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Metaphorical Chicks with Material Dicks (and Vice Versa): an Analysis of Sensemaking Apparatuses for Transfeminine Medical Transition

Jess Jacob Harris-Braun
Bard College, jh8794@bard.edu

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By

Jess Harris-Braun

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This text is dedicated to my steadfast advisor, David Shein, without whom I would have been lost. It is also dedicated to the kitchen table of Barringer House, which served me better than any library carrel could have, and the many friends who talked with me at length about my work.

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Introduction

The medical process and treatments involved in medical transition for transgender women are pursued by discursive means at length in numerous contexts which surface and resurface continually as transfeminine people navigate their lives. Throughout these myriad conversations and scientific inquiries the thread of metaphor and meaning is highlighted by informed diagnostic criteria, visible instinctive curiosity, and explicit uncomprehending fear. Trans women are surrounded by a multi-layered field of sensemaking apparatuses which direct their focus to medical transition as a material site of transfemininity, a locus of evidence. This work undertakes an analysis of these sensemaking discourses and diagnostic apparatuses, contending with the metaphors they give rise to and identifying operative ramifications imposed upon the material transfeminine loci they enclose. In short, this analysis is an unraveling of the processes of sensemaking which arise from observations of transfeminine medical transition.

A History of Medicalization

The psycho-cultural processes which make sense of transgender identity are centered on the medical, as a site of both metaphor and truth. These particular sensemaking apparatuses appropriate the medical embodiment of cross-gender identification, rather than the social, because transness is a medicalized identity. The medicalization of transness is an ongoing process which has roots in its association to homosexuality and therein, the historical mutually constituted expansions of the realm of sexuality and the power of medico-scientific ontology.

Michel Foucault's theory of this history emphasizes the reciprocal tendencies of nominally repressive approaches to sexuality:

"At issue… is the type of power [nineteenth-century "bourgeois" society] brought to bear on the body and on sex. In point of fact, this power had neither the form of the law, nor the effects of the taboo. On the contrary, it acted by multiplication of singular sexualities. It did not set boundaries for sexuality; it extended the various forms of sexuality, pursuing them according to lines of indefinite penetration. It did not exclude sexuality, but included it in the body as a mode of specification of individuals. It did not seek to avoid it; it attracted its varieties by means of spirals in which pleasure and power reinforced one another. It did not set up a barrier; it provided places of maximum saturation. It produced and determined the sexual mosaic." (Foucault, 47)

Gayness, as a phenomenon subject to this mutual production of embodied (and correspondingly medical) identity, has undergone processes of mitosis. Cross-gender phenomena and their eventual emergence from the category of homosexual tendency as transsexualism is a result of this process of fractal pursuit. Thus the medicalizing practices shared between homosexuality and transsexuality mark the lineage of these developing identities and the multiplicative methodology which begat them.

Homosexuality in the normative discourse of the 20th century has undergone a full arc of construction, normatization, and reflexive regulation in its turn. Before it emerged in the inscribed form of homosexuality it was approached through the psychoanalytic lens of inversion, which postulated a turning inward of the sexed role of the individual. Inversion, as a pre-psychiatric condition in the early 20th century, was categorically an illness of the mind but was not subject to the same process of medicalization which later diagnostic categories

prescribed. The subsequent development of homosexuality as a mental illness invokes the work of psychiatry in linking the mind to the body to reify gayness as a disease in and of itself, rather than a symptomatic expression of the psyche and its malformation. Homosexuality's varied inclusions in editions of the Diagonistic and Statistical Manual of Mental Disorders (DSM) enshrined it not only as an illness, but one which required medical intervention rather than accomodation. This problematized homosexuality gave way to a normatized gayness which was instantiated by cultural means, distancing itself from its previous incarnation as a medical identity by way of social narrativization and self-produced communal knowledges. The new gay subjecthood which these mechanisms produced was distinct, not evolved from the diagnostic category of homosexuality but deployed combatively against it as a culturally real identity supported by reference to popular gay and lesbian social movements. To create and deploy this new subject identity a cultural rejection of the medicalized gayness which came before was necesarry; a rejection much warranted by the medical approaches to homosexuality at the time.

In the context of the mid-20th century in the United States, the medicalization processes of gayness and their problematic character are clearly visible. The placement of homosexuality within the DSM enabled prescriptions of conversion therapy and the practices of shock therapy, nausea-based aversion conditioning, and lobotimies; 'cures' for homosexuality which are considered synonymous with torture in contemporary LGBT discourse. The non-prescribed processes attached to gayness via its placement within the medical framework of the mid-20th century are myriad but can be summed up as within the lens of normalization of homophobia and structural oppression against gay people. Key examples of these non-prescribed yet medical functions are anti-sodomy laws predicated on ideas of scientific unnaturality and psychological

critera such as Kempf's Disease; a explicitly nonviolent condition which fallaciously informed the legal argument of gay and trans panic defense and was only removed from the DSM in 1973.

The similar and often paired 20th century medicalization of transgender identity holds parallel examples, with early attempts at correcting 'childhood inversion' resulting in aggression towards mother figures and in some cases suicide later in life. While the contemporary examples of medicalized gayness are sparse in the United States, the medicalization of transness contains many treatments which continue to be developed. Psychiatric practice has proceeded from the DSM category of Gender Identity Disorder (GID) to the more generalized structure of gender dysphoria, which follows a cultural trend towards identifying the ramifications of transgender identification rather than its sourcing; this shift does de-emphasize the process of medical diagnosis for transness, but also acts to broaden the mechanisms of medical interpolation and encompass more trans embodiments in the analytic medical scope.

This psychiatric unfolding of transgender embodiment is paired with the ongoing development of material medical transness, which as a scientific discipline has continued to expand both in methodology and practice. The material practices therein are broadly described as gender affirming treatment, and categorically contain hormone therapy, sex reassignement surgery (vaginoplasty/labiaplasty, phalloplasty/scrotoplasty), facial feminization/masculinization surgery, orchirectomy, mastectomy, and breast augmentation. As these treatments continue to be developed and normalized, the inscription of transgender identity within the framework of medical practice gains in prevalence. Transgender medicalization, after its split from medicalized homosexuality and subsequent expansion, has become a mainstay psychic lens by which crossgender embodiments are approached and understood. Although dissociated from visibly carceral features like conversion therapy and diagnoses of mental illness, it maintains restrictive

and potentially punitive features that undergird the context of medical truth which transness is and has been situated within.

This conclusion runs counter to a prevailing understanding of transgender identity as having been liberated from carceral medicalization in the 1970s alongside gayness, diagnoses of GID notwithstanding. This conceptualization of transgender identity entails a figuratively non-carceral and de-emphasized medicalization, one which ideologically distinguishes itself from conventional medicalization (which centers on the figure of the sick patient) by syncretizing itself with contemporary ideals of medicine as an enhancement, rather than a treatment. Within this framework the moral alignment of the medical system is brought into balance with cultural ideals, and the diagnostic understanding of transgender individuals is given a much needed facelift. The idea of non-carceral medicalization is mainly ideological, and primarily held by LGBT allies and similarly aligned institutions. As an cultural lens it is necessary for the maintenance of transgender legibility within the current moral attitude towards cross-gender identification. Therein, ideologically speaking, the legible 'acts' of transness become the focal point of cultural positivity. This phenomenon is exemplified in the (already cliché) commonplace curiosity about a trans person's experience with medical transition and surgeries demonstrated liberally by self-declared allies who regard their fascination as progressive and supportive.

What this ideological stance forgets and conceals is that the gender affirming medical care at the center of this novel idealization of transgender science is still deeply entrenched in pathologizing narratives, seen most poignantly in their restricted accessibility and diagnostic requirements which have become focal points for protest in the 21st century. Even for figuratively neutral treatments like puberty blockers which can be more easily aligned with

reactionary discourse on the (non)agency of gender-variant children, prescribers frequently require a diagnosis of gender dysphoria, or in the not-so-bygone context of the DSM-4, GID, to sign off. Hormone therapy and sex reassignment surgery are encircled even more closely by prerequisites like psychiatric endorsement and substantiated mental health. These diagnostic requirements, combatted as a form of gatekeeping by informed consent clinics and intra-community narratives, do more than stall transitions and demean patients. They implicate transgender embodiment in a pathalogical narrative which stakes its authority on the purportedly dangerous nature of the symptoms and treatments it considers. Trans identities mediated by this process of diagnosis and treatment are inscribed with markers of risk and reified as medically specific, foreclosing the path toward mutable cultural ubiquity followed by homosexuality.

Sensemaking Metaphors

Transfeminine medical transition is rife with metaphorical impositions, instances of meaning which are teased out from the flesh and process of surgery and hormone treatments. Medical transition's metaphors are perhaps more poignant than those of social transition because of this attachment to flesh, because the body itself is positioned as a withholder of secrets. This idea, the secret implanted sexual knowledge which becomes visible and moldable through the medical, is foundationally described by Foucault in *The History of Sexuality*:

"Imbedded in bodies, becoming deeply characteristic of individuals, the oddities of sex relied on a technology of health and pathology. And conversely, since sexuality was a medical and medicalizable object, one had to try and detect it - as a lesion, a dysfunction, or a symptom - in the depths of the organism, or on the surface of the skin…" (Foucault, 44)

This Foucauldian analysis of sexuality and its non-repression is well suited to the upwelling of metaphor surrounding emergent medical gender transitions, which are also sex (and sexual) transitions. The medicalization of deviant sex and gender and the drive to unveil the 'secret' of that deviation are central to the process of making meaning out of medical transition. The drive toward metaphor follows in parallel with the drive toward diagnosis. Metaphorical attachments refigure and modify the significance of medicalized identities, which themselves are crystallizations of the preeminent sensemaking methodology detailed by Foucault.

The medical transitions of trans women are a murky business for cultural narratives, which seem to exhibit no shortage of fascination for intimate details and confessional commentary. *How Sex Changed* by Joanne Meyerowitz documents this development and deployment of transness, particularly transfemininity, as a spectacle in and of itself. Christine Jorgensen, whose story opens the introduction, exemplifies the transfeminine spectacle in both the media coverage of her transformation and her successful career in show business. Note as well her medical transition's contingency on her role as a subject of observational study:

"In 1950 [Jorgensen] sailed to Europe in search of a doctor who would alter her bodily sex. Within months she found an endocrinologist who agreed to administer hormones if she would in return cooperate with his research. Over the next two years she took massive doses of estrogen and underwent two major surgeries to transform her genitals. At the end of 1952 the *New York Daily News* transformed her obscure personal triumph into a mass media sensation. The initial scoop immediately escalated into a frenzy. In the first two weeks of coverage, according to *Newsweek*, three major wire services sent out 50,000 words on the Christine Jorgensen story. Reporters cast Jorgensen, who was young and conventionally beautiful, as the personification of glamour, akin to a Hollywood starlet on the rise. They followed her every

move in Copenhagen and hounded her parents at their home in the Bronx. In the winter of 1953 Jorgensen returned to the United States and surrendered to her celebrity. In the summer she launched a successful nightclub act that kept her name on marquees and her body in spotlights for the rest of the decade." (Meyerowitz, 1)

Jorgensen's transition and body were spectacularized not only to satisfy the conventional fascination of newsreaders and the sexual appetites of nightclub attendees, but also as a captivating indication of the unstoppable progress of science. This cultural ideal, arising in the post-WWII context of rapid developments of military technology and ubiquitous suburban gadgetry, resulted in a contemporarily fetishization of sex reassignment surgery (and hormone therapy, although understated) as a 'wizardry' of modern technoscience:

"After World War II a few popular magazines stated more clearly that doctors could indeed change any person's sex. With the dawn of the atomic age, magazines routinely expressed admiration for the power of science and the wizardry of technology. Medical science in particular seemed poised to find solutions to the most daunting human problems." (Meyerowitz, 41)

Transgender medicalization continues to be engaged with this transhumanist conception of medical power over the human body and self, occasionally by intra-community discourses but more frequently by cisgender commentators. While the biological modification of the body by means of surgery and hormones emerged in the early years of the twentieth century, it remains cutting edge by virtue of its attachment to evergreen questions regarding the post-colonial instantiation of ideological supremacies over nature. This enduring position reinforces a metaphorical understanding of medical transition which considers transness an attainment of a subjecthood beyond the category of humanity—transfemininity as posthuman. These

philosophical processes of sensmaking for transgender identity are one element of the inquiries which aim to observe and culturally codify medical transition, the other main element being fetishistic curiosities of a sexual nature. Together they reify the understanding of transfemininity as spectacle, generating sparse cultural contexts in which the publicization of medical treatments and surgery are encouraged and rewarded.

With only these somewhat infrequent illuminations of the experience of gender affirming treatment to fill in the blanks, medical transitions of transfeminine individuals are commonly observed as binary state switches between male and female embodiment. This abrupt shift in legible sex and/or gender, combined with practices of self-isolation and recovery periods for surgery, gives the metaphor of transition as birth or rebirth a clear foothold in social understandings of transition. The transgender rebirth metaphor echoes intra-community sentiments of reinventing the self, getting a fresh start, and participating in the act of creating gender. Given the conceptualization of birth as the moment in which gender is assigned to a person ("It's a boy!"), a successive act of gender inscription also facilitated by a doctor with attention to the body and flesh of the individual fits snugly into this new set of meanings.

The figuring of transition as a form of birth is remarkable among its contemporary non-communal transition metaphors for its emphasis on creation and self-production. Many metaphors in this context present transition as a fabrication undertaken by a surgeon or prescriber, or do away with any context of creation and describe medical treatment as palliative or repressive. Transgender rebirth instead generates a context for newfound subjecthood to be grasped at by the transition individual themself rather than applied by a scientific authority. The positive attributes of this interpretation are limited, however, by the categorical rejection of seamless existence both before and throughout treatment processes. Birth is an essentially

unconscious act, and making sense of medical transition within a framework of instinctive or thoughtless gender embodiment does generate cultural linkages which undermine the ability and skill of particularly transfeminine individuals; this is exemplified in the sometimes demeaning tendencies of cisgender observers who wish to help trans women better embody their gender category through feminizing aesthetics and cosmetics.

Transness as rebirth is a particularly cultural metaphor, bounded by the societal imaginary of delivery and infancy; the medical sensemaking apparatus which concerns clear-cut distinctions between pre- and post-transition patients arises from issues with gendered diagnostic criteria and prescriptive risk. Within its exclusively societal frame of use, the metaphorical attachment to birth flourishes unrestricted by the limited scope of individuated metaphors tied to medical contexts. Any medical treatment or paramedical ministrations can be encompassed by the *social* connotation of birth and infant care. As such, the metaphor of transness as rebirth considers transfeminine transition on the whole to be a single cohesive procedure, private but significant, and the resultant gendered embodiment as an natural yet entirely untechnical affair.

This assortment of metaphorical attachments to transfeminine medical transition are broadly cultural, in the sense of their scope if not their sourcing. Many metaphors explicitly concern the medical, however, and often are less neutral in their ideological position concerning transfemininity. The prevalence of combative sensemaking can be understood as a consequence of the general medicalization of sexual identity as described in *The History of Sexuality*. Deviant gendering, when taken as a sexual secret brought to light by medical science, becomes hypervisible to antagonistic ideologies (both reactionary and analytic).

Reactionary feminism perceives transfeminine medical transition as wounding, cruel imitation, rape, and a destruction of the ideologically sacred boundaries of womanhood. This

perspective is foundationally built upon the idea of the body, the flesh, as containing some secret information, an idea which Foucauldian theories recognize and codify in their sourcing. Because the figurative secret's legibility is malleable by way of medical intervention, the transformation of flesh is given the power to overwrite systems of meaning which are predicated on inscription onto the body. Womanhood, as a cultural identity which is secondarily inscribed onto bodies, has its process of legibility threatened by this capacity for reterritorialization; reactionary feminism rests its ideological positions upon that figure of threat. In *The Transsexual Empire*, Janice Raymond ties the idea of masculine rape to transfeminine deception, a deception intrinsic to the surgical manipulation of flesh:

"Rape, of course, is a masculinist violation of bodily integrity. All transsexuals rape women's bodies by reducing the real female form to an artifact, appropriating this body for themselves. However, the transsexually constructed lesbian-feminist violates women's sexuality and spirit, as well. Rape, although it is usually done by force, can also be accomplished by deception. It is significant that in the case of the transsexually constructed lesbian-feminist, often he is able to gain entrance and a dominant position in women's spaces because the women involved do not know he is a transsexual and he just does not happen to mention it." (Raymond, 103)

It is important to understand that Raymond is not leveling an accusation towards the conduct and actions of individuals in this and further passages. *The Transsexual Empire* aims to develop a repetoire of metaphorical attachments to transsexuality. She is engaging in the process of making meaning, of making 'trans' mean 'rape'. Deception, then, becomes the reactionary feminist figuring of transfeminine medical transition; a deception that stems from surgical interventions (which she places above social passing in the hierarchy of transfeminine

technique). Sex reassignment surgery in this context 'masks' the 'real' existence of maleness in the transsexual and in doing so articulates an 'artificial' biological femininity. This gives way to a critique of Raymond's work as an essentialist discourse, one which overrides previous foundational texts of feminist theory which posit womanhood as a constructed identity, but to approach reactionary feminism as singularly essentialist would be a flattening of the claims therein.

The metaphorical attachment of deception, violence, and rape to transfeminine medical transition is in its own way a move towards constructivist understandings of womanhood. While the reference in the quote above to the "real female form" precludes the inclusion of transfeminine embodiment into female existence, it also argues, in its attachment to surgically embedded gendering, for the power that technologies of the flesh hold to generate sex and gender. The transsexual is still essentially male in this analysis, but the sex in question *is* innately changed. Raymond's conception of the female sex relies upon its pre-existing construction by way of non-medical technologies, which leads her to reject the medical construction of sex as an usurper. Immersed in this reactionary-constructivist framework, what she writes is the metaphorical counterpositioning of one constructed womanhood to another.

"As I have shown previously, to not acknowledge the fact that one is a transsexual in a women's space is indeed deception. Finally, "penetrating" the women's restaurant was "little more than a rape. " Little more than a rape, indeed! What "little more" is there to such an act, unless it is the total rape of our feminist identities, minds, and convictions? The transsexually constructed lesbian-feminist, having castrated himself, turns his whole body and behavior into a phallus that can rape in many ways, all the time. In this sense, he performs total rape, while also functioning totally against women's will to lesbian-feminism." (Raymond, 112)

The paradigm which is constructed here explicates the primacy of medical transition for meaning-making surrounding transfemininity. In Raymond's words, the transsexually constructed lesbian-feminist is transformed in totality by 'his' surgery into an instrument of 'total rape'. He is not simply a man perpetrating violence, he is a new species of individual whose whole body is constituted by violence *in his construction*; in the way he is *made*. The simple metaphorical attachment of sex reassignment surgery as a '(re)birth' is expanded by this image of the totalizing speciation of transsexuality. The reactionary approach to medical transition is so saturated with this imposition of totalizing meaning because it is positioned, as an action-of-the-flesh, at the base of the species-level mutation which produces transsexual identity.

The deception which constitutes rape in reactionary views of transfemininity is not then purely the use of surgery to 'mask' the in-the-flesh male sex in question, but the conflation of the transsexual mutation with that of femininity. Because Raymond does not invoke literal sexual violence but instead a psychic rape of female embodiment, the claim of deception can be consider in non-literal contexts. The transsexual who "just does not happen to mention it" is not only 'himself' committing deception, every individual who accepts transsexuality is perpetrating a psychic rape of femininity. The metaphor therefore returns to medical transition, wherein the surgeon's actions themselves are steeped in psychic violence. The performance of the surgery and 'creation' of a transsexual is a violent act, and the means by which it is undertaken (scalpel, lancet, trocar; diagnosis, prescription, operation) must then be violent. This context of surgery *as* violence is not unique to reactionary feminism, nor reactionary ideologies in general.

Surgery's attachment to violence can be explicated with brief reference to its somatic materials, the blade and the flesh under it, but the entanglement of the two runs deeply in its

procedural modes as well. Michael Kelly's *Martyr's Day: Chronicle of a Small War* exemplifies the contemporary understanding of surgery as a methodology of violence as well as medicine:

"The Gulf War wasn't named a war. It was named an operation— Operation Desert Storm. An operation is not a war; it is a surgical event. It is something the definitional purpose of which is limited: get in, get the tumor, get out." (Kelly, ?)

While the sourcing of this interface is perhaps opaque, the developed structure of warfare as surgery and surgery as warfare demonstrates its depth. Kelly's account of the Gulf War echoes commonplace sentiments surrounding NATO military operations throughout the late 20th and early 21st centuries, all with heavy emphasis on technologies of precision such as tactical airstrikes and drone bombing. This discursive deployment of 'surgical' violence is also remarkable in its invocation of surgery as a near-instantaneous event, an attachment not shared by other medical treatments which invert the metaphorical linkage of surgery and violence and are explicated as a form of warfare. As Susan Sontag considers the use of military metaphor in medical discourse surrounding cancer in *Illness as Metaphor*, the temporal aspect is instead one of prolongation, endurance, and a wartime economics of the body's health:

"The controlling metaphors in descriptions of cancer are, in fact, drawn not from economics but from the language of warfare: every physician and every attentive patient is familiar with, if perhaps inured to, this military terminology. Thus, cancer cells do not simply multiply; they are "invasive". Cancer cells "colonize" from the original tumor to far sites in the body, first setting up tiny outposts ("micrometastases") whose presence is assumed, though they cannot be detected. Rarely are the body's "defenses" vigorous enough to obliterate a tumor that has established its own blood supply and consists of billions of destructive cells… Treatment also has a military flavor. Radiotherapy uses the metaphors of aerial warfare; patients are

"bombarded" with toxic rays. And chemotherapy is chemical warfare, using poisons. Treatment aims to "kill" cancer cells (without it is hoped, killing the patient)." (Sontag, 65)

The remarkable distinction then in the metaphor of surgery as violence is its temporal precision, its instantaneous nature. It must have a clear task and purpose, and aim itself at a finite result. When combined with a physical understanding of surgery as necessarily rapid for the health of the patient, surgical procedure becomes a technology of medical violence which lacks half steps, is uninterruptible and irrevocable. This aesthetic conceptualization undergirds the secondary metaphorical structure at hand in discussions of sex reassignment surgery; surgery as a dangerous act. As explicated through Raymond's analysis of the transsexually constructed lesbian feminist, surgery's power over the meaningful substance of the flesh and its secret (sexual) contents gives it the potential to endanger the ordered discourse of feminist liberation. This understanding of danger is particularly cultural, representing a threat to the legibility of the societal category of womanhood in reactionary feminist discourse. In other discourses, however, sex reassignment surgery has been regarded as dangerous in a specifically interpersonal sense. In the opening of *Standards of Care*, Beans Velocci describes correspondence between two 'founding fathers' of sex reassignment surgeries, Elmer Belt and Harry Benjamin, which shows the prevalence of this sense of interpersonal danger in dealing with transsexuals and their surgeries:

"For nearly two years before Belt sent the letter, he and Benjamin had been debating whether Edie V. Hutchens should be eligible for the removal of her penis and testicles and the construction of a vagina. The longer they delayed, the more desperate Hutchens became, but they hesitated to allow the surgery for fear that Hutchens would regret her transition and turn on them, whether with gun in hand or by other means." (Velocci, 462)

This danger and fear is situated in the figure of regret, an emotional reaction inherent to any understanding of an event as instant and permanent. Sex reassignment surgery has in some sense attained this characteristic by its supposedly irreversible nature, but it contains its own figure of regret through the anti-normativity and difficulty of embodied transfeminine existence. In its historical contexts this can be understood as a feature of societal misogyny and the cultural supremacy of manhood, which it would be unimaginable to revoke. Contemporarily, however, the figure of regret is in large part sourced from the supposedly total rejection of transgender individuals as normative subjects. Cultural discourses against transition display this normativity-focused reaction in appeals for trans people to take up more conventional queer subjectivities ("why can't you just be gay?"). Secondarily, the contemporary figure of transfeminine regret is also constituted by the potential risks of medical transition, particularly hormonal therapy. In this context the danger becomes total: the risks induced in the patient are ethical considerations of the prescriber, and thus if they eventually endanger the patient's life the clinic and prescriber are themselves endangered by potentially career-ending scrutiny and backlash. The reality of this danger to practitioners in contemporary contexts and its place as a risk to be considered alongside that to the patient is demonstrated in this advisory paper which considers the ethics of prescribing hormone therapy to a youth with a BRCA1 mutation (which increases the likelihood of breast, ovarian, and prostate cancers):

"The physician expressed concern about the risks of both giving and withholding hormonal therapy, the ability of the family to cope with these decisions in the face of the mother's decline, and the developmental capacity of a 15 year old to comprehend both the risk and devastation of a cancer diagnosis. She also privately considered the risks to her own

fledgling gender clinic if news of a controversial ethical decision became public." (Wolf-Gould et al., 7)

The contemporary risk to the physician is compounded in instances where regret is present, either as dismay at the prospect of risks and complications in gender affirming treatment or a rejection of transgender embodiment post-transition. Particularly in the case of gender affirming surgeries, endowed with the aforementioned character of irreversibility, the potential regret of the patient is a potent consideration for practitioners conscious of their politically precarious position.

Regret and its counterpart, indecision, are also symptomatic of the finite nature of sex reassignment surgeries, which are themselves gendered in definite terms and bounded by their own matrices of normative sexual expression. Surgeries for the purpose of satisfying the desire of the transsexual patient are culturally gendered, tied into ideas of psychic claim to phallic power and conversely the sexual needs of normative womanhood. The historical conception of sex reassignment surgery as dangerous to the surgeon (by means of retribution by the patient) expressed by Benjamin and his contemporaries can be understood within this framework as an anxiety about their abilities as surgeons to produce satisfactory results, which itself is sourced from the potential danger to the recipient of sex reassignment surgery as failing to properly achieve the expressly *cultural* goals of the surgery; gendered embodiment based on a claim to normative biology and a societal role which aligns with the psychic effects of biological characteristics. Failing to provide those results, when paired with the aforementioned connotations of irrevocability, constitutes a dangerous outcome for the patient, one which is emphasized in medical and reactionary cultural discourses alike.

The production of this danger to the patient is contingent on a limited normative scope of transgender embodiment, ignorant of the potential for trans existences which are not immitative of cisgender body-lives. This interplay of normative gender embodiment and the methodological aims of surgery (to produce definite results) is generative of further innate genderings of surgical procedures, going beyond the simple biological inherencies and the objective psycho-cultural satisfaction. As a technology of-the-flesh surgery is not only gendered by its contextual cultural attachments, but by its enactment as an arbitrator of normative gender and sex; a mutual process of inscription which genders both the body of the trans(gressive) subject and the procedure itself.

Diagnostic Gender Paradox and the Role of Cancer

Illnesses themselves are also individually gendered beyond their biological attachments. There are numerous conditions such as prostate cancer and pregnancy complications which are not only exclusively applicable to male or female biologies, but also medically and culturally coded as masculine or feminine. The diagnostic treatment of testicular cancer, for example, is heavily tied up with impotence and the cultural role of men as producers of households and progeny. A preservationist mindset operates within these socio-medical narratives, as the unthinkable outcome would be total loss of testicular capability (which could otherwise be medically seen as a potential preventative surgical measure). This same preservationist mindset operates complexly in cultural discourse surrounding preventative mastectomy to reduce breast cancer risk in cisgender women.

In a primary cultural sense, the sexual implications of breast reduction and removal are strongly emphasized; aesthetic losses of beauty and sexual allure are grieved by some patients and observers alike, often with little forethought to the objectificatory nature of such sentiment. In a deeper psycho-political sense the removal of breasts also forecloses some elements of childbearing, i.e. breastfeeding, which leads it to share many cultural reactions with ovariectomy and hysterectomy. Any move towards reducing the reproductive capacity of women, even in a medically positive form such as these, attracts both individual and structural opposition. In a biopolitical sense, what is at stake is the growth potential of the general population. While personal commentators may mark the psychological aspects of precluding pregnancy or motherhood, structural analyses based in the relative 'health' of large sets of citizens will object to medical practice which standardizes or is standardized upon a noncompliant set of directives; a valuation of adult women's non-risk above the maintenance of the potential birth rate.

Mastectomy, however, can also be approached as a practical move in support of the socio-cultural role of women as mothers. Biopolitical analyses aimed at maintaining the general 'health' of a productive society in the populational sense register high-frequency health risks of female biology as an existential threat to the socio-political role of womanhood. Mastectomy, then, as a preventative measure which promotes the general non-risk of potential mothers, is engaged with as both anti- and pro-reproduction in different cultural contexts which it enters by no means of its own. This discursive invocation is predicated upon its relationship to breast cancer risk, which is made a female condition by its status as a threat within cultural narratives of gendered existence. Breast cancer is emblematized by biopolitical and cultural narratives as an inherently gendered illness; a sickness of women and a symptom of womanhood.

An interesting ramification of the exceptional state of transfeminine medical transition and its attachments to danger and violence is the tailored development of an aesthetically normative womanhood which is perceived via female illness as inherently prohibitively dangerous: ‘at risk’. The breast tissue growth induced in transitioning individuals with the use of synthetic estrogen supplements carries with it an increased chance of developing breast cancer, which is upheld by care providers and commentators as a significant risk of transfeminine hormone therapy. This risk is one of many discursive elements which influences the availability of medication and the decisions made by prescribers. Because of the general similarity to the risk of breast cancer in cisgender women, intra-community transfeminine narratives may present the focus on the risks of breast cancer in medically transitioning trans women as demonstrative of bias and gatekeeping.

Whether or not the associated cancer risks justify the objections raised to hormone therapy, the usage of breast cancer as an emblem of potentially unacceptable risk manifests a double bind for the state of transfeminine womanhood: being at risk of breast cancer is built upon the cultural basis of existential threats to womanhood, but the exceptionality of transfemininity makes that risk supercede the claim to femininity itself and functions to block the embodiment of womanhood that it is foundationally sourced in. The ‘at risk’ status that operates as a prohibition on transition is precedently constituted by that which it prohibits.

The temporal paradox of transfeminine risk can be unraveled with a number of lenses. The first is one of atemporality. Under the socio-medical perspective at hand, diagnostic procedure considers a plurality of potential future lives which the patient may be enabled or restricted from enacting. For trans people, this process appears as a work of speculative medical nonfiction which categorically overwrites the patient’s claim to their own gendered reality; as

gendered embodiment is not sourced from the individual but their structural placement [see: assigned gender at birth, population based analysis (birth rates), biopolitical machination]. This use of this method entails that ‘at risk’ transfeminine patients are not engaged as masculine individuals seeking feminizing treatment, but as males with a potential future life as females. In this paradigm the contradiction above is brought forward in time, placed entirely within the speculative life of the patient as a woman in the future. Within that realm of speculation the operative process of medical decision making can legitimate the prohibitive danger by diagnosing the future patient, who is now wholly woman, with the feminine condition of breast cancer risk. The diagnostic procedure is thereafter biopolitical, as it acts to parse out a life worth living and prevent unacceptable lives from being pursued.

A second resolution approaches the conflict with an act of subject-superposition. Subjecthoods, as coincident societal roles and psychic identities, can be enacted in concurrent arrangements which result in valid forms of embodiment. If transfeminine patients are understood as simultaneously masculine subjects *and* feminine subjects, breast cancer risk gains its prohibitive status as an existential threat to the subject while the process of medical transition is still at stake. This twinned subjecthood implicates the patient in producing a structural double-life, and as an operating principle of a prohibition on transition also prevents the patient from shedding the second subject identity of manhood. In codifying twinned subject roles such as the psychological transsexual and then moderating their attachments to normative female subjectivity, the medical apparatus used this resolution to maintain a scientific normativity in its convoluted approach to transfemininity within psychoanalysis; the hallmark of the process being the practice of having new patients ‘live as a woman’ for a time before being cleared for medical transition. This trial of female embodied existence is predicated upon the hitherto male

subjecthood of the patient, which endures both legally and medically throughout the duration. Once dual subjecthood is thus opened, the contradiction of feminine risk applying to compulsorily masculine subjects is resolved, as the patient has enacted a simultaneous female subjecthood and can be medically approached on that basis.

This lens operates on the level of cultural identities, most readily functional in the capillary structures of social discourse, and as such the feminine subjecthood it assigns is often rendered distinct from other identities legible as womanhood (see for example Janice Raymond's "transsexually constructed lesbian-feminist"). The subsequent resolution of the paradoxical application of transfeminine risk may entail a maintenance of these states of abnormal womanhood, unlinked from the medical outcome of the patient's transition by virtue of their cultural derivation. The discursively psychological focus of medical analysis of the aforementioned dual-subjecthood embodiment adds scientific rationalization to instinctive rejections of post-transition women who might otherwise have successfully laid claim to female subjecthood on the basis of their body; under the lens of Raymond and her contemporaries the male-to-female transsexual is particularly atrocious because of the *contrast* between the 'psychologically male' mind and (surgically) normative female body. This step from the psychological analysis of pre-transition transfeminine subjecthood to an understanding of trans women as psychologically distinct (non-)feminine subjects is not reflected by medical discourses by and large, and is more aptly categorized as a cultural byproduct of medical procedure enmeshed with reactionary conceptions of essentialist womanhood.

While no psychic apparatus singularly resolves (or needs to resolve) the diagnostic paradox of 'at risk' transfemininity, one common and widely applicable medico-cultural lens often takes primacy in diagnostic procedure and discourse; a posing of transfemininity and

transness in general as a temporally singular act of doing, as opposed to an enduring state of being. This view flattens transgender identity to its primary socially intelligible characteristic, transition, while also ignoring the ongoing nature of social and medical transition in favor of a perfunctory conceptualization. It also harnesses and regenerates the cultural idea that post-transition trans people are entirely separate and distinct from their pre-transition selves and lives; proposing that there is a clean and instant break between precursory and subsequent binary gendered embodiments. This in turn enables and reinforces the expectation that trans individuals who undergo transition will be made 'normal' by medical treatment, effectively cis ("I can't tell the difference!"). The desire for a 'properly processed' trans person to be fundamentally normal is predicated upon this location of 'transness' in a finite act, preferably one with as short a duration as possible. The transgender-ization of the individual must be conceptualized not as form of being but as a thing which one is doing, which will end after it has completed its task (transitioning between genders).

As a by-product of essentially reactionary cultural awarenesses of transgender identification, the singular-act lens is strongly sourced from the social configuration of 'coming out' which is one of the clearest conceptual 'acts' of LGBT identity (the others being gay sex, of course). The misconfiguration of extra-community discourses on coming out is a broad topic, but can be approached succinctly with critical attention directed to its framing as an action which is done to others rather than to oneself. While announcing one's gayness does primarily involve a semantically self-focused speech act, the superficially observable direction of cause and effect flows to outward from the action toward other people. It is with that framing that singular-act understandings resolve the contradictions inherent in 'at risk' transfemininity. Considering the aforementioned conceptualization of post-transition individuals as congenitally disarticulated

from both the pre-transition self and the performed action of transness, the lens processes the emergence of breast cancer risk as an effect of an act (transgendering) being done by one person (pre-transition, male) to a different person (post-transition, female). The existential threat to womanhood is therein not enacted upon a complexly-gendered individual wherein the danger loses its key cultural characteristic, but enacted by and within a conventionally gendered discourse of male versus female which reinforces its use as a prohibitive risk intrinsic to transfeminine medical transition.

Cancer's position as a mainstay risk of hormone therapy is also an interesting reflection of the ideas surrounding the disease and its sourcing. While breast cancer in cisgender women may be seen as a natural hazard or just another step of inequity faced by women, breast cancer in trans women culturally cashes in on the figure of cancer as repression. Susan Sontag demonstrates this entanglement of disease and moralistic causation in *Illness as Metaphor*:

"According to the mythology of cancer, it is generally a steady repression of feeling that causes the disease. In the earlier, more optimitic form of this fantasy, the repressed feelings were sexual; now, in a notable shift, the repression of violent feelings is imagined to cause cancer…The source for much of the current fancy that associates cancer with the repression of passion is Wilhelm Reich, who defined cancer as "a disease following emotional resignation—a bio-energetic shrinking, a giving up of hope."" (Sontag, 22)

While perhaps the shift to violent feelings in this cancer mythos fits less well with the cultural imaginary of transfeminine transition than its predecessor, reactionary discourses on transness as self-hate and self-harm demonstrate the remarkable adaptability of the discursive link between cancer-as-repression and repressive figurations of transness.

Transition, both medical and social, is reflexively viewable as a covering-up and repression of a ‘true’ and particularly unavoidable gendered self. This true selfhood is figuratively positioned as an of-the-flesh entity which is not exclusively sex nor gender, it is an immaterial emblem inscribed in the body which is innefacable by coming out or sex reassignment surgery alike. Within the lens of repression, these milestones of normative transfeminine embodiment only bolster the figurative true self in its position opposite to them. This secret of the flesh becomes ‘the body’, a biological assemblage with innumerable parts beyond primary sex characteristics which becomes more visibly defined with each alteration. The repressive hypothesis is contingent on an acute awareness of the effects of transition; a significant respect for the powers of medical technologies and cultural perceptions which come to highlight the few areas wherein they fall short.

The mode of problematization therein is shared with the repressive conception of cancer: while emotional and societal control of the self is feasible, the body is not so easily ruled. It will reject the falsehood by means of its own tissues (consider the difficulties in suppressing the growth of tumors and facial hair, for example) and betray its own supposed functions (passing as female, or simply having a humble mastery over one’s own flesh). Under the metaphor of transness as repression the retribution enacted by the displeased body is not, at least initially, of the fatal and tumorous kind. It is conjured within the image of the non-passing trans woman which haunts the cultural sphere of normative acceptable transness. She might be given away only by a telltale vocal tone, or perhaps she is a true caricature of genderfuck drag. Either way, the metaphorical imposition of the body’s revenge against repression is characterized as inherently shocking to observers, and as a secret contained in the flesh which is always-already unveiled. The repression of the body-inscribed ‘true self’ is also made dangerous in this

paradigm, wherein the shockingly transfeminine individual is subject to social rejection and violence on the basis of her contrasting presentation. The persistent nature of this harm-inspiring shock shows an enduring atemporality which it shares with tumors: both are potentially indefinitely recurrent, disregarding the long stretches of time wherein the danger seems to be long past or made a nonfactor by means of complete material dissociation. For the repressive trans woman and the remissive cancer patient this atemporal nature means no assured escape from danger, no guarantees.

The sporadic *literal* intertwinement of cancer and transfemininity ultimately becomes just one instance of the applicable metaphor of cancer as repression, which is also invoked as a figurative framework for other complications and risks involved in medical transition. Uterus transplant rejection (mainly an historical occurrence), loss of neovaginal depth resulting from a lack of adequate dilation, and increased occurrence of blood clots are all operable within a narrative of the body rejecting repressive medical treatments. These dangers are posed reactionarily as 'natural' rejections of medical transition, risks which demarcate the boundaries of acceptable biological modification. The context of repression moralizes transfeminine experiences with these risks as warning signs ignored, leaving trans women who are categorically endangered to deal with the supposed consequences of their actions. Sontag, describing the narrative roles allotted by contrasting diseases, neatly sums up the repressive metaphor's approach to individuals at the intersection of transfemininity and breast cancer:

"... the cancer personality is regarded more simply, and with condescension, as one of life's losers." (Sontag, 49)

Transmedicalization

There exists room for a distinction in contemporary trans experience between additive gendering and transgressive gendering. This differentiation is theoretical, not practical, but the conceptual split aids in an analysis of the metapolitical impetus for contemporary gender paradigm shifts. The distinction between the two categories of gender experience is based in a diagrammatic framing of the dominant contemporary gender system as holding one definite position for 'within' containing a superior gender (male) and one indefinite position for 'without' in which both the subordinate gender (female) and all other gender experiences are contained. Under this paradigm any embodied gendering which fully transgresses its category threatens the supremacy of the 'within' position, requiring that boundary to be policed by ideological, psycho-political, and physical means. The border must be understood as impassible for the maintenance of legible definitely and indefinitely gendered subjecthoods, which self-sort into asymmetric power structures by reference to their psychic character. In contrast to transgressive embodiments, additive gendering only adds to the individual's present gender experience and does not require a complete transgression of the policed boundary of male supremacy. Regardless of its potential sourcing, this additive gendering aligns with the process of neutralization at work under the twin aims of economic incorporation and national interpolation.

The ideological machinery of capitalism is well understood as having the capacity to interpolate radical and countercultural social movements into itself as marketable subcultures and new forms of subjecthood, which reinforce existing paradigms as legible contrasting positions. The identification of this process and its promotion or disruption is then central to the

ongoing viability or nonviability of a radical or transformative movement. In this context of ideological metaconflict the evolution of trans experience carries new weight as potentially containing psychopolitical 'defangings' of previously paradigm-threatening gender embodiments. Thus, the categories of additive and transgressive gendering become an analytic knife by which one may interpret particular shifts as indicative of institutional interpolation or conversely the maintenance of transmutative power under capitalism. This theoretical paradigm of additive and transgressive gender embodiments can also be seen as a set of sub-ideological distinctions which are taken up by latent fears to produce reactionary categories of 'fake' and 'real' trans identities, grounding its usage as an analytical tool in preexisting affective deployments. Proceeding from the theory that additive gender embodiments, when enacted in lieu of transgressive ones, do not threaten previously imperiled paradigmatic gender categories, the normatization of additive transgender embodiment can be understood as an effect of transmedicalization; an adapted form of medical interpolation which aims to stabilize trans identities.

If medicalization in the Foucauldian sense refers to the production of legible subjects by their separation from normativity or interpolation under institutional power (a singlefold semiotic inscription which places them within the grasp of institutional ontologies and implants in the subject-psyche a self-identity which surveils their actions), then *Trans*medicalization, following the etymological roots of *trans* as meaning *through* or *across*, points to a novel process by which the discursive identity produced therein is not developed by an actionable process of division or internalization but rather an ongoing process of crossing policed boundaries. The subject identity produced thusly is a perpetual transgressor, acting not as a reinforcement of an internal boundary by its outside-ness but a figure of its permeability. The existence of such a subject, divulged from

the procedural inside-vs-outside positioning and altogether in/of the boundary itself, requires then a recursive subjectivization which stabilizes the semiotic legibility of the subject boundary (in the case of crossgender phenomena, that of male-internal/female-exterior) and encloses the subject in a static position; a process which results in expressly normative post-transition transgender subjecthoods This twofold subjectivization and its locus at/in the subject-boundary itself is what distinguishes transmedicalization within the Foucauldian analysis which precedes it.

Wielding this theory of subject-inscription as a dual mode of identification and successive stabilization, apparatuses of sensemaking which concern the material processes of transgressive gender embodiment become visible as inherent systems of supportive stabilization in their own right. The metaphors of transfeminine medical transition act upon partially inscribed trans embodiments to mitigate their subversive characteristics and preventatively obscure the enactment of threat upon policed boundaries of gender. Given that the threat addressed by transmedicalization is the appearance of transness as a emblem of permeability, sensemaking metaphors of transition perform a key role in mediating the cultural position of motile trans embodiments in between their initial inscription as transgressor subjects and secondary inscription as fixed-gender subjects imitative of normative cisgender subjecthood. The broad assemblage of metaphor which surrounds medical expressions of transfemininity is enacting a process of obfuscatory threat mitigation, transmuting radical gender embodiments into superficially meaningful cultural figures.

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