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# Out in Psychology

## Lesbian, Gay, Bisexual, Trans and Queer Perspectives

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*Edited by*

**Victoria Clarke**

*University of the West of England, UK*

*and*

**Elizabeth Peel**

*Aston University, UK*



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# On Passing: The Interactional Organization of Appearance Attributions in the Psychiatric Assessment of Transsexual Patients<sup>1</sup>

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**Susan A. Speer**

*The University of Manchester, UK*

*and*

**Richard Green**

*Imperial College School of Medicine, UK*

## INTRODUCTION

In this chapter we do three things. First, we discuss the concept of 'passing', how it has been defined and used in the social scientific literature on LGBTQ topics, and its special relevance for those who identify as 'transsexual'. Second, we discuss how passing has been examined in two classic ethnomethodological studies of gender by Harold Garfinkel (1967) and Suzanne Kessler and Wendy McKenna (1978), and critically evaluate the contribution of these studies to what we know about the social construction of gender. Third, in an effort to update and extend the findings of these studies, we use conversation analysis (CA) and CA-inspired studies of gesture to analyse one minute of videotaped, naturally occurring interaction between a consultant psychiatrist and a pre-operative male-to-female

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<sup>1</sup> The first author wrote this chapter and conducted all the analyses. The second author arranged access to the field site, coordinated the collection of data at that site, and provided brief explanation on the clinical management of patients. He is the psychiatrist whose interactions are analysed in this chapter.



transsexual<sup>2</sup> patient in a British National Health Service (NHS) Gender Identity Clinic. Focusing specifically on the use by both parties of appearance attributions that implicitly or explicitly 'index' the patient's gender, we explore the role that such attributions play in the patient's attempts to pass as female, and to be treated *as* a trans woman in this distinctive institutional setting. We intend this chapter to contribute to LGBTQ research on passing, identity management and appearance, as well as conversation analytic work on how gender gets 'done', 'displayed' and 'oriented to' in interaction. Finally, we explain why we believe LGBTQ psychologists might benefit from a closer engagement with CA-inspired analyses of videotaped materials.

## ON PASSING

'Passing' is a historically problematic concept that is 'fraught with all sorts of political implications' (Transsexual Roadmap, 1996–2006). Commonly understood to involve 'being accepted, or representing oneself successfully as, a member of a different ethnic, religious, or sexual group' (*Oxford English Dictionary*, 2006: passing, n.8), such a definition is problematic for at least three reasons. First, it implies deception of some kind – that the passing individual is presenting themselves as a member of a group that is *not their own*. Second, it implies a real/unreal dichotomy – that there is an original, unconstructed 'real' self, and a constructed, 'unreal', passing self. Third, it 'implies a binary of pass or fail' (Transsexual Roadmap, 1996–2006), which involves 'the denial of mixture' (Stone, 1993, p. 11), and, which 'puts the power of determining the validity of our identities in the hands of others' (Transsexual Roadmap, 1996–2006).

A broader definition of passing – and one we adopt in this chapter – treats it from within an ethnomethodological framework as involving a person 'doing something in order to be taken as she/he intends' (Kessler & McKenna, 1978, p. 19). From this perspective, passing is not about deception, inauthenticity, or the denial of mixture. Rather, it is an activity that we *all* engage in as part of our everyday lives. As Kessler and McKenna (1978, p. 19) put it, 'everyone is passing'.<sup>3</sup> When considered in this way, passing is not necessarily overt or explicit. Indeed, the whole idea of passing is that the practices that are deployed in order to pass go 'unnoticed'. As Stephen Whittle (1999, p. 7) puts it, trans individuals 'have always been programmed to pass and hence disappear.'

For those persons who fit the prescribed norms for heteronormative group membership, passing successfully is a routine, unthinking and relatively effortless accomplishment (Garfinkel, 1967). For those persons who do not fit such norms, however, and who wish to manage (what they take to be) certain 'stigma' or 'undisclosed' but potentially 'discrediting information about self' (Goffman, 1963, p. 42), passing can become an abiding

<sup>2</sup> Although the medicalization and treatment of transsexualism is subject to considerable debate (see Burns, 2006; Butler, 2004; Johnson, Chapter 21), transsexualism is formally designated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) as a 'Gender Identity Disorder' (GID). Persons with GID are said to exhibit 'a strong and persistent cross-gender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex' (The Harry Benjamin International Gender Dysphoria Association (HBIGDA) 'Standards of Care for Gender Identity Disorders', 2001, p. 4). Throughout this chapter we use the medical term 'transsexual' as opposed to the more political term, 'transgender', to describe our research participants, because this research deals specifically with individuals who seek medical treatment to change their sex. The notion of transgender is often used in a political context by transgender activists in order to avoid medical categorization.

<sup>3</sup> The first author is, for example, passing as a 34-year-old feminist academic, a home-owner, a competent driver and so on.



preoccupation (Lev, 2004). For example, closeted gay men and lesbians who have not yet 'come out' to others, may strive consciously to pass as heterosexual. Similarly, transsexuals who wish to keep their birth sex secret may work hard to pass as 'natural' men and women.<sup>4</sup> For these groups, passing involves bringing a range of features of bodily comportment and appearance under conscious and deliberate control (Atkins, 1998; Dozier, 2005; Holliday, 1999; Schrock, Reid & Boyd, 2005; Skidmore, 1999)<sup>5</sup>. As Seidman (2002, p. 31) notes, 'For closeted individuals, daily life acquires a heightened sense of theatricality or performative deliberateness'. Indeed, our society is one in which sexual ambiguity is not (yet) tolerated, with the consequence that not fitting prescribed norms is highly accountable.<sup>6</sup> Moreover, in popular consciousness gender and sexuality are inextricably linked, such that any deviations from the norm in respect to either can be *doubly* consequential. Thus, if a woman 'looks like a man' then she not only falls short of gender norms, but she is deemed to be a 'mannish' or 'butch' lesbian. Similarly if a man 'looks like a woman' he may be seen as an 'effeminate' gay man (Peel, 2005).

For persons who live with the constant fear of exposure – of being 'read' as gay or lesbian, or a member of his or her birth sex – the importance of passing cannot be underestimated. It has been noted that passing is important for a transsexual person's self-image, for validating their identity, and for 'affirming their reintegration into society' (Lev, 2004, p. 398). As Brown and Rounsley (1996, p. 135) put it, 'If transsexuals can pass, they have a far better chance of developing relationships and finding jobs'. Indeed, passing successfully as heterosexual, or as a 'genuine' male or female, may be necessary for daily survival – for avoiding public ridicule, homophobic and transphobic violence, and the psychosocial difficulties (anxiety, depression) that may result from such discrimination. At the same time, individuals can pay a 'steep price' for passing – particularly if being 'closeted' involves denying a strongly felt gay, lesbian or trans identity (Seidman, 2002). There have been a number of well-documented cases of individuals who were passing well but then 'outed' as gay, lesbian, or trans with devastating, and sometimes lethal, consequences (see Califia, 1997).

In this chapter we focus specifically on the passing practices of a person who identifies as a male-to-female transsexual.<sup>7</sup> In addition to the bodily transformations that transsexuals experience as a result of consuming high doses of 'cross-sex' hormones and undergoing sex reassignment surgery, male-to-female transsexuals may elect to undergo a range of treatments and training in order to enhance their physical appearance and ensure that they pass well. Such treatments and training may include, but are not limited to, breast surgery and implants, facial and body hair removal (via electrolysis or laser), and speech and language therapy (in order to work on intonation, adjust the resonance of the voice and raise its pitch). Some patients may request a referral to an ear, nose and throat specialist for

<sup>4</sup> Although it is important to note that it's in the very nature of being transsexual that passing as one's preferred gender may require less effort, and feel more 'natural' than passing as one's ascribed birth sex. This is highlighted nicely in a quote from the trans activist Jeanne B (quoted in Bell, 1995, p. 141, quoted in Namaste, 2000, p. 32) who states 'One interesting thing, a lot of people ask me: "What do you do to pass as a woman? To look, walk, and talk like a woman?" But nobody asks me: "How did you manage to live and pass as a man for so many years?"'

<sup>5</sup> However, it should be noted that norms for gender expression vary both historically and cross-culturally (see, for example, Hall, 1997, 2005).

<sup>6</sup> The fact that we typically feel it necessary to apologize for mis-attributing someone's gender – as though it is an insult to get somebody's gender wrong – is testament to the strength of this socially imposed and sanctioned norm (Butler, in More, 1999, p. 293).

<sup>7</sup> Male-to-female transsexuals tend to pass less easily than female-to-male transsexuals, for whom hormone treatment has a significant masculinizing effect.



vocal pitch surgery and/or a tracheal shave (to diminish a protruding Adam's apple), and a few may request referral to a cosmetic surgeon for facial feminization surgery and liposuction. Finally, most patients will elect to undergo image modification – hair, clothes, make-up, accessories and props, attention to bodily comportment, posture and movement (e.g. walking), speech, emotional expression and even handwriting.

Unlearning traditional sex roles and relearning new ones usually requires considerable training and practice. Consequently, teaching people how to pass is big business, with individuals making a living out of training people to look, sound and move more like men and women (see, for example, Doyle, 2002–2005). It follows that since learning the techniques of passing often requires considerable funds, successful passing is not an equal opportunity phenomenon.

### Critical Perspectives on Passing

The transsexual person's preoccupation with passing has been subject to a wide-ranging critique. A number of radical feminists (Jeffreys, 1990, 2003; Raymond, 1979) and others with a critical agenda (MacKenzie, 1994) have argued that transsexualism is politically conservative. For these researchers, a transsexual person's adoption of the 'hyper-feminine' or 'hyper-masculine' actions, appearances and linguistic attributes associated with 'the opposite sex', reinforces the essentialist idea that gender dualism is biologically determined, compounds women's oppression, and makes gender diversity harder to see (Golden, 2000). Indeed, some suggest that passing 'is a product of oppression' (Feinberg, 1996, p. 89). If it were not for the existence of a patriarchal social order, individuals would not feel that they must pass, and hence 'blend unambiguously into mainstream society' (Brown & Rounsley, 1996, p. 135).

It is for precisely these reasons that some trans activists and queer theorists refuse to embrace the concept of passing, and treat the pressure to conform to social expectations regarding gender norms, with contempt. They resist this pressure by celebrating their gender ambiguity and the 'transgressive potential' of trans (Hird, 2002, p. 589). For them, it is trans visibility and the *refusal to pass* that is paramount (May, 2002). In refusing to identify as either male or female, gay or straight, many trans people consider themselves 'gender terrorists' who seek to 'radically deconstruct sex and gender' (Hird, 2002, p. 589), and who aim ultimately to render the sex and gender binary obsolete. From this perspective, 'the point is not about going from man to woman or woman to man' (hence exchanging one set of restrictive gender norms for another), but rather to go 'from one category to being a transsexual' (Butler, in More 1999, p. 291).

Rather than seeing transsexuals' desire to pass as insufficiently radical, or as reinforcing the gendered status quo, an alternative feminist approach, and one we adopt in this chapter, is to recognize and accept that, as the editors to this volume point out, on a day-to-day level there are many transsexuals who 'identify with normative values and have no desire to be "gender terrorists"' (Clarke & Peel, Chapter 2). Although they may ultimately hope that their transition will render their trans status 'invisible', it is nonetheless the case that the very act of 'migrating' (King, 2003) from one sex and gender identity to another has the potential to radically disrupt commonsense assumptions about the natural immutability of sexual dimorphism, and 'what counts' as sex and gender (Butler, 2004; see also, Johnson, Chapter 21). As Hird (2002, p. 347; see also Butler, 2004) notes, 'to the extent



that transsexual people are able to “pass” as “real” women or men, they reveal that sex and gender do not adhere to particular bodies naturally’. Certainly, for many researchers, transsexuals’ passing practices offer revealing insights into familiar cultural and normative ways of *doing* sex and gender.

## DOING SEX AND GENDER

Social scientists, especially symbolic interactionists, ethnomethodologists, social constructionists, post-structuralists and queer theorists, have long been concerned with the idea that sex and gender are phenomena that one *does* rather than something one *has* – a performance rather than an essence, a situated accomplishment rather than an ascribed, pre-determined role (see, for example, Butler, 1990, 1993, 2004; Fenstermaker & West, 2002; Garfinkel, 1967; Goffman, 1979; Kessler & McKenna, 1978; West & Zimmerman, 1987). One of the first publications to shed light on the actual practices that constitute the achievement of gender was Harold Garfinkel’s (1967) ethnomethodological study of a pre-operative intersexed person called Agnes.<sup>8</sup>

Ethnomethodology takes as its topic for study ‘members’ methods’ for producing their everyday affairs. Members’ methods consist of the routinized, taken-for-granted procedures that individuals employ as they go about their everyday lives and tasks. It is because such methods are routinized and taken-for-granted that Garfinkel refers to them as “‘seen but unnoticed”’ backgrounds of [our] everyday affairs’ (1967, p. 118). Garfinkel argued that gender (what he called ‘sex status’) is one such ‘invariant but unnoticed’ (1967, p. 118) background in everyday life. It is omnirelevant, and yet its organization is something that, for most individuals who can take their sex status for granted, remains hidden. What interested Garfinkel was that for some members, such as intersexed persons, this is not the case. Far from being able to take their sex status for granted, intersexed persons are engaged in the constant ‘work of achieving and making secure their rights to live in their elected sex status’ (1967, p. 118). For them, the work of passing as a ‘normal’ or ‘natural’ male or female is an ‘enduring practical task’ (1967, p. 118), which requires constant work and ‘active deliberate management’ (1967, p. 139) on their part. Garfinkel believed that by studying their situation, the ethnomethodologist can render visible what culture makes invisible – the accomplishment of gender (West & Zimmerman, 1987, p. 131).

It was on the basis of his study of Agnes’s more and less successful experiences of passing as an ‘120 per cent female’ (1967, p. 129), that Garfinkel was able to demonstrate precisely how it is that ‘over the temporal course of their actual engagements, and “knowing” the society only from within, members produce stable, accountable practical activities, *i.e.*, social structures of everyday activities’ (1967, p. 185). He concluded that ‘normally sexed persons are cultural events’ and that members’ practices ‘produce the observable-tellable normal sexuality of persons’ (1967, p. 181).

<sup>8</sup> Intersexed person are ‘individuals born with anatomy or physiology that differs from contemporary ideals of what constitutes “normal” male and female’ (The UK Intersex Association, nd). In the appendix to the chapter in which the Agnes study was reported, Garfinkel reveals that eight years after the study took place, Agnes admitted that she had lied to the research team, and that the feminization of her body was not due to the intersex condition known as ‘testicular feminization syndrome’, but rather to her having ingested female hormones that were originally prescribed for her mother. Thus, Agnes was not an intersexed person at all, but a male-to-female transsexual (see also, Johnson, Chapter 21).



Garfinkel's ideas were rather slow to seep into feminist consciousness. It was not until 1978, some 11 years after the publication of the Agnes study, that Kessler and McKenna's book, *Gender: An ethnomethodological approach*, developed Garfinkel's ideas about the social construction of sex for a feminist audience. Kessler and McKenna (1978) studied the *gender attribution process*, which describes the methodical procedures through which members come to identify others as unambiguously male or female. By examining how members 'do' gender attributions, Kessler and McKenna hoped to find out how it was that in each instance of interaction 'we produce a sense that there are *only* men and women' (1978, pp. 5–6). Kessler and McKenna argued that while the dichotomous nature of the gender attribution process is typically hidden, it comes to the fore in situations where members attempt to assign gender to 'ambiguous' individuals, or make sense of seemingly contradictory 'gender cues'. Thus, following Garfinkel, they set about exploring what transsexualism can tell us about the gender attribution process, and about 'the day-to-day social construction of gender by all persons' (1978, p. 112).

Although Kessler and McKenna shared Garfinkel's view that 'gender is omnirelevant' in interaction and that 'gender "work" is required' (1978, p. 136), unlike Garfinkel, they did not believe that most of the work was 'required of the one displaying gender' (1978, p. 136). Instead, for them, 'most of the work is done for the displayer by the perceiver' (1978, p. 136). Hence, they argued that a gender attribution is the product of an *interaction between displayer and perceiver*: 'Passing is an ongoing practice, but it is practiced by both parties' (Kessler & McKenna, 1978, p. 137). Although displayers create the first gender attribution, primarily through means of talk and physical appearance, once an attribution has been made, the perceiver's role is central to its maintenance (1978, pp. 136–137).

The approach to gender exemplified in these studies was remarkably ahead of its time. Indeed, Garfinkel's (1967, p. 181) claim that 'normally sexed persons are cultural events', can be considered a radical comment on the social construction of sex, more typically credited to the post-feminist philosopher, Judith Butler (1990), more than two decades later.<sup>9</sup> Unlike Butler, who does not examine concrete empirical materials, and whose theory of the discursive construction of gender is a rather abstract and decontextualized one, Garfinkel and Kessler and McKenna were among the first to demonstrate, with reference to the real-life, lived experience of transsexual individuals, that and how sex is a situated accomplishment. Treating gender as an emergent product of social interaction, they drew attention to the local interpretative practices and socially shared, taken-for-granted methods that members use to create the social structural 'reality' of a world of two sexes (Kessler & McKenna, 1978, p. vii).

The lasting significance of the Garfinkel and Kessler and McKenna studies is evidenced in the numerous debates and discussions that have taken place since their publication.<sup>10</sup> Although Garfinkel has since been criticized by feminists for his 'androcentrism' (Rogers 1992a, p. 170), and for reproducing sexist stereotypes and commonsense understandings about the 'priorities and competences' of young (heterosexual) men and women (Rogers 1992a, p. 180), his analysis of 'the accomplished character' (Zimmerman, 1992, p. 197)

<sup>9</sup> As Dorothy Smith (2002, p. ix) puts it 'postmodern feminists reinvented the wheel', and 'it is tiresome to read contemporary feminist philosophers and literary theorists presenting as radically new discoveries ideas that are old hat to sociologists'

<sup>10</sup> For discussions of the Agnes study see contributions to *Gender & Society* by Bolgh (1992), Rogers (1992a, 1992b) and Zimmerman (1992), and to *Sociological Theory* by Denzin (1990, 1991), Hilbert (1991), Lynch and Bogen (1991) and Maynard (1991). For a discussion of the Kessler and McKenna study see Crawford (2000).



of gender has been described as 'a groundbreaking work in sociology' (Bologh, 1992, p. 199), and 'a profound analysis' (Heritage, 1984, p. 181) that 'affords an unusually clear vision' of the workings of the social construction of gender (Zimmerman, 1992, p. 197). Similarly, the Kessler and McKenna study has been described as 'an extraordinary book, a prescient work' (Denny, 2000, p. 63), which provides a 'bold assault on the sanctity of the two-gender model' (Tiefer, 2000, p. 36). Despite the lasting importance and clear resonance of these studies for much contemporary feminist research, however, neither has received many follow-ups, nor the attention from LGBTQ psychologists that they deserve. As the editors to this volume point out in their introduction, LGBTQ psychologists have typically ignored gender, despite widespread recognition that gender and sexuality are mutually co-implicative.

One reason for this apparent neglect, is that it is not always clear how one might apply the findings of the Garfinkel and Kessler and McKenna studies to new interactional materials. Indeed, one of the main limitations of both studies is that although they placed great emphasis on members' 'everyday interactions' (Kessler & McKenna, 1978, p. 115), 'accounting practices' (Garfinkel, 1967, p. 1), 'witnessed displays of common talk and conduct' (1967, p. 181), 'situated indexical particulars of talk' (1967, p. 181), and 'the ways transsexuals talk about . . . transsexualism, the language they use' (Kessler & McKenna, 1978, p. 114), there is remarkably little by way of first-hand evidence of participants' accounts and interactions included in their analyses. Garfinkel's data consist of 35 hours of tape-recorded 'conversations' that he had with Agnes, which he supplemented with unspecified 'additional' materials collected by the psychiatric team at UCLA (Garfinkel, 1967, p. 121). Similarly, Kessler and McKenna's data consist of interviews with 15 transsexuals, letters written over a period of two years from a male-to-female transsexual friend called Rachel, and the results of a number of games and experiments. The vast proportion of the data used or cited in these texts consist of short, decontextualized (i.e. typically monologic, one speaker, one line) excerpts from transcripts of interviews with trans individuals, and the researchers' post hoc recollections and (anecdotal) reports of events. Extended examples of 'conversations' and 'interactions' are reported by Kessler and McKenna in the appendix to their book in the form of letters written by their transsexual friend, Rachel. However, like most data used in these studies, these second-hand descriptions of interactions, conversations and events are treated as first-hand, unreconstructed evidence for what actually took place in the setting – that is, as accurate reports on reality rather than situated accomplishments or *versions*. What is missing from both studies is a systematic analysis of first-hand examples of trans persons' actual language use, their situated interactions and accounts, and their contribution to those very practices of gender construction that Garfinkel and Kessler and McKenna intended to analyse.

An approach that *does* offer just the kind of systematic analytic framework advocated here, is CA. CA developed in the pioneering lectures of the American sociologist, Harvey Sacks, between 1964 and 1972 (Sacks, 1995), and has its roots in Garfinkel's (1967) ethnomethodology, Goffman's (1983) theory of the interaction order, and linguistic philosophy (Austin, 1962; Wittgenstein, 1953). Harvey Sacks and his colleagues, Emmanuel Schegloff, Gail Jefferson and Anita Pomerantz, were among the first to translate ideas from these perspectives into an empirically grounded, data-driven, and highly systematized research agenda. Conducting fine-grained, line-by-line analyses of highly detailed transcripts of audio and (where interactants are co-present) videotaped, naturally occurring interactions, CA is primarily concerned to examine and describe the oriented-to



methods and practices that speakers use to coordinate their talk to produce orderly and meaningful conversational actions.

A number of feminists, inspired primarily by Emanuel Schegloff's (1991, 1997a, 1998a), remarks on the role of gender and other demographic variables in interaction, have begun to use insights from CA to interrogate the relevance of gender in talk, and to explore 'what counts' as gender or an 'orientation to gender' in an interaction. Instead of conceiving of 'male' and 'female' as 'external and constraining' (Heritage, 1984, p. 181) independent variables that condition and account for members' social practices, researchers within this tradition treat gender, sexuality and prejudice as emergent, socially constructed phenomena. From this perspective, such phenomena may or may not be made relevant in interaction, and constructed and oriented to as participants' concerns (for some examples of research within this tradition, see Fenstermaker & West, 2002; Kitzinger, 2000; Land & Kitzinger, Chapter 8; Speer 2005a; Stokoe & Smithson, 2001). This body of work has produced some extremely rich insights into how gender gets done in interaction, and is taking the field of research on gender, sexuality and language in productively new directions.

CA has a long history of working with videotaped materials of co-present interactions (see C. Goodwin, 1980, 1981, 2003; Heath, 1986, 2006; Sacks & Schegloff, 2002; Schegloff, 1984, 1998b), and feminist researchers are increasingly using video to analyse how gender gets done and displayed in interaction (e.g. see M. Goodwin, 2001, 2002, 2006). In addition, there is a broad tradition of research outside CA that investigates the relationship between sex, gender and non-verbal communication (for some classic examples, see Birdwhistell, 1970; Frances, 1979; Goffman, 1979; Henley, 1977; and Wood, 2002). The majority of contemporary research within the field of research on gender and language, however, continues to focus on speakers and speaking, and on audio-based transcripts alone. For most gender and language scholars, 'doing gender' is conceived primarily as a verbal activity, with the consequence that the role of the hearer, or the recipient of a gender display in co-constructing gender, is largely ignored. Consequently, we have no way of knowing what role the recipient of a gender display plays in members passing as male or female.<sup>11</sup>

In this chapter, by contrast, we adopt the view expressed by C. Goodwin and M. Goodwin, that nobody is ever building an utterance or an action alone. Rather, utterances are produced by both speakers and hearers as part of a 'multi-modal' activity system, which integrates the disparate sign systems of grammar, prosody and the body into a common course of interactive activity (Stivers & Sidnell, 2005). These sign systems interact with each other in mutually reinforcing and interesting ways. For example, speakers will often change what they are saying in the course of their ongoing talk on the basis of the looks or 'gaze' that they are getting from their recipients (C. Goodwin, 1981; C. Goodwin & M. Goodwin, 2004; M. Goodwin, 1980). From this perspective, gender is a collaborative product of the interaction between speakers and hearers.

Our aim in the remainder of this chapter is to use insights from CA and CA-inspired analyses of gesture in order to develop and extend what we know about transsexuals' passing practices. Unlike Garfinkel and Kessler and McKenna, we will not be analysing members' retrospective reports on how they passed, or our own recollections and reports

<sup>11</sup> This is somewhat ironic, given that three decades ago Kessler and McKenna (1978, pp. 136–7) stressed the central role of the recipient, or the 'perceiver' of a gender display, in transsexuals passing as male or female.



of 'passing occasions' and events. Instead, we will provide a detailed empirical analysis of one minute of videotaped and transcribed, naturally occurring interaction in which a pre-operative male-to-female transsexual patient is engaged in the act of passing with a consultant psychiatrist in the Gender Identity Clinic (GIC). We ask, what are the vocal and gestural means by which the patient works to pass as a transsexual female, and 'do gender' in this setting? How does the psychiatrist orient towards and treat these 'gender displays'? Does he co-participate in, ignore, or reject them? How does the psychiatrist's response shape the patient's next interactional move, and what is the relationship between these displays and responses? Finally, what can our analyses tell us about transsexuals' passing practices and about the social construction of gender more broadly?

Part of the distinctiveness of what we aim to show here is that gender gets done as a thoroughly embodied and *co-constructed* practice in interaction, and that an analysis of the interrelation of the talk and gestures of *both speakers and hearers* is absolutely fundamental to our understanding of how members 'do', and 'display' gender in an interaction, and pass as male or female.

## PASSING IN THE GENDER IDENTITY CLINIC

Before we describe our materials and procedures and proceed to our analyses, we will first detail some features of the psychiatric assessment process in the GIC, and how this process shapes the distinctive role of passing in this setting.

In particular, it is important to note one crucial difference between what it means to 'pass' in the clinic environment, and what it means to pass outside it: As 'insiders', the psychiatrists at the GIC (just like Garfinkel and the psychiatrists in the Agnes study), will already know that the patient was not born male or female. In this sense, patients cannot possibly pass with psychiatrists in this institutional setting in the same way they might with others outside the clinic environment who do not know about their 'trans' status. Nevertheless, there are a number of features of the psychiatric assessment process that makes the GIC an ideal setting for an analysis of members' passing practices.

First, the internationally recognized Harry Benjamin International Gender Dysphoria Association's 'Standards of Care for Gender Identity Disorders' (HBI-GIDA, 2001) specify that, before they can obtain hormone treatment or surgery, patients must be assessed by two psychiatrists at the GIC. Psychiatrists assess the patient according to a pre-defined set of medical criteria, and aim to produce a 'differential diagnosis' (that is, to accurately diagnose the type of gender identity disorder and to determine that the patient is not suffering from some related or unrelated mental health problem). As Louise Newman (2000, p. 400) puts it, 'for the mental health clinician . . . the task is to distinguish the "true transsexual" (or primary transsexual) from others with lesser degrees of gender dysphoria or other gender issues for which surgery is not considered appropriate treatment'.<sup>12</sup> Psychiatrists are essentially gatekeepers to hormones and surgery (Speer & Parsons, 2006; see also Johnson, Chapter 21 and Clifford & Orford, Chapter 10). It follows that in order to obtain their desired treatment, patients must first pass with the psychiatrist in the clinic environment as a transsexual who meets all the requisite diagnostic criteria (May, 2002,

<sup>12</sup> It should be noted, however, that clinicians themselves no longer use 'true transsexual' as a diagnostic term.



p. 459). That patients are attentive to this requirement is evidenced in the reports of patients who, concerned not to delay or risk being refused surgery, quickly learnt the 'necessary life-history required for successful "passing"' (Hird, 2002, p. 583) – a life-history whose parameters they found handily spelt out in the Standards of Care (HBIGDA, 2001) and in the 'published developmental histories of transsexuals who preceded them' (Green, 1987, pp. 7–8; see also, Johnson, Chapter 21).

Second, as part of the assessment process, patients must participate in the 'Real Life Experience' (RLE – also known commonly as the 'Real Life Test'), in which they must demonstrate that they are living full-time within their preferred gender role for a period of at least a year. This will include at least one year on high doses of cross-sex hormones. When they assess the quality of the patient's Real Life Experience, clinicians review their ability 'to maintain full or part-time employment' (or 'to function as a student' or in some 'community-based volunteer activity', HBIGDA, 2001, p. 17). The patient must also provide documentary evidence that someone other than the psychiatrist (e.g. an employer) knows them to function outside of the clinic setting in their preferred gender role, and change their first name to a 'gender appropriate' one (2001, p. 17).<sup>13</sup>

The Standards of Care (HBIGDA, 2001) does not treat physical appearance or success in passing in the preferred gender role as a formal criterion in assessing the quality of the Real Life Experience. Moreover, in recent years there has been a 'shift in thinking toward recognizing the enormous diversity in the ways that gender and gender roles can be expressed' and, some might suggest, an associated loosening of the requirement to pass as unambiguously male or female (Brown & Rounsley, 1996). Despite this, however, there are numerous reports in the literature that gender professionals 'have judged transsexuals' authenticity on their ability to pass' (Lev, 2004, p. 264). Indeed, gender professionals have noted that 'clients often look for positive feedback on their presentation. They show off their bodily changes and boast about their new breasts or hair growth' (Lev, 2004, p. 263). Certainly, we have found that it is not uncommon (as we go on to show below), for psychiatrists (as well as patients) to comment on the patient's appearance and overall ability to pass *as* a man or a woman, during the assessment sessions. Additionally, if patients do not turn up obviously 'in role', then psychiatrists will often treat this as an accountable matter. It is hardly surprising given this context that patients will interpret their success in the RLE as dependent on them showing, through their talk, bodily comportment, appearance and gestures, that they can pass as a convincing, 'always have been, always will be', male or female, in their interactions with the psychiatrist.

## DATA AND METHOD

The data excerpt we analyse below derives from a large corpus of more than 150 audio-recorded and 20 video-recorded psychiatrist–patient consultations from a large British National Health Service (NHS) Gender Identity Clinic. These data were collected by the authors as part of a large scale Economic and Social Research Council funded study of the construction of transsexual identities in medical contexts.

The clinic in our study is the largest GIC in the world. Ninety-five per cent of all NHS referrals are dealt with here, and psychiatrists at the clinic see 600 new patients each year.

<sup>13</sup> For more on the diagnosis and treatment of transsexualism see Green (2000, 2004).



The majority of patients attending this clinic self-identify as pre-operative, male-to-female transsexuals. Although statistics on such matters are notoriously problematic, this reflects the much larger incidence of transsexualism amongst males in the population (some of the latest figures from the Netherlands suggest transsexualism effects 1 in 11 900 males and 1 in 30 400 females, HBIQDA, 2001, p. 2). At the time we collected our data, there were four psychiatrists at the clinic – three male and one female. Although all four psychiatrists were involved in audio-recording their sessions with patients, two of the male psychiatrists recorded the majority of sessions for this study. One of these psychiatrists also consented to video-recording approximately 30 of his sessions for the study. Each recorded session lasts 15–60 minutes each. Although the relative infrequency of patients' appointments means that we are unable to track the progress of individual patients over time, our corpus includes examples of sessions with patients at a variety of different stages of the assessment process, from initial intake assessment interviews, to exit interviews (where they are signed off for surgery by a second psychiatrist), and post-surgery follow-ups.

Ethical approval for this study was granted by the NHS Central Office of Research Ethics Committee. Patients' participation was sought by the psychiatrist responsible for recording the session. They were provided with an information sheet and consent form, and had the opportunity to ask questions before recording commenced. Patients were advised that their decision whether or not to participate would not affect the course or outcome of their treatment, that their name and date of birth, and all names and place names referred to during the session would be changed in all reports produced by the study. They were told that stills of the videotapes may be printed in a scientific report, but that their image would be digitally disguised in order to protect their anonymity.

All data were transcribed verbatim in the first instance by a professional transcriber. Detailed transcripts were then worked up by the first author using conventions developed within CA by Gail Jefferson (2004). A simplified version of these conventions is included in the Appendix (see p. 363). Bodily movements and gestures were also noted in the margin on the transcript. Video stills have been included below to exemplify these gestures and their interlacing with the talk, where relevant to the analyses. The excerpt heading provides information about the date of the recording, and the exact location within that recording of the clip. The clip we have chosen is from an exit interview, and the patient identifies as a pre-operative male-to-female transsexual. This patient has been taking female hormones for over a year, and she presents 'in role', in traditional female attire. As we noted above, patients must be assessed by two psychiatrists before they can be referred for surgery. At her last visit to the clinic this patient obtained her first approval for surgery from one of the psychiatrists, and this interaction is taken from her session with a second psychiatrist. Four minutes prior to the start of the excerpt, the psychiatrist announces to the patient that he and his colleagues will be sending a letter to the surgeons endorsing her for surgery. This 'green light announcement' is a momentous occasion for this patient – who has been trying to obtain her surgery for 12 years (the psychiatrist tells the patient that until now she has not been deemed psychologically stable enough to proceed to surgery). The psychiatrist explains the referral process to the patient, and the risks of surgery, and informs her that she can pull out before the surgery. A minute after he first announces the clinic's approval for surgery, he states again that they will recommend her to the surgeon, subject to the condition that she is 'absolutely certain' that surgery is going to be helpful to her. The patient works to provide such assurances. The psychiatrist is at



great pains to point out that genital surgery will not alter her outward appearance, and, in particular, to correct her erroneous assumption that genital surgery will prevent further loss of hair from her scalp. Indeed, he suggests that she could continue to live as a woman without the surgery. The patient responds that she would not have gone through 'all the things' she has 'been through' unless she was sure she wanted the surgery.

The excerpt we analyse below begins at this point in the interaction, one minute prior to the end of the assessment session. It begins with the psychiatrist re-issuing (now for a third time) the clinic's approval for surgery, this time subject to the patient meeting the condition (and reassuring him) that she is 'absolutely convinced' (lines 1-2). The whole sequence is dedicated to unpacking why the patient is 'absolutely convinced' that she wishes to go ahead with surgery, and, in particular, why she wants the surgery 'now'.

**[Video 4. Clip 2. Male-to-Female Pre-op. 19.09.05. 33.30-34.30 mins. Exit interview]**

- 1 Psy: As long as you're absolutely convi:nced we'll let you  
 2 Pat *simultaneously* do it.  
 3 *engaged with bag* (.)  
 4 Pat: W'll ye::ah- I mea- I mea:n there's no good puttin'  
 5 any more obstacles in the way, I might aswell j's:t  
 6 sort of get it done when I know I can sti::ll- you  
 7 know- hopefully maybe I mean,  
 8 Pat *sweeps hair both* I- I do: (0.4) you know people at wo:rk think I've  
 9 *sides of face* got a lovely figure >I mean I've got that going for  
 10 *Psy smiles, Pat* me I (look/got)quite nice,<  
 11 *gestures hand across chest*  
 12 (0.8)  
 13 Psy: [°Okay°.  
 14 Pat: [(because/figure) slight- you know- kind of- you  
 15 know- dependin',  
 16 (.)  
 17 Pat: *Psy nods* >An- that's the men(h)< (h)ri(h)ght(h) I'm not  
 18 ( ) say that ( ) so .hhh you kno::w uh:m,  
 19 (0.4)  
 20 Pat: *Pat gestures* I mean my face is- I c'd do with putting a ba:g over  
 21 *bag over head* my head b't .hhh uh:m,  
 22 (0.4)  
 23 Pat: .Pt as a ru:le- you know like as I say the lo:nger  
 24 *Psy nods* I leave it the harder it's gonna ge:t,you know(°l-°)  
 25 Psy: Okay but whether or not you have the genital  
 26 surgery, [sitting here right now,  
 27 Pat: [Ye:ah,  
 28 (.)  
 29 Pat: Yeah,  
 30 (.)



- 31 Psy: I don' know whether you've had surgery.  
32 (1.0)
- 33 Pat: You don't kno:w.
- 34 Psy: *Psy hands out-* [( I'm) here looking at you who]=  
35 Pat: *stretched,* [Oh r:right yes that's what I'm]=  
36 Psy: *shakes head* =[who w'd know?=  
37 Pat: *and shrugs* =[saying. Yeah. Yeah. (Sure).  
38 Psy: This is not a (nudist) interview.  
39 (.)
- 40 Pat: No. Su:re. [Su:re.]  
41 Psy: [You] look like a woman.  
42 (.)
- 43 Pat: Yea:h, n[o, that's right. (Yeah that's)  
44 Psy: [You don't have to have surgery to  
45 continue looking like a woman [(of course).  
46 Pat: [Yeah but- I- I- s- I-  
47 *Psy nods* (0.6) I- I want to have relationsh(h)ip(h) so(h)  
48 wi[th a ma:n or whatever. .h[h  
49 Psy: *Psy nods* [Okay. [Okay.  
50 Pat: An' (0.4) whatever.  
51 Psy: *Psy nods and* [Okay.  
52 Pat: *starts to get* [You know so,  
53 Psy: *up. Psy stands* Okay, we will send a let[ter of referral  
54 Pat: [Yeah, okay,

## ON THE ROLE OF APPEARANCE ATTRIBUTIONS IN PASSING AS FEMALE

Like Garfinkel (1967), Kessler and Mckenna (1978, p. 136) and others (e.g. Fenstermaker, West & Zimmerman, 2002; West & Zimmerman, 1987) we are of the view that gender is *omnirelevant* in interaction. Although it is typically a 'seen but unnoticed . . . background in the texture of relevances that comprise the changing actual scenes of everyday life' (Garfinkel, 1967, p. 118), every single thing a person does or says (whether it explicitly indexes gender or not), can potentially be 'read', interpreted, or accounted for through the lens of gender.<sup>14</sup> The relevance of gender is particularly acute within the clinic environment, where the patient's actions are institutionally consequential: they have a direct bearing on whether or not they pass as a man or a woman, and, in turn, on whether or not the psychiatrist deems that they meet the institutionally ratified criteria to be diagnosed as transsexual.

<sup>14</sup> Fenstermaker, West and Zimmerman (2002, p. 29) note that 'an individual involved in virtually any course of action may be held accountable for her or his execution of that action as a woman or a man . . . virtually any pursuit can be evaluated in relation to its womanly or manly nature'. But compare Sacks (1972), who suggests that 'there is no cross-setting omnirelevant categorization device that has been *shown* to be omnirelevant' (Schegloff, nd: n5, emphasis in original).



As symbolic interactionists, conversation analysts and gender and language researchers have shown, gender gets 'indexed', 'displayed', or 'oriented to', through a range of vocal and gestural means (Goffman, 1979; Hopper & LeBaron, 1998; Ochs, 1992; Schegloff, 1997a). One routine conversational means through which gender gets indexed (implicitly and explicitly) in the GIC, and through which passing gets done, is via what we are calling 'appearance attributions' – that is, references to what the patient *looks* like. In our data, appearance attributions are initiated by both parties, and take a range of forms (e.g. 'I/you look *x*', 'I/you have *x appearance*', 'I/you are an *x looking kind of person*'). Such attributions are typically evaluative, involving positive or negative assessments of some appearance-relevant attribute.<sup>15</sup> We have marked these appearance attributions on the transcript in bold.

We have chosen this excerpt for analysis, in part, because it contains examples of both patient-initiated and psychiatrist-initiated appearance attributions. As such, it allows us to investigate the interactional circumstances in which the patient deploys appearance attributions in order to pass as a transsexual female, *and* those circumstances in which she is apparently treated as having passed successfully by the psychiatrist. Additionally, in this excerpt we have a chain of *multiple* descriptions concerning the patient's appearance. This allows us to track how such descriptions develop incrementally over time, with each successive turn in the interaction, and in response to the recipient's actions.

We will show that appearance attributions are multi-unit phenomena that can be used by patients in an incrementally upgraded or downgraded fashion to pursue (and respond to) certain kinds of participation from the psychiatrist. In this excerpt these appearance attributions are progressively *downgraded* by the patient in order to attract a response in which the psychiatrist co-participates in her performance by treating her *as a woman*.

Let us start by taking a closer look at the first few lines of the excerpt. What can we say about the interactional environment in which the first, patient-initiated (reported) appearance attribution takes place?

## THE PSYCHIATRIST'S OPENING DECLARATIVE AND THE PATIENT'S (HEDGED) RESPONSE

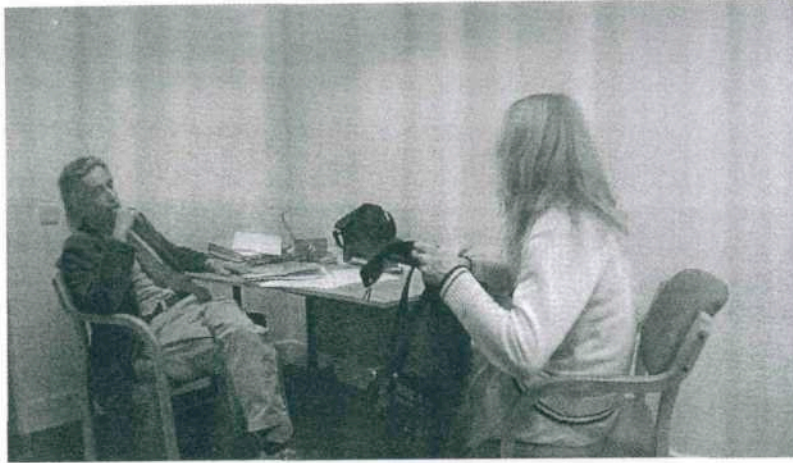
As we noted above, the psychiatrist's conditional declarative 'As long as you're absolutely convinced we'll let you do it'<sup>16</sup> (lines 1–2) re-issues the approval for surgery that he had given the patient just four minutes prior to the start of this excerpt. It also recycles his subsequent conditional approval in which he sought the patient's assurances that she was 'absolutely certain' that she wished to go ahead with the surgery. Now the clinic's approval is subject to the patient meeting the condition (and reassuring the psychiatrist) that she is 'absolutely convinced'.

In a sense, this whole exchange is dedicated from the outset to being a 'sequence-closing sequence' (Schegloff, 2007). As conversation analysts have shown, the re-mentioning of topics from prior talk is often done in closing environments, precisely in order to

<sup>15</sup> For more on the conversation analytic understanding of assessments see C. Goodwin & M. Goodwin, 1987; Heritage & Raymond, 2005; Pomerantz, 1984a.

<sup>16</sup> This utterance represents a clear orientation by the psychiatrist to the institutional, gatekeeping role of the psychiatrists at the clinic, and their control over the patient's destiny.





**Figure 16.1** Lines 1–2, Psy: ‘As long as you’re absolutely convi:nced we’ll let you do it’.

bring that talk to a close (Schegloff & Sacks, 1973). From the psychiatrist’s initiation of a sequence that echoes, almost precisely, the topic and structure of the just-prior talk, the patient would be able to project that the psychiatrist is moving toward closure of the assessment session, just prior to the ‘closing proper’. That the patient is oriented to this *as* a closing relevant environment is evident from Figure 16.1, where she is clearly in the middle of packing the paperwork that she has been showing the psychiatrist during the session into her bag.<sup>17</sup>

The psychiatrist’s declarative makes relevant and ‘prefers’ (Pomerantz, 1984a)<sup>18</sup> a response in which the patient shows herself to agree with the formulation that she is ‘absolutely convi:nced’ – to produce a ‘no doubts’ response. Indeed, given what we have just noted about the closing relevance of the psychiatrist’s declarative, this interaction could end relatively swiftly at line three with the patient saying ‘of course I’m convinced’. Instead, the patient responds with the turn initial ‘W’ll ye::ah’ (line 4). This indicates that her response will not be straightforward (Schegloff & Lerner, 2004) and treats the underlying supposition of the question – that she may have some remaining doubts about proceeding to surgery – as inapposite. She goes on to produce a (hedged) account for *why* she is convinced, and which explains *why* she needs the surgery now.<sup>19</sup> Although the psychiatrist’s question does not ask the patient to produce this kind of account, it nonetheless opens up a slot in which she can unpack, and provide evidence for, precisely why his question is inapposite (the ‘I mean’ (line 4) is dedicated to launching this task). So what does the patient’s account for ‘why now’ consist of?

Her ‘I mea:n there’s no good puttin’ any more obstacles in the way’ (lines 4–5) indexes the views of many patients who see the real life test as an inconvenient hoop they must jump through in order to get what they need. In lines 5–6, she seems to be having some trouble over formulating her response. She says ‘I might aswell j’s:t sort of get it done when I know I can sti::ll’. But still what? This turn is clearly moving toward explicating some time- or age-limited activity in which surgery would allow her to participate, but it

<sup>17</sup> Indeed as soon as the psychiatrist has finished his turn at lines 1–2, and throughout the patient’s response at lines 4–7, the patient pulls the drawstring of her bag up towards her and slowly sliding it closed, before resting the bag on her lap.

<sup>18</sup> For more on the conversation analytic notion of preference see Sacks, 1987 and Schegloff, 2007.

<sup>19</sup> Indeed, as we shall see, this entire sequence builds toward an account in which the patient specifies why she needs surgery *at all* (lines 46–48).



trails off. Indeed, it may be designedly doing so in that it relies on the psychiatrist to project where the patient might be going with this turn, and specifically to infer what time- or age-limited activities she is explicitly *not* stating. The patient's 'hopefully maybe' (line 7) is taking up a stance of desire towards this world of activities that she hopes she might 'still' be able to partake in and which she has so far been unable to articulate. However, here again, the precise specification of this world of desires and possible actions is aborted in favour of further unpacking ('I mean' – line 7).

The utterance that comes exactly next is the patient's first appearance attribution 'I-I do: (0.4) you know people at wo:rk think I've got a lovely figure' (lines 8–9.) In combination, the hedging, the temporalizing of 'sti::ll' (line 6), the stance taking of 'hopefully maybe' (line 7), and the appearance attribution (lines 8–9), provide clues that help the psychiatrist indexically to fill in or infer what the patient is getting at here: that she wants the surgery now, while she is still young and attractive enough to get a partner.

Indeed, lines 5–9 can be heard as possibly 'suppressing' (Schegloff, 2003) what they're going towards, and which we arrive at only eventually after the psychiatrist's challenge, at lines 46–48: 'Yeah but- I- I- s- I- (0.6) I- I want to have relationsh(h)ip(h) so(h) with a ma:n or whatever. .hh'. The word 'relationsh(h)ip(h)' captures the patient's as-yet-unstated desire for a (hetero)sexual relationship. In addition, the utterance is delivered in a hesitant fashion (note the cut-offs, re-starts and the 0.6 second pause in lines 46–47), and is interpolated with laughter. This hesitation and laughter suggest that the patient is orienting toward this utterance as a delicate object (Haakana, 2001). That this matter – of having a sexual relationship with a man – is oriented to as delicate by the patient, *and* exists in a sequential environment in which it gets addressed only *after* the psychiatrist's challenge, suggests that such matters may indeed have been those that were being suppressed at lines 5–9.<sup>20</sup>

## THE PATIENT'S (REPORTED) APPEARANCE ATTRIBUTION

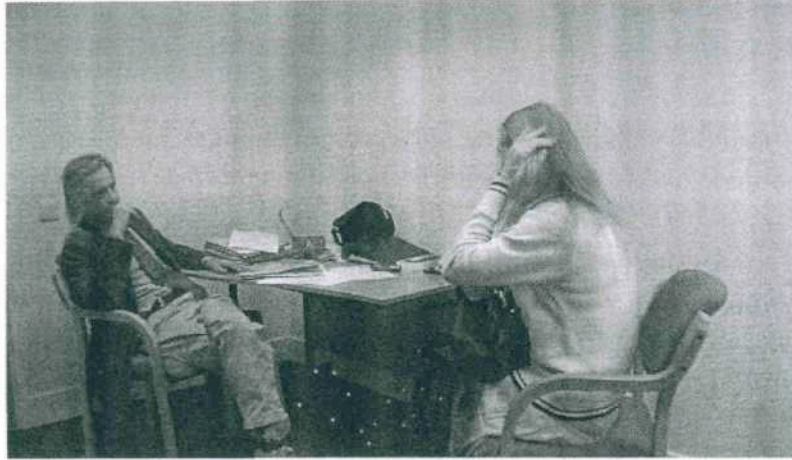
Let us now take a closer look at the appearance attribution: 'I-I do: (0.4) you know people at wo:rk think I've got a lovely figure', and its launching at line 8. The first thing we wish to note is that the launching of this appearance attribution coincides precisely with a 'self-groom' in which the patient sweeps her hair away from both sides of her face, as exemplified in Figures 16.2a, 16.2b and 16.2c, below.

That this self-groom coincides so precisely with the launching of the appearance attribution at line 8 indicates to us that it may not be entirely random (i.e. that the patient's hair is in the way of her face and needs moving at just this moment). Rather, it may be a gender display that's designedly fitted to the vocal elements of the interaction. By 'designedly fitted' we mean that as a distinctly feminine, normatively recognizable way that women groom their hair (especially, perhaps, during heterosexual interactions<sup>21</sup>), it works as an

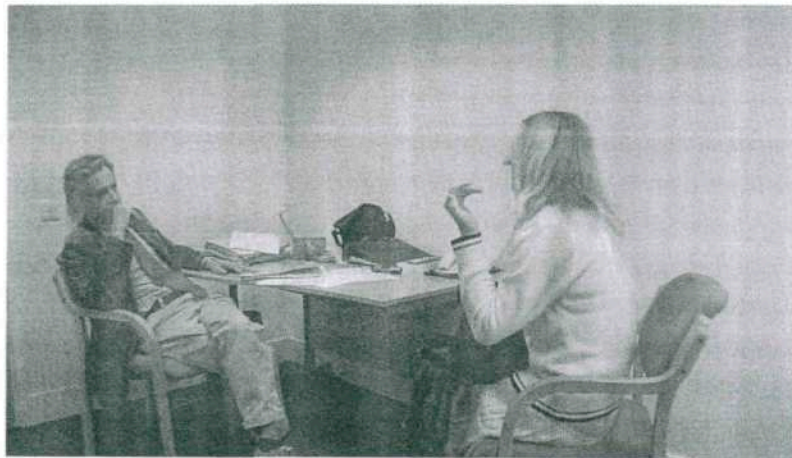
<sup>20</sup> Note that we are using the notion of suppression rather differently from Schegloff (2003, p. 246). According to Schegloff, evidence for suppression consists in the word/s that were suppressed (if they seem to have been projected) appearing in the immediately following talk. In the instance we discuss here, lines 46–48 are non-proximate to what we are suggesting constitutes the suppressed element in lines 5–9. Therefore, we can only infer (just as the psychiatrist may infer) that lines 46–48 constitutes the 'surfacing' of that suppressed element.

<sup>21</sup> Of course, the patient does not know the sexual orientation of the psychiatrist in these data, but this does not rule out the patient treating the interaction from within a heteronormative framework as a heterosexual interaction.

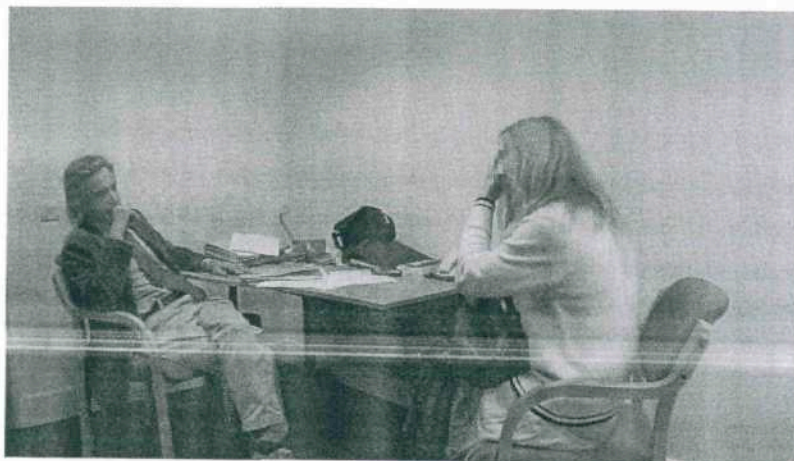




**Figure 16.2a** Lines 8–9, Pat: 'I- I do: (0.4) you know people at wo:rk think I've got a lovely figure'



**Figure 16.2b** Lines 8–9 cont'd



**Figure 16.2c** Lines 8–9 cont'd



implicit indexing of gender, and a 'seen but unnoticed' background (Garfinkel 1967) through which the psychiatrist will frame and interpret the vocal element of what the patient is saying. In combination, we see the vocal (appearance attribution) and the visual (self-groom) here as mutually elaborative and reinforcing elements of the same phenomenon – that is, of the patient showing the psychiatrist that not only is she treated by others outside of the clinic environment as a woman, but that she is able to behave like one within it.

Indeed, the second thing we wish to note about the appearance attribution at line 8 is that the turn in which it appears is launched with 'I- I do:'. This seems to be the beginnings of some kind of positive self-assessment (e.g. it could be going towards 'I do think I look nice', or 'I do have a lovely figure'), but it is repaired<sup>22</sup> in favour of the participation-seeking 'you know' (which invites the psychiatrist to fill in inferences regarding what the patient is getting at here (Fox Tree & Schrock, 2002)), and the reported compliment of a third party: 'people at wo:rk think I've got a lovely figure' (lines 8–9). This repair from 'I do:' to 'people at wo:rk think' constitutes a shift in the patient's footing (Clayman, 1992). This footing shift appears to be in the service of avoiding what Pomerantz (1978) has termed 'overt self-praise' or a 'self-brag'.

Some of Sacks's (1975, p. 72) observations are pertinent here. Sacks makes a distinction between two different kinds of statement. He notes: 'For the first, if, e.g. a little girl comes home and says to her mother, *Mama, I'm pretty* or *Mama, I'm smart*, the mother could say "Who told you that?." For the second if someone says *I'm tired* or *I feel lousy*, etc., no such thing is asked. One is responsible for knowing some things on one's own behalf, in contrast to the situation in which one is treated as likely to be repeating what another has told him about himself.'

In shifting her footing and reporting the compliment of a third-party (line 9), the patient avoids the kind of self-brag associated with the first statement that Sacks identifies above. Since, for reasons of self-praise avoidance, the patient may not be at liberty to compliment herself, these third parties ('people at wo:rk' (line 8)) are, by virtue of being third parties, *entitled* (and perhaps more entitled than she is) to make an objective assessment of her appearance.

In addition to being *interactionally consequential*, it is also *clinically consequential* that the patient formulates the description of her appearance in this way. Indeed, she is currently being assessed by the psychiatrist in part for whether she has a *realistic* view of herself in her new role. If she can convince the psychiatrist that she passes with others (both men and women) outside the clinic environment who notice and comment on feminine aspects of her appearance – thus *treating her as a woman*, then she can show that she is hardly deluded about her trans status.<sup>23</sup>

<sup>22</sup> For more on the conversation analytic notion of repair see Schegloff, Jefferson & Sacks (1977) and Schegloff (2007).

<sup>23</sup> In other words, in reporting this reference to recognizably feminine *attributes*, she shows herself to *be*, and to be recognizable by others as, a *bone fide* member of the category 'woman' (Sacks, 1995). Of course, the appearance attribution, 'I've got a lovely figure', does not index gender explicitly, through the use of gender category terms or pronouns, for example. Nor does it get oriented to explicitly as gendered by the psychiatrist in his next turn. Indeed, this utterance could *potentially* be said by men about themselves, or by others about men. In this respect, we appear to have no analytic basis from which to suggest that such utterances constitute examples of the patient *doing gender* at all. However, if we could show that this kind of appearance attribution is regularly uttered *by women* about themselves, and by others *about women*, and that such 'ways of talking' are, outside this context, *regularly treated as, or oriented to* explicitly by members as things said normatively by and about women, then we may be justified on this occasion in treating such utterances as *possible instances* of the speaker showing that she is *doing being*, or *speaking as a woman* (and we may claim this independently of whether or not members explicitly orient towards such utterances in their next turn *as doing femininity*). For more on the notion of a 'possible x' see Schegloff (2006). For more on the relationship between attributes and categories see Schegloff (nd).



The psychiatrist's pose remains steadfast throughout this first reported appearance attribution. It is possible this steadfastness, combined with his apparent failure to respond visibly or vocally to the self-groom, the patient's repeated 'you know's, and the positive reported compliment-in-progress, may account for why the patient shifts footing again at line 9, as she unpacks what she meant by, and her stance towards, the embedded compliment. Her '>I mean I've got that going for me' (lines 9–10) indexes back directly to the assessment, 'lovely figure', shows that she affiliates with it, and holds its relevance in place.

This is followed with a second appearance attribution: 'I (look/got)quite nice, <' (line 10) – an attribution in which the patient is now assessing her own figure, and displaying what she takes to be the import of the reported compliment. As she produces this appearance attribution, she gestures her hand across her chest. This gesture comes to completion after the word 'nice' (line 10), and, here again, seems to work in a mutually elaborative fashion with the talk in order to convey what it is that the patient is getting at, and to encourage the psychiatrist to respond (see Figure 16.3).

'I (look/got)quite nice, <' (line 10) – is clearly framed as a *positive* self-assessment, but is also a *downgraded* assessment that is not as strong as 'lovely figure'. Why might the patient downgrade the assessment in this way?

As we have seen, the psychiatrist remains steadfastly non-responsive throughout lines 8 and 9. He does not coparticipate in the patient's assessments, affiliate with, or ratify what she is saying. He does smile as the patient produces her gesture at line 10, as she starts to voice her second appearance attribution, 'I (look/got)quite nice'. However, this is a 'grimacy' smile that's strongly mitigated by the hand in front of his face (see Figure 16.3). This smile appears to show that the psychiatrist is responding to what the patient is saying, but without explicitly agreeing or disagreeing with it.

In our view, each of the three components of the patient's turn in lines 8–10: the reported compliment, the displayed alignment with the reported compliment, and the downgraded self-assessment, seem to work incrementally to secure, and pursue (Pomerantz 1984b) a particular kind of response from the psychiatrist. Indeed, as conversation analysts have shown, recipients of first assessments often co-participate in those assessments by producing agreeing and upgraded second assessments (Pomerantz, 1984a; see also Heritage & Raymond, 2005). We want to suggest that, in this instance, the patient

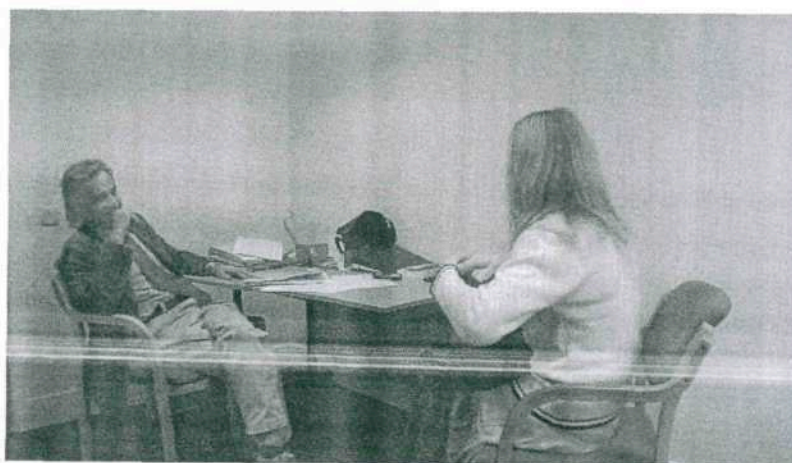


Figure 16.3 Line 10, Pat: 'I (look/got) quite nice, <'

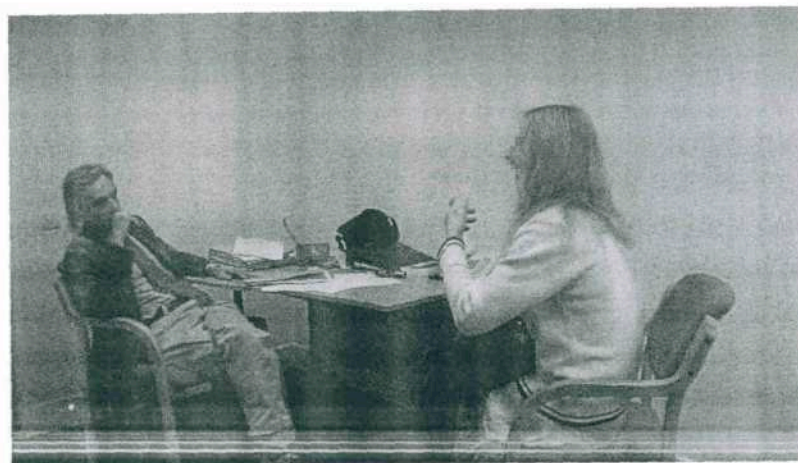


uses each of the three elements of her turn in lines 8–10 to exploit this normative feature of the sequential organization of assessments, and to secure just this kind of recipient uptake from the psychiatrist. In particular, with each added unit of her turn-so-far she seems to be working to encourage the psychiatrist to affiliate with, validate or ratify what she is saying.

### THE PSYCHIATRIST'S RESPONSE TO THE PATIENT'S POSITIVE APPEARANCE ATTRIBUTIONS

Instead of affiliating, however, the 0.8 second gap at line 12 projects a 'dispreferred' response (Pomerantz, 1984a). Indeed, following this gap the psychiatrist says a rather quiet '°Okay°' (line 13) which, like the smile at line 10, is mitigated by his hand over his face. Just like the smile, although it does not explicitly align or disalign with what the patient has said, this '°Okay°' is certainly not doing enthusiastic uptake or acknowledgement.<sup>24</sup> Indeed, it is so delayed that it overlaps with the patient's continuation of her turn. This failure on the part of the psychiatrist to respond adequately to what the patient is saying seems to be oriented to by the patient, whose turn at lines 14–15 contains overt signs of trouble: it is full of false starts, perturbations, and affiliation-seeking 'you knows': '(because/figure) slight- you know- kind of- you know dependin'. Despite this, however, each part of her turn acts like a 'filler': This turn holds the import of the prior assessment in place – and most importantly – the relevance of a response *to* that assessment. Thus, the psychiatrist *could* repeat the 'Okay' or make some other visible indication of uptake or a readiness to take a turn at any point during lines 14–16, but he does not.

Then, as if orienting to the psychiatrist's lack of affiliation so far as an indication that something is problematic or needs repairing in her prior talk (Davidson 1984; Schegloff 1997a, 1997b), the patient says '>An- that's the men(h)< (h)ri(h)ght(h) I'm not ( ) say that ( )' (lines 17–18). This turn is interpolated with 'nervous' sounding laughter, and is accompanied by a hand gesture in which the patient rotates her arm away from her body toward the psychiatrist (see Figure 16.4).



**Figure 16.4** Line 17, Pat: '>An- that's the men(h)< (h)ri(h)ght(h) I'm not ( ) say that ( )'

<sup>24</sup> See C. Goodwin & M. Goodwin (1987) for how recipients can refuse to co-participate in assessments.

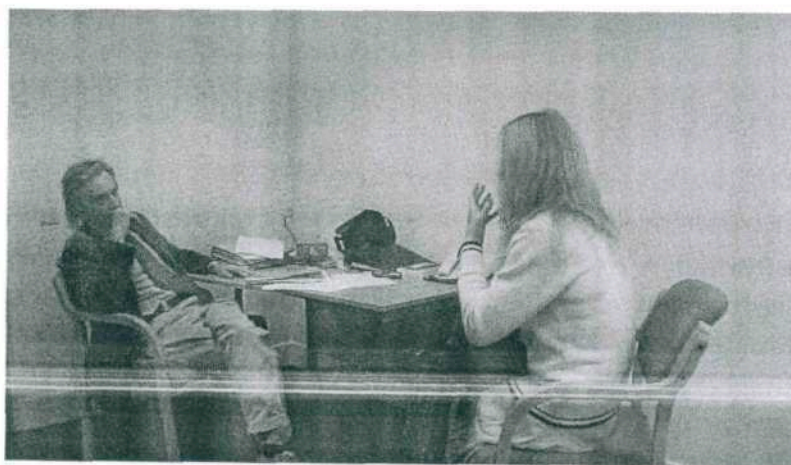


Although it is not possible to hear precisely what the patient is saying here, it appears that this utterance indexes directly back to, and is locating as a possible trouble source, her earlier reported compliment and subsequent alignment with it. Through this turn the patient clarifies that it is ‘the men(h)’ (at work) who say this about her, and that she is not saying this about herself. In doing so she works to deflect the potential imputation available at this time, that her assessment was produced independently (with the corresponding implication that it may be a self-brag), as opposed to being her *interpretation* of the compliment of a third party. The psychiatrist fails to respond vocally, but emits an almost imperceptible nod on completion of the word ‘(h)ri(h)ght(h)’ (line 17) – a nod that we are taking to be an ‘I’ve heard you’ nod, rather than an affiliative or agreeing nod.

### THE PATIENT’S SELF-DEPRECIATION

In the absence of the kind of response from the psychiatrist that she appears to be working towards, the patient continues ‘so .hhh you kno::w uh:m,’ (line 18) – thus providing further opportunities for the psychiatrist to show that he is participating in which she is saying. After a further 0.4 seconds gap of silence at line 19, the patient proceeds to unpack what it is that she is getting at by providing a third appearance attribution – this time in the form of a negative assessment or *self-deprecation* of her (facial) appearance: ‘I mean my face is- I c’d do with putting a ba:g over bag over head my head,’ (lines 20–21). This self-deprecation is accompanied by an intricate gesture whereby she points to her face and, just ahead of vocalizing the self-deprecation, exemplifies the act of putting a bag over her head (see Figures 16.5a, 16.5b and 16.5c).

This self-deprecation does three things: First, by virtue of being a self-deprecation it works to deflect any remaining imputation that the patient is engaging in a self-brag. Second, by targeting her *facial* appearance it shows (irrespective of whether or not it is ‘true’) that she has a balanced, realistic view of her appearance, that she is ‘aware’ that although she may have a lovely figure, that there are other features of her appearance that might be problematic. That she uses the recognizably humorous ‘bag over head’ metaphor to communicate this self-deprecation, also shows that she is able to *mock* herself, and that



**Figure 16.5a** Lines 20–21, Pat: ‘I mean my face is- I c’d do with putting a ba:g over my head’





Figure 16.5b Lines 20–21 cont'd



Figure 16.5c Lines 20–21 cont'd

she does not take herself, or her appearance, too seriously. Third, like the two positive assessments at lines 8–10, this self-deprecation seems to be a further attempt on the part of the patient to get a more active kind of response or participation from the psychiatrist. Indeed, as CA work on negative self-assessments or self-deprecations has shown (Pomerantz, 1984a) they usually prefer some sort of *disagreement* by the recipient. Moreover, as an idiomatic and humorous reference, the 'bag over head' metaphor is instantly recognizable, and, as such, should ideally elicit some kind of jocular disagreement or humour from the psychiatrist. The 'b't .hhh uh:m' at line 21, and the 0.4 second gap at line 22 both provide further opportunities for the psychiatrist to participate. However, here again, he remains steadfastly non-responsive.

Having moved through a chain of progressively downgraded appearance attributions ranging from the very positive 'lovely figure' (line 9), through the downgraded 'quite nice' (line 10), right through to the self-deprecating 'my face is- I c'd do with putting a *ba:g* over my head' (lines 20–21), the patient appears to have nowhere else to go with the appearance attribution to get the kind of participation from the psychiatrist that she seems to be pursuing. Indeed, she has already worked hard in her prior talk to locate and rectify any potential sources of trouble that may account for the psychiatrist's non-participation.





**Figure 16.6** Lines 23–24, Pat: ‘the lo:nger I leave it the harder it’s gonna ge:t’

When she continues her turn at line 23, the patient produces a series of clichés: ‘as a ru:le’ (line 23) and ‘the lo:nger I leave it the harder it’s gonna ge:t’ (lines 23–24). As instantly recognizable ‘truisms’, these utterances are easily and perhaps normatively ‘agreeable with’ (especially when combined with the participation-seeking ‘you knows’ at lines 23 and 24). There is also something about these clichés which may alert the psychiatrist that the patient’s account is coming to completion. For example, Schegloff and Sacks (1973, p. 306) suggest that such ‘aphoristic’ formulations can be heard as summarizing the ‘moral’ or ‘lesson’ of the speaker’s perspective. And summary assessments, ‘appear to be implicative of closure for a topic, and are recurrently deployed prior to various forms of topic shift’ (Jefferson, 1984, p. 211, see also Holt & Drew, 2005).

There is also evidence that the patient is returning to addressing the very matter that she started with – that is, accounting for why she is convinced that she needs the surgery now. The ‘as a ru:le’ formulates the gist or overall upshot of what the patient is getting at here, while the ‘like as I say the lo:nger I leave it the harder it’s gonna ge:t’ (lines 23–24) explicitly marks this as returning to something that the patient has already said. Likewise, the ‘it’ indexes right back to the psychiatrist’s reference to surgery at line 2. Finally, the temporalizing of references like ‘the lo:nger I leave it’, is reminiscent of the temporalizing of ‘when I know I can sti::ll’ (line 6), again, clearly returning to the issue of ‘why surgery now’. As we noted earlier, speakers will often return to topics from prior talk in closing environments (Schegloff & Sacks, 1973). From such re-mentionings, the psychiatrist might project that on completion of her turn, the patient will have said all that she has to say on this topic, and transition of speakership is relevant. Indeed, the psychiatrist begins to nod over the word ‘gonna’ (line 24), which suggests that he is projecting where the patient is going with this, and with a second nod repetition over the remainder of the patient’s turn at line 24, displays a readiness to take a turn (see Figure 16.6).

## THE PSYCHIATRIST’S CHALLENGE

The psychiatrist immediately follows these nods with an ‘Okay but’ at line 25, and then a hand gesture that mirrors that just used by the patient (see Figure 16.7).

In combination with the nods, the ‘Okay but’ and gesture seem to work to bracket off (rather than to agree or affiliate with) what the patient has just said, and stop her from





**Figure 16.7** Lines 25–26, Psy: ‘Okay but whether or not you have the genital surgery,’

continuing any turn possibly in progress (the barely audible ‘o-’ in line 24 *might* indicate that the patient is going to continue, but could also be evidence that her turn is trailing off in order to let the psychiatrist come in). As Wayne Beach (1995) has shown, ‘okay’s’ are often deployed by medical practitioners as a way of closing down a patient’s discussion of non-clinical matters. Indeed, in many ways, this ‘okay but’ seems to work like an explicit acknowledgement of the psychiatrist’s failure to participate in the way the patient may be working towards here. It launches a challenge to what the patient is saying, which extends over lines 25, 26 and 31: ‘Okay but whether or not you have the genital surgery, sitting here right now, . . . I don’ know whether you’ve had surgery’. This challenge is one of a series that involve the psychiatrist voicing his ‘here and now’ experience of the patient in order to counter what she has been alluding to both within and prior to the start of this excerpt: First, that genital surgery may affect her outward appearance, and, second (and by implication), that she may be more able to attract a man when she has had the operation.

Although the psychiatrist clearly *does* know that the patient is *pre-operative*, on the face of it, ‘I don’ know whether you’ve had surgery’ (line 31), could be interpreted as an indirect compliment – and a proposal that the patient ‘passes’. Indeed, the long, one second gap at line 32, and the patient’s response, ‘You don’t kno:w’ (line 33) indicates that she is having some trouble in understanding what the psychiatrist is getting at here. ‘You don’t kno:w’ targets precisely the element in the psychiatrist’s utterance that the patient is treating as problematic – thus prompting him to clarify. The psychiatrist responds by shaking his head and shrugging, his arms outstretched. Just after he initiates these gestures, he says: ‘( I’m) here looking at you who=who w’d know?’ (lines 34 and 36) (see Figure 16.8).

On seeing the onset of these gestures, and in overlap with the start of the psychiatrist’s turn, the patient shows that she’s ‘got it’: ‘Oh r:ight’ (line 35). And then something rather interesting happens: Instead of treating the psychiatrist’s turn at lines 25–31 as something that *challenges* her account for ‘why surgery now’, the patient’s ‘yes that’s what I’m=saying’ (line 35), transforms it into something that potentially *aligns with*, or *ratifies* her own position. Thus, once out of overlap, she says ‘Yeah. Yeah. (Sure)’ (line 37). The repetition of these discrete lexical items shows further, not only that she accepts and agrees with what the psychiatrist is saying, but that she is treating what he says as something that is





**Figure 16.8** Lines 34–36, Psy: '( I'm) here looking at you who= who w'd know?'

*already evident* to her.<sup>25</sup> Then, in a further effort to clarify, and as if to 'drum his position home' to the patient, the psychiatrist states: 'This is not a (nudist) interview' (line 38). The patient responds with a further repetition of three lexical items: 'No. Su:re. Su:re.' (line 40), signalling both her agreement with what the psychiatrist is saying, and that his comments are not news. The psychiatrist continues to elaborate his 'here and now' experience of the patient, this time with an *explicitly gendered* appearance attribution: 'You look like a woman' (line 41).

## THE PSYCHIATRIST'S APPEARANCE ATTRIBUTION

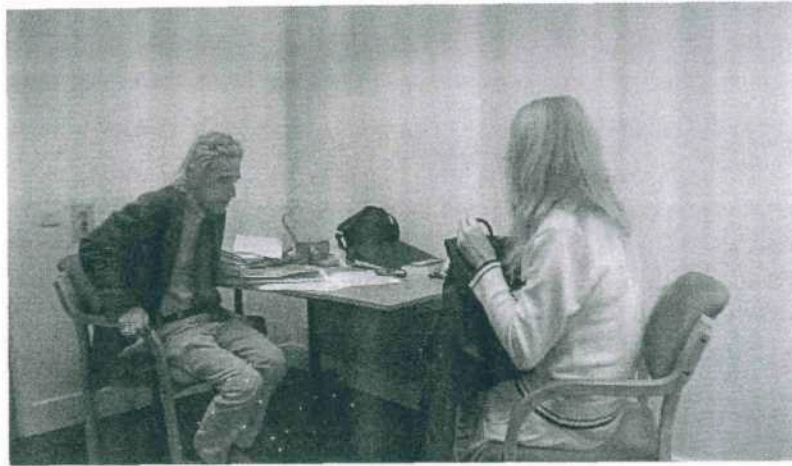
The psychiatrist's appearance attribution differs from those of the patient in that it does not contain any subjective, assessing terms like 'lovely' or 'nice' (cf. lines 9 and 10). Instead, it is produced as an objective, *clinical* statement about the patient's appearance. However, here again, instead of treating 'You look like a woman' (line 41) as part of a challenge, the patient accepts it, transforming it into a potential compliment that validates her own, position: 'Yea:h, no, that's right. (Yeah that's)' (line 43).

In the face of this, the psychiatrist now shifts away from detailing aspects of his 'here and now' experience of the patient, towards formulating the import or upshot of these experiences for his challenge: 'You don't have to have surgery to continue looking like a woman (of course).' (lines 44–45). It is only now that the patient treats what he is saying *as* a challenge and makes her own, 'bottom line' account for why she wants surgery now explicit: 'Yeah but- I- I- s- I- (0.6) I- I want to have relationsh(h)ip(h) so(h) with a ma:n or whatever. .hh' (lines 46–48). This bottom line account alludes to what we suggested the patient might be suppressing right at the start of this excerpt: that she needs the surgery now because she wants the appropriate genital equipment for a heterosexual relationship.

That the psychiatrist now treats this account as acceptable and wishes to bring the session rapidly to a close is evidenced from his five nod repetitions – initiated at the word 'so(h)' (line 47) and just prior to each 'okay' at line 49, and his repeated, sequence closing 'okays' at lines 51 and 53 (Schegloff, 2007). The delivery, positioning and relative intensity

<sup>25</sup> For more on the function of multiple sayings see Stivers (2004).





**Figure 16.9** Line 53, Psy: 'Okay, we will send a letter of referral'

of these nods and okays would allow the patient to project that the session is coming to a close, and indeed her account trails off with the generalized 'or whatever.' (line 48), the 'An' (0.4) whatever.' (line 50), and the alignment-seeking filler 'you know so,' (line 52). At line 51 the psychiatrist begins to uncross his legs and prepares to get up from his chair. He begins to stand at line 53 (see Figure 16.9), at the same time reiterating what he had said four minutes prior to the start of this excerpt: 'we will send a letter of referral', thus bringing the sequence to a close.

## CONCLUSION: ON TREATING SOMEONE AS A WOMAN

We have analysed an excerpt that contains a chain of multiple descriptions concerning the patient's appearance. We noted that these appearance attributions are multi-unit phenomena that can be used in an incrementally upgraded or downgraded fashion in order to seek (and respond to) certain kinds of participation from the psychiatrist. In this excerpt, the patient progressively *downgrades* her descriptions in order to secure a response from the psychiatrist in which he co-participates in, and ratifies her performance by *treating her as a woman*.

Of course, one might suggest that the psychiatrist's resultant *failure* to participate in the interaction in the way that the patient appears to be working towards here, can be accounted for, in part, by reference to his status as a professional expert who is expected to exemplify just the kind of *professional distance* or *clinical neutrality* that we see here (Clayman & Heritage, 2002; Drew & Heritage, 1992; Heritage & Maynard, 2006). However, this argument cannot provide a complete explanation, because the psychiatrist's own, subsequent appearance attributions: 'You look like a woman' (line 41), and 'You don't have to have surgery to continue looking like a woman (of course)' (lines 44–45) show that he is not averse to making explicitly gendered comments about the patient, or commenting on her appearance.

So what might account for this seemingly contradictory behaviour on the part of the psychiatrist? In particular, why might he appear reluctant at first to ratify or validate the patient's position, only to subsequently state that she does indeed look like a woman? There are some sequential features of these appearance attributions that have



consequences for the way in which they get produced and managed. Crucially, the patient's reported compliment (lines 8–9) and subsequent downgraded appearance attributions (lines 10 and 20–21), are relatively informal, 'lifeworld' descriptions (Mishler, 1985, pp. 81–82), which place the psychiatrist in *second position* (that is – a *responsive* position) to the patient's assessments (Sacks, 1995; Schegloff, 2007). Thus, if he were to agree with them (and to disagree with the self-deprecation), it would require him to respond by co-participating in treating the patient as a woman in a non-clinical way – agreeing with her view of her appearance.<sup>26</sup> By contrast, the psychiatrist's description 'You look like a woman' (line 41), devoid as it is of the kinds of evaluative terms (e.g. 'lovely' and 'nice') evidenced in the patient's life-world narrative, is delivered in *first position* in order to fulfil the *clinical*, and hence formal, professional task of informing the patient that an operation will not affect her outward appearance. Now the patient is in the responsive position, and must affiliate or disaffiliate with his (clinical) view of her appearance. This shows that the psychiatrist is not averse to telling the patient that she looks like a woman – that she 'passes'. Rather, he *is* averse to being placed in *second position* to a life-world narrative in which he must agree or disagree with, ratify or validate *her view of her appearance*. It follows that the precise composition and position of the psychiatrist's (clinical) appearance attributions, is bound up with his efforts to sustain a relatively neutral, medical definition of the situation in the face of the pursuit by the patient of 'counterthemes' (Emerson, 1970). And this order of things is very much in line with the psychiatrist's role as gatekeeper in this setting (Speer & Parsons, 2006).

We are not simply arguing that gender identities – and passing – is co-constructed. Rather, the distinctiveness of what we have tried to show here is that the precise form the patient's gender-infused descriptions, displays and passing practices take, is highly contingent on the type of participation that is shown by the psychiatrist. Clearly, parties are able to exploit the normative sequential features of interaction (e.g. whether one is in first position, initiating a course of action, or in second position, responsive to a course of action), in order to seek ratification of, or avoid being placed in the role of having to ratify, a particular identity. It remains to be seen whether we would see similar patterns of participation in other, non-institutional settings (such as dating interactions, for example), where participants strive to have their displayed identities affirmed and ratified by others.

A further important point we wish to note here is this: these appearance attributions do not exist in an interactional vacuum. When a speaker notes that someone has a 'lovely figure', or 'looks like a woman', it does not necessarily follow that they are off-loading some cognitive-perceptual experience of their recipient, or making a factual, objective statement about what their recipient looks like. When people make ontological statements about their own or others' appearance or gender, it does not necessarily follow that such statements are neutral renderings of some 'reality'. Thus, no matter how many times I might say 'I'm a man', or 'I look like a man' it does not automatically mean that I *am* one, or that I look like one. As one of us (Speer, 2005b) has demonstrated elsewhere, the task of attributing gender (and mis-attributing, or failing to attribute) is a complex interactional process that cannot be explained exclusively or primarily in terms of cognitive

<sup>26</sup> Although the patient does not know whether the psychiatrist is gay or straight, being treated as a woman *by a man* in a heteronormative culture, may be the ultimate validation of one's passing – and a testament to the mutually co-implicative relationship between gender and sexuality.



perceptual factors, or members' desire to apprehend and describe some gendered, 'out there in the world', reality. Rather, members consistently describe cognitive processes, including their factual-objective 'perceptions' of 'real world' people and events, as part of *doing* things (Edwards, 1997; Te Molder & Potter, 2005), and gender relevant appearance attributions get tailored to the interactional context in which the attributor finds themselves. It follows that the precise gendered reality that members construct is very much dependent on the local interactional concerns of the present.

Crucially, when we consider the detailed turn-by-turn construction of this interaction, it becomes clear that although gender is relevant to the interactions of both parties (as we noted above, it forms an omnirelevant background to the interaction), 'doing gender', 'indexing gender' and 'orienting to gender', is not the *primary* activity of either party, or the most salient thing about what they are doing with their talk at that moment. Neither patient nor psychiatrist is, first and foremost, engaged in the act of displaying or ratifying gender. Rather, these appearance attributions are delivered *primarily* in the service of *other, non-gendered business* (see also Kitzinger, 2007). Thus, the patient's implicitly gendered appearance attributions at lines 8–10, and 20–21, are produced in order to account for why she is 'absolutely convinced' (line 1) that she wants the surgery now, while the *psychiatrist's* explicitly gendered appearance attributions at lines 41 and 44–5 are deployed as part of a counter-argument designed to *challenge* the patient's account – and in particular – her alluded-to view that surgery will alter her appearance.

That the patient's attempts to pass, and be treated by the psychiatrist as a woman, may be subservient to these other activities, does not mean that gender and passing are not relevant here, or that gender is not getting done, indexed or oriented to. Indeed, in this particular setting, gender is a fairly pervasive category that gets indexed and talked about, *much of the time*. Rather, since gender is normatively a 'seen but unnoticed' phenomenon, then it makes sense that doing, indexing and orienting to gender co-exists with, and gets woven relatively seamlessly into the texture of interactional slots whose primary purpose is the accomplishment of *other* actions – even in this setting. It is this multi-layered nature of social action which accounts for how it is that in the GIC (as, perhaps, elsewhere), telling a patient that they 'look like a woman' – that they 'pass', does not necessarily involve *treating* them as one. Talking about, indexing, or doing gender on the one hand, and treating someone as gendered on the other, are very different things. Just as explicitly articulating a gender category does not automatically make gender relevant to what is going on in the talk, so too, gender can be relevant and consequential for an interaction even where a gender category is not explicitly articulated (Raymond & Heritage, 2006).

We want to end by suggesting that LGBTQ psychologists and other gender and language scholars might benefit from closer engagement with videotaped materials of interactions in real-life settings. To date LGBTQ researchers – particularly those inspired by queer theory (e.g. Butler 1990, 1993, 2004), have tended to treat gender identity as something that 'congeals' over time – an outcome of the re-iteration of a series of discrete 'performatives'. However, such theories of gender are overwhelmingly abstract and tend to be disengaged from 'the social' (Jackson 1999). Researchers within the queer theoretical tradition do not analyse 'real-life' accounts, there is no sense in their work of a peopled world in which participants interact and speak with one another, and the role of recipients in co-constructing gender – indeed *intersubjectivity* itself – is largely ignored (Speer, 2005a). Consequently, such work exists in isolation from the concrete practices of the very members whose gendered performatives it purports to illuminate.



We hope to have demonstrated in this chapter that considerable insights can be gained from examining real-life empirical materials in their turn-by-turn detail – considering both the composition of the speaker's turn, its position in a sequence of turns, and the mutually elaborative relationship of the talk with bodily gestures and movements. It is this kind of analysis, rather than abstract theorizing, that we believe offers the most promising set of tools with which to develop a systematic, empirically grounded form of LGBTQ psychology. This approach will allow us to validate our politics and theories of the workings of gender and heteronormativity in an analytically tractable fashion, in the turn-by-turn, line-by-line analysis of recorded, live interactional materials, in front of us, on the page.

## APPENDIX: TRANSCRIPTION NOTATION

.	A full stop indicates falling, or stopping intonation.
,	A comma indicates a continuing intonation.
?	A question mark indicates rising intonation.
-	A dash marks a sharp cut-off of the just prior word or sound.
↑	An upward arrow immediately precedes rising pitch.
↓	A downward arrow immediately precedes falling pitch.
LOUD	Capitals mark talk that is noticeably louder than that surrounding it.
°quiet °	Degree signs enclose talk that is noticeably quieter than that surrounding it.
<u>Underline</u>	Underlining marks parts of words that are emphasized by the speaker.
Rea::lly	Colons mark an elongation or stretch of the prior sound. The more colons, the longer the stretch.
huh/hah	Marks full laughter tokens.
(h)	An 'h' in brackets indicates laughter particles.
.hhh	A dot before an 'h' or series of 'h's indicates an inbreath.
hhh	An 'h' or series of 'h's marks an out-breath.
>faster<	'More than' and 'less than' signs enclose speeded up talk.
=	An equals sign indicates immediate latching of successive talk.
(2.0)	The length of a pause or gap, in seconds.
(.)	A pause or gap that is hearable but too short to assign a time to.
[overlap]	Square brackets mark the onset and end of overlapping talk.
( )	Single brackets mark transcriber doubt.
(brackets)	Content of single brackets represents a possible hearing.
((laughs))	Double brackets enclose comments from the transcriber.

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