Sex for Law, Sex for Psychiatry: Pre-Sex Reassignment Surgical Psychotherapy in Turkey

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Abstract: In Turkey, production of "transsexuality" as a medico-legal category dates back to 1988. Amendments in 2002 to the regulation of sexual transition shaped their present form, which requires psychiatric observation during the transition period, putting trans people under strict institutional supervision and evaluating them in terms of their gender role performance. Focusing on trans peoples' experiences of psychiatric observation, this paper illustrates the medical steps trans people take to collect evidence of their "true" sex, and shows how psychiatrists evaluate these steps. It explores how negotiations between doctors and trans people work upon conflicting meanings of bodily time, sex, gender and sexuality.

Keywords: trans studies, gender, law, medicine, the body, temporality

Résumé : En Turquie, la régulation de la transition sexuelle et la production de la « transsexualité » comme catégorie médico-légale remontent à 1988. Selon des modifications apportées en 2002, les règlements sur la réattribution sexuelle exigent l'observation psychiatrique, durant laquelle les personnes trans sont mises sous surveillance institutionnelle rigoureuse et évaluées en fonction de leur performance de rôle de genre. Se penchant sur les expériences d'observation psychiatrique de personnes trans, cet article examine les étapes médicales que suivent les personnes trans afin de recueillir des preuves de leur «vrai» sexe, et démontre comment les psychiatres évaluent ces étapes. Cet article explore également les négociations de sens contradictoires de temps corporel, de sexe, de genre et de sexualité entre les médecins et les personnes trans.

Keywords: Trans-genre, genre, droit, médecine, le corps, temporalité

Introduction

It was the 18th Annual Pride Week in Istanbul. I was sitting in a packed room, waiting for the panel to start. Titled "Transgender Body, Transition Process," and organized and hosted by LambdaIstanbul, a lesbian-gay-bisexual-trans-intersex-queer (LGBTIQ) organization, the panel brought together two psychiatrists and one trans man. The audience was especially excited by the prospect of a conversation with these medical authorities, because trans people often struggle with the intricate medico-legal processes governing sex reassignment surgery (SRS) in Turkey.[1] A medical report provided by psychiatrists is one part of the complicated and painstaking process that makes SRS legal and permissible for an individual. It comes after approximately two years of psychotherapy and, without it, the individual is not authorized for a legal SRS, which is the only way for trans people to have their identification cards (ID) re-issued according to their reassigned sex.

The psychiatrists on the panel had run these sorts of psychotherapy sessions and produced medical reports authorizing these surgeries. Some of the people who had received medical reports from them were in the audience. But as the panel and its subsequent question-and-answer session proceeded, I observed a general disturbance among the audience, especially during the discussions around obligatory psychotherapy sessions and the rules about hormone intake. A gap between trans peoples' understandings of their sex and their sexual transition and the doctors' approach to sex was evident and widening, reflecting a larger problem that also informed psychotherapy sessions. The questions of what sex, sexuality and gender mean and how sex reassignment should take place received different answers depending on who was speaking, the psychiatrists or their trans "patients." The sex reassignment process, particularly the psychotherapy period, was harshly criticized by trans people for its strict reliance on particular notions of bodily time, gender identity and the sexed body and

for how these notions led to rigorous criteria for evaluating trans people and proof of their "true" sex. Psychotherapy was challenged for carrying specific temporal and bodily assumptions about sexual transition and about being a woman or a man, and for punishing people unable to comply with such rules.

Focusing on how psychiatry works to diagnose and treat "transsexuality" in Turkey, this article has the following goals: first, to delineate the brief history of "transsexuality" as a medico-legal category and to analyze it "as a central cultural site where meanings about gender and sexuality are being worked" (Valentine 2007:14); second, to show how medical certification functions as a prerequisite for producing legal scripts of one's sexual identity commensurate with her or his sexuality and gender identity; and, third, to explore how sex, combined with time, is used as a "regulatory practice" (Butler 1993) by medical authorities, one that integrates gender non-conforming people in Turkey into a heteronormative matrix of sex, sexuality and gender. Throughout, I consider how trans people in Turkey are more than passive recipients or subjects of such discourses and practices. On the contrary, they actively negotiate, interpret, produce and desire various configurations of sex, gender and sexuality within a multiplicity of options, ranging from relatively normative configurations to new and radical imaginings. The final goal of this article is to discuss those imaginings and configurations by analyzing how trans people respond to and experience the temporal and bodily characteristics of this medico-legal sex reassignment process.

First, some words about terminology. I deploy *trans* as an umbrella term to refer to people who undergo or who have undergone varying degrees of sexual or gender transition. Following Stephen Whittle's (2006:xi) suggestion, I see *trans* as a wide-ranging category, including transgender, transsexual, male to female (MTF) or female to male (FTM) cross-dresser, queer gender and other gender non-conforming identities. As Susan Stryker and colleagues (2008:12) powerfully articulate, "gendered embodiment" is "striated and crosshatched by the boundaries of significant forms of difference other than gender, within all of which gender is necessarily implicated." I use the term *trans* to denote such diversities and differences, as well as the connections between them that shape gendered embodiment and experience, which also complies with its usage in Turkey, where the term *trans* is "borrowed" from western discourses of sexual identity to address any person experiencing gender and sexual transition. Even though the Turkish queer parlance has other alternative terms such as *gacı*, *dönme*, *lubunya* and *travesti* to talk about trans experience, the use of *trans* as an umbrella term is more widespread. It is important to note, however, that the term *transsexual* (or locally *transseksüel*) has strict medico-legal connotations, denoting only those trans people who have been diagnosed as transsexual by medical authorities and have completed their sex reassignment process according to regulatory expectations.

Two Intimates: Medicine and Law

Northern (understood also as western, global, modern) scientific, medical and political discourses and practices travel across local contexts, informing particular understandings of transgender and transsexual identity. However, critical ethnographic work on transgenderism in the global south shows that there are many other, different ways in which sex, gender and sexuality relate to one another. For instance, Don Kulick's groundbreaking ethnographic work *Travesti* (1998) explores the everyday life of Brazilian *travestis*, who approximate their bodies to female physical characteristics through cosmetic practices, hormone ingestion, clothes and hairstyles. However, they avoid both removing their penises and considering themselves to be women, instead identifying as homosexuals—that is, males who desire men and shape themselves according to men's desires. In a similar vein, Evelyn Blackwood (2007) talks about *warias* in Indonesia, transgender people with male bodies who act like women and are involved in sexual and intimate relations with men; Tom Boellstorff (2004) suggests they don't form a "third gender" but rather exemplify a male femininity. In the Thai context, Megan Sinnott (2007) and Ara Wilson (2004) examine the complex associations between sexuality, sexual identity and gender by focusing on the *tom* figure. *Tom* can be viewed as a Thai transgender term used for addressing female-bodied people with masculine identity, whose gender is hence considered to be masculine. Toms are understood to be attracted to *dees*, who are feminine women desiring or dating toms. Sinnott (2007:123) shows how *tom* and *dee* identities are mutually constructed through desirous and sexual relationships involving each type and how these desires for and sexual practices with each other are assumed to be natural outcomes of their gender, not their sexed body.

These local understandings of gender, sex and sexuality are at the same time far from untouched by transnational flows of northern medico-legal practices and discourses. As Blackwood and Wieringa (2007) argue, cultural location and global connectedness are in a dynamic and complicated relationship, preventing one from approaching gendered and sexual subjectivities as either simply local or totally determined by Northern discourses and practices. Rather, queer subjectivities

"reproduce and reconstitute the specific discourses, knowledges and ways of understanding the world of their particular locations" (Blackwood and Wieringa 2007:8). Because of its history as a travelling western medical model to diagnose and treat transsexuality in local contexts, the domain of psychiatry and psychology is a significant one for exploring the relationship between the local and the global. The Turkish history of "transsexuality" as a medico-legal category is also dependent on such transnational conditions.

"Transsexuality" was absent from Turkish law until 1988. Prior to 1988, however, there were several legal cases involving trans women who appealed to lower courts to change their sex on official records after having their SRS either in Turkey or abroad. Despite the legal approval of those pleas by lower courts, the Supreme Court rejected them all (Atamer 2005; Öztürel 1981). In 1980 and 1981 a renowned professor of forensic medicine, Adnan Öztürel, published two articles on these legal cases. Pointing out a high number of local "transsexual cases" in Turkey, he linked the then-illegality of SRS to a specific article in the Turkish Criminal Law, which stated that those who do operations on men and women that annihilate their reproductive capacity and those who give consent to such operations on their bodies, are subject to 6 to 12 months of imprisonment (Öztürel 1981:267). In 1983 this article was modified, criminalizing only cases that lacked individual consent for sterilization by the sterilized.

In 1983, the right-wing Motherland Party also won the elections following a three-year long military rule, forming a new, one-party government. As of 12 September 1980, the previous military government had inhibited individual freedoms and rights, including the right of cross-dressers and of transgender performers to work in the entertainment sector and in sex work, two of most common domains of employment for trans people. One of the banned artists was Bülent Ersoy, a trans woman singer who entered the music scene with a male body in 1971 and was forbidden to perform as singer upon revealing her "true" sexual identity as woman in 1981. Due to the strictness of military rule, she had to flee the country for nine months and, when she returned, it was as a post-op trans woman. However, official records still displayed her sex as male. She therefore appealed to the court to change her identification. It took seven years of continuous struggle for the state to concede she was a woman, change her legal sex to female and issue her a pink identification card, which represented (and still represents) its holder as of female sex in the eyes of the state.[2] Her legal victory was made possible under the Motherland Party's government, which introduced a neoliberal economic program to Turkey in 1983. Some authors argue that this neoliberal regime took advantage of Ersoy's case to exemplify a new era, promoting individual rights, freedom and tolerance (Altınay 2008:215).

In Turkey, male and female citizens are assigned blue and pink IDs respectively. Changing the colour of their ID is a substantial political concern for trans people in their fight for recognition of their sex by the state. Because she became the first trans woman whose sex was officially approved by the state, Bülent Ersoy embodies a key figure in trans people's history in Turkey. Her case led to the introduction of the first legal regulations, in 1988, regarding transsexuality, achieved by attaching a new article to the 29th clause of the Civil Code of 1926. The new article stated that "in cases where there has been a change of sex after birth documented by a report from a committee of medical experts, the necessary amendments are made to the birth certificate."[3] This article made it possible for trans people to apply for a new ID after SRS. Subsequent to surgery, if a trans person could provide a health report to the court proving the operation and its results, they could easily obtain a new pink or blue ID card.

The process was, nevertheless, not strictly governed by multiple institutions, as is seen in the current situation. Several prominent law specialists have criticized the 1988 legal regulation for exceeding its intentions, causing several gaps and contradictions in practice. They were presented in relation to legal regulations on transsexuality in some European countries (i.e., Germany, Sweden). One noteworthy criticism was that this article, in fact, created room for *cinsiyet kargaşası* (gender chaos) by allowing anyone to reassign their sex (Zevkliler 1988). As opposed to Swedish and German codes on transsexuality, which required a non-married status and state of infertility as pre-conditions for SRS, the Turkish regulation and, by implication the state, showed no concern for the issues of marriage and reproductivity in the design of the article (Sağlam 2004; Zevkliler 1988). Problems resulted. For instance, when people reassigned their sex, their marriage would automatically be annulled, as same-sex marriage was (and still is) illegal in Turkey. Moreover, according to Aydın Zevkliler, a professor well-known as a commentator on the issue, if a person was married or had children, this situation should itself be proof of one's non-transsexual identity, as such a person had "succeeded" in forming an intimate relationship with the "opposite" sex partner and reproducing by using her or his sexual organs. This meant there was no fundamental problem with the viability of his or her sexual organs at birth. Furthermore, Zevkliler

argued, sex reassignment would cause damage to children's mental health, as well as the family structure itself, the legal protection of which was prioritized by the state via numerous laws.

These legal debates urged the state to overcome such contradictions in law and ensure protection of family life. They provided justification for limiting sex change to those diagnosed as "hermaphrodites," simultaneously having both male and female sexual organs, and those whose anatomy contradicted their inner sense of sex such that they adopted the feelings, instincts and behaviours of the opposite sex (Zevkliler 1988:267–270). Zevkliler interpreted sex change as an anatomic necessity for the former group and, as a "psikolojik, psikiyatrik, psikanalitik sendrom" (psychological, psychiatric, psychoanalytic syndrome) for the latter (1988:268). Alongside psychiatric evaluations, he also promoted the introduction of other medical experts into the domain of transsexuality, such as gynecologists, urologists, endocrinologists and general surgeons, as professionals who could provide legitimate evidence for one's transsexual status.

Despite these discussions, the article on transsexuality remained unaltered until a change of government in 2002. The Justice and Development Party (AKP) came to power with a neoliberal-conservative one-party government and brought several amendments to the legal system, including modifications to civil law. Changes to the 40th clause in the Civil Code put the sex reassignment process under rigorous medico-legal control and supervision, similar to the German and Swedish protocols (Sağlam 2004). The results of the aforementioned legal debates were integrated into a strictly regulated sex reassignment process:

> A person who wants to change her or his sex has to apply to the court personally and ask for permission for a sex reassignment. For this permission to be given, the applicant must have completed the age of 18 and must be unmarried. Besides he or she must prove with an official health board report issued by an education and research hospital that he/she is of transsexual nature, that the sex reassignment is compulsory for her or his mental health and that he or she is permanently deprived of the capacity of reproduction.
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> If it is confirmed by an official health board report that a sex reassignment operation was effected based on the permission given and in accordance with the purpose and medical methods, the court will decide for the necessary changes to be made in the civil status register.[4]

Prior to 2002, trans people did not need an official report to have SRS, but now a comprehensive medical report was necessary, with a particular attention to psychiatry and psychology. This report must prove "sex change" to be a necessity for the person's mental health; with this report in hand, the individual appears in court to request permission to have the surgery. By the time the person appears in court, he or she should be unmarried, have no children and be sterile.[5] After surgery, the individual is required to receive a report stating that he or she has a "proper" penis or vagina and, with this report, return to the court to complete the sex reassignment procedures and be issued his or her new ID.

My point in this article concerns this proof of "transsexual nature." Medical processes in general and psychiatry in particular are promoted to achieve this goal. Gathering medical evidence of one's transsexual identity and, in the end, medical guarantees of the "true" sex represented by pink or blue IDs, is an arena in which the Turkish state actively and forcibly "materializes" sex "within the productive constraints of certain highly gendered regulatory schemas" (Butler 1993:xi). I now turn to detailing this process, illustrating the medical steps taken by trans people to collect evidence of their "true" sex and the ways the state's medical authorities, particularly psychiatrists, examine these steps in the interim of transition. As will become clear, not only does the medical certification process function as a prerequisite in legal scripts of one's sexual identity but, because medical authorities rely on particular understandings of gender in doing their work, these understandings influence the gender identity and, at times, sexual desire and practices of the trans people they authorize.

Setting the Trans Body for the Medical Stage

The aim of this section is to provide a general overview of the medical process of sexual transition and then a more specific overview of the psychiatric component. As previously mentioned, the Turkish state insists that before, during and after SRS, trans people must modify their bodies and prove their "true" sexual identities. This process involves many legal steps, such as provision of the comprehensive report or *heyet raporu* that authorizes SRS. People can, of course, have these surgeries without an official permit; however, those operations are regarded as illegal and, lacking the support of a heyet raporu, do not allow for changes to official records or a new ID.

The heyet raporu can only be provided by a *heyet*, a board of doctors similar to the oversight boards in North America at education and research hospitals.

The *heyet* is composed of specialists from multiple departments, including internal diseases, general surgery, neurology, psychiatry, ophthalmology, ear-nose-throat (ENT), gynecology and plastic surgery, as well as the head of the board. In Turkey, heyet raporu is something that may also be required on other occasions. For instance, employers might request recent hires to submit heyet raporu to prove their health conditions. Or students have to provide their principals with heyet raporu when they need to take a leave of absence for long periods. Depending on each situation, the hospital creates a board, selecting different departments for each individual case.

In the case of trans people, psychiatric, urological, gynecological, genetic, endocrinological and plastic surgical exams are required. All these departments serve the scientific evaluation of one's sex and gender. Medical genetics, for instance, monitors trans people's chromosomal combination to see whether they are intersex or not. Endocrinology runs three different tests, namely liver and kidney function tests, a complete blood test and a thyroid-stimulating test, both before and after hormone intake. These tests help doctors to observe the fluctuations in trans people's hormone levels between their pre- and post-hormone conditions. Based on test results, an endocrinologist decides on the required level of hormone intake. Once each of these medical actors are scientifically convinced of the need for SRS, they then gather their individual reports to prepare a final heyet raporu, which includes the individual signatures of each above-mentioned specialist. However, the psychiatric examination represents the chief phase since, among all necessary medical steps, it carries out the most detailed investigation of whether one has gender "dysphoria," or not.

The inception of this psychiatric examination dates back to 1987, when Şahika Yüksel, now a renowned psychiatrist specializing in clinical work with trans people, established the first special unit at the Psychiatry Department of the Istanbul School of Medicine dedicated to the evaluation of "gender identity problems" (Yüksel et al. 2000). Later, mostly inspired by the Harry Benjamin International Gender Dysphoria Associations' Standards of Care,[6] Yüksel introduced some psychiatric methods into her clinical work with trans people. One example is group psychotherapy, a product of a particular interpretation and application of Benjamin's Standards of Care. Over the course of 10 years, this psychotherapy method has spread to other psychiatry departments in public education and research hospitals.[7]

These evolved standards are in some ways more customary than legal. For instance, two years of psychotherapy sessions are not set as obligatory in the law; what is mandatory is the provision of the psychiatric report for SRS. But psychiatrists refrain from providing such a report before the completion of approximately two years of psychotherapy and, even when the psychiatrist is convinced about a trans person's sexual identity, issuance of the medical report can still be arbitrarily postponed dependent upon the person's financial situation. Unless one has the financial means to undergo surgery, she or he might not be granted a medical report for a long time.

Finances also play into other aspects of the psychiatric component of the heyet raporu. For instance, trans people can receive a psychiatric report from a private psychiatry clinic, although they still have to consult with public education and research hospitals for the running of other tests and for the final heyet raporu.[8] They might do this because they might prefer individual psychotherapy. While private psychiatry clinics organize their therapies into similar temporal intervals, they also offer individual rather than group therapy. The benefit of this is to allow the person more time to talk about their problems in one-on-one setting. But, while group therapy at education and research hospitals are financially covered by public insurance, individual psychotherapy services at private clinics are excluded from insurance coverage. For this reason, trans people's class background and family support play a significant role in determining their psychotherapy experience. Whereas those with wealth have the option of private psychotherapy, those without wealth and family support have to undergo group psychotherapy provided by public hospitals.

My access to ongoing psychotherapy sessions was inhibited by both pragmatic and ethical concerns. Not all of my trans informants were involved in the state's obligatory medico-legal route to have their sex confirmed. At the time of my 13 months of ethnographic fieldwork in 2009–2010, the psychotherapy process was a more substantial issue for the younger generation of trans people, as many older trans people had changed their IDs before the 2002 legal regulations. Some others were still in the process of debating whether to undergo such a stringent medico-legal process. Thus, even though I spent time with more than 20 trans people, my knowledge of psychotherapy sessions is mostly based on the first-hand accounts of three psychiatrists who were facilitating psychotherapy sessions and five trans people who either had completed or were trying to complete the psychotherapy process. They all worked at and visited the same hospital, and thus were part of the same psychotherapy group.[9]

Psychotherapy groups are composed of 30 to 40 people, who meet for two hours once a month. Even though the average completion time is two years, it varies from person to person, depending on their needs and responses to psychotherapy. No one can join the group before the psychiatrists' assessment of them individually, which also provides an initial estimate of the time needed in psychotherapy. Those I spoke with noted that they continue to keep track of the person's condition even after the person is accepted to the group; however, the frequency of one-on-one sessions also varies, depending, once again, upon an individual's psychological state during the transition process. For example, if doctors observe confusion or hesitation of some sort about having the SRS, a one-on-one session might be called for, as well as longer involvement in group psychotherapy.

Part of the psychotherapy involves directions about hormone intake. Usually, people are asked to provide their endocrinological, gynecological and urological examination results at the end of their first year. As long as the outcome is as expected, they can start with their regular hormone intake. Another function of the psychotherapy group is to deliver adequate technical information in regard to SRS, as well as its subsequent transition period.

On the surface, psychiatric support appears to be positive, helping trans people a great deal with their bodily transition; nevertheless, accounts of psychotherapy sessions by doctors and by trans people are strikingly contradictory. Whereas state psychiatrists depict psychotherapy sessions as merely supportive mechanisms, trans people claim that these therapies do them various levels of violence. I now turn to descriptions of both these groups and then portray how trans people experience these therapies.

Psychiatric Materialization of Sex

One of the major benefits of psychotherapy, as stated by Dr. Bilgin, one of my psychiatrist informants, is to prepare trans individuals for their transition, including the emotional, psychological and social changes they are expected to face in their post-op lives. According to Dr. Bilgin, trans people sometimes have high expectations of SRS that are far from being rational. For example, some trans people have a strong belief that the surgery will radically change their lives by resolving every problem they have had to cope with regarding their gender identity. Or, they think that their female or male past will no longer exist after SRS (Yüksel et al. 2000). Thus, the first goal of these therapies is to temper these expectations and to ensure psychological well-being by putting other anxieties and tensions at ease.

In each session, psychotherapy begins with individual accounts of the previous month, of its positive and negative experiences. Doctors highly value these accounts because they bring together trans people at different stages of transition. The participants share their experiences and problems acknowledging their own sexual identity, managing relationships with their families and coping with dominant gender roles existing in society. Some experiences are shared by many. For example, according to another of the psychiatrists I interviewed, Dr. Sözer, the two of most frequent sources of distress are "coming out" to parents and negotiating religious concerns surrounding operations and sexual life. More experienced members of the group become prominent figures in it, helping others, less experienced trans people with their doubts and allaying their concerns. This process also reduces the loneliness of people who see their transsexuality as an exclusively individual problem and thus experience isolation and alienation from their social environment. In short, from Dr. Sözer's perspective, psychotherapy sessions resemble awareness raising groups, providing a supportive environment and a source of empowerment for trans people.

On the other hand, the willingness or tendency of psychotherapy participants to talk about their experiences changes from person to person, making this one of the main problems reported to me. For instance, Dr. Bilgin discussed a female-bodied trans man who came from a religiously fundamentalist Islamic background and wore a headscarf to meet Islamic rules pertaining to the female body. His transition to manhood was regarded as far more complicated than many others because part of his public gender role alteration involved taking off his headscarf. However, pressure from his religious community was so drastic that he did not dare to take it off, let alone come out to his family. On top of that, he was pregnant at that time. As Dr. Bilgin emphasized, his experience could have been immensely informative for other participants if he had chosen to speak in the group. Yet, despite his two years of participation in the group, he resisted saying a single word, detailing his life story only during private sessions. Dr. Bilgin gave this example to stress the differences in each individual's capacity to engage with group psychotherapy and benefit from it.

One reason for doctors' insistence on a two-year psychotherapy period is some trans people's rush to have SRS. Doctors claimed that, although the psychotherapy duration seems to be long, trans people who "graduated" (the word they use for completion of calculated psychotherapy time) from therapy usually provided positive feedback, saying they had greatly benefited from it. These graduates sometimes even continue

to participate in the group, sharing their pre- and post-surgery experiences.

Psychiatrists also invoke a specific need for "models" for emulation, which they claim many trans people want to have during their transition period. These models provide trans people with examples or guidelines for how to be as a man or woman. One instance of this "modeling" can be observed in terms of dress codes. When trans people come to psychotherapy, many of them do not feel obliged to dress according to the code they are expected to follow in everyday life (i.e., the gender they are transitioning from) and feel freer to dress according to their "phenomenological sex" (Salamon 2010), that is, the sex they perceive themselves to be. In this respect, the group psychotherapy space also functions, as doctors pointed out, as a stage: a place where trans people can observe each other's physical appearance, identify mismatches to the appropriate gendered dress code and settle their style accordingly.

For instance, Dr. Aysan recounted how some trans women who at the very beginning of their psychotherapy appeared "gaudy looking" gradually changed into more reasonable and casual attire as their treatment expanded into its second year. When I asked her how to interpret this "gaudiness," she framed it as an effort on the part of trans women to compensate for feelings of inferiority, of having "fallen behind" womanhood. In this model, trans women try to "catch up" with a womanhood that they believe they could have already attained if they had been allowed to live as women all along. In her view, these "lost" years of not being a woman profoundly shape trans women's exaggerated performances of various gender roles. She thus saw the long duration of psychotherapy as necessary to make trans women understand that their sexual identity had nothing to do with high-heel shoes or heavy make-up. Growing such awareness, she said, also increases self-confidence.

Another positive outcome of psychotherapy stated by doctors is improved skills of self-expression for trans people. One common exercise practiced during the sessions is role-playing, which focuses on interactions between trans people and their parents. Therapists highly value this method since, they believe, it develops the ability and courage trans people need to communicate with their parents, making a huge difference when they first come out to them. When I asked the doctors if they did anything to help trans people with their family situation, they mentioned organizing two psychotherapy sessions for trans peoples' families every year. All family members, aside from the trans people themselves, can join these sessions. The main purpose is to bring families together to create a space for sharing experiences and dismantling prejudices. Medical research in Turkey also shows that families lack sufficient information about transgenderism and transsexuality and, when they discover their child is a trans person, prefer to conceal it at all costs rather than speak about it openly, due to the social pressures they face (Polat et al. 2005:390). In this environment, it is helpful for families of similar backgrounds to see how other families are experiencing the same "problem." Attendees of these meetings are usually those who are curious about, rather than strongly biased against, transsexuality. Strongly biased family members rarely attend.

Dr. Bilgin also talked about having witnessed an evident level of "homophobia" among group members. For example, she consulted trans people who felt thankful for not being gay or who evaluated their womanhood and manhood in relation to their desire for the opposite sex. It was interesting to hear of this because, as you will read in the following section, many trans people complain that doctors cannot make a clear distinction between sexual identity and sexual orientation, explaining the former in terms of the latter. This conflation of sexual identity and sexual orientation is also one of the most significant tensions.

In her work on transgenderism in Iran, Afsaneh Najmabadi (2008, 2011) points out a similar tendency in Iran to define sexual identity in terms of one's sexual orientation. Here, same-sex practices are religiously and legally prohibited, but sex change is a religiously sanctioned, state-subsidized legal practice. To start the SRS process, a gender non-conforming person is required to undergo psychotherapy for four to six months. Najmabadi argues that the ban on same-sex practices and desires adds to the pressure on gays and lesbians who might consider participating in SRS process and psychotherapy to "transsexualize" themselves in the eyes of the state and receive a religio-legal approval for their same-sex desire, allowing them to experience it under the guise of heteronormativity. That is why psychotherapy is colloquially referred to as "filtering" in Iran, as it is used by the state, together with hormonal and chromosomal tests, to recognize and separate "true transsexuals" from gays and lesbians (Najmabadi 2008:32). According to the Iranian religio-legal authorities, transgender people's same-sex desires and practices are in fact straight, because they were born in the wrong body and sex. Therefore, their pre-SRS same-sex desires and practices are diagnosed as symptoms of transsexuality, not homosexuality. Further, there is no religio-legal recognition of transsexual lesbians or gays (i.e., trans women desiring women, or trans men desiring men), because the desire and sexual practice should

always be straight. Same-sex desires and practices are perceived as markers of moral deviancy and, hence, gays and lesbians are identified and filtered out through psychotherapy (Najmabadi 2008).

Najmabadi's work is helpful for discussing how allegedly universal medico-legal models of sex transition are modified and shaped locally. While the state uses psychotherapy and SRS as a heteronormative corrective measure, queer people in Iran can manipulate it to more creative ends, creatively using their sex to live their sexuality. In a similar vein, trans people in Turkey negotiate, rework and contest the existing medico-legal models of transsexuality to establish their own diverse meanings and definitions of and relations among, gender non-conformity, sex and sexuality. I next focus on how such diversity takes place within the psychiatric domain, in terms of trans people's experience of psychotherapy and their interpreting and shaping of medico-legal understandings of sex, gender and sexuality.

Bodies that Speak the Time and "Truth" of Sex

"If you are a mad person, then you cannot be a transsexual," İlker joked, referring to the Rorschach and intelligence (IQ) tests that are the very first step in the institutionalized medical path to SRS. The Rorschach test records and analyzes people's perceptions of inkblots to evaluate their personality characteristics and emotional functioning. Psychologists use Rorschach tests, together with the IQ test, to judge trans people's mental health—specifically, any level of schizophrenia or tendency toward depression. An observation of either of these leads psychologists to declare trans people ineligible for SRS, preventing their participation in group psychotherapy as the second step of medical regulations.

Those who continue to group psychotherapy first meet the chief psychiatrist and her two assistants, who are responsible for the entire group. The assistants take notes, convey trans people's concerns to the psychiatrist and prepare the authorization of the medical report upon the completion of psychotherapy. The main psychiatrist remains remote: she surveys both her assistants and the group and makes the final decision, but seldom joins the psychotherapy sessions. When she does attend, she usually listens, observes and intervenes only if she finds it necessary. One of my trans man informants, who graduated from one of the chief psychiatrist's psychotherapy groups, expressed his and his peers' annoyance with her "law-like attitude," alert, as Foucault (2004:22) says, to "the constitution of a doctor who is at the same time a doctor-judge."

For trans people who manage to prove their mental health and become part of the psychotherapy group, the primary concern becomes the size of the group, amounting to some 40 people. There is a waitlist, as an existing client must "graduate" (or otherwise leave) before a "junior" one can enter. Further, the two-hour length of each session only leaves approximately 10 minutes for each member to express themselves. What one can say in these 10 minutes is not only limited by time but also by the institutionally structured way of speaking of one's problems. Trans people report that psychiatrists impose specific speech prompts on participants during psychotherapy, rendering them silent or unheard if they attempt to deviate. For example, the most popular prompt was reportedly, "Tell us something positive or negative that you experienced in relation to your sex this past month." The reply should be given in 10 minutes, and people are silenced when they want to elaborate in more detail, for instance, on the connections between their senses of body or sex and the many spheres of everyday life. Enclosing the group dynamic with such temporal and verbal rigidity leaves trans people facing the risk of being frozen out of the group if they pass beyond the speakable boundaries. No matter what their excuse is, they are expected to conform to this institutional template.

Consider a detailed example of this verbal regulation, which comes along with a depiction of other problematic issues essential to the psychotherapy. İlker, a 27-year-old trans man, is a LGBTIQ activist who is very well equipped to engage with gender and sexual issues. He had already graduated from psychotherapy when I met him. When I interviewed him, he had had his breasts removed but still was looking for a trusted place to have his penis construction surgery. He frowned while talking about his psychotherapy experience and the compulsory legal regulations surrounding surgery.

İlker: You must wrap your entire appearance up into socially compromised norms of gender so that you can socially reintegrate into the society. All this process of psychotherapy is for saying, "Due to psychotherapy she or he obtained this proper look! This is our achievement!" In psychotherapy, consultants always want to hear about themselves: "Are you content with the psychotherapy? Has it been helpful for you? How have you been feeling about psychotherapy?" These questions are constantly seeking evidence of what they are doing to reintegrate people into society, for self-vindication. They brag about restoring us to society as desired females and males. For example, I have a trans gay friend. If he consults with them, he would never be able to get a report from them.

Aslı: So do you mean you must be a straight person to be able to go there?

İlker: Well, yes! At best, you can be a bisexual, but never a gay. What they inspect is whether you use your birth genitalia or not. You know, they're gonna give you an authorization for SRS. So if you are still using your sexual organ, then it should stay; you cannot cut it off, you cannot dump it, because it means you are at peace with your organ. In any case, you should be troubled with your body. You should be unable to use your genitals at birth ... If I declare I am a man, then I am a man! That's it!! What is the difference between the saggy boobs I had before and the current ones? Only fat came out of them. What has changed? Nothing has changed for me!

Extremely discontent with therapists' approach to sex and sexuality, İlker claims that the entire purpose of the psychotherapy sessions is to produce sexed and gendered trans subjects fitting the heteronormative standards of Turkish society. To satisfy this aim, medical authorities attempt to treat sex in relation to the heterosexual usability of sex organs or one's degree of emotional attachment to those organs. For instance, if a pre-op trans man still takes pleasure from his vagina, despite feeling disgusted by it, then he is not considered of transsexual nature by medical authorities. Or, as in the Iranian context Najmabadi (2008) discusses, medical authorities in Turkey might treat sex and sexuality as the same in the psychotherapy process and simply define one's correct sex in relation to one's sexuality vis-à-vis a heterosexual norm. If a trans person has desire for a person of his or her phenomenological sex, then he or she is not viewed as a "true" transsexual person. According to this perspective, sexual desire should be heterosexual and one should have sexual interest for the opposite sex after reassignment surgery.

While there are trans people who use similar heteronormative assumptions to understand their sex, there are others, like İlker, who radically contest such understandings of sex, drawing clear boundaries between their sexuality and sex, complicating not only the relation between these two, but also the assumed stable link between the body and sex. These contestations are of great importance, as they demonstrate key details about the ways in which trans people in Turkey experience and negotiate medico-legal transcripts and practices of sex and transsexuality, configuring and imagining sex and gender.

Contesting the relationship between the body and sex also has a temporal dimension. Trans people's understanding of their bodily time and the disciplinary time of the psychiatric therapy shows discrepancies. As Elizabeth Freeman (2007:161) succinctly puts it, "[t]he body politics and power relations are made possible by manipulating time." As discussed, one's "truth" of transsexuality is strictly tied to a disciplinary institutional time, entailing individuals to spend two years before medical authorities to prove themselves to be a man or a woman. Within the temporal framework of psychotherapy, one's past and present gender role performances and self-accounts of sex should comply with each other, presenting narrative coherence and persistence and submitting to a linear temporal logic. The psychotherapy timeline functions to make trans people achieve bodily legibility and internalize specific values and norms of gender. However, work on queer temporality insists on the analytical salience of temporal heterogeneity and "the present's irreducible multiplicity" (Dinshaw et al. 2007:190). In contrast to the stubborn medical timeline, which subjects sexual and bodily transition to a linear temporal discipline, trans people's sense of sex and the body might display a more flexible, multi-layered and interrupted understanding of temporality. Adem's story is one portrayal of this phenomenon.

Adem, a 31-year-old trans man, works as a nurse in the emergency department of a hospital. He also describes psychotherapy as an oppressive use of power designed to mould individuals within a stringent medical configuration. Adem said that, as opposed to many girls, he never experienced a regular menstruation cycle after the age of 12, causing him a lot of stress and countless health problems. After grappling with these problems for 20 years, he was diagnosed with polycystic ovarian syndrome, which led to intensive hormone treatment, including especially high usage of estrogen. However, 10 years of treatment did not produce any concrete results. He kept feeling that his body was not a female but male one. He told his gynecologist that neither the functioning of nor his feelings about his body had changed. He experienced increasing pain, and he was taking painkillers non-stop. He no longer wanted to continue with his life in pain and decided to have an ovarian removal surgery, following his doctor's advice of last resort.

When Adem made the decision, he was in an SRS psychotherapy group. His gynecologist asked him to get official permission from the group therapist to be able to legally perform this operation and also forwarded a written note about his situation to the psychiatrist. The psychiatrist got angry with Adem for pursuing the operation, because ovarian removal surgery is considered one of the late stages of sex reassignment process, and hence should not be authorized until the period of psychotherapy is completed. But Adem's gynecologist had

been convinced to give permission after recognizing this surgery not as part of sex reassignment process but as an issue of health. Adem's ovaries were removed at the end of his fourth month in psychotherapy.

While he was on leave due to the ovarian removal surgery, Adem also decided to undergo a breast removal surgery and had his breasts removed. When the therapist discovered that he had done this, she was furious and they had a quarrel about the need to comply with the stringent rules of psychotherapy. According to these rules, the period of psychotherapy is organized into different phases: participants are expected to start hormone intake within the first six months to one year; then they are required to wait until the completion of their psychotherapy period to be legally authorized for SRS, whether it be breast removal/implantation or vagina/penis construction. Adem said that this argument was the first time he had heard about these rules. He was given no information about the group temporal dynamics at any point during psychotherapy.

Adem left the hospital that day after the dispute. When he called to arrange the next month's meeting, he was told that he was no longer a part of the group and that he had better start looking for some other places to get his medical report. He was essentially excluded from the group for not obeying the rules of psychotherapy time, which determine when and how to intervene in configuring a body into a male one. He had interrupted its linearity by following his own personal, bodily felt time. As a significant element in constituting the "truth" of his sex, the normative interval of institutional time denied alternative temporalities of his body and sex.

Proof of "true" sex in this medical stage is also strongly mediated by the prescription of hormone intakes. The time I spent with elderly trans women presented me with some background information about trans people's hormone intake. Prior to 2002, when there was no medical regulation, people could go to a pharmacy and easily buy hormones without knowing their side effects. They did not need any prescription. In the absence of sufficient medical instruction, trans people became advisors to one another in mapping out the medical route of sexual transition. Hormones represented one of the most crucial steps in this process, and many trans women started regular and heavy hormone injection as early as possible. Today, hormone intake is more seriously regulated, especially through the timeline of psychotherapy. Moreover, trans people have a stronger awareness of the medical side effects than they did 20 years ago. However, this regulation does little to consider trans people's personal expectations, demands, desires and feelings regarding their bodies, compared to the importance attributed to the state's designation of gender roles and "appropriate" body features.

According to therapists, the above-mentioned waiting time (6 to 12 months) is of vital necessity because they claim that trans people might demonstrate risky levels of hormone intake to hastily compensate for the difference between their body and the body they aspire to have. However, some trans people think that a hormone intake based on their own time frame helps them establish a more balanced and calm personality, as they gradually approach their body ideal or their imagined body of the opposite sex. In either case, hormone intake is tied to strict regulations that cause major disturbance among trans people, raising questions about rights to possession of and control over one's own body. Adem's words below, elucidate an issue also shared by other trans people:

> When I asked the assistant about when to start with my hormone treatment, she said it would vary, from six months to nine months from the first day of the psychotherapy. Why would I wait that long? I am neither starting a new life nor trying to adapt to one that I have never been familiar with. I have been like this since my childhood. In their minds there is this logic: "This person has been living as a female since he was born and then he decided to change his sex from female to male. So we need to help him with his transition process from womanhood to manhood."
>
> However, this logic does not apply to me; I have been feeling and living as a man since my childhood! I have tried to explain this many times in the group.

While trans people like Adem insist on a more flexible time schedule for hormone intake, therapists deny them the felt temporality of their bodies and force them to integrate into an institutional temporal norm. This temporal norm also operates to construct and advance normativity in their desired gender identity. The time and surface of the body are entwined with institutional norms and expectations, denying the self's temporal and bodily accounts. There are also others, like İlker, who are against the enforcement of hormone treatment as part of the psychotherapy period or against the enforcement of a properly sexed body in general. This issue came up several times in our conversations. İlker repeatedly showed his irritation at obligatory hormone intake, telling me how therapists would not issue a medical report for SRS unless trans people complied with the necessary hormone intake prescriptions.

Another significant complaint about the "truth" of their sex articulated by trans people involves the ten-

dency of consultants to see their bodies in aggregate, rather than as individual ones. As trans people foreground every individual's uniqueness and singularity, they feel immensely perturbed when psychiatrists lump them all together, for instance, as members of the same case. Preferring to stress the distinctness of life stories and experiences, they feel that they were forced—sometimes subtly, sometimes not—down a prescribed path of gender identity during psychotherapy. This enforced "sameness" can be considered an effect of formulating transsexuality as a medico-legal category, produced and shaped within the intertwinement of dominant social norms of gender, sex, desire and eroticism. For example, Lale, a trans woman I briefly met at Istanbul LGBTT, an LGBTIQ association founded predominantly by trans women, told me about her first visit to the group psychiatrist. When she mentioned that she was a trans lesbian, the consultant hesitated to put her on the wait list for the psychotherapy group. "She couldn't make up her mind about me," Lale said. She asked Lale to visit her a few more times to come to a decision. But Lale said she knew exactly why the therapist called her back:

> They are teaching you how to be a woman according to social norms. Psychotherapy is so much focused on society's expectations. They aim to reintegrate the trans individual in the society. Since this is the goal, they teach you social masculinity and femininity in psychotherapy ... She is going to carve out a heterosexual woman from me and build up proper feminine manners for me, to efface any existing masculine attitude. In other words, my femininity must be precise!

In Lale's case, lesbian desire falls outside of "proper feminine manners," thus potentially disqualifying her for SRS. Her individual experience fails to conform to the generic "sameness" the process requires. At the time I left Turkey, she was still visiting the doctor for further "clarifications" about her sexual identity. This example shows how medical authorities, while criticizing trans people for confusing sexual orientation and sexual identity, fall into the same trap and explain sex in terms of desire.

In psychotherapy, consultants also examine trans people's adjustments to homosocial environments and groups. For example, some trans men were asked how they feel in male-dominated spaces such as traditional coffeehouses and soccer games, or when they walk on streets late at night. These questions signify a few of the hegemonic masculine values and behaviours in Turkish life. On the other hand, trans women might be questioned about their feelings while they are in places or engaged in activities that are regarded as feminine, such as going to hairdressers, shopping or doing housework. A female-bodied person might claim that he is a trans man but it is important for therapists to see if he is bodily and behaviourally attuned to a masculine environment or group, or if he is capable of persuading others of his masculinity. Therapists seem to rely on the dominant social norms of gender and sexuality in doing so and make sure that each trans individual fits into proper gender roles as per social and cultural expectations.

Through psychotherapy sessions, trans people are constantly examined to see if they qualify to have "a body for life within the domain of cultural intelligibility" (Butler 1993:2). The space of psychotherapy is made into a site for testing trans people's sincerity and capability to "pass." For Sandy Stone (2006), one is considered as passing if one can live up to the dominant gender roles and make herself or himself accepted as a "natural" member of that gender. In this regard, psychotherapy turns trans peoples' bodies into "the object[s] of a technology and knowledge of rectification, readaptation, reinsertion and correction" (Foucault 2004:21), through the working of a homogenous and linear institutional temporality.

Conclusion

We know from Foucault (1980) that the category of sex has a normative function from the very beginning; in other words, it is a "regulatory ideal," as he terms it. In this respect, Butler (1993:1) asserts, "'sex' not only functions as a norm, but is part of a regulatory practice that produces the bodies it governs, that is, whose regulatory force is made clear as ... the power to produce—demarcate, circulate, differentiate—the bodies it controls."

However, people are not passive subjects, but rather active agents in such regulatory productions of embodiment. The overall picture of psychotherapy's engagement with trans people in Turkey indicates that medical standards, used during psychotherapy sessions and in the authorization of the final medical report, involve conflicting constructions of temporality of the trans body, of sex and of transsexuality. While medical authorities test (and while testing, simultaneously construct) evidence of the body's "true" sex over roughly two years, delivering a prologue to trans people's legal transformations to the opposite sex as the state's sexed subjects, trans people themselves come up with queer, plural understandings of their bodily time, sex, gender and trans identity.

In the space of psychotherapy, the need for reconfiguring one's genitals is tested in accordance with the presence or development of other aspects of bodily materiality. For example, Gayle Salamon (2010) argues how bodily features such as hairstyle, way of walking,

style of dress, pitch of voice and body shape and size are crucial elements of a body's materiality when determining one's gender—indeed, even more crucial than genitals. These qualities, moreover, have an impact on sex attribution, which might have nothing to do with the existing genitals. To explain this point, Salamon (2010:178) refers to Freud's observation: "the first determination we make about a person we pass on the street is an instantaneous *male* or *female?* and in nearly every case we make that determination with no information at all about genital configuration." Kessler and McKenna (2006:173) take this understanding one step further by elucidating this imagined genital configuration into a "cultural genital," a genital "which is assumed to exist and which, it is believed, should be there."

Part of what psychotherapy does is to examine the trans person's bodily features and body language in a temporally distributed fashion, evaluating whether the trans person presents enough material and performance to produce the sense of a "cultural genital" and then deciding whether to authorize SRS. That is to say, the psychiatrists allow trans people to reconstruct their genitals according to the gender that a person successfully passes as, rendering a particular production of bodily materiality obligatory over a specific time interval. Some trans people might have a strong desire for reconfiguring their genitals according to their phenomenological sex and according to their own bodily calendars. Meanwhile, others might not want to reconfigure their genitals in terms of these institutional expectations. The issue is not about whether to support SRS or not. Rather, it is about how the state's regulations stubbornly insist on a temporal equation of sex with genitals, producing sex in a predetermined material form and foreclosing other possible surfaces and temporalities of the body.

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Notes

1 SRS in Turkey includes trans people's bottom and top surgeries, ranging from genital reconfiguration to breast implantation for trans women, and breast removal for trans men.

2 For a more detailed description and analysis of Bülent Ersoy's legal struggle, see Rüstem Ertuğ Altınay (2008) and Başak Ertür and Alisa Lebow (2012).

3 Amendment to the Twenty-Ninth Clause of Law no. 743, Turkish Civil Code, May 12, 1988. The English translation of the code is taken from Deniz Kandiyoti (1998).

4 The English translation of the code is taken from Yeşim M. Atamer's (2005) work on the legal status of transsexuals in Turkey.

5 See Ayca Kurtoğlu (2009) for a detailed discussion of the denial of trans people's biological reproductive rights and its role in the imagination of a sexual citizenship in Turkey.

6 There are reactions against the pathologization of transsexual identity. Doctors in Turkey accept the Standards of Care for Gender Identity Disorder set by Harry Benjamin. According to these standards, transsexuality is defined as a "disorder," a definition that has raised many reactions all over the world. However, the standard is under revision and the next version is expected to modify this categorization. Authorities are uncertain about whether or not to keep the classification of "disorder," because the label can help trans people access public health benefits. If they replace "disorder" with some other definition, trans people might be denied insurance coverage for their operations, for instance. Trans people have made proposals aimed at preventing such possible deprivations while also avoiding the claim of disorder. For example, SRS could be categorized under health-related issues, akin to those necessary in pregnancy and delivery. Although pregnancy is not defined as a disorder, women's health insurance still compensates them for related expenses. To medically define transsexuality in such terms would avoid both any medically discriminative mechanism and the risk of placing trans people in a financially disadvantaged position. For instance, *gender dysphoria* is one term proposed for replacing the term *disorder*.

7 There are only a few of these hospitals, for example, including merely two in Istanbul, and all of them are public hospitals.

8 In Turkey, these hospitals are legally permitted to provide heyet raporu, but in practice the majority of trans people have their reports issued by public education and research hospitals. The reasons are threefold. First, trans people's financial constraints influence their choice of hospitals; public education and research hospitals are more financially accessible due to the insurance coverage. Second, private education and research hospitals are recently established, meaning hospital personnel are usually unfamiliar with the transition process and, in any case, are also few in number. Third, many hospital personnel are prejudiced against preparing SRS-related heyat raporu. Since beginning my fieldwork, until the moment of the final revisions to this article, I have yet to hear of any trans person who has received a heyet raporu from a private education and research hospital. The two public hospitals in Istanbul, Çapa and Cerrahpaşa, remain the most popular ones among trans people seeking SRS.

9 I use first-name pseudonyms for trans people and last-name pseudonyms for psychiatrists, as my relationship with the former group was based more on friendship than my interactions with the latter group, which always took the form in interviews in formal settings.

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