

Trans(subject)formations: Feminist Healthcare, Medicalized Life Narratives, and Why I'm a Trans Feminist

By Dylan McCarthy Blackston

Introduction

"You're a straight man now, right?"

Oh, hell no.

"Why, as a man, are you wearing a shirt that says, Protect Women's Health?"

A. My gender is far more complicated than you, stranger, realize.

B. Women, a majority of the population, receive inadequate health care, threatened access to certain health care procedures, and generally seek health care less because their schedules are often built around work and providing family care. Furthermore, when women (not surprisingly) cannot make ends meet or be present for certain events because of complex expectations of their time, they are blamed for their inadequacies as mothers, workers, and caretakers.

I concern myself with these problems because women do matter and because I, as a feminist, can see no other way of ethically functioning in the world. "So, you're gay, right? You act gay." Ummm, sure. "There's still something that's un-man about you; you'd never pass as a man." Thank you. I no longer desire to pass as any specific gender. However, I do not think you are paying me a compliment. Rather, I believe you are implying that my position in the world will never be normative embodied in an intelligible way, or meaningful in its fluidity.

These are real questions I have gotten from feminists, some of whom knew I am trans and some of whom did not. For me, participation in certain feminist spaces has been wrought with conflict. That being said, I have also felt my way into and out of certain trans “communities”¹ because I found, in moments, they lacked a clearly articulated, feminist statement on how gender systemically structures our everyday lives. Put simply, I have found that medically transitioned people, including myself, are often placed at the top of a constructed trans hierarchy. This is especially unsettling for me as a feminist who finds such hierarchies completely counter to playing with and deconstructing gender in order to understand some of the manners by which it dramatically structures our experiences. While some feminists have historically excluded transpeople from groups by using language such as, “You lack a woman’s experience,” for transwomen, or, “You copped out,” for transmen, feminism has also functioned, in meaningful ways, to make other versions of gender intelligible in a binaristic system. This is not to say that the women’s liberation movement of the 1960s and 1970s paved the way for trans identity. After all, parts of the movement functioned to stymie butch/femme representation and burgeoning trans visibility. Contrastingly, in much of trans identity politics today, there is an often overt linearity expected of trans people. This is occurring at the same time that academics employ a queer framework to analyze how identity categories can enable exclusionary politics.

Trans(subject)formations

¹ Throughout the paper, I use quotation marks around the word communities to indicate a discomfort with the word. Because this paper attempts to explore non-linear narratives of trans lives, assuming there is one community of trans people with one unified story counters my hope of figuring multiple forms of trans embodiment and trans subjectivities into and against dominant narratives of trans-ness.

I state all of this to provide some background for how genderqueer and trans-identified people often have complex relationships to both feminism and trans identity politics. This only reiterates how deeply intertwined feminism, trans studies, and queer theory are. Louis Althusser's theory of interpellation is infused with notions of synchronous hailing and subject formation. In "Ideology and Ideological State Apparatuses (Notes towards an Investigation)," he notes that individuals are always-already subjects (Althusser, 2008, p. 46) as they are born into ideological structures that will constantly "hail" them to comply with their orienting path. Even in utero, fetuses are granted subjectivities as girls or boys. Thus, from birth, individuals are hailed by the family ideological state apparatus to become the subjects they already are (Althusser, 2008, p. 50). However, this simultaneous hailing and subject formation must be questioned in the case of queer subjects; specifically those whose gender is reformulated after they are born. Pointed in specific directions by Ideological State Apparatuses such as family, school, or religious institutions, queer subjects are pushed to recognize certain hails that they in turn, defy through disidentification with normative media, gender expressions, and sexual interest and/or behavior. However, queer subjects whose gender is redefined beyond birth also respond to normative hails originating from within their self-formed families and peer networks. These hails are often more challenging to defy insofar as they are produced within one's supposedly non-normative "community." Yet, the gendered hails originating from within a queer individual's "community" are still alternately formulated and the subjects formed remain non-normative bodies. Therefore, it is critical to imagine ways by which trans subjects can and do take agentive, feminist

action against normalizing hails in order to inhabit yet-to-be determined subject positions and forms of embodiment.

By analyzing the first meeting of an Atlanta, Georgia-based trans group, I begin an exploration of how the hails of multiple ideologies often fail to interpolate queer individuals into heteronormative subjects. Conversely, I analyze how genderqueers have been pushed by ideological state apparatuses (ISAs) as well as their own “communities” to medically transition in order to adequately orient themselves toward fulfilment—albeit only partial fulfilment—of certain ideological expectations. Analysis of this meeting will be layered with an analysis of Feminist Women’s Health Center’s Trans Health Initiative,² including its overall purpose and mission as well as its function within and against normatively gendered subject formation for trans individuals.

With regard to the normative hails from ISAs and trans ‘communities,’ I will employ Jasbir Puar’s theorization of the homonational subject to explore how the medically transitioned subject, even when seeking totally normative gender expression, still remains a non-normative body. Furthermore, Saba Mahmood’s theoretical exploration of “uncoupling the notion of self-realization from that of the autonomous will” (Mahmood, 2005, p. 14) is useful to this analysis because she suggests multiplying the ways that agency is represented. She pushes for removing the concept that agency can only be achieved through resistance (the progressive model) and instead looks to ethics—especially in their local-ness and particularity—for help (Mahmood, 2005). When her

² Feminist Women’s Health Center is located in Atlanta, Georgia. For more information, see www.feministcenter.org

theory is compared to medicalized transgenderism, the ties to enlightenment thought and liberal subjecthood are apparent.

At its core, the concept of transgender as a pathology based upon gender dysphoria and subsequent healing through medicalized transition conjures notions of freedom through transition. Simply put, the hormone-taking, surgically altered subjects might be considered “free” or “healed.” Their post-transition bodies are seen to medically match their mind and, to some degree, they are granted agency as the correctly gendered subject. However, as will be discussed later, the subject that results from this ‘healing’ is still only an almost-citizen subject. Furthermore, Mahmood (2005) argues that not everyone has the same (or any) desire to be free (p.10). She notes that ideals of the liberal subject are deeply imbricated with existential thought inasmuch as both suggest that individuals can overcome all obstacles, throw off restraints and seek transcendence (Mahmood, 2005, p. 7). This transcendence for the transgender subject would be synonymous with freeing oneself by medically transitioning and thus enabling body to match mind. The dominant discourse is that transpeoples’ minds/hearts do not match their bodily morphologies. Yet, in attempting to decouple agency from resistance in her discussion of women’s involvement in the piety movement in Egypt, Mahmood provides an opening for other versions of agency. Mahmood (2005) suggests that because history and culture are not fixed and thus reactions to and acceptance of historical and cultural practices are not fixed, one cannot assume that agency, generally, or how individuals can be and are agentive in their actions is fixed either (p.14). Using this idea as a framework, I explore how presenting a singular, dominant narrative of trans bodies,

particularly as our bodies relate to medical transition, leaves out the multifarious gender experiences that trans people articulate in order to create new forms of agency. In short, it is a fallacy to suggest that one narrative or one form of agency is universally applicable.

Trans Double Bind

I began periodically volunteering with the Feminist Women's Health Center's Trans Health Initiative (THI) in early 2011. I was interested in seeing how trans healthcare could be safely and kindly provided. When I began hormone replacement therapy, I did not have health insurance and the THI did not exist. I had a very difficult time finding care, let alone quality care. In fact, I know very few people who had an adequate first experience with a healthcare provider once the discussion of hormone replacement therapy was broached. Indeed, just receiving any general healthcare as a genderqueer person is ridiculously challenging and often differently formidable if one has medically transitioned. Furthermore, while I had support from my friend-family, some of whom were facing similar struggles with gender and healthcare, I found that my stance on the needs of my body was often at-odds with a faction of people who called themselves gay or feminist. While volunteering at the Feminist Women's Health Center (FWHC), I found a different type of feminist and trans healthcare. For example, though trans patients are often trained to act unwavering in their decision to medically transition in order to get the diagnosis they need to receive hormones, the care I witnessed FWHC provided openings for patients to ask questions, even if those questions contained hesitations and concerns. It is incredible that this type of conversational care is considered a radical

approach to healthcare, but frankly it is radical in comparison to the care trans people are likely to receive at many other clinics.

Through my volunteer experiences and my general interest, I began to participate in more trans-specific events, such as attendance at community gatherings relating to trans healthcare. One of the first meetings I attended as a THI volunteer was organized by a new Atlanta trans group. Rather than providing information about the services their organizations provided and the activism in which they were engaged, the central focus of the meeting quickly shifted to a space for sharing personal narratives about not receiving adequate healthcare or not receiving acceptance from the gay community. Furthermore, with the exception of a couple of staunchly self-identified feminists, almost all of the speakers made medical transition into an expected step for all transpeople without regard to other needs. Herein lies a double bind for trans people. On the one hand, these spaces enable information sharing and the capacity to voice grievances about the availability of healthcare, even in its liberal formations. On the other hand, there is a false unity with regard to the healthcare that trans people are seeking, thus disabling a broader discussion of other ways in which trans people are excluded from care.

Without becoming excessively critical, I should note that I believe this type of rhetoric to be counterproductive to what José Esteban Muñoz considers the opportunity that many queer people take to “tactically misrecognize the hails of dominant ideology” (Muñoz, 1999, p. 168). He states, “Disidentification permits the subject of ideology to contest the

interpellations of the dominant ideology” (Muñoz, 1999, 168-169). But this resistance to expected interpellations is more than a contestation to dominant ideology through alternate interpellations; rather, it is splitting the dominant hail from subject formation by queering not just the type of subject one becomes, but also when the individual becomes that subject. Put into simpler terms, genderqueer subjects, though always-already subjects to ideology, tactically resist ideology’s total control over the timing of their gender formations.

For example, if an infant is identified as female at birth and is subsequently hailed to become what she was already identified as prior to her birth (referencing sonogram technology), she has already been oriented in a specific direction. Sara Ahmed explores the family line of son replicating father by analyzing the hopeful utterance of “Look, there is a little John and a little Mark!” (Ahmed, 2006, p. 83). Ahmed (2006) states, “Through the utterance, these non-yet-but-to-be subjects are ‘brought into line’ by being ‘given’ a future that is ‘in line’ with the family line” (p. 83). She is speaking in phenomenological terms about the straight line that forecloses the future by naturalizing the past. By producing a naturalized past and a foreclosed future via the straight line, any derivation from the line is read as queer. Thus the queer person “can only ... be read as the source of injury: a sign of the failure to repay the debt of life by becoming straight” (Ahmed, 2006, p. 91). Even more importantly, there are certain time and spatial implications of following a slanted rather than a straight line.

The straightening effects of gendered hails can be re-read as spaces for different turns. If one does not respond correctly and as a result does not become correctly oriented toward normative gender, one becomes a queer body with endless directions in which one can turn (Ahmed, 2006, p. 107). If the queer body does not respond correctly, then ideology's control over the future is not a given fact. Let us say that the female child mentioned above deviates from the straight path and decides to embody what would be considered, by normative culture, masculine traits, masculine comportment, and masculine dress. Furthermore, let us say that she decides to identify as a gay man named Roger. Then, let us say that Roger decides to perform as a woman in high-femme fashion in his local gay bar's drag performances. In the end, is Roger correctly gendered? Is he back on the straight path? No, he is not. If one of feminism's main tenets is to question why certain gendered bodies are required to participate in specific naturalized gendered roles, it seems that transgender bodies would inevitably be a part of this model of self-determination.

Correct Information: The Regulation of Truth and Time

It should be noted that many health care providers and community groups alike attempt to provide "correct information" to trans people. While this information is frequently needed and incredibly well-intentioned, providing "correct information" often simply means providing correct information about medical transition. It is clear that the effects of dominant gendered ideology are intense and constant. However, the push and pull of trans subjects to conform to society's gender normative behavior and appearance should not be furthered by people who have found access to healthcare and safety just as difficult. Through this narrative, a new gender hierarchy has been created, one that

promotes a linear trajectory to gendered self-formation through medical transition. This hierarchy has formed a new ideological expectation where a trans individual is hailed into becoming a 'real' man or a 'real' woman through medical transition and, as a result, is following a newly formulated version of straight time.³ The top of the hierarchy becomes the surgically altered, hormone-taking subject. Are certain feminist theorizations of gender, particularly those that explore gender as wholly constructed and fluid in representation, elided to create a singular trans life narrative?

I do not mean to imply that a personal decision to medically transition is negative. After all, to say that it is wholly negative would be to imply that I have made a bad decision by choosing to medically transition. These decisions are much more complex than that. To the contrary, alternate gender expressions and behaviors should come in all forms. It is disturbing, however, when these myriad expressions and behaviors are expected to comply with a newly formulated, though equally exclusive and linear, path that does not leave room for multiplicity and imagination. The agentic particularities that accompany altered interpellation or "tactical misrecognition" (Muñoz, 1999) of heteronormative hails should not be reinstated by a group of transpeople or health care providers attempting to provide "correct information." It counters the communal functions available through "tactical misrecognition" (Muñoz, 1999). Moreover, personal narratives and healthcare providers who present 'correct information' of medical transition are discursively reconfigured to universally represent the trans "community" story. This reconfiguration

³ For more information regarding straight time, refer to the writings of J. Halberstam, José Esteban Muñoz, and Elizabeth Freeman.

does not conflict with the dominant discourse, but rather supports the claim that transgender is an illness that is only 'healed' once body matches mind.

Queer Time, Real Bodies, and Feminism

Because trans people are more likely to have different histories than they are perceived to have had (e.g. a transman who is expected to have had a 'normal' boyhood), time is altered, re-worked, and shows dynamic qualities that do not perpetuate the circulation of the same normative histories. There is an interesting divide here with regard to the 'realness' of the material body and the hope of queerness. For example, Gayle Salamon (2010) notes that many trans theorists have asserted that the trans self is formed through a dismissal of social construction's gendered ideologies (p. 74-75). Salamon (2010) claims that these theorists argue that social construction is only able to formulate normative bodies (p. 75). To the contrary, this is assuming that the self is constructed outside of ideologies or dysphorically functioning beyond ideologies, which is certainly untrue (Salamon, 2010, p. 75). Furthermore, the ability to formulate a gendered self outside of genders' ideologies while still being interpellated through other ideologies (e.g. race- or class- specific hails) seems to be a separation too stark to deal with a messy lived subjectivity (Salamon, 2010, p. 100). Lastly, stating that one can construct one's gender completely outside of ideology dismisses the hope of "becoming" and presupposes that gender can become "set" through complacently defined transnormative linearity. The word transnormativity could thus be filled in for homonormativity in Lisa Duggan's statement, "complacency is the affect of homonormativity" (Duggan, 2009, p. 280). Having hope could thus be a defiance of the

complacency that beds itself with linear medical transition — a model that ignores ‘sideways’ (Duggan citing Stockton) notions of multiple trans subjectivities which could be useful in activist struggles.

It seems that some trans people simultaneously reject ideology’s expected gender representations while also accepting that there is linearity to transition where the end result is to alternately fit into heteronormative expectations of gender. However, insomuch as it is expected of all genderqueer people to perform the same actions to be considered correctly trans (and healed), I consider this rejection part of a more dominant transnormative path that is counterproductive to the agentive capacities that “tactical misrecognition” (Muñoz, 1999) could provide. Transnormativity, therefore, allies itself with a stagnant identity defined primarily through medical interventions. But these interventions, on the individual and communal level, can certainly be ethically and critically examined through a feminist lens. Medicalized gender transition coupled with a feminist stance that understands gender to be a primary locus of oppression and privilege can provide alternate formations of the trans-feminist subject.

Healthcare and Identity

Jasbir Puar states, “Intersectionality privileges naming, visibility, epistemology, representation, and meaning, while assemblage underscores feeling, tactility, ontology, affect, and information” (Puar, 2005, p. 128). The aforementioned Roger (our queer subject) does not necessarily have a constantly fluctuating ontology, but rather, one that can fluctuate. His subject formations are not contingent upon correct responses to

gendered hails. Rather, the queer subject, Roger, is queered from multiple directions and thus has been formed by hails that are not “separable analytics” such as race, gender, or class. Instead, he is formed by a confluence and dissipation of “time, space, and body against linearity, coherency, and permanency” (Puar, 2005, p. 127-128). This brings Butler’s theory of performativity (Butler, 1990) to the fore as well as Foucault’s attack of the repressive hypothesis (Foucault, 1978) insomuch as ideology is not only repressive, but also produces performative acts that are agentic as well as discourse-altering. I am drawing from these three scholars and converging their theories to assert that the queer subject who embodies this confluence and ephemerality is agentic through performative enacted responses to ideologies’ hails from all directions.

The Trans Health Initiative, which specifically provides care to trans/intersex people who were deemed female as infants, does not require the letter⁴ from patients in order to prescribe testosterone. As Chloe Kupfer, Trans Health Initiative Coordinator at Feminist Women’s Health Center, states:

Requiring a letter would make therapists the gatekeepers for HRT [hormone replacement therapy], requiring many clients to follow difficult and sometimes dangerous guidelines. The THI program respects the fluidity of gender identity and expression, and rejects the notion that one must live within their ‘gender,’ which often means conforming to binary, social norms, for a period of time. (SEWSA presentation)

Kupfer goes on to note that mental healthcare professionals can provide excellent services for transpeople facing a variety of issues, including societal pressure and abuse that result from their gender expressions. However, it is my assertion that the

⁴ The “letter” refers to the letter from a therapist that many trans patients in the U.S. are expected to obtain prior to being allowed to begin hormone replacement therapy (HRT).

Trans Health Initiative—by recognizing the terror, impossibility, and extreme participation in a gender binary that accompanies being asked by a therapist to pass a “real life test”⁵ —is taking a huge step toward radicalizing linear transition. After all, how is the “real life test” real? What is more real about inhabiting that particular form of embodiment than inhabiting one’s pathologized, dysphoric body? It should be noted that the care that FWHC provides is enabled through a feminist understanding of gender, not through the exclusion of feminist thought. By functioning under an informed-consent model rather than requiring a letter, Feminist Women’s Health Center acknowledges the monetary struggles associated with multiple therapist visits and also, in many ways, depathologizes care by removing barriers put in place to prevent trans people from making decisions about their own bodies.

Conclusion

Althusser makes it clear that individuals are always being hailed by ideologies to become correctly oriented subjects. The capacity for “tactically misrecognizing” heteronormative gendered hails can be productive for alternate subject formation; but when the hails originate from within the transgender ‘community,’ they can also be reinscribing the same gendered roles and expectations. While medical transition can be a form of “tactically misrecognizing” the hails of dominant gendered ideology, when this is the only alternate subject formation deemed ‘correct,’ it becomes alternatively hegemonic. As such, it seems that because the queer individual is formed by hails from

⁵ Passing the “real life test” typically involves completing a year of living in, dressing as, or “correctly” performing the gender to which you desire to transition.

all directions, there is an opportunity to turn in unknown directions, react in different moments, and thus become an unexpected subject.

These multiple opportunities for alternate responses to gendered hails suggest that queer subject formation is fluctuate. Therefore, it seems apt that the Trans Health Initiative at Feminist Women's Health Center provides testing and care that does not foreclose the agentic actions that trans/intersex people could take in response to gendered ideologies. Rather, THI recognizes that the broader healthcare system, even in its attempts to "help and heal" trans people, often manages to perpetuate a binaristic gender system that values a certain linear, individuating path to be followed prior to and during medical transition. The Trans Health Initiative actively counteracts this narrow foreclosure of future agentic actions by trans people and works under a feminist framework to make this type of care available. Therefore, it is impossible to unknot the relationship between trans subjectivities and feminist subject positions because in many cases, and for many of us, the relationship is one of constantly embodied trans feminism.

References

- Ahmed, S. (2006). *Queer phenomenology: Orientations, objects, others*. Durham, NC: Duke University Press.
- Althusser, L. (2008). Ideology and ideological state apparatuses (notes towards an investigation). *On Ideology* (1-60). Brooklyn, NY: Verso. (Original work published 1970).
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York, NY: Routledge.
- Duggan, L. & Muñoz, J.E.. (2009). Hope and hopelessness: A dialogue. *Women & performance: A Journal of feminist theory*, 19(2), 275-283.
- Kupfer, C. (2011). Providing radical, Feminist health services for transmasculine clients. *Paper presented at the Southeastern Women's Studies Association (SEWSA) conference*. Atlanta, GA.
- Foucault, M. (1978). *The History of Sexuality: Volume 1: An Introduction*. New York, NY: Random House. (Original work published 1976).
- Mahmood, S. (2005). *Politics of piety: The Islamic revival and the feminist subject*. Princeton, NJ: Princeton University Press.
- Muñoz, J.E. (2009). *Cruising utopia: The then and there of queer futurity*. New York, NY: New York University Press.
- Muñoz, J.E. (1999). *Disidentifications: Queers of color and the performance of politics*. Minneapolis, MN: University of Minnesota Press.
- Puar, J.K. (2005). Queer times, queer assemblages. *Social Text*, 23(84-85), 121-139.
- Salamon, G. (2010). *Assuming a body: Transgender and rhetorics of materiality*. New York, NY: Columbia University Press.
- Warner, M. (2000). *The Trouble with normal: Sex, politics, and the ethics of queer life*. Boston, MA: Harvard University Press.