were' (ibid, p. 153) and hence they 'acknowledged the immutability of their male identities and pursued the surest way available in this culture to achieve recognition for who they were deep down' (ibid, p. 182). Along similar lines GIRES (2008, p. 5) refers to the transsexual's dilemma as being constituted by a fundamental conflict between inhabiting one's socially-imposed gender identity and knowledge of one's inner, true gender identity. The difficulty of this 'charade of presenting themselves as something they know they are not' means that they must change sex in order 'to be complete, whole people and to live in accordance with their internal reality' (ibid).

Whilst I think that Rubin's work makes valuable contributions to contemporary discussions of transsexuality, I worry that his emphasis on authenticity can lead to an overly individualised, atomistic account of identity which in turns distorts the ethical issues involved in changing sex. Thus, rather than challenge the phenomenological experiences of transsexuals, I want to consider how adopting a properly intersubjective and performative model of the gendered self allows us to rethink (a) the diagnosis and treatment of transsexuality; and (b) how issues of success, failure and regret are understood and responded to. This, I argue, provides a richer, more complex and nuanced account of the ethics of changing sex, which is fully attendant to the issues of responsibility and responsiveness that follow from the social nature of the self. It also reveals ways in which the clinical diagnosis, treatment and understanding of transsexuality can be improved.

From an Authentic to an Intersubjective Self

One problem with the notion of authenticity is that it can lead to a model of the self, and an account of one's sex/gender identity, as being inwardly discovered rather than

intersubjectively constituted. The idea of the self as intersubjectively constructed dovetails neatly with the shift from an authentic to a performative model of identity. Spearheaded by Butler's work (e.g. Butler, 1990; 2004) and central to many contemporary forms of feminist, queer and trans theory (e.g. Benjamin, 1998; Ferguson, 1993; Lloyd, 2005; Lorraine, 1999; McNay, 2000; Phelan, 1994), the concepts of performativity and intersubjectivity capture the idea that one's identity and sense of self are constituted socially through a complex intertwinement of social discourses, practices and patterns of recognition. Understanding the self as intersubjective thus captures three important features of identity: (i) it is socially constructed rather than inwardly discovered or generated; (ii) it is neither fixed nor necessarily unified or coherent; (iii) it is not something inner and private that be known solely through a process of introspection (McQueen, 2015).

In terms of transsexuality, this suggests that one's sex/gender identity is not something persistent and present-from-birth. Rather, one's sense of self is a process of continual becoming that is constructed through interaction with others as well as socio-institutional practices and discourses, and thus incomplete, fragmented and continually evolving. This implies the sense of false embodiment central to many transsexual narratives cannot be grounded in the belief that one was born and has always been a "man" or a "woman", for such identities are only developed through time as they are intersubjectively and performatively shaped. The problem with narratives of transsexuality that emphasise authenticity and inwardly generated identity is that they can downplay or simply overlook the extent to which our capacity to understand and shape ourselves is dependent upon the wider social context in which we are situated.

It is noteworthy that even those theorists who highlight the performative or constructed nature of identity can nevertheless present a problematic account of the gendered self as inwardly-generated. For example, Kate Bornstein's influential defence of sex change stresses the fact that gender is fluid and ambiguous, which means that each of us has 'the ability to freely and knowingly become one or many of a limitless number of genders, for any length of time, at any rate of change. Gender fluidity recognizes no borders or rules of gender' (Bornstein, 1994, p. 51-2). Similarly, Feinberg (1998, p. 24) argues that each 'person's expression of their gender or genders is their own and equally beautiful. To refer to anyone's gender expression as exaggerated is insulting and restricts gender freedom'. Feinberg (ibid, p. 53) claims that we should have complete liberty to explore and alter our sex and gender in

any way we want, asserting that everyone has 'the right to express their gender in any way that feels most comfortable'.

Both Bornstein and Feinberg appear to invoke an atomistic concept of the self in which one's sex/gender identity is a matter of voluntaristic self-creation rather than social constitution. For example, Bornstein (1994, p. 40) claims that 'Gender identity is a form of self-definition: something into which we can withdraw, from which we can glean a degree of privacy from time to time'. Similarly, she (ibid, p. 39) declares that 'I love the idea of being without an identity, it gives me a lot of room to play around; but it makes me dizzy, having nowhere to hang my hat. When I get too tired of not having an identity, I take one on: it doesn't really matter what identity I take on, so long as it's recognizable'. However, it is not the case that we can simply "take on" or "take off" an identity at will, and it is unclear what it means to be "without" an identity. Thus, it is incoherent to assert that we are entirely free to don a gender identity in a way analogous to an actor taking on a particular character or a new costume. As Heyes (2006, p. 278) notes, 'None of us are at liberty to become any kind of person we want, and to align oneself with a particular identity formation is a necessarily intersubjective activity'. Identity formation is a social affair: for any of us to properly "have" an identity we require others to ascribe that identity to us.

Part of the issue with Bornstein's account is that she implies that we have full autonomy to become any identity we wish. This is the situation of the "gender outlaw" who recognises 'no borders or rules of gender' (ibid, p. 52). Against this Butler's account of performativity reveals sex/gender identity as both tightly scripted and socially-imposed, meaning that it is wedded to constraining norms that place us within an inescapable scene of constraint when attempting to fashion an identity we feel comfortable with. Thus, whilst Bornstein and Feinberg rightly highlight the fluidity and plurality of gender identities, they nevertheless remain tied to the notion of an atomistic self insofar as they present one's gender identity as inwardly generated. This generates an individualist vision of social life, which downplays or simply forecloses the essentially intersubjective nature of the self. This, in turn, distorts our understanding of the ethical and political issues involved in changing sex. For example, in reducing sex change to a matter of an individual's tastes and preferences, one is in danger of rendering sex a purely aesthetic issue. This disconnects sex/gender identities from important ethical issues, such as the ways in which certain gender identities (especially masculine identities) are entwined with socio-political practices of domination and the effects that our

gender-transformations have on those around us (Heyes, 2007). The authentic, atomistic model of the self also has problematic effects on the diagnosis and treatment of transsexuality, as the following sections reveal.

Diagnosis and Demand

Although the precise definition of "transsexuality" is contested, it seems reasonable to assert that central to the experiences of many transsexuals is the desire to alter their physical body in order to better align it with their internal sense of gendered self. This is often achieved through the use of hormones and surgery. Thus, transsexual's demand for sex change is intertwined with the medical diagnosis and treatment of transsexuality. The relationship between transsexuals and the medical community is much debated and I do not want to tread already well-worn ground here (e.g. Cromwell, 1999; Davy, 2011; Hines, 2007; Meyerowitz, 2002). Instead, I want to note that the diagnosis of transsexuality is frequently guided by the concepts of authenticity and atomism. **Specifically, medical practitioners tend to see their role in the diagnostic process as a matter of correctly identifying "authentic" transsexuals, which is aided by the presence of particular aesthetic markers and the structure of transsexual self-narratives (Davy, 2011). This goes hand-in-hand with the tendency for medical practitioners and researches to treat sex and gender identity as both "real" and fixed (Hird, 2003, p. 183). Hence, the diagnosis of transsexuality is often assumed to involve determining the individual's "true" identity.**

A related assumption underlying the diagnostic procedure, and which is often invoked in legal rulings involving transsexuals (Sharpe, 2002), is the "present from birth" narrative. This states that the desire to change sex has been present from birth, or at least early child. Hence, certain forms of childhood behaviour and experiences are offered as evidence of a fixed, "authentic" transsexual identity. This helps to establish that the transsexual identity is authentic because their desire for sex change is "genuine" and not a mere passing fantasy. This tendency to equate authenticity with a single, persisting sex/gender identity is further reflected in the medico-legal requirement that one intends to spend the rest of one's life as one's desired sex/gender (GRA, 2004). The result is that an authentic transsexual is someone who has always wanted to live,

and will always want to live, as the opposite sex. As Rubin (2003) reports, transsexuals have always known who they really are on the inside.

May (2002), a practising psychosexual therapist working in the NHS with transsexual and transgender clients, reflects on the challenges involved in employing feminist and queer perspectives about the construction of gender within a medical context that rests upon 'a more rigid stability of gender identity' (ibid, p. 450) and reinforces 'schemata of "real" and "true"' (ibid, p. 458). She observes that the idea of a stable, unambiguous and "true" or "authentic" sex/gender identity is 'used as a measure of the desirability of medical intervention' (ibid, p. 450), which can work against individuals who eschew ideas of inner, persisting, authentic identity (cf. Davy, 2011; Hird, 2003; Whittle et al. 2008). One reason for this is that therapists and clinicians often 'equate mental "robustness" with notions of the "stable self"', an unchanging fixed identity' (May, 2002, p. 450). Consequently, 'within such a framework, shifting identities tend to be seen as denoting instability and a lack of authenticity' (ibid), thus rendering individuals who experience their identities as such as unsuitable for treatment because they are not mentally "robust" enough.

Although the idea of an inner, authentic essence may be phenomenologically real for some individuals, it does not fit with the experiences of all (or even most) transsexuals. Consequently, using the idea of authentic transsexuality to guide the diagnostic process can be problematic for individuals who deviate from the requisite narrative (Cromwell, 1999). As Davy (2011, p. 31) notes, this approach can 'exacerbate transpeople's oppression by compelling them to enact a colonized concept of an ontologically recognized ("authentic") Transsexual identity'. This model is also at odds with a properly intersubjective, performative model of the subject in which one's sense of self is tenuously constructed and reconstructed through a series of social negotiations and self-interpretations. We cannot definitely know who we are prior to engaging performatively with an identity and thus our sense of self is constantly subject to revision. As Hird (2002, p. 587) notes, the 'problem with authenticity arguments is that they do not take sufficient account of gender as an ongoing product of interaction'. This means that there is more instability and uncertainty within sex/gender identities – and identity more generally – than the model of authenticity allows. To quote Davy (2011, p. 29), 'feminine and masculine embodiment is always in a state of flux and will never become stable and fully graspable'.

In light of this, it seems appropriate to be cautious of Rubin's (2003) attempt to reinscribe transsexual identities as authentic and inwardly-generated, as this overlooks the complex social processes involved in developing and maintaining a sense of gendered self. In defending the idea that our inner gender identities are "immutable" (ibid, p. 182) and that there is a 'core gender that is situated inside oneself, a gendered soul' (ibid, p. 145), Rubin works to individualise and internalise identity. For example, he refers to a person's identity as 'the letter buried within them' (ibid, p. 183), which provides instructions on how to become who we are. This is why the participants in Rubin's study saw themselves as becoming 'the men they always already were' (ibid, p. 153). One consequence of this picture is that the medical diagnosis of transsexuality is assumed to be a matter of accurately identifying the inner truth about individuals, rather than representing part of the process by which an individual's identity is intersubjectively and continuously constructed.

However, this diagnostic approach, in which successful diagnosis is aimed at ensuring one's authentic self is realised in/through one's physical body – 'bodies are an expression of that core self' (ibid, p. 145) – can reinforce the idea that one knows definitively, and indeed has always known definitively, one's authentic identity. This can undermine those individuals who are unsure about their sense of self and/or who want to undergo hormonal or surgical treatment in order to *cultivate* rather than merely reflect a sense of gendered self. Indeed, many transsexuals who understand their sex/gender in line with a performative, intersubjective model of identity have to tailor their self-narrative when interacting with medical professionals in order to ensure that they meet the expectations of what an authentic transsexual is (e.g. Davy, 2011; Hines, 2007).

Reflecting on this issue, May (2002, p. 459) notes that current 'medical discourses and practice, along with psychosexual therapy, are ill equipped and lack the confidence to create space for the contemplation of confusion and conflicts'. Reflecting on this issue, Prosser (1998: 108) concludes that in order 'to be a transsexual, the subject must be a skilled narrator of his or her own life. Tell the story persuasively, and you'll be likely have to your hormones and surgery; falter, repeat, disorder, omit, digress, and you've pretty much had it'. Consequently, one important challenge for clinical practitioners and therapists working with trans individuals during the diagnostic process is to 'model for clients how a sense of unsureness and ambiguity may sometimes be the most

appropriate positon for them to adopt' (May, 2002, p. 459). Until the medical approach adopts a more intersubjective, performative model of sex/gender, which sees one's identity as fluid and unstable rather than fixed and real, it will rest upon a problematic diagnostic procedure that works against those individuals who deviate from established narratives of the "authentic" transsexual.

Interpreting Success, Failure and Regret

The role of authenticity in the diagnostic process has an important impact on how notions of success, failure and regret are understood with regard to changing sex. As noted above, the idea of authenticity tends to go hand-in-hand with the "present from birth" narrative and the idea of sex/gender identity as something fixed and stable throughout one's life. This means that the "correct" diagnosis is one that accurately identifies a person's true identity, which in turn works to legitimise hormonal and/or surgical treatment and, ideally, ensure a successful outcome. A successful outcome of treatment is one in which the individual has satisfactorily realised their inner sex/gender identity, thus resolving the prior sense of gender dysphoria or false embodiment. Within this narrative, the experience of regret by an individual who has undergone SRS is linked to a failure to accurately diagnose their condition beforehand. Consequently, the expectations and management of success, failure and regret are approached from a perspective that assumes the transsexual's self is (a) fully-formed and recognised prior to transitioning, and (b) fixed and stable.

This perspective is evident in an assessment of post-transition regret conducted by Olsson and Möller (2006). The authors begin by stating that 'Persistent regret after sex reassignment surgery (SRS)… must be considered, along with suicide, as the worst possible outcome of SRS' (ibid, p. 501). Consequently, 'Every regret case represents a major clinical and ethical problem' (ibid, p. 502). This immediately raises the question of why regret must be considered to be "the worst possible outcome" and "a major clinical and ethical problem". Although Olsson and Möller do not offer an explicit answer, the assumption appears to be that regret indicates a *failure* and a *mistake*: a failure to secure the individual as a stable, recognisable gender; a mistake in that it turns out that the person was not really a transsexual (or, rather, an authentic / genuine case of transsexuality). However, perhaps the individual understood themselves to be transsexual prior to transitioning and in the process of

transitioning came to feel that they actually are not, or that their new identity is not what they expected / hoped it to be like. This need not be interpreted as either a failure or a mistake, but rather indicative of the nature of identity: something that is a constant becoming, a continuous process, which can never be entirely controlled or accurately predicted.

Olsson and Möller (ibid, p. 502-3) state that their case report 'will hopefully contribute to a growing body of knowledge that in the future will reduce the number of bad choices for SRS and also the number of regret cases'. However, maybe regret and bad choices cannot be eradicated or even significantly reduced precisely because one cannot determine what the outcome of SRS will be prior to the process itself. This is likely to be the case no matter how "authentic" the individual's gender dysphoria and no matter how accurately this is diagnosed by clinicians. Indeed, it is likely to be the case *because* there is no such thing as an "authentic" transsexual (i.e. someone who "really is" a man / woman trapped in a woman's / man's body). No one, not even the individual undergoing SRS, can know for sure what they will be like after transitioning. The position adopted by Olsson and Möller only makes sense if one assumes that (a) there is a kernel of transsexual identity present within the individual and persists throughout their life, and (b) that this can be correctly identified by therapists and doctors – for it is only on the basis of these two conditions that one could eradicate "bad choices" and regret by ensuring that only "authentic" transsexuals are given sex reassignment surgery.

These issues are identifiable in a number of other clinical studies that try to determine the likelihood of success and regret following sex change (e.g. Lawrence, 2003; Smith et al., 2001; Smith et al., 2005; Landén et al., 1998). Reflecting the concerns of Olsson and Möller, Landén et al. (1998: 287) state that 'Every effort must be made to avoid individuals who ask for a reversal of sex reassignment'. Similarly, Smith et al. (2005, p. 90) declare that 'it is imperative to try and prevent post-operative regret'. Finally, Smith et al. (2001, p. 472) note that 'one of the main objections of professionals against a start of the sex reassignment procedure before 18 years [of age] is the risk of postoperative regret'. Whilst it seems entirely reasonable to aim to minimise regret with regard to sex change, especially considering its somewhat irreversible nature, we should resist thinking that regret can be avoided and success can be guaranteed so long as only "authentic" transsexuals are offered sex reassignment surgery. This is because we cannot know definitively who we are prior to the performative engagement with a particular identity, which raises important issues for a

medical approach that remains wedded to the idea of one's gender identity as authentic and fixed. As May (2002, p. 460) observes, 'For the therapist who, having considered the degree to which gender is constructed, sees the process of *becoming* rather than the static position of *being* as that which governs gender identity, the assumptions central to medical discourse cease to make adequate sense'.

Davy (2011) and May (2002) note that many transsexuals are posing a challenge to certain medical models of gender because they are choosing to stop SRS at different stages. Specifically, the fact that certain transsexuals do not deem it necessary to have full SRS generates a problem for both diagnosis and "cure". To quote May (2002, p. 459):

> One of the central challenges of transgender metamorphosis for the medical model and those working within or alongside its belief system, is that it may well not proceed to what have been seen as obvious conclusions, recognizable stopping points. Both male-to-female and female-to-male transsexuals may stop short of full reassignment, raising problems in occupying a continuum of transgression which values fluidity and represents a head-on challenge for medical discourses.

One reason why this is a challenge for the diagnosis of transsexuality is because diagnosis is intended to identify "authentic" transsexuals who fit within the narrative of becoming unambiguous men or women, which in turn casts the "cure" as achieving stable, unambiguous gender identification (Davy, 2011, p. 30). On this model, transsexuals who decide to stop SRS would imply a failure of accurate diagnosis. Reflecting on this issue, St. Jacques (2007) observes that individuals who, having undergone SRS, decide that they are not transsexuals are typically situated by medical practitioners within a narrative of "regret". However, by understanding SRS as process by which a person's self is *constructed* rather than *realised* we can better make sense of individuals who choose a more ambiguous sex/gender identity. This alternative reading would imply that no "mistake" is made in diagnosing an individual as a transsexual who then chooses to remain in a more permanently "trans" state. Rather, the process of diagnosis and treatment is a central condition for an individual realising their capacity for self-transformation, wherein the individual's self unfolds throughout the process in potentially surprising and uncontrollable ways.

Considering the above, it would be beneficial if clinicians viewed the diagnostic procedure less as an exercise in accurate, authoritative identification of authentic selfhood, and more a central component in helping individuals to realise their capacity for continual creative self-fashioning. This would better reflect the always-incomplete, performative nature of the gendered self in which "man" and "woman" are each understood as 'a term in process, a becoming, a constructing that cannot rightfully be said to originate or end' (Butler, 1990, p. 33). To become more ethically sensitive and responsive to the idea of gender as a process of intersubjective becoming, the medical approach to sex change should acknowledge that the process by which trans individuals 'find a voice, a way of being and an emotional performance with which they are comfortable, must inevitably incorporate a process of trial and error' (May, 2002, p. 458). The problem is that currently 'there is little margin for error within a medical framework that reinforces schemata of "real" and "true"' (ibid).

The tendency for the medical approach to rest upon the idea of one's sex/gender as inner and fixed can generate a problematic ethical relationship between clinicians and transsexuals, wherein clinicians take themselves to be the gatekeepers of medical technologies and the guardians of transsexuals whose role is to prevent transsexuals making "bad" choices, e.g. choices they will later regret. This not only fosters a paternalistic relationship between clinician and trans individual, but it can also foreclose a sense of responsibility and responsiveness on the part of clinicians toward their clients/patients insofar as they overlook or misunderstand their own important role in the process by which the transsexual seeks to *construct* their self. This is not to say that many current clinicians do not genuinely want to the best for their clients/patients, and I am sure that they very often care about their welfare. However, so long as clinicians see themselves as "curing" trans individuals of an internal "problem" or "disorder", there is the danger that trans identities will continue to be pathologised as deviations from healthy sex/gender norms (Hird, 2003; Butler, 2004). This will foster ethically questionable relationships between trans individuals and members of the medical community, in which the former are cast as miserable, sick or unnatural individuals in need of the "cure" offered by medical science.

In light of this, medical practitioners and therapists should be encouraged to reflect on how their own gender expectations and perceptions affect their clients' self-

understanding and experiences of sex change (Davy, 2011; Whittle et al, 2008;), which in turn highlights the need for educating clinicians about trans identities and current perspectives on the social construction of gender (May, 2002). In particular, it is necessary to challenge the idea that clinicians are the "experts" or authoritative judges who properly understand the nature of transsexuality and sex/gender. Rather, it 'may be more productive therapeutically and personally to admit to the very sense of being "at sea" on questions of gender and embodiment' (May, ibid, p. 460). This would help clinicians to respond better to the frequent confusions and uncertainties that trans individuals can feel about their identities, especially those individuals who do not find they easily fit within the gender binary of unambiguous masculinity or femininity. It would also move us away from the idea that there is a "true", "proper" or "correct" way of embodying sex/gender norms, which in turns recasts what it means to undergo "successful" SRS.

The Sociality of the Self

In addition to shaping how we understand success, failure and regret with regard to changing sex, our picture of the self also has a strong impact on how we understand our ethical relationships with others. One important implication of the intersubjective, relational nature of the self is that questions of self-transformation are automatically linked to questions about our responsiveness and responsibility to others. This is because our attempts to change our own identities can strongly affect the identities of others, which implies that we should be ethically sensitive to the ways in which our attempts at self-transformation impact those with whom we stand in important interpersonal relationships. A problem with conceptions of the self as inner and authentic is that they can foreclose such issues by presenting the self as something created intra-subjectively rather than intersubjectively. This is evident in both Bornstein's and Feinberg's defences of sex change outlined above, in which the self is presented as atomistic and individually-scripted. Indeed, Heyes (2007, p. 55) notes that Feinberg 'tries to sidestep the ethical field into which one inevitably stumbles when talking about the merits of various "gender expressions." This elision comes from hir [sic] willingness to treat gender as an *individual* matter, rather than as a web of relations in ongoing tension and negotiation'.

This is why I think we need to be cautious about Rubin's defence of the idea of authenticity within transsexual narratives (Rubin, 2003). The participants in his study consistently reported that they 'have always been men, despite their female bodies' and thus 'who they are at heart does not change during transition' (ibid, p. 143). This implies that our encounter with others is simply a matter of being recognised for who we already are, rather than a process by which our gendered self is constructed. As Rubin (ibid, p. 145) writes, transsexuals' transitions 'are *only* a means of making their core gender identities visible and recognizable to the public' (emphasis added). Whilst it seems reasonable to assume that this is *part* of the process of transitioning, I do not think that it can be *all* there is to it. The reason for this is that the very process of transitioning is itself a means by which the self is worked on and developed. The self is always in-process, continually being made and unmade through our social interactions.

Changing sex thus contains an unavoidable element of unpredictability and uncontrollability. To suggest, as Rubin does, that transsexuals have always definitively know who they are, and that who they really are does not change during transition, implies a stability of the self and capacity for authoritative, introspective self-knowledge that belies the fluidity of identity and the opacity of the mind. Butler (2005) suggests that the myth of authoritative, absolute self-knowledge underpins problematic ideas of self-mastery and sovereign agency that distort our ethical relations with others. By acknowledging the limits of self-knowledge, which are a consequence of the intersubjective constitution of the self, she argues that we can cultivate an alternative ethical relationship with others founded on openness, responsibility, shared vulnerability and mutual dependency.

Attending to the intersubjective and performative dimensions of the self also challenges Rubin's idea of a "core gender identity" which resides wholly *within* the individual and which they discover themselves. The sociality of the self means that our gender is, in a sense, *outside* ourselves: 'What I call my "own" gender appears perhaps at times as something that I author or, indeed, own. But the terms that make up one's gender are, from the start, outside oneself, beyond oneself in a sociality that has no single author' (Butler, 2004, p. 1). Consequently, my capacity to understand myself 'is not only socially mediated, but socially constructed... In this sense, I am outside myself from the outset'

(ibid, p. 32). A danger with authenticity narratives is that they can cause us to see other people as threat to our ability to identify and realise our authentic selves, rather than as an inescapable precondition for having a sense of self in the first place. This, in turn, can distort the responsibilities and dependences we have with regard to one another in virtue of the relational, socially-constituted nature of the self.

One implication of this intersubjective aspect of selfhood is that our attempts at self-transformation have to be situated within the context of our current personal relationships and political discourses in order to see how they affect those around us. Rather than suggesting that this provides a reason not to undergo a change of sex, it implies that the decision to transition is never made in a social vacuum and never pertains solely to one's inner, authentic self. Arguments for the right to change sex that fail to consider this issue are thus ethically problematic, as are diagnostic approaches in which the individual is treated as a social atom rather than an intersubjective node. Insofar as we are bound up with the lives of others, we have obligations and commitments to them that arise from these relationships (Hines, 2007). Of course, many trans individuals are acutely aware of the social dimensions of the self. Davy (2011, p. 105) reports that 'Relationship factors, such as marriage and partnerships, were important considerations in decision making processes'. Similarly, Hines (2007) found that the decision to transition is often strongly affected by an individual's family relationships. This is particularly the case for older transsexuals who are married with children. One participant in Davy's study went into "remission" for a year in order to save her marriage (Davy, 2011, p. 105), whilst Rubin (2003, p. 121) describes a transsexual who chose not to transition in order to preserve their marriage.

Whilst some people may see this refusal to transition as a denial of one's authentic self – and hence a betrayal of who one really is – we can also read the decision as an ethically-informed one that acknowledges the social nature of the self and the claims that certain others have on us. Rather than offering definitive arguments for or against changing sex, a properly intersubjective model of the self reveals the ethical complexities involved in an individual's choice to change sex, wherein the very notion of an "individual" choice is unsettled. What this model does highlight is that one's decision to change sex cannot be justified just because this is who one really, authentically is. There are at least two reasons for this. First, one cannot definitively and indubitably know this is who one really is prior to the act of transitioning. Second, one's decision should be made through

reference to the social network of relationships within which one exists as a social being. In contrast to the authentic and atomistic perspectives on changing sex, the desire and decision to transition is not a purely private or personal matter and cannot be justified in terms of realising who one really is. Rather, to change sex is also to change one's social relationships, and the decision to transition must be made in full acknowledgement of this.

In light of this, it would be useful if the family members and/or friends of individuals seeking sex change are encouraged to take part in clinical discussions between medical practitioners and transsexuals – subject, of course, to the wishes of the transsexual. I am certainly not advocating that other people should *necessarily* be incorporated into such discussions. Rather, we should not automatically assume that the process of changing sex is a purely private affair that pertains solely to the individual and their "inner" authentic identity. Indeed, given the fact that the support of family and friends strongly affects a person's experience of transitioning, the medical approach to diagnosing and treating transsexuality should fully reflect the sociality of the self. Consequently, if we are concerned with producing positive outcomes from SRS, then placing others at the centre of this process would likely help to achieve this goal. Clinicians should thus work to facilitate the inclusion of family and/or friends within their meetings with trans individuals. This will help to avoid the assumption – reinforced by current practices of diagnosis and treatment – that one's identity is an individualised, private affair that is threatened, rather than constructed, by and through our relations with others. This, in turn, can aid the individual seeking sex change to make a properly ethical and informed decision, one which truly reflects the sociality of the self.

Conclusion

This paper has explored the ways in which the concepts of authenticity and atomistic identity shape contemporary narratives and debates about transsexuality. I have argued that the trope of authenticity not only adversely affects the diagnosis and treatment of transsexuality, but also generates ethically problematic relationships between clinicians and trans individuals. By understanding the gendered self as a continual process of performative becoming, in which our identities are intersubjectively constituted, we can (i) revise the procedures for

diagnosing and treating transsexuality; and (ii) rethink how the concepts of success, failure and regret are understood with regard to sex change.

Shifting from an authentic to a performative, intersubjective model of the self can also alter how we understand interpersonal relationships. Rather than see other people as a threat to the realisation of our authentic self, by appreciating the sociality of the self we can see one another as essential parts of the processes by which our identities are tenuously and often unpredictably constructed. It also suggests that we consider the impact that our attempts at self-transformation have on those around us. This shift in perspective can foster more responsive and responsible interpersonal relationships. Finally, the sociality of the self highlights the value in incorporating significant others into clinical discussions about changing sex. Such ethical issues can be foreclosed by a model of the self as authentic and atomistic, wherein identity is individualised as something intrinsic to the individual. This ultimately overlooks the social nature of the gendered self and the ethical issues connected to the decision to change sex.

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