Approval

Name: T. Garner
Degree: Doctor of Philosophy (Gender, Sexuality, and Women's Studies)
Title of Thesis: Stitching Up the Natural: “Manboobs,” Pregnancy, and the Transgender Body

Examiner Committee:

Chair: Dr. Catherine Murray
Professor, Gender, Sexuality, and Women’s Studies, and Communications

Dr. Helen Hok-Sze Leung
Senior Supervisor
Associate Professor, Gender, Sexuality, and Women’s Studies

Dr. Cindy Patton
Supervisor
Professor, Sociology / Anthropology

Dr. Susan Stryker
Supervisor
Associate Professor, Gender and Women’s Studies, University of Arizona

Dr. Marina Morrow
Internal Examiner
Associate Professor
Health Sciences

Dr. Nikki Sullivan
External Examiner
Associate Professor, Critical and Cultural Studies
Macquarie University

Date Defended: November 29, 2011
Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the “Institutional Repository” link of the SFU Library website (www.lib.sfu.ca) at http://summit.sfu.ca and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author’s written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

While licensing SFU to permit the above uses, the author retains copyright in the thesis, project or extended essays, including the right to change the work for subsequent purposes, including editing and publishing the work in whole or in part, and licensing other parties, as the author may desire.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library
Burnaby, British Columbia, Canada

revised Fall 2011
Abstract

This thesis is an examination of the construction of the “natural” male and female body through gynecomastia surgery (chest surgery for “excess” breast tissue on men) and pregnancy, read within the discursive fields of medicine and online support groups. I take as my starting point the accusation that the transgender body is constructed, which rests on the assumption of a “natural” body, free from “harm,” “physical intervention,” “modification,” and “mutilation.” In contrast to most academic engagement with transsexuality, I shift the focus to the “natural” body and emphasise its construction through close comparative interrogation using Foucauldian discourse analysis. Comparing gynecomastia and female-to-male transsexuality, I highlight the production of the “natural” male body through gynecomastia surgery, and by exploring pregnancy in relation to infertility, I reveal the constitution of the “natural” female body through pregnancy. Through this reconsideration of gynecomastia surgery and pregnancy as naturalised body modification, I emphasise the sexed body as effect rather than cause or, in other words, I challenge the common understanding of sex as biological foundation. Reading for, what I identify as “technologies of the natural,” disrupts the natural/constructed binary and challenges dominant ideas about sexual difference and reproduction. It provides the means to contest the narration of a “natural body,” which continues to represent the ground upon which transgender people are subject to physical violence and excluded from social
and political life, and, further, constrains all bodies within a rigid epistemological and ontological framework.

Providing a cultural, poststructural perspective on sex and gender, this interdisciplinary project draws from feminist theories of the body, transgender studies, queer theory, cyberstudies, the politics of reproduction, sociology of health and illness, critical race studies, disability theory, and poststructuralism. Situated within the framework of “somatechnics,” it is an attempt to reconceive the body, technology, and the relation between them, and provide a reconsideration of the nature of embodiment. Given the extent to which the sexed body is a site through which unequal relations of power are maintained in our present social landscape, this project is a necessary contribution to the interrogation of the operations of power (and resistance) in this historical and cultural moment.

**Keywords:** construction of the “natural” male and female body within medical and online discourse; sex, gender and sexual difference; body and technology; transsexual/transgender and body modification; pregnancy, infertility and the politics of reproduction; gynecomastia surgery, female-to-male (FTM) chest surgery, cosmetic surgery, and sex reassignment surgery
Dedication

To my family, both near and far, I owe you everything.
Acknowledgements

No piece of written work ever has a single author so I would like to acknowledge everyone who has made this thesis possible.

First, I thank those who walk the halls of the Department of Gender, Sexuality, and Women’s Studies, the academic home from which this thesis grew. From the beginning of my graduate life, when I had little idea of the direction of my project, the staff and faculty within the department have offered unending support, guidance, and encouragement. In particular, I want to thank: Kat and Roberta, without whom the department would crumble, for your enduring and caring support; Mary Lynn for a truly wonderful graduate seminar in my first semester, which convinced me that I was in the right place, and for your support and warmth ever since; Lara for always taking the time to offer reassurance that getting through grad school was possible; and Catherine for your practical advice and your belief in my future potential. With the graduate students within the department, I have shared conversation, laughter, tears, good food, and a few drinks, without any of which I would never have survived the years. I would especially like to thank Sonja, who was the original ‘mother’ of the cohort, for her calmness and wisdom, and for leading the way, graduating as the first PhD student of the department. Most significantly, my friendships with Beth and Sue, forged over sushi lunches working on a group project in a methodology class in the very first semester, will last my lifetime. Thank you for being there through
thick and thin, for keeping me sane, for beers on the patio, and for long walks on the beach – I couldn’t have done this without you.

All those involved with my supervision have been exceptional throughout the long years of this project. Ever since I met Bobby at my first ever academic conference, he has offered support and warmth. His input through “comps” was invaluable and provided the foundation for my research, and I continue to find his work important and groundbreaking. This project began as a short conference paper, which I presented at Transsomatics in 2008, and I would like to thank Susan for organising this pivotal event in my academic career. The passion and ideas generated by this group of influential and inspiring people, and their interest and critical engagement with my work, gave me hope for this project, and from that conference paper chapter three was born and the rest of the thesis followed. Since then, Susan has offered me guidance and support throughout the writing process. As well as this contribution, Susan’s academic work is at the heart of this thesis and I am grateful for her brilliant and inspirational research that continues to blaze a trail for others to follow. Cindy has supported me from the very first semester, teaching that first class in methodology and opening my eyes to a whole world I knew nothing about through her vast array of knowledge and expertise. Since then, she has helped in shaping my vague and confused ideas into a comprehensive and focused project, and the solid methodological foundation is thanks to her! I have always appreciated her critical perspective on my work and her challenging approach has made me more confident in myself and my research.
I have known Helen since I was an undergraduate student intent on taking any course taught by her, not only to fulfill my Gender Studies requirements, but because she inspired me creatively, emotionally, and academically in every single one. She has been an exceptional senior supervisor, guiding my work with the perfect combination of drive and space, providing brilliant critical insights but, ultimately, waiting patiently for me to find my own path. I am forever indebted for her time, passion, and support, both personal and academic, over the years. Her never-ending faith in me and my research has made this thesis possible. I would also like to thank her for introducing me to every tea shop in Vancouver, and I hope we continue our thought-provoking conversations over cups of tea for many years to come.

Throughout my graduate career, I have presented at many conferences and the sharing of ideas and passion in the larger academic network has kept me going on this long and arduous path. In particular, I would like to thank Diane Naugler and Jaye Cee Whitehead for organising small but powerful events within which my work was nurtured. I would also like to thank those academics who have taken the time at conferences to express support and provide critical direction for my research, most notably Cressida Heyes, Sam Murray, Nikki Sullivan, Rebecca Jordan Young, and Lennard Davis. Within the broader community, I am forever grateful to Jean Swanson for showing me how powerful the combination of quiet passion can be.

I would also like to express my deep gratitude for the insightful feedback and excellent guidance I received during my thesis defence from my committee
and the examiners, Nikki Sullivan and Marina Morrow. It was a far more enjoyable experience than I had ever imagined and their engagement and appreciation for my research was inspirational. It was within the defence that this project truly became something, now not only for me but also for others – they opened my eyes to the possibilities of this critical research and I thank them for giving me renewed confidence in it. Their ideas for the future direction of this work are invaluable, and I cannot wait to think on them further and see where they may take me.

My family deserves a special mention. Emily believed in me before I believed in myself and, throughout the years, has given me more than words can describe. This thesis is truly hers as much as mine. Jack and Finn have made life much more full and, in the process, have given me focus and drive in a way that nothing else could. They are my reward at the end of a long day. They have shown me how to be present and opened the world for me. I am excited to welcome the newest addition to the family in a few months – reaching this academic finish line has been driven by the recognition of that impending deadline so I extend my thanks to the little one. Debbie and Dave, and the rest of the Hodge clan, have given love, laughter, support, and, above all else, good food! Grandma Hodge was my number one fan, always checking on my progress, so this one’s for you – rest in peace, I’m finally finished! Mum, Dad, Max and Liz, and now baby Henry, have watched and cheered from afar but always been there for me. Mum, thank you for allowing me to question everything
from a very early age, and Dad, thanks for challenging and supporting me every step of the way.

Finally, there are those upon whose shoulders I climb – too numerous to name, you are the authors, academics, activists, and artists who have inspired, challenged, and changed me; you may not know me but you have shaped both my life and my research.
# Table of Contents

Approval.......................................................................................................................... ii  
Abstract .............................................................................................................................. iii 
Dedication ............................................................................................................................ v  
Acknowledgements .............................................................................................................. vi  
Table of Contents ............................................................................................................... xi  
List of Figures ..................................................................................................................... xiii  

## Chapter 1: Introduction: Stitching Up the Natural .......................................................... 1  
Medicine and the Internet ................................................................................................... 8  
Thanks Janice Raymond! The (Un)natural Foundation of Transgender Theory ............ 11  
Somatechnics ..................................................................................................................... 16  
The Body and Power ......................................................................................................... 24  
The Normal and the Pathological: The Normalised Body ............................................. 29  
Conclusion: The Naturalised Body .................................................................................... 33  

## Chapter 2: Looking for the Natural Body ..................................................................... 40  
Foucauldian Discourse Analysis ....................................................................................... 43  
Research Domains: Medicine and the Internet .............................................................. 46  
  Health and Disease: The Medicalised Body ................................................................. 47  
  Internet as Textual Spatiality: Online Community ....................................................... 51  
  Textual Interactions ....................................................................................................... 57  
The Body in/of the Text .................................................................................................... 61  
  Medical Discourse ......................................................................................................... 61  
  Online Discourse .......................................................................................................... 82  
Ethical Considerations ...................................................................................................... 103  

## Chapter 3: Chest Surgeries of a Different Nature ........................................................ 113  
The Nature of Harm ......................................................................................................... 113  
  Disorder .......................................................................................................................... 113  
  Whole versus Part: Sex and gender ............................................................................. 120  
  “Above all do no harm:” The ethics of surgical modification ...................................... 130  
  Regret ............................................................................................................................. 135  
  Authenticity: “Minimal scarring” and “proper” nipple placement .............................. 139  
Conclusion .......................................................................................................................... 150  

## Chapter 4: (De)Emphasising Chest Surgery as Transition .......................................... 153  
The (Dis)embodiment of the Virtual ............................................................................... 153  
Transition ......................................................................................................................... 160  
  From “bio-guy” to “cissexual male” ........................................................................... 160  
  Transman or trans man ............................................................................................... 169
List of Figures

Figure 1. Wrinkle lines in “normal” male chest (left) versus gynecomastic chest (right) ................................................................. 126

Figure 2. Nipple location in relation to other parameters of the body ......................... 145

Figure 3. Anatomical parameters measured .............................................................. 148

Figure 4. Anatomical parameters measured and average results obtained ............... 149
Chapter 1: Introduction: Stitching Up the Natural

“…there is no reference to a pure body which is not at the same time a further formation of that body” (Butler)

The symbols on the doors of public washrooms continue to evoke the model of binary sexual difference; medical studies are currently concerned with discovering the basis of this sexual difference in the brain; sport of all levels remains divided along the lines of sex; and the contemporary debate over the institution of marriage is framed as “same-sex” versus “opposite sex,” both terms grounded in binary sexual difference. Despite numerous challenges from multiple arenas, (or perhaps because of these threats), it is abundantly clear that the current Western social landscape continues to be marked by an investment in the logic of sexual difference; the notion of the binary sexed body remains in force, structuring public space, state legislation, medical knowledge, and cultural institutions. This idea that the body is sexed as male or female is taken for granted such that it is not considered an idea but a biological given, a material foundation. Contemporary Western society is grounded upon the belief that male and female are stable, incommensurable sexes separated by distinct corporeal differences, and this belief is naturalised to the extent that it persists as an ahistorical and transcultural phenomenon or, in other words, a “natural” fact of life. This project is an attempt to challenge this belief by making visible the construction of the “natural” male and female body.
In the current Western social and political landscape, the idea of the “natural” figures large in the face of increasing human intervention, with little recognition of the constitutive relation between the two ideological poles. In its opposition to the insatiable demands of capitalist industrialism, the environmental movement, arguably one of the defining political efforts in the West, is grounded in a conception of the “natural” environment free of human construction. And, in a similar fashion, nostalgia for the “natural” human body is expressed in the face of advancements in technological engagement with the body, primarily in the fields of communication and medicine. The ever-increasing proliferation of communication technologies in the lives of Western citizens, from cellphones to laptops, has prompted a distinction between the virtual online body and the so-called “real” unmediated body. In relation to the biomedical, social and technological shifts have contributed to the increasing availability of reconstructive surgery and its corollary practice, cosmetic surgery, as well as sex reassignment surgery, and in response to this proliferation of body modification, the notion of the “natural” body is used to mark those modified bodies as constructed. However, it is important to emphasise that the attribution of construction is not strictly associated with surgical intervention – some bodies pass through surgery unscathed – rather, the accusation of construction is a hierarchical judgment used to perpetuate injustice and violence in the name of the “natural” body. In particular, practices of cosmetic surgery and sex reassignment surgery are identified as those of construction, while other surgical
practices, even those involving similar techniques, are merely defined as *restoration* (of the natural).

There have been a variety of academic studies concentrating on the former, the construction of the body through cosmetic surgery or sex reassignment surgery, but this project shifts the focus to the latter. As with critical theoretical approaches to the question of race, some of which have shifted their attention toward whiteness (Dyer; Frankenberg), and some recent scholarship on disability, which has turned to the issue of normality (Davis), I focus not on the constructed body but on that against which it is always compared and found lacking: the "natural" body. As such, this project is an attempt to emphasise the ways in which the "natural" body is itself constructed, in particular, highlighting the technologies through which the body of sexual difference is naturalised. After all, “there is no reference to a pure body which is not at the same time a further formation of that body” (Butler, *Bodies That Matter* 10). Until we know precisely how it operates within and across different contexts, we cannot escape the tyranny of the natural and the harmful exclusions enacted in its name. Through this exploration, it becomes evident that there is no singular, static natural body, as much as it proclaims its pureness; rather, it is slippery, wily, and always multiple – the natural may be represented as exclusive but both its contents and its borders are highly contingent. In fact, its inherent vulnerability is what necessitates the constant reiteration of its stability (Butler). This project of mapping the citations of the natural within these specific contexts joins others in
the search for “points of fissure in the micro powers of modern regulatory apparatuses” (Currah and Moore 4).

In this exploration of the construction of the “natural” sexed body, I examine two specific bodily practices, pregnancy and gynecomastia surgery, the removal of “excess” breast tissue or fat in non-trans men. I aim to explore the significance of “nature” as a site through which power operates and I focus on these two bodily practices because of the extent to which each of these practices presume the “naturalness” of the female and male body, at the same time as explicitly constituting particular bodies as “naturally” female and male. They stand in such close proximity to the “natural” sexed body because they reference sites on the body significantly overdetermined in our conceptions of the sexed body as “naturally” reproductive – reproductive organs and breasts respectively.

According to Thomas Laqueur in *Making Sex: Body and Gender from the Greeks to Freud*, the model of sexual difference is grounded in bodily distinctions related to understandings of reproduction; for example, where previously, the uterus was thought to be the folded-in equivalent of the penis, the uterus is now reconceptualised as a site of difference. In fact, it was the ultimate site of difference, the location of the “essence” of femaleness, through much of the eighteenth century to the mid-nineteenth century, before medical attention shifted to the ovaries, and then the hormones, which continue to play a large part in Western conceptions of sexual difference (Oudshoorn 8). However, regardless of the specific nature of the current understanding of biological sexual difference, it remains grounded in the idea of reproductive difference; the most common
challenge to my project of denaturalising the male and female body, and the relation in between, is the assertion that the latter gives birth while the former does not. Distinctions on the basis of reproductive potential are considered absolute or, in other words, “natural” facts of life. As such, the borders between male and female are especially well marked in discourses around bodily sites that are associated with reproduction, such as those focused on these two particular bodily practices, gynecomastia surgery and pregnancy.

My epistemological lens in approaching these forms of bodily transformation is the transgender body, which has been described within various contexts as “unnatural,” “incomplete,” “inauthentic,” and “constructed.” As outlined above, this accusation of construction levelled at the transgender body rests on the assumption of a “natural” body, always elsewhere, free from “harm,” “physical intervention,” “modification,” and “mutilation.” This project aims to challenge this presupposition by bringing the “natural” body from ‘elsewhere’ into sharp focus. For the FTM,¹ the natural male body is that which we will never be, and the natural female body is that which we have mutilated. The exploration of the naturalisation of the male and female body through a reconsideration of the practices of gynecomastia surgery and pregnancy provides a way to invoke trouble at the sites of these “natural” bodies and the ways they are used to assert the “unnaturalness” of the transgender body. As Nikki Sullivan emphasises, it is not about evaluation but interrogation of “the ‘social imaginaries’ – the perceptual

¹ I am following the Trans Care Project’s use of ‘FTM’ instead of ‘trans men’ as “shorthand for a spectrum that includes not just transsexuals, but anyone who was assigned female at birth and who identifies as male, masculine, or a man some or all of the time” (Simpson and Goldberg 1).
schemas – that constitute embodied subjects and their affective investments in ways that incite and then discriminate against particular bodies and bodily practices” (“Price to Pay” 407). There is an urgent need to engage with these issues for the mark of “unnaturalness” on those bodies is taken to justify exclusion from social and political life: denial of health care, state recognition, housing, employment, and even a safe place to ‘pee.’

The shape of my argument is grounded in the relation between, on the one hand, the “natural” male body that underlies gynecomastia surgery and the trans body, and, on the other, the trans body and the “natural” female body constituted by pregnancy. In the case of the former, the connection is clear – gynecomastia surgery and FTM chest surgery are almost exactly the same surgical practice yet they are framed in significantly different ways within, for instance, medical discourse, and I will undertake a close comparative analysis of these discursive framings in order to reveal the nature of these differences. In the case of pregnancy, the relation is less explicit and is found in the space between my body and the body of my pregnant partner. I began to think about pregnancy as a naturalised body modification after the third person told me that I may be able to breastfeed too. I realised that, through the process of pregnancy, both our bodies were being marked as female – marked as being of the same sex and reproductively capable in the same way. While pregnancy has multiple meanings, it is so thoroughly naturalised that it has rarely, if ever, been considered a body modification so this formulation provides a unique perspective on what is most often taken to be a biological practice that the female body
merely undergoes. The extreme discomfort I felt through the association of my body with that biological practice caused me to notice the constitutive elements of pregnancy, the ways in which pregnancy ‘females’ the body – it was precisely because of my body’s resistance to this process of naturalisation that I was made aware of it. I will be reading both gynecomastia surgery and pregnancy from this bodily location, through the lens of this trans body, a body that I have never imagined pregnant but daily envision without breasts.

I am interested in the ways in which the “natural” and the “normal” are figured in discussions of these body modifications, and the consideration of the social, cultural, and political consequences of these formations. When we are no longer considering these processes as merely acting on “natural” male and female bodies, we can turn to the question of how they constitute particular bodies as naturally male and female? I am concerned with closely examining the operations of these particular technologies of the natural. Understanding them as naturalised body modifications allows me to ask a whole new set of questions that cannot be formulated in other conceptions that leave them grounded in the natural. Where are these “natural” bodies located within discourses of gynecomastia surgery and pregnancy? How are they constructed through these particular body modifications and excluded from others – how are some transitions naturalised to the extent that they are not considered body modifications while others remain mired in the notion of becoming (“unnatural”)? How are the contours of the “natural” male and female body shaped within these practices and how are they maintained through the surrounding discourses? In
other words, how are bodies ‘maled’ and ‘femaled’ through these particular body modifications? What specific themes are employed in the service of the naturalisation processes of gynecomastia surgery and pregnancy – for example, how are notions of disorder and bodily integrity or wholeness used as naturalising techniques? How do other markings of power, such as race, class, and disability, intersect with both naturalised and “unnatural” transition? These are fundamentally political questions – I am interested in exploring the construction of the “natural” body in order to consider the political implications of the naturalisation of certain bodies and their transformations. My project both starts and finishes with the consideration of the ways in which some bodies are rendered “unnatural” through the heavy policing of the borders of the “natural,” and the extent to which the “natural” rests on the disavowal of the “unnatural.” As Samantha Murray says in *The ‘Fat’ Female Body*, “[k]nowledges and discourses rely on binary structures, which are always haunted, and brought into being by the presence (or absence) of their correlative term” (35). By considering these issues and highlighting the contingency of the relation between particular bodies and the “natural,” I hope to open up spaces for different geometries of embodiment, forms that recognise their simultaneous natural- and unnatural-ness.

**Medicine and the Internet**

I explore the discursive framing of gynecomastia surgery and pregnancy within the domains of medicine and the Internet. Here, I will only briefly gesture as to why I consider these areas central for my exploration because I save
further elaboration for the following chapter. The categories of transsexuality, gynecomastia, and infertility, (which I identify as a rich site for the exploration of the constitutive nature of pregnancy), are, first and foremost, biomedical categories, markings defined in relation to health and disease, and it is the nature of these markings and how they operate in the construction of the natural sexed body that I explore at the outset. This engagement situates this project in close proximity to scholarship from the sociology of health and illness, which Bryan S. Turner describes, in the foreword to Foucault, Health and Medicine, as “a critical epistemology of disease categories as elements of the moral control of individuals and populations” (ix). Grounded in the premise that “disease categories are not neutral, unambiguous descriptions of physiological processes,” this field treats health, illness, and disease as fundamentally social concepts (Nettleton and Gustafsson 1). Though the aforementioned text recognises Foucault’s influence on the field of sociology of health and illness, I think it is worth emphasising further the ontological consequences of the relation between disease and the body that Foucault gives us and that I find particularly compelling in terms of this project. I spend more time explaining this in chapter two but, briefly, the concepts of body and population upon which liberal modes of government are grounded emerge in relation to notions of health and disease to the extent that the body as we understand it in Western, contemporary life is always already the body of disease. By this, I do not mean that we are always at risk of ill-health in some form of another but that our conception of the body cannot be disentangled from notions of health and disease; in other words, the
body comes into being through discourses and practices concerning disease, such that disease categories are not simply “elements of moral control” but are implicated in the very formation of bodies. Given that the medical domain has ultimate authority over determining the boundaries of health and disease, we are fundamentally medicalised bodies. As such, medicine is a dominant set of discourses and practices through which bodies are (trans)formed, making it an essential site for this exploration.

That being said, given the extent to which we are “plugged in,” we are also networked bodies. According to the Pew Research Center’s *Internet and American Life Project* 2010 Tracking Surveys, 77% of American adults now use the Internet, a number that has grown steadily since it’s first recording in 1995, when only about 15% of American adults used the Internet. Internet use is even more ubiquitous amongst American teenagers (12-17 years old), with 93% of them using the Internet. Of further significance, 83% of current adult users engage with the Internet in order to look for “health/medical info,” the third highest activity after checking email (92%) and using a search engine for general information (87%). Thus, the Internet is not only a primary communication device, it has become a significant site through which the markings of health and disease are negotiated. Upon medical diagnosis of a disease, the first response

---


of most North Americans and Europeans is to search the Internet for information and support; this has the effect of undermining the authoritative power of the medical establishment and has contributed to the shift in the paradigm of health care from patient to consumer. However, within this formulation, medical knowledge remains primary and Internet discourse is situated as merely response, but in this time of unequal access to health care and the increasing influence of the Internet, the Internet may, in fact, be the first port of call for someone experiencing bodily change or discomfort. Also of significance is the way in which the Internet can operate as a social “space,” (a function that I explain in the following chapter), and the combination of all these factors makes it an essential object of analysis in the exploration of the constitution of the body. This engagement aligns this project with scholarship from the diverse field of Internet studies, in particular feminist, queer, and philosophical accounts of the relation between technology and the body. I argue, (and, again, I elaborate more on this assertion in the following chapter), that, especially in relation to the bodily practices under consideration in this project, medical discourse and Internet discourse are the central sites through which the body is constituted.

Thanks Janice Raymond! The (Un)natural Foundation of Transgender Theory

This project is grounded in transgender theory – my epistemological framework is made possible by those theoretical approaches that challenge notions of “natural” and “unnatural” through the transgender body. Transgender theory is founded on questioning nature; to a great extent, it rose up against the
accusation that the transsexual body was “unnatural,” as the following historical account highlights. In 1979, Janice Raymond, one of the most prominent outspoken members of the radical lesbian feminist movement, wrote *The Transsexual Empire: The Making of the She-Male*, a tirade against the use of medical treatment on transsexual individuals. In contrast to the medical diagnosis of gender dysphoria, she conceives of transsexualism as being the result of a society obsessed with normative gender roles. She devotes an entire chapter to the presence of transsexual women, a group she refers to as “male-to-constructed-female transsexuals,” in lesbian feminist spaces. Within this chapter, she centres her argument on the employment of Sandy Stone, a transsexual woman, at Olivia Records, an all-woman recording company, a case which had sparked a debate that raged back and forth within feminist publications during the summer of 1977. In an interview published in *Off Our Backs* in 1979, Raymond declares that the “constructed female…is the ultimate, man-made violator of our time/space and of our experience as women” (qtd. in Sturgis 14). The transsexual woman was the exclusion against which the category of woman was naturalised as those born and socialised as women, a category that became signified during this time by the term, “womyn-born womyn.” In 1991, Sandy Stone personally responded to Raymond’s arguments in an article entitled *The Empire Strikes Back: A Posttranssexual Manifesto*, which is acknowledged by Susan Stryker and Stephen Whittle in the 2006 edited collection, *The Transgender Studies Reader*, as “the protean text from which contemporary transgender studies emerged” (221). In this foundational text, Stone responds to
the accusation of construction, not by naturalising transsexuals as their own ontological category, a form of third gender, but by recognising transsexuals as their own genre, a unique form of narrative containing a diversity of stories (296). In advocating that transsexuals respond to medical and theoretical colonisation of their bodies by using their own bodies to write themselves onto the conventional discourse in an attempt to disrupt it, she challenges Raymond’s essentialist assumptions.

Without wanting to give too much credit to Raymond, her diatribe can be considered one of the conditions of possibility that provided the ground for the discipline of transgender theory, as the multiple and varied scholarship contained loosely under this sign can be read as a response to her original accusation of “unnaturalness.” Further, these responses can, provisionally and strategically, be grouped under two main threads, one that seems to claim the natural through historical and cross-cultural association (Cromwell; Feinberg; Herdt) and the other that disclaims it (Bornstein; Halberstam; Hale; Noble; Stryker; Wilchins).

While I am situating this project more in line with the second paradigm, I am also attempting to fragment and trouble this understanding – to affirm the unnaturalness of all bodies can have the effect of eliding the very real consequences of the differences within this unnaturalness, and these distinctions are precisely marked by the relation of bodies to the natural, however mythic it may be. I am interested in mapping (and disrupting) some of these differences within this project. I want to acknowledge that it is the totality of this critical work upon which my approach to the body and the “natural” starts and, to a great
extent, always returns. In particular, Susan Stryker’s scholarship has been highly influential as she is a central figure within transgender theory whose work explicitly focuses on disrupting the notion of the “natural.” In her evocative and powerful piece, “My Words to Victor Frankenstein above the Village of Chamounix: Performing Transgender Rage,” she responds to the accusation that transsexual bodies are “unnatural” by reclaiming the name of “monster” that has been so often thrust upon her. Rather than defending transsexual bodies as natural, she instead turns the question of naturalness back on the body of the accuser, asking us all to acknowledge our monstrous nature:

Hearken unto me, fellow creatures. I who have dwelt in a form unmatched with my desire, I whose flesh has become an assemblage of incongruous anatomical parts, I who achieve the similitude of a natural body through an unnatural process, I offer you this warning: the Nature you bedevil me with is a lie. Do not trust it to protect you from what I represent, for it is a fabrication that cloaks the groundlessness of the privilege you seek to maintain for yourself at my expense. You are as constructed as me; the same anarchic Womb has birthed us both. I call upon you to investigate your nature as I have been compelled to confront mine. I challenge you to risk abjection and flourish as well as have I. Heed my words, and you may well discover the seams and sutures in yourself (247).

In shifting the focus from the margins to the centre, this project attempts to answer Stryker’s call to investigate nature by identifying the “seams and sutures” of the “natural” male and female body found within the discourses of gynecomastia surgery and pregnancy.

The accusation of “construction” levelled against the transsexual body relies on a limited view of technology. Within feminist critiques of transsexuality, most notably Janice Raymond’s and Bernice Hausman’s more recent rendition,
transsexuality (as well as other bodily practices, such as cosmetic surgery) is positioned in a very specific relation to technology, which inscribes transsexual bodies as literally constructed while implicitly positioning non-transsexual bodies as firmly located in nature. Emerging in her 1995 article, “Transsexuality: The Postmodern Body and/as Technology,” and constituting the dominant approach within her current work, Stryker offers a reconceptualisation of technology that disrupts the dichotomy between nature and technology through the recognition that technologies are constitutive of all bodily being, not merely those bodies most explicitly and directly acted upon by medical technologies. Both Hausman and Stryker are influenced by Foucault in their understanding of the productive nature of technologies in forming subject positions; however, Hausman’s mistake is that she does not extend her argument to a consideration of the contingency of her own embodiment as “naturally” female, which, significantly, she asserts in the opening pages by referencing her pregnancy and her concerns that she “will give birth to a hermaphrodite” (x). Though she does recognise that “[t]ranssexuals and nontranssexuals alike live in a world of discourse that structures and supports the narratives of identity defining our existence” (xi), her focus on the technologies, both material and discursive, through which the transsexual becomes possible has the effect of naturalising the “nontranssexual” as free from technological intervention. In contrast, Stryker disrupts the border between both nature and technology, and transsexual and non-transsexual, by emphasising the technological constitution of all bodies.
Somatechnics

This reconceptualisation of technology is the foundation of the emerging framework of “somatechnics,” an approach that fundamentally informs this project. The term “somatechnics” was originally coined by Susan Stryker and references a theoretical perspective that emerged out of the practices and discourses produced and discussed at the Body Modification conferences held at Macquarie University, Australia in 2003 and 2005 (Cadwallader and Murray 260). Outlined in the first book-length edited collection that engages with this concept, Somatechnics: Queering the Technologisation of Bodies (2009), Nikki Sullivan and Samantha Murray frame “somatechnics” as an attempt to reconceive the body, technology, and the relation between them. Basing their formulation on reductive approaches to technology, they use as their example critical engagements with reproductive technology. On the one hand, they present Shulamith Firestone’s utopian view of reproductive technology as the means of freeing women “from the tyranny of reproduction” (qtd. in Sullivan and Murray 1); and, on the other, they refer to “anti-technology radical feminists,” such as Gena Corea, Renate Klein, Janice Raymond, and Robyn Rowland, who argue that reproductive technologies are tools of patriarchy that maintain and propagate women’s inequality (ibid 2). While, within the former approach, technology is figured as good and, in the latter, technology is fundamentally bad, they both rely on a view of technology as separate from the “natural” body, where female “nature” is understood as a foundation to be overcome or revered respectively. In contrast, somatechnics is:
an attempt to highlight the inextricability of soma and techne, of ‘the body’ (as a culturally intelligible construct) and the techniques (dispositifs and ‘hard technologies’) in and through which corporealities are formed and transformed. This term, derived from the Greek soma (body) and τεχνη (craftsmanship), supplants the logic of the ‘and’, suggesting that technes are not something we add or apply to the body, nor are they tools the embodied self employs to its own ends. Rather, technes are the dynamic means in and through which corporealities are crafted, that is, continuously engendered in relation to others and to a world (3).

Grounded in contemporary poststructuralism, this is a theoretical framework in which embodiment is understood “as the incarnation or materialisation of historically and culturally specific discourses” (3). Material existence is not something that precedes these structuring dynamics, but is something that depends on them. Rather than presuming, as the feminists referenced above do, that bodies are “simply mired in being unless they undergo explicit, visible, and identifiable transformational procedures,” somatechnics operates under the central principle that all bodies are “entwined in (un)becoming,” or, in other words, that “all bodies mark and are marked” (Sullivan, “Transmogrification” 561). Given that somatechnics is defined in opposition to theoretical approaches to reproduction and its relation to technology, it is noteworthy that this project is the first to explicitly engage with reproduction within a somatechnics framework. This perspective allows me to reconfigure the issue by placing the emphasis, not on reproductive technologies, but on reproduction as technology.

“Somatechnics” draws from a wide variety of disciplines, including feminist theories of the body, transgender studies, queer theory, critical race studies, disability theory, and poststructuralism. From these fields, my research relies most heavily on academic work that emphasises the contingency of current
beliefs about the sexed (and raced, classed, and disabled) body, and focuses on the ways in which these conceptions are produced and naturalised (Butler, Bodies That Matter, Gender Trouble; Davis; Foucault, History of Sexuality; Grosz; Haraway; Heyes; Laqueur; Shildrick; Stryker, “My Words”; Sullivan, “Somatechnics”). Through the recognition that all bodies are constituted through the vast array of knowledges, spatial relations, state and judicial regulations, political regimes, and other culturally and historically located social “imaginaries” through which we be-come, this framework provides a way of thinking beyond the natural/constructed binary. Jennifer Terry and Jacqueline Urla describe this perspective in their introduction to Deviant Bodies: Critical Perspectives on Difference in Science and Popular Culture:

Bodies do not exist in terms of an a priori essence, anterior to techniques and practices that are imposed upon them. They are neither transhistorical sets of needs and desires nor natural objects preexisting cultural (and, indeed, scientific) representation. They are effects, products, or symptoms of specific techniques and regulatory practices...Knowable only through culture and history, they are not in any simple way natural or ever free of relations of power (3).

As Elizabeth Grosz says, “there is no “natural” norm; there are only cultural forms of body, which do or do not conform to social norms” (143). This theoretical approach challenges the sex/gender distinction, which is mapped on to the natural/constructed binary, grounding the notion of gender as construct on the idea of sex as “natural” foundation. This mapping produced “the position that there is a natural or biological female who is subsequently transformed into a

---

Moira Gatens uses the term “imaginaries” to refer to “those ready-made images and symbols through which we make sense of social bodies and which determine, in part, their value, their status and what will be deemed their appropriate treatment” (viii).
socially subordinate ‘woman,’ with the consequence that ‘sex’ is to nature or ‘the raw’ as gender is to culture or ‘the cooked’” (Butler, *Gender Trouble* 47); this has, until relatively recently, been the most influential understanding of the relation between sex and gender within feminist discourse (Tremain 189). Using this framework, in which culture is understood as the site of human intervention and construction, feminists fight for cultural change in order to shift notions of appropriate social role, behaviour, and characteristics, or, in other words, to re-construct gender. However, for Donna Haraway, this political and epistemological approach amounts to a “repression of the construction of the category ‘nature’” and, therefore, an inability to pay attention to “how bodies, including sexualized and racialized bodies, appear as objects of knowledge and sites of intervention in ‘biology’” (134-5). In other words, the emphasis on gender as construct has the effect of rendering sex as material foundation that exists outside of or prior to historical and cultural change. It also has the effect of universalising the opposition of nature and culture, which is, in fact, “derived from and related to a very specific world view at a specific historical moment” (Yanagisako and Delaney 4). As Judith Butler asserts, the category of sex is a socially instituted and socially regulated fantasy, not a natural category, but a political one – “the very shape and form of bodies, their unifying principle, their composite parts, are always figured by a language imbued with political interests” (*Gender Trouble* 161, 160). Though taken as fact, foundation, and essence, the content of the idea of the “natural” is one that shifts across time, space, and body, taking on different forms and asserting itself with varying levels of force within distinct
contexts, thus, recourse to the “natural” is always a political act that enacts exclusions of particular bodies. Calling such a fundamental presupposition as the “natural” into question allows us to do the work of examining the details of how and where it is used, and the consequences of these potent techniques of hierarchy.

Given that the “natural” body is left to the domain of biology within popular conceptions of embodiment, where biology is taken to be simply the scientific description of living organisms, it is noteworthy that some of the first challenges to the presupposed immutability of the “natural” body come from within this scientific discipline itself. While other feminists still clung to the political power of disengaging gender from sex, a move that renders sex a fixed category of “nature,” feminist biologists, such as Ruth Bleier, Anne Fausto-Sterling, Donna Haraway, and Ruth Hubbard, exposed the myth of the “natural” body by highlighting the historical and cultural contingency of scientific “facts.” This body of work that emerged in the late 1970s brought the realm of the biological under scrutiny, reconceptualising it as a “social discourse open to intervention” rather than a field of determinism (Haraway 134). In Donna Haraway’s hugely influential collection of essays, *Simians, Cyborgs, and Women: The Reinvention of Nature*, she builds on this scholarship in focusing on the “invention and reinvention of nature – perhaps the most central arena of hope, oppression, and contestation for inhabitants of the planet earth in our times” (1). Ruth Hubbard, declared by Haraway in the chapter, “In the Beginning Was the Word: The Genesis of Biological Theory,” as the “scientific mother” for fostering these feminist critiques.
of science, recognises that “[a]t present science is the most respectable legitimator of new realities,” because, on the basis of theories of representation, scientific descriptions are merely considered to mirror reality (qtd. in Haraway 78). However, as this foundational scholarship highlights, “[l]anguage generates reality in the inescapable context of power; it does not stand for or point to a knowable world hiding somewhere outside the ever-receding boundaries of particular social-historical enquiries” (78). In other words, “the power to determine the language of discourse is the power to make flesh” (76). In Haraway’s exploration, the meaning of “nature” as the core of reality is replaced by the image of “nature” as ‘coyote,’ the “potent trickster” that can reveal the fundamentally social and relational character of the interaction between human and “nature” (3).

In proposing new ways of imagining embodiment, Haraway generates the figure of the “cyborg” in the chapter titled, “A Cyborg Manifesto: Science, Technology, and Socialist Feminism in the Late Twentieth Century.” Haraway imagines the “cyborg” as a way through the problem that the category of “woman” upon which feminism had been grounded has been necessarily fractured to the extent that it no longer withstands the weight of the movement. As Haraway clarifies, there “is nothing about being ‘female’ that naturally binds women. There is not even such a state as ‘being’ female, itself a highly complex category constructed in contested sexual scientific discourses and other social practices” (155). The figure of the “cyborg” challenges the dualisms upon which the idea of the ‘female’ body is based, most significantly, nature/culture,
male/female, self/other, and mind/body, as “a cybernetic organism, a hybrid of machine and organism” (149). Originally published in 1985, this text has been tremendously influential; in fact, the article is explicitly identified as an influence on transgender theory through its inclusion in *The Transgender Studies Reader*, not only because it directly informs Sandy Stone’s “Posttranssexual Manifesto,” written while Stone was a graduate student of Haraway’s, but, most importantly, because it grapples with pertinent issues, such as the fact that Man and Woman are fictions that serve to naturalise a particular social configuration of production and reproduction within a globalised matrix of state power. Susan Stryker’s reclamation of the “monster,” described in the previous section, is reminiscent of Haraway’s appeal to the “cyborg,” and the theoretical framework of “somatechnics” clearly owes acknowledgement to the fact that it builds upon the strength of this foundation. Although I am, of course, not writing “origin” stories, merely recognising an historical debt, to a great extent, the “cyborg” is the original somatechnical creature, expressing its potential through the capacity to reimagine the relation between body and technology.

What is especially potent for my project is that somatechnics is an approach that, as well as recognising that bodies are multiple and contradictory, co-constituted by various knowledges simultaneously competing on and for our bodies, also centres the fact that bodies are never static – the competition is never complete, there is never a final score, despite our blind faith in one (evident in the social significance of the notion of ‘bodily integrity’). The powerful phrase, “bodily (trans)formation” (Sullivan and Nourry 324), focuses our attention
on this, the fact that the work of forming bodies is constant, and happens within diverse, contradictory sites – the body is always already undergoing change. Analysing the ways in which this bodily change is conceptualised is significant in understanding the contours of power and resistance that shape the body, where body modification is not limited to so-called “non-mainstream” practices, such as piercing and tattooing, but refers to the ways in which everyday life “is marked by culturally specific technologies of bodily alteration: from daily routines of dental hygiene, showering, eating, to our increasingly sedentary lifestyles and reliance upon medicine for bodily knowledge, these all shape the ways that we are embodied” (Cadwallader and Murray 259). This engagement with the politics of body modification brings into focus the borders between and within bodies, both individual and political, because it is these demarcations, themselves simultaneously formed and transformed, rock solid and immensely vulnerable, that shape bodies and their (trans)formations. This approach repudiates an individualised conception of the body and the self in favour of a relational perspective – in these explorations of body modification, there is no ‘us vs. them,’ always ‘us and them (and them…)’ to the extent that none of these terms are intelligible without the other; exploring those bodily practices always necessitates an engagement with these bodies. This paradigm informs my exploration of the borders constructed around the “natural” male and female body through the bodily practices of gynecomastia surgery and pregnancy.
The Body and Power

Foucault’s perspective on the “nature” of the body is clearly influential on the critical thought being produced under the sign of “somatechnics” and is fundamental to this project. In Foucault’s scholarship, he identifies a particular, historically-specific, relation between body and power that marks the Western subject, and defines this relation as “bio-power,” techniques of state regulation and reproduction that act on and through the body. In contrast to the view that power is exercised through prohibition, denial and censorship, understood as constraints on the subject, Foucault, particularly in *The History of Sexuality, Volume 1: An Introduction*, argues that it is power itself that constitutes subjects (10, 37). Foucault describes the shift from sovereign power – the right of life and death over subjects – to the management of the population and the body as a resource for the state, and asserts that it is this focus on life, rather than death, through which power gained access to the body (ibid 138-139, 143). Foucault names this power over life, “bio-power,” and defines its emergence in two interlinked forms, an “anatomo-politics of the human body” and a “biopolitics of the population” (139). “Anatomo-politics” is:

> centred on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls (139).

It refers to the disciplining of the individual body, through techniques such as those exercised through the school, the army and the prison, which materialise relations of power in the physical body. “Biopolitics” is
focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary (ibid).

These are supervised through an entire series of regulatory controls that constitute a biopolitics of the population.

This is not to say that the population and the body are merely the objects of state power relations; rather, these concepts are, in fact, the conditions of possibility for the emergence of this form of power – it is only through contemporary understandings of population and body that power can be exerted over/through them. The relation between these elements is made clear in Shelley Tremain’s understanding of “bio-power” outlined in “On the Government of Disability: Foucault, Power, and the Subject of Impairment:”

Foucault’s term “bio-power” (or “bio-politics”) refers to the endeavour to rationalise the problems that the phenomena characteristic of a group of living human beings, when constituted as a population, pose to governmental practice: problems of health, sanitation, birthrate, longevity, and race...Biopower is then the strategic movement of relatively recent forms of power/knowledge to work toward an increasingly comprehensive management of these problems in the life of individuals and the life of populations (185).

Bruce Curtis, in an analysis of Foucault’s articulation of the concept of “population” throughout his scholarship, details the relation further in the consideration of how a population is constituted from a collection of bodies:

Population depends upon the establishment of equivalences among the subjects within a particular territory. Political-scientific knowledge depends on the discipline of potential objects of knowledge. It is only on the grounds of constructed and enforced equivalences that one body comes to equal another, that each
death, birth, marriage, divorce, and so on, comes to be the equivalent of any other. It is only on the grounds of such constructed equivalences that it is possible for statistical objects to emerge in the form of regularities and to become the objects of political practice. Population is coincident with the effective capacity of sovereign authority to discipline social relations (529).

Bodies are simultaneously constructed as difference, as a form of individuality, and as the same, in their relation to the population as a whole. The “state’s power (and that’s one of the reasons for it’s strength) is both an individualizing and a totalizing form of power” (Foucault qtd. in Curtis, 527), such that the body becomes the site of disciplinary power, a trainable phenomenon, in relation to forms of individuality generated within a totalising web of social control.

For Foucault, sex is central to this notion of power. The historical conception of the relation between power and sex has been one of repression, but, in *The History of Sexuality, Volume I*, Foucault argues that the deployment of sexuality was one of the most important concrete arrangements in the nineteenth century joining the two techniques of power, anatomo-politics and biopolitics, to form the “great technology of power” (140). Sex is not exterior to power, rather “sexuality appears as an especially dense transfer point for relations of power” (ibid 103). In this paradigm, power operates not through direct control but through the normativity of sexual categories, which operate on all levels, take up multiple forms, and have become the primary means of management of population and body (144). As Heyes says in *Self-Transformations: Foucault, Ethics, and Normalized Bodies*, Foucault shows how “sexuality as a field of power generates a normal identity from which numerous deviations can be defined” (31).

Foucault’s conception of the positive relation between power and sex disrupts the
notion of the self as founding subject. In contrast to the assumption that the self precedes the taking up of sex, Foucault argues that it is the very notion of ‘sex,’ a complex idea formed within the deployment of sexuality, that “made it possible to group together, in an artificial unity, anatomical elements, biological functions, conducts, sensations, and pleasures” (154). Within this conceptualisation, the self understood as causal entity is actually an effect of these power relations, an effect that obscures the very nature of power (ibid 155). The notion of power over life, described by Foucault in the historical shift from the right of death to the power over life, should be understood more strongly as the power to invest life – the extent to which we can live is the extent to which we submit to regulation. It is only through the categories of sex, positively marked by power, that we become intelligible to ourselves and others, and have the potential to access our body and identity (155-156). According to Foucault, the ‘I’ is completely culturally, politically, historically produced and constrained by contingent conditions, hence making it the docile body optimised as a resource for the state. In short, the sexed body is a significant site through which unequal relations of power are maintained in our present social landscape. As such, marking the ways in which sex categories are naturalised is of vital importance to the interrogation of the operation of power (and resistance) in this historical and cultural moment.

Reproduction is at the heart of current Western understandings of sex and, thus, it is a dominant idea through which power operates. In Foucault’s terminology, the “species body” upon which biopolitical regulation focuses is the body of reproduction. Sylvia Yanagisako and Carol Delaney, in Naturalizing
Power: Essays in Feminist Cultural Analysis, emphasise the naturalisation of reproduction in their genealogy of the notion of reproduction in relation to evolutionary theory, showing that reproduction as a “natural” fact is an idea that has a short history. According to them, evolutionary theory, as a theory of origins generated in response to a crisis of faith in the Creation story of the Bible within 19th-century European society, situates order in the natural rather than the divine (5), and associates humans with animals in the classification of species. Though challenged by fundamentalist Christian groups in the United States, particularly in recent debates over the teaching of evolutionary theory versus Creationism in schools, this association is largely taken for granted within contemporary Western society, and it is ideas of sex and reproduction that provide for the association between human and animal. Where reproduction was “at first considered a quaint metaphor, hardly a description of fact,” a metaphor that “consisted of analogizing human procreation to that of animals and plants” (7), now reproduction is held to be quintessentially natural, a process purely based on our “animal” behaviour. While men and women have, arguably, always been defined by their contribution to procreation, and these contributions have perhaps always been positioned as hierarchical, the difference of the contemporary paradigm is the absolute association of reproduction, and the reproductive potentialities of male and female, with nature. I cannot remember the number of times I have had to engage in arguments about human behaviour made on the basis of appeals to animal characteristics, particularly in relation to justifying men as sexually aggressive and non-monogamous predators merely interested in
“sowing their seed.” This cultural euphemism, which is only intelligible through the association of human reproduction with nature, figures the male reproductive role as fleeting and distant allowing the male body’s productivity and creativity to be elsewhere, while the female body is reduced to its reproductive role through the association of the female body with earth, for what else can fertile soil do but stay and bear life? These ideas have been so thoroughly naturalised that the biological “facts of life” are taken to be the ultimate bedrock of sexual difference, and male privilege is merely taken to be the natural consequence of these differences in reproductive potential. As such, discourses and practices associated with reproduction are significant technologies through which unequal power relations are enacted on the body, and this project, which attempts to denaturalise reproduction, is an important and timely contribution to the disruption of these power relations.

**The Normal and the Pathological: The Normalised Body**

In this cultural and historical moment, power operates primarily through normalisation and, as such, my focus is on technologies of normalisation in relation to the bodily practices of gynecomastia surgery and pregnancy. As Heyes is quick to emphasise, normalisation does not simply refer to any process through which conformity is encouraged but rather, in Foucault’s account, involves “a set of mechanisms for sorting, taxonomizing, measuring, managing, and controlling populations, which both fosters conformity and generates modes of individuality” (Heyes 16). We are all normalised bodies, though few of us are normal, in fact, as Heyes highlights, “almost every body is now “failed” in some
respect,” as “technologies for disciplining and transforming bodies proliferate, organizing themselves around ever more fine-grained and idealized norms” (16-17). Though the power of normalisation rests on the fact that, as Foucault says in his lecture series on the abnormal, “it has extended its sovereignty in our society” (Abnormal 26), medicine is currently a dominant site of normalisation, marking bodies in relation to more and more detailed divisions and categorisations. So, in order to explicate the processes of normalisation, particularly in relation to this project, it is informative to consider in detail how medicine became a field through which bodies are sorted and defined in relation to normality. According to Foucault in The Birth of the Clinic: An Archaeology of Medical Perception, it was a reconfiguration of disease at the anatomo-political level and a directly related shift in state emphasis onto health at the biopolitical level that necessitated a shift in medicine. As medical knowledge becomes political consciousness and is wholly integrated into social space, it “must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of healthy man, that is, a study of non-sick man and a definition of the model man” (Foucault, Birth 34). Through this focus, medicine becomes organised more in relation to normality than health or, perhaps more accurately, health becomes a norm and medicine acquires a normative authority that allows it to prescribe physical and moral standards for an individual and the society in which he/she/ze lives (ibid). As Canguilhem highlights in The Normal and the Pathological, medicine became governed not by the binary of health and disease but by the relation between the normal and the pathological.
This can be understood as a shift from a qualitative approach to a quantitative perspective. Rather than being based upon the ontological difference of disease, within this conception, the pathological is situated in continuity with the normal, merely a variation of degree not of nature. Through the assertion of this identity, pathological facts are said to reveal physiological facts or, in other words, knowledge of the normal (Canguilhem 43). It is the shift from substance to degree, the assertion of the homogeneity of the normal and the pathological, that allows medicine to become, not just a field grounded on the idea of the ‘normal man,’ but a technology of the norm or, in other words, a set of discourses and practices that aim toward disciplining bodies in relation to a set of norms. As soon as the pathological is understood to be continuous with the normal, then the normal is in constant danger, at risk of degeneration, and must be protected at all costs. Medicine is no longer solely concerned with curing the ill but, rather, with maintaining and propagating normality. Murray describes this as the emergence of a “disciplinary medicine,” a “mode of unprecedented scrutiny, social control and regulation,” through which we are constructed and (re)produced “as (normal or pathological) subjects” (15). The norm circulates between body and population such that bodies are disciplined in relation to regularities of the population.

The discussion above may give the impression that the norm is merely an idea generated within a model, albeit an idea that has significant force in the contemporary Western social landscape; however, as Jessica Cadwallader emphasises in “Suffering Difference: Normalisation and Power,” the disciplining of bodies in relation to the norm is far more intimate than generally imagined in
popular renditions of the pursuit of normalcy (388), where there is, first, the embodied self and, then, the embrace or rejection of normality. In fact, these normalising disciplinary measures do not merely act upon the body, but actually constitute modes of “subjectification” through which the subject is constructed. In other words, they generate ways of being in the world, such as male and female, and heterosexual and homosexual. Thus, wholesale rejection of normalisation is impossible for without these categorisations we would be unintelligible – normalisation is simultaneously constraining and enabling. Further, as Murray explains, using the theories of both Georges Canguilhem and Linda Alcoff, our relation to norms is not rational but visceral:

> it is at a tacit level that subjects perceive that which is not normal, not simply as a variation, but rather characterised as a *repulsive positionality*. The positioning (or desire to be positioned) as *normal* is not simply a veneration of a standard model, but is fundamentally constructed by an anxiety and repulsion of *difference* (47).

Thus, the insatiable quest for that which is marked as normal is driven by an intense aversion to that which is defined as the opposite, the abnormal. However, it is not only fear that drives us *from* the abnormal but also desire that pushes us *toward* the normal, as we are constantly haunted by “the spectre of normativity” (Murray 35). Though this normativity “is nowhere concretely to be found,” it’s epistemological force “weighs on us heavily, effecting a range of behaviours such as self-surveillance, and an acute awareness of the coding of certain behaviours as indicative of a tacit agreement to aspire to this ‘normative body’” (ibid). As Foucault emphasises, the power of the norm is not related to the negativity of exclusion but the positivity of transformation:
The norm brings with it a principle of both qualification and correction. The norm’s function is not to exclude and reject. Rather, it is always linked to a positive technique of intervention and transformation, to a sort of normative project (Abnormal 50).

Thus, discipline in relation to the norm is quite different to punishment, for it operates, not through coercion, but through “positive techniques,” such as the ideas of individual responsibility and free choice in ‘improving’ our embodied selves. For instance, we believe that we freely choose to diet and exercise for our own ‘health’ and we blame those who look like they do not, in other words, those who embody a visible sign of difference, as lazy, immoral, and unclean. It is a far more insidious form of power than external authority because it operates through and within our own bodies and, as such, it is inescapable.

Conclusion: The Naturalised Body

However, normalisation is far from seamless; in fact, we live with the inherent contradiction of embodiment as both essential difference and continuous variation. On the one hand, normalisation constitutes the natural body, in that divisions between bodies are naturalised to the extent that the contingent nature of these boundaries is erased; in other words, the fact that the natural body is an effect of disciplinary power is invisible. However, on the other hand, the normal and the pathological are situated as variations of degree not essence so that degeneration of the normal is a constant fear and aspiration to the normal is an insatiable desire because it is understood to be attainable within this conceptualisation. Though these exist simultaneously, they are weighted differently in different contexts, such that some bodies are more natural than
others or, in my approach, some bodies are more naturalised than others. By this, I mean, that some markings of normalisation are taken to be absolute, such as the distinction between the “natural” male and female body, which does not allow for slippage between these categories, while others are not, such as the distinction between the fat and thin body, which, as the size of the diet industry shows, is a boundary that is fraught with possibilities of crossover. Though both divisions are contingent, that fact has been more fully erased in relation to the former, such that the work of being male or female is largely invisible while the work of being thin is clearly apparent. In other words, we believe unquestionably that we are born male or female but not that we are born thin or fat – the former is taken to be a natural fact, one of the primary unchangeable elements of the body, while the latter is primarily understood as an aspect of embodiment that requires intervention throughout life. That being said, in the current age of genes, there is a search for the genetic basis for obesity, a quest that relies on the notion of an essentialised difference between the fat and thin body; and, in relation to the perceived stability of the sexed body, the intense fear of gynecomastia reveals the inherent vulnerability of the male body. Thus, through normalisation, bodies are simultaneously stable and vulnerable, concerned with both being and becoming. It is the combination of these elements that provides both for the potency of this form of power and the destabilisation of its effects.

In this project, I am concerned with one of the modes of normalisation that has been most thoroughly naturalised, that is taken as stable and associated absolutely with being, that is, the binary of the sexed body as male or female.
join the body of critical work that is invested in making the work of being male or female visible, in other words, highlighting the extent to which male and female are modes of becoming. I am concerned with revealing, what I call, the “technologies of the natural” or “naturalisation techniques,” the specific discursive operations through which the male and female body are materialised as natural, in other words, how the natural sexed body is itself constructed. By applying the term ‘technology’ to the idea of the ‘natural,’ two concepts considered mutually exclusive, I maintain the emphasis on the principal tenet of ‘somatechnics,’ that the body is always in a state of becoming, even the “natural” body. I undermine the binary of constructed versus natural by changing the terms to constructed versus naturalised, where the naturalised body is one whose construction has been successfully erased. Rather than taking the natural body as cause as in the dominant conception of the sexed body, I focus on its characteristics as effect, as contingency, as inheritance. Emphasising the historicity of our categories of experience, which have been materialised in and through the body, disrupts the belief that they are inevitable and natural, and opens up possibilities for different, perhaps less totalising, ways of conceptualising bodies. The “natural” body is not seamless, it is marked through and through by contemporary relations of power, and the first step in disrupting the violence done in the name of the “natural” is to carefully unpick each and every one of the stitches that mark it.

While, as I have argued above, the sexed body is marked by both stability and vulnerability, there are domains in which it appears more vulnerable and these are key sites to identify in the exploration of technologies of the natural
because these strategies become far more visible in the face of destabilisation. As such, I focus my interrogation on specific instances of the male body with breasts and the female body that is unable to achieve pregnancy. Given that breasts and pregnancy are taken as fundamental signs of the female body, the gynecomastic body and the infertile body are intensely vulnerable in relation to their maleness and femaleness respectively and, in response, the restabilisation strategies are rendered highly apparent, providing for a rich exploration of the construction of the natural male and female body. While it is often the transsexual body that is taken to be most vulnerable in relation to the sexed body and, as such, is often the target of studies on the construction of the body, that focus is itself a technology of the natural through which non-trans bodies are rendered natural. In contrast, I assert the inherent vulnerability of the “natural” male and female body and emphasise its construction. However, the trans body is not absent from this exploration but, instead, features in a very different way: rather then the ultimate site of construction, it is situated as that which can reveal the constructed nature of the “natural” male and female body; rather than being one of the most undermined bodies, never considered “real,” it serves to highlight the constitution of the “truth” of the “natural” male and female body; rather than maintaining the binary of constructed versus natural, it fundamentally disrupts this binary in revealing the “natural” as product. Thus, this project both centres and makes marginal trans embodiment as it is both grounded in but not focused on the trans body, in the sense that the emphasis is on those bodies that are
taken to be naturally male and female but my particular approach to these bodies
would not be possible without the trans body.

I will end this chapter with a description of each subsequent chapter and
the ways in which they link together – in other words, I will describe the
connections I make in order to tell this particular story. The next chapter is also
an introductory chapter, but it focuses on my methodological approach, and
includes: an account of the way in which I use Foucauldian discourse analysis;
further justification of the significance of the selected research domains, medicine
and the Internet, as well as how I consider them in relation to each other; the
details of the specific research sites within these domains, including their context;
and, last but by no means least, ethical considerations, particularly in relation to
the exploration of the Internet. The main body of this dissertation is divided into
two sections, where the first is focused on the naturalisation of the male body
through a comparative analysis of gynecomastia surgery and FTM chest surgery,
and the second is focused on the naturalisation of the female body through a
consideration of pregnancy in relation to infertility. Within the first section, chapter
three is an examination of the medical discourse surrounding these practices.
Read through and against each other, these discourses reveal the ways in which
the natural body is constructed through particular bodily modifications, and
excluded from others. This naturalisation is achieved through the use of multiple
and varied themes that intersect with the natural, but I identify the primary
technology to be the discursive figuration of harm. As such, within this chapter, I
focus on the nature of harm, and the conceptions upon which it is grounded,
including disorder, bodily integrity, regret, and authenticity. Chapter four compares the online community discourse surrounding gynecomastia surgery and FTM chest surgery, focusing on two particular Internet sites. After identifying the significance of online communities for trans and gynecomastic men in relation to the (dis)embodiment of the virtual, my analysis draws out the ways in which the transition of chest surgery is (re)imagined in this space, ultimately finding that each set of men attempts to embody the medical narrative of the other, such that, at least to some extent, men with gynecomastia assert themselves as, in Foucault’s terms, a “species,” while trans men declare themselves simply men with gynecomastia. Chapter five starts the second section, and involves an analysis of (in)fertility within medical discourse, and its relation to pregnancy. Within this discursive domain, infertility disrupts the femaleness of the body, and pregnancy becomes the technology of the natural through which the body achieves femaleness. However, within chapter six, which is an exploration of an online community of women with infertility, infertility undermines the femaleness of the body to the extent that pregnancy does not absolutely provide for the transition to female. Instead, knowledge of the body becomes a central goal, thus asserting the relation between sex and knowledge. In the conclusion, I reassert my attempt to shift our ways of thinking about the body from the idea of the “natural” body to a conception of naturalised body modification.

My aim in telling these ontological stories is not simply to make them visible but because identifying them is a significant part of, in Foucault’s words, “thinking ourselves differently.” While many critics find Foucault’s theories
ultimately depressing, reading the fact that we are fundamentally constrained by power relations as a source of despair, I find hope in the recognition that we are absolutely contingent for it reminds us that the modes of embodiment that we live through can be different – not in the sense of a progress narrative but rather that history is discontinuous such that, just as things have been different in the past, they will be different in the future. Revealing these stories is a way of provoking a future that provides for different forms of embodiment, equally constraining, it’s true, but perhaps more livable for more people. Reconfiguring one of Foucault’s declarations, Ladelle McWhorter says, in *Bodies and Pleasures: Foucault and the Politics of Sexual Normalization*:

> [t]he successes of history belong to those who are capable of seizing these stories, to replace those who had used them, to disguise themselves so as to pervert them, invert their meaning, and redirect them against those who initially told them; controlling this complex mechanism, they will make it function so as to overcome the storytellers through their own stories” (60).

Let us “overcome the storytellers” who use the “natural” body against us by “seizing these stories” and telling our own in their place, stories that recognise the simultaneous natural- and unnatural-ness of all bodies, stories that provide for multiple and varied geographies of embodiment.
Chapter 2: Looking for the Natural Body

This chapter articulates my methodological approach or, in other words, where and how do I read the natural sexed body? By definition, technologies of the natural are often invisible – the specific discursive operations that constitute a process of naturalisation have been erased to the extent that the natural is able to figure as the foundation upon which culture acts. As such, revealing them requires, what may be called, comparative interrogation. In this approach, I draw heavily on Nikki Sullivan’s work where she uses the method of bringing together what seem to be different body modifications, and emphasising the similarity of the bodily changes together with the distinctness of their discursive framings in order to highlight the contingency of our general conceptions of these bodily practices. Through this process, she shifts our ethical imperative from the assessment of body modification, which leaves us stuck in the dead end of derision versus valorisation, to the political interrogation of “the ‘social imaginaries’ – the perceptual schemas – that constitute embodied subjects and their affective investments in ways that incite and then discriminate against particular bodies and bodily practices” (“Price to Pay” 407). Comparison, for instance, as in the first section (chapters three and four) between the discursive figurations of FTM chest surgery and gynecomastia surgery, is productive because it makes visible the stark differences between the ontological presuppositions underlying these medical practices and the work that goes into
securing those foundations. Without placing these two practices in proximity and reading them through each other, I would have been unable to think through these bodily transformations in the same way. To a great extent, it is the comparative framework that allows me to explore the question, not of how these processes act on “natural” male and female bodies, but rather, of how they produce particular bodies as naturally male and female?

In terms of pregnancy, it is the exploration of the relation between the body that is unable to achieve pregnancy and the pregnant body that I use to determine the naturalisation techniques associated with pregnancy. Given the naturalised belief in the fertility of the female body, infertility is a highly threatening bodily condition and the restabilisation strategies made visible in the pursuit of pregnancy highlight the constitutive nature of pregnancy. Infertility undermines the very femaleness of the body and reading the ways in which pregnancy is figured in relation to this threat reveals the extent to which pregnancy is a body modification in this context. I use the phrase body modification in order to emphasise that pregnancy is not merely a bodily process that acts on the female body but a bodily practice through which the body becomes female. When pregnancy comes easily, this body modification is naturalised to the extent that it is erased as modification – pregnancy is merely considered a sign of the reproductive ability of the female body that came into being at conception. It is only when pregnancy does not come or, at least, not easily, that pregnancy is made visible as both reproductive and productive, in the sense that it is through the generation and growth of the body of a baby, made
visible through the swelling of the ‘belly,’ that the female body of the mother is produced. In short, I argue that the female body is the *effect* of pregnancy not the *cause*, and this argument about the productive power of pregnancy is made possible through the interrogation of the relation between infertility and pregnancy.

FTM chest surgery, gynecomastia surgery and pregnancy may seem like an odd combination of incongruous bodily practices to include in the same project; however, placing them in proximity to each other is vital for the nature of this exploration. While pregnancy is thought to be absolutely natural and FTM chest surgery is fundamentally associated with construction, thinking about these bodily processes in relation to each other allows me to consider them in different ways. It provides for the possibility of queering reproduction in the engagement with pregnancy as body modification, a move that emphasises the extent to which it is naturalised rather than natural. While pregnancy remains in opposition to FTM chest surgery, my approach situates them not as essentially different but as variables on a spectrum of body modification, where the paradigm of essential difference is structured by the binary of constructed versus natural and the spectrum refers to a scale that stretches from visibly constructed to invisibly constructed or, in other words, naturalised. Gynecomastia surgery would perhaps be situated somewhere in the middle, naturalised in relation to FTM chest surgery but considered as construction in relation to pregnancy. All three of these bodily practices are topics worthy of their own interrogation, so it may be said that I sacrifice depth for breadth in my exploration but, in fact, the richness of
these bodily trans-formations is only revealed by bringing them together and reading them through each other.

**Foucauldian Discourse Analysis**

Somatechnics, with its recognisably Foucauldian influence, is based on a conception of the inextricability of discourse and materiality. Here, discourse is not merely descriptive, representing a real materiality that is always elsewhere, rather, it is constitutive, productive, of forms of embodiment – the distinction between signifier and signified does not apply in this framework for we come to be to the extent that we submit to discourse. This is not to say simply that we are determined, far from it, for that would imply a notion of power as singular; bodies are the sites and manifestations of the multiplicity of discursive regimes, and this provides the corporeal with the potential of recalcitrance in the face of dominant power configurations. So, discourse analysis is ultimately an exploration of bodies and their (trans)formations. After all, it is the reading of the stories we tell about our selves, stories completely imbricated in shaping the contours of our bodies.

Foucault’s notion of discourse is very specific and, while I am not undertaking an historical approach as Foucault does, I use his understanding of discourse as far as possible. Foucault considers discursive formations, not as representations of some external reality, but on their own terms and according to their specific internal characteristics. Discursive formations are regular systems of rules that provide the conditions of existence of “objects, modalities of statement, concepts, and theoretical choices” (*Archaeology* 64). Discourse is
defined as the set of statements that make up an individual system of formation, and Foucault’s historical analysis of statements is focused on what was said and the way in which it was said (107); this form of analysis does not interpret statements, but questions them about their modality of existence – what it means that these particular statements appear and not others (109). As Foucault says in the preface to *The Birth of the Clinic: An Archaeology of Medical Perception*:

> Is it not possible to make a structural analysis of discourses that would evade the fate of commentary by supposing no remainder, nothing in excess of what has been said, but only the fact of its historical appearance? The meaning of a statement would be defined not by the treasure of intentions that it might contain…but by the difference that articulates it upon the other real or possible statements, which are contemporary to it or to which it is opposed in the linear series of time (xvii).

The question is not, what does a statement imply or what is an author’s intention but why are some statements sayable while others are not? For Foucault, a statement is not reducible to a sentence, a proposition, or a speech act; it is a particular series of linguistic elements immersed in a specific field of enunciation, and within which a subject-position can be assigned (*Archeaology* 95). As such, Foucault’s aim is not to exclude the subject from analysis, as many of his critics worry, “but to define the positions and functions that the subject could occupy in the diversity of discourse” (ibid 200). This form of textual analysis is concerned, not with judgement, whether it be condemnation or celebration, but with *meaning*; I am interested in interpreting the text, looking for those discursive practices and figures that become intelligible within these communities. I am not asking why people undergo this type of surgery or whether reproductive technologies are right and wrong but, rather, what are the bodily imaginaries that make these
(trans)formations possible in this particular social and historical moment, how do they operate and what are their implications? As Jonathan Sterne recognises in relation to online discourse analysis in "Thinking the Internet," it is not about the "determination of what a given event on-line means for its participants (although this may be part of it), but how the possibilities for meaning are themselves organised" (262).

Foucault conducts historical analysis because he believes that it is hard, perhaps impossible, for us to identify the discursive rules in existence in our own time and place, "since it is from within these rules that we speak, since it is that which gives to what we can say…its modes of appearance, its forms of existence and coexistence, its system of accumulation, historicity, and disappearance" (Archaeology 130). It is only with chronological distance that the system of formations and transformations emerges with sharpness and can be described. As a discourse on discourse, the threshold of this description’s existence is the "discontinuity that separates us from what we can no longer say" (ibid). As such, according to Foucault, it is difficult for us see the ruptures within our own time that may make future modes of subjectivity possible. I believe that, to a certain extent, the form of comparative interrogation that I undertake allows me to identify regularities and discontinuities within the present that reveal the contingencies of our categories of being. In this approach, we do not have to wait for the future, for the present to become the past, in order to reveal the relations of power through which the body is materialised; rather, we can articulate the technologies of the natural that declare the worth of some bodies and
discriminate against others right here and now. As Foucault himself says in the quote above, it is possible to look for the meaning of a statement in “…the difference that articulates it upon the other real or possible statements, which are contemporary to it…” (Birth xvii).

Within the discursive contexts under investigation in this project, there are specific themes employed in the demarcation of the “natural” body, and, throughout each chapter, I focus on highlighting these tropes and exploring the overlaps and divergences between them. For example, the notion of ‘harm’ plays a central role in defining the post-surgical FTM chest as “unnatural” within medical discourse on the transsexual body, while its absence in medical discussions of gynecomastia surgery, or its association with the pre-surgical body, is a naturalisation technique used to construct the male body as one without breasts. ‘Disorder’ is used within the medical discourse in relation to all three bodies under investigation – the trans body, the gynecomastic body, and the infertile body – but the differences in the ways this notion is applied are significant in determining the (un)naturalisation processes operating within these contexts. Through the consideration of central themes such as these, I am able to map the operation of these naturalisation techniques.

Research Domains: Medicine and the Internet

My exploration is focused on medical discourse and Internet discourse. I briefly mentioned in the introduction that I consider these two discursive contexts to be central sites through which bodies are constituted, particularly in relation to
the bodily practices under consideration in this project, and I provide further elaboration of this assertion here.

**Health and Disease: The Medicalised Body**

Given the extent to which the modern body is the medicalised body, medical knowledge is a particularly powerful discourse through which bodies are materialised. Let me explain further what I mean by the concept of the medicalised body through a close look at Foucault’s work on the nature of health. In Foucault’s later work, in particular, “The Politics of Health in the Eighteenth Century,” he shifts his emphasis from “social medicine,” a particular form of medical power that took the poor body as its object, to “noso-politics,” which refers to “the emergence at a multitude of sites in the social body of health and disease as problems requiring some form or other of collective control measures” (168). This is a far broader understanding of the influence of the notions of health and disease in recognition of the fact that the “problematisation” of these notions in the eighteenth century is achieved through multiple initiatives beyond merely State intervention in the practice of medicine, such as those located within religious groups, charities, and academic societies (167). Though the poor body remains a site of social anxiety, the new noso-politics inscribes the specific question of the sickness of the poor within the general problem of the health of populations, and makes the shift from the narrow context of charitable aid to the more general form of a ‘medical police’, imposing its constraints and dispensing its services (171).

This displacement of the problem of health from assistance to general policy objective, from the body of sickness to the health of population, is grounded upon
a relation between body and population that marks the health of every individual body as a priority for the population (168). In this paradigm, the policing of health is not vertical and centralised, but dispersed and multiple. Medicine, as a “general technique of health,” becomes increasingly important in “the administrative system and the machinery of power” (176), and the doctor increasingly occupies a position of social power as the expert “in observing, correcting and improving the social ‘body’ and maintaining it in a permanent state of health” (177). Murray describes this as a shift from “the medical treatment of individual complaints to medicine as a mode of state governance” (15). Through this shift, the scope of health and disease is enlarged to include urban planning, prescriptions of diet, sexual behaviour, arrangement of living space, clothing, and multiple other macro- and micro-practices of everyday life (Foucault, “Politics of Health” 176). Thus, responsibility is situated at both the personal and the political level, with the health of the individual body defined in relation to the health of the nation. Murray emphasises this in her articulation of the way in which the ‘fat’ body is read as both a moral failure and a threat to the social body (30-31). In the contemporary Western social milieu, we all understand and position ourselves in relation to ideas of the healthy body, such that the markings of health and disease generated within medical discourse do not merely act upon the body, rather, they are a foundational site through which embodied forms of individuality are generated.

Contributing to the politicisation of medicine is a change in the conception of disease and its relation to the body. Within The Birth of the Clinic: An
Archeology of Medical Perception, Foucault identifies a shift from classificatory medicine to anatomo-clinical medicine that was enacted through a reconfiguration of the “spatialisation of the pathological” (10). Within classificatory medicine, the medicine of species, a disease is defined by its position in a family, not characterised by the space of localisation in an organism. In fact, in order to know the essence of the disease, it is necessary to subtract the patient and his/her/hir particular qualities (15). The order of disease is uncovered through the determination of family resemblance, the degree of similarity between one disease and another (6-7) – it is about class not seat. In contrast, within anatomo-clinical medicine, which, according to Foucault, developed in the 19th century, disease exists in space, more specifically, in the localised space of the organism (188). Thus, the “being of the disease disappears” and disease becomes “no more than a certain complex movement of tissues in reaction to an irritating cause” (189), constituting a “shift from medical ‘ontology’ to the notion of organic ‘sickness’” (191).

According to Foucault, this shift was enacted through the readmittance of pathological anatomy, the opening up of corpses, into the clinic (126). It is “from the height of death that one can see and analyse organic dependencies and pathological sequences” or, in other words, that one can grasp “the truth of life and the nature of its illness” (144). It is only through the negativity of death that life is endowed with positivity – through mortality comes vitality. While, within the medicine of classification, disease is considered both natural and ideal (8), within anatomo-clinical medicine, disease is the embodiment of the fact of death within
life itself (55). It “is no longer a pathological species inserting itself into the body wherever possible, it is the body itself that has become ill” (136), such that “the idea of a disease attacking life must be replaced by the much denser notion of pathological life” (153). Where once life was situated in opposition to the inorganic, it now appears in relation to death, and disease is no longer an accident but the “internal, constant, mobile dimension” of that relation (154). As Georges Canguilhem describes in The Normal and the Pathological, a text that influenced Foucault’s scholarship, “the menace of disease is one of the components of health” (285). Foucault describes the form of medical perception that operates from this perspective of death as the “anatamo-clinical gaze,” and he marks the shift to this form of “death-bearing perception” as the defining moment in the history of Western medicine (Birth 159, 146). Through this shift, disease is both spatialised and individualised (159) – the differentiated form of the individual is opened up to the gaze through the spatialisation of disease, which is an effect of the perspective of death, such that it is on the basis of death that knowledge of the individual is made possible (170). As Tremain writes in “On the Government of Disability,” “the modern body is created as the effect and object of medical examination” (186). To summarise, through the anatamo-clinical method, the concept of disease is reconfigured, from one that is understood in relation to nature to one that is conceived in relation to death, where death is no longer a counter-nature but embodied in the living bodies of individuals (Foucault, Birth 196-7). It is through this reconfiguration of disease that the idea of the individual body is constituted and, as such, the modern body
is the medicalised body, the body always already marked by health and disease. Given the extent to which medicine, and the science upon which it is founded, is taken as a domain concerned purely with description (of the “natural” body), it is important to emphasise its dominant role in the production (of the “natural” body).

**Internet as Textual Spatiality: Online Community**

Having detailed why I consider medical discourse to be central to this exploration on the basis of the idea of the medicalised body, I now turn to the significance of Internet discourse. In theoretical approaches to the Internet, there is a marked polarity between those that view it as space and those that consider it as text. While I read the Internet as text, I follow Mark Nunes in recognising the ways in which space is produced through Internet discourse, and I consider the Internet’s spatiality to be a dominant factor in the significance of Internet discourse as a site through which the body is constituted. As Nunes emphasises, the language we use to describe the Internet invokes spatiality: we ‘navigate,’ ‘surf,’ and ‘cruise’ through ‘sites,’ ‘homepages,’ and ‘chat-rooms,’ all within ‘cyberspace,’ which seems to have displaced ‘Information superhighway’ as the overarching term for the Internet, (a shift that is significant because, while both reference space, they refer to substantially different forms). While the ubiquity of this terminology implies that the Internet is popularly accepted as space, Nunes instead identifies it as a “topography,” where he uses J. Hillis Miller to define topographies as “performative speech acts that simultaneously map and create a territory” (“Virtual Topographies” 61). He goes on to say that, with the Internet, “this performative function is even more marked, since no reassuring ‘ground’
rests beneath the writing of place” (ibid, emphasis mine). The phrase, the “writing of place,” marks the Internet as text but text that constitutes space. In his later work, Cyberspaces of Everyday Life, he elaborates on this fundamental point by emphasising that he does not want to reduce cyberspace to “mere metaphor,” which is “a framework that places language and ‘space itself’ on opposite sides of an unbridgeable ontological and epistemological divide” (4). Instead, he argues that:

the ‘here’ of cyberspace, while doubled, denotes a sense of place that straddles the language/materiality divide: a ‘hyperpotential’ hereness that coincides with a material presence (my body, here at the keyboard), yet at the same time displaces that presence ‘into’ networks of exchange.

To speak of cyberspace as merely an artifact of language does not really account for this novel relation to space, as both material form and conceptual structure, mapped by the everyday use of network technology (5).

As Nunes emphasises, the problem of cyberspace forces us to recognise that language is material as much as it is symbolic (10). The Internet is such a significant domain precisely because it foregrounds this relation between text and space – “the immateriality of cyberspace is at the same time described and acted upon as a space in which embodied events do indeed take place” (ibid). As textual spatiality, it becomes an ideal site for the exploration of the constitution of embodiment.

Rather than cyberspace containing a singular spatial figuration, Nunes identifies two dominant “virtual topographies,” corresponding to Deleuze and Guattari’s descriptions of smooth and striated space (“Virtual Topographies” 62).
Striated space consists in points and direct pathways between them (captured by the phrase, 'cruising the Information Superhighway'), while smooth space refers to a plane of fluidity (represented in popular language as 'surfing the ‘Net’). Shawn Wilbur, quoted in Nunes, marks the distinction between the former and the latter as "one of being, rather than becoming or creation" (74). Online forums are good examples of striated spaces in the way they can function as virtual towns, in that participants generally do not 'surf' through but aim at and arrive at these points within cyberspace. This makes them especially fertile for this project because the “image of inhabitable cyberspace provides all sorts of opportunities for exploring ontology, and in particular, the assumptions that lead to our understanding of body, presence, and community” (71-2). However, Nunes is also quick to emphasise that the nature of these striated spaces means that these questions are most often erased rather than addressed. As such, my exploration focuses on web forums for the opportunities they provide for reading stories of ontological destabilisation and restabilisation.

Online forums function as virtual towns to the extent that they constitute community. I focus on specific web forums that operate as virtual support groups, which is a particular form of social organisation that lends itself to community formation. It is not inevitable that “communities will automatically form” on the basis of these organisations (Hine 20), rather, community may be achieved within these social groups if a number of conditions prevail. There has been much debate about the attribution of the term ‘community’ to online groups, a debate grounded in different perspectives on the dis-embodiment of the virtual
and the subsequent possibility (or not) of ‘real’ relationships. Nancy K. Baym highlights the fact that early research on computer-mediated communication “generally argued that computers are inherently inhospitable to social relationships” (35). While we have come a long way from that position, the debate still rages. Within Nessim Watson’s exposition of the dispute, he engages with Neil Postman’s criticism of the notion of ‘virtual community’ and identifies that, for Postman, the crucial feature of communities is “common obligation” (122). Watson is quick to agree that some form of obligation or stake is missing from online groups but, for him, that merely implies a redefinition of ‘community’ rather than a denial of it (123). I would argue that common obligation is not always absent from online collectivites. If we concede the artificiality of online identities or consider only groups formed around common interests (as Watson does), then, it is true, there is no ground for common obligation. However, in the case of the online groups under consideration here, there is much at stake; in fact, to the extent that these texts provide the possibility of trying on a “real identity,” everything is at stake.

This common obligation is grounded in the level of connection felt between members, which becomes the most significant condition for the formation of a community online. Howard Rheingold has used the term ‘virtual community’ to describe such “social aggregations that emerge from the Net when enough people carry on those public discussions long enough, with sufficient human feeling, to form webs of personal relationships in cyberspace” (xx, emphasis mine). In contrast to the early research on the Internet, which, in
emphasising the limitations of online communication, especially in comparison to face-to-face interaction within offline communities, failed to acknowledge it as a “site of rich cultural interchange” (Hine 14), Rheingold recognises the potential of these technologies in forming committed and sustained connections between people, in an age in which they feel increasingly isolated. This sense of connection is strong within forums dedicated to transgender lives, those focused on men with gynecomastia, and those supporting infertile women. Transgender people or those with gynecomastia may have never talked to anyone in person about their bodily discomfort – they may be ‘closeted,’ frightened, unaware of anyone else with their ‘condition,’ or they may live in an isolated place. Infertile women do not bear a visible bodily ‘stigma’ in the same way, but ‘passing’ as fertile makes it even more difficult to interact with others in relation to, what remains, a taboo subject. So, for all three groups, recognising themselves in others online and hearing their own experiences reflected back has the potential to provide the basis for immediate associations which can lead to important social relationships. Through these web platforms, friendships are made, older generations pass on their wisdom to the young, people celebrate each others achievements in the good times and provide support during the bad; in short, they become sites of community, sometimes even family.

For transgender people, men with gynecomastia, and infertile women, the significance of online communities is related to the dis-embodiment of the virtual. I recognise that the body still functions within online texts (and this is vital to my exploration), but the physical body is absent from this form of communication,
and it is this absence that, to a great extent, allows the formation of these communities. As Stephen Whittle highlights in “The Trans-Cyberian Mail Way,” passing has been considered of primary importance to transgender individuals – while in mainstream social interactions it provides safety, within off-line transgender communities themselves it has been used as a status signifier. Currently there has been some movement away from the importance of passing within transgender communities, but cyberspace still remains the only “safe area where body image and presentation are not amongst the initial aspects of personal judgement” (Whittle 158). From the comments men with gynecomastia make about their bodies, the same is true – they welcome the opportunity to discuss, get information, and tell their stories without being inhibited by the ways in which their physical presentation is being perceived and judged. For infertile bodies, which always initially pass as fertile, the issue is not physical presentation but is still related to bodily shame. In the off-line world, infertility remains a taboo subject clouded with secrecy, and any confession of infertility is a revelation that challenges the presumption of fertility and can be met with disbelief, rejection, embarrassment or any number of other awkward and potentially hurtful reactions. In contrast, an online forum formed around the experience of infertility is grounded on the presumption of infertility and so removes the fear of revealing the infertile body and provides a context within which a socially significant supportive community is formed.
Textual Interactions

While medical discourse is a dominant authority in this historical and cultural moment, it does not exert a sovereign power over the body, rather, “people think and act at the intersections of discourses” (Yanagisako and Delaney 18), and, as I have said, I identify both medical discourse and online community discourse as central to the point of intersection through which trans, gynecomastia and infertile people live. Due to the extent to which people are enmeshed in the technological medium of the Internet, and the potential for the formation of significant social relationships, online discursive sites provide a central frame through which bodies come to matter. In contrast to medical discourse in which the body is largely objectified, online discourse features subjects actively engaged in (re)writing their bodies, though often in negotiation with medical authority. It is through these processes that one can read the (un)naturalisation techniques through which bodies are materialised within online texts.

As well as the general significance of medical discourse and Internet discourse to the constitution of embodiment, there are also specific historical shifts that provide the ground for arguing that these two particular discourses provide a central frame through which the particular bodies under consideration come to matter. According to two genealogies of the transsexual, Henry Rubin’s Self-Made Men: Identity and Embodiment in Transsexual Men and Bernice Hausman’s Changing Sex: Transsexualism, Technology, and the Idea of Gender, the conditions of existence for the transsexual, the transformations that have
made it possible to say ‘I am a transsexual,’ are primarily located within medical discourse. While Hausman does not consider any other sites of discursive force, Rubin also includes shifts in the discourses within the lesbian community, thus emphasising the constitutive power of community discourse. In relation to the gynecomastic body and the infertile body, the conditions of existence likely include similar ruptures in the medical discourse, as well as within the discourse of the emerging online community. While I am not concerned with uncovering these ruptures, this genealogical approach makes it clear that these specific discursive sites, and the relations between them, may be particularly fruitful in exploring these bodily (trans)formations.

While medical discourse may be characterised as objective and online community discourse considered to be subjective, and different parties give weight to one or the other of these characteristics, I consider these discursive contexts on equal terms, giving extra weight to neither of them. Although I have situated my analysis of the medical discourse first in each section, this should not be read as a sign that I regard medical discourse as primary and online discourse as response. Similarly, while I recognise the importance of online support forums, I do not consider subjective discourse to be of greater significance than other discourses in exploring these forms of embodiment. We can argue that we are not determined by other discourses but we can never say we are not a/effectected by them. For Foucault, the inclusion of memoirs in his historical analysis is not because he gives them special consideration as exemplar confessions due to their relation to the subjective. Rather, when he
published memoirs, he included other related documentation, such as press releases, medical reports, and legal discourses, in order to reveal the conflict between these ‘truths’ in existence in the same time and place. In relation to the discourses published with the memoir of Pierre Riviere, Foucault says:

"[a]ll of them speak, or appear to be speaking, of one and the same thing...But in their totality and their variety they form neither a composite work nor an exemplary text, but rather a strange contest, a confrontation, a power relation, a battle among discourses and through discourses" (“Pierre Riviere” n.p.).

Like Foucault, I am interested in the stories we tell of ourselves, the ‘confessions,’ and the ways in which they transform, whether it is those told by individuals or institutions. While Foucault approaches all texts on the same terms, that does not imply that he elides the differences between them; in fact, for Foucault, it is of the utmost importance to register the “material existence” of statements within a discourse, because the time and place in which an utterance was spoken, the characteristics of the speaker, and the medium through which a particular statement was expressed are constitutive of a statement (Archaeology 100-101). I am very much aware of this when reading medical texts alongside online support forums – the distinctness of their materiality is of vital importance in reading them together as texts.

In relation to their distinct materiality, the choice to situate my reading of the medical discourse first in each section has more to do with the bounded nature of the specific areas of medical discourse under consideration, (and, hence, the relative straightforwardness of the analysis), and the openness of online discourse, which almost defies analysis. These characteristics, bounded
versus open, are features both of the context and content of each discourse and this openness is one of the challenges of conducting Internet research. While a particular medical textbook or article is always the same when I return to it, there is no stability within Internet discourse. On an online forum, threads can and do change, through the addition of new responses or editing by a member or moderator, rendering the text distinct at different moments in time. As well as this, the whole system interface can be updated, changing the appearance and function of the entire forum and the website in which it is contained. One of the online forums under consideration in this project went through just such a transformation making much of my early research on this site ineligible. This instability, which makes it hard to 'look back' at the text, is a particular research challenge that must be acknowledged when engaging with online texts. However, it is also what makes Internet discourse such an exciting research site. While medical texts are written by one author or, if there are more, at least offer a relatively singular conception of the body, online forums are texts written by multiple authors all competing over the nature of the body, which makes them very fertile sites for the exploration of materialisation.

Although much of this online (re)writing of the body occurs in negotiation with medical knowledge, and I do, of course, explore this interaction, I do not directly align the medical chapters with the corresponding online chapter because that would limit the exploration of the online discourse to themes that

---

6 This is true but I can no longer claim that I analysed the latest version of the World Professional Association for Transgender Health “Standards of Care” because, during the writing of this thesis, a new version was developed, which was released on September 25, 2011.
emerge as central within the medical domain, giving the latter too much authoritative power. Instead, I engage with each site on its own terms, analysing its own discursive logic in an attempt to make visible the forms of embodiment produced within it, recognising overlaps between each domain but not erasing divergences. The medical narrative is merely one thread, albeit a significant one, stitched into the fabric of the online forums and so I allow space to see where and how other threads from the wider social and historical context are drawn in. Both discursive contexts offer glimpses of the larger picture of the (un)naturalisation of the bodies and bodily practices under consideration and, when read together but not constrained by each other, they provide a clearer view of the ontological story of these bodies.

**The Body in/of the Text**

After reading a wide survey of the material in order to map out each field, I focus on close textual analysis of a few exemplary texts, not necessarily those that are most representative but those that are influential within the field and those that are particularly rich in (un)naturalisation techniques. I now turn to a methodological description of these texts and the specific lines of enquiry directed at them.

**Medical Discourse**

While medical discourse is often discussed as if it were singular and monolithic, its character is, in fact, far more complex – as more and more subspecialties of medicine open up, more and more intricate and often
contradictory figurations of the body emerge, and the body is materialised in relation to these multiple and varied threads. As such, it is important to be very precise in identifying which area of medical discourse I am engaging with in these explorations so I give detailed information on the particular texts and their context in order to situate my reading and emphasise its partiality.

**Chest Surgery**

My analysis in chapter three is based on a body of medical literature, situated in a Western context, concerning FTM chest surgery and gynecomastia surgery. In relation to the former, my exploration starts with general clinical guidelines, primarily the sixth version\(^7\) of the influential Harry Benjamin International Gender Dysphoria Association’s (now the World Professional Association for Transgender Health) “Standards of Care for Gender Identity Disorders” (SOC). These “Standards of Care” describe themselves as the “professional consensus about the psychiatric, psychological, medical and surgical management of gender identity disorders” (Meyer at al 1), and have a weighty presence within this medical field, providing the foundational framework in many contexts, particularly in the United States, Canada, and Western Europe. While individual plastic surgeons performing FTM chest surgery are not bound by these guidelines – according to WPATH, they are simply intended to help professionals “understand the parameters within which they may offer assistance to those with these conditions” (ibid) – it is often the case that physicians are

\(^7\) I can no longer claim that I analysed the latest version of the World Professional Association for Transgender Health “Standards of Care” because, during the writing of this thesis, a new version was developed, which was released on September 25, 2011.
deemed reputable to the extent that they adhere to these standards. For a more detailed general approach that remains consistent with WPATH’s “SOC,” I also examine “Care of the Patient Undergoing Sex Reassignment Surgery,” a collaboration between a Canadian plastic surgeon trained in transgender surgery, Dr. Cameron Bowman, and a community-based health professional, Joshua Goldberg.\(^8\) I recognise the existence of other standards of care,\(^9\) however, none currently have the influence that the WPATH “SOC” have within the field of transsexual health care.

As well as these general perspectives that provide the institutional framework within which FTM chest surgery is performed, I also analyse more technical medical literature. While there is a large body of medical literature detailing the various procedures of subcutaneous mastectomy, there are few articles engaging with this practice in relation to the FTM body (Monstrey et al, “Chest-Wall Contouring” 849). From the small pool of texts, I focus on those written by experienced, well-respected practitioners in the field of transsexual surgery who are at the forefront of determining the parameters of this domain, primarily work by Dr. Stan Monstrey\(^10\) and Dr. J.J. Hage,\(^11\) who Monstrey identifies as the most published specialist in the field of transsexual surgery

\(^8\) This is a very comprehensive manual available for download from the website of the Vancouver Coastal Health’s Transgender Health Project and has been used by practitioners and programs both nationally and internationally.

\(^9\) For instance, the “Health Law Standards of Care for Transsexualism” (1993) from the International Conference on Transgender Law and Employment Policy, Inc., which are based on the principle of harm reduction.


\(^11\) “Chest-Wall Contouring in Female-to-Male Transsexuals: Basic Considerations and Review of the Literature” (Hage and van Kesteren 1995).
(“Surgery: Male-to-Female Patient” 110). Both Hage and Monstrey clearly operate within the parameters of the WPATH “SOC” as Monstrey was the president of WPATH from 2005 to 2007 and they were both on the committee involved in writing the sixth version. I approach the authoritative medical discourse on FTM chest surgery with an historical context, although I do not explore historical shifts in the language and meaning of transsexual surgery in detail. Here, I primarily use the foundational work of Dr. Milton T. Edgerton to provide this background. Edgerton is a plastic surgeon who was one of the founding members in 1963 of what was, as he describes it, “probably the first Gender Identity Clinic in the United States that offered surgery for appropriately selected transsexual patients” (“The Role of Surgery” 2). He was influential in the foundation of the present paradigm of transsexual treatment, in particular in the development of the WPATH “SOC,” and he served as the president of the Harry Benjamin International Gender Dysphoria Association (the precursor to WPATH) from 1983. As well as general foundational texts, I also explore historical pieces focused on the detail of the surgical practice of chest surgery in order to be aware of the contingency of the language found in more recent descriptions of the surgical process.

---

12 “The Surgical Treatment of Transsexual Patients: Limitations and Indications” (Edgerton, Knorr, and Callison, 1970); “The Role of Surgery in the Treatment of Transsexualism” (1984) presented in 1983 as Edgerton’s inaugural address as incoming president of HBIGDA, and followed by the third version of the “SOC” (1981), which were originally drafted in 1979.

13 “Creation of a Male Chest in Female Transsexuals” (Lindsay 1979); “Reduction Mammaplasty in Gender Dysphoria” (Kenney and Edgerton), which appears in both the Abstract Book of the 11th Symposium of HBIGDA in 1989 and as a chapter in Reduction Mammaplasty (1990), an edited collection by Dr. Robert M. Goldwyn, an extremely influential figure in the field of breast surgery.
The medical discourse of FTM chest surgery is grounded in the medical history through which transsexuals became “treatable bodies” (Rubin 61, emphasis mine). According to Henry Rubin, in his genealogy of the FTM subject in “The Logic of Treatment,” the story of the “emergence of female-to-male transsexualism can be told as the medicalisation of inversion and the making available of medical techniques appropriated from both the emerging science of endocrinology and the surgical treatment of war veterans” (34). In relation to the former, this process was formalised through the pathologisation of transgender as the mental disorder of “Transsexualism,” which was introduced in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III, published in 1980 by the American Psychiatric Association, and replaced by “Gender Identity Disorder” in the latest version of the DSM, produced in 1994 (Meyer et al 4). In terms of advancement in medical technology, Rubin identifies the discovery of “paradoxical hormones,” “male” hormones in biologically normal females and vice versa, as the defining moment (42). He argues that these discoveries in the 1930s “created the possibility of sex change treatments” because they shifted the understanding of sexed bodies from a dualistic model in which the male and female body are conceived as mutually exclusive categories to a “hermaphroditic model” in which pathologies are “deviations of degrees” (42-3). In relation to this paradigm, Rubin documents how FTM patients situated themselves as intersexuals, locating the “disorder” in the body rather than the mind in order to secure hormonal and surgical treatment rather than psychological therapy (54).

---

14 Gender identity disorders are also featured in the most recent International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), the classification manual produced by the World Health Organisation in 1992.
However, Rubin acknowledges that the medical establishment did not support this position, and Bernice Hausman details the emergence of the sexological category of transsexual as not intersexual (or homosexual or transvestite), although she argues that one of the central concepts underlying it was produced within intersex research: “gender became a dependable and fixed category in the face of uncertain physiological sex” (63). This understanding set the stage for changing the body on the basis of psychological identity in sex or, as it became codified in the 1950s, ‘gender identity’ (7). In a review of the etiological literature on transsexualism written in 1971, the influential sexologist, John Money, and his colleague, R. Gaskins, conclude that no laboratory diagnostic tests have consistently marked transsexuals as morphologically, hormonally, physically, or chromosomally different and, thus, Money and Gaskins produced the foundational definition of transsexualism as “a disturbance of gender identity” (qtd. in Monstrey et al, “Surgical Therapy” 200). Thus, a transsexual is identified as “a biologically normal person and therefore completely different from an intersexual state” (ibid). This definition, including the demarcation from intersexual and other categories of “inversion,” largely remains in force today.\textsuperscript{15}

This understanding of transsexualism does not necessitate surgical treatment; in fact, there is still controversy about whether psychological or surgical therapy is the more appropriate treatment protocol, a debate that is central to the constitution of the (un)natural body within medical discourse on transsexualism so it will be discussed in detail in chapter three. Hausman argues

\textsuperscript{15} There are inconclusive studies on ‘brain sex’ and genetic origins for transsexualism that are attempts to ground transsexuality in bodily difference, thus appealing to the intersex model.
that advances in surgical techniques and anaesthesiology due to World War II and a subsequent rise in public acceptance of cosmetic surgery contribute to the emergence of the transsexual and its ground in surgical treatment (49-50). Here, she is arguing that it is through the possibility of surgery on “biologically normal” persons that the category of transsexual is constituted. According to Hausman, this possibility was generated within the cosmetic surgery discourse that is based on an “assertion of the natural connection between body and personality, ‘outside’ and ‘inside,’” (53). Sander L. Gilman describes this as “the idea that the external body (with whatever qualities are ascribed to it) reflects the values of the soul” (23). Refracted through “the Enlightenment ideology that each individual could remake him- or herself in the pursuit of happiness” (Gilman 17), surgery was reconceptualised as self-transformation rather than merely bodily change, becoming the means to transform oneself from immorality to morality, ugliness to beauty, and unhappiness to happiness.

While this shift provided the conditions for sex reassignment surgery as we understand it today, the surgical techniques themselves have a far longer history. Rubin identifies the roots of FTM chest surgery “in the medical treatment of “disorderly” female bodies,” referencing mastectomies performed as early as 1669 for large, pendulous breasts that endangered a woman’s health, and later in the twentieth century, for women with a potentially cancerous tumour in the breast (58). However, what Rubin does not recognise is that FTM chest reconstruction is also, to a large extent, grounded in the medical treatment of “disorderly” male bodies. According to Letterman and Schurter in “The Surgical
Correction of Gynecomastia” (1969), the first surgical treatment for large male breasts was performed by Paulus Aegineta (322), the “great Byzantine physician” who practised in the latter half of the seventh century. This is a far longer history than that of breast surgery on female bodies, (although the medical literature on women is larger), and current forms of gynecomastia surgery and FTM chest surgery are grounded in these surgical techniques. In fact, the relations between the sub-specialties within the broader domain of breast surgery involve multiple overlaps and divergences. Historically, FTM chest surgery was seen as a specific case of reduction mammaplasty, as evidenced by the inclusion of Kenney and Edgerton’s chapter in Reduction Mammaplasty in 1990, which has the effect of situating FTM bodies as female. Significantly, a comprehensive consideration of gynecomastia surgery is not included in this edition. Although separated, the medical discourse on gynecomastia surgery, at least historically, also recognises its debt to this field, often borrowing or refining a technique from breast surgery on women. However, as the fields of gynecomastia surgery and FTM chest surgery have become established, surgeons practicing within them have tended to mark them as distinct specialisations. Most references from a more current article on gynecomastia surgery refer solely to the other literature on gynecomastia surgery and, while it is not uncommon for a surgeon to practice both gynecomastia surgery and reduction mammaplasty on women, the medical discourse remains distinct. While the medical discourse on FTM chest surgery references that of gynecomastia surgery, borrowing its surgical techniques but framing them in relation to the “pathology” of transsexualism, as a discursive field
it remains markedly distinct from that of gynecomastia surgery. As such, the text, “Circumareolar Mastectomy in Female-to-Male Transsexuals and Large Gynecomastias: A Personal Approach” (Colic and Colic 2000) is exceptional in its consideration of both sets of patients together and, thus, I include it for analysis.

I now turn to the field of gynecomastia surgery, providing an overview of the context and the specific texts that I base my analysis on. There are no professional guidelines available for the treatment of gynecomastia so the medical literature I examine consists of texts written by specialists in the field from their personal clinical experience. There are generally two approaches to the issue of gynecomastia in the medical literature, those that focus mainly on etiological considerations and those that concentrate on treatment, hormonal or surgical. While I am primarily interested in the discursive representation of gynecomastia surgery, I briefly consider some of the key texts from the former perspective in order to provide a sense of the medical background in which gynecomastia surgery is situated. All except Menville’s much-referenced 1933 text are written by specialists in endocrinology, demonstrating the shift to the “hormonal body” as the primary lens through which bodies have been understood from the 1930s onwards (see the Infertility section for more details about the emergence of this conception).

16 “Gynecomastia” (Menville 1933); Gynaecomastia (Hall 1959), the only book devoted entirely to the issue of gynecomastia; “Gynecomastia as a physical finding in normal men” (Nuttall 1979); and a more recent rendition, “Gynecomastia” (Braunstein 2007).
I include these discussions of etiological considerations of gynecomastia because they highlight the extent to which gynecomastia is “normal,” yet surgical removal always remains a treatment option. In contrast, within the medical discourse on transsexualism, it has never been considered “normal” and treatment is linked to the contested terrain of theories of origin; as such, surgical treatment is never taken for granted. Randi Ettner, in “The Etiology of Transsexualism,” a comprehensive review of past and present hypotheses and controversies, recounts the story of John Hopkins Hospital discontinuing sex-reassignment surgeries in 1979 on the basis of a research study that declared that transsexualism was “…a psychological problem which warrants no more attention than simply letting time heal” (Fleming, Steinem, and Bocknek, 1980, qtd. in Ettner 1). In that moment,

owing to the intricate relationship between treatment and etiology, and the growing controversy, it became pressing to understand the genesis of transsexualism. If it was, as some maintained, a psychiatric disorder, then surgery was not the appropriate treatment. It might even be unlawful (ibid 2).

Thus, while the etiology of gynecomastia is not threatening to the viability of gynecomastia surgery, the same is not true for FTM chest surgery. In light of this history, current proponents of medical treatment for transsexuals, such as Ettner, attempt to separate etiology and treatment:

Human behaviour is exceedingly complex and largely unfathomable; just as the precursors of genius intelligence or other prodigies remain obscured, the etiology of transgenderism remains unknown. The goal of treatment, however, is known and is indisputable: to assist gender-variant patients who request medical interventions by providing state-of-the-art treatment (10).
This separation means that, while causes of gynecomastia may be referred to in the medical literature on gynecomastia surgery, origins of transsexualism are largely absent from discussions of FTM chest surgery. These speculative ideas compete for validation in their own discursive domain, which is held at a distance from the medical discourse concentrating on surgical intervention. In those rare instances in which theories of origin are recognised, it is only in order to maintain the distinction through the assertion of the necessity of surgical modification regardless of etiological understandings, as in “Surgical Therapy in Transsexual Patients: a Multi-Disciplinary Approach” (2001) by Monstrey et al:

As to the therapy of transsexualism, most specialists believe that psychotherapy or trying to adjust the mind to the body is of no use since it has been proven to be almost impossible to successfully convert a transsexual patient back to his or her biologic sex with psychotherapy. The majority of modern behavioural scientists, regardless of their thoughts on the etiology of this disorder, agree that it is better to adjust the body to the mind, which means that in appropriately selected patients gender reassignment has been proven the best way to normalize their lives (200).

Thus, I do not examine the distinct discourse on the causes of transsexualism because the multiple hypotheses included in it are not pertinent to my exploration; what is relevant is the fact that surgical treatment always remains in need of justification and this can be read within the medical literature focusing on surgical modification.

In relation to surgical approaches to gynecomastia, I focus on those texts that have become “classics” in the field of gynecomastia surgery, those that have defined the parameters of the surgical domain. I recognise these specific texts as exerting this level of influence through the extent to which they are cited in the
current literature, both in relation to gynecomastia surgery and FTM chest surgery, and also through the fact that surgical techniques have been named after some of the authors, such as, the “Webster technique” of peri-areolar incision.17 The articles considered represent the advancement in surgical technique from bilateral mastectomy to liposuction from 1946 to 1983. Since the application of liposuction to the treatment of gynecomastia, there has been little significant change in the practice of gynecomastia surgery. More recent articles offer refinement but rarely the introduction of new techniques seen in the historical texts, and the language used to describe the condition and treatment has not undergone the shifts seen in the literature on FTM chest surgery, so I include only one.18 The selected article from 2004 provides a more current rendition of the medical and cultural meanings surrounding gynecomastia, and includes a consideration of “skin-sparing” procedures in contrast to those that remove the skin.

The medical discourse on gynecomastia has a long history. As mentioned above, surgery on male breasts was recorded as early as the seventh century when it was practised by Paulus Aegineta, who justified his surgical practice by declaring, “as this deformity has the reproach of effeminacy, it is proper to operate on it” (qtd. in Letterman and Schurter, “Surgical Correction of Gynecomastia” 322). Apparently, his influence was far-reaching both in his own

17 “Mastectomy for Gynecomastia through a Semicircular Intra-areolar Incision” (Webster 1946); “Transareolar Incision for Gynecomastia” (Pitanguy 1966); “Surgical Correction of Massive Gynecomastia” (Letterman and Schurter 1972); “Classification and Surgical Correction for Gynecomastia” (Simon et al 1973); “Correction of Extreme Gynecomastia” (Wray at al 1974); “Concentric Circle Operation for Massive Gynecomastia to Excise the Redundant Skin” (Davidson 1979); and “Surgery for Gynecomastia” (Teimourian and Perlman 1983).
time, for he travelled extensively in Europe and the Middle East and his knowledge and skills were highly respected, and beyond, as his writing was the basis of the surgical treatise of Albucaasis written in the twelfth century, which became the “standard surgical textbook for the next several hundred years” (ibid). Thus, while the shift in understandings of the relation between body and psyche that underlie the cosmetic surgery discourse (described above in relation to the emergence of sex reassignment surgery) contribute to the current prevalence of gynecomastia surgery, the surgical process itself dates back to the seventh century. This story, and the fact that it is retold over and over again in the medical discourse on gynecomastia surgery, is an attempt to establish legitimacy through historical origin. According to Gilman, “[w]ithin surgery, aesthetic surgery may well be unique in its concern for its own history,” which can be read as an “attempt to provide a “serious” medical context for aesthetic procedures” (15). However, aesthetic surgery dates from the late nineteenth century while this historical story marks the origin of gynecomastia surgery far earlier; thus, the story of Paulus Aegineta can also be read as a strategy to distance gynecomastia surgery from the field of aesthetic surgery in which it is currently situated. As well as the claim of historical precedence, this is also achieved through the appeal to transhistorical ideas of the “normal” sexed body. Quoting Paulus Aegineta and his association of gynecomastia with “the reproach of effeminacy,” Webster argues that the fact “[t]hat this deformity causes acute psychic trauma has been recognised for centuries” (561). This has the effect of asserting the “abnormality” of the breasted male body as a transhistorical fact
rather than a culturally informed idea. Although the field of gynecomastia surgery remains under the umbrella of aesthetic surgery, this strategy marks gynecomastia surgery as distinct from aesthetic surgery, which is always under attack for its apparent ground in present conceptions of beauty and normality.

Clearly there is a significant structural difference between the medical discourse surrounding FTM chest surgery and gynecomastia surgery. Discussions of FTM chest surgery are situated within a framework guided by professional standards, while the medical discourse concerning gynecomastia surgery is not situated within such a disciplinary framework. Despite the fact that surgical practices designed to reduce the size of male breasts historically precede FTM chest surgery, there is no professional association “devoted to the understanding and treatment of” gynecomastia and no consensus on standards of care. The non-existence of professional guidelines specific to gynecomastia surgery can be attributed to the fact that it is presumed to be unnecessary to define the “parameters within which [medical professionals] may offer assistance” as assistance in the form of gynecomastia surgery is readily offered with few, if any, conditions – the American Society for Aesthetic Plastic Surgery states that “men of any age who are healthy and emotionally stable are considered good candidates for male breast reduction surgery” (“Male Breast Reduction” n.p.). Clearly, desire for the surgery is not taken to be a sign of emotional or mental instability as in the case of FTM chest surgery, where it is this assumption that necessitates the presence of a professional organisation concerned with defining the parameters through which to determine the nature of mental instability and
whether surgery is the appropriate treatment. I have taken the time to consider some of the more pertinent distinctions between the “material existence” of statements made within the medical discourse surrounding FTM chest surgery and gynecomastia surgery because these structural differences are central to my interrogation (Foucault, *Archaeology* 100). They are both a consequence of the ontological presuppositions at work in each field and a reinforcement of those assumptions, thereby becoming naturalisation techniques in themselves.

In reading the medical literature, I paid specific attention to the ways in which the terms ‘natural’ and ‘normal’ were used, as well as synonyms, such as, in relation to normal, ‘typical,’ ‘common,’ ‘appropriate,’ and antonyms, such as ‘abnormal,’ ‘atypical,’ ‘unusual.’ I was also as aware as I could be of the silences, because what is taken for granted, what is, in other words, most natural or most normal, is often what goes unsaid. The comparative approach toward the medical discourse of FTM chest surgery and gynecomastia surgery was particularly effective in revealing the silences in each discursive network because what was absent in one became loud and clear when placed in proximity to its presence in the other. Through this process, I was interested in examining figurations and assumptions of the “natural” male and female body and the “normal” male and female body within the medical realm, as well as where and how they become aligned. As well as looking for explicit articulations of the “natural” and “normal” body, I was watchful for specific themes that intersect with these notions and thereby operate as naturalisation techniques within the medical discourse. Further to reading each set of medical literature in relation to
each other in order to map the operation of these central tropes, I paid some
attention to historical shifts in language and what these implied about the
changing nature of the “natural” body even within the same field. I was also
interested in how and where FTM chest surgery and gynecomastia surgery are
situated in explicit relation to each other because these rare connections
highlight the extent of the distancing generally found between these surgeries
and the bodies undergoing them.

**Infertility**

In chapter five, I analyse specific texts within the medical discourse
surrounding infertility. This discursive field is vast and highly technical; in fact, the
amount of medical knowledge produced on infertility speaks to the anxiety that
infertility produces – there is clearly a lot of medical interest in explaining,
diagnosing, and ‘correcting’ infertility. As such, representations of the condition of
infertility are multiple; there are many causes and various treatment options,
although it is revealing from the very outset that some form of treatment aimed at
pregnancy is always assumed. In order to focus my analysis, I limit my
exploration to those medical texts that provide the framework for the clinical
practice of infertility treatment. I surveyed the top five medical schools in Canada
according to the Maclean’s 2009 university rankings (Dwyer) to identify those
books recommended to postdoctoral medical students focusing on infertility, an
area which is subsumed under the general specialty of Reproductive
Endocrinology and Infertility (REI). Within the small pool of resources, two books
came up consistently: *Clinical Gynecologic Endocrinology and Infertility* by Leon
Speroff and Marc A. Fritz, (the seventh edition as it is the last written by Speroff, an influential figure within the field), and Yen and Jaffe’s Reproductive Endocrinology: Physiology, Pathophysiology, and Clinical Management edited by Jerome F. Strauss and Robert L. Barbieri, (the sixth edition as it is the most recent). Both these textbooks were first published in the 1970s and have gone through multiple editions, demonstrating their early and continued influence within the medical field defining the condition of infertility. Speroff’s is described as “the most widely read subspecialty book in the world” (Fritz 2008), while Yen and Jaffe’s is referred to as a “classic text” (Jenkins). For those who complete the transition from student to physician, these textbooks become the reference resources of choice. Although they do not provide the most up-to-date or the most technically complex conceptualisation of infertility, which would be found in current journal articles, these two volumes provide the foundation for medical training within this field and influence the parameters of clinical practice, the interface between medical knowledge and the patient. Thus, I primarily focus my analysis on these two texts, occasionally citing other texts within the field to further elucidate my argument.

I mentioned above that infertility is located within the biomedical field of reproductive endocrinology, which clearly has implications for understandings of (in)fertility and provides the context for the medical discourse on infertility. Endocrinology is the study of hormones, internal secretions that are thought to act as “chemical messengers” within the body and, in particular, are ascribed a

---

19 Henceforth, I refer to them as Speroff’s and Yen and Jaffe’s respectively because they are commonly abbreviated to these monikers.
fundamental role in sexual differentiation (Starling, qtd. in Oudshoorn 16). Currently, we take these concepts for granted to the extent that the terms testosterone and estrogen are commonly and unquestionably used as explanations for sexual behaviour; however, this has not always been the case. In *Beyond the Natural Body: An Archeology of Sex Hormones*, Nelly Oudshoorn discusses the birth of the “hormonal body,” describing the processes through which the theoretical concepts of sex hormones became material realities through the 1920s and 1930s (138, 13). According to Oudshoorn, the discipline of sex endocrinology emerged within a scientific tradition beginning in the eighteenth century concerned with the attempt to “localize the ‘essence’ of femininity in different places in the body” in the urgent establishment of sexual difference where previously there had been an emphasis on bodily similarities between male and female (8, 7). First, attention was focused on the uterus and later the ovaries; however, with the emergence of sex endocrinology, it became sex hormones that were identified as “agents of masculinity and femininity” (ibid 20). This shift reconceptualised the relation of sex and the body by locating the female “essence” not in an organ but in chemical substances that circulate throughout the body making the hormonal body a “body deeply inscribed with difference” (Oudshoorn 8, 145; Birke 42). Within this model, “the female body became increasingly defined as a reproductive entity,” primarily due to the fact that endocrinology provided the concepts and tools for the investigation and intervention in “female reproductive functions to an extent that was not possible before” (Oudshoorn 147).
Yen and Jaffe’s is firmly grounded in the idea of the hormonal body. The first chapter is dedicated to the “Neuroendocrinology of Reproduction” and, while this is in part due to the fact that Samuel Yen was a reproductive neuroendocrinologist, the chapter’s focus also provides the framework for the entire edited collection (3). The first section starts by situating the origins of endocrinology in an experiment conducted by A.A. Berthold in 1849 in which, through the castration and transplantation of testes, he demonstrated the role of “blood-borne substances” released from the testes in maintaining the secondary sex characteristics and behaviour of roosters. The invocation of this historical story at the outset of the book places Yen and Jaffe’s firmly within the scientific tradition that Oudshoorn chronicles and its paradigm of essential sexual differentiation.

Speroff’s also relies heavily on the hormonal model but the foundation of the book’s approach is that of molecular biology, the science of the gene. Instead of a story about the origin of endocrinology, the first chapter starts with the historical figure of Gregor Mendel who studied the laws of heredity within his garden of peas in the 1860s (3). According to Speroff and Fritz,

“[w]e have entered the age of molecular biology. It won’t be long before endocrine problems will be explained, diagnosed, and treated at the molecular level. Soon the traditional hormone assays will be a medical practice of the past. The power of molecular biology will touch us all…” (3)

Oudshoorn describes how the sciences of genetics and endocrinology demarcated their disciplinary boundaries in the early twentieth century by dividing the process of sexual development into "sex determination regulated by genetic
factors, and sexual differentiation influenced by hormonal factors” (22). However, Speroff and Fritz appear to be defining genetics, not as complementing endocrinology but, rather, as superseding it as the latest invocation in the quest for the essence of sexual differentiation. Within this paradigm, a “gene for maleness” has been identified (Birke 37), SRY, which is described in Speroff’s as “almost certainly the true sex-determining region” on the Y chromosome (322). This appears to mark a shift in the search for essential sexual difference to a focus on the male body, (or perhaps the female body remains hormonal while the male body becomes genetic). While each textbook may have a different emphasis, both are ultimately grounded in a paradigm of sexual differentiation.

Medical discourse is particularly significant in the exploration of infertility because it is changes in medical technology that have provided the conditions of possibility for infertility. Sandelowski and de Lacey highlight these conditions in their genealogical investigation of ‘infertility,’ in which they describe the shift from the notions of barrenness, attributed to a curse from God, and sterility, understood as an immutable biological condition, to the concept of infertility, which “connotes a medically and socially liminal state in which affected persons hover between reproductive incapacity and capacity: that is ‘not yet pregnant’ (Greil, 1991) but ever hopeful of achieving pregnancy” (35). Within this understanding, new assisted reproductive technologies (ARTs) are not a response to infertility as often thought; rather, infertility, with its association with the possibility of pregnancy, only becomes imaginable as a consequence of the potential of these technologies to overcome reproductive obstacles (ibid 35).
In reading the medical literature, I investigate the discursive framing of the infertile body as unable, (or not yet able), to complete the ‘natural reproductive destiny’ of the female body. I examine the ways in which infertility is figured as unnatural in opposition to the ‘natural’ and ‘normal’ fertile pregnant body, as well as the ways in which this opposition is undermined so that it is never an insurmountable barrier. The liminality referred to above, the representation of infertility as a state between “reproductive incapacity and capacity,” which translates as a body sexed as not-female but always containing the possibility of achieving femaleness, plays a significant part in both the maintenance and undermining of this barrier, and I will identify the techniques through which liminality is realised. Throughout this exploration of figurations of infertility, I also pay attention to the absences, the bodies that are excluded from the infertility discourse, in order to identify the ways in which these silences are part of the construction of the “natural” female body as heterosexually reproductive. Infertility is multiple – there are those who cannot be “naturally” fertile but are seeking to be so, those who may be “naturally” fertile but are employing “unnatural” methods of reproduction, those who choose not to be pregnant, and various other configurations – but the infertility discourse reduces this variation to the singular, those that seek to appear (and, by association, to be) “naturally” fertile. This foreclosing of other bodies and reproductive options, even from within the “unnatural,” has the effect of circumscribing the “natural” fertile female body more tightly.
Online Discourse

Research Sites

Within chapter four, I conduct a comparative analysis of the online discourse of two communities, one supporting FTMs and the other focused on men with gynecomastia. In chapter six, I examine the discourse of an online community for women with infertility. While I separate my analysis in later chapters, I bring the three online groups together for this methodological description because the consideration of their structural similarities and differences more readily reveals the nature of these online texts. While all of these web forums contain a large number of comments from a variety of participants, providing a multiplicity of perspectives, it must be recognised that the Internet is far from being the ideal paradigm of communication – it is circumscribed to the extent that access to computers is structured by power configurations, such as race, class, and disability, as well as the fact that these relations operate within cyberspace itself, although in different forms.

There are a vast number of FTM online groups, many more than those dedicated to the issue of gynecomastia, covering a variety of topics ranging from fitness to family, so in order to circumscribe my exploration of the online discourse of these communities, I concentrate on one of the most established general support groups. There are groups that focus on FTM chest surgery but I found these were often solely concerned with the practical details of the surgical process, and I am far more interested in the ways in which bodies are (trans)formed through the stories told in relation to transgender transition. After
surveying a few of the main online peer support forums, I decided to focus primarily on *FTM Forum*\(^{20}\) because it has more members than these other groups and, more significantly, it has more traffic, which signals an engaged and interactive membership. It also has a more open membership call than many trans forums:

> ftpm is a forum for all self-identified female-to-male individuals or FTM-questioning individuals, as well as our friends, partners and supporters. In the context of this community, FTM is a blanket term referring to anyone who was assigned female at birth and feels that that is an incorrect or incomplete description of their gender. There is no identity policing here – if you self-identify as an FTM or as a friend or ally, then you are welcome here.\(^{21}\)

This broad definition of FTM allows for multiple embodiments, identities and perspectives to be represented within this space and, as such, much debate is occupied with the negotiation of this multiplicity in relation to conceptions of “FTM” or “trans,” which makes it a rich site for the investigation of the meaning of FTM embodiment and, in particular, its relation to the “natural.” For my exploration on gynecomastia surgery, I analyse the discourse on the discussion boards of *gynecomastia.org*,\(^{22}\) the largest online resource for information about gynecomastia. In contrast to the proliferation of transgender presence on the Internet, gynecomastia has a much more centralised existence online, with *gynecomastia.org* being the most significant hub of peer support – this is captured in the extent to which journeys through cyberspace directed towards

---

\(^{20}\) [http://ftm.livejournal.com](http://ftm.livejournal.com)


\(^{22}\) [http://www.gynecomastia.org](http://www.gynecomastia.org)
gynecomastia lead back to it, as well as in the large number of members it boasts, almost 13,500, in comparison to only 2775 on FTM Forum.²³

There are a large variety of communities for women with infertility on the Internet, from those found on dedicated infertility websites to those situated within the framework of larger parenting websites covering a broad range of subjects related to conceiving, pregnancy, and parenting. I engage with the infertility discussions found within one of those broader parenting sites, *MotheringDotCommunity,*²⁴ because I am interested in the interactions between the infertility and fertility, as well as the transition from infertility to pregnancy.

Started in 1999, and now with over 150,000 members, *MotheringDotCommunity* (*MDC*) is one of the largest and most active parenting and pregnancy discussion boards on the Internet, according to *Big-Boards*, an online resource that “tracks the most active message boards and forums on the web” (“Parenting Forums”). It is based primarily on a white, heterosexual, able-bodied, middle-class perspective, but with multiple close-knit, small communities within it that offer support to a diverse range of embodiments and identities. Although it is hard to say how many of the 150,000 members are involved specifically with the infertility forums, these forums are often the most active, indicating an engaged community. As *MDC* is such a huge discussion board with multiple forums and sub-forums, where applicable, I will primarily focus on describing the ways in which those dedicated to infertility operate.

²³ The nature of online groups changes over time so these figures reflect the membership as of July 3, 2010.
²⁴ [http://www.mothering.com/community](http://www.mothering.com/community)
More significant than the size in this exploration is the site’s explicit and unabashed commitment to the notion of the natural in relation to family and parenting. The old name of the message board, MotheringDotCommune, more directly associates this parenting perspective with the philosophy of life commonly called “hippy” or, more recently, “crunchy.” According to their “User Agreement,” they will not tolerate discussions of topics implied to be unnatural, such as “crying it out, harsh sleep training, physical punishment, formula feeding, elective cesarean section, routine infant medical circumcision, or mandatory vaccinations.”

Although infertility treatment is not included in the list, discussions of infertility sit somewhat uncomfortably within the assertion of the “natural;” not only is infertility itself experienced as unnatural, the medical treatment of infertility, undertaken by many women on the infertility forums of MDC, is a technological engagement associated with the unnatural, evident in the fact that it is situated in opposition to “natural conception.” Members themselves recognise the incongruity of infertility treatment and the philosophy of MDC, as can be seen in this discussion started by Milk8Shake detailing her infertility medication:

Milk8shaker: I’m talking about: high dose folic acid, baby aspirin, progesterone, heparin injections and broad spectrum antibiotics. And probably bed rest.

Unless you’re looking for a fight, don’t tell me how MDC unfriendly that regiment is.

*SimplyRochelle:* I'm pretty sure most of us would throw all things crunchy under the next speeding train if it meant we got a sweet baby out of it.

*Tear78:* And yeah, um, I second Rochelle's comment. Crunchy-smunchy, we want healthy babies! I should show you the list of medications I need to order. S-C-A-R-Y and definitely not crunchy.  

These tensions – the “unnatural” situated within the “natural,” as well as discussions of infertility in close proximity to those of fertility – make *MDC* a particularly rich research site for the exploration of the naturalisation of the fertile female body.

In all the proclamations of what communications technology can or cannot do for us, the use of the term ‘technology’ (or ‘cyberspace’ or whatever general term is applied) includes a capitalisation that is rarely acknowledged. In these accounts, Technology is represented as a monolithic object and there is little recognition of the multiple differences between the myriad of online sites and technologies. When conducting research on online discourse, it is important to remain grounded in the specific, or to use a familiar ethnographic place-marker, the local, nature of the site under consideration, not as a factor separate to the content but as part of the content itself. Although readers are likely familiar with online forums, there are structural differences between them that are significant in this form of textual analysis. As a model for outlining the configurations of *FTM Forum, gynecomastia.org, and MotheringDotCommunity,* I draw from Baym’s

---

detailed description of an online community, in which she identifies five factors that interact to contribute to the unpredictable emergence of particular computer-mediated communication (CMC) patterns: “the external contexts in which the use of CMC is set, the temporal structure of the group, the infrastructure of the computer system, the purposes for which CMC is used, and the characteristics of the group and its members” (39). However, for this form of textual analysis, I find the first two factors she defines to be of primary importance and so here I provide details of the context of the online texts under consideration and their temporal structure, which dictates how I analyse them.

There are multiple layers of external contexts that impact any online social congregation, including amongst others, the national cultures from which members originate, political allegiances, offline communities, and the broader online context within which these forums are situated. According to Baym, “[r]ather than disappearing when one logs on, the preexisting speech communities in which interactants operate provide social understandings and practices through and against which interaction in the new computer-mediated context develops” (40). Within FTM Forum, gynecomastia.org, and MDC, most members are geographically situated in North America (primarily USA), thus, all forums, as well as sharing the common language from the dominant cultural context, English, are also informed by the same American cultural consciousness, from which members draw “common ways of speaking, and a good deal of shared understandings” (ibid). This foundation is significant for (online) communities because of the extent to which community can be formed
through the (re)telling of similar stories requiring no further explanation because they reference shared cultural objects, such as, on gynecomastia.org, the high school memory of suffering through “skins vs. shirts” sports games.

Within MDC, as well as the broad understanding of health care within an American context, specific interactions with infertility clinics provide shared experiences and language in relation to infertility treatment, for example, the use of acronyms, such as “IVF” for “in vitro fertilisation” and “IUI” for “intra-uterine insemination.” Alongwith these acronyms that originate within the medical establishment, there are also multiple others that have emerged within the broader online infertility community, to the extent that MDC contains a large glossary to orient new members who may not be accustomed to the online language of infertility. This includes a range of terms, from the basic, such as “TTC” for “trying to conceive,” to the more specific, such as “ewcm” for “egg white cervical mucous,” the cervical mucous associated with ovulation. Without some fluency in this language, the discussions on the infertility forums of MDC are incomprehensible.

While the American cultural context provides a general ground for all forums, interaction within FTM Forum also draws on “shared understandings” from subcultural frameworks, such as feminist, queer, and other transgender communities, either off- or on-line. This allows, for example, the use of abbreviations that have emerged within the wider context of transgender communities, such as T for “injectable testosterone” and DI for “double incision.” More significantly, these backgrounds provide for a community grounded in a
specific political awareness of discrimination that recognises the systemic nature of this issue as opposed to individualising it, as occurs on gynecomastia.org.

While this political consciousness is not totalising – there are various factions within the community of FTM Forum – it does, in general, provide for a critical perspective on the broader American cultural context within which this community is situated.

Beyond the offline cultural context, there are further layers of online external context that impact these texts. The wider context of the Internet is the “overwhelmingly American, generally well-educated, predominantly white, economically comfortable substrata of the population with access to and knowledge of computers who dominate the Internet” (Baym 40). Thus, the diversity of members found in any particular online site is already circumscribed to some extent by this factor. In relation to the inner circle of online influence, FTM Forum, gynecomastia.org, and MDC are situated in very different online domains, which affects the nature of the groups. FTM Forum is a “LiveJournal Community,” so it is situated within the online space of LiveJournal, which describes itself as “a vibrant global social media platform where users share common passions and interests,” and boasts 28.8 million individual and community journals and over 156 thousand posts in the last 24 hours. In contrast, gynecomastia.org is a discussion board found within a website dedicated to providing information about gynecomastia managed by Merle James Yost, a psychotherapist and author who had gynecomastia and the

surgery to address it.\textsuperscript{28} The website began as a section on Yost’s professional website but generated so much traffic that he started a new site devoted solely to the issue of gynecomastia.\textsuperscript{29} While visitors to the website are encouraged to drop by the discussion boards to “get in contact with other men with gynecomastia,” Yost continues to promote his own practice through the site by advertising his book, \textit{Demystifying Gynecomastia: Men with Breasts}, and inviting input on the research design of his continuing project on the psychological impacts of gynecomastia. As well as the research angle, the other significant factor structuring the site is the sale of surgery. The command, “Find a Surgeon,” is prominent in three frames of the site and, upon clicking any of these links, the visitor discovers that the website is financially supported by the surgeons listed on this web page. Some surgeons are also frequent contributors to the discussions, and, although they do provide information and support, they also use the forum as a marketing platform through which to sell themselves as the embodiment of the “surgical solution.” While it could be said that both \textit{gynecomastia.org} and \textit{FTM Forum} are situated within a space of support and profit because users of \textit{LiveJournal} are encouraged to support the site through paid accounts, and advertisements appear on the \textit{LiveJournal} home page, the profit motive does not explicitly target members of \textit{FTM Forum}, so the community itself remains sheltered from these commercial forces as a haven of support.

\textsuperscript{28} Since completing my research, the site has been passed onto a plastic surgeon, Dr. Miguel Delgado, who now acts as the administrator, so the context of the forums has shifted away from Yost’s research and support mandate to more explicit surgical promotion.

\textsuperscript{29} “Gynecomastia,” \textit{Merle James Yost, LMFT ~ psychotherapist and author}, July 4, 2010, \textltt{http://www.myost.com/gyne.html}. Information no longer found here because of change discussed in Footnote 28.
The tension between support and profit is far stronger on MDC because it is situated within the business website for Mothering, a print magazine founded in 1976 that describes itself as “the birthplace of the natural family living community.” This business has gone through a significant change while I have been conducting my research for this project, one that reconfigures the context of MDC substantially. Until very recently, the business was dedicated to the magazine, Mothering, which is edited and owned by Peggy O’Mara who has gained international celebrity as an author and speaker on “natural family living,” and through the mouthpiece of the magazine, has contributed significantly to making the principles of “natural family living” part of the mainstream, becoming a hugely influential figure in the parenting industry in the process. The website began as the customer service hub for subscribers to the magazine and only later became the site of the discussion forums. Over the last few years, the website has become a more engaged and full online presence of the magazine offering a variety of features and resources, including news, articles, recipes, blog posts, and reviews, but still remained marginal to the “mother ship” of the magazine, utilising less than 30% of staff resources. However, it is clear that readers are currently far more engaged with the online context of Mothering. As Peggy O’Mara says:

Our online community is more than 15 times larger than our print or digital community. Mothering magazine currently has a bimonthly circulation of 100,000—but Mothering.com receives 1.5 million unique visitors a month, and is ranked by Quantcast [web analytics

---

service] as one of the top 2100 sites online. This means that while we a niche print publication, we are a major Web presence (ibid).

As such, *Mothering* made the decision in January 2011 to cease publication of the print magazine and become solely a web-based company. Thus, the website has shifted from being marginal to the company to being central, and now exists as its only source of revenue. This has meant that the website and, in particular, the community discussion board, which is the most active area of the online space, has increasingly become the site of advertising to the extent that there is a tension between offering information and support and promoting profit, a tension that is so intense that it has put the board in crisis.

Over the years, there have been a number of changes to the interface that reflect the profit motive and undermine the provision of support. Two, in particular, have impacted the sense of community on *MDC*: the inclusion of advertisements and the prohibition of links to blogs in member’s signatures. Before the recent upgrade, advertisements were very invasive, even appearing within the threads themselves in the content of member’s posts, but they disappeared after logging in as a member. Since the upgrade, the advertisements are perhaps less obtrusive, situated in a banner at the top and to the right of the screen, but they no longer disappear upon logging in. Now, members have to pay for that privilege by becoming a Mothering Supporter for $30 a year. There is also the issue of what kind of company is able to advertise as the advertising rates were increased in 2005 and are now felt to be prohibitive
to small, family businesses. In relation to blog links, members again have to pay, this time, $80 a year, for a feature that was previously freely available, and was experienced as an important community builder.

These changes are situated within a general shift toward censorship and suppression of dissent on MDC by living laughing learning in a blog she started in June 2009 called Mothers dot Censored. In one of only two posts on the blog, entitled "Mainstreamization of Mothering," she writes:

When threads get moved around by moderators because we are seemingly unable to decide for ourselves whether our topic fits in Nutrition and Healthy Eating or in Health, I simply chuckle.

When the advertisements started to litter the interface, I was understanding—everyone needs to make money. In the tough economic times, MDC needs to support itself.

When my name and address were sold to a natural toys catalogue, I forgave.

When we were not allowed to simply gossip about celebrities, I rolled my eyes.

When the Politics and Current Events forum closed because we debated too much, I cringed.

When the Talk Amongst Ourselves forum got so over-moderated, I sighed and stopped posting there. Where is the fun in chatting when it takes 24 hours for a post to get approved? You tell me!

But when we are no longer allowed to have links to our own blogs in our signatures—our loss blogs, our homeschooling blogs, our craft blogs, our simply "life and sh#t" blogs— I move out.

No matter how heart breaking this decision is, I can’t support the incessant censorship and the dictatorship of Mothering. Enough is

---

enough. We strive to raise our children in a consensual way, with
dignity and respect, and yet we are treated as mindless children
ourselves. We aren’t allowed to debate, we aren’t allowed to
exercise simple decision making, we aren’t even allowed to gossip,
and now we’re required to hide our blogs, our stories about our
passions, in our profiles!

Good Bye, MDC. I’m sad, but I’m also empowered to no longer be
a part of the mainstreamization of Mothering.

*PaigeC* goes so far as to call *Mothering* “draconian and fascist” in her personal
blog when administrators delete a thread in which “community members were
voicing concern over the new signature guidelines.” The control even extends
beyond MDC, as *one smarmy mama* reveals in a post about “Mothering
Magazine and MDC” on her personal blog:

> I have had Cynthia Mosher [administrator] and IrishMommy
> [moderator] both use things I have posted on OTHER SITES as
> reasons to give me "administrative warnings" and I'm not the only
> one who that has happened to. Ask around. They watch, and they
> store it. If you speak out against MDC elsewhere, they do whatever
> they can to punish you ON MDC.

In support of her claim, she was subsequently banned from *MDC*. While these
ex-members clearly feel that discussion is restricted on *MDC*, often in the service
of profit, and that this control undermines their sense of community, others
accept this form of restriction as a necessary part of maintaining the boundaries
of this community.

---

taveled to parenthood*, Apr. 18, 2011, [http://www.babydustdiaries.com/2009/06/an-open-
letter-to-motheringdotcommunity]

Moderation is used to uphold the rules that define what can and cannot be said within the online space, and, as is clear from this discussion, it is rigid within *MDC*. Moderation involves moving inappropriately placed threads or deleting entire threads or individual posts that violate the User Agreement, which includes the following guidelines:

We host discussion of nighttime parenting, loving discipline, gentle weaning, natural birth, homebirth, successful breastfeeding, alternative and complementary home remedies, informed consent and many other topics from a natural point of view. We are not interested, however, in hosting discussions on the merits of crying it out, harsh sleep training, physical punishment, formula feeding, elective cesarean section, routine infant medical circumcision, or mandatory vaccinations...We will not host discussions that involve explicit sexual references and are cautious about discussions on volatile topics such as abortion, religion and race. We do not host abortion debate.35

Users who continue to act outside the bounds of the community norms can be suspended or banned from the forum entirely. In fact, there is an elaborate points system to determine when and if those extreme measures will be taken:

Alerts are issued by a moderator. Warnings are issued by an administrator. Each moderator alert equals one point. An administrative warning will equal three points. Warnings will be issued at the discretion of the administrators. If a member reaches 9 points, the software will automatically suspend the account for a period of 30 days. After a suspension, if a member receives an additional 9 points, the membership will be removed. Suspension may be from a specific forum or all of MDC (ibid).

While it is common for online discussion boards to have community guidelines, and both *FTM Forum* and *gynecomastia.org* have their own version, these proscriptions go far beyond the usual request for respectful dialogue. They are

---

fundamentally autocratic rather than community-based and are not open to
discussion:

Please do not post on the board to debate, criticize, argue or
challenge the MDC User Agreement, the moderators,
administrators, or their actions (ibid).

The appropriate space for debate and criticism, the Questions and Suggestions
forum, is the only forum on MDC within which moderation occurs before posting,
so concerns about the board are subject to the most control. As well as this,
advertising, which is the source of much criticism within the space, is subject to
contracts that disallow “public discussion.”36 Thus, discussion on MDC is very
closely monitored and tightly circumscribed,37 all in the name of the “natural” and
grounded in the profit currently associated with that attribution. I have detailed
this at such length because this circumscription is the context within which the
online text of MDC is produced.

Reading the Body in Online Texts

Before immersing myself in these communities, I had imagined that I
would use search terms, such as “natural,” “normal,” “male,” and “female,” to
focus in on the naturalisation techniques found within these texts; it seemed
especially fortuitous that online sites are generally well suited for this kind of
approach with their advanced search features. However, after trying this method

37 Since writing this, MDC has, according to Cynthia Mosher, the Web Director, committed to
“trying to give members more space and opportunity to work things out between themselves
and those in the discussions to encourage one another to do that” (“Where are the
moderators?” April 28, 2011, Questions and Suggestions, MotheringDotCommunity, May 27,
2011, <http://www.mothering.com/community/forum/thread/1310640/where-are-the-
moderators>)}
briefly, I realised that approaching a text through search terms is hugely problematic, primarily because it isolates fragments out of context giving no sense of how a particular comment fits in with the text as a whole, which disallows an exposition of the internal logic of a discourse as revealed within the text. Further, naturalisation techniques are specific to a discourse – although there may be overlaps, it cannot be presupposed and should itself be open to investigation – so, for instance, the constitution of the natural male body within gynecomastia.org occurs through particular operations, which may or may not explicitly refer to the concepts of “natural” or “male.” As such, I learned that reading the production of bodies within a text must not be approached through the lens of search terms, which by necessity rely on concepts from beyond this specific discursive location.

In order to determine the internal discursive logic of these online texts, I attempt to engage with them on their own terms, which means that I make different methodological decisions in relation to each one. These choices are directly related to the temporal structure of each forum so I will spend some time detailing this factor. All three forums are asynchronous forms of communication, so, rather than users being online simultaneously, they can read and respond to posts at different times; 38 however, beyond this similarity, other temporal factors are different and methodologically significant. Due to the nature of LiveJournal, threads on FTM Forum are organised chronologically by the date of the original post so a thread is generally responded to quickly and only remains ‘alive’ for a

---

38 gynecomastia.org does also feature a synchronous chat space, “The Lounge,” but it is rarely used.
few days before it is superseded by other topics. In contrast, it is not uncommon for conversations on gynecomastia.org to be a few months or even more than a year long. This is due to the fact that threads on gynecomastia.org are first organised by general topic and then within each forum by date of most recent response so members can unearth an old thread and bring it back to the top of the pile simply by adding a new post. gynecomastia.org also features an advanced search feature that aids in re-igniting material from the archives and allows threads that particularly resonate within the community to keep re-surfacing over and over again, such as “What is your worst gynecomastia memory :’(,” a conversation started on September 4, 2008 and most recently continued on July 2, 2010.

The chronological order of FTM Forum and the high level of engagement from its members combine to form a series of lively, but more importantly, finished conversations. As such, reading a fragment in time is a good way to discern the discursive practices of the community – what can be said and how, or more specifically, what objects are created and maintained, and through what techniques, as well as what ideas inform the process. Due to the extent to which the members of FTM Forum draw from current cultural references, I chose, not to focus on the most prolific time in the community’s history, but the most recent, so my analysis in chapter four is primarily based on reading every post in the month of May 2010 (as well as older threads linked from within this time period). I also scanned through 3 months (February – April) of those threads “tagged” as “surgery-top surgery,” reading those whose titles suggested they were relevant.
based on my experience with these subject matters. However, as mentioned above in relation to online forums devoted exclusively to FTM surgery, these discussions are primarily restricted to more practical elements of surgical modification and I am more interested in the broader issues of bodily (trans)formation in relation to chest surgery.

This reading practice does not make sense when translated to gynecomastia.org, where threads are not fixed in time and repetition is very common. As such, I approached gynecomastia.org with the flexibility needed to engage with it as the constantly changing text it is. I concentrated on three boards, the two most frequently visited, “Gynecomastia Talk” and “User Photos,” and “Your Stories,” the board in which members share their experiences of living with gynecomastia and undergoing chest surgery. For the same reasons as above, I chose not to explore those boards explicitly focused on the details of the surgical practice. I also decided not to include the “Gynecomastia Acceptance” section because members interacting within these boards are not planning on undergoing surgical modification but are engaged in other forms of bodily (trans)formation, such as the practice of wearing a bra and/or techniques of breast enlargement. Through the different concerns discussed, it becomes a sub-community that is, to a great extent, defined in opposition to the dominant community of gynecomastia.org. As such, I explore the interaction between the two ‘sides' because these heated discussions provide a significant frame through which the border around the "natural" male body is drawn but do not engage with the acceptance discourse beyond that. Within the three boards under
consideration, I focused on the topics that resonated within the community, those threads that received approximately 10 or more responses. I generally limited my exploration to 6 months, from January to June 2010, but kept that parameter loose because conversations previously contained in that time frame may be moved to the front of the pile by the addition of a more recent post. As I scanned the boards for the most popular threads, I also remained aware of the repetition of issues of concern represented in the thread titles, as well as those posts that received no response. Generally on gynecomastia.org, members can count on a reply from at least the most frequent posters so a lack of response signals as much about the community’s discursive practice as the reiterations contained within the most popular threads. My analysis of both FTM Forum and gynecomastia.org focuses on two or three threads that are rich sites for reading the constitution of body and community.

In approaching the text of MDC for the purpose of exploring how infertility is figured within this space, I focus on those sub-forums that engage with infertility in some form, whether it is medically defined or shares some characteristics and is experienced as infertility. For instance, miscarriage is not strictly the same as infertility but recurrent miscarriage brings with it similar issues, although also its own set of challenges. Queer bodies may not be individually infertile but together they often are and will, therefore, often undergo infertility treatment so, again, they engage with similar issues that make it pertinent to explore them in relation to the figuration of infertility.
While *MDC* is organised in a similar way to *[gynecomastia.org]*, there is a significant temporal difference that impacts how I read these sub-forums. Within the infertility forums, the most active threads are organised in relation to the timing of trying to get pregnant so they operate on a monthly schedule, such as the “October 2010 Infertility One Thread.” These are large, rambling threads that start on the first day of the month and end on the last day, never to be become active again as the conversation moves to the next month’s “Infertility One Thread.” The other far less active threads organised around a specific question generally have a shorter lifetime although there are rare exceptions if a conversation addresses a topic that particularly resonates within the community. As in *[gynecomastia.org]*, the advanced search feature on *MDC* aids in this practice of re-engaging material from the archives; however, it is clear from the levels of activity that most members engage with the monthly conversations on the infertility forums of *MDC* so these are the most significant in discerning the discursive practices of the community. I primarily concentrated on reading the most recent of those within the selected sub-forums, but I also scanned through the sub-forums for threads that resonated within the community, those that received approximately 10 or more responses, as well as those that seemed directly relevant judging from the title. I generally limited my exploration to the last six months, from May to October 2010, but tried to remain flexible because,

---

as in *gynecomastia.org*, conversations previously within the time frame may get moved out, to the front of the pile, by the addition of a new response.

It is worth saying a little more about the nature of these monthly threads because they may not be familiar even to a seasoned online forum user. Unlike other threads, the monthly threads are more akin to, what I call, ‘kitchen table’ conversations, where, by this, I mean: they have a host or, in this case, a “threadkeeper;” they are not focused on a single issue or experience but rather feature unlimited topics and tangents that overlap with each other; and they are saturated with overwhelming expressions of love and support. On the first day of every month, the new threadkeeper starts the thread by listing all members that have been included in previous threads as well as their place in the journey of infertility. Throughout the month, others can ask to be added and then the list is updated so every member in this small sub-community is named and welcomed into this space of support, including those “taking a break” or even “Graduates” from as long ago as 2007.\(^{40}\) Here, members share much more than their experiences with infertility or medical treatment, including family news, work frustrations, school celebrations, and relationship challenges, basically all of life’s ups and downs, as well as their hopes and dreams. Much of a member’s post is engaged with “personals,” the practice of responding to other members individually. This is supported by a feature of the board’s system that allows a member to “multi-quote” from a number of different people’s posts, thus allowing

a member to keep track of other people’s news and respond appropriately in her own post. Writing “personals” is an important activity that is understood to contribute significantly in the formation of the community, so those who do not do it often start their post with an apology for lack of time or an expression of urgent news. After addressing others in the “personals,” members usually turn to themselves, ending the post with “AFM” (as for me), followed by a recounting of their own story. Through discursive practices such as these within the monthly threads, community is formed and the body of infertility is materialised.

**Ethical Considerations**

As I have declared from the outset, I consider both medical written material and online forums as *text*. This is not self-evident in relation to online forums so I have spent far more time considering my ethical approach to the Internet than I have in relation to medical discourse. This asymmetry is necessary in part due to the nature of the Internet and in part due to the newness of this technology and academic interaction with it, so I detail some aspects of these factors in order to provide the context for my ethical approach to the selected online forums. The majority of ethical perspectives on Internet research assume the use of human subjects and the ethical considerations that go along with that approach (Frankel and Siang; King; Waskul and Douglass). The ethical recommendations of the Association of Internet Researchers (AoIR), which declares on its homepage that it is “the top international association for students and scholars in any discipline in the field of Internet studies” (n.p.), are primarily
concerned with a human subject research model, and include only one mention of a different approach:

Are participants in this environment best understood as “subjects” (in the senses common in human subjects research in medicine and the social sciences) - or as authors whose texts/artifacts are intended as public? (Ess and AoIR Ethics Working Committee 7).

However, the formulation of the question remains tied to a human subject research perspective as it asks us how to consider “participants in this environment” rather than how to engage with online text, which is, arguably, what we see when we look at the Internet. Elizabeth Bassett and Kate O’Riordan, in their contestation of the human subjects research model, argue that spatial metaphors such as this one, which uses the spatial term, “environment,” and positions participants “in” it, provide for “the dominant construction of the Internet as a place in which human subjects act” (245). Michele White, in her succinctly titled paper, “Representations or People?,” also makes this point, stating that the use of “space” as the dominant descriptive term applied to the Internet supports the view that people are congregating some where, but she also adds the consideration of time, declaring that “narratives about the Internet being alive are supported by the seeming authenticity of real-time delivery” (256). What is significant in both articles is the emphasis on the fact that the realism underlying the human subjects research model is constructed through the figuration of space (and time) in relation to the Internet. Bassett and O’Riordan emphasise that the “Internet is not simply a virtual space in which human actors can be observed: it is a medium through which a wide variety of statements are produced” (234). They acknowledge that the human subjects research model is
appropriate in some contexts but are concerned that the domination of this approach leads to a failure to engage with the "significant textuality of Internet media" (234). My project attempts to address their concern and provide more balance to research approaches to the Internet through an exploration of this "significant textuality."

A different formulation of the AoIR question referred to above would perhaps ask should we consider online text as written material or like a transcript of spoken discourse, which is the question Susan Herring attempts to answer in her ethical consideration of critical and linguistic approaches to the Internet, (ultimately situating it somewhere in between). This brings with it a series of other oppositions: is it public archive or private record?; is it cultural production or conversation between people?; is it subject to copyright, which requires full citation and credit, or is it subject to privacy concerns, which include informed consent and anonymity? While Joseph Walther unambiguously asserts that the "analysis of Internet archives is not human subjects research," relying on the public availability of such material to ground this declaration (207), Herring and Bassett and O'Riordan recognise that the division between public and private is not clearcut in relation to the Internet and neither attribution can be applied to all aspects of the Internet, given its multiplicity and diversity of forms. Herring sets the boundary between open-access domains, which she identifies as public, and closed-access areas that require approval to read the textual material, which she defines as private (165). Bassett and O'Riordan take a more nuanced view, recognising that open access domains "are a 'public' space in both the
Habermasian senses of the literary and the political” but “they also engender intimate forms of communication,” although, ultimately, they declare the open-access forum under consideration in their research to be “in no way ‘private’” (241). However, rather than applying these characteristics uniformly to Internet domains of a specific form, they base their ethical consideration on an analysis of the particular forum, showing how it is presented as public and both textual and spatial by its producers but constructed as private and spatial through the textual statements made by the participants themselves (241). Thus, the determination of public or private is a question of careful consideration of the online forums under consideration; although, in conclusion, both articles emphasise the need for more education about the default public nature of the Internet.

The issue of public versus private is not merely abstract theoretical pondering, it comes down to the very real consideration of harm but, as with the distinction itself, the attribution of harm is not as clear as some Internet researchers maintain. For Storm King, there is a very real danger of psychologically harming “cyberspace participants” who operate on the Internet with a sense of “perceived privacy” through research that considers Internet discourse to be available for public quoting and merely subject to copyright regulations. While he does recognise some forms of online discourse as public (127), the “perceived privacy” of the participants trumps this characteristic and he asserts that any research protocol that does not recognise this has the potential to “objectify” participants and potentially leave them with a “sense of violation.” In his ethical guidelines, he urges researchers “to consider the effect of their report
as if it were to be read by the subject” (124) and emphasises that the “hallmark of ethical research with human subjects is the ability to predict and compensate for any negative consequences to the subjects involved” (125). As such, for King, ethical research requires gaining informed consent for data collection (with some exceptions) and anonymity in reporting. Although the consideration of harm to individual participants is primary for King, he also mentions harm to the community under consideration and to the field of Internet research itself. He argues that, if members of an online group identify themselves within published research conducted without their knowledge:

> [t]he sense that their group is no longer anonymous will negatively affect the interpersonal dynamics and adversely impact the level of intimacy among participants…The risk exists for the research to damage the very phenomena of cyberspace interpersonal dynamics that one is intent on exploring (121).

As such, all research must consider whether it is promoting “acceptable standards for future work” (124), and it is abundantly clear that King includes the human subjects research model within the boundaries of acceptable and excludes all other forms of Internet research.

Other researchers reconfigure the notion of harm at the heart of the human subjects research model. White argues that ethical perspectives such as King’s are harmful in themselves because they provide grounds for the regulation and even censorship of other research protocols (250). Walther also addresses this issue, providing a critique of Frankel and Siang’s ethical guidelines precisely because their influential statement, which is the report of a workshop sponsored by the National Institutes of Health and the American Association of Sciences, is
aimed at Institutional Review Boards (IRBs), the committees at higher education institutes that regulate research projects. According to Walther, while the report does acknowledge different methods in Internet research, its primary concerns pertain to the privacy of participants and potential harm to them, which foregrounds the human subjects research model (208).

For IRBs, these problems with the Report may put a great chilling effect on the review and approval of research that involves the Internet in any form. Taking the report seriously may lead an IRB to require assurances from investigators that are impertinent, irrelevant, impossible, and unwieldy, depending on the nature and methodology of the specific study being proposed (206).

For Walther, there is a very real danger that valid and valuable research will be prohibited at the institutional level on the basis of ethical guidelines that presume the use of human subjects. Herring also emphasises the exclusions of these ethical perspectives, arguing that the notion of research as consensual disallows critical research. She identifies the Internet as ideal for the analysis of the discursive construction of power and declares that consensus-based guidelines that inhibit critical research of this nature are themselves “ethically problematic” (165). For Bassett and O’Riordan and White, the issue of harm includes a consideration of the politics of representation. White urges us to recognise the advanced skills in constructing Internet personas, avatars, and homepages and, thus, to acknowledge the author or artist for their cultural production. Bassett and O’Riordan worry that their decision to use pseudonyms and disguise the name of the online forum they analyse may negate the forum’s aim to promote the political visibility of LGBT subcultures, which has implications beyond this particular forum.
The politics of representation create an imperative for the researcher to preserve the same level of visibility. LGBT identities and communities are underrepresented in traditional print and broadcast media. The ease of communication available through Internet technologies gives marginalized or subcultural groups access to a medium of statement that has the potential to challenge this underrepresentation. Academic discussion of subcultural groups can potentially add to their cultural capital, legitimise and increase acceptance of the diversity of culture, challenging the monolithic and dominant conceptualisation of society as structured through the heterosexual matrix (Butler, 1993) (243).

Clearly, the attribution of harm in relation to Internet research is not clearcut and includes careful consideration of the appropriate research method, the particular online context, and the wider implications of the research.

Following Bassett and O’Riordan, I acknowledge the hybridity of the Internet and attempt to apply “a hybrid model of relational ethics that incorporates text, space and bodies” in my analysis of specific forms of the Internet (247). I have tried to balance the considerations of harm, in all its multiplicity and diversity detailed above, with my research objectives. As such, I take into account the public/private nature of the selected online forums in terms of access, membership and other relevant factors. In relation to FTM Forum, membership is easily obtained once the prerequisite of having a LiveJournal account is fulfilled and applicants are not subject to screening, in contrast to many trans online communities that require some form of declaration of FTM identity. While membership to FTM Forum is readily available, it is not required to read all of the threads because some are fully accessible while others are only open to members. gynecomastia.org is also a text in the public domain. The forums are completely accessible to any Internet user, with membership only
required in order to post a comment. Becoming a member is a simple matter of registration; it is not tied to an identity category so no self-identification or declaration is necessary. Like gynecomastia.org, MDC is accessible to any Internet user, although a few forums are private and only open to members who have met the required posting criteria or have paid a subscription. So, in part due to the public nature of the forums, in the sense that they are, (to a varying extent), accessible without membership, I did not gain informed consent for data collection from any of the online forums I analysed. However, another significant reason for this decision pertains to the fact that I felt that doing so would impact the discourse being studied. I am interested in the stories we in our communities tell each other in the construction of our selves and our bodies, not the stories we tell researchers; I am interested in the questions we ask, not the answers we give to a standard set of research questions.

In reporting my research, I refer to the forums by name, not pseudonym. In relation to gynecomastia.org and MDC, this decision is grounded in the fact that both forums are contained within larger websites that are explicitly public and situated within overt commercial contexts. There are other factors to consider in relation to FTM Forum because, as outlined in the previous sections, its form and context are significantly different. However, although it is not contained within a commercial context, the administrators have made a number of decisions that reflect a desire to make it visible. It is easy to make forums of this nature completely inaccessible without membership and to make gaining membership an arduous process so the accessibility of FTM Forum and the ease of becoming
a member are significant features. Also, the forum lists *FTMInternational* as their overarching website, which refers to a group that has been providing support, education, and political representation for 25 years, and includes among its specific aims the promotion of FTM visibility ("FTMInternational FACTS"). This connection, (although not official given that *FTMInternational* has its own online forum), along with the other features described above can be read as signs that the forum administrators have some commitment to the political task of promoting FTM visibility themselves. As such, following Bassett and O’Riordan’s comments on the politics of representation, I want to honour the level of visibility provided by the administrators of the forum and do what I can to “add to their cultural capital, legitimise and increase acceptance of the diversity of culture, challenging the monolithic and dominant conceptualisation of society as structured through the heterosexual matrix” (243). I also do not use pseudonyms in place of user names because I consider user names (and avatars) to be a significant part of the “constructed and performative aspects of Internet characters” (White 261), and to erase them would be to invest in an “indexical relationship between an Internet character and the user’s body” (258); user names are an important feature of the text, not a direct reference to the author.

The nature of the Internet is an interesting and challenging problem that remains ripe for future exploration. Its multiplicity and diversity elide easy definition and singular categorisation but it is both necessary and urgent to continue to engage with its characteristics given the ontological, epistemological,
and ethical implications. Ultimately, I sincerely believe in the broader political implications of this project, which is driven by the recognition of the harm done to trans bodies in the name of the natural. Mapping where, when and how the natural is invoked is a way to challenge the belief that the natural body is self-evident, simply the one we are born with, and to undermine the accusation of unnaturalness that afflicts many bodies. I give this real harm, experienced daily and often brutally, more weight in my ethical considerations than the potential harm to online authors. I believe that this work is an important intervention in the theoretical and social movement to reconsider what it means to be embodied and to allow more lived space for diverse forms of corporeality, not marked by the over-policed boundary between natural and unnatural.

41 See, in particular, Mark Poster’s *What’s the Matter with the Internet?* (2001) and Allucquere Rosanne Stone’s *The War of Desire and Technology at the Close of the Mechanical Age* (1995) for considerations of the materiality of the Internet.
Chapter 3: Chest Surgeries of a Different Nature

The Nature of Harm

My analysis in this chapter is based on a body of medical literature, situated in a Western context, concerning FTM chest surgery and gynecomastia surgery. For the specific details of the texts under consideration and their context refer to chapter two but, in brief, I analyse the dominant clinical guidelines, select authoritative articles, and influential historical approaches. The naturalisation techniques at work within these texts are multiple so, in order to provide some structure to my analysis, I focus on the central theme, which I identify as the notion of harm. I explore how and where it is applied, and its relation to other themes through which (un)naturalisation is achieved, such as disorder, bodily integrity, regret, and authenticity.

Disorder

The determination of harm is grounded in the attribution of ‘disorder’ so I start by considering how the term ‘disorder’ is used and the consequences of these discursive framings. The notion of ‘disorder,’ which according to the Canadian Oxford Dictionary refers to “an ailment or disturbance of the normal state of body or mind” (Barber, my emphasis), grounds the ontological presuppositions at work in these medical discourses. It is applied to both FTM patients requesting chest surgery and non-trans men presenting with gynecomastia but, despite the fact that these patients often share psychological
discomfort with their bodies and a persistent desire for surgical transformation, it is used in significantly different ways. The distinct locations of the ‘disorder’ within these two medical contexts have the effect of naturalising the pre-surgical FTM body in the former and the male body without breasts in the latter.

Within the medical discourse of FTM chest surgery, the disorder is located in the mind through the designation of Gender Identity Disorder (GID). This diagnosis, on which access to chest surgery for FTM patients is often dependent, is considered a mental health issue and is included in both the *International Classification of Diseases-10* and the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (Meyer et al 2). Kenney and Edgerton (1990) introduce their chapter on FTM chest surgery with the following:

Cross gender identity, one form of which is known as transsexualism, is a pediatric neuropsychiatric disorder of profound magnitude. It affects an individual’s total concept of self. Transsexualism has been defined by Money and Gaskins as “a disturbance of gender identity in which the person manifests, with constant and persistent conviction, the desire to live as a member of the opposite sex and progressively takes steps to live in the opposite sex full time” (545).

In terms of treatment protocol, the location of the disorder in the mind leads to a recommendation of psychotherapy, or at the very least a mental health assessment, before proceeding to physical intervention. In the “Standards of Care” that provide the institutional framework for sex reassignment surgery, surgery is only described as “medically necessary” in cases of “profound GID,”

---

42 I am aware of multiple community discussions on the removal of this designation as a mental health disorder and the implications of this on the provision of medical insurance but I am not engaging with this issue here because I am solely concerned with the ways in which FTM chest surgery is described within medical discourse.
where profound GID is identified by the persistent desire for surgical transformation of the body (Meyer et al 18). By implication, the normal state of mind assumed by the diagnosis of GID consists in bodily comfort and no desire for surgical transformation. The conceptualisation of gender identity disorder as a mental health concern figures the pre-surgical body in a specific relation to the natural; through the containment of the abnormal within the mind, the body of the pre-surgical FTM is effectively rendered as normal and natural.

In contrast to the medical framing of FTM chest surgery, the ‘disorder’ or ‘disease’ associated with gynecomastia is firmly located within the body; more specifically, it is contained within the breast or breast tissue. The very use of the term ‘gynecomastia’ dissociates the breasts from the body on which they are found; gynecomastia stems from the etymological roots of the Greek *gyne* meaning woman and *mastia* meaning breasts, so it literally translates to ‘woman’s breasts.’ The implication of this designation of the breasts as not-male, despite being found on male bodies, is that the male body without breasts is discursively framed as natural from the very outset. This occurs in spite of the medically recognised commonality of the condition, especially during puberty and in old age; following on directly after the attribution of “abnormality” by Weisman et al, in the most recent article under consideration, they assert the normality of gynecomastia, acknowledging that studies have shown the incidence to be as high as 65% in 14-year-old boys and from 40-60% in the adult male (97). Other language used in defining gynecomastia is also far from neutral – it is often described as the “excessive” development of breast tissue in men and is thought
to be caused by a hormonal “imbalance.” These terms further the effect of rendering breasts on men thoroughly abnormal and unnatural. As such, psychotherapeutic management is never considered as a treatment or even an eligibility requirement for surgery; instead, the treatment options are limited to physical intervention – radiotherapy, hormonal therapy, and surgery, although surgery is claimed as the most effective (Webster 560; Braunstein 1233). In most of the literature, treatment of some sort is assumed – having non-trans men walking around with breasts is evidently not appropriate. So, in this use of the term ‘disorder,’ the normal, and by implication, natural, state of the male body is framed as one without breasts.

The psychological discomfort of men with gynecomastia is frequently acknowledged but rarely included as an element of the disorder. Webster, in his foundational article introducing the semicircular intra-areolar incision in 1946, writes:

The psychic trauma caused by the “reproach of effeminacy” is the main reason for operative interference in gynecomastia of the benign type. In modern life when exposure to the body is so frequent, and this is particularly the case in military life, the gynecomastia patient is subjected to jibes and teasing from his fellows. The repeated ridicule may bring about changes in the individual’s behavior patterns. He hesitates to undress before others in the gymnasium or on the beach, and he refrains from going in swimming. He may even shrink from exposing himself in a thin undershirt. Thus, a complex is started which may lead to severe psychotic disturbances (560).

Not only is “psychic trauma” not pathologised in relation to gynecomastia, it is, in fact, taken unequivocally as an indication for surgery, as Pitanguy reiterates in 1966:
Surgery is justifiably and principally indicated for those patients who have excessive preoccupation with their feminine appearing deformity, those who are so preoccupied that their behaviour is disturbed and, consequently, their ability to face life situations effectively (414).

Hall, in his comprehensive treatise from 1959, even considers the psychological distress of the parents in relation to the need for surgical intervention: “[p]arents may be more distressed than patients, although this is not easily detected with certainty during a single interview and in any case is probably an indication for surgical treatment” (146). The recognition of psychological discomfort in relation to the gynecomastia body undermines the diagnosis of Gender Identity Disorder, which presupposes the normal state of mind to consist in bodily comfort and no desire for surgical transformation. Here, psychological discomfort is considered entirely appropriate and normal rather than a mental health issue and is, unquestionably, taken to be justification for surgery.

While psychological discomfort is referenced in the majority of the medical texts on gynecomastia surgery, Pitanguy’s article is rare for his measurement of psychological improvement alongside the evaluation of surgical results. In his consideration of the “degree of mental disturbance” before the surgery (419), “[p]ersonality disturbances of the patients were grouped as “social” or “psychologic,” social behavior being that limited to sporting activities and psychologic being of a more complex nature, possibly involving sexual equilibrium” (415). It is unclear exactly what is meant by “sexual equilibrium” in this context, although there is reference to a 17-year-old who had “the sensation of having a woman’s breasts” (418), so it most likely indicates the threat of
gynecomastia to the sexed body and self. Fortunately, for this teenager who felt like a man in a woman’s body, Pitanguy reports “very good psychologic recuperation” after chest surgery. Pitanguy makes visible that success of gynecomastia surgery is measured, in part, by psychological transformation, a fact that is generally taken for granted within the medical literature on gynecomastia surgery but must be emphasised in the medical discourse on sex reassignment surgery because of the extent to which it is considered harmful to the physical body.

Within the medical literature focused on etiological considerations of gynecomastia, it is more common to question the attribution of ‘disorder’ to the condition of gynecomastia (Nuttall, 1979; Braunstein, 2007). In “Gynecomastia as a Physical Finding in Normal Men” (1979), the endocrinologist Nuttall measures the level and incidence of gynecomastia in a small sample of 306 members of the Reserve Air Force Unit and those applying for admission. These men were defined as “normal” on the basis of passing the medical qualifications for military service, which includes, of relevance to the evaluation of gynecomastia, a lack of enlargement of the liver, “normal” genitalia, no chronic medication or alcohol intake, and a body weight within the United States Air Force limits (338). Nuttall finds that 36% of “normal” adult men between the ages of 17 and 58 have breasts, with a low of 17% for the 17 to 19-year-olds and a high of 57% for those over 45 (339), and concludes that “[t]hese data indicate that palpable gynecomastia is common in normal adult men. This high prevalence must be taken into consideration when attributing gynecomastia to a drug or disease
state” (338). More recently, Braunstein (2007) also appeals to the commonality of the male body with breasts when he asks, should gynecomastia among older men “be considered to be pathologic or a part of the normal process of aging” (1235, my emphasis)? However, even in these instances within the medical discourse where non-trans men with breasts are both normal and natural, the desire to remove them is also considered both normal and natural. Although Braunstein acknowledges the high incidence of physiologic gynecomastia, he still recommends the treatment of surgical removal for those patients who are simply “troubled by their appearance” (1236).

The medical term “idiopathic” is sometimes used interchangeably with physiologic in relation to non-pathological gynecomastia, although their meanings are far from identical. Idiopathic is defined in the Canadian Oxford Dictionary as “of unknown cause or arising spontaneously” (Barber) and is used in medical contexts in association with a disease or condition, not in relation to normal, healthy functioning. It stems from the Greek idios, one’s own, and pathos, suffering, so approximately translates as the poignant phrase ‘one’s own suffering,’ which implies a lack of external cause, a suffering contained, an affliction of its own kind. While the term physiologic figures gynecomastia as a normally occurring state, idiopathic once again renders it a diseased condition, one with a hidden or as yet undiscovered cause. The moments where these terms are reduced to each other mark an inability to consider gynecomastia as normal despite the absence of a pathologic condition, perhaps because this absence is considered temporary within the medical progress narrative that
assumes technical advancements will reveal more of the underlying causes. In an episode of the medical drama, *House*, the antagonist Dr. House sums up this philosophy by defining ‘idiopathic’ as meaning “we’re idiots, because we don’t know what’s causing it.” In this understanding, grounded in the belief in the ultimate omnipotence of the medical gaze, it is a lack of knowledge that marks gynecomastia, not normalcy.

**Whole versus Part: Sex and gender**

In relation to FTM patients, the notion of disorder is applied to the *whole* – the FTM patient effectively becomes the disorder – while in reference to those presenting with gynecomastia, the disorder is contained within a *part*. As well as being evident within descriptions of the disorders, this is also expressed through the language used to refer to the patients themselves. FTM patients have their very own identifying label, the transsexual, while patients with gynecomastia have no corresponding term – gynecomastia is described as a disorder that “occurs” or “presents” in “normal males,” merely a “relatively common condition” that men “have” or live “with.” They are not reduced to the disorder, rather it is limited to a part, which is merely attached to them but not of them. In Foucault’s terms, the transsexual has become a species, while gynecomastia remains a condition.

Only twice does a corresponding term to that of transsexual appear within the medical literature on gynecomastia surgery. In Colic and Colic’s discussion of circumareolar mastectomy, in which they include both FTMs and men with gynecomastia, they give the breakdown of their 17 patients as “12 female-to-
male transsexuals and 5 extreme gynecomastias” (450). Later, they revert back to the more common description of “patients with ginecomastia (sic)” (453). The more significant example is in a small section of Menville’s 1933 article on the histological characteristics of gynecomastia. In his discussion of gynecomastia being the “result of…a lack of sex differentiation in the sex organs,” a condition which he defines as bisexuality and associates with “hermaphroditism and pseudohermaphroditism,” he uses the label “gynecomast” (1056). It is primarily limited to one paragraph within which he reports on cases of “gynecomasts who have nursed infants,” such as “Chinagawayo, a Zulu chief, and a gynecomast at 55 years, [who] had forty wives and over a hundred children, some of which he nursed himself” (ibid). Employing ‘gynecomast’ as a noun implies the recognition that these particular bodies cannot strictly be reduced to ‘man,’ but the anecdotal style of the description of such “remarkable” cases, taken largely from a book published in 1897 and entitled Anomalies and Curiosities of Medicine, which stands in stark contrast to the technical mode employed in the rest of this medical study, has the effect of relegating these bodies to the mythical. The denaturalisation of the ‘gynecomast’ is further achieved through certain operations of racialisation. The stories Menville tells, as opposed to the case studies he presents, exoticise these bodies, always situating them geographically and racially elsewhere. Throughout the remainder of the article, the term ‘gynecomast’ is noticeably absent, as Menville reverts to the more regular approach of describing gynecomastia as merely a condition men or boys may have or develop. The ‘gynecomast’ is never seen or heard of since and, in 1959,
Hall thoroughly undermines Menville’s characterisation of this ‘species’ on the basis of the “progress made by endocrinology:"

It is of course true that sex differentiation is the result of competition between male and female influences, but Menville was not in a position to understand the role of these influences in the aetiology of gynaecomastia. He failed to state clearly that gynaecomastia can affect young men in whom no other evidence of “lack of male sexual influence” exists (12).

The diseased part, the breast tissue that is framed as containing the disorder of gynecomastia, is further demarcated from the rest of the body through the use of sexed and gendered terms. The patient’s sex and gender are rarely questioned or threatened, remaining male and masculine despite the fact that, within discussions of the causes of gynecomastia, it is identifiably linked to intersexuality, although the term ‘intersex’ is never applied.  

The list of underlying pathological conditions sometimes includes one or more of the following: “hermaphroditism,” Klinefelter syndrome, incomplete androgen insensitivity, and “testicular feminization” (now generally called complete androgen insensitivity syndrome). Hermaphroditism refers to the presence of both male and female reproductive organs, Klinefelter syndrome is marked by the chromosomal karotype XXY, and (in)complete androgen insensitivity syndrome is defined as the body’s inability to respond to androgen (to varying degrees). All of these are identified as intersex conditions by the Intersex Society of North America. This is never acknowledged in the medical literature – the term

43 Or the phrase Disorders of Sex Development (DSD), the more recent iteration of the medical grouping of these bodily conditions.

44 I use quotation marks here to emphasise that this is the expression used in the medical texts despite pressure from activists to avoid use of this term.
‘intersex’ is noticeably absent – and the possible presence of one of the above so-called “disease processes” rarely threatens or disrupts the presupposition of the natural male body. Writing in 1956, Hall goes so far as to advocate secrecy to contain the threat of Klinefelter’s syndrome, asserting that the patient “be treated as male, regardless of chromosomal sex, and neither he nor his relatives informed of the genetic sex in cases where this is female” (147). While concealment is not encouraged in more current literature, the continued use of ‘men’ and ‘male’ in reference to bodies of this nature functions as a similar form of denial and an erasure of the sex variations implied by these conditions, of which gynecomastia itself can be read as a sign.

There are two noteworthy examples of recognition of the sex variations that gynecomastia may signal. As well as Menville’s discussion of the ‘gynecomast,’ which is a characterisation of a sexually ambiguous body, Webster notes, in relation to his patients, that the “body may be of the feminine type, eunuchoid, or of the normal male type” (557). Due to the acknowledgement of these multiple bodies, Webster avoids applying the terms ‘man’ and ‘male’ in discussing his cases, instead using ‘patient’ followed by a precise marking of their body type. These two texts, which open up the possibility of bodily variation beyond notions of male and female, highlight the general absence of such considerations within the medical literature on gynecomastia, which remains intent on asserting the natural male body as one without breasts. And, even within Webster’s article, the focus is on the foreclosure of such possibilities of bodily multiplicity through the surgical production of the “normal male type.”
In contrast to the maintenance of the body as unequivocally male, the breasts are repeatedly sexed and gendered as other, as female or feminine. I have already mentioned the fact that the term ‘gynecomastia’ itself, which translates to ‘woman’s breasts,’ does this distancing work but many of the descriptions of the disorder also operate in the same way. From the historical to the most recent, Webster in 1946 defines gynecomastia as a condition in which “the appearance of the breast simulates that of the female” (557) and Wiesman et al in 2004 describe it as “the presence of femalelike mammary glands in a male” (97). There are moments within the medical discourse when the breast is acknowledged as male but the enlargement of the breast is rarely included in this identification. Rather, there are multiple examples of it being described with terminology such as “feminine shape,” “feminine appearance,” and “feminine appearing deformity.” Through these discursive devices, the offending breast tissue is rendered entirely distinct from the whole, which remains the “normal male” body without breasts.

This is very different to the ways in which sex and gender are applied to the FTM patient. The FTM pre-surgical body is, without question, sexed as female; within the conceptualisation of gender identity disorder, it is the pre-surgical mind, taken to be the location of gender identity, which is sexed and gendered as other, as male or masculine. Although GID is a mental health diagnosis, it is indicated by a specific relation to the pre-surgical body, which, in the ICD-10, is the “wish to make his or her body as congruent as possible” with the “opposite sex” (qtd. in Meyer et al 5). For FTM children, the criteria includes
the “persistent repudiation of female anatomical structures” (ibid). These diagnostic elements have the effect of sexing the entire body, not merely the breasts, as female.

Beyond the diagnosis of GID, the descriptions of FTM chest surgery further the maintenance of, what Thomas Lacqueur describes as, the “two-sex model,” which refers to the contemporary Western social imaginary that figures male and female as “stable, incommensurable, opposite sexes” grounded in “sharp corporeal distinctions” (5-6). Kenney and Edgerton, in their foundational surgical description in 1990, feature an image of the female and male torso separately in order to highlight the differences. The caption reads:

Compared with the female chest wall pattern, in a male chest appearance, the nipple-areola complex is smaller and higher in position in the chest wall. The inframammary fold is also more oblique, following the inferior margin of the pectoralis major muscle (549).

In comparison, Letterman and Schurter’s image comparing gynecomastia to the “normal” male chest consists in one chest containing both, rather than two distinct bodies separated by a large divide:
Hage and Kesteren’s 1995 article builds on Kenney and Edgerton’s approach by identifying awareness of these sexual differences as fundamental to FTM chest surgery, warning that:

[i]n order to obtain satisfactory results in chest-wall contouring as part of gender-confirming surgery in female-to-male transsexuals, the surgeon should be aware of the differences between the female and male mammary anatomy and should take notice of the possible techniques to overcome these differences. So far, not much attention has been given to either (386).

However, the significant difference between these two texts separated by only five years is the absence of the recognition of gynecomastia in the later text. Both reference Davidson’s “doughnut technique,” but only Kenney and Edgerton
acknowledge it as a procedure developed for the treatment of gynecomastia. For the purpose of Hage and Kesteren’s approach based on the emphasis of “sexual difference,” the male body with breasts cannot be included alongside the FTM body because it undermines their assertion of the absolute difference between the sexed male and female body. This distinction from the gynecomastic body is also found within both Monstrey (“Surgery: FtM” 2007) and Bowman and Goldberg (2006), where gynecomastia is acknowledged but only in order to assert the difference between the surgical practices of gynecomastia surgery and FTM chest surgery. This difference is declared despite the fact that a comparison of Bowman and Goldberg’s 4-point categorisation of breast size and skin quality for FTM patients (15) and Simon et al’s influential 1973 classification of gynecomastia (49) reveals the extent of the similarities, both in relation to the description of the breasts to the surgical technique recommended, from intra-areolar incision (“keyhole” approach) to free nipple graft.

As mentioned above, Colic and Colic’s 2000 article is rare precisely because it does not make an absolute distinction between the FTM body and the gynecomastastic body. The introduction begins:

[b]reast reduction or amputation in female-to-male surgery presents a specific surgical problem: obtaining a good breast shape of the masculine type. Over a 2-year period, 17 patients (12 female-to-male transsexuals and 5 extreme gynecomastias) were operated on using the circumareolar approach for subcutaneous mastectomy…This technique provides naturally flat masculine breasts (450).

Although FTM chest surgery is presented as a “specific surgical problem,” and the patients are nominally divided into two groups, they all undergo the same
surgical procedure in order to achieve “naturally flat masculine breasts.” The tension between disassociation and association continues throughout this article. The transsexual breasts are described as “typically female,” while the gynecomastia patients are said to have “moderately big breasts” (453). However, the bodies in the photographs within the text are not divided and marked as FTM or gynecomastic, rather, they are simply identified as a series of ‘patients.’ Within this article, the pre-surgical FTM body oscillates between difference and sameness, female and male. However, the general disassociation of FTM chest surgery from gynecomastia surgery in the medical discourse on the former, rather than the acknowledgement of the overlap, grounds FTM chest surgery in the distinction between the female and male body, firmly situating the pre-surgical body as unequivocally female.

This also has the effect of maintaining the post-surgical body as female; the surgical modifications are never enough to fully “overcome” the fact of “sexual difference.” Rather than aiming for the achievement of a male chest, Hage and van Kesteren define the principal objective of the surgery as “to masculinize the chest by deleting the female contour” (386). Bowman and Goldberg’s paragraph on revisional surgery captures this tension beautifully:

Performing an aesthetically pleasing subcutaneous mastectomy in the biological female who desires a male chest can be a challenging operation. It differs from mastectomy for breast disease (or as a prophylactic measure) since the goals are very different: the aim of chest surgery in the FTM is not just to remove all of the breast tissue, but also to recontour the chest to create a masculine appearance. The procedure is also usually more difficult than a gynecomastia correction since the FTM transsexual often has considerably more breast volume and a greater degree of ptosis (natural droop) to contend with (26).
The pre-surgical body is unquestionably asserted as that of a “biological female” and, although the patient may wish for a “male chest,” the surgery can only deliver a chest that looks masculine. In contrast, gynecomastia surgery is figured as merely a “correction,” such that the male body both precedes surgery and is maintained through surgery. In relation to FTM chest surgery, the appearance of the chest is described as male, while, in relation to gynecomastia surgery, it is the chest itself that is characterised as male – in the former, maleness is an attribute, while in the latter, it is the ground. As such, the goal of gynecomastia surgery is not concerned with maleness, because that is taken for granted; rather, the focus is on the normal, in terms of “size and contour” (Webster 574).

However, in the most recent text on FTM chest surgery, Monstrey offers a rare instance in which the possibility of the materialisation of a male chest is asserted (“Surgery: FtM”). In this chapter, Monstrey summarises Hage and van Kesteren’s goals as “the creation of an aesthetically pleasing male chest” (137). Here, although the chest is not framed as male initially, (the male chest is created not restored), it does at least become male. However, in general, the distinction remains – through FTM chest surgery, the chest remains female or at the most not-male and becomes merely male-looking, male-like, ‘male-lite,’ while, through gynecomastia surgery, the chest is male and simply becomes normal.

In both the medical discourse on FTM chest surgery and that of gynecomastia surgery, there is an intense opposition between male and female, and it is this that is taken to drive the desire or necessity for surgery, but the

---

45 I owe this expression to Amy Fox, a colleague and student of mine who constantly challenges perceptions.
borders marking that opposition are located in different places, where in the former it splits the whole and threatens bodily integrity while in the latter it functions to contain the whole and guarantees the survival of bodily integrity throughout the surgical intervention. As such, FTM chest surgery is conceptualised as a significant transition, while gynecomastia surgery is not considered as transitional in the same way because it does not constitute a border crossing in this context. The difference between these bodily figurations effects a number of factors that underlie the (de)naturalisation of the body modifications under consideration, most notably in relation to the attribution of harm.

“Above all do no harm:” The ethics of surgical modification

The different conceptions of ‘disorder,’ and the ways in which sexed bodies are materialised through them, translates into an ethical issue in relation to one of the fundamental principles of medical care, “primum non nocere,” above all do no harm. This phrase has been in common use since at least the turn of the century and is currently one of the fundamental principles of medical care. From Edgerton’s passionate presentation in 1984 in defence of surgery for transsexuals to Monstrey’s recognition of the ethical challenges of such surgery in 2007 (“Surgery: General”), the debate over whether sex reassignment surgery constitutes a violation of that principal tenet continues to rage. In the “SOC,” one of the first considerations in relation to surgery is the recognition of the “resistance against performing surgery on the ethical basis of “above all do no harm,” understood to be grounded in the ethics of altering “anatomically normal
structures” (Meyer et al 19). Referring to the issue of medical liability, Monstrey acknowledges that this resistance can go so far as to conceive of sex reassignment surgery as “physical violence” and implicate surgeons themselves for “purposely applying physical violence” to a patient (“Surgery: General” 93). The defence against this position is forceful, however, it is in part through this debate, through the overbearing presence of the presupposition that this surgery ‘does harm’ as well as the defence against that belief, that the pre-surgical body is rendered “anatomically normal,” healthy, natural.

Throughout the medical literature on gynecomastia, there is not one mention of this ethical consideration, because breasts on non-trans men are generally not considered to consist in healthy tissue. The surgical removal of this tissue is not understood as an act of harm to the body, an act of harm to bodily integrity, to wholeness, as it is in relation to the FTM body, because of the differing boundaries of the natural male and female body within these two discursive contexts. In the medical discourse on gynecomastia, it is the post-surgical body that is framed as natural, in spite of the direct construction of the body through the medical practice of subcutaneous mastectomy. Even in those instances in the medical texts where "physiologic gynecomastia" is acknowledged (where physiologic refers to normal and healthy as opposed to pathologic, which is associated with disease), ethical considerations are noticeably absent. Above, the naturalness of the post-surgical body is grounded in the distinction made between healthy body and diseased breast tissue but, in this case, that border does not hold; hence, the surgical removal is of
“anatomically normal structures,” yet it is still not considered harmful to one’s bodily integrity, thus preserving the post-surgical body as natural once again. This is achieved through the relocation of the attribution of harm from the physical to the psychological. As discussed above, the presence of breasts on non-trans men is without question taken to be the cause of “personality disturbances,” “severe maladjustment,” “psychological discomfort,” and even “psychic trauma.” These psychological disorders are often characterised by the inability to engage in physical activity, (which, in Webster’s 1946 article, is directly linked to military life where “exposure of the body is so frequent” (560)). Through this association, sport is identified as a central aspect in being male. As such, harm is associated with the pre-surgical body “suffering” from gynecomastia, unable to enact appropriate maleness, and surgical modification is once again framed as the removal of harm.

Those who justify sex reassignment surgery attempt to employ a similar transfer of the notion of harm. This can be seen in the “SOC” in the full defence against the ethical concerns aimed at transsexual surgery:

Many persons, including some medical professionals, object on ethical grounds to surgery for GID. In ordinary surgical practice, pathological tissues are removed in order to restore disturbed functions, or alterations are made to body features to improve the patient’s self image. Among those who object to sex reassignment surgery, these conditions are not thought to present when surgery is performed for persons with gender identity disorders. It is important that professionals dealing with patients with gender identity disorders feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort of patients diagnosed with gender identity disorders, professionals need to listen to these patients discuss their life histories and dilemmas. The resistance against performing surgery on the ethical basis of “above all do no harm”
should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having profound gender identity disorder (Meyer et al 18-19, emphasis mine).

Edgerton is even more forceful in his assertion of the psychological distress of transsexualism:

…no one can deny that this is an identifiable, severe, and incapacitating disease. Transsexualism is not a variation represented at one end of the bell-shaped curve that describes the normal ranges of gender identities. Let there be no confusion – it is a pathological condition that is undesirable for both the patients and society (2)

This is an attempt to shift the conception of surgical intervention, from perceiving surgery as ‘doing harm’ to considering it as an alleviation of mental suffering. The difference between this and the situation above is the extent to which the psychological harm of gynecomastia is taken for granted and given absolute weight, so much so that surgical modification is never, under any circumstance, considered harmful. In contrast, in relation to transsexualism, there is a continual tension between the harm associated with surgery and the harm related to gender identity disorder, and the provision or denial of surgery rests on the weight assigned to each. As mentioned above in relation to the attribution of disorder, psychological harm must be asserted constantly in the face of the presupposition that surgical intervention is nothing short of “mutilation,” an assault on bodily integrity. This difference is grounded in conceptions of the natural male and female body, where gynecomastia surgery is always understood as the process through which an unnatural body is made natural,
made whole, while FTM chest surgery is considered to achieve the opposite, and must always face the weight of that condemnation.

This point is underscored by the presence of eligibility and readiness criteria in the professional guidelines for sex reassignment surgery. Despite assertions to the contrary, these are, at least to some extent, concerned with testing the weight of the psychological harm of gender identity disorder in order to assess whether it exceeds the harm associated with surgical intervention. One of the requirements for FTM chest surgery is completion of at least 3 months of "real-life experience" or psychotherapy for a duration set by a mental health professional, usually a minimum of 3 months (Bowman and Goldberg 3). “Real-life experience” is defined as the “act of fully adopting a new or evolving gender role or gender presentation in everyday life” (Meyer et al 17), which for FTMs often involves binding, the act of constraining the breasts with some form of fabric under tension in order to reduce visible breast size, in effect, simulating the results of chest surgery before getting the surgery. There is a noticeable absence of any discussion about a “real-life experience” or any other eligibility requirements for non-trans men undergoing chest surgery. These patients do not have to bind for a minimum of 3 months in order to convince the medical establishment that they are really ready for surgery.46 In fact, all they have to do, if anything, to make surgical treatment a necessity is to assert their “embarrassment” over the condition.

46 Riki Ann Wilchins, in Read My Lips: Sexual Subversion and the End of Gender, emphasises this disjunction in her marvellous rendition of the clinical encounter of a woman requesting a “nose job” who is told by the doctor that she has “rhino-identity disorder” and must “live as a small-nosed woman for three years…just to be sure” (63).
This marks a substantial difference in access to the surgical procedure of subcutaneous mastectomy and highlights the distinct meanings associated with the surgery in each medical context. As well as gynecomastia surgery not being considered harmful, it is also evidently not understood as part of a “transition” – the distance between the pre-surgical body and the post-surgical body is figured as minimal through the absence of any preparatory requirements for the shift from one to the other. FTM chest surgery, on the other hand, is conceptualised as part of a “transition,” one that needs much preparation, including a “real-life experience.” These factors situate the pre-surgical body and the post-surgical body far from each other, across an almost impassable border, and serve to strengthen the sexual divide. Gynecomastia surgery is seen as simply the small, seemingly trivial, step from male body with excess breast tissue to male body as nature intended, while FTM chest surgery is conceptualised as part of a long journey from female to male.

**Regret**

Operating in association with the notion of harm as a (de)naturisation technique with specific implications in relation to gynecomastia surgery and FTM chest surgery is the concept of regret. Bowman and Goldberg precede the descriptions of transsexual surgical procedures with a discussion of regret, warning that “primary care providers are often concerned that their transgender patients will experience regret following SRS” (4-5). In an attempt to reassure these ‘concerned physicians,’ they, first, assert that “temporary concerns” after any surgery are fairly common, and then, emphasise that rates of “persistent
regret” reported by post-operative transsexuals are at the lower end of the scale in comparison with rates of regret declared by non-trans individuals after a variety of surgical procedures (ibid). They note that the figures on regret after SRS are taken from a meta-review that analyses 74 outcome studies and 8 reviews, covering a 30 year period, from 1961 to 1991; clearly, regret in relation to SRS has been an object of intense study for many years and remains so to this day. I recognise that Bowman and Goldberg are attempting to undermine the association of regret with the transsexual body, however, they continue the persistent focus on regret in relation to the post-surgical body. The fact that regret is never considered in relation to the pre-surgical body highlights that regret is not merely an object, rather, it is a (de)naturalisation technique in itself. It operates in ascribing harm to the surgical procedures transsexual individuals may undergo and not acknowledging the harm that may be caused by not going through this process.\(^{47}\) The focus remains on bodies unable to go back to the exclusion of the consideration of bodies not able to move forward. Through this practice of attribution and exclusion, the notion of regret is a very effective means of marking the pre-surgical body as natural and the post-surgical body as unnatural.

Edgerton also considers the question of regret but he does so in a way that engages with the harm of not providing surgical treatment, turning the attention on the necessity of transsexual bodies being allowed to move forward.

\(^{47}\) Julia Serano, in a post entitled “transsexual regrets” on her personal blog, *Whipping Girl: the blog with the trans feminine touch!,* acknowledges this in the following reconfiguration of regret: “While taking hormones or having surgery is an irreversible, life-altering change, one that is sometimes followed by regrets, so too is puberty when you’re a young trans person.” <http://juliaserano.livejournal.com/2168.html>
He begins by identifying the multiple challenges based on regret that are made against surgical treatment for transsexualism:

Won’t the patients later find themselves unhappy with the surgically provided genitalia? Won’t many wish to have the surgery reversed? Will they find that the anatomical reversal of their original gender fails to make them feel more “complete” or “harmonious” (2)?

He responds with his personal clinical experience, declaring that although some of the patients he treated after having prior unsatisfactory surgery abroad “suffered from major problems, such as rectovaginal fistulas, stenosed vaginas, or strictured urethras, not a single patient regretted having had the original surgery” (2). However, as well as emphasising the absence of regret, he also highlights what surgery does provide, which he describes as “substantial and lasting subjective relief” (3). For Edgerton, these two factors are adequate justification for the continuation of the medical provision of sex reassignment surgery. However, although Edgerton attempts to undermine the attribution of regret to the post-surgical body, the very act of engaging with the issue to some extent reasserts the association of regret with the post-surgical body and not the pre-surgical body.

Within the medical discourse on gynecomastia surgery, there is rarely any mention of regret following surgery. The one and only time regret is associated with gynecomastia surgery is within Hall’s 1956 treatise on gynecomastia, in which he briefly considers the relation of gynecomastia to, what he calls, “transvestism:”

While the definitive treatment of this condition has yet to be established, it seems unwise at present to undertake measures
designed to turn these patients “into men”. Not only is present-day hormone therapy quite powerless to alter the way of thinking and the sexual orientation of these individuals, but so strongly do they believe in their essential femininity that they bitterly resent attempts to make them more masculine. A patient at Guy’s Hospital suffering from Klinefelter’s syndrome with transvestite tendencies underwent the Jerome Webster operation only to express deep regret at having submitted to the procedure…(149).

In this context, gynecomastia surgery is recognised as a procedure that turns patients “into men,” but this recognition is only possible because, for these particular patients, gynecomastia surgery is experienced as transition because it is unwanted. In relation to other patients with gynecomastia, the production of the male body through gynecomastia surgery, literally, the becoming of men, is invisibilised because the surgery is not understood as transitional. Apart from Hall’s recognition of this specific case of regret, the notion is decidedly absent from the rest of the medical discourse on gynecomastia surgery; regret is just something that does not cross anyone’s mind – there are clearly no ‘concerned physicians’ here. This absence highlights the distinctions between the ways in which “nature” is discursively figured in each medical domain. Gynecomastia surgery is merely thought to be “restoring” the male body to its natural state; the procedure is naturalised to such an extent that it allows no space for the consideration of harm or regret. It is not simply that it is taken for granted that there is no regret associated with the post-surgical body, it is rather that posing the question of regret makes no sense in this context due to the distance maintained between the natural and the notion of regret. The absence of the association of regret with the post-surgical body is one of the devices through which the post-surgical body is characterised as natural.
Authenticity: “Minimal scarring” and “proper” nipple placement

I said above that gynecomastia surgery is very rarely considered harmful; those instances when it is are related to the perceived authenticity of the chest—it must look natural in order to be natural. In this context, ‘looking natural’ means to appear free of construction, or, in other words, with no “evidence of operative interference” (Webster 561). Scars reveal the cuts made in making these chests male and hence undermine the notion of the natural body as one that is without technological intervention. Writing in 1946, Webster situates himself as the first to emphasise the minimisation of scars and bases his technique on this consideration:

There is no indication that any surgeon has recognised that the scars resulting from these operations may cause nearly as much embarrassment as the original condition, especially so when the scars are bilateral and symmetrical and explanation of their presence is made more difficult. Nor has an operation been devised that prevents the formation of visible scars that give evidence of operative interference, an ideal which should be sought in order to secure complete success from the psychologic standpoint.

With this object in view, an operation with a semicircular intra-areolar incision was devised by the author, and was first performed in 1934 (561).

Since then, the field of gynecomastia surgery has been grounded in the “ideal” of minimal scarring, with each new technique introduced on the basis of the extent to which it approaches that ideal. In 1966, Pitanguy begins his article on the transareolar incision with the issue of scarring, saying that the “surgical treatment of gynecomastia surgery would offer no difficulties from the technical vantage point if it were not for the apparent scar the surgeon is obliged to leave following resection of the glandular mass” (414). He refers to the surgical scars using the
medical terms, “cicatricial stigma,” but the non-medical meaning associated with stigma, that of shame, is at the forefront when he identifies scars as “a reminder to patients of previous deformity” (414). Echoing Webster, he links the aesthetic result to the psychological impact, stating that the technique “presented culminated a search for a more direct approach to the lesion and for a less apparent scar, an indispensable quality to the psychologic satisfaction of the patient” (417). The one instance that undermines this relation between scars and psychological distress is found within Wray et al’s 1974 consideration of the technique of free nipple graft for the correction of “extreme gynecomastia.” This article features a small survey, consisting in the following questions:

I am satisfied / unsatisfied with the results of my operation

I now am more willing / less willing to let other people see me without my shirt

I take part in physical classes more / less than before my operation

The scars from the surgery worry me not at all / a little / some / a lot (41)

On the basis of this, the authors report that, although “the scars are extensive, the patients have much preferred the surgical scars to the gynaecomastia and have accepted the result with satisfaction” (ibid). However, the minimisation of scars remains of primary importance as they repeatedly emphasise that this technique is a last resort, only recommended for “extreme” cases.

The attitude to scars in the medical context of FTM chest surgery is noticeably different. While “minimal scarring” is an aim of surgery, it is not
fundamental to the surgical field. In contrast, scars are identified as a “risk” or “complication” of surgery, ideally minimised but fully expected and accepted. Writing in 1979, Lindsay demonstrates this acceptance of scars but also remains aware of what scars can reveal and attempts to undermine the perceived presence of prior breasts through the technique of the C incision, which he declares “has the added advantage that the scar can be ascribed to a chest operation rather than mastectomy” (42). Hage and van Kesteren also accept the resulting scars from surgery, even after use of the Webster technique on smaller breasts, which in relation to gynecomastia surgery is thought to be adequate in minimising scars. As such, here the emphasis is on concealing or, as with Lindsay, downplaying the scars. In relation to small scars, they emphasise that “hair growth surrounding the nipple, though often sparse, may help to obscure the scarring” (388), while, with respect to large excisions, they stress that the resulting scars should avoid the original inframammary fold and instead be located in order to “simulate the inferior and lateral free margin of the pectoralis major muscle, hence emphasizing this margin” (389). Colic and Colic directly reference this form of acceptance in their study of chest surgery on both transsexual and gynecomastia patients:

To amputate a breast is a complex procedure after genital transformation: it often leaves unacceptable scars and a misconception that the patient should be happy despite the scars because the hair will grow around them after hormonal substitutional therapy (450).

In contrast to other medical literature on FTM chest surgery, instead of focusing on overcoming sexual difference, they concentrate on the minimisation of
scarring, reporting that all “patients were very satisfied with the result because of
the periareolar scar only” (ibid); however, this example remains an anomaly. The
different level of concern for scars in relation to gynecomastia surgery and FTM
chest surgery is a consequence of the naturalness attributed to each chest.
While scars threaten to undermine the naturalness of the chest after
gynecomastia surgery, the FTM chest does not achieve naturalness through
surgery and therefore the threat of scars is not as great. The intensity of the
concern about the visibility of scars in relation to gynecomastia surgery
emphasises to what extent being natural is in fact passing as natural – in order to
be natural, the body must without question look natural.

Scars are not the only impediment to looking natural, there is also the
issue of nipple placement, which operates in service of what Derrida refers to as
the “metaphysics of the proper” (244). Menville, in his 1933 article on
gynecomastia, declares that “[a]s a rule, the nipple is of little consequence to the
male patient,” and thus could be removed with the offending breast (1081).
However, the response to Menville’s statement is vehement; Pitanguy remarks
that Menville’s “technique did not attract followers for obvious reasons” (414),
and Simon et al clarify those reasons through their assertion that “[r]emoval of
the nipple is to be condemned even in the most severe cases, as the resultant
deformity would be as bad or worse than the original condition” (48). Breasts on
non-trans men are considered thoroughly abnormal, but the male chest without
nipples is evidently met with equal or perhaps more horror. Notably, the concern
over nipples is entirely focused on form not function. The significance of nipples
is solely attributed to their appearance on the chest and any consideration of other factors is noticeably absent. This is not entirely shocking given that male nipples have long been described as a case of evolutionary mystery through which they have been reduced to appearance. According to Elisabeth A. Lloyd in *The Case of the Female Orgasm: Bias in the Science of Evolution* (2005), male nipples have been situated as parallel to the female orgasm in some evolutionary accounts on the basis that neither can be associated with reproductive success, which is taken to be the “crucial element” of “natural selection” (5). Lloyd identifies Donald Symon’s explanation as the “best available” (13), an account in which both male nipples and female orgasm are described as “by-products” of the adaptive process in the other sex, not adaptations in their own right (14). The medical literature on gynecomastia surgery maintains these evolutionary perspectives in attributing no function to the male nipple. As “homologue” of the female nipple, which, as Lloyd explains, may even include as part of its evolutionary function, sexual sensation as reward for nursing (13), the male nipple could also function as an erogenous zone of the body. However, this possibility is erased from the medical discourse on gynecomastia surgery as there is no consideration of the maintenance of nipple sensation through surgery. Although the male nipple is once again reduced to its form through its figuration as a central feature of looking “natural,” to a great extent form is function in this context, in the sense that *looking* “natural” is *being* “natural.” This is why, in contrast to Menville’s disregard, the male nipple is considered absolutely necessary in the materialisation of the “natural” male body.
The mere presence of nipples is not enough, they must be in the appropriate location and of suitable dimensions, and this is particularly emphasised in relation to FTM chest surgery. Lindsay declares that the “average female areola must be reduced considerably to resemble the male structure…The nipple should be only 2 cm in diameter, and great care must be taken to place them symmetrically and in the correct position” (44). He gives detailed instructions in relation to anatomical landmarks in order to determine the “correct position.” Although the treatment of “severe” gynecomastia also involves the relocation of the nipple, the determination of nipple and areolar size and location is not as much of a concern within this context. Wray et al simply include a brief note that the “nipple site is chosen overlying the fifth rib immediately medial to the inferolateral free margin of the pectoralis major muscle” (40).

This difference in the level of concern about the “proper” placement, size and shape of the nipple and areola is another technique through which sexual difference is asserted in relation to FTM chest surgery. Through the anxious consideration of anatomical measurements, the pre-surgical female body is marked as fundamentally distinct from the male body, while the more relaxed method in relation to gynecomastia surgery maintains the maleness of the chest throughout surgical modification.

In their article on FTM chest surgery, Hage and van Kesteren reference artistic relationships of anatomy from the 1950s in their consideration of nipple reduction and positioning, drawing on two historical texts in particular: the article, “Artistic Relationships in Surface Anatomy of the Face: Application to
Reconstructive Surgery” (Broadbent and Mathews 1957), and the book, *Atlas of Human Anatomy for the Artist* (Peck 1951). The authors of the former are a surgeon and an artist respectively and, while they concede that “faces, hands, breasts, feet, etc., vary according to age, race, and disease,” they still assert that there is a “recognised and acceptable average” (1). An image of this “average” in relation to the placement of nipples is reconstructed within Hage and van Kesteren.

**Figure 2. Nipple location in relation to other parameters of the body**


However, Hage and van Kesteren undermine the fact that Broadbent and Mathews determine nipple placement in the male and female using the same
bodily points and lines, arguing that there is a “sexual difference in nipple position” (390). They conclude their lengthy investigation with the assertion that the nipple “should be placed on the line going straight upward from the native site of the nipple at the crossing of the fourth or fifth rib over the inferior margin of the major pectoralis muscle” (391), a conclusion that is remarkably similar to Wray et al’s quoted above in relation to gynecomastia surgery but one that took a considerably longer time to reach.

The more recent medical evaluations of nipple placement rely more on empirical anatomic studies of the “average” than aesthetic judgement. This change reflects a more widespread shift in attitudes towards the body through which the body has become the central object/subject of normalisation. Cressida Heyes characterises normalisation as “the production of models and standards against which populations can be assessed,” using, as an example, the “unusually recent norm” of the body/mass index (BMI) – a height/weight ratio (33). As emphasised in the previous chapters, the medical field has become a particularly significant site of normalisation through the measurement of bodies in relation to such norms. In this context, the empirical study of the “proper” placement of the male nipple is the establishment of a norm, not one against which individuals are directly assessed but one employed in the service of propagating that norm through the construction of chests in its image. There are
four studies of this nature that I will examine in more depth. Despite the lack of anxiety about nipple placement in relation to gynecomastia surgery, all of these studies are aimed at improving the results of gynecomastia surgery, although Beckenstein et al (1996) and Beer et al (2001) also briefly recognise the application to FTM chest surgery. Within the first study of this kind in 1994, Murphy et al justify their approach by asserting that nipple placement in free grafting in the treatment of “severe” gynecomastia has, so far, been “arbitrary,” while they can provide an “accurate” “standard” (818). In similar fashion, Beckenstein et al lament the fact that there “is no established criteria for the nipple position or areolar diameter in males. There have been recommendations for areolar diameter, but none are based on actual measurements” (33). They cite “unsatisfactory results” based on these various recommendations, and stress that “better results can be achieved by repositioning the nipple-areola complex in a “normal” anatomic position,” adding that the “anatomic parameters that [they] have defined should aid in achieving the objective of restoring a more, normal male chest wall” (35).

Within this medical field, this nipple norm is produced through the empirical study of “normal” men. Murphy et al’s study is based on a small sample of 20 men judged to be “aesthetically perfect” (818), where this phrase references a similar study of the breasts of female subjects conducted by J. Penn in 1955. In order to “study the natural location of the nipple-areola complex in the

46 “Nipple Placement in Simple Mastectomy with Free Nipple Grafting for Severe Gynecomastia” (Murphy et al 1994); “Anatomical Parameters for Nipple Position and Areolar Diameter in Males” (Beckeenstein et al 1996); “Appropriate Location of the Nipple-Areola Complex in Males” (Shulman et al 2001); and “Configuration and Localization of the Nipple-Areola Complex in Men” (Beer et al 2001).
normally built male,” Shulman et al examine 50 nonobese men between 18 and 40 years old with no evidence of gynecomastia (348). Beckenstein et al’s and Beer et al’s articles discuss two very similar studies of 100 “healthy” men between the ages of about 20 and 35. By “healthy,” Beckenstein et al mean “ideal body weight and without evidence of gynecomastia” (33), and Beer et al mean no “subjects who had previous breast surgery, hormone therapy, inverted nipples, gynecomastia, or malformations on the thoracic cage” (1948). As such, the average is already circumscribed by these exclusions. On each of these 100 men, nipple placement in relation to other anatomical points and lines on the body, as well as nipple size, was measured and recorded, in order to determine the “average” or “ideal” dimensions of the “natural” male body (see Figures 3 and 4 below). These parameters were expected to be highly useful in gynecomastia surgery to aid in “restoring a more normal, male chest” (Beckenstein et al 35).

Figure 3.  Anatomical parameters measured

At the end of both of these two empirical studies of “average” nipple placement and size, there is an acknowledgement, one to the Swiss Armed Forces and one to the United States Forces. While it is never explicitly acknowledged in the method, (the study participants are merely designated “volunteers”), it is clear that in both cases they have been recruited from the military. So the anatomy of the “normal” male body, framed as the average of “natural” male bodies, has in fact been constructed from a very selected pool of physically fit male bodies. Applying this highly circumscribed norm in the assessment and construction of bodies operates to reduce the multiplicity of bodies to the “ideal.” Throughout, “proper” nipple placement is a naturalising technique – to look normal is to be natural.
Conclusion

Medical discourse is not merely representative of the body and the medical technologies applied to it; it is a technology itself through which bodies are materialised in specific forms. Thus, the language of surgical practice is not merely descriptive, it changes the very configuration of the body under the surgical knife. Reading medical discourse is a strategy of intervention in the materialisation of bodies produced in the service of hierarchical structures of power. Through it, we can become aware of the specific strategies employed within these particular fields of medical discourse and, armed with this knowledge, we can attempt to ‘undo’ them. Transsexual activists and their allies recognise the power of language in forming our perceptions around bodies and the changes they undergo, as well as the consequences of these perceptions, both materially and affectively. Changing the terms used in reference to surgical procedures is part of a process of reclaiming, of shifting, an attempt to change our pictures and our bodies. A central example of this is the recent use of the phrase “chest reconstruction” instead of “breast surgery” to refer to FTM chest surgery. Both terms, “chest” and “reconstruction,” shift the configuration of the landscape under the surgical knife. Applying “chest” to the upper torso marks it as male and shifts the breasts from being a normal part of the body to becoming an unwelcome “shape” or “contour.” “Reconstruction” entails building or forming something again, either entirely starting over or a “reshaping.” In relation to surgery, it’s meaning is closely associated with both “correction” and “restoration” – to reconstruct a body part is to take the broken pieces and put them back
together again in their original state. This text itself, through such devices as the repetitive use of “FTM chest surgery,” is part of this attempt to reshape bodies through discursive force or, in other words, to mark them in an alternative way.

The medical discourse around gynecomastia surgery is a particular example of a somatechnology operating at the level of the ontological. Gynecomastia surgery is effectively a process of becoming natural. This chapter has discussed some of the ways in which the notion of harm operates as the central technique through which this constitution of the natural is effected, and some of the consequences of this – what we consider to be harmful to the body, what we consider an attack on the integrity of the body, is grounded in our relation to the natural. Through the attribution of male breasts as harmful, surgical modification in the form of gynecomastia surgery is assumed to the extent that the post-surgical body is naturalised. In contrast, for trans folks assigned female at birth, it is the surgical procedure itself that is considered harmful, often perceived as a “mutilation” of the natural body. Clearly, some cuts are considered to do harm while others are thought to correct it. While within the medical realm these determinations of harm are taken to be neutral and self-evident, based on the presupposition that the natural is that which should not be harmed, this chapter emphasises the extent to which the notion of harm itself is used to contour the boundaries of that natural. The material effects of these discursive appeals to nature has a significant impact on the embodiment of FTM patients versus those undergoing gynecomastia surgery. This chapter also reveals the highly disciplinary construction of the ‘natural’ – the natural body is
not the opposite of the constructed body, not even the normal body, it is instead
the materialisation of an ideological body. I hope this chapter has the effect of
changing the relation of trans bodies to the natural, although rather than claiming
trans bodies as natural in the same way that post-gynecomastia-surgery bodies
are figured, I would like us to consider the extent to which all bodies are
constituted through and by technologies or, in other words, to what extent all
bodies are ‘not-quite’ the natural.
Chapter 4: (De)Emphasising Chest Surgery as Transition

Within this chapter, I conduct a comparative analysis of the online discourse found on gynecomastia.org and FTM Forum. Details about these research sites, their context and my methodological engagement with them, including ethical considerations, can be found in chapter two.

The (Dis)embodiment of the Virtual

For transgender people and men with gynecomastia, the significance of online space is related to the dis-embodiment of the virtual. As Stephen Whittle highlights in “The Trans-Cyberian Mail Way,” cyberspace still remains the only “safe area where body image and presentation are not amongst the initial aspects of personal judgement” (Whittle 158). Although Whittle is talking about cyberspace in relation to transgender people, his assertion applies equally to men with gynecomastia. According to the comments they make online, they welcome the opportunity to discuss, get information, and tell their stories without being inhibited by the ways in which their physical presentation is being judged. For those living in bodily discomfort, the weight of constantly worrying about their body and how other people are perceiving it is heavy. In providing a space in which that weight is lifted, the virtual world offers a sense of freedom from the constraints of the body – what is unspeakable in person can be typed on the screen precisely because of the absence of visual bodily signs.
The dis-embodiment of cyberspace has been subject to both celebration and criticism within theoretical (and popular) approaches to the Internet. There are so-called “cyber-visionaries” who view the virtual world from a utopic perspective as an arena of boundless freedom in which identities can be tried on and discarded at will. For Michael Benedikt, this is merely an extension of “our age-old capacity and need to dwell in fiction, to dwell empowered or enlightened on other, mythic planes,” but it is “cyberspace’s inherent immateriality and malleability of content” that provides the ideal platform for such story-telling (22). This approach, often referred to as “beat the meat,” a phrase appropriated from William Gibson’s *Neuromancer* trilogy, implies that the physical world is a constraint against which the virtual world provides for the transcendence of the “prison” of materiality and nature, allowing the “infinite possibility for sensation and perception and form” (Lanier, qtd. in Robins 139). Cyberspace is likened to a “playground,” in which the imagination is set free to soar beyond materiality and it’s inherent mortality.

For critics, it is the very same feature of cyberspace that is the focus, though here the possibility of multiple and fluid identities is met with alarm as it is imagined that this opportunity will inevitably lead to deception and fraud. In “Will the Real Body Please Stand Up? Boundary Stories about Virtual Cultures,” Allucquere Roseanne Stone tells the story of “Julie,” a severely disabled woman who built deep and intimate friendships with other women on the Internet (434); upon finding out, several years later, that “Julie” turned out to be a male psychiatrist, many of ‘her’ closest friends felt hurt, angry and, even, violated. This
case of what Stone calls “computer cross-dressing” (435) is the kind of extreme example referred to in critiques of cyberspace, particularly within the popular media, in which such ‘horror stories’ are highlighted in order to undermine utopic visions of the limitless possibility of online selves. On the basis of such ‘dishonesty,’ which is also imagined as limitless within the supposedly sanction-free space of the virtual, the likelihood of the development of ‘real’ relationships is discounted and therefore the idea of ‘virtual community’ considered unimaginable. Kevin Robins, who urges us to “re-politicise” the technological imaginary, argues that disembodied identities, empowered by the omnipotence the virtual world provides, “can only be seen as asocial and, consequently, amoral” (144). For Robins, it is “the continuity of grounded identity that underpins and underwrites moral obligation and commitment” (145). However, while Stone admits that, within the electronic web, “warranting, or grounding, a persona in a physical body, is meaningless,” she is quick to assert that “[e]thics, trust and risk still continue, but in different ways” (435).

Both the celebratory and the condemnatory vision of the Internet as masquerade have the effect of propagating the distinction between the ‘real’ physical world and the ‘artificial’ electronic world. The endless possibility of online masks is associated in both paradigms with the transcendence of reality, where the real is considered to be grounded in materiality. While, in the former, the reality of the physical is represented as monotonous imprisonment to be overcome and, in the latter, the ‘real’ physical body is taken to be the only guarantee of honesty on which to base a relationship, both continue to maintain
the demarcation between ‘real’ and ‘artificial.’ In contrast, Nessim Watson, in his consideration of what is at stake in the attribution of ‘community’ to online social aggregations, undermines this border through the recognition that “all individuals present themselves strategically, sometimes truthfully and sometimes not, to others in everyday life regardless of the medium of communication” (107). Stone also disrupts the real/artificial divide by declaring that, in her study of virtual systems, she “will call both the space of interaction that is the net and the space of interaction that we call the ‘real’ world consensual loci,” where “[e]ach consensual locus has its own ‘reality,’ determined by local conditions;” however, she does include the caveat that “not all realities are equal,” emphasising that one can die in the ‘real’ world but not in the ‘virtual’ (435).

In another response to the presumed artificiality of online identities, David F. Shaw, asserts that it is, in fact, the electronic realm that provides for the opportunity of the gay subjects in his study to take on a “real identity:”

Most importantly, while the playground potential of the IRC [internet relay chat] inarguably exists and people will (and do – even on #gaysex) try on different personalities, the uniqueness of #gaysex lies in the fact that it presents an opportunity for gay men, who often go through life hiding this most vital aspect of their identity, to try on this real identity (144).

This phenomenon is reflected within online social groups made up of FTMs and those containing men with gynecomastia. While these members share the joy of the cyber-visionaries in leaving the physical body behind, it is not to play with fiction but to live reality. The physical body is experienced as an impediment to a ‘real’ self that is made possible within cyberspace precisely because the mask of
materiality is cast aside. In the so-called ‘real’ world in which bodies are constantly decoded as surfaces of signification, FTMs and men with gynecomastia often feel mis-recognised. The dis-embodiment of cyberspace allows them to re-write the meanings associated with their bodies. Whittle highlights the extent to which transgender people have taken up this potential, and, in fact, argues that the current transgender political movement, focused on diversity of gender expression and identity rather than maintenance of the binary sex system, would not be possible without online social spaces. According to Whittle, the offline transgender community of this movement is preceded by and grounded in online transgender communities, thus undermining the perceived primacy of offline, so-called ‘real,’ relationships and communities. In relation to gynecomastia, there is no offline community, and while one or two members of gynecomastia.org have introduced the idea of starting up a local support group and a few members would welcome it, many more value the online space above face-to-face interaction, finding it to be a virtual community of “gyne brethren.”

For all this talk of the dis-embodiment of the virtual, perhaps it is not surprising that it has generally been cyber-feminists and cyber-queer theorists who have “complicated the narrative of bodiless communication” (Blair and Takayoshi 11). For Vivien Sobchack in “Beating the Meat/Surviving the Text, or How to Get Out of this Century Alive,” it is a question of recognising that the disembodying fantasy is just that, a fantasy – the technological can never be separated from its material ground, and it is this ground upon which affection and morality are based (211, 213). This affirmation of the lived body is an
understandable response to the story told by cyber-visionaries that, according to
Kathleen Woodward, views technology as a “prosthesis of the human body, one
that ultimately displaces the material body, transmitting instead its image around
the globe and preserving that image over time” (50). For Sobchack and
Woodward, it is this disavowal of the body through technological revolution that
must be challenged. As Katherine Hayles says, “[a]s we rush to explore the new
vistas that cyberspace has made available for colonization, let us also remember
the fragility of a material world that cannot be replaced” (91).

For others, including myself, the more significant issue is the extent to
which bodies are, in fact, present within cyberspace. Stone argues that
communication technologies are sites of “dissociation and integration” (Desire
88); while they allow for the destabilisation of the presumed relation between the
self and the body, online social groups respond to this perceived threat by
“searching for ways to enact and stabilize a sense of presence in increasingly
diffuse and distributed networks of electronically mediated interaction” and also
“ways to stabilize self/selves in shifting and unstable fields of power” (ibid 88). In
some situations, this online presence is welcome and perhaps even empowering
(Wakeford) whereas, in others, this form of visibility can actually have the effect
of contributing to invisibility and silence, such as, in Joanne Addison and Susan
Hilligoss’ experience within an online discussion group in which they felt that their
lesbian bodies were perceived as a threat. In this case, the image of the lesbian
body was excessively visible at the expense of their individual embodiment,
which was rendered invisible through silencing. However, whether celebrated or
silenced, in both cases it is evident that the body exerts a presence in online space. For Wakeford, it is this recognition that “doing cyberspace is itself embodied” that leads to the dissolution of the dichotomy between ‘real’ and ‘virtual’ (101). In the same vein, Katherine Hayles urges us to consider the “possibility that pattern and presence are mutually enhancing and supportive,” rather than “opposites existing in antagonistic relation” (91), although it must be recognised that the nature of these cybernetic embodiments depends on the flux of power operating within online social groups to the same extent as that in offline spaces. “The realm of cyberspace, rather than providing an ideal space for free play, may simply provide a differently configured apparatus of social control” (Deegan, Chernaik, and Gibson 6).

Within gynecomastia.org and FTM Forum, the body is at the heart of most discussion threads – after all, it is bodily issues that have brought users to these sites. On gynecomastia.org, users offer up their bodies by describing them in great detail and, in many cases, posting pictures of their breasts and inviting ratings of the severity of their ‘condition.’ Offline, these men fear this type of judgement but, within this online space, they welcome it because of the extent to which they are involved in this process of re-embodiment. While it is the dis-embodiment of the virtual that encourages entry, it is through the processes of re-embodiment that one can read the (un)naturalisation techniques through which bodies are materialised within online text.
Transition

In this chapter, I focus my analysis primarily on two or three threads from FTM Forum and gynecomastia.org. In both gynecomastia.org and FTM Forum, the ways in which the concept of transition is represented and negotiated becomes a significant discursive practice through which bodies (dis)appear. The following sections engage with some of the central techniques employed in (de)emphasising transition and the effects they have on conceptions of the FTM and male body.

From “bio-guy” to “cissexual male”

The space or lack of it between “trans” and “man” may seem insignificant to the uninitiated but it takes on huge importance in the context of FTM Forum in the formation of bodies and the meanings associated with them. There are two sides that contribute to these formations, both involving the relation of non-trans men to trans men, though one provides a transformation of the relation primarily through the first term and the other through the second. I will start with an exploration of the ways in which the first approach is achieved within FTM Forum. The terms used to refer to non-trans men, those men who were assigned male at birth, and the discussions around these terms have the effect of situating trans men in proximity to non-trans men, and this is one technique through which transition is downplayed and the dichotomy between natural and unnatural is

---

49 I use the term, non-trans men, to reference the object that is at the heart of this debate. This debate emphasises the highly political nature of such language usage and, as such, I recognise that this is not a neutral term. I choose it, in part, because this term is not one that is under consideration here so it provides some distance between my analysis and the online discussion but, to a greater extent, because I acknowledge the problems articulated in relation to both terms that are featured in the debate.
challenged. The dominant view of FTMs is that the FTM body is distinct from the “natural” male body and will always remain so because the border between sexed bodies is insurmountable. Within FTM Forum (and the wider transgender community), it is felt that the use of terms such as “bio-guy” to refer to non-trans men represents this perspective and has the effect of maintaining the opposition between the FTM body and the “natural” male body, where “biological” marks the latter as authentic and, by implication, the former as artificial or not “the real deal.” As such, it is met with extreme hostility in the following members-only interaction between icarus_after, one of the more frequent, and more antagonistic, posters whose avatar is Superman, and indigo_mindset, whose ignorance about the use of “biological” in contrast to “trans,” as well as his general lack of knowledge about the different procedures of FTM chest surgery, mark him as a newcomer to the community. indigo_mindset starts the thread by asking a question about the effect of chest surgery on nipple size and sets off the altercation with icarus_after with this comment, in which he situates his body in opposition to the “biological male” body:

indigo_mindset: I'm about a C-cup and my nipples aren't that big - about an inch and a half in diameter - but they don't look like they'd belong to a biological male. That's where my issue comes into play.

icarus_after: …it is inaccurate and fucking offensive to use the term "biological male" to refer to someone who is non-trans.

indigo_mindset: …What's wrong with me using the term "biological male" for people born with XY chromosomes? What would you rather have had me use? I'm surprised you're offended to the point of cursing.
I'm transgender. I'm a male. I was born biologically female, and this is something I have come to terms with despite what chemical and physical changes I may make to my body to become more masculine.

*icarus_after:* …if you think you were born biologically female, that's fine. Calling nontrans men "biological men" implies that I am not biologically male, a notion I flatly reject.50

At which point, *icarus_after* directs *indigo_mindset* to a thread from two years earlier about when to “disclose” transgender status in relation to dating, which features the following argument:

*icarus_after:* as far as I'm concerned, my biological sex is male.

*i_am_frozen:* Your biological sex isn't male. You can't change your science. Bio refers to biology the last time I checked. And you can't change your genetics. All of us here are men but we aren't bio men...

*icarus_after:* Man, no kidding, you have a copy of a kerotype test that was performed on me? So you know what my genetic makeup is? And you also know that I am neurologically female? That is amazing!...

*i_am_frozen:* When you use the words, "as far as I'm concerned" that is referring that you aren't bio male. There you go...

*icarus_after:* …I said that I, like many men here, do not like the term "bio" as a stand in for "non-transsexual"...

I'd guess that you, actually, don't know your "biological sex" either, if you're basing it on genetic kerotype. Biology is about more than genital configuration, which I'd warrant is all you have any concrete knowledge of for yourself. Studies indicate that, just as we have sex organ characteristics that—typically, but not always—align with our kerotyping, we also have neurological sex. It is clear to me that my neurological sex is and always has been male. I do not know what my kerotype is, and since many men (including those with

---

reproductive systems most commonly identified as "male") have kerotypes that are not XY, i am not particularly concerned about that. if you are comfortable defining your sex based on your natal genitals, that's great for you. i understand that my sex is not represented by my genitals. genital configuration is one way sex might be identified, but it is not absolute, and even in the most traditional understanding of sex, it's not a constant; that is, many people have a kerotype (XX, XY, XXY, etc.) that does not correspond to their genitals. also, clearly, some people have a neurological sex that is different from their genital sex.

biology-- or, to turn your phrase, "my science,"-- is considerably more complex than taking a gander at the contents of one's knickers. to say that a non-transsexual man is a "bio male" first assumes a lot of things you don't actually know about the man in question and second assumes a lot of things i can tell you are in direct contradiction to what many men with transsexualism understand about themselves.51

In this exchange, i_am_frozen appeals to a view of transsexuality based on the Cartesian theory of mind/body duality, in which it is conceived as the incongruity between male self and female body, where the body is reduced to the “science” of “genetics,” which is assumed to be expressed in “genital configuration.” However, icarus_after adopts a different understanding of the physical, one in which multiple biological indicators of sex are recognised. As such, he is able to assert “biological maleness” by over-riding “natal genitals” and “genetic kerotype” on the basis of “neurological sex,” which he claims absolute access to. This strategy of disallowing “biological maleness” as a ground for the difference between trans men and non-trans men has the effect of undermining this presupposed difference.

Through both the representation of transsexuality as a misalignment between the various indicators of sex and the recognition of other bodies with misalignment, *icarus_after* aligns transsexuality with intersexuality. As mentioned in the previous chapter, according to Henry Rubin in “The Logic of Treatment,” this form of association with intersexuality is part of the historical story of how FTMss became “treatable bodies” – how the treatment protocol began to shift from psychological therapy to surgical modification (498). Rubin asserts that traditional medicine provides for the treatment of a body only in the presence of physical abnormality, so nascent FTMs “sank their problems deep into their flesh,” appealing to a “hidden pathology” (497, 493). While the Cartesian understanding of transsexuality maintains the debate between psychological therapy and surgical modification as the appropriate solution, intersexuality is invoked in order to justify the latter, which then becomes “medical intervention within its proper domain of action” (497). Thus, there is much at stake in the association between transsexuality and intersexuality, as it is understood to provide for the “correction” of this “physical issue” through the surgical transformation of those bodily characteristics that are considered female. However, the course of treatment still rests on the evaluation of (im)mutability. Although, in this understanding, the mind/body dualism is replaced by multiple sexual factors all located in the physical, according to *icarus_after*, neurological sex (and karotype) are fixed while other sexual features can be modified. As such, he asserts that his “neurological sex is and always has been male” in order to justify both his “biological maleness” and the surgical correction of female sexual characteristics.
The difference between the first and the second exchange quoted above at length is significant in relation to the formation of the community and, in particular, its behavioural norms. In the first, icarus_after quickly and harshly scolds indigo_mindset for the use of “biological” in relation to non-trans men. Through this technique of “flaming,” icarus_after marks indigo_mindset as an outsider to the community and also determines the parameters of community engagement around this issue. The fact that no-one challenges icarus_after makes it seem as though his position is the community perspective on this form of language usage and indigo_mindset’s silence reflects his position as newcomer and his agreement with the guidelines as presented to him. In contrast, though many members express their support of icarus_after’s position in the second thread, there is also considerable disagreement. icarus_after is the first responder to the original post and expresses his dislike for the term “biological,” though in noticeably less extreme language: “…i, like many guys here, bristle at the prefix "bio" to describe non-transsexual men.” In reply, sambleu, the original poster, quickly declares: “I hate the term cis and their biological sex is male. So, that's how I phrase it.” Unlike indigo_mindset, sambleu marks his position as insider by succinctly demonstrating his awareness of the debate around the dualism of “bio” and “trans,” as well as the emergence of “cis” to replace “bio.” The fact that he does not explain the term “cis,” (which I will clarify in a moment), identifies the conversation as an internal debate amongst those with the appropriate knowledge. The debate over the language used to label non-trans men and, by implication, trans men, rages long and hard in this
thread, which reaches 207 comments and includes multiple very heated interactions. Some members feel that the nature of this conversation undermines the goal of support within the community, while others assert that community is formed through such disagreements.

One such dispute within this thread provides a different perspective on the "biological," which I will emphasise before examining the operation of "cis."

*turkishb* defends the use of "bio" in the following:

to me, the fact that i am trans is sort of oppositional to being bio in a big broad way. if i was biologically male, then my maleness would more or less be enjoyed fully from my biological matter, but i had to supplement it. therefore i transcended my biology to attenuate my body to my mind. i would actually say a great deal of people, then, fit on some spectrum of trasness [sic], as even for those who have male-born bodies may have dysfunctions too. but then, there i am informed also by transhumanism in general. do i think my sex is situated biologically in me, in some ultimately defining way? (we both know i sort of don't.) but i would wager i am neurologically more male, or that my consciousness is more male. (they aren't the same thing.)

so to me, not so offensive.

And later:

...does bio really capture the essential, determinant nature of sex? Because obviously, for us it didn't, but we would not think ourselves less authentic. (And it would have trouble in other places, too.) It's only because bio, and biology, is standing in for a deeper authenticity that that's at issue. What I mean is, bio doesn't necessarily have that value attached to it, and didn't for the OP [original poster].

Who, or what, would I call bio? Probably someone who has not introduced any artificial (that isn't a dirty word to me) treatment or supplementation of their sex identity. For someone with an XYY chromosomal identity, they generally live functionally as men and don't supplement their identities as men. (As far as I know, when I
last read about it.) So they’d be bio-men. Does bio refer to their chromosomal info? Sure, but in context with what their needs were as a living being. Sex, obviously, is a category that relies on an aggregate of factors.

Am I bio-sexed? I don't rely totally on my own biology for my sex, so no. I'm transsexed, a transsexual. If I was intersexed, or had Klinefelter's, or a botched circumcision, or hypogonadism, or was post-menopausal I would probably be supplementing or changing my biology to correct it into the greater aggregate of a functional sex. In that sense, I would be transcending my biology, and be on the trans scale. Are they anywhere close to us? I think it might actually be useful to say yes. Especially if we're saying transsexuality is a medical concern, I think that body context is sort of useful.

Interestingly, turkishb makes some of the same moves as icarus_after but for a different purpose. Just as icarus_after does, turkishb aligns transsexuality with intersexuality, but for turkishb, this marks intersex bodies, (if supplemented in some way), as non-biological in the same way as transsexual bodies, while for icarus_after, this association is made in order to claim the biological status of intersexuality for transsexuality. In short, turkishb defines intersex as transsexual while icarus_after defines transsexual as intersex. The former is attempting to undermine the “deeper authenticity” associated with “biological,” while the latter is invested in the “biological” in order to redefine transsexuality as authentic. Despite this significant divergence, both ultimately ground their maleness in the neurological, which, even turkishb admits, constitutes a “biological sexing.”

The term “cis” emerges as an attempt to avoid these issues of authenticity or realness associated with the “biological” or, in other words, an attempt to move beyond the binary of natural versus artificial. As zen_pop_culture explains:
I've always seen "cis" as a nice answer to the dichotomy of trans and bio, or even trans and non-trans. "cis" means "on the same side as"—so, in other words, whatever you were assigned as was correct, and you never had to do any shifting to get to the right place. Whereas "bio" or "genetic" are implying that I'm not biological or genetic at all. What am I, then, an ectoplasm? An android? And also, people often use "bio" or "genetic" against us when it doesn't even relate to our gender—"John, that makes you a bio woman" or "Linda's a genetic male!" "Cis" can't really be conflated in that way because there's no way it can be turned against us—I'm cisgender, sure, because my gender has never shifted throughout my life. But I can't be called cissexual (a cissexual female, or whatever) because biologically speaking, the sexual aspects of my body are not "on the same side" as they were when I was formed in utero. I admit I'm not a cissexual male, but somehow for me it's not as othery as "bio."

Through the use of "bio," and its meaning as fixed, transsexual bodies are rendered (un)natural— as I emphasise, for the FTM body, the "biological" or natural female body is that from which it can never fully escape and the "bio" male body is that which it is forever unable to achieve. The dichotomy of "cis" versus "trans" is intended to avoid the delegitimisation of transsexual bodies associated with the attribution of "bio" to non-trans people. "Cis" does not have the same implications of devaluation because it is not a term through which power operates as the term "biological," or its synonym, "natural," is. While zen_pop_culture highlights these advantages with the term "cis," some members echo sambleu, the original poster in this sub-thread, in their dislike for it, and loganloveslego goes so far as to declare it "elitist:"

Think back to where and when you learned it? Who did you learn it from? What opportunity presented you with the parameters to understand it?

There are so many words and idea's that surround 'trans' that MANY and MOST people are not even given the oppourtunity to
understand. I think creating terms that most people CANT know unless they seek education or it's forced upon them, is another way of 'othering'....

Here, loganloveslego reveals the class dimensions of language use in emphasising the lack of access to the discourse surrounding the term "cis," and that the use of that term can have the effect of marking the border between those who have that access and those that do not. Although, as mentioned above, I have chosen to use "non-trans" over "cis" (or, for that matter, MAAB (male assigned at birth)) for some of the reasons above, I acknowledge the power in a community defining a language shift in order to challenge presuppositions about the natural that damage transsexual bodies.

**Transman or trans man**

The other side of the redefinition of the relation between non-trans men and trans men addresses the second term and is focused on the difference of transsexuality, and whether this difference is emphasised or not determines how transition is understood. The debate around this issue produces the objects of “trans man” and “transman,” where the former downplays difference from non-trans men and therefore transsexuality as a form of transition, while the latter is more invested in emphasising the distinction. (The line is not absolute between these identities and my characterisation of them but predominantly so in this context). To a great extent, the distinction between “trans man” and “transman” relies on different conceptions of the history of the body and the ways in which that history marks the post-transition body as (dis)similar to non-trans men. These issues were made especially evident in a particular thread started on May
7, 2010, which generated 91 comments and much heated debate. fruit_ing opens

the conversation with the following:

…sometimes I feel like an alien among men raised as men. What other guy spent 6 years bleeding out their genitals? Maybe part of it is due to my being a feminist.. but part of it seems like, due to my upbringing, and the reality of my body, I will never be able to see the world the way male raised males do. And..I'm okay with that, because hell if most of the differences I see aren't ones that m.r.m.'s come off worse by comparison.

Just curious to hear some other thoughts.. and how y'all think of yourselves- transguys? Just plain ole guy? Why?52

Here, fruit_ing primarily marks the difference between non-trans men and “transguys” in “the reality” of his (female) body, reduced in this instance to menstruation, (which is acknowledged later as a way to “sum up the differences in a compact way” though not a “definite barometer”). fruit_ing seems to espouse a form of bodily essentialism, to the extent that he is accused by smilesweetirony of replicating the “womyn-born-womyn crap.” In the following interaction, ftmny supports fruit_ing in the assertion of binary bodily difference while prettyboicris vehemently disputes the grounding of difference in the body:

ftmny: …we have to accept that there re things about us.. that are always going to be different no amount of wishing is going to change how we were born.. surgery can do a good enough jb with some things but the mere fact that surgery was necessary makes us different.. that doesn't mean we can't socialize and consider ourselves just another guy.. i do most of the time myself.. our history however does make us different..

pretty_bio_cris: Please speak for yours. If YOU want to be different and view yourself as such because of a transition history then go right ahead.

I see myself as different from other men because I am an individual with unique experience. The history of my body is not the difference.

Also your statement "the mere fact surgery was necessary makes us different."

That is like telling a child born with some other medical condition (Blindness, genetic disorders and so on). It doesn't matter what treatment you get you will be different and accept it!

If I wanted to "accept" having been born with a different physical body I wouldn't have had surgery. I refused to accept the hand dealt to me to I made the necessary changes FOR ME! That has lead me to be just another guy PERIOD!

Not only does ftmny emphasise the history of the sexed body in marking the difference between non-trans men and transmen, he also highlights the necessity of surgical transition as a divergent factor. In contrast, prettyboicris downplays the transitional nature of transgender body modification by defining transsexuality as a "medical condition," similar to others that may need "treatment" but do not necessarily imply difference to other non-trans men. sin_nombre and transprose take this point further, the former by describing "medical conditions" that may cause non-trans men to have bodies with female sexual characteristics and the latter through the recognition that non-trans men with such bodies may seek "treatment" that would mirror "treatment" for the "medical condition" of transsexuality:

sin_nombre: There are men and male-assigned individuals who've bled out their genitalia, often due to CAH [congenital adrenal hyperplasia]. There are men and male-assigned individuals who've grown breasts without having taken exogenous estradiol. There are non-trans men who have larger than 'normal' hips and asses and there are non-trans men who were born with ovaries. I'm sure there
are non-trans men who've dealt with all or most of the above because those conditions aren't that uncommon.

transprose: …i don't see my body as meaningfully different from males who were male-assigned-at-birth.

i don't think that there is any experience that i have had, or will have, that a cissexual male somewhere, at some point hasn't had.

HRT, chest reconstruction, genital surgery…

Of particular relevance to this analysis, non-trans men with gynecomastia and the surgical modification they may undergo are included in this attempt to undermine the assumed distance between the trans and non-trans body.

Beyond the body, fruit Ing also emphasises upbringing as a significant factor that sets transmen apart from non-trans men, asking later in the thread, “…what guys were raised as women for 18 years? Isn't that bound to make a difference?” algomuyraro agrees with fruit Ing on the basis of not knowing “how to play football, or tie a tie, or change a tire.” However, prettyboicris emphasises that the way in which fruit Ing and algomuyraro essentialise “male raised males” rests on a disavowal of the extent to which cultural assumptions of race and class intersect with what it means to be “manly.” In response to algomuyraro, prettyboicris says:

…I think some of these conversations focus more on American culture and does not take into considerations other cultures. I guess I have a different view on this stuff because I have a specific cultural I was raise in and also have different cultures that I interact with that do not subscribe to any of the things mentioned.

In my culture Football= Soccer not pigskin! Also Men are supposed to know how to cook, clean, sew, iron, take care of the basic needs of children and do these regularly.
Tying a tie is not necessarily a skill to be mastered depending on what type of work you do and where you work.

As well as this challenge to fruit_ing's argument, doctorrobotnik rejects the notion that he had a “female childhood” that marks him as distinct from non-trans men:

i think the actual impact that for those of us who were "raised as female" can be overrated. speaking for myself, i tend to fit the "typical trans narrative." i knew i was a boy from a very young age and although i didn't know what trans was, or if it was even possible/to transition until i was WAY older, i always had an internal sense of being male. because of this, though i was raised/socialized female, a lot of it didn't "stick." when i was given messages by family or society that "girls should do this/be this/whatever," part of me always knew that i wasn't a girl and those messages weren't for me. so i may have "played the role" but never truly internalized much of the stuff directed at me. similarly, general social messages and ideas directed at guys, though not me, were things i would pick up on and pay attention to. i'm certainly not claiming to have been socialized as male, but i dont feel like i had a "female childhood" either. i mean, most little girls don't grow up knowing that they're really boys, but happen to be in the wrong body. i guess i would say i had a "trans childhood," as always knowing i was male gave me a different perspective on messages i was being given.

does that make me different than most non trans guys? sure. did i miss out on learning a lot of things that most guys do? sure. but again, there is no "typical" male childhood and a lot of guys are raised in different ways, and learn certain things and not others. i guess that while my history is certainly different, it doesn't mean i have no basis to relate to non trans guys and i did go through some of the same stuff, including male puberty, deciding what kind of man i wanted to be, etc. so while i admit that i am different, i don't think the way i was raised deserves as much weight as many people want to give to it.

The denial of a “female childhood” is another way of downplaying transsexuality as a form of transition. In this way, continuity is maintained through the surgical, hormonal, and social modifications by locating it within an uninterrupted male identity (from boy to man), which, as mentioned above, is often attributed to
male-oriented neurobiology. As such, chest surgery is not understood as part of the transition from female to male because there is no sense of being female in the first place; instead, chest surgery becomes a confirmation of self through the alignment of sex characteristics. While doctorrobotnik does not deny his difference, he also emphasises the different ways in which non-trans men are raised. In other similar arguments, rather than a distinct upbringing grounding a divide between non-trans men and trans men, the difference, if any, is associated with uniqueness, the fact that everyone is different to one another. It is a claim of difference among both non-trans men and trans men not difference between those groups. In contrast to fruit_ing's argument, in these perspectives, the declaration of difference is a technique of claiming the sameness of trans men to non-trans men: as prettyboicris says, “we are different in the sense that all men are different.”

Although fruit_ing asserts his superiority over “male raised males” within his declaration of distinction between non-trans men and trans men, the more common experience of this relation for trans men is one of inferiority, of not measuring up as a “real man.” However, doctorrobotnik and other members argue that non-trans men have similar experiences of alienation.

eternal_saudade: I consider myself just a guy, because I think it's a misnomer to believe there is a typical guy, because I think many other guys feel just as alienated as transguys do sometimes, just in different ways. Anyone who is different from the norm tends to feel different, it doesn't mean they aren't who they are, just that they don't belong to the majority statistic. So, like I said, I'm just a guy who is a little different from the "norm," but I don't feel the need to place myself in a separate category because of it.
doctorrobotnik: word. talking to my non trans male friends about this stuff, they all shared feeling like they were weird, or different, or weren't "man enough" or didn't fit in at least at some point in their lives. that really helped me accept that i'm not "different" just because im a transsexual, i'm different because i'm me, and non trans guys can have these feelings as well.

In this perspective, neither difference (of body, upbringing, or any other factor) or feelings of inferiority based on perceived difference can be taken as ground for a universal trans (or non-trans) experience. As such, there is no “separate category” of “transguys” because there is no definitive way to mark a distinction between non-trans men and trans men.

mercurychaos: I'm a trans man — the "trans" part is an adjective, which I could replace with a lot of other adjectives if I wanted to. I feel "just like any other man" in the sense that I am male. Everything else will inevitably vary, and this would still be true even if I were not trans.

The constitution of trans men or “just men who happened to transition” (prettyboicris) within this debate is a technique through which transsexuality as transition is downplayed in order to undermine the presupposed distance between the “natural” male body of non-trans men and the “constructed” body of trans men – it is, in effect, a way of saying ‘we are all equally (un)natural.’ I give varanus, one of the moderators and a well-respected member of the community, the final word as he sums it up so eloquently:

Obviously my history affects my present, as does anyone's. But you know, men of trans experience aren't the only ones who've had alienated childhoods and adolescences (those of us who did, of course). We're not the only group of men who felt incompetent or like we missed something. We're not even the only men who have secrets (those of us who are stealth) or non-normative genitals that need surgical correction (those of us who do).
The Suffering of Gynecomastia

In contrast to the medical understanding of gynecomastia surgery, gynecomastia surgery is reconfigured within gynecomastia.org as a life-changing transition – members describe being “born again” and “becoming whole.” While the surgery is recognised as providing a significant physical change, it is the mental transformation that is emphasised, to the extent that the transition is largely considered to constitute a shift from mental illness (depression, withdrawal, anxiety, lack of confidence, shame) to mental health (happiness, assertiveness, confidence). In part, the mental anguish is stressed because insurance coverage for the procedure may be provided on the indication of pain and the evidence that surgery is necessary to alleviate that pain. However, the mental pain is also very real, deep and long-lasting, and this suffering is to a great extent taken to be the foundation of the community, which is why the Acceptance forum sits uneasily within the rest of the board. The psychological stress of gynecomastia is especially evident in the thread, “What is your worst gynecomastia memory :’(,” a conversation that clearly resonates with the community given that it was started in September 2008 and continues to grow, reaching 238 comments so far, a significant number in a forum in which most threads are less than 10 comments long. On this thread, non-trans men with gynecomastia echo each others stories of lifetimes of the inability to hug freely, to run or swim without inhibition, to have sex without shame, and much more,

53 As of July 15, 2010.
54 In reference to the above discussion, I include this modifier in order to undermine the structural privilege generally accorded non-trans men by simply referring to them as “men” while continuing to demarcate trans men as “trans men.”
particularly in relation to restriction of movement in space and limitation of personal growth. ellipsis7 shares his story in the following excerpt:

The worst experience I've had with gyne can't be nailed down to a specific moment, but it was the everyday struggle of trying to hide it from everyone. I'd feel petrified just walking down the street without a coat on. I'd worry about certain wind gust hitting my chest the wrong way, or being around a cute girl I was interested in, sparking a great conversation with her, getting to a point where it was obvious that we had a huge connection, only to know that I'd have to end the relationship once it started to get intimate, due to the possibility of having to be naked around her. I couldn't go anywhere without heavy shirts or coats in warm or cold weather, and had to deal with the mental agony of having to explain to people why I wouldn't take them off. Or knowing that I was a alright looking dude, but because I couldn't be myself that people would feel weird around me due to the vibe I was sending out.

Here, he locates the suffering of gynecomastia not in the physical condition itself but in the “everyday struggle” of living with it: the constant worry about what to wear and how to explain the inappropriate clothing, the inability to engage in social interaction, even the consideration of the direction of the wind. The weight of bodily discomfort is not limited to those moments in which the breasts are made visible through the hurtful words or actions of others, though those situations are multiple; rather, the shame of gynecomastia is so debilitating because it remains constant. Although there is harassment from others that highlights the policing and regulation of sexed and gendered bodies within social space, the constant suffering is largely due to the breasts becoming the object of self-surveillance, the most powerful technique of normalisation. As

55 In order to represent the text as it appears on the forums under consideration, I make no attempt to correct the spelling and grammar of the original.
headheldhigh01, a regular and well-respected poster, says “…i was thinking sometimes it's not just the big nasty stories, though they're the worst and we all have them, sometimes it's death by a thousand paper cuts too.” In contrast to the medical classification of gynecomastia, which focuses on the physical size of the breasts, within this context, the severity of gynecomastia is measured more in relation to the level of suffering. Despite the frequent appeals to “rate my gynecomastia” based on user photos, members agree with headheldhigh01, who declares in his signature: “if it screws up your life the same, is there really any such thing as "mild" gyne?”

Although many of the worst gynecomastia memories cited by members involve situations in which they have to reveal their bodies, such as in locker rooms or swimming class, Wedvilla and others reiterate the extent to which gynecomastia affects their whole life:

I’d say that I’ve underachieved significantly in my life, always tantalisingly close to ‘normal’ things like wife and family and career, but they remained elusive, lost in the fug of depression and misery and daily compensation / hiding strategies G necessitates.

I think we all learn to strategise our G from an early age, but what I only realised not so long ago was that it was this daily grind of misery and strategising that had stunted me, my life was the bird to its cage, so to speak. The more I thought about it, I realised / remembered that my life, and particularly my young 10/11 year old life onwards, had contained countless little incidences that cumulatively caused my adult dysfuntionality…

…I’m finally facing up to it and getting it sorted next month, but the one thing I’d like to say to any youngsters reading this and these pages, is whatever you do don’t waste your twenties and thirties by not facing up to it, do whatever you can as soon as possible to get the cash together, and get it sorted and give yourself a chance of a fulfilling life.
Wedvilla was 42 at the time of writing and was about to have chest surgery, which he imagines as a technology through which he will transition from “dysfunctionality” to fulfilment, reclaiming the life lost to gynecomastia for all those years through the achievement of those “‘normal’ things like wife and family and career.” On gynecomastia.org, it becomes clear that gynecomastia surgery not only removes the glandular breast tissue but, more significantly, the stress and anxiety associated with that tissue – the joke often cited by members, it’s a “weight off your chest,” references the dual action of surgery in addressing the physical condition and the “mental scars” (steveo40) caused by it.

As in Jessica Cadwallader’s study, “Suffering Difference: Normalisation and Power,” the discursive operation of suffering on gynecomastia.org is a central normalisation technique in the production of the “natural” body. In distancing the gynecomastic body from the “natural” male body, it asserts the necessity of surgical modification, but not only to “correct” the body, more significantly, to restore mental health. Taking suffering to be a natural and neutral response to the biological “mishap” of gynecomastia elides the political nature of the experience of suffering, which, as Cadwallader emphasises, is more appropriately understood as an “anatamo-political technique of power that plays a critical role in biopower’s normalisation of both the individual and species body” (389); however, I do not discount the “realness” of suffering or unsympathetically advocate living with it in the struggle against ideas of the normal. That is an argument second-wave feminist Janice Raymond used against transsexuals in The Transsexual Empire: The Making of the She-Male and it is not one I want to
repeat. Just because the nature of bodily discomfort is to some extent contingent on social, cultural, and economic conditions does not mean that it is the weight we should bear in order to change those conditions. However, I do hope, along with Cadwallader, that the deconstruction of suffering may provide a space in which “the normal has been so thoroughly placed in question that difference may be able to be difference rather than deviance” (392).

**Becoming a Man**

Much of the suffering of gynecomastia is caused by the fact that breasts are marked as female. Within the contemporary Western social imaginary that figures male and female as “stable, incommensurable, opposite sexes” grounded in “sharp corporeal distinctions” (Laqueur 5-6), the appearance of breasts on a body previously understood to be male threatens both body and self. This is at the heart of the mental anguish experienced by men with gynecomastia and the reason that horror, not acceptance, is generally considered the appropriate response to the presence of breasts. On the thread referenced above, the comments and taunts aimed at men with gynecomastia constantly assert the femaleness of the breasts – one girl told *EJ1990* he had “baggage like a girl,” while another said to *impervious*, “your boobs are bigger than mine.” By extension, the femaleness of the body itself is asserted, as *kevinrex*’s narrative demonstrates:

…as of late my worst is probably when i was talking to one of my female co workers. we got into a conversation about pregnancy. she told me i should never get pregnant because it will make my boobs get bigger. some of my coworkers who were eavesdropping laughed.
As I argue in the next chapter, pregnancy is a technology of the natural through which bodies are marked as female, so the appeal to pregnancy here highlights the extent to which gynecomastia ‘females’ the body.

As such, gynecomastia is represented as a barrier to the achievement of manhood, which is associated primarily with success with the “opposite” sex and in sports. In relation to the former, success is often defined as sexual intercourse, with many members blaming their virginity on gynecomastia, and those who have engaged in sexual relations emphasising the extreme self-consciousness that makes the experience uncomfortable. *mthatch1* writes in the thread referenced above, “[d]uring sex, I make every effort to lie flat and avoid being seen,” a description that shows that, although he has technically engaged in sex, manhood is not achieved through it because he is unable to take up the role stereotypically associated with maleness within sexual intercourse, that of being in a position of dominance both in terms of being physically on “top” and leading the sexual interaction. However, success is not only about intercourse, it is also identified with a level of intimacy that fosters love, which, to some extent, undermines the masculinised narrative of an absolute obsession with sex above all else. The same story about losing a great love resurfaces time and time again on *gynecomastia.org*, particularly as a “worst gynecomastia memory” on the same thread. *gyne-be-gone*’s rendition is the following:

Having gynecomastia also destroyed my relationship with the one and only girl I have ever really loved. We had dated for once as sophmores in high school but it wasn't very serious. Then as juniors we became really good friends again and decided to date again. It became very serious but I was terrified to have sex with her because I didn't want to take my shirt off. I always was thinking of
reasons not to have sex even though I really REALLY wanted to! Because of this she thought I was a big fat pussy who "wasn't ready" and it just killed me inside. it was a lose-lose situation. She eventually dumped me, and this was a major reason why. A later found out she was cheating on me with another "friend" of mine since I was to afraid to have sex with her I fucking hate gyne, it ruined my teenage years. I finally got the surgery done, I'm 29 but its to late, that girl is gone forever along with all the great care free teen age years that I missed because of hiding my chest and worrying about my appearance.

The presence of breasts undermines heterosexual masculinity because heterosexuality is considered to be grounded in the bodily difference between male and female. The gynecomastic body is represented as unable to achieve heterosexual masculinity because it is situated in such close proximity to the female body – in helloHELLO’s description of a situation in which a girl felt his chest and said "oh whats that...looks like we can get bras together," the assertion of bodily similarity derailed the sexual intimacy. The breasts are considered an “obstacle,” a physical barrier that prevents men from entering into sexual relations with women, and, within this understanding, gynecomastia surgery becomes necessary in order to accomplish heterosexuality.

In contrast, those who accept their breasts (or worse, take pleasure in them and/or attempt to improve their growth) are treated as pariahs, excluded from the category of "normal" men, to a great extent because they are perceived as homosexual or transsexual, both of which are linked with other “perversions,” such as bestiality or pedophilia.57 Although the “Acceptance” forum exists, it is marked as “fetishistic” in opposition to the “medical” characteristic of the rest of

---

the site. While it is clearly demarcated from the rest of the discussion boards, many members feel this section should be entirely eliminated from the site. It is through the exclusion of the acceptance of breasted bodies that the border of the dominant community is maintained around “normal” men who “hate this condition.” Just as gynecomastia is represented as threatening to the individual male body, the bodies of those who accept their breasts are considered a threat to the community. Much of this border control is done in the name of youth, and propagates the dominant narrative of ‘homosexual recruitment,’ or at a more physical level, a conception of homosexuality (or other “perversions”) as a virus that could infect bodies that come into contact, even online contact. The current of paternalistic protection presupposes the heterosexuality and masculinity of the (young) male body and has the effect of distancing homosexuality from both the normal and the natural.

As well as the association of heterosexuality with maleness, sport is also identified as a significant factor in the achievement of manhood. carguy starts a thread called “the Sports issue” with the following comment:

I’ve had surgery and resolved everything physically but one thing still haunts my mind. You guys ever think of where you might be if you played your fav sport and was actually good at it? I'm bringing up this topic because I’ve been watching college basketball games and track-and-field. It hurts to know that I might never see my full potential. I missed all those workouts and insights on the game throughout high school. I was very good athlete in middle school and then the monster Gyne reared its ugly head. I tried even playing football with it, but it hurt like crazy when I got hit in the chest to the point of throbbing pain. Of course I didn't know of surgery or anything so I kept it to myself all throughout high school. For me, being an athlete meant respect from my peers. When I stopped working out, I felt like a little boy among men who were getting better and better as I became more and more out of shape.
There were kids that I KNEW I was better than, being successful and popular playing sports. Its like being robbed of an inheritance you deserved/worked for.\textsuperscript{58}

Here, sport is not only about gaining respect and popularity, it is figured as a practice through which the transition from boy to man is achieved and, although the “inheritance” \textit{carguy} references is directly associated with “being successful and popular,” there is also a strong sense that \textit{carguy} feels fundamentally “robbed of” the transition. Thus, the presence of breasts is not merely an impediment to an involvement with sport, it prevents an engagement with a crucial technology of the natural without which \textit{carguy} remains “a little boy.”

Framing gynecomastia as a barrier in the transition from boy to man is a technique through which surgery is represented not just as necessary but as urgent. The achievement of heterosexuality and sports success are identified as significant rites of passage of the teenage and early adulthood years and, as such, there is much emphasis on undergoing surgery as early as possible. Many of the members on \textit{gynecomastia.org} appear to be young,\textsuperscript{59} and the overwhelming advice from older members (see \textit{Wedvilla’s} comment cited earlier) and even the mothers on the forum is to act fast in addressing the condition of gynecomastia through surgical modification. Thus, regret, which saturates \textit{carguy’s} post above, is aligned with the pre-surgical body, the body with breasts, in contrast to both the medical literature on FTM chest surgery, in which regret is


\textsuperscript{59} This is borne out by the 2009 \textit{Cosmetic Surgery National Data Bank Statistics} compiled by the American Society for Aesthetic Plastic Surgeons, which reveals that the majority of gynecomastia procedures are undergone by 19-34 year olds (58\%) and a significant percentage are carried out on those 18 and under (9.6\%), a far larger figure than most other cosmetic procedures in that age group, only topped by surgery on the ear or nose (10).
firmly associated with the post-surgical body, and the medical discourse on gynecomastia surgery, where regret does not feature at all.

The representation of manhood as the achievement of heterosexuality and sports prowess, although the “natural” male body is still considered a necessary ground, supports a social constructivist approach to sex and gender. It would appear the experience of gynecomastia provides for an understanding of the extent to which, to quote Simone de Beauvoir, “one is not born, but rather becomes,” a man. Chest surgery is rarely taken as a threat to the natural, rather, it is considered necessary in the realisation of the natural male body. However, surgical modification is only the beginning of becoming a man in providing the bodily ground through which one can achieve heterosexuality and physical prowess, which then makes the man. Thus, within this context, chest surgery is imagined as a significant part of the transition to becoming a man.

From Presence to Absence

Drawing on Drew Leder’s argument in The Absent Body, in which he describes how “the body, forgotten in its seamless functioning, comes to thematic attention particularly at times of breakdown or problematic operation” (127), I argue that the body with gynecomastia becomes present where previously it was absent. Leder is concerned with bodily dysfunction in relation to “intentional disruption” (81), (being unable to act in the way one intends to), and, while the growth of breasts on men is not strictly considered a bodily dysfunction, the discussion above in relation to the failure to achieve heterosexual masculinity and engage in sports demonstrates the ways in which the perceived abnormality
is experienced as bodily dysfunction. Thus, the gynecomastic body comes to attention to the extent that it is perceived as deviating from the standards of normality and inhibiting the practices through which manhood is achieved.

Through this conception of the gynecomastic body as problematic in its presence, chest surgery is reconfigured as a technology through which the body regains its previous absence. For Sander L. Gilman, in “The Wrong Body” within Making the Body Beautiful: A Cultural History of Aesthetic Surgery, the only other academic analysis of gynecomastia surgery, gynecomastia surgery is the means to “become (in)visible in the cohort of men without breasts” or, in other words, “to pass” as “real” men (262, 36); however, it is not just about the possibility “to look like everyone else” but more significantly about the sense of bodily comfort associated with appearing normal. The gynecomastic body is a body that is always present, impossible to forget even for a moment, and so gynecomastia surgery is figured as a way to achieve bodily comfort, where this is imagined as an ideal of bodily absence or disappearance. patsdude describes this transition in the “worst gynecomastia memory” thread:

There was no specific memory for me. Just the constant scheming of how I can get in the pool without anyone seeing me, or rummaging through all of my shirts to find one that wouldn't look awful. I'm almost 2 weeks post op and I can't tell you how great it feels to wear a polo and walk into a room without thinking about my gynecomastia. If you're having second thoughts about the surgery get it done, its well worth it.

While for patsdude, it feels “great” to live “without thinking” about his breasts, for demha, the absence is marked by a “dull” feeling because the chest is not “new” but merely reclaimed:
Right now I’m post-op and I can’t describe well enough what it feels like to be able to take my shirt off without hesitation. People say it feels great! but to me it’s a dull feeling, nothing like receiving a new privilege or benefit. More like finally getting what I was obligated to get.

Here, chest surgery is represented as a way of getting what was rightfully owed to him – the male body that should naturally have been and can now be made visible “without hesitation.” Leder describes the absent body as characteristic of normal and healthy functioning, which is why “forgetting about or “freeing oneself” from the body takes on a positive valuation” (69). Through gynecomastia surgery, the “everyday struggle” (ellington7) of the present body becomes “a freedom that you never had before” (MrRossZ28), a freedom associated with the absent body, the “natural” male body without breasts. In comparison, for FTMs, the post-surgical body remains present, at least to some extent, despite some level of bodily comfort being reached through surgery. The constant assertion of the sameness of trans men and non-trans men described above is evidence of the weight of that presence.

As well as textual declarations, “before” and “after” photographs, a significant feature on gynecomastia.org that is not only limited to the User Photos forum, assert the transition from presence to absence – after all, the breasts are literally absent from the “after” pictures. However, they also highlight the fact that the absent body is never fully recaptured. The need to make the post-surgical body visible through the “after” picture and to receive the appropriate judgements of “normalcy” – “damn i’m jealous.. you'r chest looks totally flat now..”
— demonstrates the extent to which the body remains present, although now present not in discomfort but in comfort. While the absence associated with the “natural” male body would not be thought of at all, the post-surgical body, though recognised as different from the gynecomastic body, remains visible. Arguably, a body that has become present may never fully achieve absence, though the fact that “after” pictures generally depict a limited time period (from immediately after surgery to, at the most, 2 years later) may indicate that time is a significant factor in the transition to absence.

**Beyond Chest Surgery**

While I have highlighted the dominant representations of transition in relation to chest surgery, there are other forms of transition that have an effect on the constitution of the bodies under consideration; in both *FTM Forum* and *gynecomastia.org*, chest surgery is but one aspect of bodily (trans)formation. Within the former, other significant technologies include genital reconstruction surgery (“bottom” surgery), testosterone treatment, tattoos, changes to clothing and/or hairstyle, and other social reconfigurations, such as the legal change of name and sex category. In particular, the transitional nature of testosterone treatment is emphasised, both through the multiplicity of threads addressing this issue and the depth of discussion of bodily change. This may be due to the fact that, while the result of chest surgery, a flat chest, is fairly universal, the transformations caused by the addition of testosterone vary substantially for each

---

individual, primarily in relation to their racial and ethnic background. Thus, there is much online space within *FTM Forum* dedicated to descriptions of these changes, from the growth of facial hair to shifts in cognition, from those who have been taking T, as well as speculation from those who plan to. To a great extent, testosterone treatment is identified as the most significant technology through which manhood is achieved. As *jdogg79* says in a thread started by a member excited about their first testosterone “shot:”

> That's awesome that you got to start T. It's a big step and definitely a good place to be. I remember being really excited (i've been on t for 6 years) and then really impatient for the changes to come. It took a good 3-6 months for voice to really start changing and as for facial hair, it was probably a year before i noticed anything. it's kind of like you are going through puberty. a 14 year old boy doesn't look and sound like a man overnight.61

In this comment, the transition of hormonal treatment is emphasised but simultaneously naturalised through the comparison to the bodily changes of puberty through which a boy becomes a man.

Within *gynecomastia.org*, the transitional force of exercise and dieting are emphasised, (though clothing and posture also play a part). A significant form of writing the body within this online space occurs through the marking of one’s body in relation to the medical categorisations of Body Mass Index and body fat percentage and, as such, there is much focus on exercise regimes, weight training, and diet strategies. In some contexts, exercise is situated in opposition to surgery as a naturalised body modification in contrast to the “artificial” nature

---

of surgery. However, in general, the discursive treatment of exercise becomes a technique through which surgical modification is downplayed. Within popular representations, gynecomastia is associated with being overweight so new members often ask whether exercise can get rid of gynecomastia and this question provides a space within which the breast is described as containing fat and gland, a representation that asserts the necessity of both exercise (to combat the fat) and surgery (to excise the gland) in the elimination of gynecomastia. In this understanding, surgery is normalised as an extension of weight loss, a form of body modification taken for granted as an appropriate and acceptable response to bodily discomfort. The distinction between weight loss and surgery is further blurred through the use of such terms as “chiselled,” “ripped,” “cut,” and “shredded” in reference to the body resulting from exercise, as these terms imply work done on the body or, in other words, the body being formed or sculpted through the use of external tools acting on it. Dr. Bermant, a prominent plastic surgeon on gynecomastia.org, employs this understanding in his description of the relation between weight loss and surgery: “losing weight is a coarse tool,” while “plastic surgery is better used for refinement.”

Conclusion

Within both FTM Forum and gynecomastia.org, the representation of the transitional nature of surgical modification, whether it is downplayed or emphasised, is a significant frame through which bodies are constituted in relation to the natural. As discussed above, the shift from the category “bioguy” to “cissexual male” and the production of the trans man on FTM Forum are
strategies through which transsexual transition is downplayed and the border between the so-called “natural” male body of non-trans men and the “artificial” body of trans men is undermined; in effect, these operations work through an assertion of sameness based on the extent to which we are all (un)natural. In contrast, transition is emphasised on gynecomastia.org, from mental pain to mental health, from boy to man, and from presence to absence, and through these techniques the gynecomastic body is constituted as distinct from the “natural” male body. The description of themselves as men with a “medical condition,” which appears within both FTM Forum and gynecomastia.org, is in the former employed to assert proximity and the latter to affirm distance from the “natural” male body. However, both of these approaches operate to naturalise the surgical modification and assert its medical necessity.

While the naturalisation techniques employed in these distinct online spaces are different, the overlaps in relation to lived experience are striking; in particular, the suffering of being in the “wrong body” is shared by both FTMs and men with gynecomastia. However, the response to this suffering is different due, in part, to the ways in which it is medicalised; transsexualism is pathologised and so FTMs declare their “normalcy,” while gynecomastia is recognised as benign so men with breasts pathologise themselves. To a great extent, FTMs and men with gynecomastia achieve this by situating themselves as the other group. As mentioned above, both groups reference themselves as men with a “medical condition” but, in relation to FTMs, this “medical condition” is imagined to be gynecomastia while, in relation to gynecomastia, it echoes the “disorder” of
transsexualism. This generally occurs indirectly but occasionally explicitly, as demonstrated in the following quotes, the first from *FTM Forum* and the second from *gynecomastia.org*:

There are men and male-assigned individuals who’ve grown breasts without having taken exogenous estradiol. There are non-trans men who have larger than 'normal' hips and asses and there are non-trans men who were born with ovaries. I'm sure there are non-trans men who’ve dealt with all or most of the above because those conditions aren’t that uncommon (sin_nombre).

At the end of the day, looking at myself in the mirror, I just felt so bummed out about my body. I compare it almost to a transgender person feeling uncomfortable in the body they were living in. I was a man yet had these features that made me feel so unmanly.

Finally, after years of dissociating myself from my body and feeling crappy about myself, I finally contacted some plastic surgeons…I just wanted to look like an normal guy with a flat chest. Simple. (snowstorm).

*sin_nombre* associates FTMs with men with gynecomastia (and other "medical conditions") in order to emphasise the fact that there are non-trans men with female bodies in an attempt to undermine the presupposed distance between the trans and non-trans body. From the other side, *snowstorm* associates men with gynecomastia with transgender folks, highlighting the experience of intense discomfort, to the extent of disassociation, of living in the body of gynecomastia.

As well as situating themselves as each other, these two groups appropriate each others' clinical narrative. Some of the naturalisation techniques outlined above in relation to gynecomastia surgery echo the medical discourse,

---

which does acknowledge the psychological discomfort of gynecomastia and the subsequent psychological satisfaction gained through surgical modification, as well as the association of manhood with sport (and heterosexuality). However, the significant difference is that, within the medical discourse, gynecomastia is limited to a part of the body while, within the online community discourse, gynecomastia is clearly experienced as a “disease” that undermines the whole of the body. Thus, gynecomastia surgery is simply considered a removal of breast tissue within the medical discourse while, on gynecomastia.org, it is re-conceptualised as a significant transition. Referencing my argument within the previous chapter, while men with gynecomastia have not become a “species” within the medical discourse, they are, at least to some extent, asserting themselves as one within online space and forming a community on the basis of the bodily difference of being “gynecomasts.” In part, this is an attempt to access insurance coverage for surgical modification, a way to assert its medical necessity on the basis of a threatening “medical condition.” It is also due to the fact that the gynecomast community is younger than the transgender community, and so the transgender community have moved beyond this classic narrative of the assertion of bodily difference or identity. However, it is largely due to the intensity with which men with gynecomastia feel their bodily difference. In contrast, FTMs challenge the medical framing of “transsexual” as species, declaring themselves to be men with breasts who need surgery to regain the “natural” male body. Referencing the quote above, it’s as “simple” as that.
Chapter 5: Infertility and the Failure to Achieve Femaleness: Pregnancy as Technology of the Natural

This chapter marks the shift from the consideration of discursive representations of gynecomastia surgery to the exploration of textual figurations of pregnancy. Thus far I have attempted to disrupt the notion of the “natural” male body through an exploration of the naturalised construction of this body through gynecomastia surgery. This section is focused on invoking trouble at the site of the “natural” female body through a reconsideration of the practice of pregnancy.

The pregnant body is an overdetermined site of signification, loaded down with multiple meanings and associations; as potent image, it features as the driving force in multiple overlapping discursive fields. In particular, within the various strands of feminism, there is a marked preoccupation with pregnancy (and the associated practices of birth and mothering), although the meanings assigned to it are highly contested. Simone de Beauvoir, the influential French feminist, attributes women’s lack of equality with men to the biology of their reproductive role, asserting in *The Second Sex*, originally published in 1949, that the pregnant woman is “ensnared by nature” (495). However, although she defines the “enslavement of the female to the species” as biological fact, she recognises that the degree of “bondage” depends on social context (37, 35).
Shulamith Firestone, in the 1970s call for feminist revolution, *The Dialectic of Sex: The Case for Feminist Revolution*, also ascribes the imbalance of power between men and women to the biological basis of reproductive difference, describing pregnancy as “barbaric,” the “temporary deformation of the body of the individual for the sake of the species” (226). She identifies technological advancement as the precondition for cultural revolution, imagining the utopic possibilities of employing reproductive technologies to separate women from their childbearing role, “freeing” them from the “tyranny of their reproductive biology” (233).

In contrast to these figurations of pregnancy that reduce it to limitation, as a constraining factor on women’s freedom, there are theorists that offer a re-evaluation of pregnancy. In these accounts, women’s emancipation depends, not on the separation of women from reproduction, for that would merely provide an opportunity to gain power on patriarchal terms but, rather, on dismantling patriarchy (often in its expression through discourse) by recognising and honouring the difference of the female body including its potential for pregnancy and birth (Daly; Rich; Cixous). For Beauvoir, “[w]oman, like man, *is* her body; but her body is something other than herself” because of the occurrence of pregnancy (and other reproductive events) (29). However, for Helene Cixous, the experience of pregnancy means that “woman is body more than man is” (95), and it is this overflow that makes possible *écriture feminine*, a form of writing based on the unconscious, the body making “itself heard,” which has the potential to disrupt Symbolic discourse (97). Cixous attributes pregnancy, the
experience of “not-me within me,” with the possibility of undermining the singular self and allowing for the presence of the other (90). Julia Kristeva agrees, declaring that pregnancy “extracts woman out of her oneness and gives her the possibility – but not the certainty – of reaching out to the other, the ethical” (182).

What both these perspectives have in common, whether pregnancy is denigrated in the pursuit of sameness or celebrated as difference, is that it is associated with nature and the female body, where these are often reduced to each other and situated in opposition to the male, understood as transcendence, culture, and/or discourse; at the very least, pregnancy is considered to be “the threshold of culture and nature” (Kristeva 182). There is the sense that there is something uncontainable about pregnancy, that there is excess, overflow, multiplicity, fluidity…qualities that escape capture by language: “the heterogeneity that cannot be subsumed in the signifier nevertheless explodes violently with pregnancy” (Kristeva 182). As such, pregnancy is often employed in feminist discourse to bring back the “real,” the “fleshy,” particularly in relation to poststructuralist analyses, which in this context are considered to be lacking in their recognition of the “earthy significance” of the body (Bigwood 54). These attempts are often grounded in the philosophical framework of phenomenology, primarily Maurice Merleau-Ponty’s rendition due to his focus on the body. In “Renaturalising the Body (with the help of Merleau-Ponty),” Carol Bigwood accuses Judith Butler, (the most common villain in debates of this nature), of going “too far in her denaturalization of the body,” so far that the poststructuralist body represented in Gender Trouble is merely a “disembodied body,” left with “no
real terrestrial *weight*" (59). In order to give more *weight* to her point, Bigwood, who includes passages detailing her bodily condition throughout the paper, then launches into the following description:

> Going into my ninth month now: feeling heavy, out of breath, emptying my bladder every hour, bleeding hemorrhoids, sweating under my pendulous breasts. This weight. It is not a weight that I wilfully bear with muscular strength like a pack on my back. It is a weight that I live with, that has slowly entered into every aspect of my bodily being. Heavy like stone.

Here, it is the pregnant body that provides the necessary fleshy “weight” that can rescue us from the “alienation” and “anthropocentrism” that marks the body reduced to a “cultural phenomenon” (59); it is the pregnant body that can reinsert nature into what is represented as a model of “pure” culture, although not as a biological given, rather, through the concept of a “lived body,” which refuses the distinction between nature and culture. Bigwood defines this body as “incarnate yet indeterminate,” “not an a priori closed to historical change and cultural variation but a kind of a prior that continually opens us to them,” where the incarnate is described as the “noncognitive,” “nonpersonal” body, the body that “runs through us, independently of us” (60, 66).

Not only is pregnancy situated as the prime example of this “unmotivated upsurge of being” (Merleau-Ponty, qtd. in Bigwood 67), it is also identified with the female body as part of its “indeterminate natural structures” (68). For Iris Marion Young, and many other feminist theorists, this translates into the fact that pregnancy is one of the most significant “core elements of female body experience” (10). So, while pregnancy is understood to contribute to the
constitution of ‘woman,’ in relation to ways of being and/or subjectivity, it remains associated with the constancy of the female body, which, although indeterminate, comes before the taking up of meaning. The presupposition that the female body is that which precedes pregnancy, that which makes pregnancy possible, has blinded us to the possibility of considering that it could be the other way around, that pregnancy could be a body modification through which the body becomes marked as “naturally” female. The association between pregnancy and the female body is so tight, so absolute, that it is taken for granted that pregnancy is simply a “natural” fact, a biological potentiality, of femaleness. This chapter is an attempt to “see otherwise” (Sullivan, “Price to Pay” 406) in relation to pregnancy, to look at it in a different way from a different perspective, to prise apart the female body and pregnancy in order to put them back together in an alternate relation. I am not denying that there are some bodies and not others that have the potential to become pregnant, rather, I am arguing that pregnancy is a significant bodily practice through which bodies are unquestionably marked as female. As such, I ask not how does pregnancy act on the female body but in what ways is pregnancy employed in the constitution of the “natural” female body?

For the interrogation of the constitutive power of pregnancy, I have found exploring it in relation to infertility to be particularly productive. Discourses of infertility are sites in which our current social concerns about reproduction (and its intersection with multiple other issues, such as class, race, sexuality, religion, and the nation) bubble to the surface. As reproduction is one of the central
themes through which sexual differentiation occurs, these sites are significant in
the examination of the production of the “natural” male and female body. Infertility
discourses are grounded in the presupposition that pregnancy is the
achievement of the teleological imperative of the “natural” female body, at the
same time as situating pregnancy as a technology of the natural that constitutes
the female body. The threat of infertility, represented as undermining both body
and self, is such that the restabilisation strategies employed in the face of this
disruption make naturalising narratives highly visible. Thus, I examine
representations of infertility in the medical discourse and ask how pregnancy and
the female body are framed within the context of infertility? Within the vast array
of medical texts concerning infertility, I focus on two textbooks that have
significant institutional influence: *Clinical Gynecologic Endocrinology and
Infertility* (Speroff and Fritz) and *Yen and Jaffe’s Reproductive Endocrinology:
Physiology, Pathophysiology, and Clinical Management* (Strauss and Barbieri)\(^{63}\); for details on these texts and how I analyse them, refer to chapter two. In this
chapter, I emphasise the techniques through which liminality is realised because
the representation of infertility as a state between “reproductive incapacity and
capacity” (Sandelowski and de Lacey 35), which translates as a body sexed as
not-female but always containing the possibility of achieving femaleness, plays a
significant part in both the maintenance and undermining of this barrier through
which pregnancy operates as constitutive.

\(^{63}\) Henceforth, I refer to these texts as *Speroff’s* and *Yen and Jaffe’s* as that is the common
abbreviation found within the medical field.
Feminist Engagement with Reproductive Technologies

I am, of course, very much aware that this association of pregnancy and the female body with the natural is not universal within medical discourse. The conception of the female body as pathological, and pregnancy as an extreme manifestation of this condition, is the ground upon which the medical field of obstetrics and gynecology is formed, and it is through this speciality that this understanding is propagated. In this context, pregnancy is framed as sickness and defined in reference to risk; it is only with hindsight that pregnancy can be described as normal and natural and only because medical professionals were successful in managing and controlling the risks. Through the logic of this model, the medical institution asserts its necessity in the care of the pregnant body. In the face of this medicalisation of pregnancy (and childbirth), earlier radical feminist critiques went to great lengths to reclaim pregnancy as natural (Rich), and this perspective is being re-ignited in the resurgence of the midwifery movement and the rising recognition of the influence of the doula in providing vital labour support, both grounded in the normalcy of pregnancy and birth. This appeal to the natural is based on the belief that we can strip away all externalities to reveal pregnancy and childbirth in their true, pure form. Annandale and Clark point out the untenability of this claim, emphasising that “obstetrics and midwifery are self-referential: natural birth finds the conditions for its existence in its very critique of biomedicine” (30). In this debate, medical(ised) pregnancy and natural(ised) pregnancy are “relational concepts” (30) that compete for significance in determining the meaning of pregnancy. In contrast, within medical
discourse on infertility, pregnancy (as sign of fertility) and infertility are the
“relational concepts” and it is through this opposition that pregnancy becomes
naturalised. Clearly, the figure of the pregnant body is not singular within medical
discourse, which undermines its claims to biological foundation with its
implication of fixed singularity. This alerts us to consider the precise context in
which these practices are framed, paying particular attention to their location
within a network of relations.

The notion of the natural has obviously not been free of scrutiny in critical
analyses of infertility; after all, reproductive medicine is a field that invites
reconsiderations of our relation to the natural through its challenge to the
naturalised narrative of the “standard (modern biological) model of the facts of
life,” in which conception is the result of a “natural sequence of biogenetic
events” (Franklin 103). However, while the idea of the natural has been the
object of deconstruction in much of the more recent academic literature, it has
primarily been situated in relation to motherhood, conception and/or kinship. The
presumed naturalness of motherhood has been challenged through the
exploration of mothering as a contested site of social, cultural, and political
significance, particularly in relation to reproductive technologies through which
the “fragmentation of motherhood” becomes possible – the singular figure of the
mother becomes dispersed among three potential figures, “the biological
mother,” “the gestational mother,” and “the social mother” (Ragone 119). This
reconfiguration of parenthood undermines the conception of family as grounded
in genetic connection, so-called ‘blood’ relations, and has the potential to
transform the notion of family, at the very least by expanding it to include single mothers by choice and queer couples. However, although assisted reproductive technologies (ARTs) have the potential to destabilise the traditional normative family, they are in fact often employed in order to restabilise this family. In classifying infertility as a source of extreme suffering, medical intervention is justified in terms of the ‘restoration’ of the “natural drive for biological parenthood” and the “miracle of procreation” (Cussins 74), and “structured on a strongly coupled, ultraheterosexual, consumer-oriented, normative nuclear family scenario” (Thompson 52). It is clear that infertility treatment is an intriguing site of simultaneous de- and re-stabilisation strategies in relation to the natural and provides “fertile ground” (ibid) for the interrogation of those techniques of (un)naturalisation.

All this critical attention on explicitly technological reproduction has the effect of (re)naturalising the body modification of pregnancy. While the border between the “natural” and the “artificial” is troubled in relation to parenthood and family, it is maintained and reinforced in relation to bodily processes, where technological assistance remains situated in opposition to natural occurrence. Considering pregnancy as technology, as body modification and not merely a natural state, allows us to look at the work it does as a central concept through which materialisation of the sexed body occurs in the context of medical discourse on infertility. As such, I aim to explore the constitution of the “natural” female body, the ways in which the body is ‘femaled,’ through the idea of pregnancy as the natural function, the teleological impulse, of the female body.
Rather than examining the technology of reproduction as in many critical feminist approaches to infertility, I explore reproduction as technology.

The production of “naturally” sexed bodies in relation to (in)fertility is underexplored in critical discussions of infertility. In fact, many feminist theorists, either implicitly or directly, take the “gendered nature of bodies in an anatomical or physiological sense as relatively stable constructions already in place when couples, men, and women enter the domain of reproductive technology” (van der Ploeg 479). Much of the focus is on the generation of gendered identity, in particular as woman or mother, but these approaches tend to presuppose the female body, leaving it entirely untouched or looking through it to the level of subjectivity. Where there is recognition of the constitution of sexed bodies in and through the discourse and practice of infertility medicine, it remains primarily hypothetical. For example, Annandale and Clark postulate that “medical specialists may assist men and women to overcome a gendered notion of their bodies” but declare that the more likely consequences are “affirmation and reinforcement of a sex and gender identity” (35). I am concerned with the examination of the details of this “affirmation and reinforcement” in the constitution of the “nature of bodies” within the medical discourse on infertility, an investigative process which goes beyond speculation and looks closely at the operation of the (un)naturalisation techniques employed within this realm. This unique approach challenges both the feminist and medical engagement with infertility in undermining the distinction between the technological and the natural
through the emphasis on the construction of the “natural” female body through the technology of pregnancy.

(In)fertility and Sexual Differentiation

Having provided the context of the two medical textbooks in the methodological discussion in chapter two by locating them within a long scientific tradition engaged with the “essence” of the female (and male) body, I now embark on a detailed analysis of the discourse of (in)fertility found within these volumes. Within both, the issue of infertility is divided such that there is a chapter devoted to female infertility and one focused on male infertility, though, interestingly, within the 4th edition of Yen and Jaffe’s (1999) infertility was limited to just one chapter, which is explained by the admission within Speroff’s that “[i]n the past, the female partner was the primary focus of attention and male factors were regarded as a relatively uncommon cause of infertility” (1135). Thus, all responsibility for the failure to reproduce was and, to a great extent, continues to be, placed on the female body. Before I engage with the chapters explicitly focused on infertility, I will first establish the connection between fertility and sexual differentiation represented in the discussions of what is referred to in Speroff’s as “Normal and Abnormal Sexual Development” and in Yen and Jaffe’s as “Disorders of Sex Development” (319; 367).

In both textbooks, the subject matter is divided into sections, in which the first deals with “normal” reproductive function and the second follows with “pathological” factors. And within both books, the chapter focusing on “abnormalities of sexual differentiation” is located at the beginning of the
pathological section (Speroff and Fritz 319), thus highlighting its primacy in relation to reproductive disorders. Of the utmost significance for this discussion is the fact that the association between the “normal” male and female body and fertility is both presumed and maintained within these chapters. The connection between infertility and “disorders” of sex development (DSD) is such that “infertility was seen as an immutable feature of DSDs” (Arboleda and Vilain 391). While infertility can be a sign of a number of major underlying bodily factors, such as the absence of a uterus in a phenotypic female or the presence of a chromosomal pattern of 47,XXY in a phenotypic male, it can also be the sole bodily indication of an intersex condition. In fact, within the spectrum of androgen insensitivity (AI), infertility in the phenotypic male, 46,XY, is at one end while complete AI in the phenotypic female, 46,XY, (also infertile but due to the absence of internal reproductive organs), is at the other end. In the former, infertility itself is marked as an intersex condition while, in the latter, it is read as a sign of intersexuality.

Within both medical textbooks, fertility is the primary concern throughout these chapters on “abnormal” sexual development; for every condition described, the presence or absence of fertility is considered, as well as the likelihood of preservation or restoration of fertility through treatment. In Yen and Jaffe’s, the issue of fertility frames the entire chapter from the beginning, where “prediction of future fertility” is identified as fundamentally important, equal to “diagnosis” and “understanding of pathophysiology” (367), to the end, which features a detailed tabulation of all the “disorders” and their corresponding “fertility levels” (391-2).
While there are rare cases of intersex bodies becoming “spontaneously fertile,” it is largely through assisted reproductive technology that “patients with DSDs, who were previously infertile or subfertile, have the opportunity to have biologic children” (ibid 391). Thus, infertility is no longer marked as an “immutable feature” of intersexuality and the connection between the “normal” sexed body and fertility is, at least to a certain extent, undermined through technology (ibid).

However, the male and female body remain largely defined in relation to fertility potential. This can be seen clearly in discussions of the attribution of sex, particularly in cases of ambiguous genitalia, in which fertility is marked as fundamentally important. While in Yen and Jaffe’s, it is listed with other considerations, such as “chromosomal composition” (390), within Speroff’s, “future fertility” is identified as the primary factor in the assignment of sex and this declaration provides the conclusion for the entire chapter (354). On the other side of the association, infertility is understood to be a factor that has the potential to disrupt the idea of the male and female body. In the discussion of complete androgen insensitivity, Speroff and Fritz assert that “although infertile, these patients are completely female in their gender identity, and this should be reinforced rather than challenged” (340). Here, infertility is represented as a barrier to “complete” femaleness, albeit one that can be overcome and, by implication, fertility is associated with absolute and assured femaleness. While fertility potential is also significant in the attribution of maleness, another factor is identified as crucial in order for the patient to become a “psychologically normal, healthy, and well-adjusted adult,” and that factor is sexual function, which, within
Speroff’s, is reduced to the question of whether the phallus can “ultimately develop into a penis adequate for intercourse” (354). Thus, along with fertility, “penile adequacy” is marked as a fundamental element of the male body. As no corresponding measure of sexual function is described for the female body, it remains reduced to fertility.

The Achievement of Pregnancy

Having established the association between fertility and the female body in discussions of (ab)normal sexual differentiation, I now turn to an interrogation of the discursive representation of (in)fertility and pregnancy found within the chapters dedicated to female (and male) infertility, as well as those chapters that offer more detailed descriptions of the assisted reproductive technologies employed in the treatment of infertility. In relation to reproduction, the notion of the natural has been associated with conception and the genetic connection that “natural conception” assures. However, while it has been argued that the “natural drive” for genetic offspring is at the heart of reproductive medicine (Cussins 74), I argue that the most significant aim is the achievement of pregnancy because it is through pregnancy that the “natural” female body is realised.

Let us first consider the idea of “natural conception,” which, in fact, contains one of only two explicit uses of the term “natural” found within this discursive domain.\(^64\) it is applied to ‘conception’ in order to contrast “natural conception” to technologically assisted conception. The idea of “natural

\(^64\) The other is contained in the phrase, “natural populations,” from which “normal” fertility rates are established and the effects of aging on fertility is determined. The idea of “natural populations” is discussed later in the section dedicated to the (in)fertility spectrum.
conception” is given some weight, for example, when identified as a possible advantage of tubal surgery (Speroff and Fritz 1051). It is also identified as a desired outcome of one of the lowest steps on the “staircase” of treatment approaches, under the option of “expectant management,” the medical term for no treatment or, in other words, wait and see if “natural conception” occurs (Barbieri 540). However, it is quickly relegated to inefficiency in relation to assisted reproductive technologies (ARTs) and their far higher pregnancy rates.

This alignment with technologically assisted conception is made absolute in the preface to Yen and Jaffe’s, in which the editors identify the first successful “in vitro fertilisation and embryo transfer” as a “landmark event,” not only in relation to infertility treatment but to the field of reproductive endocrinology in general (xi). They go on to describe this technology as the “greatest medical advance in the past century: the capacity of humans to master the process of reproduction” (xi). Thus, the aim of infertility treatment is identified, not as an aid to “natural conception,” but, as control of reproduction. The idea of control also emerges in reference to the phrase, “spontaneous pregnancy,” which is what “natural conception” is said to give rise to. Within the context of control, “spontaneous” is situated in opposition to planned, timed, and controlled, all ideal features of the ability to “master” reproduction. While “natural conception” is subjugated, I argue that the technological is employed in service of a higher order of the natural, a natural that is taken for granted to the extent that it goes unspoken, or unwritten in this context, and that is the association between pregnancy and the natural female body.
What about the “natural drive” for genetic connection, which has been associated with infertility treatment? Well, this is clearly a significant factor. The procedure of intracytoplasmic sperm injection (ICSI), a “revolutionary addition” to the repertoire of ARTs introduced in 1992 (Turek, “Male Infertility” 557), demonstrates the great lengths undertaken to achieve genetic connection. ICSI involves the retrieval of a “single selected sperm,” which is then manually injected directly into the “oocyte,” the egg cell (Speroff and Fritz 1236). Before the introduction of ICSI, men with no or little sperm were “considered sterile and untreatable by any means other than the use of donor sperm” (ibid 1235). Although never explicitly stated, clearly ICSI is considered the “major breakthrough for male infertility treatment” because it provides for a previously unobtainable genetic connection (De Vos and Van Steirteghem 759). However, other procedures that do not offer genetic connection are also regularly employed especially due to the aging population of women attempting to conceive. For women with ovarian failure, previously “considered irreversibly sterile” (Speroff and Fritz 1252), IVF with oocyte donation from a “healthy young” donor is the “only method that currently allows these women to carry a pregnancy” (Hornstein and Racowsky 753). The achievement of pregnancy is the sole factor here and the loss of genetic connection fails to be mentioned.

After the section on oocyte donation, both medical texts feature a brief mention of gestational surrogacy. While, in Speroff’s, gestational surrogacy is first related to the “opportunity to have genetic offspring” and then explained as involving another woman “who is willing to carry a pregnancy on behalf of an
infertile couple” (1256), within Yen and Jaffe’s, the procedure is associated with pregnancy in the first sentence, where it is described as a form of assisted reproduction through which a “woman other than the infertile woman conceives a pregnancy for her” (753, emphasis mine). Here, it is not the embryo, which holds the blood relation, that is depicted as being carried by another party but the pregnancy, which is explicitly identified as being carried for the woman who is unable to achieve pregnancy for herself. Thus, the practice of gestational surrogacy is framed as a gift of pregnancy, with the added advantage of genetic connection.

**Pregnancy as Sole Sign of Success**

It becomes clear from reading these medical texts that there is often little difference between infertility and fertility, to the extent that infertility can be associated with “normal” responses in relation to the standard infertility evaluation, (a situation described as “unexplained infertility”), while fertility can present “abnormal” results. There is, however, one significant difference, that which allows one group to be marked as fertile and the other to be defined as infertile, and that is the presence or absence of a past or current pregnancy. Despite the reliance on multiple diagnostic tests to determine the etiology of infertility, it is acknowledged that there is no definitive test for reproductive function except pregnancy. Pregnancy is both that which separates infertility from fertility and the sole path through which the transition from infertile to fertile is achieved, a body modification that denaturalises those bodies that fail to
conceive and then renaturalises them if they subsequently complete what is
taken to be their teleological goal.

The denaturalisation is effected from the very outset through the clinical
definition of infertility, which, according to Barbieri in Yen and Jaffe’s, is “the
inability to conceive after 12 months of frequent coitus” (517). Thus, infertility is
marked by absence not presence – it is defined, not in relation to the presence of
disease but rather as the lack of pregnancy. While the definition is grounded in
the couple – sexual intercourse requires at least two parties – the condition of
infertility, the ‘failure,’ is only (in)visible on the woman’s body. As the site of the
symptom of infertility, it is her body alone that becomes marked by infertility,
regardless of the causes behind it. Within Yen and Jaffe’s, there is some
recognition of this in the acknowledgement that “the female partner bears a
disproportionate degree of responsibility for the loss symbolically represented by
infertility” (545). Of further significance, the patients contained in the definition are
clearly understood to be a heterosexual couple. Within both Speroff’s and Yen
and Jaffe’s, there is little recognition that other family configurations, for example,
queer couples and single parents, employ assisted reproductive technologies,
and where there is, these families are merely inserted into the existing model,
one that situates these technologies in relation to this conception of infertility. As
such, within this framework, lesbians and single women who desire pregnancy
are associated with “severe and uncorrectable male factor infertility” (Speroff and

---

65 There is discussion about whether infertility itself connotes disease and/or disability within other
related texts, notably publications from the American Society for Reproductive Medicine, the
which the Supreme Court ruled that reproduction qualifies as a “major life activity” as defined in
the Americans with Disability Act.
Fritz 1156). Thus, non-traditional families are excluded from the foundational logic of the field of infertility medicine. The very definition of infertility is grounded in the idea of the fertile, heterosexual, female (and male) body, and pregnancy remains the sole manifestation of the opposition between infertility and fertility.

Renaturalisation of the body is achieved exclusively through pregnancy as is evident in the medical treatment recommended for infertility and the way in which success of this treatment is defined. Even in those cases where a body part has been identified as ‘broken,’ the emphasis is on achieving pregnancy rather than ‘fixing’ reproductive function. This is particularly clear in relation to tubal factor infertility for which the treatment options are identified as either reconstructive surgery or in vitro fertilisation (IVF) (Speroff and Fritz 1051). The fact that an assisted reproductive technology is considered a “treatment” on the same terms as a surgical procedure that actually restores tubal patency demonstrates the extent to which success within the medical discourse of infertility is not related to the correction of individual body parts or processes but is solely associated with the manifestation of pregnancy. As such, due to the fact that IVF now achieves pregnancy rates that generally exceed those obtained after surgery, IVF is identified as the “best and most logical choice” (Speroff and Fritz 1053). According to Barbieri in Yen and Jaffe’s, some fertility specialists do not even complete the full spectrum of diagnostic tests available because the determination of the ‘problem’ will “not influence their approach to treatment because their practice is to move quickly to IVF” (539). Despite undermining one of the basic goals of infertility medicine, described in both texts as the
identification and correction of “all fertility factors” (Barbieri 540), this approach makes sense within this context in which infertility is defined as lack of pregnancy – treatment is ultimately concerned with the achievement of pregnancy not the restoration of reproductive function. The success rates depicted in various figures and throughout the text reflect this understanding through their sole focus on pregnancy rates. Irma van der Ploeg highlights this discursive framing of pregnancy as the only success in “Hermaphrodite Patients: In Vitro Fertilisation and the Transformation of Male Infertility,” an exploration of the ways in which male infertility gets played out on the female body. However, while she declares that this move further legitimises medical intervention on the female body, I argue that the female body is at stake even in the case of male infertility because the lack of pregnancy, regardless of the cause, undermines the female body. Further, I am more interested in the fact that this understanding of success means that the transition from infertility to fertility is only possible through pregnancy; the body parts of infertility are made whole and renaturalised as female through pregnancy.

The Transition from Infertile to Pregnant

A striking feature of medical discourse on infertility is the absence of the infertile body as a whole, and it is through this lack of bodily integrity that the pregnant body asserts its presence: where infertility is incomplete, the pregnant body is complete; where the infertile is a collection of body parts, the pregnant body appears whole; where infertility is failure, the pregnant body is the only sign of success; where the infertile is not-quite female, the pregnant body is marked
as female; and underlying all the above, where infertility is unnatural, pregnancy is natural. However, it is also through the absence of the infertile body that the transition from infertility to pregnancy remains open. Infertility is not framed as a different body with fundamentally dissimilar attributes to that of the pregnant body, merely as a (temporary) inability to achieve pregnancy – an abnormal bodily state but not a distinct bodily substance. As Barbieri stresses in Yen and Jaffe’s, “[i]n contrast to sterility, infertility is not an irreversible state” (517). Thus, the transition is not understood to entail a crossing of bodily boundaries or, in other words, an attack on bodily integrity, as the infertile is not considered a bounded body of its own.

Despite pregnancy being the body modification that allows this transition and provides for the achievement of the female body, it is framed as merely a sign that the fertile body was present all along. This lack of acknowledgement of the transitional nature of pregnancy is a classic feature I associate with technologies of the natural; the transition is naturalised to such an extent that it is not considered a body modification. In order to achieve this, infertility and fertility have to be framed in a way that simultaneously sets them apart and brings them together – through the distance, the “naturalness” of fertility is secured against the “unnaturalness” of infertility, while the proximity ensures the possibility of the achievement of fertility without emphasising the transition. The bodies that we are (thought of) determine the bodies that we can become, so the infertile can become the fertile through pregnancy, a technology of the natural. It is the possibility of the transition that is central to the medical discourse on infertility,
although never explicitly acknowledged, and it is achieved through various techniques identified in the following sections.

The Dismemberment of Infertility

One of the primary methods of keeping the path to fertility open is the dismemberment of infertility, through which the infertile body as a whole is rendered absent. In the investigation into the causes of infertility, infertility appears in relation to a collection of bodily processes and body parts, of which one or multiple are assumed to be failing in their function. The female body is replaced by female “factors,” which are limited to those related to reproductive ability: “abnormalities” in ovulation and/or the function of the reproductive tract (Barbieri 519). Thus, the infertile is reduced to the ovaries, the cervix, the fallopian tubes, and the uterus, where these are considered as distinct parts within the reproductive system and are tested in turn for their “integrity” (Speroff and Fritz 1028). With respect to the ovaries, their function is said to be determined by relevant hormones so infertility also becomes defined by the cyclical patterns of hormonal levels, measured directly or through basal body temperature, which is connected to hormonal production. As such, the infertile becomes a collection of parts and a series of numbers, which are assessed in relation to “normal” functioning and “normal” levels respectively. There has been much critical analysis of this feature of medicalisation and the metaphors of production used to represent the breakdown of the body into parts as machines or information systems (see, in particular, Martin). However, I am more interested in what this dismemberment achieves within the context of (in)fertility and
embodiment and how it contributes to the naturalisation of the whole fertile female body.

In the representation of the disembodied parts of infertility as dysfunctional, the language used to describe them is often far from objective or neutral. One particular example stands out and that is the use of the term “hostile” to describe the cervical mucous associated with infertility (Speroff and Fritz 1038). Cervical mucous is understood as a vital participant in the reproductive process, particularly in its interaction with sperm. In order to determine the nature of that interaction, the postcoital test, which involves an evaluation of the motility of sperm present in a sample of cervical mucous retrieved soon after intercourse, was a standard feature of the infertility examination in the past. A positive result is associated with cervical mucous that “accepts” and “nurtures” sperm, while a negative result is said to indicate “hostile” and “impenetrable” cervical mucous (ibid 1037-8). Not only does the use of “hostile” attribute feelings of animosity to this reproductive component, it does so in a very particular way due to the association of the term with antagonistic and aggressive interactions, such as those characteristic of war. It also has the effect of framing “normal” reproduction in opposition to these images of hostility. So, while the cervical mucous of infertility is represented as putting barricades up and forcefully preventing the sperm from entering, the cervical mucous of fertility is figured as welcoming and friendly to the arriving sperm. (In fact, one book dedicated to the treatment of infertility takes this idea beyond cervical mucous to the whole body as evidenced by the title, *Is Your Body Baby-Friendly?*) It is
significant that these terms have gendered associations, with ‘hostility’ being marked as a stereotypical masculine characteristic and ‘nurturing’ being attributed to femininity and, in particular, mothering. Thus, within these representations of cervical mucous, infertility is associated with masculinity, which is understood to undermine the female body.

**Absence of Intersex**

As well as through the dismemberment of infertility, the lack of an infertile body of a different nature is also achieved through the relative silence around intersex conditions and their implications. Considering the association between infertility and intersex conditions discussed earlier, these conditions warrant more consideration within the chapters dedicated to the evaluation and treatment of infertility. In relation to female infertility, it is only within *Yen and Jaffe’s* that there is a short section on “genetic causes” of infertility, in which it is acknowledged that “major chromosomal abnormalities are often associated with infertility” (539). Within *Speroff’s*, “unusual problems” are said to account for 10% of female infertility, there is no further articulation of the nature of these “problems” (1028, which likely include intersex conditions). There is more recognition within the chapters on male infertility because “abnormalities of sperm production” are often associated with intersex conditions (Speroff and Fritz 1143). In particular, the presence of an intersex condition is considered in relation to ICSI, where ICSI is described as a “two-edged sword” because, on one hand, it allows “men who would otherwise have no chance for paternity the opportunity for fatherhood;” however, on the other, “because man and not nature selects sperm for ICSI, how
it alters natural selection is not clear” (Turek “Male Infertility” 557). Despite recognition of intersex conditions here, it is not the male patient and their genetic infertility that is the focus, it is the child who may be more likely to have a chromosomal “abnormality.” Thus, once again, attention is deflected away from an intersex body, a body of a different nature.

As evident above, it is not that intersex conditions themselves are absent from the discursive treatment of infertility, (though often they are), rather, it is the fact that they are never acknowledged as “intersex” or “disorders of sex development.” The terminology is limited to such phrases as “genetic causes,” “chromosomal abnormalities,” or the specific medical names for individual intersex conditions. The evaluation for infertility involves various examinations intended to determine an intersex condition though never declared as such, including assessment of secondary sexual characteristics, information about family history in order to reveal genetic disease, and the appraisal of hair growth and clitoral development. The physical examination of the female patient may include, for example, looking for “signs of androgen excess,” but there is no indication that this “excess” is worthy of consideration because it can be associated with congenital adrenal hyperplasia, a condition that the Intersex Society of North America defines as a disorder of sex development (“Intersex Conditions”). Further, in books whose authors pride themselves on providing definitive references for the field of reproductive endocrinology and infertility, it is striking that there is no cross-referencing between the brief recognition of intersex conditions and the chapters that more fully discuss the implications of
these conditions, especially as there is in relation to other issues. The lack of full disclosure in relation to intersex conditions and their implications has the effect of distancing infertility from a body of a different nature and, thus, preserves the possibility of transition from infertile to fertile. Despite infertility challenging the femaleness of the body, the lack of acknowledgement of intersex maintains the rupture as incomplete and keeps the path open to the achievement of femaleness through pregnancy.

The Border Between Infertility and Fertility

As mentioned above, the disembodied parts of infertility continue to be evaluated in relation to “normal” despite the fact that “abnormalities” cannot unequivocally be associated with lack of fertility and fertility cannot be assured by “normal” results. “Unexplained infertility,” a diagnosis, (or, more appropriately, a lack of diagnosis), associated with “normal” test results, is estimated to account for, at most, 30% of infertility cases (Speroff and Fritz 1053). Further, it has been shown in studies that subject fertile patients to a standard infertility evaluation that over two-thirds of fertile patients have an “abnormal” result in at least one infertility test and that, in most of the tests, there were “no significant differences” between fertile and infertile patients (Guzick et al 2306). David Guzick, a leading researcher in the area of unexplained infertility, acknowledges in Infertility: Practical Pathways in Obstetrics and Gynecology that “the ability of many components of the standard infertility tests to discriminate between infertile and fertile patients is not consistently evident” (306). Thus, despite the drive to demarcate the border between infertility and fertility, demonstrated by the
continued reliance on these standard infertility tests, the opposition is undermined by the tests themselves as it is revealed through them that, in many cases, there is no discernible difference between infertility and fertility. While this is framed as lack of knowledge, which technological progress will provide, it has the effect of breaking down the border between infertility and fertility such that crossing from the former to the latter remains open. The possibility of this transition is determined to be relatively high given that “expectant treatment,” a wait-and-see approach mentioned above, is recommended for the treatment of “unexplained infertility” (Barbieri 540). In fact, it has been determined that the effects of other treatment options are “relatively small” and “may only hasten pregnancy for couples who would ultimately conceive on their own, given time” (Speroff and Fritz 1056).

The (In)fertility Spectrum

The possibility of the transition from infertile to fertile is also maintained through the use of an (in)fertility spectrum in relation to the issue of classification. Strictly speaking, the use of the prefix in- in the term ‘infertility’ implies opposition to ‘fertility,’ as in not-fertile. However, within the medical discourse, fertility and infertility are not understood as binary, forever confined apart from each other; rather, their relation to each other is described in reference to a spectrum, which allows both distance and proximity and, more significantly, the possibility of transition from infertile to fertile. The spectrum is based on the concept of fecundability, which refers to “a population estimate of the probability of achieving pregnancy in one menstrual cycle” (Barbieri 517). According to Barbieri, the
clinical definition of infertility does not recognise the variability in “fertility potential” as it implies a dichotomous state: either pregnant after 12 months of trying to conceive and hence, fertile, or not pregnant, and infertile (517). Barbieri emphasises that this is “similar to analyzing a continuous variable, such as height, by using a dichotomous variable: ‘short’ and ‘tall,’” and, as such, he recommends “fecundability” as a more useful concept to capture the variation in fertility potential (517).

The (in)fertility spectrum is bordered by absolute sterility at one end and “superfertility” at the other but the most significant point, that which all other rates are compared to, is that of “normal” fertility. According to Gary Horowitz, in his overview of female infertility in *Clinical Reproductive Medicine and Surgery*, this mark of determination is found in “natural conditions (i.e., in the ‘normal couple’)” (507). He goes on to describe how these conditions are discovered within a “natural population,” a group “in which couples are generally permitted to reproduce without any societal limitation to reproduction,” and identifies the Hutterites of North America as a frequently used example of such a population (508). He defines the Hutterites as a close-knit, communal society in which “all families share equally,” and asserts that, as such, there is no direct “incentive to limit the size of the nuclear family unit” and, therefore, no use of contraception (508). In determining the “gold standard,” “the peak fecundity rate reflected in the natural setting,” Horowitz cites studies of the Hutterite community, which set it at 20% per cycle in 20-year old women. As a result, 0.2 becomes the “normal” fertility rate against which patients are measured. Although infertility is
determined in relation to this figure, it is also true to say that fertility only becomes meaningful through the comparison, revealing the extent to which fertility and infertility are knowable through each other.

There are clearly a number of problems with this baseline of normality and the presumptions upon which it is grounded. Of primary significance is the fact that the concept of a “natural population” is ultimately flawed as it assumes the possibility of no societal interference in the biological process of reproduction. As this analysis shows, reproduction cannot be understood as either biological or social; rather, it can only be conceived through the knowledges and practices of reproduction articulated within a specific cultural framework and a particular historical moment. While the Hutterites are not using contraception, there remains a social structure within which reproduction occurs, which disallows the application of “natural” to their reproductive activities. Despite the recognition that differences in fertility rates “likely reflect variations in socioeconomic conditions at different times and in different places,” the notion of “natural populations” is still employed within Speroff’s in the establishment of peak fertility rates and the effects of aging (1015). The idea of “natural” reproduction is fundamentally untenable yet it remains the defining feature of the (in)fertility spectrum as the point of “normal” fertility.

The material implications of describing (in)fertility in relation to a spectrum are significant. The shift from an understanding of fertility and infertility as a binary, in which fertility is 1 to infertility’s 0, to a conception of the spectrum of fertility potential allows the transition from infertility to fertility through pregnancy
to become possible. Placing (in)fertility within the logic of probabilities transfers the emphasis from quality to quantity, from body type to body potential. Within this mathematical model, infertility becomes merely subfertility in relation to “normal” fertility and ‘correcting’ it becomes not a matter of changing bodily type but merely improving the odds. Not only is fertility placed on a scale with infertility, a scale that can be traversed, it is situated in proximity to infertility, making the scale seem more easily traversed – 0.2 is only a fifth up the spectrum. This rate, as well as the fact that the top of the range is identified as a mere 0.35 (Speroff and Fritz 1024), reveals that humans are an “extremely infertile species” (Short 12). A 1 in 5 chance of becoming pregnant each month is very low in comparison to other mammals; put it like this, if industrial agriculture had to rely on those kinds of odds, we would all be vegetarian – the “normal” fertility rate for a cow is approximately 0.75 (Short 12). Despite the “normal” fertility rate being used to classify other rates of fertility potential as abnormal, the lowness of the rate has the effect of simultaneously disrupting the presuppositions of human fertility as “natural” and infertility as “unnatural.”

The “Ideal” Body of Fertility

As well as medical treatment, mechanisms for the achievement of the fertile female body are emphasised through the association of this body with “ideal” age, weight and lifestyle choices. In the evaluation of infertility, the age of the female patient is considered, the body mass index (BMI), a measure of weight relative to height, is determined, and a detailed history of diet and leisure activities, such as smoking and drinking, is recorded. The assessment of these
factors is grounded in the presupposition that “normal fertility depends on a healthy body” (Turek, “Male Factor” 85). However, despite the recognition that these factors are considerations in the male infertility evaluation, far less attention is paid to them in relation to the male patient (Turek, “Male Infertility” 547-8). While both medical textbooks include lengthy descriptions of the consequences of “weight abnormalities” on female infertility (Barbieri 521), obesity is only given a very brief mention in a list of what to assess in the male physical examination (Turek, “Male Infertility” 547). In relation to women’s weight, the “ideal” parameters are clearly defined, with fertility being associated with a BMI of between 20 and 25. In contrast, Speroff and Fritz admit that the “relationship between BMI and fertility in men has not been carefully studied” (1023). In relation to age, it is noteworthy that, within Speroff’s, there is a section on male reproductive aging, which identifies an “age-related decline in male fertility” (1140), though in comparison to this two-page section, the relation between aging and female fertility is given over eight pages and is the leading section in the chapter on female infertility. Clearly, while male factors are now acknowledged as important in the evaluation of infertility, the focus remains on the female partner, whose dietary and lifestyle choices become increasingly subject to medical interrogation and, more significantly, to self-surveillance.

There are multiple problems with the application of the body mass index, (such as the fact that it was originally determined on the basis of a small sample of Scottish convicts), and taken together with the fact that the BMI is not assessed for male patients in this context, despite being connected to
reproductive capability, this type of measurement becomes less a question of reproductive potential and more about determining appropriate bodies for reproduction. Considering that the BMI is essentially a beauty standard with no actual ground in the characteristics of health, it becomes clear that the notion of the “healthy body” underlying “normal” fertility is reduced to the “ideal” body, one that is young and slim, and thus suitable for reproduction. The effect of this association between fertility and the ideal body is that the fertile female body is represented as achievable through weight loss (or gain) and, as such, the responsibility for infertility rests on the patient who must subject themselves to self-policing in the name of “normal” fertility. The implication is that the broken parts of infertility can be put back together and made whole and fertile through the ‘right’ lifestyle choices.

The field of reproductive medicine is, of course, a domain saturated with technologies of “biopower” and this figuration of the “ideal” reproductive body is a striking example of the ways in which the two interlinked forms of “biopower,” an “anatomo-politics of the human body” and a “biopolitics of the population,” converge (Foucault 139). Biopolitics is the management of the species body, the population, through regulatory controls centred on ‘problems’ such as birthrate, public health and mortality. It is the biopolitical nature of infertility that is highlighted in the opening of the chapter on female infertility within Speroff’s, which features a section concerned with the “Epidemiology of Infertility in the U.S.” (1014-15). Epidemiology is defined as “the basic science of public health,” which is said to be “concerned with the overall health of a community” (Merrill 4).
Thus, the use of the term ‘epidemiology’ in relation to infertility situates infertility as a public health issue or, more significantly, as a public health problem. As such, this section is saturated with population statistics detailing the decline of birth and fertility rates, downward trends that are attributed to more women completing higher education and focusing on careers, which leads to later marriage and more divorce (Speroff and Fritz 1014-15). In a book whose explicit aim is to assist in the clinical application of reproductive knowledge (vi), we learn that recently 44% of law degrees have been earned by women and that half of all marriages end in divorce (1015). There are clearly many assumptions about reproduction at play here, such as, that it occurs only within the context of marriage and that it is mutually exclusive to a career. Thus, despite the recognition that the proportion of working women with infant children has increased, the “overall health of the community” is at stake because women are avoiding “pregnancy until their education and career goals have been met and marriage and family become a priority” (Merill 4; Speroff and Fritz 1015). There is, of course, no mention of other factors that contribute to this public health ‘problem,’ such as the lack of national child care or the fact that the purchasing power of wages have decreased to the extent that it is hard to raise children on one salary alone.

Population statistics are also used to great effect in relation to the issue of weight and fertility within Speroff’s, where we are told that “[a]pproximately 62% of American women are overweight and another 33% are obese,” implying that 95% of American women are over their “ideal” weight (1023). These facts are
irrelevant to the clinical care of female infertility. There may be evidence-based associations between age and weight and the achievement of pregnancy but what matters, then, is the age and weight of the female patient under consideration not the fact that a large proportion of the population attempting pregnancy are old and overweight, not to mention, educated and remarried after divorce. To situate the female patient in relation to these biopolitical techniques is to imbricate the female patient in a web of power relations through which the individual body is sculpted in relation to the norms of the population.

The sculpting is achieved through the techniques of anatamo-politics, which, in this context, take the form of medical advice about lifestyle choices. The female patient is encouraged to lose (or gain) weight to achieve her “ideal” BMI and discouraged from cigarette smoking, marijuana use, alcohol consumption, and heavy caffeine ingestion (Speroff and Fritz 1023). Despite the fact that, for example, there is no proven causal relationship between smoking and infertility, the focus remains on discouraging smoking because “it seems prudent to take an active and preventive approach to infertility” (ibid 1023). Prevention and its target, risk, are key features of the public health approach and it is through these ideas that the body becomes situated in relation to a possible, or future, reality. These disciplinary practices may emerge within the medical clinic but they become part of everyday routines of self-surveillance. Thus, the infertile woman regulates herself through the knowledge that 2 cups of coffee a day is fine but more “may delay conception” (ibid 1023) or that she should be eating according to a “dietary pattern characterized by high consumption of monounsaturated fats rather than
trans fats, vegetable rather than animal protein, low glycemic carbohydrates, high-fat dairy products, and multivitamins” in order to reduce her risk of “ovulatory infertility” (Barbieri 522). This form of self-regulation is highly effective because the infertile couple is, apparently, eager and motivated to do anything they themselves can do “to maximise the likelihood of achieving a successful pregnancy,” and these measures are presented to them as features over which they “can have specific control” within the field of medicalised infertility treatment in which control is most often taken away from them (Speroff and Fritz 1023).

The technologies of biopower in operation within the medical discourse on infertility highlight the fact that there is more at stake in relation to infertility than the individual female body – through the appeal to declining birth rates, infertility is framed as undermining the nation too. Within this context, pregnancy provides for the achievement of the female body on whose reproductive efficiency rests the nation. There is a long tradition of nationalistic rhetoric that links the fertility of the female body to the service of the nation. Charlotte Perkins Gilman, an early twentieth century feminist, declared that “the business of the female is not only the reproduction but the improvement of the species” (qtd. in Solinger, 7). Discourses of nationalism are, of course, grounded in racism and the biopolitics of infertility is no exception. While there is no explicit mention of race, it asserts its presence as white through the noticeable absence of racial considerations. For example, the educational statistics cited within Speroff’s neglect to be broken down by race, which would reveal that the vast majority of women completing higher education in the US are white and non-Hispanic (“Educational Attainment
in the United States: 2009, Census 2010”). More striking is the deliberate exclusion of racial information in relation to the overview of the characteristics of those who seek infertility services (1015). When I consulted the source referenced by Speroff and Fritz, I found that one of the significant conclusions of the study is that, among those seeking treatment, non-Hispanic white women are more prevalent than “in the general population of women with impaired fertility” (Hervey Stephen and Chandra). This is to a great extent due to economic disparities between racial groups but can also be attributed to the fact that the history of non-white reproduction is more closely associated with sterilisation than encouragement to achieve pregnancy. Thus, the identification of pregnancy as a technology of the natural for the achievement of the female body must be tempered by the recognition that the transition is only fully naturalised for those bodies that fit the “ideal:” white, thin, and heterosexual.

**Conclusion**

I began this chapter by emphasising the association between fertility and the sexed body, in particular, the female body, and the challenge that infertility brings to the femaleness of the body. However, I continued by showing how the threat of infertility is contained through a number of techniques within the medical discourse on infertility through which the difference of infertility is erased. Thus, infertility is simultaneously situated at a distance from fertility and in proximity to it such that the achievement of fertility always remains possible. Through this proximity, the border between infertility and fertility is undermined such that the transition from infertility to fertility is invisibilised and the technology through
which it is achieved, pregnancy, is naturalised. By highlighting these operations, I make visible the fact that, in this context, pregnancy operates as a technology of the natural through which the fertile female body is achieved. In contrast to feminist engagements with infertility that have the effect of maintaining the belief in the “natural” fertile female body through their focus on the construction of infertility, I read the medical discourse on infertility in order to reveal the construction of the “natural” fertile female body. In short, infertility has been the academic focus to the neglect of a consideration of the production of fertility and, by implication, femaleness, and my project aims to address this by shifting the focus and, hence, reconfiguring the debate around (in)fertility and its relation to the female body. Denaturalising pregnancy through my approach, in which I argue that pregnancy is a form of body modification, a naturalised transition rather than “natural” condition, challenges both feminist debates and medical discourse on (in)fertility. In both sets of knowledge, the divide between technology and the body is maintained such that technology is understood to act on the body. In contrast, my project is an attempt to undermine that dichotomy by emphasising the construction of the body through technology. However, I do not limit the concept of technology to the explicitly technological, such as, in this context, assisted reproductive technologies, but instead reconceptualise technology in the tradition of somatechnics through the consideration of pregnancy itself as a technology. The feminist engagements that remain within the former perspective have the effect of reaffirming the distinction between the technological and the
natural, (which, in this context, is the opposition between assisted reproduction
and “natural conception”), while, in contrast, I deconstruct the binary through the
identification of pregnancy as a technology of the natural. Rather than the fertile
female body being the ground of pregnancy, I argue that, at least in the context
of infertility, pregnancy is a body modification through which the fertile female
body is produced or, in other words, the female body is the effect of pregnancy
rather than the cause. Approaching pregnancy through this perspective allows us
to fundamentally reconceptualise our ideas of reproduction and its relation to the
“natural” female body.

231


Chapter 6: Infertility Online: The Unknown Body and the Incomplete Transition

This chapter is an analysis of the online community discourse on MotheringDotCommunity focused on the representation of infertility. Due to the inherent invisibility of infertility and the fact that it remains a subject associated with shame and privacy, it is hard to find infertile people offline. While offline infertility support groups do exist, MotheringDotCommunity (MDC) is far larger, easier to access, and more diverse. Here, women with infertility can find the support they need from other people who share the suffering of this disappointment and who can provide experience, advice, or simply the space to be sad; in short, these forums become sites of community. The attribution of community is important because it means these forums are significant frames through which infertility is constituted in the sense that there is enough at stake in the interactions to make them matter. While the disembodiment of the virtual may not be a primary factor in the appeal of the online realm to those with infertility, techniques of re-embodiment are central. Thus, the online discourse on infertility within MDC is a central location through which understandings of the “natural” female (and male) body are produced.

MDC is a broad parenting site and I explore this form of online forum rather than one focused solely on infertility because I am interested in the

66 http://www.mothering.com/community
interactions between the infertile and the fertile body, as well as the transition from infertility to pregnancy. For more details about MDC and my methodological perspective in relation to this online forum, see chapter two. The online discourse on MDC provides a far more complex and contradictory view of the body and its relation to (in)fertility than that found within the medical discourse, although similarly infertility is situated both far from and near to fertility. In relation to the former, the infertile body asserts its presence, primarily through figurations of the broken body; in relation to the latter, as in the medical discourse, infertility is reduced to numbers and levels, bodily parts and processes, to the extent that the infertile body itself disappears. However, this disappearance is never fully achieved and there is far more emphasis on distance within the online discourse, such that the transition to the fertile female body that remains open within the medical texts is, to a great extent, always incomplete here; the threat of infertility is never fully contained. This reveals another transition that is sought within this context, perhaps more urgently, from the unknown body of infertility to knowledge of the body, whatever that knowledge may contain.

**The Difference of Infertility**

The “signature” is a formalised method of framing infertility within MDC, where this refers to the text or pictures that always accompany a member’s post at the bottom and can include a number of expressions chosen by a particular member as their stable representation of themselves to the community. Within the signature, it is rare for a woman to frame herself through the medical condition related to infertility she may be suffering from. In general, signatures
express the infertile woman in a relational manner, as the central node of a family network, as the signature of lesliesara83 shows:

 Leslie, mama to Paige 7, Zara 3 and ttc #3 22 mths and counting. [angel baby (AB)] Oct/01 [AB] July/10 [AB] Sept/10 Hoping for a [baby] in July

The children (and often “dh” (dear husband)) are of primary importance in relation to lesliesara83, and the inclusion of miscarriages identifies those “angel” babies as part of the family. Clearly, lesliesara83 defines herself primarily through family and this is part of the reason that the condition of infertility is a direct challenge to her foundation. Missing a part of her family, whether it be from the past or the imagined future, is, in a very real sense, missing a part of her self.

Beyond the infertility forums, members often represent themselves in relation to their parenting beliefs within the signature as well, using the extensive collection of “smilies” on MDC. Some of these symbols, often called “emoticons,” may be familiar to regular online users but many of them are specific to MDC, such as those that feature a co-sleeping bed, a breastfeeding mother, and a cloth-diapered baby. The pregnant body may be represented as a point in time on a time scale structured around the length of a pregnancy cycle, as in heathenmom’s signature: “***4***8***12***16***20***24***28***32*[stork symbol]*36***40.” Ubiquitous in other forums, these forms of parenting symbolisation rarely appear within the signatures of those within the infertility

---


forums, (only, perhaps, if a woman is suffering from “secondary infertility,” the
inability to conceive after previously achieving and maintaining pregnancy), and
the general absence of these types of expressions marks these members as
neither pregnant nor parent but bearing the difference of infertility.

The Broken Body

There has been much written within feminist theory about the breakdown
of gender identity or biographical disruption in the face of the challenge of
infertility and these threats are clearly evident on the infertility forums on MDC.
As a-sorta-fairytale says in a thread titled “Do you ever feel like m/c [miscarriage]
has changed you- and not for the better?;”

I felt like i was no kind of woman. I could not birth a baby, i could
not carry a baby, i could not get pg [pregnant]. I felt like the hugest
most awful excuse for a woman on earth. 

However, there has been less recognition of infertility as bodily failure – the
extent to which these representations of infertility express not only gender
disruption but an ultimate threat to the material ground of sex. Some previous
analyses on narratives of infertility have acknowledged representations of bodily
failure but have often reduced it to the status of metaphor, such as in relation to
thinking of the ’body as machine’ (Greil), or as a stand-in for failure of
womanhood or motherhood. Just as Prosser asserts that “the proliferation of the
wrong-body figure [across transsexual narratives] is not solely attributable to its

69 “Do you ever feel like m/c has changed you- and not for the better?,” July 6, 2010, Trying to
Conceive After Loss, MotheringDotCommunity, Nov. 19, 2010,
<http://www.mothering.com/community/forum/thread/1240907/do-you-ever-feel-like-m-c-has-
changed-you-and-not-for-the-better>
discursive power” (69), I want to take the trope of bodily failure at face value, and engage directly with significations of the ‘broken’ body and how they operate at the material level. Within this online discursive context, it is through these figurations of infertility as bodily failure – as a rupture in the conception of the body as reproductively capable – that the “natural” female body is constituted as reproductively capable.

Where the body appears explicitly within the infertility forums of MDC, it is present in its breakdown, its inability to achieve what is taken absolutely for granted before the experience of infertility, that is, pregnancy. A conversation initiated by TessaPie entitled “still obsessing over TTC [trying to conceive] even though we just adopted, what’s wrong with me???” demonstrates this figuration of the body:

I was so happy until I came back to work to hear everyone's pg [pregnancy] joy. I had no idea I’d feel this way. My husband is shocked. He says, "but we have the best baby." and it's true. We do. She is perfect, amazing. And yet I long for... what? Not for a bio baby exactly, because she is the baby I want and I don't care about a baby who looks like me (this is something I have gotten over) but I do care that my body cannot do this special, important thing.70

Infertility treatment is often considered to be driven by the desire for a biological connection; however, TessaPie makes explicit that the “bio baby” is not the primary object of desire, rather, it is the bodily ability to achieve pregnancy. In response, chiefmir highlights the shame associated with this failure:

I remember, even having had one biological daughter and being “this” close to bringing home our daughter via adoption—feeling ashamed and somehow “dirty” that my body wasn’t able to do the ONE thing that it was supposedly made for.

Here, pregnancy is figured, not just as a “special, important thing,” but as “the ONE thing” that the female body is “made for;” this has the effect of reducing the female body to reproduction so the failure of the latter is understood as the ultimate threat to the former. The connection of this inability with feeling “dirty” can be read as an association of the infertile body with immorality within the Western social imaginary, where uncleanliness and immorality are linked together. Thus, infertility is figured not only as a physical breakdown but an ethical one as well and, by implication, the fertile female body is associated with goodness. In the same thread, missme replies with the following:

I really responded to your post. I’ve always felt that I would try to conceive for a while, but wouldn’t go as extreme as IVF [in vitro fertilisation]. I thought I would go right to adoption, because I just want a little one to love, right? And the surest route is surely the best, right? But watching my sister care for my 2 week old nephew (she struggled with infertility, too), I realize that the longing to birth a baby is deep and different in a way. My body is longing to grow and birth and feed a baby. Will I love any adopted child I might be blessed with - not a doubt in mind! Will my body and heart stop their longing? Maybe eventually...But it looks like IVF is in my future first.

Again, it is not the biological connection that is at the forefront here, but the ability of the body to be pregnant or, rather, to ‘do’ pregnancy and the associated practices of birth and breastfeeding; a baby can be gained through adoption but the body still longs “to grow and birth and feed a baby.” The infertility treatment of IVF is represented as “extreme,” which could reference a number of features of
IVF – the so-called “unnaturalness” of the procedure (measured by its distance from “natural” conception), the physical invasiveness of it, or the financial cost – but all will be faced in order for the body to achieve pregnancy.

**Infertile in a Fertile World**

The difference of infertility, experienced as failure of the body, is even more apparent in the presence of other pregnant bodies. Continuing the thread referenced above, *bella99* says:

> I had always said that I would NEVER go as far as IVF, that I would adopt if it became difficult or impossible to get pregnant. And yet, when that possibility loomed ahead, I changed my mind.

> Why? Because as I watched friends and family around me get pregnant and watched their bellies grow, I realized that as much as I wanted to be a mother, I also very much wanted to be pregnant. It wasn't biology necessarily that was important to me, it was feeling a life growing within me and watching my body do it, and know that it COULD do it.

Watching other “bellies grow” in pregnancy makes painfully visible the lack of pregnancy on the infertile body, highlighting the inability of the infertile body to “do it,” to achieve pregnancy. The following conversation on the October 2010 Bitter Sushi Ladies thread captures the intensity of the experience of being infertile in a fertile world:

**jenger**: I'm finally doing it! I am hiding every gd [goddamn] person who posts about their (or their partners) pregnancy on facebook. I can't take it. I just hide 'em, anytime I see a mention of it. I have been thinking about doing it for months, and now that I'm finally
doing it - and to pretty much everyone, even good friends - I feel LIBERATED! I encourage others to try...71

miriam_bat_avraham: I find, for some reason, that when it comes to people who have had fertility issues, I'm not in the slightest jealous and rarely bitter around their cute babies. I guess it's because the feeling that they earned it trumps that "ugh, they didn't even try and THEY got a baby!" feeling that I get with others. Which is totally unfair and no one's fault anyways, but it happens. Still avoiding two pregnant friends...

MahnaMahna: I can't click sometimes on the recent rash of "omg I'm PREGNANT" threads on my local AP [Attachment Parenting] board. I swear it feels like EVERYONE is pregnant right now. Seriously. And they're all my friends. It's really wearing on me to have to be happy for everyone. Also, I'm PMS'ing.

lapis: jenger: I not only hid pregos [pregnant women] and new babies on my fb [FaceBook]... i deleted them!!! oh the horror!

enigo: I never thought I would be this person, but I swear I'm going to have to rethink my whole "not slapping pregnant women" policy.

miriam_bat_avraham: It's absolutely the complaining that gets to me. That's really the one thing. I can handle the jealousy of it not being me until she starts acting like pregnancy is a huge burden she never wanted. Seriously, I'd take 8 months of bedrest if I had to. I don't WANT to, but I would, no question. We'd figure it out.

Sweet.Bee: I've participated in a number of other threads here, but I'm starting to find it difficult to jump for joy when someone is around for 2 days then posts "oh my gosh, guess what? I'm pregnant!", while I'm still waiting and wishing. I hope that doesn't sound mean. The real killer was taking a month off from the boards to chill out, then returning to find I didn't recognize most of the people who were posting.

I know I haven't been trying as long as most of you, so hopefully I'm not offending anyone. I'd just like to be around others who

understand the annoyance of seeing a pregnant woman around every corner.

_Apricot:_ So, three preggos announced yesterday in my life. Arrgh.

One was a family that was done, so done. One a 2 month married. One single, no regular dude.

_Sweet.Bee:_ Thank you for not chasing me away. And sorry about all the pregnant women. Our town is populated by nothing but perpetually pregnant women.

_Nanette56:_ I'll never forget what it was like to have my heart break month after month, as I moved into the year mark and beyond. Not to mention the avoidance of baby showers, babies, and pregnant women in general (I don't think this ever goes away, pregnant or not BTW [by the way], even in my DDC [Due Date Club]^{72}, it seems everyone hit it on the first try and it's a very painful reminder).

_slylives:_ I hope people don't mind me posting here - this feels so much "my place" than the "I can't believe I got knocked up without trying!" threads in the DDC. But if you would prefer me to disappear for a while, I get it completely.

Evident in this conversation is the fact that, from the position of infertility, the public nature of pregnancy is recognised. Not only is pregnancy a very visible bodily sign that translates an intimate private act into a public celebration, the Western social landscape is full of fertility rituals, such as pregnancy announcements, baby showers, and declarations of the baby’s sex. On top of the personal loss and betrayal of the infertile body, facing the fanfare of fertility is too much to bear, to the extent that these members minimise socialisation with family and friends and avoid going to pregnancy saturated events. As such, infertility becomes, at the least, a reconfiguration, and, at the most, a severe restriction of

^{72} Due Date Clubs is a sub-forum within MotheringDotCommunity where pregnant women due in the same month support each other through the process.
space. In the previous thread cited, in which TessaPie writes about returning to work after adopting a baby, she even asserts the necessity of the drastic measure of changing employment:

But when it happened for real, when I got to work and each coworker came in to tell me, all glowing, "OH you missed my news!!!!!!!" I felt like I'd been kicked in the stomach. I am seriously looking for other jobs even though I love my job and love my coworkers. I don't feel I can make it through another 6+ months (more with the woman I share a room with, she's only at 7 weeks) with this current round of pregnancies and then another round in a year or so. It will kill me.

More than simply being left out, those unable to take part in the fertility rituals are not fully able to participate in the social institution of fertility through which bodies become normalised. The intensity of the marginalisation is evoked in TessaPie's short but powerful last statement: “It will kill me.”

In the technological world we live in, avoiding interaction with pregnant bodies is not only limited to offline situations but is also a feature of online use. jenger starts the conversation above by declaring the act of “hiding” all pregnant Friends on her FaceBook page, where FaceBook is a popular social network site that allows people to exchange current news and photos of their personal lives, and “hiding” is a practice that conceals the posts of others so that they do not enter jenger's personal web space, though she can still choose to enter theirs thus giving her control over her interaction with the pregnant body. In response, lapis confesses that she went further and actually “deleted” them, an act of cutting them completely out of her online social group, (at least from her perspective). The wider online network of MDC is also seen as threatening and
many infertile members return to the community on the infertility forums even after they have achieved pregnancy because it remains, as sylives says, “my place.” MDC is designed so that “graduates” from the infertility forums can move to their relevant Due Date Club in the I’m Pregnant forum and then, from there, move to Life With a Babe in the Parenting forum; however, as Nanette56 and sylives reveal, these other sub-forums are themselves saturated with naturalised fertility. The experience of infertility reveals the extent to which there is “a pregnant woman around every corner,” perhaps not literally but in the sense that in the current Western perspective pregnancy is the site of public celebration and the fertility rituals that surround it dominate the social environment. Through this social saturation, the difference of infertility is continually asserted.

The Unknown Body

The inability of the body to become pregnant is framed as a lack of knowledge of the body, such that the broken body is also the unknown body. In a thread called “So frustrated, so confused and feeling like I don’t know my own body anymore” in the sub-forum, Trying to Conceive After Loss, danilouwho writes after a miscarriage:

I could talk for hours about how heartbreaking the miscarriage was, but on top of that... I just don't feel like I'm [in] touch with my body anymore!

...
I would like to try and get pregnant again... but right now I just want to feel connected to my body again.\textsuperscript{73}

And in a later post in the same thread: “I just want to stop feeling like such a stranger in this body.” This echoes Drew Leder’s theory of the “dys-appearing body” articulated in The Absent Body (1990) – the broken body may be present but the painful awareness of its breakdown puts it at a distance, from which it is unknowable and strange. Leder marks this as “secondary absence,” in contrast to the “primary absence” of health or, in this case, fertility, where “secondary absence” is marked by presence, though not as a “simple positivity” but one born from the “absence of an absence” (91). For danilouwho, this is in direct contrast to the knowledge she had of her body prior to the experience of miscarriage, as she expresses in the original post:

…I have always been very attentive to my cycles, my cm [cervical mucous], and my symptoms when my period would roll around. In fact, probably every single cycle for the past 4 years, I could tell you about 5 days before that AF [Aunt Flo (menstruation)] was coming. I always got breakouts, sore bbs [boobs (breasts)], bloating and slight cramps. Always. I also always had very telling cm, when it was dry, it was dry and when it was watery, it was very watery, and when it was abundant, it was abundant.

I have a lot of food issues, gluten, dairy, alcohol... and I'm just a sort of sensitive person (as far as how my body reacts to things) anyways so I like knowing what is going on with me.

As opposed to Leder's “primary absence” of health and 'normality,' or his characterisation of menstruation as a mode of “dys-appearence” (90), the “dys-appearence” of infertility is here contrasted to the body exerting a reassuring

presence through menstruation. It is perhaps telling that Leder cannot imagine menstruation as a state of health as it is understood here. In response to danilouwho’s original post, scarletjane also expresses this relation to the body of menstruation:

First, I'm so sorry for your loss. And I'm so sorry you're dealing with the confusion about your body on top of that. I remember having the same feeling after my loss in January. I just wanted one thing to be stable. I just needed my cycles to show me that reproduction was possible, and it was so unsettling to have them be wacky. It took me several months to return to normal cycles, so it is likely just the hormones trying to rebalance and find their normal again. I so know how frustrating this can be, but if you possibly can, just try to be patient.

Maybe it will be helpful to really focus on your health and doing everything you can to support the healthiest possible body. That really helped me and gave me a positive focus.

Here, “normal cycles” are a sign that reproduction is possible, which is associated with “health” and balance. In this case, it is through the presence of menstruation that the body becomes knowable and recognisable as fertile, thus, not a secondary or primary absence in Leder’s terms but, in fact, a primary presence.

Of course, menstruation is not always a positive presence in relation to (in)fertility; it may be reassuring in the immediate aftermath of miscarriage or for someone with polycystic ovarian syndrome or some other ovulation irregularity, but for most women trying to conceive it is the recurring sign of failure. As Phantaja says in the thread, “Do you ever feel like m/c [miscarriage] has changed you- and not for the better?,” “I don't know if I'll ever see having my period as a part of everyday life, but a constant reminder that I. Failed. Again.” Clearly,
menstruation has multiple meanings, as a sign of both fertility and infertility and will be understood and experienced differently in relation to different bodily contexts and histories, a fact that Leder fails to recognise in his generalised attribution of menstruation as a mode of “dys-appearance.” However, whether menstruation is a presence in its simple positivity (primary presence) or a presence that is marked by absence (secondary absence), the “dys-appearance” of infertility is always associated with a broken relation to the body, where the infertile body is represented as unknown and out of control. By implication, the body preceding infertility, presupposed to be fertile, is represented as known, whether this knowledge was, in fact, positive, located in the awareness detailed by danilouwho above, or imagined in the absence of any dysfunction that takes away the assumption of knowledge of the body.

The Transition from Infertility to Fertility

The (Re)Configuration of Infertility

The infertile body, marked as broken and unknown, disappears through the reduction of infertility to numbers and levels, and, as in the medical discourse, this is one of the techniques through which the border between infertility and fertility is undermined and the transition from the former to the latter made possible. One of the primary ways that infertility is represented on MDC is through the fertility chart. This graphic depiction of reproductive signals appears in multiple places, such as the first overview post of the ‘kitchen table’ threads, member’s introductory posts, or within their signature. The chart primarily shows basal body temperature (BBT), which is recorded at the same time every
morning as soon as the charting woman wakes up but there are multiple other factors that can also be represented, such as period flow, cervix position, openness and softness, consistency of cervical mucous, result of urinating on ovulation predictor kits (OPKs), cramping, sexual intercourse, and saliva ferning, which can be seen under a microscope and is a measure of a rise in the level of estrogen before ovulation. So, at a minimum, the charting woman uses a digital thermometer accurate to two decimal places but may also include in her collection a speculum for observation of the cervix, OPKs, and an ovulation microscope; however, despite all these technological tools, these measures are considered “natural.” Through the fertility chart, the body is reduced to a line on a graph, which, if ovulation occurs, is biphasic and has a cross-hair pinpointing “O” day. Knowledge of the body is undeniably gained through these measures – not many people other than those charting know that the cervical mucous that signals ovulation is the consistency of egg-white or exactly what day their body starts producing such mucous – and, within the infertility forums of MDC, this knowledge is associated with increasing fertility. Thus, the practice of charting is an effort to regain the fertile female body, breaking it down into reproductive signals in an attempt to make it whole through the achievement of pregnancy.

The representation of infertility through charting has some similarities to the reduction of infertility within the medical discourse but there are also substantial differences. Although charting reduces the body to a series of points, it also shows that the body cannot be captured by the snapshot of one day; it is, rather, a pattern over time – one point reveals nothing, it is only through
comparison to the rest that a picture is drawn. Thus, rather than simply reducing
the body or rendering it absent, it is perhaps more accurately a reconfiguration of
the body. This understanding is cast in direct opposition to the mainstream
medical framework in the following post by LessTraveledBy in the October 2010
Bitter Sushi Ladies thread:

The doctor I went to was actually a private fertility specialist that
had been recommended by many women. She was really great in
many ways. However, she, just like all doctors here, had too much
of a medical mindset for me…

I told her that I had charted for years and showed her. She said
temps are old-fashioned and a hassle since I can use OPK’s
[Ovulation Predictor Kits], instead. OK…. However, an OPK will not
tell me that I definitely ovulated, will not bring info about spotting,
etc. An OPK would not have diagnosed me with hypothyroidism,
like my charts basically did. I have some (to me) interesting stuff on
my charts and cannot find anyone in the whole country to look at
them…I wish I could get that sort of care where they would truly try
to find out what is wrong with me…74

While OPKs merely detect the surge of luteinising hormone associated with
ovulation giving a positive or negative result, charting provides far more
information about the body. OPKs may help in achieving pregnancy through
providing the appropriate timing for insemination, though, as LessTraveledBy
emphasises, they give no definitive answers, while charting provides a multi-
layered, complex, long-term picture that is understood by her to help in getting to
the heart of “what is wrong.” In contrast to the medical discourse, in which
pregnancy is the sole sign of success, here, knowledge of the body is considered

74 *=~* Bitter Sushi Ladies – October 2010 Thread *=~*,” Sept. 30, 2010, Trying to Conceive,
MotheringDotCommunity, Nov. 3, 2010,
<http://www.mothering.com/community/forum/thread/1267105/bitter-sushi-ladies-october-2010-
thread>
to be of the utmost importance. Later in the thread, charting is associated with caring for the “whole body” (apricot) so it is, in fact, a practice that challenges rather than echoes the medicalised reduction of infertility.

**Self-Surveillance**

As mentioned in the previous chapter, within the medical discourse on infertility, part of the responsibility for infertility is shifted from the medical context to the individual patient herself through the narrative that the broken parts of infertility can, at least to some extent, be made whole and fertile through the ‘right’ lifestyle choices. This shift results in the female patient situating herself at the centre of an everyday routine of self-surveillance. While the online discourse found on MDC can be read as documentation of these forms of self-surveillance, it can also be seen as a challenge to the medical discourse in not conforming to the disciplinary practices identified within it, such as the focus on weight loss, and in redefining success not as merely pregnancy but knowledge of the body. Further, in contrast to the understanding of the disciplinary practices within the medical texts, in which they are considered to produce the “ideal” body of fertility, that is, the “ideal” candidate for medical treatment, these practices are reimagined within this context as regimes of body modification themselves, through which the transition from infertility to fertility could be achieved without the assistance of reproductive technologies. In this way, they provide for a naturalised transition that is situated in opposition to a medicalised transition.

There are multiple regimes of body modification beyond medical technologies discussed on the infertility forums of MDC, including dieting, food
elimination, exercise, and supplement programs. Through these regimes, fertility becomes understood as an ability in relation to the dis-ability of infertility and infertile women subject their body to an extensive routine in an attempt to improve their ability to achieve pregnancy. I cite the following conversation on the October 2010 Bitter Sushi Ladies thread at length because it shows the negotiation of one such bodily regime, the practice of taking supplements:

rcr: AFM - I am planning to re-assess the vitamins that I take (or, don't take) today. I stopped taking all the pills when I started the miscarriage (which is funny, because DH [dear husband] is totally still great about taking them every day). I am looking for some good web sites with info about dosages to take - everything that I have found has lists of supplements (which I know), but I have not found anything about how much to take - anybody know of anything?

miriam_bat_avraham: rcr: You too with the vitamins... I need to get on that. I've been taking some baby aspirin and Mucinex since I bought it yesterday, but I'm thinking I don't need them yet because I'm not getting +OPKs [ovulation predictor kits] yet...

rcr: So, just when I thought I knew everything there was to know about ttc [trying to conceive], I came across this baby aspirin thing a few days ago. Why do you take it? How much? Only after a +opk? It is on my list of potential stuff to take now. I need to look into it more.

rcr: I have been searching the internet for TTC [trying to conceive] female vitamins, and making a promise to myself to actually take them. Here is my potential list, what do you think (many of these I already have, but don't actually take too often, btw [by the way])?

E - 400 iu (this also has 250 selenium in it) - I have seen dosages everywhere from 400 to 2000 iu - maybe I should take more? The prenatel also has 400 iu, so that would be 800 iu total.

B- complex - 50 mg (this also has 250 mg of C). The prenatel I take has 50 mg of B6, and this complex has 50 mg of b6. Should I take more? I did have a LPD [luteal phase defect].
EPO [evening primrose oil] - 1300 mg

L-arginine - 1000 mg (this was a surprise to me that it can help female fertility, because DH has been on it for a long time now)

D - 2000 iu (plus the prenatal has 400 iu)

baby aspirin after O [ovulation]

What about Zinc? The prenatal has 15 mg in it. I can't find any dosage info online.

collieflower: Thanks for starting this supplement discussion. I would add the following:

B complex - I only take 50mg and the difference in my LP [luteal phase] has been huge! It used to be all over the place, and usually too short. Now it is exactly 14 days. Every single month. I love it. Now if only I could get the first half of the cycle to be somewhat regular...

Magnesium - for me, this is the key to handling stress. I take 250 mg twice each day. I notice when I forget to take it.

miriam_bat_avraham: rcr: I heard baby aspirin makes the lining better for implantation? I don't even remember. I'll just try anything at this point...

Kinza: I have a question. I have read the recommendation several times (not just on this thread or this board, even) to take baby aspirin to help with implantation. Does anyone know of a good, solid source for this advise? I googled this a little while ago and came up with lots of websites, one of which said baby aspirin long-term could hinder implantation, but short-term it could help. But, it was just a website, no citations with any kind of studies to back it up or definitions of long-term versus short-term. The places I found that said "Take it, it can't hurt!" with no caveats were the same kind of thing--just people talking, no citations. Most of the websites said aspirin alone was enough, but two mentioned that it was only effective taken in conjunction with Heparin. Several websites mentioned that aspirin could help many women, not only the women who have had miscarriages.
I'm taking enough supplements now to kill an elephant, so I don't know why I'm worrying over starting aspirin so much, but I am. I think I'm concerned because I could research all my other supplements and find information that I could trace citations back to something other than message boards or articles written by laypersons. So, I'm long-winded. Anyone know a good website for baby aspirin and fertility?

**miriam_bat_avraham**: Kinza-- very good question. I think I remember someone on here saying they took it, which is why I bought it... but research is kinda a good thing, heh. I'll look around.

ETA [edited to add]: Here's what I found--


Summary: "The addition of aspirin low dose (100 mg/daily) to the standard long protocol for oocyte retrieval did not improve implantation and pregnancy rates in unselected patients undergoing IVF cycles."

So I guess it's not worth taking, then.

**luminesce**: rcr: I'm taking a GNC [store name] prenatal (without iron) but I'm only taking 1 of the 2 pill dosage. It is the only multi-vitamin I've found that doesn't seem to upset my stomach. I also take 4,000 IU Vitamin D. I do wonder if I'm missing some nutrients though, particularly B vitamins. My diet was really terrible for a while when struggling with my son's food sensitivities while breastfeeding. For some reason, though, I can't get over my possibly unreasonable fear that taking supplements might actually hinder the fertility process instead of helping it.

**LessTraveledBy**: I took soy isos [isoflavones] for the first time (50 mg for 3 days and 75 for the last two). Today I have nice looking FM [fertile mucous]. (Only you would understand the joy! ha ha.) Throughout the past couple of years I have had anything from almost no mucus to this really odd jello-looking stuff, so this is truly a joyful day to me. I have been taking EPO and drinking green tea, so I am not sure whether soy has done anything or not. I am also on a ton of vitamins. It does give me hope, though.
Through this conversation initiated by *rcr*, members establish an intensive bodily regime of administering an assortment of vitamins, minerals, and other substances. *rcr*’s extensive “potential list,” as well as *Kinza*’s evocative statement that she is “taking enough supplements now to kill an elephant,” show the extent of this self-medication. These substances are considered, at the most, helpful in increasing fertility and, at the least, harmless, though each member has their own level of comfort with these attributions; while for *miriam_bat_avraham*, hearsay is enough to convince her to add a substance to her daily dose (“I'll just try anything at this point...”), *Kinza* relies more heavily on health research found on the Internet, an approach which challenges *miriam_bat_avraham*’s nonchalant use of baby Aspirin and leads her to stop taking it on the basis of the empirical evidence. However, only *luminesce* questions the whole notion of this bodily practice, wondering if it “might actually hinder the fertility process instead of helping it,” though she prefaces this challenge to taking supplements by calling it a “possibly unreasonable fear.” The representation of these substances as “supplements,” (which is also the way they are marketed), means they are understood as merely making up for a “deficiency.” Although taken in order to enhance fertility, they are not considered technologies of body modification, but “restoration” of the body to what is understood to be a naturally fertile state and, as such, they are generally included in the idea of “natural conception.”

---

While taking such an array of supplements is a dedicated bodily practice, changes in diet, such as the elimination of certain food groups, is represented as a far more intensive exercise. It involves considerable changes to the ways in which one buys, prepares, and orders food, and affects not only the infertile woman but likely her whole family too. Later in the October 2010 Bitter Sushi Ladies thread, the following conversation occurs on food elimination, cited again at length in order to show the extent of this bodily practice:

**Tara2:** BSL [Bitter Sushi Ladies], I need some advice/Just saw my oriental medicine practitioner and will be starting a gluten free, dairy free, and refined sugar free diet for the next 6 months... gulp!

I just know mothering has some resources on here. Perhaps you ladies have some experience with this as well?

I need all the help I can get.

**Taxlady:** I've been gluten and casein free for over a year! It seems daunting at first, but I will tell you - after about two solid days you will feel a huge difference and the difference gets better and better!

I started out by only eating things I knew didn't have gluten, ie - no bread or pasta. I ate meat and veggies and made my own salad dressing (lots of dressings have wheat products and milk). Soy sauce which is hidden in many things for salty flavoring is a gluten trap - normal soy sauce has wheat in it. Then I ventured out into the world of g/f [gluten free] pastas and breads. My husband and I like quinoa pasta way more than the semolina regular kind. You just have to read the labels. Going to restaurants was hard because I am shy, but the DH [dear husband] took control there and would ask the wait staff for me.

I did this to control my crohn's disease and it has kept me off of crohn's medications for the entire year. I did not know that it could have been gluten making it hard for me to get pregnant, but some ladies on this site opened my eyes to that!
If you have any questions, please feel free to PM [private message] me.. Going gluten free was like the best thing I ever did for my health!

*enigo*: Tara, I don't do sugar (aside from what is in fruit naturally) and I don't do dairy, I also quit coffee. I will say I do feel better at the very least. Gluten would be tough. It's in so many things! Also I eat 99% organic. Sheesh! I sound so boring!

I did read an article a while back about the benefits of a gluten free diet for fertility. You'd think I would take heed!

*Kinza*: Oh, no. Somehow I have never connected gluten and fertility issues. This is horrifying. I love bread I guess I'll go do some more blasted research. Bread bread bread. And pastaaaaaaa.

*Taxlady*: Kinza - maybe you tolerate gluten just fine and then you have nothing to worry about. My husband, my mother, my sister, my father all tolerate gluten and milk like champs. Don't be horrified - I have read that it helps with PCOS [Polycystic Ovarian Syndrome] (I haven't been diagnosed with that). and I've been gluten free but I'm still not pregnant. Who knows.. I DID NOT MEAN TO HRRIFY YOU! Sorry!

*collieflower*: Tara2 - I tried the gluten-free, no dairy and no sugar for a while. Am now back on wheat and dairy, but not sugar. A few things that helped me out:

- going slowly. I tried to cut out major forbidden foods (breads, pastas, white sugar, cheese) etc at first. Then, when those were out of the diet, I would shoot for the harder stuff like soy sauce, yogurt, stuff with hidden sugars and gluten.

- sugar substitutes. I know you are usually advised to even avoid honey and maple syrup, but what I do is make up granola bars with oats, nut butter, bananas and a teeny bit of honey. Then, when I get an unbearable sugar craving, at least I have something sweet to munch on, instead of bolting to the nearest corner store for a Mars bar.

- quinoa, quinoa, quinoa. I can't get enough of it. Great rice substitute, gluten-free (I'm 99% certain), and contains protein.
I have no self-discipline, so if I could manage to avoid most of these foods, most of the time, it’s totally possible. Good luck!

**Kinza:** Oh, I know I might be fine with gluten—I’m not blaming you for my horror! I just didn’t know about a possible link. I can’t tolerate dairy now. I was horribly allergic as a small child, but now just get wretchedly ill (no allergic reaction) when I eat it... which I do sometimes. But cutting dairy doesn’t correct all my issues, and I have an autoimmune problem, so I have been considering going gluten-free for a while, just haven’t done it yet (bread, pasta, happiness, love, all that). So, now I see there might be a fertility link and that might make me more serious about stopping gluten.

**lapis: tara2:** elimination diets are difficult. but sometimes they really do help.... and sometimes they don’t. It takes some playing around and a lot of patience but if you start to feel better it will make it easier to keep going. At the moment I do not eat gluten (haven’t for the last 2.5 years) and find it very easy for me... but I have had time when I’ve had to cut out MUCH more to figure out what was going on and it was a long process finding the thing that really was bothering me... anyhow good luck. and p.s. if you are allowed to eat corn, Polenta can totally save a meal...

As shown, the elimination of food groups includes gluten, sugar, and dairy, all major features in much of Western cuisine and this considerable change of diet causes significant bodily transformations – as TaxLady says, she felt a “huge difference and the difference gets better and better.” Undertaken initially for another medical reason, Crohn’s disease, she describes this diet as “the best thing [she] ever did for [her] health.” Situating it in contrast to taking Crohn’s medication, she effectively marks it as natural,

76 not body modification, merely restoration, similar to the way in which supplements are understood in the discussion above. This naturalisation occurs despite the original poster attributing the recommendation of this form of diet change with “oriental medicine,”

---

highlighting that medicalisation is associated with the Western medical institution. While not primary for her, *TaxLady* also makes the connection between gluten and infertility, though she undermines it later in response to *Kinza*, by saying, “I’ve been gluten free but I’m still not pregnant. Who knows..” *lapis* also stresses the lack of an absolute link with fertility, saying of elimination diets, “sometimes they really do help…. and sometimes they don’t.” For her, following this form of diet was about knowing the body, trying to “figure out what was going on and it was a long process finding the thing that really was bothering [her].” *Kinza* is hearing about the connection between “gluten and fertility issues” for the first time and her reaction demonstrates the extent of her commitment to know the body of infertility and train it to achieve fertility. Despite no absolute connection, the possibility that there “might be a fertility link” is enough to make her seriously consider giving up gluten, in spite of the love and happiness she (jokingly but intensely) associates with bread and pasta. She clearly feels an urgent need to do everything she can to enhance her fertility; already “taking enough supplements now to kill an elephant,” she is willing to subject her body to a more rigorous training regime, a more intensive body modification, in the attempt to increase her ability to achieve pregnancy. These measures are represented as a way to gain knowledge and control over the body that has become unknown and out of control through infertility. While these practices are understood to be based on a cause and effect relationship between these forms of body modification and enhancement of fertility, these connections are never figured as absolute, so this
control over the body is largely imagined and is, in fact, limited to the bodily practices themselves, which may be a large part of their attraction and comfort.

While this attempt to gain control of the body through these forms of self-surveillance is a major response to infertility on the infertility forums of MDC, there is also a counter discursive theme that relinquishes this form of control and undermines the shift of responsibility to the individual through the assertion of infertility as a "medical condition." In this perspective, none of the above bodily regimes are considered useful because they do not address the medical factor, and recommendation of such practices is met with anger and scorn. Within the thread, " "It'll happen when you give up" --- make anybody else want to hurl objects?," which is focused on the advice to relax but also features responses to other suggestions, goldfinches reacts sarcastically "when people start saying, "such and such an herb worked for me". No way, you had infertility that was magically cured with a simple herb? Lucky!!" The two perspectives under consideration here rely on different figurations of the body: the former is grounded on a holistic view of the body in which (in)fertility is a feature of the body as a whole that can be influenced by diet, exercise, or other bodily regimes that could provide a re-balancing; while the latter is based more on a medicalised view of the body that breaks it up and reduces infertility to a broken part or process of the body.

This divergence makes sense given that, at least to some extent, these two responses to infertility, that of attempting to gain control and that of giving it up, are divided along the lines of “unexplained infertility” and infertility with a medically identified underlying cause. In the same thread, gemasita later says:

I usually get the "just relax" comment when maybe someone asks if we have kids and I just say, "not yet," and somehow that is an invitation to give me advice. What they never know when they say that is that I DON'T HAVE TUBES. I just want to reply that no amount of relaxing is going to grow tubes in my body!!!!!!!!!!

Clearly no amount of relaxing, dieting, exercising or undertaking any other such bodily practice is going to enhance gemasita’s fertility. Although obviously a difficult situation, the knowability of the “problem” underlying infertility releases gemasita from subjecting her body to multiple other regimes that may (or may not) enhance fertility. For ~Adorkable~, infertility has made her recognise the particularity of bodies, which means that undertaking a bodily practice on the basis of other people’s success does not make sense:

the other one that gets me is when they try to assure you by telling you someone else’s story, cause like if it worked for them then it will be the same for everyone??~!!!!!

me - "i am starting ot feel like im running out of time"

"of no your not, my sister's sister in law's neighbor had 4 kids when she was in her late 40's" - Them

me - "so you understand that does not relate to me in any way"

I'm just saying it shows you can do it/havent run out of time/whatever" -Them
me - "no, it shows that THEY can do it. and other s can get preggo just by looking at a guy, i have no more in common with the former than i do the later."

While the ability to get pregnant is taken to be the common ground of female bodies, infertility challenges that foundation, and renders ~Adorkable’s~ body singular with little in common with other female bodies.

**The Incomplete Transition: Once Infertile, Always Infertile**

Within the medical domain, the achievement of pregnancy constitutes the transition from infertility to fertility. However, in the online community of infertility on MDC, that transition is always incomplete – the infertile woman may achieve pregnancy but the experience, identity, and, more significantly, the body of infertility remains. Dom&O expresses this later in the thread referenced above, by saying: “IF [infertility] is like fighting a war, even when its over it still leaves its scars all over you.” As discussed earlier, the forums on MDC are structured such that “graduates” from the infertility sub-forums, those who have achieved pregnancy, move to the Due Date Clubs and then on through the stages of parenting. However, often “graduates” do not move on and remain “lurking” on the infertility sub-forums because, as sylives says in a quote referenced earlier, “this feels so much "my place" than the "I can't believe I got knocked up without trying!" threads in the DDC.” The presence of pregnancy does not erase the struggle it took to achieve that pregnancy; the divide remains between the infertile body and the fertile body, and the community of the former still feels like home. As crazyrunningmama says in her articulation of some of the “scars:” “I don’t think I will ever forget the pain, the uncertainty, the heartache, the $$$$,$$
sense of failure (3 IVF’s, 4 FET’s, one miscarriage and a chemical pregnancy)."
To a great extent, the body remains broken and unknown; in this discursive
context, pregnancy is not a practice through which trust and knowledge of the
body is regained. Using Leder as interlocutor again, his theory does not
recognise the fact that the body, once present, is never forgotten. In contrast to
the medical discourse, pregnancy does not provide absolutely for the transition to
the fertile female body within this context.

This is nowhere more true than in relation to recurrent miscarriage, which,
as explained earlier, is considered a form of infertility within this community. As
lokidoki says in the following excerpt, pregnancy is not reassuring in the context
of a bodily history of loss:

lokidoki: I got a BFP [big fat positive] this morning ! Now the real
fear sets in on is this going to stick! Not sure when to call the
doctor...he said I could come in and get betas tested and schedule
an early ultrasound to put my nerves to rest...but I am kind of
feeling like I should at least wait a week to make sure it sticks
before I go doing all of that!78

lokidoki: I am scared and nervous ~ so nervous. Just hoping I start
to throw up this week like I did with DS [dear son] to put my fears to
rest a little. You do just really feel like you lose an innocence you
once had about pregnancy once you experience miscarriage or I
imagine still-birth too. With my DS I just sailed through like nothing
could harm us ~ that he and I were perfectly safe from all the evils
of the world. Sadly I know I will not get that back with this
pregnancy. I m/c [miscarried] at 6w6d [6 weeks and 6 days] so
once I make it to the first u/s [ultrasound] I think I will be able to let
go a little.

Loss, MotherDotCommunity, Nov. 5, 2010,
<http://www.mothering.com/community/forum/thread/1267344/hope-healing-and-conceiving-
again-october-2010>
sarah2881: lokidoki - congratuatlions!!! Stick little bean, stick!!!! I conceived DD2 [dear daughter 2] after my first m/c and it was very sad to not have that innocence, but it did make me enjoy every moment of what I did have with my DD2 and it turned out to be a long healthy pregnancy. I don’t think the fear ever totally leaves, the hard part for me was watching friends and family who were PG [pregnant] and still got to have the innocent experience, i was a bit envious.

Rather than being a positive sign of the reproductive ability of the body, pregnancy is associated with fear and lack of innocence. Here, there is knowledge (of what may happen though never why) through which pregnancy becomes a gauntlet that must be run in order to achieve a live baby. The spectre of miscarriage brings the weight of “all the evils of the world” onto the body of pregnancy. While for lokidoki, there is no pleasure or fulfilment in pregnancy, for sarah2881, though still marked as distinct from those who “have the innocent experience,” pregnancy is reconceptualised as time spent with her unborn baby and she attempts to “enjoy every moment.” In relation to the former, pregnancy is an obstacle to be overcome in the realisation of a live baby, merely a means to an end, while, in relation to the latter, pregnancy is understood to be (at least potentially) the end. In either case, pregnancy does not provide for the transition from infertility to fertility, which always remains incomplete.

The Transition from Unknown to Known

To a great extent, the transition from unknown to known is more significant within the online context than the transition from infertile to fertile given primacy within the medical discourse. While, within the medical domain, pregnancy provides for the transition, which is naturalised as restoration of the “natural”
female body, pregnancy does not operate in the same way online; it is, of course, welcomed but the infertile body remains. Ultimately, lack of knowledge is at the heart of the experience of infertility and, thus, knowledge of the body is represented as a significant achievement. As such, much of the discursive practice in this context is focused on ways in which to know the body and it is, in part, through these techniques that the body is constituted as unknown. The bodily practices of “charting” and “peeing on a stick,” (testing for ovulation or pregnancy), and the ways in which infertility is written through thread introductions, as well as the techniques of self surveillance outlined above, are represented as attempts to transition from infertility to fertility but they are also, perhaps more fundamentally, imagined as providing knowledge about the body as I have emphasised throughout.

**Medical “Knowledge”**

The focus on knowledge can especially be seen in discussions on the clinical practice of infertility treatment, where knowledge is either represented as the ultimate goal or as necessary for the achievement of fertility. While the medical institution may imagine itself as the source of all knowledge on the body, it is not considered that way in the infertility forums of *MDC*; in fact, it is often represented as an obstacle to knowledge in relation to infertility. As discussed in the previous chapter, “fixing” infertility is solely about achieving pregnancy within the medical domain; however, as emphasised above, in the online community discourse in the infertility sub-forums of *MDC*, pregnancy itself does not necessarily restore knowledge and faith in the body. The following is an excerpt
from the “October 2010 Bitter Sushi Ladies” thread, which contrasts mainstream medical treatment to a “health science” called NaProTechnology (Natural Procreative Technology). This approach is grounded in Catholicism, thus does not support so-called “artificial reproductive technologies,” such as IUI (intrauterine insemination) or IVF (in vitro fertilisation), so the focus is on providing women with the “opportunity to know and understand the causes of the symptoms from which they suffer” (ibid).

**LessTraveledBy:** So I went back and read more about NapRo technology. Had not realized they are in Europe, also, where most of the women going there are not Catholic. (Even though all the work of Dr. Hilgers was based on NFP [Natural Family Planning] and Catholic teaching on sexuality.) Apparently, they have a higher rate of success than the normal rate of IVF. Also, they stress finding out what the problem is so that whether or not the couple does have a baby, they can at least know what is going on and find peace. That is exactly what I would like. I am also so frustrated of the doctors in my country laughing at my charts and not being able to get almost any information from them.

Then again, I had to diagnose myself with hypothyroidism, also. Too bad I a not able to prescribe anything for myself... ha ha. (Not really!)

**Sweet.Bee:** Why are the doctors laughing at you? Have you found they don't take women TTC [trying to conceive] so seriously where you are? When I went in a few weeks ago, my doctor wouldn't do anything but insist that I "relax". I had asked him for something to give me a more normal ovulation (it's so much later than it used to be), but apparently they're really reluctant to give women anything around here due to a strong fear of multiples. I must have sounded pretty crazy, but I really wanted him to do something, even if it only meant testing me. Just so I could feel more in control. But he wouldn’t.

---

LessTraveledBy: The doctor I went to was actually a private fertility specialist that had been recommended by many women. She was really great in many ways. However, she, just like all doctors here, had too much of a medical mindset for me. As we will not be doing IVF or anything like that, I am a real oddball here. Basically the attitude seems to be that if I am not willing to do that, I must not really want a baby that much. It is as if I am demanding special treatment or something by not doing it their way... Well, I suppose I am.

I told her that I had charted for years and showed her. She said temps are old-fashioned and a hassle since I can use OPK's [Ovulation Predictor Kits], instead. OK.... However, an OPK will not tell me that I definitely ovulated, will not bring info about spotting, etc. An OPK would not have diagnosed me with hypothyroidism, like my charts basically did. I have some (to me) interesting stuff on my charts and cannot find anyone in the whole country to look at them. The NapRo people want hormone tests every month for months, etc. I wish I could get that sort of care where they would truly try to find out what is wrong with me...

Apricot: AnuMaria [LessTraveledBy], there's a lot you can do to increase your fertility without even flirting with "bad" stuff, like ivf, sperm analysis, or iui. I'd encourage you to explore. Don't believe the hype on NaPro. Other people care about your whole body and will be respectful of your religious requirements.

LessTraveledBy: You forget that I am not in the US... The doctors here have little respect and don't seem particularly interested in what the real problem is. This is also my 3rd year of trying to help my body. There is always something new one can try (thus mentioned acupuncture) but it is getting quite impossible mentally. You know, to always be researching for "something out there." If I found a good doctor who told me she could do nothing for me, I would be quite happy with that. (Well, you know what I mean.)

LessTraveledBy: Anyway, I feel I really need to find out why we have not been able to have another. If I could know that, and know that we have poor chances of that ever happening, it would change a lot for me. Then I could tryly ask "What's next?" and move on. I CAN deal with the idea of never having another biological child. If I knew that to be the case, I would simply be grateful for our wonderful dd [dear daughter]. However, it is this not knowing anything and thus not being able to move on that is killing me.
Through this comparison with NaPro, the characteristics of mainstream medicine on infertility are represented as: an absolute focus on pregnancy (as treatment), through which clients not willing to undergo IUI or IVF are marginalised; and a view of itself as a technologically advanced approach in comparison to “old-fashioned” techniques, such as “charting;” and, in general, a dismissal of a woman’s own knowledge of her body. As Apricot says, there are doctors who care about the “whole body,” but they are always represented on the forums as the exception thus maintaining the negative view of the mainstream medical institution. While pregnancy remains the ultimate goal of mainstream medicine, for LessTraveledBy, the knowledge of her body’s capability, whether she can become pregnant or not, is more important than the actual achievement of a pregnancy. The lack of knowledge leaves her in a stagnant state from which she cannot move forward with her life.

This quest for knowledge redefines the success or failure of medical intervention in infertility, where success is associated absolutely with pregnancy. In the introduction to the “Fall IVF Support Thread,” Tear78 talks about starting the process of IVF: “I feel positive and eager for the first time in a LONG time, because this process will at least give us information about my eggs: something I’ve been in a dark hole worrying about for many months.” While a lack of pregnancy would constitute a failure from the medical perspective, Tear78 would “at least” gain information about the viability of her eggs, knowledge that is only available through IVF. Later in the same thread, ratgrl, after describing her

---

experience of an ectopic pregnancy followed by surgery to remove the fallopian
tube and fetus, and then further surgery to remove “uterine polyps” that were
discovered during the follow-up, simply states:

I hope this whole thing doesn't scare/depress anyone. As much as
it's been a long and sometimes a hard road, I know in the end I'll
have a little person from it. Whatever we have to learn about my
body and the wonky ways it works to get there is knowledge well
earned.

For ratgrl, what would feature as a complete disaster in the medical domain is
reframed positively as a source of knowledge of her body, though, in contrast to
LessTraveledBy above, ratgrl understands knowledge to be a way to navigate
the “hard road” to the achievement of “a little person,” such that the transition
from infertility to fertility remains primary. However, knowledge is still celebrated
even in the face of a lack of pregnancy.

While the medical institution is figured as a barrier to knowledge, the
community is imagined as the ultimate source of knowledge as members provide
multiple and varied information on the medical processes involved in the
diagnosis and treatment of infertility on the basis of their own experiences. Thus,
though the journey of infertility remains medicalised, the community, to a great
extent, becomes more influential than the medical establishment in determining
the path chosen. Doctors are represented as unwilling to answer questions, short
on time, and focused solely on outcome not process. In contrast, the community
provides a large reservoir of knowledge from which members can draw in order
to navigate “this medical mumbo-jumbo journey” (Mfuglei, “The Veteran's
Thread……October 2010”). Members explain medical acronyms, the timing and purpose of medications or injections, as well as the subjective experience of the process. The size and diversity of the community means a variety of medical approaches are represented, which, though all of them are limited within some general constraints, has the effect of undermining the notion of a standard protocol. This community knowledge allows the individual member to tailor the medical process to their own needs and bodily response – for example, if an infertile woman has a bad reaction to a particular drug, she can suggest an alternative to her doctor on the basis of the community knowledge from which she draws. In this way, knowledge of the body is no longer sterile, objective, and issued from the top down, but, instead, is decidedly subjective, multiple, and emanates from the ground up. As Milk8Shake shows in the following conversation, this allows the infertile woman to shift from the position of patient, with its association of passivity, to that of advocate:

*Milk8shak*e: AFM [as for me]: Ok, so when I go to the doctor Thurs he is just going to think I'm some psycho because I'm going to basically take him hostage with my list of demands. It's a big list

*Tear78*: Milk8Shake, your blurb is all set, and you don't feel one lick of guilty for giving that doctor a list of demands! It's your body, and your life! Go get 'im!

*Milk8shak*e: So I meant to fill you all in my doctors appointment the other week.

---


He was quite impressive overall!

Here's the scoop:

- He had actually read my med records before I arrived (shock)! I hate having to repeat my story a million times just because doctors are lazy and time poor.
- He actually acknowledged that I had been through the wringer.
- He spent a bunch of time explaining things to me, and went through everything on the list of questions that I gave him. I was there for about 50 minutes!
- He admitted that he was not "all knowing" and needed time to research my condition and some of my questions.
- He let me talk! Even when I disagreed with him.

_Megan73_: Wow, Milk8Shake! I am so glad to hear that you found a doctor who will listen and give you respectful, realistic information instead of being the patronizing jerks we all know so well. That means SO much.

Although represented as an exception to the rule, this doctor is effectively forced to honour the knowledge and needs of Milk8Shake in the face of her long "list of demands," which demonstrates both her competence and engagement. Within and through the community, and the collaborative knowledge created within this space, infertile women become powerful advocates for their bodies and lives rather than merely passive patients as they are framed within medical discourse and practice.

Knowledge is sought in order to discover the source of infertility because it is thought to provide a site for treatment; it is through knowledge that the body becomes treatable in the transition to fertility. However, even when extensive medical testing is provided, the source is often never found, as in the case of "unexplained infertility," an all too common medical diagnosis or, in fact, non-diagnosis. Although Milk8Shake receives the tests she desires, she reports back...
to the community later in the thread referenced above that the results from the
doctor scan of her uterus show that “it all looked pretty "normal,"” to which she
responds “I'm starting to hate that word!” In the context of infertility, normality is
not reassuring because it does not provide knowledge of the “problem,” which
remains an enigma. Milk8Shake wants the tests to reveal an abnormality through
which the nature of infertility can be known and she expresses her intense
frustration at not knowing here:

Can I just say: **I AM TIRED OF WAITING**
I feel like all I have been doing for the last (nearly) nine months is
waiting.
It's a frickin long time. I'm sick of it. I just want some goddamn answers.
I want them now. I want to know what my stupid life is going to
hold.
I just need something, anything to look forward to and say "this is
my plan".
It's so frustrating.

For Milk8Shake, “goddamn answers” are of primary importance, perhaps more
than the achievement of a pregnancy, though she never explicitly states that.

This urgent need for knowledge is also evident in the following excerpt from the
October 2010 Bitter Sushi Ladies thread:

**enigo:** So get this, I got my results back from the hormone tests.
Perfect...So perfect in fact, that she said she could not believe it.
She said that usually there is a two page report that comes back
with the results. My report is less than a paragraph. She'll bring in
the paperwork for me to bring home and Google on Friday. Right...
so lemme just say...If I am the healthiest most perfect person...on paper. Where's my damn baby

**miriam_bat_avraham**: Hey, good news that your hormones are all good! But I know that it makes it even more frustrating... it's almost better to find something minorly wrong and fixable than to find out everything's okay and you have no idea what's wrong!

The fact that *enigo*'s hormone levels are “perfect” gives her no satisfaction because it provides no answers to the ultimate question of why she is unable to achieve pregnancy. As *miriam_bat_avraham* says in her response, finding “something minorly wrong” is better because knowing the (possible) cause of infertility provides a locus for treatment. This can be seen later in the thread when *lapis* is in this situation:

Hello ladies... just been taking a ttc/forum break for the last bit... but wanted to pop in and share some diagnostic news: They found a polyp! in my uterus! and I'm getting it out next monday.... along with a laparoscopy and an HSG. here in Austria I get to spend a few nights in the hospital so that should be funny but I already met the surgeon (who seems great) and basically everyone agreed that although there "could" be other things affecting my fertility, the polyp is almost certainly making things more difficult.

anyhow I've been taking the last couple months off from ttc and its been a very good thing for me and my sanity. Excited for this surgery.

In response to this news, *collieflower* says: “*lapis* - Helloooooo! I've been wondering about you lately! Glad to hear that you have some possible answers. That's wonderful. GL [good luck] with the surgery.” Far from being a concern, discovery of an abnormality is “wonderful,” and is met with relief and excitement,

---

precisely because it is understood to be a source of knowledge in relation to infertility. The presence of the polyp provides the infertility with a cause, making it knowable, which is understood to be treatable; the polyp is taken to be the site of disruption to fertility, which can then be restored. Of course, as collieflower points out, the presence of the polyp only provides “possible answers” and even lapis admits that there “‘could’ be other things affecting [her] fertility.”

In the face of this uncertainty, LessTravelledBy, in the conversation referenced earlier, declares that she would rather know that there was “nothing” more that the doctor could do for her, implying the presence of a major untreatable problem at the root of absolute infertility, than be in her current position of “not knowing anything.” She ends with a passionate plea: “it is this not knowing anything and thus not being able to move on that is killing me.” The liminal state of infertility, its nature as both “reproductive incapacity and capacity” (Sandelowski and de Lacey 35), which translates as a body sexed as not-female but always containing the possibility of achieving femaleness, is clearly hard to live with. While this conception of infertility is financially effective for the medical institution because there is no defined end to infertility “treatment” in the form of assisted reproduction, LessTraveledBy and the others referenced above show the intense suffering associated with that lack of definition because there is always hope that the next time will deliver – as Arthur Greil shows, infertile women identify themselves as “not yet pregnant.” Knowledge is imagined as a way of providing an either/or answer for a transition from infertile to either sterile or fertile. Ultimately, the medical establishment is framed as failing to answer the
questions of infertility definitively, leaving the infertile women on *MDC* dissatisfied and looking for that knowledge elsewhere.

**Conclusion: Sex and Knowledge**

Knowledge about the body is attained through the various bodily practices detailed on *MDC* – from the position of the cervix to the texture of the cervical mucous through the menstrual cycle, from the bodily reaction to a gluten free diet to the emotional response associated with magnesium, and from the daily basal body temperature to the length of the luteal phase. However, despite this vast amount of knowledge generated on the infertile body, far more than the fertile body, the fact that it remains understood as unknown highlights the extent to which knowing the body is associated with the presupposed fertility of the “natural” female body. In relation to the naturalisation of fertility, infertility prompts an urgent search for a cause, an answer to the one significant question: ‘why is this body unable to achieve pregnancy or maintain it?’ As such, only knowledge that addresses that question, only knowledge that could help in restoring the femaleness of the body through the “natural” state of fertility, is counted as knowledge of the body. This reveals the extent to which knowing the body as female is taken to be equivalent to knowing the body.

From the moment we are born, we are classified as male or female, merely on the basis of the presence or absence of a penis. Even those who are intersex are most often initially classified according to the binary of sex. My exploration of the discourse of the online infertility community on *MotheringDotCommunity* reveals the extent to which this demarcation of sex is associated with absolute
knowledge of the body. Marking the newborn body as female is understood to provide knowledge of the types of transitions that that body will have the potential to undergo, including puberty and starting menstruation, which marks the commencement of reproductive ability, and later, pregnancy, the culmination of that ability. This knowledge is taken for granted to the extent that these potentialities are absolutely associated with any body considered to be female. It is not that these bodily changes are taken to be proof of the female body, but that the “natural” female body is taken to be the ground upon which these changes occur. In this discursive context, infertility, the lack of ability to achieve pregnancy, pulls this ground from under one’s feet, challenging the femaleness of the body and simultaneously rendering the body unknown. The threat of infertility is not contained as it is in the medical discourse and the rupture caused by infertility is never healed. Although pregnancy does operate as body modification rather than bodily state, a becoming rather than a being, it does not function seamlessly as a technology of the natural.
Chapter 7: Conclusion: From the “Natural” Body to Naturalised Body Modification

It has been a long time coming, in terms of number of pages for you the reader and number of years for me the researcher, but I am approaching the end of this project and I can finally see that the central thread running throughout this story is the idea of transition. Some transitions are assumed and thoroughly naturalised, such as the transition from child to adult through puberty, while others are emphasised and marked as body modification, such as the transition from female to male through chest surgery. The difference between these forms of transition is thought to be grounded in medical intervention, such that the “natural” body is maintained through puberty because it remains the original body without medical intervention while the “natural” body is undermined through FTM chest surgery due to the construction it undergoes. Within this understanding, the FTM post-surgical body is considered “unnatural.” I have attempted to challenge the dichotomy between “natural” and constructed through an emphasis on the construction of the “natural,” biological, body within particular contexts. The attribution of unnaturalness to the transgender body is harmful because it allows both physical and political violence to be done to these bodies, and it constrains all bodies within a rigid epistemological and ontological framework. My project joins others in rising up against the violence enacted in the name of the “natural”
through the reconceptualisation of the nature of the body such that other geographies of embodiment can flourish.

There has been much academic engagement with the construction of the body but it has primarily focused on those practices explicitly marked as construction, such as cosmetic surgery, sex reassignment surgery, tattooing, piercing, and other so-called body modifications. This has the effect of maintaining the distinction between natural and constructed. Shifting the focus to the centre rather than studying the margins is a very effective way to challenge the boundary between the centre and the margin, as well as a way to emphasise the co-constitutive nature of the two poles. Joining those in critical race studies who have turned their attention to whiteness (Dyer; Frankenburg) and those in disability studies who have turned to the issue of normality (L. Davis), I shift the focus to the notion of the “natural” body, a move which builds upon and extends transgender scholarship. As shown in the introduction, the field of transgender studies is founded upon the binary of natural versus unnatural and much of the academic work within this discipline has solidified this binary through an assertion of the naturalness of transgender phenomena within history and across cultures. This project goes beyond the reclamation of the natural in the affirmation of transgender subjectivity and joins other critical transgender scholars in deconstructing the notion of the natural and the binary within which it is situated. I act upon Stryker’s call to interrogate nature through an examination of the “seams and sutures” of the “natural” body, the body against which the transgender body is always found lacking, in order to show the extent to which it
is constructed. In this exploration, I focus on a feature that is taken to be a fundamental immutable characteristic of the “natural” body, sexual difference. Rather than taking the “natural” male and female body as the ground upon which bodily processes act, I consider how the “natural” male and female body are constructed through particular bodily processes. In other words, I challenge the common understanding of sex as biological foundation and assert sex as effect of particular bodily processes rather than cause.

Although I primarily situate my project within the field of transgender studies, my focus on the two particular bodily practices of gynecomastia surgery and pregnancy within two distinct bodies of text from medicine and the Internet places this project at the intersection of multiple disciplines and in engagement with a number of theoretical debates. Gynecomastia surgery has never previously been the subject of such a detailed exploration. In general, male aesthetic surgery, the domain in which it is nominally located, is underexplored (Holliday and Cairnie), and this omission has the effect of circumscribing the study of aesthetic surgery to its relation to a patriarchal beauty industry that normalises and colonises female bodies (K. Davis 19), as well as maintaining the association between masculinity and disembodiment. My exploration reconfigures these issues in emphasising the ways in which gynecomastia threatens the male body, a challenge that is then contained through surgery, imagined not as achievement of beauty but “reconstruction” of the “natural” male body.
In contrast to gynecomastia surgery, pregnancy has been the object of much academic research, in particular, within feminist theories (of the body), but it has not been considered as body modification, which highlights its operation in the construction of the body. The female body is assumed to be the ground upon which pregnancy acts but I offer a queering of reproduction by flipping the two terms and exploring the ways in which pregnancy produces the “natural” female body, (at least, in the context of infertility). Imagining the female body as effect rather than cause disrupts the naturalisation of reproduction, a central site through which sexual difference is asserted. Studies on infertility itself have also neglected consideration of the challenges that infertility brings to the “natural” female body, and the focus on assisted reproductive technologies solidifies the dichotomy between the natural and the technological and maintains the association of the “natural” with “natural conception” and “blood relation.” I reconfigure this field through my exploration of pregnancy as a technology of the natural, a body modification that produces the “natural” female body that has been fundamentally undermined by infertility.

Not only have gynecomastia surgery and pregnancy not been explored in this way before, they have never been examined together. Bringing them into proximity with each other, and approaching them through the perspective of transgender transition, is a powerful and effective way of challenging the assumption that they are bodily processes that act on the “natural” male and female body respectively and emphasising the extent to which they are naturalised body modifications. Reading for, what I identify as “technologies of
The natural,” disrupts the natural/constructed binary and challenges dominant ideas about sexual difference and reproduction.

The analysis of these practices within medical discourse brings this project into conversation with the sociology of health and illness. I emphasise that the markings of health and illness through which transsexuality, gynecomastia and infertility are defined are not self-evident as presupposed but, instead, shift in relation to each other through time and across culture. Where, in the former conception, medical texts are understood to be merely descriptive, I follow Foucault (and others) in asserting their productive nature in relation to forms of embodiment. While medical discourse is grounded in the idea of the natural body, I emphasise its role in telling naturalisation narratives rather than directly representing the natural body; in other words, I highlight the fact that it is constitutive not descriptive. Although the binary of male and female is considered primary to the attribution of health and illness, I have attempted to show through my exploration of gynecomastia and infertility to what extent it is, in fact, produced through the dichotomy of health and pathology (as well as the binaries of natural/unnatural and normal/abnormal upon which this binary is grounded).

The comparison of gynecomastia surgery and FTM chest surgery in the medical context, and the detailing of the practical similarities and discursive divergences, is a particularly strong challenge to the conception of transsexuality as mental instability, which, although it potentially provides accessibility to surgery, is a fundamentally harmful attribution. It also provides a way to imagine a
reconceptualisation of FTM chest surgery that does not pathologise the patients yet still maintains the necessity of the surgery.

This reconceptualisation is asserted within the online discourse of *FTM Forum*, where the transsexual body is associated with the gynecomastic body, a connection that I made visible by bringing together medical discourse and online community discourse, two distinct but highly significant bodies of text through which the bodies of gynecomastia, transsexuality, and (in)fertility are produced. Medical discourse is grounded in the notion of the natural body and, while the natural may be restabilised within online discourse, these texts can never be read merely as reproduction of the medical discourse. In fact, detailing the naturalisation narratives that are found within the chosen sites of online discourse, where they succeed and where they fail, where they overlap and where they diverge, is a way to further challenge the stories upon which medical discourse relies. While the natural body is relatively singular within the particular sites of medical discourse under consideration, reading online community discourse offers a far more nuanced and contradictory figuration, which undermines the notion of the natural in both contexts providing the possibility of opening up new figurations of embodiment. This complexity is a feature of both the content and context of the discursive domain of the Internet, which, as well as being a particular research challenge, also invites further exploration. While I consider the Internet as text, this project has convinced me of the necessity for further research into the nature of the Internet and further consideration of the relation between text and space.
Through this project, I have emphasised gynecomastia surgery and pregnancy as technologies of the *natural*, in particular, within the medical discourse on gynecomastia and infertility respectively. However, I have been surprised to find the extent to which gynecomastia and infertility operate as technologies of the *unnatural* in producing the gynecomastic and the infertile body, in particular, within the online forums under consideration. Within medical discourse, the difference of gynecomastia and infertility is primarily erased or, at least, contained, and, thus, the gynecomastic body and the infertile body are disallowed in order to deemphasise the transitional nature of gynecomastia surgery and pregnancy, which has the effect of naturalising these body modifications. In contrast, the gynecomastic and the infertile emerge as, in Foucault’s terms, a species within the online discourse, and the transition of gynecomastia surgery and pregnancy is emphasised, although the former is more effective in the achievement of the “natural” body while the latter is often incomplete and unsuccessful in erasing the infertile body. Both forms of embodiment and subjectivity are grounded in suffering and this is at the heart of these online communities. The intensity of the suffering, which drives the desire to transition, echoes that associated with transsexuality but the nature of the suffering is fundamentally different. I noticed on both *gynecomastia.org* and *MotheringDotCommunity* that the word “robbed” was used in relation to the conditions of gynecomastia and infertility. Through this evocative term, the body before gynecomastia or infertility is constructed as natural and the conditions of gynecomastia and infertility are imagined as the villains in disrupting their birth-
right, the male body without breasts and the fertile female body respectively. Along with the idea of being “robbed” comes a deep sense of injustice at what has been taken away, so that gynecomastia surgery and pregnancy are imagined as giving back what is rightfully theirs, a return of their “natural” body not a construction. In this paradigm, suffering is the appropriate response and the desire to transition is entirely normalised in contrast to the common understanding of transsexuality where both are pathologised.

However, there is a significant overlap with transsexuality and it is this that provides the possibility for the gynecomastic and the infertile to be (re)conceptualised as species within the online discourse; this overlap is the location of the borders of male/female and health/pathology through which the body is defined. Within the medical discourse on gynecomastia and infertility, these borders are situated, in relation to the former, in order to contain the male body and situate gynecomastia as merely excess “feminine” tissue, and, in relation to the latter, in order to contain the female body and locate infertility within a reproductive process or organ, which, in some cases, is masculinised. In contrast, these borders are redrawn within the online sites under consideration. Gynecomastia is represented as a threat to the male body such that the border between male and female cuts through the body rather than maintaining the bodily integrity of the male body; and infertility is figured as undermining the female body to such an extent that the body remains always not-quite female. While in the medical discourse, the border of male and female remains firmly between sexed bodies, in the online discourse, this sexed border is found within
bodies. Body modification, as visible rather than naturalised transition, is associated with border crossing and so is fundamentally linked to the location of the borders through which we mark bodies. Thus, the reconfiguration of these borders within the online discourse makes visible the extent to which gynecomastia surgery and pregnancy are body modifications in that they provide for the possibility to cross a border, from gynecomastic to male and from infertile to female respectively. Thus, they can be read as a form of transsexual transition within the online discourse as opposed to naturalised body modification as in the medical discourse.

This project provides a way to undermine the binaries through which the transsexual is pathologised and all bodies are constrained in emphasising the fact that the body is always associated with becoming. Through stitching up the natural, I offer both a challenge to the regulatory system of sexual difference and an invitation to imagine new forms of embodiment and subjectivity.
References


White, Michele. "Representations Or People?" *Ethics and Information Technology* 4.3 (2002)


