Technologies of the Natural: 'Male Enhancement', Gender Confirmation Surgery, and the 'Monster Cock'

by

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Abstract

Responding to Susan Stryker's (2006) call to identify the "seams and sutures" of the 'natural body', this dissertation analyzes the social incarnation of the 'natural male body' through 'male enhancement' discourse in Canada and the United States (247). As one of the few sociological investigations into the medical practice of male enhancement, this research reorients our analytical gaze away from the somatic transformations of historically-oppressed people's sexed bodies, towards bringing the male body, cis masculinity, and whiteness into the spotlight of critique. This investigation is grounded in fifty hours of online observations of a male enhancement forum for cis men interested in augmenting their genitals; and twenty in-depth, qualitative interviews with medical practitioners who specialize in male enhancement procedures. Drawing on the theoretical and analytical tradition of somatechnics, I juxtapose bodies and somatic transformations in relation to each other to reveal the underlying assumptions, justifications, and prohibitions for particular forms of bodily being. I first compare how male enhancement for cis men and gender confirming genital procedures for trans people are discursively produced in contrasting ways, despite how both sets of these procedures use overlapping medical knowledges to intervene on genitals, aiming to produce similar aesthetic results and to reduce patient suffering. Yet male enhancement is discursively framed as 'restorative' or 'augmentative' of the natural male body, whereas gender confirmation surgeries are rendered 'constructive' of an unnatural body. In the second half of my analysis, I demonstrate how male enhancements that result in 'monster cocks', by definition, make penetrative sexual practices impossible or cause sexual partners pain, thereby creating a tension between sexual practices that male the body, and dominance practices that accomplish masculinity. Reading the monster cock in relation to discourses about the 'female reproductive body', dyspareunia, and racialized bodies, I trace how male enhancement discourse works to shore up the contours of whiteness, cis masculinity, and the male body. This project aims to disrupt the naturalized white male body against which all others are measured, and attempts to make an intervention into how bodies come to matter.

Keywords: male enhancement; augmentation phalloplasty; cis masculinity; trans embodiment; gender confirmation surgery; racialization and whiteness; somatechnics; the body and technology; medical discourse; naturalization

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Chapter 1

Identifying the Seams and Sutures of the 'Male' Body

> *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.*
>
> —Susan Stryker
>
> *My Words to Victor Frankenstein above the Village of Chamounix: Performing Transgender Rage*

Sociologists and feminists have given a great deal of attention to the bodies of people who have historically faced oppression and who engage in somatic transformation of their genitals, identifying their bodies as socially constructed sites of gender and sex. Feminists have a lot to say about how 'designer vaginas' and other 'female genital cosmetic surgeries', for example, produce 'female bodies'[1] according to logics of binary gender and

[1] I acknowledge that 'female' and 'male' are not a reflection of the 'nature' of bodies, and employ these terms consistently throughout this manuscript as socially (re)produced divisions of materiality. For the purpose

heteronormativity (Pentney 2012; Braun 2009, 2005; Green 2005).[2] Investigations into surgical procedures for trans (Hausman 1995; Billings and Urban 1982) and intersex people (Fausto-Sterling 2000; Dreger 1998; Kessler 1990) for the purpose of demonstrating that sex is socially, medically, and technologically constructed number too many to list here. Repurposing the common feminist quip 'but what about the men?' into a gesture towards deconstruction I ask, 'how does male enhancement constitute cis men's bodies?'

It is not as though the importance of 'male' genitals to the intelligibility of masculinity and the male body is lost on social scientists. There is an abundance of academic interest from social theorists in investigating penile aesthetics (Brennan 2017; Flowers et al. 2013; Castro-Vázquez 2013); the gender, sexual, and racial meanings of penis size (M. Hall 2015; Del Rosso 2011; Lever, Frederick, and Peplau 2006; Poulson-Bryant 2006; Bogaert and Hershberger 1999); the medicalization of erectile performance (Gurevich et al. 2018; Maddison 2009; Potts 2005; Bordo 1998); the changing social and historical meanings of (de)circumcision (Kennedy 2015; Fox and Thomson 2009b, 2009a; Gilman 1997); the (often forgotten) importance of the testicles to men's construction of masculinity and the 'male' body (Karioris and Allan 2017); among other topics related to 'male' genitals (Hayes and Dragiewicz 2018; Owen and Campbell 2018; Inhorn 2007; Stephens 2007; Cameron 1992). And while there is also a growing body of research examining cis men's participation in aesthetic practices (Atkinson 2008; Holliday and Cairnie 2007; Weber 2006), I echo sociologist Jared Del Rosso's (2011) surprise that so few social scientists have investigated 'male enhancement' in general, much less as a

of improving the style and clarity of this dissertation, however, I chose to strategically limit the moments when I use scare quotes around these (and other) concepts.

[2]Heteronormativity is the commonsense idea spread throughout the globe through colonialism that heterosexual coupling is the elemental form of human association (see Warner 1993). It promotes and naturalizes monogamy as the cornerstone of the family and of human civilization, as well as the alignment of primary and secondary 'sex characteristics' with one's gender and sexuality. Heteronormativity suggests that females are naturally feminine women who are attracted to and form sexual and romantic relationships with males who are naturally masculine men.

rich site for understanding how power operates—particularly through medical discourse—to materialize the body as 'naturally male'.[3]

This analysis reorients our analytical gaze away from focusing on the construction of historically-oppressed people's bodies and identities, and towards bringing masculinity and the 'male' body into the spotlight of critique. Attempting to respond to Susan Stryker's (2006) challenge to "discover the seams and sutures" of the 'natural body', this dissertation analyzes the social incarnation of the 'natural male body' through 'male enhancement' discourse in Canada and the United States (247). Within the analytical chapters of this dissertation, I explore how the male body comes to matter: a play on words that expresses how bodies become material, take on meaning, and gain legitimacy.[4] Anchoring my analysis is a comparative somatechnic method that enables me to juxtapose bodies and somatic transformations in relation to each other to underscore how they are discursively framed in contrasting ways, revealing the underlying assumptions, justifications, and prohibitions for particular forms of bodily being. This manuscript offers an examination of how medical discourse creates, maintains, rearticulates, and contests categories of human difference rooted in the 'natural body' and upon which socio-political violence is so often justified in Canada and the United States.

This investigation is grounded in roughly fifty hours of online observations of a male enhancement forum for cis men interested in augmenting their genitals; and twenty in-depth, qualitative interviews with Canadian and US plastic and cosmetic surgeons, urologists, and other medical practitioners who specialize in male enhancement procedures. Of the twenty physicians in my sample, six also specialized in gender confirmation procedures for trans

[3]I use 'male enhancement', among other variations of the term, to refer to penile length and girth augmentations and scrotal enhancements. Physicians from my sample often used the terminology 'augmentation phalloplasty' to name medical interventions that aim to increase the length and/or girth of the penis. While I occasionally use this language in this dissertation, I noticed that it caused more confusion than elucidation during interviews with doctors. This is in part because some trans folks also undergo phalloplasty procedures, making it difficult to distinguish between the set of patients and procedures I was discussing. I also selected this term because medicalized language was not accessible to friends and colleagues, but they immediately understood the meaning of 'male enhancement'. I acknowledge that this terminology is politically imbued and contentions; in this manuscript, I work to demonstrate how even the term 'male enhancement' discursively functions to naturalize the male body.

[4]See feminist philosopher Judith Butler's (1993) *Bodies that matter: On the discursive limits of "sex"*.

people.[5] By examining this data through a feminist poststructuralist lens, I demonstrate how various discourses operate to naturalize the particularly white male body both before and after going under the proverbial knife.

I understand this project as entering into an ongoing conversation about the 'nature' of bodies and subjectivities. This research builds on previous scholarship—most of which I outline in Chapter 2—but here I detail the historical accounts of male enhancement, theoretical insights from men and masculinities studies, and comparative analytical approaches from somatechnicians working to deconstruct masculinity and the male body. I provide an outline of this research in the sections that follow, beginning with an overview of the history of male enhancement within my research context.

A Brief History of Male Enhancement

Genital practices of penis stretching, elongation, and stone and bead implants have been recorded throughout the world, from the Middle East (Wylie and Eardley 2007) to South America (Talalaj and Talalaj 1994, cited in Wylie and Eardley 2007), and from Africa (Lemperle and Elist 2015) to Asia (Oktavian, Diarsvitri, and Dwisetyani Utomo 2011; Fischer et al. 2010; Hull and Budiharsana 2001), each with their own social and historical meaning.[6] While some of these genital practices reportedly began over one hundred years ago, historians locate the emergence of penile enhancement practices in the United States within the last sixty years (Luciano 2002; Haiken 2000).

The development of medical interventions into the penis in the United States coincided with the advent and proliferation of plastic surgery techniques after the First

[5]Feminist sociologist Travers (2018) defines gender confirmation surgery as "surgical procedures that enable the body to conform to gender identity, including but not limited to chest reconstruction, genital reconstruction, and facial reconstruction" (221). I limit my use of the term 'gender confirmation surgeries' to refer only to *genital* interventions for trans folks for my purposes of comparing genital surgeries elected by trans and cis people. My hope is that this research begins to problematize this language by demonstrating how male enhancement itself is a form of somatic intervention that works to 'confirm' a cis man's gender.

[6]However, the majority of sources (peer-reviewed or otherwise) that state penis augmentation has existed throughout time and across cultures rarely provide evidence to support their claims. For example, Lemperle and Elist's (2015) book advertising male enhancement as well as Wylie and Eardley's (2007) peer-reviewed article do not cite scholarship—much less provide original data—to support their claims about jelqing as an ancient Middle Eastern practice, and should be regarded with cautious suspicion. Despite this, a dozen articles cite these sources as authorities.

World War; surgeons initially operated on the penis to address 'deformities' from birth and war-related injuries (Luciano 2002; Haiken 2000). However, it was not until the 1960s, according to feminist historian Elizabeth Haiken (2000), that doctors sought to perform male enhancement procedures. In these early procedures, medical practitioners attempted to inject liquid silicone under the skin of the penis to add girth, but negative outcomes led physicians to search for alternative methods to augment cis men's genitals. Haiken explains that with the development of liposuction technologies in the 1980s, surgeons like Dr. Ricardo Samitier saw an opportunity to reuse the otherwise discarded fat by transplanting it into the penis. These autologous fat transplants—meaning fat that comes from one's own body—consistently resulted in infections, a lumpy appearance due to uneven absorption of the fat, and several other complications.

Haiken (2000) reports that length procedures began in the United States after Dr. Harold Reed—a urologist located in Miami—imported a lengthening technique developed in 1990 by Dao-chou Long, a physician from China. Reportedly, this technique—what physicians in my sample called the suspensory ligament release—was originally developed to 'correct' congenital disorders in infants, and was adopted by US male enhancement physicians to elongate the penises of adults. The procedure involves cutting the ligaments that keep the penis attached to the pubic arch and partially 'rooted' in the body. As practitioners emphasized throughout our interviews, some people have more interior penile length than others; if a patient has limited interior length, physicians are adamant that cutting the ligaments will not result in any elongation. For patients who do have interior penile length, severing these ligaments ostensibly allows the interior portion of the penis to extend outward, with the aim of elongating the flaccid penis. Some of the doctors in my sample claimed that a suspensory ligament release could result in up to two added inches in flaccid length; however, most were skeptical of these gains. To maintain this added flaccid length, patients need to maintain traction on the penis for several months using various techniques and/or medical devices in order to prevent reattachment. Without proper post-operative care, retraction can result in loss of the *original* penile length, not just loss of the added length.

Historian Lynne Luciano (2002) describes some of the complications from the suspensory ligament release procedure and girth augmentations using fat injections.

> Problems ranged from nerve damage, scarring, inhibited erection, and lowered erectile angle to penis shafts marred by concave areas, nodules, or benign fatty tumors. Rare but frightening complications could also develop from the inner root of the penis failing to hold its new position, causing it to swivel disconcertingly. (193)

While some of these complications and negative outcomes may be reversible through revision surgeries, doctors expressed that there is no guarantee they will resolve, or that additional complications will not arise.

The experimental character of augmentation phalloplasty meant that most doctors did not have training to perform these procedures, and as medical practitioners with their own private practices, they received limited oversight and regulation (Bannon 1996).[7] Moreover, not all physicians were board certified in urology or plastic surgery (Luciano 2002). The American Urological Association—one of the most influential organizing bodies in urology—reaffirmed their 1994 policy statement as recently as 2018, stating that they do not support the division of the suspensory ligament nor the subcutaneous fat injections because neither procedure has "been shown to be safe or efficacious" (AUA 2018). Some physicians eventually lost their medical licenses for botched procedures, or were sentenced to prison for the deaths of their male enhancement patients (Luciano 2002; Haiken 2000; Bannon 1996).

While new lengthening procedures are relatively rare, physicians in my sample report improved techniques to reduce negative outcomes. Fat injections now use much smaller, micronized fat to reduce complications and poor results. Multiple other girth augmentation procedures using saline injections, implants, fat grafting, hyaluronic fillers, polymethyl methacrylate (PMMA) injections—an acrylic material inserted around the erectile tissue of the penis—and other materials have since come onto the market. Practitioners report that each of these girth procedures produces varying degrees and

[7]The history of scrotal enhancements in the United States or Canada is notably absent from the literature. This absence persisted in my conversations with physicians, and therefore, in this dissertation. I agree with Karioris and Allan (2017) that more social science research is needed about the scrotum.

permanence of augmentation, as well as its own set of complications (see Chapter 5 for additional information). However, even with these new materials and enhancement techniques, litigation over botched procedures continues; current doctors face legal consequences for negative outcomes from their male enhancement procedures, including a physician in my sample.[8]

By 1996, male enhancement practitioners had performed an estimated fifteen thousand augmentation phalloplasties on cis men, amounting to an estimated $24 million dollar annual industry at the time (Bannon 1996).[9] Luciano (2002) estimates that just one physician, Dr. Rosenstein, had performed five thousand enhancements from 1991 to 1996, up to ten procedures a day, amounting to about $200 thousand dollars per week in patient fees, totaling at least $30 million dollars (191). Some claim that US physicians were attracted to the male enhancement industry as a result of reduced incomes spurred by managed care (Bannon 1996). This was certainly the case for four of the US practitioners that I interviewed, like Dr. Wexler, who reported that his current career in male enhancement is unrelated to the specialty for which he was originally trained in medicine.[10] He began performing male enhancement procedures after he realized that cosmetic interventions could be charged at a premium out of pocket.

Cis men who engage in any degree of penis enlargement require some funds or access to financing since none of these procedures are covered by insurance in Canada or the US without a diagnosable problem. The prices of male enhancement procedures performed by the practitioners in my sample range between, for example, $1,000 to $3,000 dollars for one

[8]This male enhancement practitioner requested that I not quote or identify him, even with a pseudonym, due to the lawsuit he is facing.

[9]Unfortunately, male enhancement procedures are not delineated in the American Society of Plastic Surgery (ASPS) report of cosmetic procedures 'for males'. In fact, their report regularly excludes procedures men tend to elect such as hair transplants and circumcisions (Holliday and Cairnie 2007). With that said, the ASPS (2019) estimated that men accounted for eight percent of professionally-administered cosmetic procedures, including both surgical and minimally-invasive interventions in 2019. That amounts to 1.3 million cosmetic procedures throughout the body performed on men within one year.

[10]All physicians' names and the names of male enhancement websites from which I generated data for this project are pseudonyms.

Priapus Shot[11]—of which doctors claim most cis men seeking enhancement require three shots or more to see any results—and upwards of $17,000 dollars for invasive surgeries. Additional costs for airfare, hotel stays, car rentals, prescription medications, follow-up visits, and unexpected hospitalizations make male enhancement procedures prohibitively expensive for many cis men in Canada and the United States. Revision surgeries that either modify an enhancement or remove enhancement materials (when possible) carry an additional price. Some cis men from my online observations of *Enhancement Forum* claimed that they spent upwards of $30,000 dollars on the entire procedure to gain half an inch to two inches in length or girth, the permanence of which is not guaranteed. Some physicians in my sample offer discounts, but they are usually given to firefighters, police and military officers, or veterans.

The men who engage in do-it-yourself genital practices at home face less financial burdens; however, they too can make costly purchases of penis enlargement equipment, such as stretching and hanging devices, vacuum pumps, creams, vitamins, supplements, books, and expert knowledges (such as consultations with doctors) in order to accomplish their body projects. On the other hand, jelqing is a do-it-yourself male enhancement technique that does not necessarily require equipment. It is often described as 'milking' the semi-erect penis with strong pressure to thicken the tissue for mild enhancement (see Wylie and Eardley 2007). Cis men perform these genital practices on their own, or sometimes in addition to surgical interventions such as lengthening procedures. The history of these and other at-home male enhancement practices in Canada and the United States is less clear, and more research is needed.

Given the rise and expansion of the male enhancement market within the last thirty years, one might expect sociologists and gender scholars to identify male enhancement as a rich site for analysis. However, limited social science research has been conducted on male enhancement. Beyond the medical literature on augmentation phalloplasty and scrotal enhancements, existing research examines ads for 'erectile enhancement' supplements

[11] Physicians described Priapus Shots as a non-invasive, non-surgical injection of platelet rich plasma derived from the patient's own blood to "heal" and "restore" the vasculature, producing a mild girth enhancement.

(Brubaker and Johnson 2008), compares ads for penis augmentation procedures with ads for breast enlargement (Robinson 2008), or provides a brief historical overview of the male enhancement industry in the United States (Luciano 2002; Haiken 2000).

None of these investigations, however, examines how male enhancement discourse materializes and naturalizes cis men's bodies as male, which are the aims of the present analysis. To lay the theoretical groundwork for this project, I situate how men and masculinities scholars and somatechnicians have made sense of the male body as socially produced in the sections that follow. I begin by situating these bodies of scholarship in relation to theories of masculinity.

Masculinity and the Male Body

Since knowledge has historically been produced by "men talking to men about men" (Gutmann 1997, 385), and since patriarchal dominance works to systematically trivialize, silence, and erase non-men, focusing on men and masculinity within a feminist and trans somatechnic analysis may seem to detract from a larger emancipatory project that commonly centers the lives of the subaltern. However, this project joins other feminist scholars by redirecting my analytical gaze from the margins—from studying the bodies of trans folks, cis women, and people of colour, for example—towards the centre—analyzing the male body, cis masculinity, and whiteness—as a means of troubling the natural foundations upon which so much social inequity is justified in Canada and the United States. In this section, I contextualize my research within existing bodies of scholarship that theorize masculinity and deconstruct the 'male' body.[12]

Early theories of masculinity in sociology, such as role theory forwarded by Talcott Parsons (1954), conceptualized masculinity as a gender role enacted by men. The maleness of these men's bodies was not only assumed, but served as the foundation from which masculinity emerged. This perspective claimed that biological differences between female and male bodies resulted in well-defined cultural roles. Feminist theorists called into question the naturalness of these gender roles (see Reeser 2010). In contrast to treating gender

[12]For a dedicated discussion of race, racialization, and whiteness, see Chapter 2.

as essential, foundational, stable, complete, universal, or natural; gender scholars coming from a feminist tradition conceive of masculinity as constituted through unequal social arrangements. Sociologist R.W. Connell (1995), for example, identified a multiplicity of masculinities that are configured in relationship to social hierarchies. After all, not all men benefit from patriarchy equally.

The main arguments driving multiple masculinities theory depend upon the notion that gender, sexuality, and race intersect to differentially position individuals in relation to patriarchy, heteronormativity, racism and other systems of power (Connell and Messerschmidt 2005; Connell 1995). Such an argument calls attention to how the field of social arrangements generates "relations of alliance, dominance and subordination" that pivot on different gender, sexuality, and race positions (Connell 1995, 37). Relations between masculinities and other social positions instruct Connell's socio-historically mobile typology of hegemonic, complicit, marginalized, and subordinated masculinities. Detailing each of these sets of social relations is beyond the scope of this literature review; however, defining hegemonic masculinity is important for understanding how the field of social relations are hierarchically organized in relationship to patriarchy.

Hegemonic masculinity is the "currently accepted strategy" for successfully defending patriarchy, a strategy that also generates resistance to it (Connell 1995, 77). Thus, hegemonic masculinity needs to be flexible and mobile in order to respond to critiques that may threaten the legitimacy of patriarchal claims to authority and dominance. Since hegemonic masculinity is not intended to serve as a stable or essentialist character type, it manifests in diverse ways depending upon one's socio-historical location. Connell (1995) delimits hegemonic masculinity, stating that the "number of men practising the hegemonic pattern in its entirety may be quite small" since hegemonic masculinity is an ideal type that is rarely accomplished in social practice (79).

Multiple masculinities do not form a reified typology of categories, yet many misinterpret Connell's model in this way. A proliferation in identifying and cataloging 'types' of masculinity—such as 'medicalized masculinities' (Rosenfeld and Faircloth 2006), 'Black masculinity' (see Reeser 2010 for several examples), or the increasingly popular

'toxic masculinity' (Berdahl et al. 2018; Kupers 2005)—has come to characterize much of the field of men and masculinities studies.[13] As sociologist and masculinity scholar C.J. Pascoe (2007) points out, this trend tends to "construct static and reified typologies" that neglect social context and ignore the empirical work that instructs Connell's model of multiple masculinities (8). Instead, Connell's model conceptualizes masculinity as always "historically contingent, contested, and deeply implicated in local relations of dominance and oppression" (McLean 2017). As such, masculinity is a set of dialogical practices, performances, and relations between the self and others configured by the larger social context (McLean 2017; Del Rosso 2011; Pascoe 2007; Sheff 2006; Brickell 2005; Connell and Messerschmidt 2005; Connell 1995).

The masculine formations I trace in this dissertation are socially and historically-situated configurations of practices and discourses of dominance over one's sexed body and the bodies of others. Throughout this manuscript, I use the language of *phallic masculine embodiment*—not to be confused with phallic masculinity (Brunner 2010; Thompson and Holt 2004),[14] and not to add to the never-ending inventory lists that classify 'types' of masculinity (see Messner 2004)—but rather, to capture the practices and discourses of dominance over one's own body and the body of others that I identify in my analysis. Phallic masculine embodiment is not reduced to the 'male body' in terms of the penis or 'male' genitals generally; bodies that are not socially assigned as 'male' can enact phallic

[13]Toxic masculinity is not a sociological concept (Connell and Messerschmidt 2005). Psychiatrist Terry Kupers's (2005) article on toxic masculinity in prison reveals that the crux of the concept rests in separating "those aspects of hegemonic masculinity that are socially destructive, such as misogyny, homophobia, greed, and violent domination; and those that are culturally accepted and valued" (716). In addition to implying that normalized attributes such as greed and misogyny are not "accepted and valued" by dominant culture in Canada and the United States, the concept does little to identify the sets of social relations and institutions that sustain it, instead gesturing to identities and attributes. Moreover, the term does not lend itself to a historical nor an intersectional analysis because it assumes toxic masculinity is uniform across time, space, and groups. While some feminists have adopted toxic masculinity as part of their vernacular, the term came from the mythopoetic men's movement that blamed mothers and women for the production of 'weak' men (Ferber 2000).

[14]Laura Brunner (2010) develops the concept of phallic masculinity in her media studies analysis of the television series *Sex and the City*, suggesting that phallic masculinity is an ideal type, rather than a specific or diverse representation of real men's experiences in the world. Rooted in physical strength, disembodiment, and high socio-economic status and prestige, phallic masculinity is representative of the 'universal male subject'. While phallic masculinity depends upon disembodiment—meaning an absent presence of the body—Brunner seems to conflate phallic masculinity with the male body.

masculine embodiment even if those bodies are not centered in this present manuscript.[15] By using the term 'phallus' to indicate domination (see Pronger 1999), phallic masculine embodiment refers to dominance practices enacted through and over the body.

Whereas many contemporary sociologists and feminists who study masculinity theorize gender as a social construction and problematize the ways in which masculinity is made to appear natural—replicating some of the issues from a Parsonian theory of masculinity—they do not always successfully call into question the 'naturalness' of the male body, much less acknowledge the social processes that constitute the body as 'male'. Some masculinity scholarship offers descriptions of the social behaviours of men, acknowledging that the *forms* masculinity takes are socially constructed and thus contingent upon unique socio-historical contexts; however, this work often reduces masculinity to men and male bodies (see Gutmann 1997 and Connell 1995 for critiques of this body of literature). Some anthropological scholarship, for instance, treats the male body as the biological foundation for social patterns of behaviour (Friedl 1975); as the site for inherent drives that determine masculine subjectivities (Tiger 2004); and as the somatic material that limits masculinity to cis men (Gregor 1985).

According to this scholarship, masculinity is a social scaffolding that may differ in its presentation, but nevertheless tends to be constructed upon a 'natural' male body as foundation. By reducing masculinity to the male body, scholars render the male body as the presocial, pre-discursive site from which masculine identity 'naturally' emerges. Theories that naturalize the body as the origin of gender offer an inadequate contribution to emancipatory politics for grounding identity in a 'stable' and 'immutable' body. While descriptive studies of masculinity in cross-cultural contexts effectively illustrate the socio-historical specificity of masculinity, the field of masculinities studies requires a corresponding theoretical understanding of gender that problematizes the naturalization of sexed bodies and their entangled but irreducible relationship with gender, sexuality, race, and other systems of power.

[15]Taking cue from trans scholars and activists who use the language of 'sex assignment', I avoid using language of 'being born' a particular sex as this obscures the social processes that are actively sex*ing* the body into a binary categorization.

A few ways masculinity scholars have disentangled the relationship between masculinity and maleness is by examining female (Pascoe 2007; Pronger 1999; Halberstam 1998) and trans masculinity (Halberstam 1998; Connell 1995). At the centre of their argument is an insistence that non-male bodies that enact masculinity undermine a naturalized alignment between sex as the foundation and gender as its effect. Positioning themselves within a larger framework of queer and feminist theory, non-male masculinity scholars strategically and provisionally stabilize the contours of the sexed body for the purposes of deconstruction.

Pascoe (2007), for example, draws from her ethnographic field work observations of masculinity and (hetero)sexuality in a US high school to build the argument that girls who enact female masculinity trouble the naturalization of the male body as the core from which masculine subjectivities emerge. How girls carried, positioned, and talked about their bodies as differently-sexed accomplished the discursive work of recasting themselves as masculine. Metaphorically donning a phallus, for example, or fashioning one's chest as muscle, not breasts, helped render intelligible their masculine enactments. Even though the masculine girls cite the phallic or muscular body, Pascoe (2007) demonstrates that their gendered enactments were not reduced to the material body, and therefore, disrupted the naturalized alignment between male bodies and masculinity.

While non-male masculinity may decouple gender from the body, it does not necessarily demonstrate the social materialization of the body. Other scholars (Del Rosso 2011; Rosenfeld and Faircloth 2006; Longhurst 2005) investigate the vulnerability of the male body to performative failure, attending to cases when the male body fails to cite the regulatory norm of sex, thereby necessitating the ongoing reiteration of its stability to shore up its contents and boundaries.[16] Employing a sociological lens, Jared Del Rosso (2011) analyzed cis men's understandings of their penis and its size by observing internet forums for cis men who believe their penises are 'short'. While still coded as 'male', penises that are perceived as 'short' nonetheless pose a threat to the natural male body. Central to Del Rosso's claims is an insistence on the fragility of the discursive contours of

[16]Judith Butler (1993) explains that a *regulatory norm* "produces the bodies it governs" (1).

the penis and male body. His work suggests that somatic failure exposes how bodies materialize through gender. From his observations, for example, he learned that men cajole their penises by stimulating a mild erection to "fluff up" their size so they appear larger before a sexual encounter or in homosocial spaces, such as the gym or men's bathroom (715).[17] The meaning of the sexed body emerges within a field of social relations, in this case, under the gaze of sexual partners and other men. The male body, therefore, does not transcend the social; it is made and remade through social practice.

Scholarship that examines the medicalization of cis men's bodies has also effectively demonstrated the social production of the male body (Szymczak and Conrad 2006; Longhurst 2005; Saint-Aubin 2002). *Medicalization* refers to the expansion of medical jurisdiction, a process by which elements of everyday life are defined as illnesses or disorders and are brought under the management of medicine (Conrad 2007; Rosenfeld and Faircloth 2006). One of the strengths of this literature lies in its ability to render visible how the male body materializes through medical discourse. Social geographer Robyn Longhurst (2005), for example, demonstrates that cis men with breasts—who would be diagnosed in Canada and the United States with gynecomastia—are rendered abject in ways that normalize and naturalize men with flat chests. Parts of the male body that are incompatible with binary sex illustrate how a "whole series of corporal exclusions" are required for male bodies to remain discrete and intelligible as naturally male, and reveal the persistent social energy needed to bring male bodies back into alignment with binary sex (Reeser 2010, 94).[18]

Learning from these bodies of literature, this dissertation focuses on how the processes that naturalize the 'male' body become more visible when the body is destabilized or fails to cite regulatory norms of gender, sex, and race. Therefore, it is in part when the naturalness of the male body becomes more vulnerable within male

[17]For the purposes of this manuscript, the term 'homosocial' refers to social interaction between people of the same ('homo') gender or sex (Maddison 2009, 48). Homosocial spaces include locker rooms, bathrooms, sex-segregated sports, 'man caves', and virtual male enhancement forums.

[18]Similarly, Butler (1993) queries "What is excluded from the body for the body's boundary to form?" (65).

enhancement discourse—such as from a possible diagnosis of an intersex condition[19]—that I direct my attention (see Chapter 4 for an example of this analysis). As the analytical chapters in this manuscript demonstrate, the threat of the unstable 'natural male body' is contained through male enhancement discourses and practices that position cis men's bodies simultaneously as less male and as always already male. By repudiating the spectre of failed 'male' embodiment, physicians can momentarily neutralize threats against the integrity of masculinity and the male body. Male*ing* the body, therefore, is a constant process of being and becoming, vulnerable to failure.[20]

There are additional means, however, of demonstrating the social materialization of the 'natural male body' within male enhancement discourse that do not rely on bodily failure as a necessary analytical entry point. In particular, men and masculinities studies can learn from the theoretical and analytical tradition of somatechnics to demonstrate how the sexed and racialized body is an unstable artifact of social and historical discourses that naturalize the body. In the section that follows, I explain how a somatechnic method aids this research, and briefly outline the comparative analysis I take up in this project.

The Somatechnics of Male Enhancement

Since masculinity and male embodiment are social and relational processes, I must necessarily engage with other bodies, identities, and somatic practices. I can follow the example of somatechnicians who map the materialization of the male body as natural by

[19]For the purposes of this thesis, the term *intersex* refers to bodies that display a range of traits (such as hormones; chromosomes; gonads; reproductive organs; hair, fat, and muscle distribution; bone structure, etc.) that do not correspond according to cultural expectations for binary sex. A person culturally and medically-assigned as intersex, for example, could have 'male' XY chromosomes; but their body could also be resistant to androgens or 'male hormones'; and have hair, fat, and muscle distribution that is culturally interpreted as 'female'. I employ this definition of intersex in this thesis for the sake of clarity, as a socially-agreed-upon understanding of the term broadly used within feminist theory. There is a long (and problematic) history within feminist theory of gesturing to intersex people to show that the gender and sex binary is a particularly social fiction (see Magubane 2014; Alm 2013 for critiques of this scholarship); however, in many ways, the definition of intersex I just provided upholds the *naturalness* of the binary by suggesting that intersex embodiment is separate from, and an aberration of, femaleness and maleness. Despite my strategic use of the term in this thesis, my political and ethical commitments to troubling the binary extend beyond this definition of intersex, and are explained in more detail in Chapter 2.

[20]Similar to how gender (Messner 2000; West and Zimmerman 1987) along with race and class (Jones 2009; Vidal-Ortiz 2009; West and Fenstermaker 1995) are processes of 'doing' difference as ongoing social and relational accomplishments, within this dissertation, the sexed body is not a noun but a verb.

placing them in relation to other bodies, subjectivities, and somatic transformations (Garner 2011; Fox and Thomson 2009a, 2009b). I explain the aims and methods of a comparative somatechnic approach in more detail in Chapter 2, but briefly, somatechnics understands all bodies as an ongoing process of somatic materialization that is continuously shaped by socially and historically-specific discourses (Sullivan and Murray 2009). A somatechnic understanding of the body troubles the division between nature and technology by emphasizing how all bodies are constituted through technologies, not only those bodies that carry the most visible traces of explicit 'modification', surgery, or other interventions (Sullivan and Murray 2009; Sullivan 2005b). A somatechnic method prioritizes a comparative analysis that juxtaposes bodies and somatic transformations in relation to each other to reveal the underlying assumptions, justifications, and prohibitions for particular forms of bodily being (Sullivan 2009b).

As I demonstrate throughout the analytical chapters of this manuscript, the 'natural male body' invoked by the practitioners who participated in this research is the effect of what somatechnician T. Garner (2011) calls technologies of the natural: "the specific discursive operations through which the male and female body are materialised as natural" (35). Identifying the technologies that render the male body natural helps to show how the social processes upon which maleness, masculinity, and whiteness rely are concealed both before and after surgical intervention. Employing this concept reorients my analytic gaze towards the socio-historical context and the discursive devices that constitute the body as naturally male.

Adopting a somatechnics approach, I read the male body in relation to trans, female, and racially-marked bodies, particularly Black cis men's and Asian cis women's bodies. Confirming and extending the work of somatechnicians—resembling most closely Garner's (2011) analysis comparing gynecomastia surgery for cis men with trans chest surgery—I first compare how male enhancement for cis men and gender confirming genital procedures for trans people are discursively produced in contrasting ways. Gender confirmation surgery is medically (and culturally) regarded as construction, while cosmetic genital procedures for cis men are characterized by male enhancement

practitioners as "restorative", "therapeutic", and "augmentative" of the 'natural male body'. This is despite how both sets of these procedures use overlapping medical knowledges to intervene on genitals, often aiming to produce similar aesthetic results and to reduce patient suffering. Surgical expertise and knowledge of the body overlaps considerably between these two sets of patients and procedures, as six doctors within my sample perform both male enhancement procedures and gender confirmation surgeries.

The contrasting ways in which these two procedures are discursively framed constitute cis men's bodies as 'natural' by presuming that 'maleness' not only preexisted medical or do-it-yourself genital interventions, but that despite explicit intervention, the 'maleness' of the body remains intact after cis men obtain male enhancement. As Garner (2011) notes:

> [I]t is important to emphasize 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 injustices and violence in the name of the "natural" body (2).

In my project, by charting practitioners' inferential and explicit invocation of the 'natural' and the 'unnatural', we can see how cis men's bodies within male enhancement discourse are renaturalized and rescued from abjection at the expense of trans bodies. Deconstructing the discourses employed by male enhancement practitioners about the 'natural male body' helps us to trace how power (and resistance) constitute cis men's bodies.

In the second half of this analysis, I apply the insights of somatechnics—including the inextricability of technology and the body, the materialization of the body through discourse, and the relational comparative analysis between bodies and somatic practices—to trace physicians' erasure and selective invocation of the 'monster cock'. A 'monster cock' is defined by *Enhancement Forum* members as a penis whose size relative to the sexed bodies of circlusive[21] sexual partners (often after an augmentation) makes penetrative sexual

[21] 'Circlusion' refers to the way a ring or tube—for example, a mouth, anus, or vagina—actively pushes on something else—like a dildo or penis (see Adamczak 2016). I use the language of 'circlusive sexual partners' instead of 'penetrated partners' so as to avoid constructing them as passive objects of phallocentrism. However, one may engage in both circlusive and penetrative sexual practices. For my purposes in this

practices impossible, or causes sexual partners pain. I demonstrate that the figure of the monster cock creates a tension between the ways in which the male body is constituted as male, and how cis men accomplish masculinity: through heterosexual penetrative 'success', and through phallic masculine embodiment serving as a sign that one has the largest penis that a sexual partner has ever circluded (which necessarily compares one's penis to the penises of others).[22] I trace how male enhancement discourse works to shore up the contours of whiteness and the male body through heterosexuality, the 'reproductive body', and the normalization of the particularly white male body. Through discourse analysis, I am able to witness the male body as the effect of gender, sexuality, and race.

I lay out my approach to discourse analysis in Chapter 3, but discourse broadly refers to the set of statements that direct what counts as 'truth'. While discourse is made up of statements, my aim is not to interpret language to unearth the hidden meanings of speech, to excavate the intentions of the cis men posting on *Enhancement Forum* or the physicians during our interviews, nor to assess and declare what is 'truth' and what is not. This is why I mostly avoid making (counter)claims about the veracity of physicians statements, about their procedures or otherwise. Similarly, discourse analysis does not ask what statements essentially mean, but rather, how do these discourses operate, and what categories and sets of relations do they produce?

My analysis supports the claim that the 'natural' body operates discursively in ways that perpetuate, maintain, and legitimize inequity along the lines of race, sex, gender, and sexuality. Erasing the construction of the 'male body' through naturalization techniques—while foregrounding the construction of trans bodies, or the (un)naturalness of cis women's and racially-marked bodies (particularly the bodies of Black cis men and Asian cis women)—functions to maintain oppressive social arrangements, and undercuts our abilities to enact

dissertation, I refer to folks as 'circlusive sexual partners'—even if they may also engage in other sexual practices like penetrating a partner—when I aim to foreground specific sexual relations pertinent to monster cocks. Circlusion should not be interpreted as the entirety of one's sexual practices, just the particular practices most salient to this analysis.

[22]This analysis is limited to and by physicians' talk about cis women as their patients' sexual partners.

social change. Through this project, I aim to unsettle the standard of the 'natural male body', cis masculinity, and whiteness.

Trans and Cis

The aims of this manuscript do not include forwarding a reconceptualization of the meanings ascribed to 'trans' and 'cis'. Recognizing that cis and trans are contested categories, and any exegesis I could offer up for either term would be necessarily incomplete, provisional, contingent, socio-historically situated—and therefore, circumscribed by medical, legal, and popular conceptualizations of the terms—I nevertheless must provide some explanation of my use of these categories in this dissertation.

The term *cisgender* is derived from the Latin prefix 'cis', meaning 'on this side', in comparison with the prefix 'trans', meaning 'across'.[23] At birth, or perhaps during a sonogram, declarative (and constitutive) statements like 'it's a girl!' are a social assignment of gender—based most often on a doctor's or parent's observation of an infant's genitals—that carries with it a host of assumptions about the gender (and sexual) development of the infant into a feminine person, a girl, a woman. In Canada and the United States, 'cis' is broadly used to indicate a culturally recognized-correspondence between one's sexed body assigned at birth and one's gender (Kolysh 2016; Schilt and Westbrook 2009). In this way, cis implies agreement, but also immutability, meaning a retention or maintenance of one's gender and sex assignment from birth (Enke 2012). This implied stability in cis identity and embodiment, however, runs counter to gender scholars' insistence that gender is an ongoing social and relational process of accomplishment (West and Zimmerman 1987) and repudiation of other gendered ways of being (Pascoe 2007) that can change throughout the life-course (Simon 2015), and that only persistent social energies make gender appear immutable.

Garner (2011)—a trans scholar who uses the pronouns 'they' and 'their'—explains that before the emergence of the terms 'cis' and 'cisgender' in common vernacular, 'bio

[23]Throughout this manuscript, I try to explicitly identify cis people as 'cis' out of recognition for, and in an effort to balance, how trans people and their bodies are constantly marked in and outside of this text.

female' and 'bio male' were common descriptors used by the trans community in Canada and the United States. However, they illustrate that emphasizing biology when distinguishing between trans and non-trans people has the tendency to attribute authenticity to biology and artificiality to trans identity.

> 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. (168)

With that said, there have been some critiques from within the trans community of the term 'cis' for being elitist and inaccessible along class lines (Garner 2011) as well as concerns about creating a new binary separating trans from cis existence and experience (Manion 2018).[24] Holding these critiques in tension, I have elected to use the language of 'cis', not only because it is now relatively well-established terminology amongst trans communities (and the wider public), but also because it foregrounds the culturally-recognized correspondence between sex assignment and gender, which holds particular relevance for the analysis of this project.

Any definition of the term 'trans' also delimits its application and membership, and "has the potential to inadvertently reproduce exclusions at its boundaries, be counter to alternative trans significations, and render invisible inequalities within the category through the erasure of difference" (Simon 2015, 1). Perhaps this explains in part why there exists a productive tension within trans studies between explicitly defining what 'trans' means, and leaving the concept open. I offer up this attempt at definition as a necessarily partial explanation. In Canada and the United States, the category 'trans' is commonly understood as describing people whose sex and/or gender assignment at birth does not culturally correspond with their sense of self. Trans folks disrupt assumptions of

[24]Some scholars, like feminist sociologist Meagan Simon (2015), suggest that "[b]oth people who have and have not transitioned can use cis to mark a coherently gendered body" whereby 'trans' serves as a temporary identity through hormonal and surgical transition towards cis subjective embodiment (83). In this formulation of 'cis', socially-recognized coherence between one's body and gender forms the bedrock for cis identification, regardless of when that coherence materializes, not necessarily 'matching' one's assigned gender/sex at birth. This (re)conceptualization, while useful in capturing some trans peoples' experiences, can limit the meaning of 'trans' to somatic transition that only some trans folks (can) pursue or experience.

cultural correspondence between gender and sex assignment, as their sense of gender throughout the life course may not always or ever culturally 'agree with' how they were socially assigned.

Using the language of 'transgender' as an umbrella term, trans theorist Susan Stryker (2008) conceptualizes this category in relationship to a starting point to which one has not consented, a "movement across a socially imposed boundary away from an unchosen starting place" (1). Echoing this movement, cultural theorist C. Riley Snorton (2017) understands 'trans' as a "movement with no clear origin and no point of arrival" (2). Feminist sociologist Meagan Simon (2015) centers gender within the the term 'trans' "to signify a constellation of embodied subjectivities that somehow transgress or trouble normative understandings of gender" (1). According to this description, those who may 'fit' under the umbrella term 'trans' include those who identify as transgender, transsexual, genderqueer, nonbinary, bigender, pangender, and agender, etc. I loosely adopt these definitions of 'trans' for this manuscript. Understanding 'trans' in terms of a demarcation between gender and sex assignment is useful for this project in part because it is upon this gender trouble, this movement, that doctors' logics hinge for both opening and closing the gate for trans folks' access to genital technologies.

Any definition of 'trans' within a project that analyzes the 'natural body' must explicate their relation. Transgender theory coming from a queer or poststructuralist tradition often defines 'trans' as rooted in a transgressive politics that denaturalizes gender and the sexed body, representing gender as fluid and fragmented (Whitehead et al. 2015; Whitehead and Thomas 2013; Enke 2012; Whitehead et al. 2012; Garner 2011; Sullivan 2009b; Stryker, Currah, and Moore 2008; Stryker 2006b; Halberstam 1998), whereas other threads of transgender scholarship define 'trans' in alignment with a politics of human rights and recognition, and typically foregrounds trans narrative and the phenomenology of the body (Namaste 2000; Prosser 1998). As Namaste (2000) makes clear, some of the scholars coming from a poststructuralist tradition can—in their efforts to demonstrate that gender and the sexed body are socially constructed—neglect the everyday experiences of trans people, fail to center their needs, and can problematically

represent trans folks as cultural dupes of the gender binary. This project agrees with others (S. Hines 2006; Hird 2002) that attention to the everyday lives of trans people is compatible with understanding gender and sex as discursive, yet entirely real and material in their consequences. While my objective in this manuscript is to denaturalize the body in alignment with a more transgressive politics, I do not take aim at the bodies nor the identities of historically-oppressed groups. Rather, I aim to deconstruct the 'natural male body', cis masculinity, and whiteness. In the next section, I list the research questions that orient this project in order to accomplish such a deconstruction.

Research Questions

This research is founded on a loose patchwork of inquiries seeking to engage with multiple sets of intersecting and competing discourses that arise within the private practices of twenty medical practitioners who specialize in male enhancement. The questions below seek to identify the seams and sutures of the 'natural male body' through male enhancement discourse. This research asks:

- What is the character of the relationship between 'male enhancement' discourse and the materialization of the male body?
- How are particular bodies and subjectivities rendered (un)natural in male enhancement discourse both before and after somatic intervention?
- Which bodies and subjectivities are excluded from male enhancement? How do these absences point to the social materialization of particular configurations of gender and the 'natural' sexed body?
- How does male enhancement discourse operate in relation to the male body compared to trans, racially marked, and female bodies?

Organization of the Dissertation

In Chapter 2, "Theorizing Male Enhancement", I detail the theoretical debates, historical analyses, and conceptual tools from which I draw to identify the character of the

relationship between 'male enhancement' discourse and the materialization of cis men's bodies. This project builds on and is indebted to thinkers who have come before me within trans studies, critical race theory and whiteness studies, queer theory, feminist science studies, somatechnics, masculinity studies, sociology of the body, disability studies, and poststructuralism.

I begin by outlining Michel Foucault's conceptualization of power, which instructs the theoretical and methodological choices of this project, including my use of somatechnics as an analytical framework. Somatechnics helps to resolve a theoretical tension within feminist literature; by reimagining the body and technology as inextricable, somatechnics disrupts the veneration of the 'natural' body and the antagonism leveraged against the 'modified' body. As a theoretical tradition and analytical method, somatechnics is compatible with the overall aim of this project in deconstructing the 'male' body and identifying the operation of (de)naturalization techniques invoked by male enhancement practitioners. In the remainder of the chapter, I synthesize feminist science with the history of the sexed and racialized body to equip readers with an understanding of how male enhancement physicians' statements fit within or trouble the ongoing legacies of binarist and bioreductive science. The focus of feminist science studies on sex ambiguity, the sexed body as a racial project, and sex similarity sets the stage for how I conceptualize the social production of the sexed body, gender, and race in this manuscript.

It is within Chapter 3, "Method and Methodology", that I discuss the paradigms that orient this research and inform the creative processes—the methods that generated research data—for this project. Here I delineate the pilot study I conducted through observations of a virtual male enhancement forum that enabled me to ground my interview schedule with physicians in existing discourses of male enhancement. I provide a broad overview of my research field in the private medical practices of twenty male enhancement doctors; my recruitment methods; the characteristics of my sample; the expertise of the practitioners I interviewed; and my semi-structured interview protocol. An outline of how I use grounded theory and an explanation of the comparative analytical

method of somatechnics precedes a description of my approach to discourse analysis. Taking account for my part in the generation of knowledge, I reflect on my situated position in relation to my participants and this research, including some of my ethical and political commitments. I conclude the chapter by reflecting on the uneven relationship between investigators and participants—particularly between women researching men while discussing sexual themes—and the absence of institutional support from research ethics boards and universities to help researchers navigate their vulnerability to violence in the field.

The analytical chapters in this dissertation are divided into two sections. The first primarily relies on physicians' responses to one question from my interview protocol: "Why do you suppose that transgender people require counseling and a professional letter written on their behalf to receive elective genital procedures and your cisgender patients do not?" Building on the work of somatechnician T. Garner (2011), the first two analytical chapters of this dissertation examine the naturalization of cis men's bodies through a comparative discourse analysis of male enhancement and gender confirmation surgery. The theme of the second section analyzes how male enhancement practitioners erase or selectively invoke the trope of the 'monster cock'. I demonstrate how male enhancements that result in 'monster cocks', by definition, make heterosexual penetrative practices impossible or cause sexual partners pain, thereby creating a tension between sexual practices that male the body, and dominance practices that accomplish masculinity. In addition to examining the way that 'the natural' is leveraged against historically-oppressed groups, the through line that connects all analytical chapters is the (re)naturalization of the 'male' body and cis men's subjectivities through male enhancement discourse.

In Chapter 4, "Authenticity and Suffering: Juxtaposing Gender Confirmation Surgery and Male Enhancement Discourses", I analyze how the operations of *authenticity* and *suffering* function within the differential medical management of trans and cis bodies to naturalize one's sex assignment at birth, thereby characterizing the post-surgical trans body as 'unnatural'. Male enhancement practitioners commonly offer cis men access to genital technologies after one consultation—sometimes within the same day—without

questioning cis men's identities as authentic, and in fact by locating their gender authenticity within the male sex assignment they were given at birth. Even when cis men's bodies fail to cite the regulatory norm of sex—as in the case of intersex patients, for example—practitioners reassert cis men's gender and sex authenticity by separating their shortcomings of an "underdeveloped penis" or "boobs" from the rest of the 'male' body. On the other hand, practitioners express doubt in the authenticity, stability, and permanence of trans identity, reflecting wider social anxieties that there are 'fake' trans people who will change their minds after surgery. Trans patients are required to prove themselves authentic by living in their affirmed gender, sometimes waiting years to receive letters of support from mental health professionals in order to gain the kind of access that cis men are readily provided.

In the second half of this chapter, I examine how even though both trans folks and cis men experience suffering, it only makes sense to practitioners to alter the body to ease cis men's suffering from what they perceive to be social burdens, but not to ease the so-called "inner", mental anguish of trans people. Trans people's suffering—despite serving as the key criterion for diagnosing trans folks with Gender Dysphoria, and the primary symptom to be addressed by gender confirmation surgery—works to undercut their access to genital technologies. As I demonstrate through physicians' comments, they continue to pathologize and individualize trans suffering as an "inner", "psychological problem" of mental and emotional instability—ignoring experiences of gender euphoria and creative transfiguration—while normalizing cis men's suffering as a predictable and acceptable response to suffering from "genital ridicule". Even though physicians acknowledge that the "genital ridicule" cis men can experience is often perpetuated by other men, practitioners largely ignore these forms of harassment, claiming that the "demands" from the "liberated female" for equal access to sexual pleasure are "more damaging". In some cases, doctors identified suffering as the clearest indication that cis men are eligible for male enhancement procedures, rather than a clear sign that they need mental health support. Physicians' logic appears to suggest that internal, psychological problems cannot be ameliorated by external, medical interventions into the soma.

I continue this comparative analysis in Chapter 5, "Harm, Regret, and Dissatisfaction: A Somatechnic Analysis of Trans and Cis Genital Interventions", to understand how 'the natural' structures the somatic (im)possibilities for cis and trans folks differently through discourses of *harm*, *regret*, and *dissatisfaction*. Doctors frame trans people's gender transition as harmful to the sex they were assigned at birth, claiming they are "swimming against the stream of nature", whereas the sexed bodies of cis men do not experience harm despite genital interventions through male enhancement. Instead, physicians suggested that cis men can experience harm to whiteness from receiving "unorthodox" procedures that racially mark the body, such as bead inserts into the shaft of the penis. According to practitioners, cis men can also experience harm to normative masculinity by undergoing penile reductions, or *any* enhancement while suffering from Body Dysmorphic Disorder (BDD). In the case of BDD—which like Gender Dysphoria is a condition outlined in the Diagnostic and Statistical Manual of Mental Disorders—we see a rare overlap between the gatekeeping of trans patients and the gatekeeping of body dysmorphic cis men. While the two cases are irreducible, physicians' logics are fairly consistent across their medical practices that external modifications to a patient's genitals are inappropriate interventions for addressing internal, diagnosable, psychological problems that doctors view as defying the 'natural' body or mind.

The second half of this chapter is dedicated to understanding how regret and dissatisfaction operate differently within the medical management of trans and cis patients undergoing genital interventions. Practitioners police the embodiment projects of trans people under the assumption that they will inevitably regret irreversible transformations because the sexed body—the 'natural core' from which gender identity ostensibly emerges, according to physicians—will persist even after genital interventions. However, gatekeeping gender confirmation surgeries on the basis that they are irreversible, while not gatekeeping male enhancement procedures—which are not necessarily reversible nor predictably safe—demonstrates the asymmetrical treatment of these two groups of patients, and the shaky foundation upon which doctors justify closing the gate to genital technologies for trans patients, while keeping it open for cis men. Moreover, the

presupposition that trans people regret somatic transformation is not borne out by clinical research, which shows the incidence of trans people's regret is incredibly rare. Only one practitioner resisted discourses of trans regret, and I share his comments in this analysis. While doctors were apprehensive about trans patients regretting transition—locating regret within a 'core bodily identity'—they only expressed concern about cis men's potential *dissatisfaction* with the results of a male enhancement procedure.

I transition my focus to the second theme of this dissertation in Chapter 6, "'Too Big Doesn't Mean Anything': 'Monster Cocks', the 'Reproductive Body', and the Racialization of Genitals". Here I map out the erasure and selective invocation of the monster cock. According to cis men's accounts on *Enhancement Forum*, acquiring a monster cock through penile augmentation is a process of exerting dominance over female bodies, and by exercising physical and sexual superiority over other male bodies, a process of dominance I call phallic masculine embodiment. However, given that monster cocks, by definition, impede penetration due to their size, accomplishing phallic masculine embodiment through monster cock augmentations competes with how the body is maled through heterosexual penetrative practices. Physicians work to frame the 'female reproductive body' as naturally capable of "accommodating" any size penis as a means to confirm cis men's bodies as male through heterosexual penetration. Physicians claim that—for their heterosexual patients—a penis could never be 'too big' or cause a circlusive 'female' sexual partner pain from penetration because of the biological "design" and the "natural" capacity of the vagina to birth babies.

In physicians' limited attempts to acknowledge cis women's unwanted pain from penetration, they (de)naturalized cis women's sexed bodies as ill and aging, or racialized Asian cis women's vaginas as "small by nature" for failing to "accommodate"—much less sexually enjoy—a monster cock. (De)naturalizing cis women's bodies that 'fail' thus shores up the naturalness of the male body. Practitioners also denaturalized the genital size of Black cis men as the only people with penises large enough to cause cis women unwanted vaginal pain through penetration. Both the 'big Black dick' and the "tight Asian pussy" function discursively to naturalize and reassert the maleness of particularly white cis men's

bodies. Overall, this chapter traces the discursive devices employed by male enhancement practitioners in service of naturalizing penetrative heterosexuality, the 'female reproductive body', whiteness, and the 'male body'.

In Chapter 7, I conclude by identifying the significance of the similarities and divergences between this research and similar scholarship, explaining the implications of this research for different bodies of scholarship, and by outlining possible future directions for research on male enhancement.

Chapter 2

Theorizing Male Enhancement

> *Physical bodies, like the material world that encloses them, really exist. But by the very nature of their existence, nothing is actually self-evident about what will be seen as self-evident in the nature of the body. And often, what seems so self-evident about the experience of the body belongs to history, not nature.*
>
> —Roger Lancaster
>
> *The Trouble with Nature: Sex in Science and Popular Culture*

Throughout this chapter, I explain and contextualize the theoretical foundations and analytical devices I use in this project to identify how bodies come to matter through male enhancement discourse. I begin by outlining Michel Foucault's theory of biopower, which grounds this research and informs my somatechnic understanding of bodies. This chapter critically analyzes a central theoretical tension within feminist theory about the character of the relationship between the body and technology, which tends to treat body projects as either liberatory or oppressive and creates a false dichotomy between a 'natural' body untouched by social intervention versus an artificially 'constructed' body. The theoretical tradition of somatechnics—which understands bodies as inextricably bound up with technologies—provides a way out of these worn debates. From here I detail a set of conceptual tools, including *(de)naturalization*, that are situated within poststructuralist theory and aid me in deconstructing the 'natural body' invoked by male enhancement practitioners. A brief synthesis of feminist science studies, as well as the history of the sexed and racialized body in Canada and the United States set the stage for how I conceptualize the 'male' body within medical discourse.

Conceptualizing Power

Social scientists often theorize power in its juridical form, explaining how institutions—as well as subjects—can possess power, exercising it from the top-down onto a population, and wielding power so as to be repressive through prohibitions, punishment, and negation. According to this punitive, hierarchical framework, those who possess power are in a position of authority to oppress those who lack power. Foucault (1990) traces the historical transition away from this form of juridical power—the sovereign power over the life and death of subjects—to what he distinguishes as *biopower* as a more effective form of managing and controlling bodies and populations through productive measures rather than direct physical punishment. Since Foucault's use of biopower diverges from common interpretations of juridical power, it is particularly instructive in this project and germane to the analytical framework of somatechnics that orients this research.

Biopower refers to historically-specific technologies of the state that invest in and administer life (rather than death) through regulation and discipline (rather than punishment) of the population and the body. Two interconnected strategies constitute biopower's management of the population and the body, *biopolitics* and *anatomo-politics*, respectively. Biopolitics of the population refers to the regulation and surveillance of births, mortality, health, sanitation, marriage, divorce, and other social problems faced by the state managing a population. In other words, biopolitics invests in and manages the productive and reproductive capacities of life and the health and longevity of the population. Anatomo-politics of the human body, on the other hand, is the materialization of relations of power in the individual body, the disciplining of the bodily form as an investment in and resource for sovereign power. Institutions such as schools, prisons, and the military render the body a disciplined site for subject formation to optimize its efficiency, utility, and political docility. Through anatomo-politics, power produces obedient and 'willing' bodies as a state resource. Power that conceals our submission to regulation because we are disciplined, 'willing' subjects is arguably far more insidious than punitive hierarchical forms of power that come from external authorities.

Foucault (1990) focused on, among other things, the history of sexuality because it demonstrated a nexus point between biopolitics of the population and anatamo-politics of the human body. Sexuality is at the center of both biological reproduction necessary for sustaining a population (biopolitics), and is "a vector through which power insinuates itself into subjectivity" through discourse to produce "comportments, miens, attitudes, and other bodily postures and practices" (anatamo-politics) useful to sovereign power (Pugliese and Stryker 2009, 3). Furthermore, non-normative sexuality serves as a justification for disciplining the body and the self through institutions such as the heteronormative family, the church, the mental asylum, and the internment camp (see Pugliese and Stryker 2009). As such, Foucault claimed that sexuality became an important nexus point through which power operates for the management of life.

In this research, the connection between biopolitics and anatamo-politics hinges on somatechnologies that Stryker and Sullivan (2009, 52) suggest "function as 'the capillary space of connection and circulation between the macro- and micro-political registers through which the lives of bodies become enmeshed in the lives of nations, states, and capital-formations' (Stryker, Currah, and Moore 2008, 14)" [citation in original]. In other words, the possibilities for bodily being, the possibilities for bodily formation and transformation are entangled with the integrity of the body politic. Bodily (trans)formations through somatechnologies are possible insofar as they enable bodies "to be integrated into a particular social field as a resource for the exercise of sovereign power" (Stryker and Sullivan 2009, 57). I provide an exegesis of somatechnics as a theoretical tradition and method of analysis later in this chapter.

Foucault demarcates his scholarship on power from other theories by treating power not as a possession—something that some subjects or institutions 'have' and others do not—but rather, as diffused, enacted over and through all bodies through normative expectations. Trans activist and legal scholar Dean Spade (2015) summarizes a Foucauldian conceptualization of power with the following:

> Power is not a matter of one dominant individual or institution, but instead manifests in interconnected, contradictory sites where regimes of knowledge and practice circulate and take hold. This way of understanding the dispersion of

> power helps us realize that power is not simply about certain individuals being targeted for death or exclusion by a ruler, but instead about the creation of norms that distribute vulnerability and security. (4)

Thus, power is not a tool wielded by authorities, but rather, exists at the level of everyday life. A Foucauldian conceptualization of power is distinctive because it is not just prohibitive, repressing the subject and the body through coercion. According to Foucault, it is also productive, applying positive techniques through normative expectations that both enable and control the body and the subject. Power has positive content; "it traverses and produces things, it induces pleasure, forms knowledge, produces discourses" (Foucault and Gordon 1980, 119). In this way, power is not simply top-down, but capillary from the bottom up whereby subjects participate in our own discipline through norms, because power incites desire and a "will to knowledge" (Foucault 1990, 12).

Norms do not merely act upon the body as if it is an existing canvas ready to be painted, but rather, norms discipline and constitute the body. The normative power of gender, sex, and race, for example, are not deterministic, nor are they negotiated by a presocial self who can enact their unencumbered agentic will. Rather, gender, sex, and race are compulsory. According to Foucault, absolute abstention from these unequal systems of power is not possible since power is everywhere, always changing, multiple, and conditional. Our bodies and selves are rendered intelligible in relationship and in resistance to the operation of power.

In contrast to other conceptualizations of power, normative power masquerades as our own agentic choice and individual responsibility to improve our bodies and selves. Self-reflection and self-regulation of one's body, soul, thoughts, and comportment—also known as *subjectification*—is not evidence of a presocial self, capable of negotiating how much it will 'listen' and 'conform' to normative expectations. Instead, subjectification is always mediated and circumscribed by discourse, especially by expert knowledge. In other words, the self is the effect formed through these social expectations, not the cause. Disciplining bodies through normative power produces:

> [m]odes of subjectification, through which individuals are brought to work on themselves, under certain forms of authority, in relation to truth discourses, by

> means of practices of the self, in the name of their own life or health, that of their family or some other collectivity, or indeed in the name of the life or health of the population as a whole. (Rabinow and Rose 2006, 197)

Thinking through body projects using a Foucauldian analysis of power enables sociologists studying the body to conceptualize cosmetic interventions—which are commonly framed and experienced as an empowering lifestyle 'choice'—as rendering individuals responsible for embodied self-improvement. Participating in medical discourse can certainly help us to take care of ourselves, while also rendering us increasingly dependent upon expert knowledges; engaging in male enhancement can feel like self-authorship, while making our bodies more docile; transforming our bodies through cosmetic interventions can induce new pleasures, while also constraining somatic possibilities.

A Foucauldian analysis of normative power allows me to study the social materialization of gender, the sexed body, and race within discursive sites where power and resistance take place simultaneously. Understanding normative power as it relates to my research, individual social actors who elect or perform male enhancement procedures are not simply cultural dupes or disempowered casualties of medical discourse and cisgender masculinity, for this implies that we can transcend the systems of power that constitute our bodies and subjectivities. Social actors are neither passive conformists nor free agents—for that would misunderstand the operation of power—rather, social actors always exist in some way related to or in resistance against technologies that (trans)form our bodies and selves.

Situated within a Foucauldian conceptualization of power and the body is where I locate the analytical framework of somatechnics that lies at the center of this project, both in terms of broader theory about the body and analytical method. In the sections that follow, I introduce this theoretical tradition and analytical approach. As a way to situate and contrast my analysis, I start with a brief explanation of how many feminist theorists in the west—particularly Canada and the United States—have historically conceptualized the body as natural, biological, and separate from technology and social materialization.[1]

[1]The terms 'western' and 'eastern' are colonial language that centers England (the site of the prime meridian that divides the earth into two hemispheres), while erasing Indigenous peoples, practices, and ways of

The Body and Technology

Contemporary, commonsense understandings of the body in dominant western thought are often rooted in ancient Greek philosophy and Enlightenment thinking, conceptualizing (and thus bringing into being) the body as natural, biological, and material flesh independent of social influence and 'immaterial' discourse. In this construction—which invokes Cartesian dualism—the body is ontologically separate and inferior to the mind,[2] and therefore, must be controlled, regulated, and mastered (Grosz 1995).

As Sullivan and Murray (2009) make clear, Cartesian dualism permeated some of early second wave feminism in Canada and the United States, which valued intellectual participation in public life over reproductive labour, largely because the biological body functioned as such an unyielding site of oppression and subjugation for women that feminists sought to move beyond and overcome the body.[3] Liberal and radical feminists such as Betty Friedan (1963) and Shulamith Firestone (1970), respectively, often targeted the 'female body'—particularly cis women's reproductive capacities and the socially-imposed obligations to bear children—as central to women's subordination to men, preventing women (particularly white, wealthy, and married women) from participating equally in 'matters of the mind', like economic and political life.[4] In the *Feminine Mystique*, Friedan (1963) confronts Sigmund Freud's assertion that anatomy is woman's destiny, claiming that the lack of fulfillment that (white, wealthy, married) women experience in the mid-century United States is a result of being relegated to the

knowing in their ancestral lands. My reluctant use of the term 'western' in this dissertation refers to various, sometimes disparate modes of thought—from ancient Greek philosophy to contemporary allopathic medicine—at the centre of white and colonial institutions situated within the geographical space of what is now known as Canada and the United States.

[2]Disability scholars like Tobin Siebers (2008) argue that treating the body as inferior or inconsequential compared to the mind is an effect of ableism.

[3]See also Simone de Beauvoir's (1989) *The Second Sex* for a critique of women's "subordination to the reproductive function" (66).

[4]Poor working women, single women, women of colour, and lesbian women had to engage in paid labour by necessity, because class exploitation, sexism, racism, and queer oppression prevented them—or their partners—from accessing a 'family wage' sufficient to support their family's basic needs (hooks 2015; Lorde 1984; A. Davis 1983; Rich 1980). This is often ignored in white feminist theorizing.

"drudgery" of fulfilling the female role as a mother and wife (13). Friedan advocates for women to pursue an intellectual life, participate in politics, discover personal passions, enter the paid economy, and refuse to be limited to female biology.

Firestone (1970) took a more militant approach against the reproductive body in *The Dialectic of Sex*. "*Pregnancy*", she writes, "*is barbaric*" [emphasis original] (184). Extending Marx and Engels' work, which advocates for the proletariat's seizure of the means of production as the path to overcoming class exploitation, Firestone identifies *reproduction* within the biological family as the site through which women—as a sex class—must overcome their oppression by men. Identifying women's subordination to and dependence upon men as originating within the 'nature' of the body—pointing to how non-human animals mate, reproduce, and care for their young as a reflection of humans' originating nature—Firestone dismisses socio-cultural explanations for the oppression of women. She, therefore, renders women's inequality a natural consequence of the biological division of reproductive labour. Reproductive technologies create what Firestone (1970) sees as an opportunity for women to "transcend Nature" (10).[5] Overcoming 'female biology'—what Firestone (1970) referred to as "the tyranny of reproduction"—was, among other goals, necessary to achieve feminist revolution (185).

Histories of the regulation of the 'reproductive body' demonstrate, however, that technologies purported to help overcome problems associated with female biology and reproduction are not liberatory for women universally. Cultural theorist C. Riley Snorton (2017) offers a critical examination, for example, of how various techniques and technologies that formed the foundation of contemporary gynecology as a medical practice in the United States were made possible by white men doctors' experimentation without anesthesia on enslaved Black women's bodies, including Anarcha, Betsey, Lucy, and the many others who went unnamed. By the very condition of their enslavement, their bodies were not only accessible to James Marion Sims—the white doctor who experimented on them—but enslavement also made their bodies controllable, and "inexhaustibly available

[5]On the other hand, Firestone (1970) did not support the use of technologies altogether; she also cautioned that "the new technology, especially fertility control, may be used against [women and children] to reinforce the entrenched system of exploitation" (11).

through their interchangeability" (24). Enslaved Black women's bodies became a "living laboratory within a political economy wherein their atomized flesh took on an adjunctive function in the production and reproduction of a series of proprietary instruments and procedures" in gynecology (18).

So the medical 'progress' of gynecology from which white women particularly benefited to overcome 'female biology'—one of the cornerstone goals of early second wave feminism—came at the expense of Black women who were enslaved and tortured by white men. Other feminist scholars have rightly problematized and offered alternatives to the racist (hooks 2015; Briggs 2002; Lorde 1984; A. Davis 1983), colonialist (Briggs 2002), classist (hooks 2015), heteronormative (Rich 1980), and essentialist (Grosz 1995) logics of early second wave feminism, including its focus on overcoming 'female biology' and reproduction.

However, less often critiqued are the problematic idea(l)s central to second wave (and other) feminist conceptualizations of technology and its relationship to the body as either liberatory or oppressive (for critiques of this dichotomy, see Pentney 2012; Sullivan and Murray 2009; Sullivan 2006). Feminist debates have historically treated technologies as either an escape from the burdens of the female body that I detailed above, or as a vehicle to re-entrench women's inequality (Braun 2010, 2009, 2005; Jeffreys 2006; Green 2005; Bordo 1998; Raymond 1994), arguing that narratives of empowerment through technology ignore the larger structural systems—such as patriarchal institutions—at work in disciplining women's bodies through interventions such as cosmetic procedures and reproductive technologies. For example, regarding cosmetic body projects, feminist philosopher Susan Bordo (1993) claims that "to feel autonomous and free while harnessing body and soul to an obsessive body-practice is to serve, not to transform, a social order that limits female possibilities" (179).

While these two positions within feminist theory seem to be diametrically opposed—either celebrating freedom from the 'female' body brought on by technologies or warning against these technologies as weapons of patriarchy—both arguments rest on the assumption that 'nature' is fundamentally independent from technology. This project

takes as its starting point a somatechnic understanding of the body, which posits that bodies are continuously constituted through technologies and techniques of the soma.

Somatechnics

At the same time as technologies proliferate in almost every field, increasingly gaining access to the body—through fitness and sleep trackers, sex toys connected to cell phones that enable self-administered oral sex (Yagoda 2017), and implantable art technology powered by energy from our bodies (Treggiden 2014)—in Canada and the United States—despite our consumption of these somatechnologies and the normalization of others—we value the 'unmediated body' exempt from social interventions (see Garner 2011). This is reflected in one of the most common responses I received from professors, colleagues, friends, and strangers alike upon learning the substance of my work: surprise, uncomfortable laughter, and disgust from the "unnaturalness" of male enhancement.

These reactions, I came to recognize, are largely predicated on the broad assumption that bodies 'should' be—let alone can be—'natural' and free from technological and social materialization. To quote trans historian Jules Gill-Peterson (2014), "The ontological separation of technics and living beings underwrites the notion of an integral body, according to which incorporation of technology is a fall from the original wholeness of birth" (405). Dominant bodily imaginaries in the contemporary western social and political landscape assume and value the existence of the 'natural' body—a body not subject to modification, mutilation or other forms of construction—which contrasts sharply with the sociological understanding of the body as socially (re)produced.

The proliferation of technologies that gain access to our bodies means that all bodies are increasingly constituted through somatechnologies. Even those who do not submit to surgical interventions are somatechnic. Consider the example forwarded by feminist theorist and somatechnician Beth Ann Pentney (2012), that human development itself is somatechnic. While many may recognize reproductive technologies, such as in-vitro fertilization, as undeniable examples of the somatechnic development of a human zygote—the single-celled organism that results from a fertilized egg—few would likely imagine how even the cessation of birth control technologies makes "human development

somatechnic at pre-conception" (Pentney 2012, 19). In other words, the development of a human zygote is enabled and foreclosed by the gestational parent's relationship to technology.

Somatechnologies are not merely medical interventions into the body, such as through pharmaceuticals and surgeries. Consider the insights from anthropology that cooked food—a result of using fire as a tool—has dramatically constituted human bodies. Cooked food increases digestibility, and therefore, caloric intake; with increased calories, cooked food reduces the time humans have to dedicate to acquiring and consuming food, enabling other pursuits; it reduces the amount of time foods need to ferment in the gut to extract nutrients, so the length of the intestines decreased in size; and it reduces the size of our molars and the frequency of oral cavities (Wrangham and Carmody 2010). The human body is therefore necessarily somatechnic.

Both the general population and many feminist scholars often regard technologies thought to 'modify' the body as fundamentally distinct from the basic, yet largely unacknowledged ways our bodies are socially crafted. Imagine how knowledge and service-based labour structurally enable increasingly sedentary lifestyles and particular forms of embodiment compared to work that demands more physical exertion or facilitates leisure time to engage in more movement (see Cadwallader and Murray 2007). Consider the numerous quotidian, yet unexamined bodily grooming and hygiene practices, use of 'corrective' devices such as prescription glasses and braces, and eating habits that all shape bodily being, and how we take these practices up in situated ways related to our gender, race, age, and cultural position(ing)s.

Similarly, the concept of *body-reflexive practices*, coined by sociologist and masculinities scholar R. W. Connell (1995), helps elucidate how gender constitutes the body: "the social relations of gender are experienced in the body (as sexual arousals and turn-offs, as muscular tensions and posture, as comfort and discomfort) and are themselves constituted in bodily action (in sexuality, in sport, in labour, etc.)" (231). Imagine the ways that disability, sexuality, class, and other systems of power shape bodily being. As such, our bodies are not natural biological facts versus purposefully modified

aberrations from nature, but rather, all bodies reflect an ongoing process of bodily becoming that is continuously shaped by socially and historically-specific techniques and technologies. As sociologists Holliday and Cairnie (2007) contend "the 'natural' body is a discursive illusion" (73).

As a means of disrupting these false dualisms—of technology versus the 'natural' body, and of worn feminist debates about the liberatory potential versus inherent oppression from technological interventions into the body—I situate this work within the scholarly tradition of somatechnics. This research draws from previous somatechnicians who analyzed gender and the sexed body (Alm 2013; Pentney 2012; Garner 2011; Fox and Thomson 2009a, 2009b; Sullivan 2009a, 2009b, 2007), disability and normalcy (Sullivan 2008b, 2008a; Cadwallader 2007; Sullivan 2005a), as well as whiteness and racialization (Sullivan 2012, 2007; Pugliese and Stryker 2009).[6] Rooted in a Foucauldian conceptualization of power and the materiality of discourse, somatechnics understands technologies and bodies as inextricable. A somatechnic account of the body troubles the division between nature and technology by emphasizing how all bodies materialize through technologies, not only those bodies that carry the most visible marks of explicit construction through cosmetic body 'modifications', surgery, and other interventions (Sullivan and Murray 2009; Sullivan 2005b). Within this framework, soma (body) and techné (technologies and techniques) are intimately entangled; the body is only rendered intelligible through the technologies that constitute it.

As a theoretical framework situated within poststructuralism, somatechnics foregrounds how discourse and materiality are inseverable; bodily being is "always already technologised, and technologies as always already enfleshed" (Sullivan and Murray 2009, 3). The material body does not precede technologies as a presocial form, but rather, it is "the incarnation or materialization of historically and culturally specific discourses" (Sullivan and Murray 2009, 3). In this way, there is no natural body upon which social interventions—such as male enhancement technologies—can inscribe themselves. There is

[6]However, the field of somatechnics that studies trans/gender and sexuality is largely "racially unmarked with an assumed whiteness" (Janzen et al. 2020, 379).

no pre-discursive body that is 'modified' by culture. Instead, as the Somatechnics Research Center website explains, "technologies are the means in and through which bodies are constituted, positioned, and lived" (cited in Pentney 2012, 19). In other words, it is in relation to technologies that bodies become meaningful.

Thinking through the body as a "tangible outcome of historically and culturally specific techniques and modes of embodiment processes", this project recognizes that the body is not only constituted through technologies like the surgeon's knife, but also by the ontological assumptions about bodies and somatic practices that lead to their legitimation or prohibition (Pugliese and Stryker 2009, 2). A somatechnic lens understands that technologies are not simply machinic—the popular understanding of technology as tangible tools—such as the scalpel, silicone implants, fat transplants, and other technologies that physicians use in male enhancement procedures; they are necessarily epistemic, meaning technologies are related to the production of knowledge and the operation of power through bodily practices such as male enhancement (see Sullivan 2009a). The aim of the somatechnician, then, is to simultaneously inhabit and challenge categorical knowledge—meaning to strategically and provisionally invoke categories of being (such as 'cis' or 'man') and embodiment practices (such as 'enhancement' or 'mutilation')—while troubling these categories as contested sites of social and political meaning (Sullivan 2009b).

Within the analytical chapters of this dissertation, I explore how bodies come to matter through various somatechnologies. In the next section, I identify some of the conceptual tools that I use to accomplish this goal, while contextualizing their relationship to trans, queer, and poststructuralist theory.

Technologies of (De)Naturalization

Given that the sexed and racially-marked body is a dense nexus point—or what Sullivan (2009b) refers to as "profoundly significant battleground"—through which unequal relations of power are perpetuated in our present socio-historical moment in Canada and the United States, this project examines the operation of power and resistance through the naturalized body (283). In other words, this research analyzes the 'natural', concentrating on how

bodies—and behaviours that my participants framed as effects of those bodies—are rendered (un)natural. The term *naturalization* is particularly useful in this project, and refers to the *process* by which social phenomena—such as gender, the sexed body, and race—become understood as natural, biological 'truths' (see Lancaster 2006, 2003). Instead of assuming that female and male bodies or Black, white, and Brown bodies are biological, material realities of sex and race, respectively, employing the concept of naturalization reorients our analytic gaze towards the socio-historical context and the discursive devices that materialize the body as natural.

Locating processes of naturalization enables me to deconstruct the static, presocial 'body with a sex' or 'body with a race'. Deconstruction as an analytical tool allows me to refer to the body without necessarily reifying the body as natural. Within this dissertation, when I acknowledge the processes by which the body becomes natural*ized*, it gives me more theoretical license to study the 'natural body' as an unstable artifact of these processes, opening up the theoretical terrain for understanding how bodies materialize. Utilizing the body as a conceptual object does not detract from, but rather, facilitates my project of rendering visible the social materialization of the body and the processes that naturalize it. Applying the concept of naturalization, for example, enables me to differentiate between processes that are actively sex*ing* the body[7] from the idea of the natural, fixed 'body with a sex'.

Given that the term 'naturalization' refers to the processes by which gender, the sexed body, and race appear to be natural, then the term *technologies of the natural*—coined by somatechnician T. Garner (2011)—refers to the discursive devices that accomplish the work of naturalization. Writing particularly about the sexed body, Garner describes technologies of the natural (or "naturalization techniques") as

> 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

[7]The phrase 'sexing the body' comes from Anne Fausto-Sterling's (2000) book *Sexing the Body: Gender Politics and the Construction of Sexuality*, which I describe in more detail in the next section whose title is an homage to her book.

> 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. (35)

As I demonstrate throughout the analytical chapters of this manuscript, the 'natural male body' invoked by the practitioners who participated in this research is the *effect* of technologies of the natural, whereby the social predicates and processes upon which maleness, masculinity, and whiteness rely are successfully concealed both before and after surgical intervention. I suggest in my analysis that erasing the construction of the cis male body through naturalization techniques—while foregrounding the construction of trans, cis women's, and racially-marked bodies—works to maintain oppressive hierarchies. In borrowing the term 'technologies of the natural', however, I apply it to more than the materialization of the sexed body into a binary; I also understand naturalization techniques as the specific discursive operations through which the body is marked by race as a biological reality. I use the concepts 'technologies of the natural' and 'naturalization' interchangeably throughout this manuscript.

Similarly, I use the terms 'denaturalization' and 'renaturalization' throughout this manuscript by drawing upon trans, queer, and poststructuralist theory (see Simon 2015; Whitehead 2012; Garner 2011; Stryker 2006a).[8] [1] Some may interpret these terms to imply that the sexed or racially-marked body was natural from the outset, only to become undone or redone, respectively. Contrary to this reading, the term 'denaturalization' refers to processes that render bodies unnatural without invoking an original nature. 'Renaturalization' appears in this manuscript to communicate how bodies that are natural*ized*—such as the 'female' or 'male' body—can fail to cite the regulatory norms of gender and sex, and go through a process where they are *re*naturalized through discourse to shore up their fragile boundaries and contents to make them appear natural. For both terms, the difference between 'nature' and 'naturalization' is key to their meaning. It would be a mistake to interpret these terms as a return to or departure from an

[8]See also Judith Butler's (1990) *Gender Trouble: Feminism and the Subversion of Identity.*

originating nature; rather, they signal a reassertion of or desertion by naturalization processes.

Some scholarship within trans studies affirms the naturalness of trans identity and embodiment throughout history and across cultures (see Namaste 2000; Prosser 1998; Feinberg 1996), in part for reasons of gaining broader intelligibility and social legitimacy (DeVun and Tortorici 2018), and for finding community across time (Chu and Harsin Drager 2019). While I am circumspect and critical of naturalization processes generally—including narratives that treat trans bodies and subjectivities as natural and universal across time and space—*some* trans folks have been able to mobilize naturalization techniques as a strategic tool to enable particular embodied subjectivities, as well as to secure greater safety in some contexts. The everyday realities of trans folks who navigate cisnormativity and the violence of trans-oppression that make drawing on tools like naturalization a necessary means of survival should not be minimized. And I must be transparent that I do not face the everyday violence of trans-antagonism; as a cis person, I benefit from the system-wide normalization and renaturalization of my body and gender. Recognizing that naturalization discourses can leave behind multiply-marginalized trans folks,[9] and acknowledging that this tool is partial (if not problematic) for a larger project of emancipatory trans/gender politics, naturalizing discourses have—to different degrees—expanded the possible forms of embodiment and subjectivity to include otherwise historically-oppressed groups of people.

With that said, this project aligns itself with trans scholars (see Gill-Peterson 2018b; Snorton 2017; Stryker and Aizura 2013; Garner 2011; Towle and Morgan 2002) who are cautious, if not critical of claiming—and appropriating (Pyle 2018)—historical figures as 'trans ancestors' as evidence that trans subjectivity and embodiment are natural or universal throughout history and across cultures, in part because it decontextualizes

[9]See Skidmore (2011) for a discussion of how processes of naturalization have historically been possible through disciplinary mechanisms like whiteness, heteronormativity, and middle-class respectability politics, enabling some trans folks to be integrated into the social order at the expense of racialized, working class, and queer others.

trans and Two-Spirit identity, embodiment, and experience.[10] Instead of reading backwards in time as a method of granting nature and universality to trans people[11]—with the aim of securing greater safety and cultural recognition—I ask, how do both trans and cis bodies materialize through socio-discursive fields of power? How does the social materialization of cis men's bodies become successfully concealed within male enhancement discourse so as to be regarded as natural, whereas trans—and at times—cis women's and racially-marked bodies are deemed unnatural?

Sexing the Body

At the centre of a project theorizing male enhancement is the need to conceptualize 'the body' generally, and the 'male body' specifically, recognizing as feminist poststructuralists insist, that any reference to the body further brings that body into being (Sullivan 2009a). This work is no exception. The current social imaginary of the sexed body in contemporary, dominant, western culture—including most medical and scientific thought—claims that there are two sexes—'female' and 'male'—from which binary gender 'naturally' materialize feminine and masculine identities. While western science, medicine, and popular discourse may increasingly acknowledge that there are intersex bodies, by

[10] While Two-Spirit is a contested term across different Indigenous groups, Kai Pyle (2018)—a Two-Spirit Métis and Sault Ste. Marie Nishnaabe scholar in American Studies—defines Two-Spirit as a term that refers to "Indigenous people who fall outside the accepted boundaries of modern white or "Western" gender and sexuality, both past and present" (576). Pyle (2018) problematizes non-Indigenous appropriation of Two-Spirit peoples as trans ancestors, making clear that 'Two-Spirit' is not language for either cisgender or transgender non-Indigenous people; it was developed by and for Indigenous Peoples to describe their gender, sexuality, and spirituality. Some Two-Spirit people also use terms specific to their Indigenous Nations, as well as LGBTQ descriptors. Instead of attempting to reclaim Two-Spirit people from history as trans-ancestors, Pyle (2018) advocates for trans*temporal kinship: "the ability of transgender and Two-Spirit Indigenous people to establish kin relations across time, with both ancestors and descendants" (575-576). This is not a flattening of Two-Spirit people across time; "even though modern Two-Spirit people may not be identical to historical Two-Spirits, both Two-Spirit and non-Two-Spirit Indigenous people nonetheless recognize a continuity, a kinship, between the two" (584).

[11] Jules Gill-Peterson (2018a) claims a different approach to reading archives; instead of taking up a recuperative project that stretches "contemporary categories backward" (8) to locate trans children in medical archives from the twentieth century, she suggests that the children identified in her book expand, refigure, and "multiply the meanings of 'trans', moving it in many different directions" (10). In other words, instead of applying our current categories backwards, Gill-Peterson brings forward children from the twentieth century to remake the meaning of 'trans'. For an additional example of how scholars can read historical archives for gender fungibility without declaring it is a "matter of personal definition—a kind of trans self-fashioning", see Snorton's (2017, 63) chapter "Trans Capable: Fungibility, Fugitivity, and the Matter of Being".

and large Canadian and US culture regards these bodies as 'aberrations' from the binary norm that do not challenge the transhistorical existence of female and male as natural, biological, stable, definable, measurable realities (Sanz 2017; Davis, Dewey, and Murphy 2016; Magubane 2014; Fausto-Sterling 2000; Dreger 1998; Kessler 1990).

However, as I demonstrate below, the sexed body is far more of a social and historical object than a biological truth, owing in part to the fact that the sex binary is so fragile. Evidence from historians of sex and feminist science scholars demonstrates that the sex binary is a relatively recent creation, that neither medicine nor the natural sciences (the presumed authorities on bodies and on sex) can reliably define and measure the sexed body, and moreover, medical doctors actively engage in the physical creation of binary sex alongside the material erasure of sex-ambiguous bodies in order to shore up the binary. Below I provide a brief history of the sexed body and feminist science scholars' responses to binary sex research. It is not my intention to provide a detailed and thorough review of their critiques here; other feminist science scholars like Veronica Sanz (2017) have already published more comprehensive analyses. Rather, my aim is to set the stage for how the sexed body is conceptualized in this project.

The One-Sex Model

Troubling the stability and transhistorical existence of 'female' and 'male' bodies helps to identify how they are socially (re)produced, rather than natural divisions of materiality. While bodies may have material limits, they cannot be defined as female, male, or intersex outside of the historically-situated discourses that materialize particularly sexed bodies. Historians of sex (Richardson 2013; Delgado-Echeverría 2007; Meyerowitz 2002; Oudshoorn 1994; Laqueur 1990) offer multiple accounts for how bodies materialize as female and male by challenging the ahistoricity of stable, 'natural', binary bodies, and by temporally and socially locating the emergence of the sex binary and other explanations of materiality throughout history.

By analyzing scientific discourse, historian of sex Thomas Laqueur (1990) examines the (re)making of the sexed body over the centuries from Ancient Greece to the contemporary west. The ancient Greeks made sense of bodily existence through a

"one-sex" model, which treated women as an imperfect version of men. According to this model, "the vagina is imagined as an interior penis, the labia as foreskin, the uterus as scrotum, and the ovaries as testicles" (Laqueur 1990, 4). By the beginning of the nineteenth century, however, dominant western discourses shifted and began differentiating bodies and social practices into a "two-sex system" that created ontologically distinct female and male bodies as "stable, incommensurable, opposite sexes" with corresponding genders (Laqueur 1990, 6).[12] Through European colonialism, this two-sex system—interwoven with race classifications rooted in eugenics—were forcibly adopted throughout the world (see Morgensen 2011; Schiebinger 1993; Bleier 1984). In fact, the materialization of the sexed body is intimately entangled with the social (re)production of race (Gill-Peterson 2017, 2014; Snorton 2017; Stein 2015; Magubane 2014), which I detail later in this chapter.

Instead of interpreting this shift from the one-sex to the two-sex model as a linear progression in the sophistication of scientific thought (as most positivists and post-positivists would suggest), this shift demonstrates how the body is socio-historically contingent and multivalent. If the sex (and gender) binary were a natural reality, it would remain stable across time (history) and place (culture). Cases culturally regarded as 'outliers' (such as intersex bodies, trans folks, cyborgs,[13] and infertile bodies)[14] would not compel the reiteration of the binary's boundaries because they would pose no threat to its coherence. For Laqueur and other historians of sex, the distinction between females and

[12]Thanks to Dr. Susan Stryker for informing me that historians have called into question the accuracy of Laqueur's account of the "one-sex" / "two-sex" models, claiming that his text *Making Sex* does not capture the messy nuances of the changing conceptualizations of the sexed body throughout time. See Brooke Holmes (2019) "Let Go of Laqueur: Towards New Histories of the Sexed Body" for a summary of these critiques.

[13]See cyborg feminist Donna Haraway's (1991) manifesto *Simians, Cyborgs and Women: The Reinvention of Nature* for a detailed account of how the "cyborg enjoys the pollution of categories and illegitimate fusions", disrupting the 'natural body' and the strict distinction between technology, human, and animal (176).

[14]See Garner's (2011) chapter, "Infertility and the Failure to Achieve Femaleness: Pregnancy as Technology of the Natural" arguing how pregnancy is not a natural experience of a female body, but rather, a form of body modification that actively engages in female-*ing* the body. Pregnancy is not so much an effect of the sexed body, but rather, a cause. The bodies of cis women who cannot bare a pregnancy—which is constructed as essential to being 'female' in the contemporary west—thus challenge the 'natural', binary division of females and males.

males as two opposite and complementary sexes is far from a biological, natural fact; the two-sex, two-gender model is an effect of power relations that reflect the unique historical conditions and specific sets of social relations from which it emerged.

The Enduring Two-Sex Model

The sex binary is durable, persisting in the contemporary western context in a myriad of forms; however, arguably the most dominant means of perpetuating this system is by essentializing female and male bodies as sex dimorphic with corresponding feminine and masculine genders, respectively. *Essentialism* in this context refers to the process by which bodies and subjectivities are reduced to a specific set of attributes or 'essences' deemed essential to their intelligibility within the two-sex, two-gender system. My colleagues and I have demonstrated elsewhere that essentialist claims are not always grounded in scientific or medical discourse (Whitehead et al. 2012). However, the preponderance of essentialist explanations for human bodies and subjectivities that abound in contemporary Canada and the United States—and specifically in my interviews with male enhancement practitioners—find sustenance in *bioreductive science* (Lancaster 2006), which increasingly reduces human identity and behaviour to biological, genetic, or evolutionary causes. According to bioreductive science, the body is the raw biological material from which human identity and behaviour 'naturally' emerge. By identifying biology instead of our social worlds as responsible for human identity and behaviour, bioreductive science naturalizes existing social relations (such as gender and racial inequality), thereby limiting our capacity to change oppressive social arrangements.

Early feminist science studies scholars (Birke 1986; Bleier 1984) demonstrate how science and medicine take up bioreductive, gendered dichotomies in ways that promote hierarchical relations of domination, such as passive / aggressive, irrational / rational, nature / science, body / mind, and subjective / objective. These false dichotomies are mapped onto the feminine and female / masculine and male, respectively, whereby the former side of each dichotomy is denigrated and the latter is venerated. We can see this application of essentialist, gendered binaries in, for example, scientific descriptions of bodies during the process of reproduction; ostensibly the female ovum passively awaits insemination from an

active, energetic, and aggressive male sperm (Campo-Engelstein and Johnson 2014; Martin 1991). Despite recent scientific 'discoveries' within reproductive medicine that challenge these old gendered metaphors with new, allegedly more egalitarian ones,[15] these bioreductive logics persist, dispersed throughout disciplines of the 'natural' sciences, shaping scholarship on sex differentiation (how two sexes develop, starting in the womb through death), sex determination (how to assign a sex to ambiguous bodies), and the development of gender identity and sexuality.

For instance, in Canada and the United States, scientists are increasingly in pursuit of the 'trans brain' (see Nota et al. 2017; and Savic, Garcia-Falgueras, and Swaab 2010 for examples of this research), and the 'gay gene' (see Sanders et al. 2015; and Hamer et al. 1993 for examples of these studies). One of the prevailing bioreductive hypotheses about the existence of trans people is that prenatal hormones produce "opposite" sex differentiation of the genitals compared to the brain (Savic, Garcia-Falgueras, and Swaab 2010, 57). According to this hypothesis, for example, trans women develop a penis in utero, but their brains become feminized and de-masculinized. However, brain organization researchers searching for the 'trans brain' do not adequately address the existence of non-binary, agender, and gender queer folks. Moreover, claiming that the brain is immutable contradicts the wealth of scientific evidence of brain plasticity (Jordan-Young 2010; Lane 2009; Fausto-Sterling 2000), and sociocultural evidence that gender changes for people within different contexts, social relationships, and throughout the life course (see Simon 2015).

The political purchase of bioreductive science can become clearer by understanding the logics that have historically bolstered the scientific pursuit of a 'gay gene' and other biological explanations that people were 'born gay'. Mirroring some arguments from the US civil rights movement organized by Black activists in the 1960s, gay rights activists responded to conservative backlash by naturalizing homosexuality. Gay rights activists suggested that, like being Black in the United States, people would never choose an identity that carries as much risk in the US as homosexuality; that

[15]Recent scientific literature describes the cervix as less of a passive 'destination' for sperm, and more as an active participant in reproduction, 'storing' sperm in its tissues to increase chances of conception, 'sucking' semen into the uterus, 'sorting' healthy sperm from damaged cells, etc. (Levin 2005).

homosexuality is natural to their biologies; and that identities that are natural cannot be changed by some force of will or through the tortures of conversion therapy, so therefore, it is ethically bankrupt to persecute people for their immutable and innate natures (see Whitehead 2012). "Rather than arguing that same-sex sexuality ought to be a valued choice (similar to the choice to marry)," writes feminist sociologist Jaye Cee Whitehead (2012), "marriage equality activists ceded this ground by tacitly accepting—or at least not refuting—that only identities beyond one's control deserve state protection" (98). Like identifying the 'trans brain', locating a 'gay gene' could corroborate the 'born this way' narrative to help historically-oppressed groups secure access to official care structures like marriage and healthcare, from which polyamorous, single, and poor people would continue to be excluded.

While there has been a surge in identifying the 'gay gene' and understanding the 'trans brain' from biological sciences, there is a general dearth of natural science research pursuing the discovery of the 'cisgender brain' or the 'straight gene'. Bioreductive explanations of human behaviour do little to question normalized identities or challenge inequality. Instead, scientific 'discoveries' that begin with normative assumptions reinforce the status quo and stabilize otherwise fragile categories like gender, the sexed body, sexuality, and race. Compared to the treatment of historically-oppressed groups, those with normative bodies and identities are less subject to the medical and scientific gaze and the risk of pathologization.

Arguments that install the subjectivities of historically-oppressed people within the 'nature' of their bodies—such as installing gayness in genes—risk opening themselves up to eugenic projects that aim to engineer heterosexuality and cis identity, and eliminate homosexual, queer, and trans existence. The search for the trans brain and the gay gene are examples of how the naturalization of gender, sex, and sexuality within bioreductive science can reaffirm existing social inequalities stemming from heteronormativity, queer antagonism, and cissexism, as well as reveal how relying on techniques of naturalization can constrain our capacity to change these oppressive social arrangements. Avoiding the traps of naturalization and essentialism, feminist science studies directly disrupts the narratives

of bioreductive science primarily by identifying the social assumptions that inform their research design and conclusions, and by challenging this body of scholarship on its own terms according to the scientific method. I present a distillation of some of the arguments from feminist science studies in the next section.

Feminist Science

Bioreductive scientists' continued search for sex difference has persisted deeper "in every tissue of the body, from the heart to the brain and the liver" (Richardson 2013, 213), and "in every bone, muscle, nerve and vein of the human body" (Schiebinger 1986, 42). Making determinations about sexed bodies is complicated, however, by the various ways in which western science, medicine, and dominant culture measure sex: gauging hormone levels (Fausto-Sterling 2000; Oudshoorn 1994); karyotyping 'sex chromosomes' (Richardson 2013; Delgado-Echeverría 2007); isolating genes allegedly responsible for sex difference (Richardson 2013; Fujimura 2006; Keller 2000); studying the human genome's role in sex differentiation (Richardson 2013); classifying gonads (Fausto-Sterling 2000; Dreger 1998); measuring genitalia (Fausto-Sterling 2000; Kessler 1990); identifying reproductive tissues (Fausto-Sterling 2000); dissecting and imaging the brain (Jordan-Young 2010; Fausto-Sterling 2000; Bleier 1984); and mapping differential bone structure (Schiebinger 1993).

Feminists of science persuasively dispute the claim that the sexed body is binary and natural, providing evidence that the sex binary is a socially and historically-produced classification whose dominant organizing logic as it is currently conceived in Canada and the United States places bodies into two dichotomous categories—female and male—based on primary and secondary sex characteristics. Using historical and sociological evidence and analysis, feminists of science contextualize the claims of binary sex research, identifying how their concepts and modes of thinking about bodies emerged under—and therefore, were made possible by—particular historical conditions and sets of social relationships, notably during times of changing gender relations. Equipped with knowledge of biology and the scientific method, feminists of science demonstrate how bioreductive research imposes

gender, race, and heterosexuality onto various sites of the body, while erasing the social and historical predicates upon which the 'science' of these markers of sex rely. In the next few sections, I present several feminist responses to the claims of binarist and bioreductive science.

Sex Ambiguity

The proliferation of bodily markers of sex within binary science research multiply the ways in which the sexed body can be socially categorized (Sanz 2017; Shapiro 1991).[16] Sex ambiguity reveals that within a single body, not all of these traits correspond to one sex category despite the unexamined assumptions in western science, the use of biomedical technologies, and the persistent social energy to bring bodies into normative 'alignment'. Scientists' uncritical commitment to a "unified theory of sex" (Sanz 2017)—which posits that all markers of sex (such as chromosomes, gonads, hormones, etc.) should align according to two, ontologically distinct female or male bodies—is therefore, a commitment not to biological truths, but to social values that we hold about gender and bodies, and the unequal social arrangements that stem from those values.[17]

In the absence of a 'unified sex', these bodily markers reflect how sex determination is less a biological fact than a social process dependent on shifts in scientific thought, medical technologies, and political expediency that enable some traits to take on "supremacy" as the best determinant of sex at particular moments throughout history (Hirschauer and Mol 1995, 373). We can see how this history continues to play out by observing the International Olympic Committee's ongoing struggle to decide how athletes can compete—as a woman or a man—oscillating between different sites of the body—such as genitals, gonads, or (as in the recent case with Caster Semenya) hormones—that supposedly serve as a reliable and valid indication of one's 'true' sex (see Pieper 2019; Henne 2014; Jordan-Young and Karkazis 2012; Garcia Dauder and Gregori 2009).

[16] While one may assume that this multiplication of variables to determine sex would destabilize the gender and sex binary, Sanz (2017) observes that it has had a contradictory effect of fortifying the binary, whereby some variables are invoked to compensate for the limitations of others.

[17] Sanz (2017) defines a unified theory of sex as "a linear model that aligns all [sex] variables in a relation of sequential dependency by distinguishing between sex determination and sex differentiation" (19).

In addition to the problems posed by attempting to reliably define and measure the sexed body according to binary logics, scientists and medical doctors also actively engage in the concomitant surgical and hormonal *creation* of binary bodies through the material *erasure* of sex-ambiguous flesh, thereby preserving the binary (see Sanz 2017; Davis, Dewey, and Murphy 2016; Fausto-Sterling 2000; Dreger 1998; Kessler 1990). Social expectations about gender and (hetero)sexuality become material realities when doctors medically 'correct' sex-ambiguous bodies. In the case of intersex infants, for example, parents and doctors commonly treat intersex bodies that challenge the binary as 'birth defects', as mistakes of nature,[18] rather than as bodily variation. Physicians' decisions to operate on 'sex-ambiguous' genitalia, gonadal tissue, and reproductive organs have been predicated less on biological markers of sex—given that the markers of sex in these bodies do not culturally 'align' and are, by definition, intersex—and are instead based on "parental reaction and the medical team's perception of the infant's societal adjustment prospects given the way her/his [*sic*] genitals look or could be made to look" (Kessler 1990, 13). In other words, social assumptions about gender inform the doctor's perception of the infant's presumed sex, challenging the broader cultural assumption that the sexed body serves as the foundational core from which gender identity 'naturally' emerges.

Heteronormative expectations also become flesh through the medical management of intersex infants. As part of the decision-making process over medical interventions into the bodies of intersex infants, doctors attempt to predict whether the size of an infant's tumescent tissue—such as a clitoris or penis—would grow to be a sufficient size as an adult to penetrate a vagina, and whether a genital canal would be large enough upon becoming an adult to "receive a normal-sized penis" (Kessler 1990, 19). 'Normal' sexual function, therefore, centers on the ability to penetrate or be penetrated, rather than on the capacity for sexual pleasure. When doctors suppose an infant's tumescent tissue will be 'too small' to penetrate a future sexual partner, for example, many doctors assign the infant as a girl,

[18] Language of 'nature's mistake' of sex originally comes from trans history, namely Christine Jorgensen's personal correspondence with family (cited in Serlin 1995). But as Gill-Peterson (2018b) points out, the history of the medical management of intersex people overlaps with the histories of trans people, who sometimes claimed to be intersex to legitimate their requests for medical transitions as a correction to 'nature's mistake'.

they reduce the tumescent tissue to the 'normal' size of a clitoris, and they plan future surgeries to widen or create a genital canal sufficient for penetration. Through this process, doctors physically construct bodies according to the cultural rules of binary gender and heteronormativity that work to materially erase sex ambiguity, intersex existence, and queer sexuality.

Historically, the physical formation of binary bodies and the effacement of intersex existence disproportionately intervenes on white bodies. The materialization of the sex binary is, therefore, simultaneously a project of whiteness and inextricable from race-making (see Gill-Peterson 2018b, 2017, 2014; Magubane 2014). Sociologist Zine Magubane (2014) offers a critical examination of how the erasure of sex-ambiguous flesh through 'normalizing' surgeries and hormone therapy is racially and nationally-specific. In the United States, for example, to inherit property or to vote were exclusive to white men, and therefore, contingent on a system that differentiated bodies by sex and race. Medical intervention into intersex bodies was deemed necessary for white people in order to maintain whiteness and the privileges it confers. Sex-ambiguous Black bodies created less of a gender panic in the US, Magubane (2014) suggests, because they did not disrupt systems of citizenship and the allocation of rights that were grounded in whiteness and a hierarchical sex binary. Moreover, sex-ambiguity in Black and Brown bodies functioned in the United States to confirm essential biological difference between racially-marked bodies and whites (Gill-Peterson 2018b; Stein 2015; Magubane 2014). I provide a more detailed social history of how race became a biological category in Canada and the United States in the section "Racializing the Body".

While science and medicine are often considered objective and value-free, feminist science studies demonstrates that both are always socially and politically oriented. Our knowledge of the body is enabled and foreclosed by preexisting discourses that are already deeply embedded in our concepts and modes of thinking. Scientific research designs already contain within them prevailing discourses on sex, gender, and race. Examples of how these discourses instruct binary sex science are located in the section that follows.

Sex Similarity

Arguably, one of the most powerful critiques on the coherence of the two-sex system accomplished by feminist science studies is the critique of binary sex research on its own terms, using the scientific method. Demonstrating that female and male bodies are actually quite similar—more than they are different—is central to feminist science critiques. While scientists behind binary sex research divide physical traits (such as hair, fat, and muscle distribution) along the binary, scientists' own

> anthropometric research using quantitative data shows that these features conform to a bell-curve distribution rather than a discrete binary. Often, however, only the mean difference between sexes is given, which obscures the intragroup variability and considerable overlap between male and female populations. (Hubbard 1990 cited in Sanz 2017, 4)

In other words, there is more variability *within* categories such as 'female' or 'male' than there is *between* these categories, suggesting that bodies assigned 'female' and 'male'—at a population level—have more in common with each other than they are different. If we understand the prefix 'inter' of intersex to suggest that the body is "between" or "among" sex, or is "mutually" or "reciprocally" sexed, then all bodies in varying chemical, genetic, physiological, and morphological ways are inter-sex, not just bodies whose ambiguity is officially diagnosed as intersex by medical authorities and socially recognized as intersex by cultural norms.[19]

This conclusion is supported by the data from feminist science. For example, feminist biologist Anne Fausto-Sterling (2000) critically assessed the leading biological studies in human and non-human animal research that attempts to determine sex difference by measuring hormones, the brain, and genitals. In her analysis of hormones, she begins in much the same way as science and technology scholar Nelly Oudshoorn (1994) and sociomedical scientist Rebecca Jordan-Young (2010) by acknowledging that 'sex hormones'—such as estrogen and testosterone—exist across bodily being. Bodies culturally and medically-recognized as female require testosterone for growth and

[19]Dictionary.com, s.v. "inter (prefix)," accessed September 8, 2020

reproduction, despite this hormone being considered a 'male sex hormone'; for normal bone development and fertility in males, they need estrogen, which is labeled a 'female sex hormone'. These hormones also regulate the maintenance and growth of organs that are not sex-specific, such as the lungs, intestine, and liver. Asking why these sets of molecules are called 'sex hormones' when they act on organs throughout the entire body and are not specific to female or male bodies, Fausto-Sterling (2000) demonstrates through a history of science how these chemical messengers "infuse the body, from head to toe, with gender meanings" (147).

During the late nineteenth and early twentieth centuries, endocrinology and the birth of the 'sex hormone' emerged parallel to a tumultuous time of (re)fashioning gender, sexuality, and racial classifications within the United States and nations across Europe (Fausto-Sterling 2000). Multiple social debates coalesced around the gender and sexual panics over homosexual men, the racial anxieties about immigrants, the use of eugenics to 'improve' the nation's racial stock, and the changing meanings of masculinity as a response to women's rights and suffrage movements. It was within this context that binary, innate sex difference was assumed to be fact, and shaped the direction of hormone science (Fausto-Sterling 2000).[20]

Much of the scientific research on hormones involved non-human animal studies that transplanted gonads, glands, and extractions from them between 'female' and 'male' rats, mice, guinea pigs, or chickens. The logic was that removing these gonads and glands would produce an observable change in the animal related to the absence of hormones that they secreted, whereas adding gonads, glands, and their extracts to animal bodies that lacked these hormones would 'restore' missing functions or stimulate cross-sex growth. The study of hormones was anchored so much in non-human animal studies, that when standardizing the measurement of hormones across different fields of study, scientists settled on using M.U. for mouse unit (popular in the United States) and R.U. for rat unit (common in Europe) (Fausto-Sterling 2000, 185).

[20]For a dedicated discussion of the production of race through hormone science, see the section "Racializing the Body" later in this chapter.

With standardization came a narrowing of the definitions for these hormone molecules. For estrogen, standardization reduced the actions of the 'female hormone'—which again, impacts multiple systems throughout female, male, and intersex bodies—to its effects on the reproductive cycle of female mammals, called estrus, during which they are in heat. Notably, understanding the 'female hormone' in terms of estrus excludes primates who do not go into heat, including humans. Moreover, standardization diminished estrogen's role in a myriad of other physiological processes and effects unrelated to sexed bodies, such as growth in bones, blood vessels, and kidneys. Standardization, therefore, not only defined estrogen according to a process, estrus, that does not occur in human bodies while still applying its definition to human bodies and behaviour, it also contributed to sexing estrogen as female and responsible for female sexual behaviour by obfuscating its broader actions.

The broader physiological effects of testosterone were similarly excluded from testosterone's standardized definition. Through standardization, scientists narrowed testosterone's actions to the physical developments that were thought to distinguish non-human animal males from females. Scientists chose to observe testosterone's effects, for example, on the growth of deer's horns, enlargement of the prostate in castrated rats, or the development of mating plumage in select birds (Fausto-Sterling 2000). However, unlike estrogen, which was limited to effects found in the sexual cycles of some female mammals, research on testosterone could not identify an "acceptable" mammalian source, and settled for standardizing the measurement of testosterone based on the degree to which it develops the fleshy growth atop the heads of roosters, known as the cockscomb (Fausto-Sterling 2000, 185). The unit of activity of testosterone was measured by the daily dose required to produce a measurable growth of the comb in castrated male chickens.

The problematic science behind the standardization of estrogen and testosterone was met with great skepticism at the time it went into effect, but not enough to unsettle the standard that continues to inform our knowledge of these molecules as 'sex hormones' rather than as 'growth hormones' today, much less how scientists apply standards for non-human animals to human bodies. Since standardization, "any physiological activity those

hormones had were, by definition, sexual" even though scientists knew then as they know now that hormones have broader effects on parts of the body that are not sexed, such as nerves and the heart (Fausto-Sterling 2000, 187).

Many prominent scientists studying hormones at the time carried unexamined social assumptions of natural biological difference between females and males into their research. Physiologist Eugen Steinach, among other medical scientists, described gonadal secretions—what are now referred to as estrogen and testosterone—as antagonistic. While Fausto-Sterling (2000) suggests this could be a plausible description of their findings, descriptions of sex hormone antagonism was not inevitable; other scientists such as Dorothy Price and Carl R. Moore reproduced Steinach's research and found that hormones were certainly powerful growth regulators, but they were not specific to sex. Fausto-Sterling (2000) concludes that by diminishing the role of both estrogen and testosterone acting on organs that are not sexed in both female and male bodies, while also labeling these hormones as antagonistic

> superimposed on the chemical processes of guinea pig and rat gonads a political story about human sex antagonism that paralleled contemporary social struggles. Physiological functions became political allegory—which, ironically, made them more rather than less credible, because they seemed so compatible with what people already "knew" about the nature of sex difference. (162)

Social assumptions about gender difference, in other words, brought into being hormonal difference through scientific discourse. The sexing of hormones within science demonstrates the power of discourse to make the "social become material" (Fausto-Sterling 2000, 235). Describing sexed bodies—which is always filtered through a social and political lens—does not simply reveal the nature of those bodies. Scientific research shapes the meaning and social materialization of bodies, further bringing the binary body into being. To quote Fausto-Sterling (2000),"[s]cientists use truths taken from our social relationships to structure, read and interpret the natural" (116).

Feminist science scholars have found that unexamined assumptions about the essential nature of bodies shape the research process (Jordan-Young 2010; Upchurch and Fojtová 2009; Scully and Bart 2003; Nechas and Foley 1994; Martin 1991; Hubbard 1990; Messing 1983). From the research questions that scientists consider to have merit, to the

particular tools of measurement they choose to use, to the participants they decide to include or exclude from a study, scientists make socially-informed decisions that are inextricable from their knowledge claims. How scientists operationalize variables, how they create categories and manipulate data into interpretable research results, and what they do with cases that do not conform to a binary vision of bodies are dependent in part upon the scientists' history and social location, and therefore, their vested interests and those of the institutions within which their knowledge production is situated (see Fausto-Sterling 2000).

However, even if the social assumptions that undergird scientific claims about differently-sexed bodies were scientifically sound, the methodological rigor and research findings of binary sex research in pursuit of measurable sex dimorphism are flawed since these investigations by and large do not fulfill basic tenets of scientific investigation. Departing from Fausto-Sterling's analysis, which analyzed the social and historical contexts and assumptions about gender that informed scientists' research designs and conclusions, sociomedical scientist Rebecca Jordan-Young (2010) synthesized and analyzed the current body of research investigating hormones and 'hardwired' differences between women and men's brains—referred to as brain organization research—by assessing the accuracy of these studies against their own internal metric of study validity and reliability (meaning, are their conclusions accurate and can you reproduce the results?). Specifically, Jordan-Young assessed the extant brain organization research for sufficient sample sizes, standardized measures, control groups, the validity of quasi-experimental research designs, how the studies fit together (or do not) to form a theory, and replicability—an essential part of the scientific method.

After reviewing more than three hundred research studies on brain differences from the 1960s to 2010, Jordan-Young found that any 'discovered' differences between female and male brains come from a limited number of small scale studies that show only small statistical differences in the averages, ignoring the vast similarities between female and male brains, neglecting the wealth of studies that contradict these findings, as well as overlooking the social and cultural influence on brain development. Jordan-Young persuasively argues

that the extant biological findings on brain differentiation by sex lack basic scientific rigor, challenging science on its own terms. Jordan-Young (2010) summarizes the research on brain difference as "longstanding folk tales about antagonistic male and female essences and how they connect to antagonistic male and female natures" (291). She concludes that it is deceiving for brain difference research to suggest that cognitive patterns can be divided by female and male brains, because there is too much overlap between and variation within these categories for them to be substantively meaningful.

Whether binary sex researchers consider negligible findings problematic, or whether they are aware of how their social decisions shape the research design and findings, as Sanz (2017) makes clear:

> The problem with this commitment [to the binary] is precisely its character of assumption. In an enterprise (science) that bases its epistemic legitimacy in demonstrations and proof, the problem with the sex binary is that there has never been a hypothesis or a theory to test—it is an epistemological framework that runs behind, above, and beyond particular theories and research projects. In Western biological sciences, the binary is common sense, a kind of tacit knowledge that permeates many other aspects of our culture. (20)

Scholars who claim that western science and medicine are transcendent above cultural influence and are capable of producing objective and value-free results have not examined how their situated position impacts their knowledge production and conclusions, much less taken responsibility for how their positionality is reflected in their research.[21]

Findings of sex similarity that complicate or refute the binary science of the sexed body largely remain hidden from public view (see Richardson 2014; Fausto-Sterling 2000). When scientists are faced with results that belie their assumptions about femaleness and maleness, they often exclude this finding from their analysis, effectively ignoring contradictory information to their original hypotheses (see Fausto-Sterling 2000; Oudshoorn 1994). Hyde (2005) makes the case that sex researchers have had a history of excluding findings of sex similarity, and moreover, are over-reporting results that point to

[21]Through the concept 'situated knowledge', Donna Haraway (1991) is "arguing for politics and epistemologies of location, positioning, and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims" (195). For an elaboration of this term and how it impacts my approach to knowledge production in this research, see Chapter 3.

sex difference; seventy-eight percent of research results that indicate sex difference contained such negligible findings as to be close to zero. This is not an 'objective' research approach, but a socially-informed decision to make the data speak a particular narrative that conforms to the status quo. Feminist science studies scholar Sarah Richardson (2014) also identified several cases that even when natural science research produced evidence of sex *similarity* between 'female' and 'male' bodies, the news media misrepresented the findings as evidence for sex *difference*. Richardson notes that this is a common trend in the media, whereby "gender beliefs can distort our interpretation of scientific results" (no page). When natural science research challenges sex difference, Richardson claims it often does not become a major story in the news media because sex similarity garners less readership than sex difference.

Far from being a natural fact, the creation of the sex binary is a reflection of the cultural values we hold about gender, (hetero)sexuality, and race—as well as a tool to legitimize the inequality brought on by those values. To quote Patrick Geddes, a prominent biology professor during the emergence and popularization of the two-sex model, he said "[w]hat was decided among the pre-historic Protozoa cannot be annulled by an act of Parliament" (cited in Laqueur 1990, 6), meaning the dimorphic nature of the body that was decided among early life forms cannot be undone by social policy. Consequently, when we treat the sex binary as a biological fact, we embed inside the body any and all social inequality that stems from the binary division of sex. Worse yet, we absolve ourselves of changing these oppressive social arrangements because, as Professor Geddes contends, no social legislation can change the natural order of sex, much less the inequality that stems from it. This manuscript challenges the cultural assumption of 'woman' and 'man', 'female' and 'male' as stable categories of biological difference, recognizing them instead as categories that police bodies, as well as naturalize, and therefore, work to justify unequal social arrangements.

Racializing the Body

Similar to the medical construction of the sexed body that seeks to identify sex "in every bone, muscle, nerve and vein of the human body" (Schiebinger 1986, 42), the scientific production of race also took on an interior, constitutive role starting in the 1760s (Snorton 2017), and lasting throughout the practice of ethnology in the mid nineteenth century, whereby "the African race's darker color infiltrated 'the whole inward man,' inside and out, including organs and viscera" (Stein 2015, 48). Returning to Eugen Steinach, the physiologist who framed hormones as 'antagonistic', he did not limit his research on hormones to sexing the body; social assumptions about colonized peoples also informed his investigations. Collaborating with his colleague in endocrinology, Paul Kammerer, Steinach made race and sexuality chemical by tethering them to hormone molecules (Gill-Peterson 2014).

Continuing with non-human animal studies, Steinach and Kammerer conducted experiments to track how heat impacted the gonadal development of rats, and claimed that elevated temperatures stimulated gonadal tissues to produce sex hormones earlier than under cooler temperatures. Correlating these observations of rats with white anthropologists' claims about colonized peoples in tropical climates—which were replete with their own colonizing logics and racist assumptions (Lewis 1973)—Steinach and Kammerer postulated that people in warmer climates experienced puberty, and thus sexuality much earlier compared to whites (Gill-Peterson 2014). By cohering the sexed body (of rats), through climate, to race and sexuality in humans, they naturalized racially-marked peoples as hypersexual, a stereotype that continues to exert influence in the lives of people of colour today.

Similar to the sexed body, race continues to be conceived in the popular imaginary as a natural, biological reality of human bodies, often thought to be primarily a result of genetics passed down through families. This is despite the wide recognition within both social (Stein 2015; B. Lawrence 2003; Frankenberg 1993) and contemporary biological sciences (Hunley, Cabana, and Long 2016; Brace 2002) that race is not a natural, biological phenomenon that is universal in its meaning and effects across space

and time. Rather, race is a socially-(re)produced and historically-situated system of classification that organizes bodies into multiple groups, largely based on physical features, but also cultural practices. Similar to feminist biologists who demonstrate that there is more variation within sex categories than between them (Fausto-Sterling 2000; Hubbard 1990), biologists who search for a genetic cause of race demonstrate that within race categories there is more genetic variation than between them (Hunley, Cabana, and Long 2016; Lewontin 1972). Comparing the genetics of Black peoples as a group with Asian peoples as a group results in *less* genetic variation, for example, than comparing Black peoples to each other, which results in *more* variation, calling into question the dominant organizing logics of 'biological difference' that work to classify populations as separate 'races'. Like sex, race is not a natural characteristic of the body, but rather, is socially and historically *assigned* to bodies.

While observable physical traits that are typically associated with race—such as skin and eye colour; facial morphology; hair colour, texture, and distribution; bone structure; as well as body fat distribution—are produced from the expression of sets of genes and interaction with one's environment (called a phenotype), race is not reducible to these traits—much less these genes. Race categories built on these traits are the unstable effect of splicing up the continuum of possible bodily features into boxes imagined as tidy, but consequently, subject to failure. As author and journalist Ta-Nehisi Coates (2015) writes,

> Difference in hue and hair is old. But the belief in the preeminence of hue and hair, the notion that these factors can correctly organize a society and that they signify deeper attributes, which are indelible—this is the new idea at the heart of these new people who have been brought up hopelessly, tragically, deceitfully, to believe that they are white. (7)

As Coates points out, the term 'race' connotes more than just a range of possible physical traits. 'Race' also implies "deeper attributes" like morality, 'civility' versus 'barbarity', physical and mental capacities, personalities and dispositions, and social behaviours attributed to people with particular phenotypes. Therefore, race categories manufacture groups of people as sharing not just physical traits, but also particular expressions of

social—yet naturalized—characteristics upon which white supremacy "distribute[s] vulnerability and security" (Spade 2015, 4).

For instance, a common rationalization for Black people's disproportionate vulnerability to police brutality and other state-sanctioned violence in Canada and the United States is predicated on the racist presupposition that Black people are 'naturally' violent as a race, so therefore, vulnerability to the deadly force of the state is not only reasonable, but just. This argument refuses to acknowledge structural racism in Canada and the United States, including the historical origins of policing rooted in slave-catching (Stein 2015). Significantly, the histories of slavery—as well as colonialism and white nationalism—in the US and Canada helped inaugurate the dominant conceptualizations of race that we continue to operate with today. I turn to this history in the section that follows.

Race in Canadian and US History

Sociologists know that race is socially (re)produced in part by historically tracing how 'race' as an overarching concept—as well as its specific categories—have been created and transformed throughout time and space. Early in European colonization of what is now known as Canada and the United States,[22] for example, colonists constructed difference—and systemic exclusion from social, political, and economic life based on this difference—between them and Africans and Indigenous Peoples primarily according to culture and religion. However, as chronicled by Melissa Stein (2015)—a historian of race and gender—since non-European people could convert and their cultures adapted, Europeans sought to structure society around a visual economy of permanent physical differences as a means to institutionalize sociopolitical division and entrench their power. Europeans aimed to justify their social dominance with biological claims about bodily difference. Turning to scientists to help him naturalize existing institutions and sets of social relations, for example, Thomas

[22]Indigenous groups have different names for the land now known as Canada and the United States. Many Indigenous Peoples refer to this land as Turtle Island. The Iroquois story of Creation, for example, explains how the land came to be known as Turtle Island. Instead of attempting to produce an incomplete summary of this Traditional Story filtered through my understanding as a white settler, I encourage readers to refer to the book *And Grandma Said–Iroquois Teachings as Passed Down through the Oral Tradition* recorded by Tom Porter (2008) (Sakokweniónkwas), a Bear Clan Elder of the Mohawk Nation.

Jefferson sought to justify his and his peers' enslavement of African peoples, as well as the genocide and subjugation of Indigenous Peoples that was central to the white settler nation-building project of the United States (Stein 2015). Jefferson called upon white scientists of race to find evidence of natural, physical differences between Europeans and African peoples.[23]

For these white scientists, studying race enabled them to assert social and political influence. That influence was reflected early in the kinds of questions they thought merited investigation. Whiteness studies sociologist, Robin DiAngelo (2018) writes, "Illustrating the power of our questions to shape the knowledge we validate, early race scientists didn't ask, 'Are blacks (and others) inferior?' They asked, 'Why are blacks (and others) inferior?'" (16). Operating with the preconceived assumption that Europeans were superior to African and Indigenous Peoples (among others), physical differences, including colour, became central to determining social status. According to Stein (2015), Anglo-Christians gradually began to think of themselves as white, and whiteness conferred material rewards and rights of citizenship that shielded white people from the social vulnerabilities to which they subjected people of colour.

We also know race is a social technology by observing how different physical traits—from skulls, hair, and skin, to beards and breasts, to genitals—took on supremacy and particular racial meanings at different points in time to serve the needs of white colonists (Stein 2015). Scientists' attribution of racial meanings to sexed bodies—including genitals and their reproductive capacities—cohered around the aims of white society. Indeed, race science often framed Black people as failing to perform gender and embody sex according to white standards (see Snorton 2017; Stein 2015; Gill-Peterson 2014; Magubane 2014). Given the centrality of gender and sex to the intelligibility of social subjects, any deviation from normative whiteness functioned to justify race scientists' and enslavers' dehumanization

[23]In *Notes on the State of Virginia*, Jefferson speculated about the theory of polygenesis, that Black and white people were likely different species, before calling upon scientists to seek out evidence to support this theory: "It is not against experience to suppose, that different species of the same genus, or varieties of the same species, may possess different qualifications. Will not a lover of natural history then, one who views the gradations in all the races of animals with the eye of philosophy, excuse an effort to keep those in the department of man as distinct as nature has formed them?" (cited in Stein 2015, 8).

and exploitation of Black people. Interests and anxieties of white society that related to race and the sexed body included preventing miscegenation,[24] homosexuality, and relatedly, the perceived 'race suicide' of whites (Stein 2015); expanding medical science—such as endocrinology and gynecology—that largely benefited whites at the expense of enslaved Black people (Snorton 2017); as well as controlling the bodies and sexualities of Black men who were constructed as threatening to white men's dominance (Stein 2015; hooks 2004; A. Davis 1983).

The science of race and sex thus formed a nexus on disciplining the body. While remaining irreconcilable and irreducible, race and the sexed body were co-constituted through discourses of scientific racism (see Gill-Peterson 2017, 2014; Snorton 2017; Stein 2015). As one example of many, race and sex materialized through justifications for maintaining and expanding the institution of slavery, which relied on exploiting the reproductive labour of Black women "as breeders to increase the slave population" in both Canada (Kihika 2019, 28) and the United States (see Stein 2015).[25] In the United States during the mid nineteenth century—after the transatlantic slave trade had ended, during the rise of abolitionism, and at a time when proslavery authorities were intent on expanding slavery into the territories—US physician Samuel Cartwright entered the debate on race. He claimed that Black women had larger pelvises than white women, leading him and many of his colleagues to believe that Black women experience less pain during childbirth (Stein 2015).[26] Cartwright decided that Black women's fertility and purportedly limited birthing pains functioned as evidence that Black women were "designed for reproduction", a conclusion that served to legitimate the perpetuation and

[24]Miscegenation refers to "a mixture of races" particularly through "marriage, cohabitation, or sexual intercourse between a white person and a member of another race". Merriam-Webster, s.v. "miscegenation (n.)," accessed September 18, 2019.

[25]For a more detailed accounting of slavery, Black women's labour history, and anti-Black racism in Canada, see race and labour scholar Maureen Kihika's (2019) dissertation *Negotiating Borders: The 'Everyday' Encounters of Black African Immigrant Caregivers in Vancouver, British Columbia.*

[26]This notion that Black and white people have biological differences in pain tolerance persists today, whereby both laypeople and medical professionals believe Black people can handle pain better than whites; as a result, medical professionals do not take the pain of Black people seriously when managing their health care, and make less accurate treatment recommendations (Hoffman et al. 2016). Moreover, this idea reinforces the racist assumption that Black people are 'drug seeking'.

expansion of slavery as an institution (Stein 2015, 80).[27] In other words, ethnologists like Cartwright naturalized race and sex as rooted in biology—as impossible to legislate away—as a means of protecting the wealth of colonial empires, extracted from the reproductive potential of Black women, and—as I demonstrate below—from the theft of Indigenous Land.

In Canada and the United States, 'Indian' identity has also historically been, and continues to be, a highly contested racial category created by and for white settler society. Colonial governments such as Canada's sought to limit Indigenous[28] resistance against white settlers' theft of the territory by eliminating Indigenous Peoples from their land—both through physical genocidal violence, but also through cultural genocide—by codifying who was white and entitled to land, who was a 'status Indian' and legally-permitted to live on 'Indian' reserves, and who would remain landless (B. Lawrence 2003). The construction of 'Indianness'—a race-based discourse of classification, regulation, and control of Indigenous populations—enabled colonial governments to dispossess Indigenous Peoples of their land. This process aimed to reduce hundreds of extremely diverse ethnicities, language groups, and nations to a single racial identity as 'Indian', at times sharing little more than "common experiences of subjugation" (B. Lawrence 2003, 5). Several pieces of legislation, such as the Canadian *Indian Act*, sedimented a process of constructing and regulating Indigenous identity that continues to shape the lives of diverse Indigenous Peoples in the land referred to as Canada today.

One of the ways in which the colonial government of Canada constructed who was white and who was 'Indian' was through marriage. The *Gradual Enfranchisement Act* passed in 1869, for example, legislates how the social production of race is co-constituted by

[27] As I demonstrate in Chapter 6, similar discourses about the "design" of women's 'reproductive bodies' persist in contemporary medicine in Canada and the United States, but to serve different, socio-historically specific functions.

[28] The term 'Indigenous' in the context of Canada refers to groups such as First Nations, Métis, and Inuit peoples. Some Indigenous individuals refer to themselves as 'Native' and 'Indian', and moreover, Canadian federal legislation and policy—as well as dominant public discourses—continue to use these labels. However, on the advice of Greg Younging (2018)—a member of Opaskwayak Cree Nation in northern Manitoba and publisher of the writing guidebook *Elements of Indigenous Style*—this language is not what I, as a white settler, have adopted in this manuscript, except when I am referencing those discourses in historical documents and legislation.

gender, whereby Indigenous women who married white men would legally lose their status as 'Indian' so that their children could be classified as white, and thus their white boys would be able to inherit property according to the aims of white settler nationhood. European women who married Indigenous men, on the other hand, defied the "social boundaries of whiteness" so their racial status was legally changed to 'Indians' (B. Lawrence 2003, 9). The racial classification of white and Indigenous men did not change through marriage, however, demonstrating how the attribution of race is a particularly gendered project. Between 1876 and 1985, about 25,000 Indigenous people lost their status, the majority of which were due to gender discrimination in Section 12(1)(b) of the *Indian Act* (Holmes 1987 cited in B. Lawrence 2003). The exponential loss from cultural genocide beyond this initial calculation only starts to become clear when we understand that for every woman who lost status and band membership, all of her descendants also lost status (B. Lawrence 2003). Legal historian Peggy Blair (2005) estimates that "[b]etween 1958 and 1968 alone, more than 100,000 women and children lost their Indian status" as a result of the *Indian Act* of Canada (1).

Throughout both Canadian and US history of colonialism, the construction of 'Indianness' has taken on different forms—from revoking or assigning racial identity through the perpetuation of gender discrimination in marriage, to attributing racial classifications to people by evaluating their lifestyle and language through a colonial gaze, to instituting a system of blood quantum (B. Lawrence 2003). At each level, the process of constructing 'Indian' identity was rendered a reflection of an Indigenous person's racial 'nature', rather than a social and political project that enables whites to steal Indigenous Land. "Indeed, to speak of Native identity at all in some ways reinforces the notion that the word 'Indian' describes a natural category of existence", writes Bonita B. Lawrence (2003), an Indigenous studies sociologist and Mi'kmaw woman (4). "And yet it is equally clear that the label 'Indian' has been an external descriptor, meaningless to the Indigenous peoples of the Americas prior to colonization" (B. Lawrence 2003, 4).

To be clear, claiming that race is a socially (re)produced technology rather than a natural 'truth' of the body does not empty it of all meaning. Race is certainly not 'fake'; it continues to have real, material effects in the lives of Black and Indigenous Peoples,

other people of colour, as well as whites. While the creation of 'Indianness' in Canada and the United States enables the dispossession of Indigenous Land (B. Lawrence 2003), and the invention of Blackness in Canada and the United States aimed to legitimate colonists' enslavement of African peoples (Stein 2015), the manufacturing of whiteness functions—at least in part—as "a guarantee of immunity from such social degradation" as slavery (Chang 1985, 44), as well as a chance for white men to secure and own property.

Like other racial categories, *whiteness* does not carry a transhistorical essence, rather, it is constantly changing across time and space. Unlike other racial categories, whiteness is a social location of structural advantage, the accrual of material rewards and rights of citizenship (Stein 2015) that is maintained largely by remaining "unexamined and unnamed" (Frankenberg 1993, 1), or as feminist and social activist bell hooks frames it, by investing in "whiteness as mystery" (hooks 1997, 340). Its invisibility "at once insists on objectifying and rendering its others in racialized terms, even as it effaces its own racial status" so as to claim universality (Pugliese and Stryker 2009, 4). Indeed, whiteness as normative power functions to universalize "its claims, entitlements and privileges whilst also relegating it beyond the purview of critical inquiry" (Pugliese and Stryker 2009, 4). Ta-Nehisi Coates (2015) asserts that

> "White America" is a syndicate arrayed to protect its exclusive power to dominate and control our bodies. Sometimes this power is direct (lynching), and sometimes it is insidious (redlining). But however it appears, the power of domination and exclusion is central to the belief in being white and without it, "white people" would cease to exist. (42)

Similarly, bell hooks (1997) describes the way that "whiteness makes it's presence felt in black life [...] as a terrorizing imposition, a power that wounds, hurts, tortures, is a reality that disrupts the fantasy of whiteness as representing goodness" (341). The idea of race and the social categories it produces or renders invisible, therefore, emerged not from 'objective' observations of human biology and behaviour, but from the social and 'scientific' pursuit of naturalizing existing inequalities from oppressive social arrangements.

However, the construction of race is not a relic from a distant colonial or antebellum past. Throughout Canadian and US history into our colonial present, white society has

used race as a set of biologized categories to naturalize hierarchies according to the needs of fluctuating political priorities. The *Indian Act* still exerts its influence over the lives of Indigenous Peoples in what is known as Canada today. In the United States, the attribution of racial status to Black bodies differed according to state law, meaning that if one crossed state lines, their racial status could change. In 1924, for example, the anti-miscegenation legislation of the *Virginia Racial Integrity Act* instituted the 'one drop rule', declaring that a person with *any* African ancestry would legally make a person Black (see Khanna 2010; Dorr 1999). Today's taxonomies of race may construct people with European ancestry as white, but poor and working-class immigrants with the same ancestry would not have been regarded as white in the recent past (Barrett and Roediger 1997). In the United States, Italian and Irish immigrants were not always white (Guglielmo and Salerno 2003; Barrett and Roediger 1997; Ignatiev 1995), and in Canada, Slavs may have been regarded as white, but were still subject to processes of racialization (Burkowicz 2016). Between 1940 and 1970 when the US wanted to recruit more labour from Latin America, those who are now referred to as Latinx people[29]—who have primarily Indigenous, African, and/or European ancestry—were largely considered white in the United States (see Rodriguez 2000). After 9/11, Arab peoples—despite officially being recognized as white in the US census—have increasingly become understood as sharing particular, identifiable, physical, and social traits that are framed as inferior to whites (Selod 2015).

Racialization

In lieu of treating race as a fixed, biological, and natural reality of the body, this project understands race as the unstable *effect* of a social process identified in sociology as *racialization*. According to sociologists Murji and Solomos (2005), the concept of racialization describes the "processes by which racial meanings are attached to particular issues—often treated as social problems—and with the manner in which race appears to

[29]The 'x' in Latinx replaces the gendered 'a' (feminine) and 'o' (masculine) at the end of the term so as to be gender inclusive. Other terms, such as Latine, also exist. However, some people reject designations like Latinx, claiming that even though it moves towards gender inclusivity, it maintains a colonial project that erases Indigenous existence by labeling Indigenous Peoples as 'Latin' (Tlapoyawa 2019). I hold this concept in tension while learning from others who are building anti-oppressive language in its place.

be a, or often the, key factor in the ways they are defined or understood" (3). In this way, processes of racialization tend to center race as the axiomatic and essential characteristic to understanding social problems.

Racialization applies to more than social problems, however. Here I draw on sociologist of race, Saher Selod's (2015) conceptualization of racialization as a social process whereby "new racial meanings are ascribed to bodies, actions and interactions. These meanings are not only applied to skin tone, but other cultural factors such as language, clothing, and beliefs" (79). Identifying a hierarchy in processes of racialization, anti-racist feminist Yasmin Jiwani (2006) describes this concept as "the meanings attached to physical and cultural differences [that] imply inferiority where such differences are seen as departing from a norm" (272). And borrowing from sociologist Jakub Burkowicz (2016)—whose work within whiteness studies identifies how that hierarchy is structured in Canada—racialization refers to the processes by which a group of people become "represented and interpreted as possessing certain identifiable and immutable racial traits which [are] often judged inferior" to whiteness (8). This does not mean that whiteness is exterior to processes of racialization; as feminist sociologist Gillian Creese (2007) argues, power relations in both Canada and the United States are dependent upon whiteness as a racialized category.

The concept of racialization redirects our analytical gaze towards that which is constantly generating, transforming, and eliminating racial categories that refer to, but are not reducible to the body. Understanding bodies as racialized is compatible with a Foucauldian analysis of discourse; both conceive of social processes as marking and organizing bodies into categories as a disciplinary technique. Racialization enables me to deconstruct race as a biological 'truth', to understand race as constructed by racism. In popular conceptions, race is the material reality of the body upon which racism is based; however, the concept of racialization inverts this narrative. Race is the effect—not the cause—of racism. To quote Coates (2015), "race is the child of racism, not the father" (7). As I demonstrated previously with a brief history of the emergence of race as a

concept—particularly the construction of Black and 'Indian' identity—exploitation came first, then ideology followed to justify that exploitation.

One of the ways in which white society maintains and justifies racial exploitation is through powerful organizing tropes that construct Black people as threatening. In Canada and the United States, the constructed threat of Black masculinity to the propriety of white femininity has historically and presently fomented anti-Black racism, and works to justify state-sanctioned police brutality and other forms of everyday violence against Black men under the assumption that they are sexually violent. This is reinforced by the discourse of the 'big Black dick', which I identify and contextualize in the next section.

The 'Big Black Dick'

The popular perception within the United States and Canada is that penis size is related to, if not determined by race. According to the prevailing stereotype, Black cis men have the largest penises compared to all other racial groups. English scholars Gary Lemons (1997) and Scott Poulson-Bryant (2006) refer to this racialized discourse as the 'big Black dick'. Operating across multiple spaces, the discourse of the 'big Black dick' forms the basis of everyday expressions (i.e. 'once you go Black you never go back'), is common within entertainment media, is represented in its own genre of pornography, and permeates the male enhancement industry (see Chapter 6). At the time of this writing, the 'big Black dick' discourse is circulating at Black Lives Matter protests against police brutality in Canada and the United States. Some protest signs mobilize essentialist and objectifying expressions such as "I love ♡ black dick so you will hear me speak", "Your daughters love every INCH of us so why can't you?!", and "Black dick matters" (see Craven 2020).

With a few exceptions among the twenty male enhancement practitioners who participated in this research, the majority reproduced ideas about the racial genetics of penis size and the stereotype of the 'big Black dick' during our interviews. Despite physicians' confidence in the racialized genital taxonomy they shared with me, there is no reliable nor conclusive scientific research supporting these claims.[2] There is no evidence that the median penis size of Black cis men is larger than the median penis sizes of other groups divided by racial categories, despite the tenaciousness of penis size researchers to

find such evidence. There is not even a scientific consensus attesting to the median penile length of human beings regardless of race category. Existing statistical averages of cis men's penile dimensions are scientifically suspect; studies calculating penis size often sample—and therefore, center as normative—white, young, working-class, cis men enrolled in the military; they lack standardized methods for measuring penile length and girth; and produce unreliable results that are not generalizable.[3]

Even if researchers collected a large, racially-diverse and representative sample of the population, even if they were able to standardize their methods of measurement, and even if they designed a study that could control for all variables that might affect the accuracy of measuring penile length and girth—which many male enhancement practitioners doubted was possible—it would not change the analysis in this manuscript. It matters very little whether the 'big Black dick' is a material reality of the Black body; it has already produced very real social, historical, and material effects. Seeking out racialized differences in genital dimensions is part of a long history of attributing racial meanings to bodily difference that I discussed previously.

In fact, physicians' taxonomy of penis sizes by race is reminiscent of ethnological studies in the nineteenth century. Consider, for example, US ethnologist Samuel Morton's study in phrenology and craniology[30] whereby classifying human skulls—specifically, measuring their size and shape to attribute social values to different 'races'—was a means of naturalizing racial difference and the social inequities that are justified as stemming

[30]Stein (2015) explains: "Whereas phrenology typically read the bumps on the head for clues about personality traits and abilities, craniometry or craniology measured and/or weighed the capacity of the skull: the bigger the capacity, the bigger the brain it must have held and thus the bigger the intellect and reason" according to psuedo-scientific logics (37). Both fields of study have been debunked as racist, and largely abandoned by academics. For an example of how a male enhancement practitioner from my sample reproduced similar logics of phrenology—by measuring physical traits for clues about personality traits—see Chapter 6 under the section "The 'Genetics of Race' and the Racialization of Black Men's Genitals".

from that difference (Stein 2015).[31] Penis size research has already been taken up by contemporary eugenicist and white supremacist academics to naturalize race inequality.[32]

Despite the lacunae in the medical literature on penis size for cis men of colour, the 'big Black dick' is still defined as real in the broader social imaginary of contemporary Canada and the United States. Therefore, it produces material consequences in the lives of Black cis men. We can witness this assumption as well as the white appropriation of the 'big Black dick' in director Jordan Peele's (2017) horror film *Get Out*. The plot hinges on white enslavers who lure, hypnotize, and abduct Black people to either auction off or purchase their living, but sedated bodies. After purchasing Black people's bodies, white characters transplant their brains into the heads of their Black victims so that they can gain the alleged assets or skills of Black bodies. When the Black protagonist, Chris, unknowingly meets these white body-enslavers at a social gathering, they each objectify his Black body as athletic or exotically "in fashion". One white woman asks Chris while glancing at his groin "Is it true? Is it better?" wanting to confirm her assumption that he has a large penis, and if sex is better with a 'big Black dick'. Peele's portrayal speaks to the white objectification and (in this film, literal physical) appropriation of Blackness—including the 'big Black dick'—without threatening whiteness, and indeed, while upholding white supremacy.

While the story of *Get Out* is a fictional representation of contemporary racism in the United States, white objectification and appropriation of the Black body generally, and the 'big Black dick' specifically, is palpably real. Drawing on feminist philosopher Cressida Heyes's (2009) work, which contends that all cosmetic surgeries are racially marked—including somatic projects of whiteness and racial appropriation taken up by

[31] Morton actually created his taxonomy of racial difference by unintentionally measuring sex difference: "his sample of nonwhite races included more female skulls, usually smaller in size than male skulls, and he—and the many scientists who cited his work—read the smaller average skull size he calculated for those races as evidence of their inferiority. In other words, he read sex difference within a race as proof of physiological and intellectual difference between the races" (Stein 2015, 38).

[32] Self-proclaimed eugenicist Richard Lynn claimed in a 2013 peer-reviewed journal that—because Black cis men's penises are on average larger than the penises of other 'races'—Black people in general are less evolved, especially when compared to white people. Instead of lending credibility to Lynn's racism by citing this publication, see Thomas (2011) as well as Volken (2003) for critiques that establish how Lynn's research methods generally lack basic scientific rigor, and see Valone (2002) for a critical review of one of Lynn's prior publications identifying it as racist and xenophobic.

white people—this dissertation understands male enhancement as a racialized somatic practice.[33] The distinction between race and racialization is meaningful here. I am not suggesting that the 'big Black dick' is a natural, biological reality of Black men's bodies that white people appropriate; that argument would rely on the ontological stability of 'race'. Rather, since in Canada and the United States our cultural, medical, and scientific understanding of Black cis men's bodies is that, on average, they have larger penises compared to the penis sizes of all other racialized groups, and because male enhancement is a procedure that seeks to augment the dimensions of cis men's penises, these genital practices are racially inflected as Black. Male enhancement is a set of cosmetic interventions that facilitate the appropriation of the 'big Black dick' without threatening whiteness. Indeed, white cis men can "appropriate pieces of 'ethnic' physicality for their exoticism and eroticism, without risking the oppression that more marked bodies are vulnerable to" (Heyes 2009a, 203).

The oppression that white cis men are spared when appropriating pieces of racialized physicality through male enhancement is partially rooted in the history of the 'big Black dick' discourse. This discourse works to reduce Black cis men to their bodies and reinforces the figure of the Black rapist, that Black cis men allegedly "harbour irresistible and animal-like sexual urges" (A. Davis 1983, 182) that are reflected in and through their biological, sexed bodies (Stein 2015). Political activist and feminist philosopher Angela Davis (1983) makes clear that the figure of the Black rapist who targets white women did not exist during the Civil War, even though white women were left unattended while white men were fighting, calling into question the assumption that Black men are naturally violent. It was not until after the Civil War that the figure of the Black rapist became politically

[33]Heyes's (2009) work suggests that "refining a nose that carries the implication of Mediterranean or Middle Eastern ancestry" can "aim to make already white people whiter" (203). She identifies cosmetic procedures that result in "pouty, bee-stung lips, or 'Latin' buttocks modeled after Jennifer Lopez" as common interventions white women in Canada and the US undergo to appropriate racially-marked, exotic, and erotic physicality without the intention to necessarily "pass as racially transformed" (203). Taken even further to look like or 'pass' as Black women, the term 'blackfishing' identifies how white women appropriate physicality racialized as Black by wearing dreadlocks and other uniquely Black hairstyles, applying deeply pigmented makeup or self-tanning lotion, and undergoing cosmetic procedures to produce features racially-inflected as Black. Celebrities like Kim Kardashian and Ariana Grande, as well as race scholars such as Rachel Dolezal and Jessica Krug have all been accused of blackfishing (see Rasool 2018).

instrumental. She writes: "Before lynching could be consolidated as a popularly accepted institution [...] its savagery and its horrors had to be convincingly justified. These were the circumstances which spawned the myth of the Black rapist" (A. Davis 1983, 185).

Of course the figure of the Black rapist inverts the actual direction of violence, which is disproportionately and structurally enacted by whites against Black communities, what bell hooks (1997) describes as the projection of 'terrorist' onto Black people, despite whiteness being terrorizing (174). Indeed, white men's sexual terror against Black women in particular was integral to the operation and perpetuation of slavery as an institution that has ongoing repercussions in contemporary Canada and the United States. The reverse framing of the actual direction of sexual violence is bound up with Canadian and US histories of the 'big Black dick' and the Black rapist trope. Acknowledging the legacies of the 'big Black dick' within the Black rapist trope, we can see how white supremacist society mobilizes this discourse to justify lynching and other state-sanctioned violence against Black bodies. And as I demonstrate in the analysis of Chapter 6, the 'big Black dick' is also an easy scapegoat used to distract from the violence enacted by particularly white cis men.

The 'Natural' Body

The aim of this chapter was to present the theoretical, historical, and analytical foundations for theorizing the 'natural' body as an effect of power. By drawing on Foucault's work—which understands the body as the materialization of relations of power—I can examine how the 'natural male body' comes to matter through male enhancement discourse. Employing a somatechnic analysis—which conceptualizes bodily being as inextricable from technology—provides a way out of worn debates about whether somatic transformation is liberatory or oppressive, and disrupts the false dualism of the natural versus constructed body. A somatechnic orientation, therefore, enables me to examine how all bodies materialize through socio-discursive fields of power. In this chapter, I also defined (de)naturalization, racialization, and other conceptual tools that aid me in this analysis. In the analytical chapters that follow, I juxtapose male enhancement with gender confirmation surgery, and the 'monster cock' in relation to the

bodies of cis women and cis men of color, to show how the racialization and sexing of particularly white cis men's bodies becomes successfully concealed within male enhancement discourse so as to be regarded as natural.

The task of the next chapter, however, is to outline the epistemological and ontological assumptions that instruct the creative processes in the generation of data and knowledge for this research. Here I delineate the pilot study I conducted observing online male enhancement forums; the characteristics of my sample, the methods I used to recruit twenty male enhancement practitioners to participate in semi-structured, in-depth, qualitative interviews; my approach to coding interview transcripts and analyzing discourse; and a necessarily partial accounting for how my situated position shaped the generation of knowledge in this project. I conclude the next chapter with a call for institutional accountability for supporting academics who face gendered and other forms of systemic violence while conducting research in the field.

Notes

[1]Throughout this dissertation, readers may notice that attribution to some authors (specifically Judith Butler and Donna Haraway) who are key to poststructuralist theory on gender—and therefore, would otherwise figure prominently in the body of this dissertation—is limited exclusively to the notes section. I made this decision after witnessing their responses to survivors of sexual assault and harassment enacted by other professors. As one example, Butler has responded to allegations of sexual assault made against her friend and colleague Dr. Avital Ronnell in ways that are disappointingly incongruous with her stated commitments to social justice (see Greenberg 2018). Feminist scholar Haida Arsenault-Antolick claims that instead of publicly supporting and believing survivors of sexual assault, Butler has defended a confirmed sexual abuser by mobilizing Dr. Ronnell's "power and status as a rationale to dismiss her victim's experiences" (personal communication). These actions are inextricable from her scholarly work about gender violence and "whose lives and trauma are 'grievable'". Butler's actions do not undercut her scholarship, but there is a clear "disconnect from her work and her own actions" that "needs to be reckoned with". For a discussion of Donna Haraway's responses to survivors of sexual assault, see Subbaraman (2018). On the other hand, I have entirely removed from this dissertation scholars who have been publicly accused of engaging in sexual misconduct, such as Michael Kimmel. Notable gaps in this dissertation's review of theory and literature that may result from their removal should demonstrate that as white cis men, they have been afforded a lot of space in the discipline. My aim was to make space for others in this dissertation, including queer, trans, and nonbinary theorists; academics of colour; early career scholars; and cis women intellectuals.

[2]Most of the penis size studies mentioned by male enhancement practitioners in our interviews reflected sampling issues common to penis size research; cited investigations were often conducted in the United States during the 1950s and 60s, and focused exclusively on white, working-class men, whose penile measurements were most often recorded during their time in the military. Cis men who discussed racialized penile dimensions on support sites like *Enhancement Forum* sometimes gestured to sales information from condom companies that suggest people in African countries tend to purchase larger condom sizes compared to people in Canada and the United States, and people in Asian countries tend to purchase the smallest condom sizes compared to all others. *Enhancement forum* members do not problematize to what extent existing stereotypes may have impacted consumer's purchasing habits. Nor have they considered how sex education varies widely between and within these countries about how to use prophylactics effectively, including education about the proper fit of condoms, which remains an important variable (among others) unaccounted for in corporate sales records. Moreover, basing our understanding of human bodies on sales information from for-profit companies seems dubious at best, and cannot be generalizable.

[3]For example, some penis size research measures erect length (see Habous et al. 2015), others gauge flaccid stretched length (see Spyropoulos et al. 2002); some calculate penile length from the skin on the upper side

of the shaft to the tip of the glans, others employ a 'bone-pressed' method by pressing into the suprapubic fat pad on the upper side of the shaft measuring out to the tip of the glans; some calculate penile girth using the dimensions of the base of the penis as well as the coronal ridge (see da Ros et al. 1994), whereas others measure the midshaft to quantify penile circumference (for examples of this research, see Ponchietti et al. 2001; Wessells, Lue, and McAninch 1996; Alter 1995). Given that a researcher touching and measuring study participants' flaccid or erect penises would largely impact the results, it is common within this body of research to ask participants to privately measure and report their own penile dimensions. However, this creates other inaccuracies and inflations of the figures; problems with participant self-measurement and self-reporting of those measurements are widespread within penis size research (for examples of this research, see Grov, Wells, and Parsons 2013; Bogaert and Hershberger 1999; Choi et al. 1999; Smith et al. 1998; Richters, Gero, and Donovan 1995; Jamison and Gebhard 1988). It is in part for this reason that the Kinsey data on penile dimensions is imprecise and unreliable (see Sutherland et al. 1996; Wessells, Lue, and McAninch 1996). Harding and Golombok (2002) concluded that self-reporting measurements has very low test-retest reliability ($r = .60$ for length, and $r = .53$ for girth) (355) due to "unreliability of the measurement method", but also due to "natural variability" (356) in testing conditions: "temperature, arousal, and previous ejaculation can affect the dimensions of both the flaccid and erect penis" (352). The tendency for penis size research to have very small sample sizes limits the generalizability of results from this body of scholarship (for examples of this research, see Spyropoulos et al. 2002; Wessells, Lue, and McAninch 1996; Richters, Gero, and Donovan 1995; da Ros et al. 1994). A failure in some studies to report a standard deviation and a range alongside mean penile dimensions (for example, see Jamison and Gebhard 1988) also limits our interpretation of the data considerably. The overwhelming focus in penis size research on white participants (see Spyropoulos et al. 2002; Richters, Gero, and Donovan 1995; da Ros et al. 1994; Jamison and Gebhard 1988), cis men in the military (see Spyropoulos et al. 2002), and cis men under the age of 40 (see Spyropoulos et al. 2002; Ponchietti et al. 2001) normalizes the sexed bodies of white, young, working-class, cis men enrolled in the military.

Chapter 3

Method and Methodology

Orienting Paradigms

The aim of this chapter is to be transparent about the orienting paradigms and creative processes that generated the knowledge claims in this manuscript. Before identifying the creative processes, meaning the methods I used to co-generate data with male enhancement practitioners, I want to first identify the paradigms—the "world-views through which all knowledge is filtered"—that orient this research as they relate to ontology and epistemology (Hesse-Biber and Leavy 2004, 6). 'What can be known' from male enhancement practitioners about the materialization of particularly-sexed and racialized bodies is a question of ontology. Whereas the 'ways of knowing' how sexed and racialized bodies materialize through discourse, and the relationship between the research field and the researcher, is a reflection of epistemology. The ontological and epistemological presuppositions that underlie this project are rooted in a critical constructivist paradigm or world-view.

A critical constructivist position in relation to knowledge production recognizes that claims to 'objectivity' and 'universal truth'—as well as the 'view from nowhere' that underlies such claims—are misrepresentative at best, and deliberately dangerous at worst (see Smith 2012; Sullivan 2009b). Knowledge claims always emerge from somewhere, from some situated position in relationship to systems of power, within particular sets of social relations, and under specific historical conditions (see Kihika 2019; Smith 2012; Guba and

Lincoln 2004). Feminist biologist Ruth Hubbard (1995) explains that western scientists' claims to objectivity

> cannot guard against the biases and commitments shared by substantial interest groups, and it can avoid them even less if these commitments are shared by the entire culture. [...] Since scientists are a rather homogeneous group—predominantly European or Euro-American, male, upper middle class—and have passed through an educational process that has taught them to look at the world in specific ways, their so-called objectivity is enclosed within their shared commitments. [...] Scientists always make choices; but they pretend that their choices are driven by the internal logic of their subject and by the free play of their educated curiosity. Yet it is dangerous to ignore the contextual framework that shapes their subject matter, their curiosity, and their choices. (208)

Since all knowledge is shaped by context as well as the situatedness of our subjectivities and ethical commitments, feminist and critical race scholars call for a transparent accounting of how our situated positions inform the knowledges we create (Kihika 2019; Harding 2004; Hubbard 1995).[1] True to a critical constructivist paradigm, I recognize that data generation between male enhancement practitioners and myself is a social and relational process of meaning making. For this reason, I have taken account for my role in the research process in the section "Situating Myself" at the end of this chapter. The data we generated in the form of written notes about practitioners' comments, descriptions of practitioners' mannerisms or appearance, and illustrations of the interview context that accompanied audio recordings and interview transcripts are a necessarily situated and partial construction of our interactions and the events that unfolded during interviews.

[1]It is important to note here that the situatedness of knowledge does not mean that all knowledge is equally valid. While Donna Haraway (1991) problematized dominant forms of western scientific thought in her original writings about the situated character of all knowledge, she did not reject wholesale scientific inquiry or method. One common misinterpretation and dangerous co-optation of poststructuralist critiques of scientific knowledge specifically is that if we can problematize scientific thought as socially informed rather than as objective 'truth', then 'alternative facts' and uncritical opinions are equally as credible as scientific inquiry and evidence-based knowledge within the 'marketplace of ideas'. To combat this narrative and effect political change, scholars, educators, and activists must situate 'alternative facts' within the specific social and historical conditions that produce them, namely under white supremacy, colonialism, neoliberal capitalism, and heteropatriarchy. This renders visible the relations of power and systems of domination that make 'alternative facts' appealing and seemingly advantageous to particular groups of people. Furthermore, as academics and community activists, we need to be cognizant of and transparent about the tension within our own work between commitments to generating knowledge, while we are at the same time embedded in fields of power.

Guba and Lincoln (2004) suggest that the ultimate objective of constructivist research is to "distill a consensus construction" of reality (27). This is not the aim of the present research. For this reason, in addition to a constructivist world-view, this investigation is expressly critical; in particular, this research seeks to locate the interstitial spaces within the operations of power in our socio-historical moment to create openings for alternative forms of embodiment and subjectivity beyond cisnormativity, whiteness, and phallic masculine embodiment.

Early Observations of Virtual Male Enhancement Forums

Recognizing myself as an outsider to the populations and genital practices central to this project, I began this research with a pilot study observing virtual homosocial spaces like online support sites for cis men interested in 'do-it-yourself' and medically-assisted male enhancement. Informed by this pilot study, I could come moderately prepared to my interviews with male enhancement experts. By observing the talk of cis men in these virtual spaces before building an interview guide for my discussions with practitioners, I could ensure that my lines of inquiry would center existing discourses within the field of male enhancement.

Enhancement Forum—a pseudonym for one of the primary websites I observed for the pilot study—allows forum members to develop personal profiles, post customizable avatars (which often depicted sexualized images of women's bodies), exchange private messages with other users, post before-and-after photos of their flaccid and erect genitals to share their enhancement gains, publicize their genital measurements and assessments of their erectile quality in the signatures of their posts, and contribute to a wide assortment of thread topics. Common topics contained in these forums include information about new products and techniques that enlarge 'male' genitalia, narratives about embarrassing locker room interactions and sexual experiences—many of which are framed as traumatic 'origin stories' for why cis men started their male enhancement 'journey'—requests for and suggestions about reputable male enhancement practitioners, and advice for pre- and post-operative care.

At the time of my observations, *Enhancement Forum* offered over 3,900 individual members support, guidance, and community where they can share humorous, heart-breaking, embarrassing, confessional, and explicit conversations and photographs. Sociologist Jared Del Rosso's (2011) observations of virtual communities on PenisSanity.com—a forum for men with small penises—resemble my own readings of message board participation on *Enhancement Forum*:

> Missing were the antagonistic markers of many online forums, such as 'flaming', which is characterized by postings of 'profanity, obscenity, and insults that inflict harm to a person or an organization'. [...] In their place seemed to be a collective ethos of care and support. (709)

Disagreement and debate were present on *Enhancement Forum*; however, they often related to questions such as "How big is big enough? What is the ideal penis size?" or "Who is best qualified to receive elective surgical procedures? Those with a deformity, disease, or small measurements? Or does everyone have equally as legitimate reasons for electing surgical intervention?" These disagreements never resulted in a consensus and often generated some of the most compelling discourses and data.

For the pilot study, I visited forums twice per week for a period of two months in 2013, amounting to about fifty hours of observations. I chose *Enhancement Forum* and other support sites as my fields for virtual observations because compared to other websites, they had some of the highest post traffic dedicated to discussions about male enhancement at the inception of this study. My degree of participation in these forums was limited to registering with the websites and observing a variety of threads; I did not post on forums or contact site members, but instead acted as what site members call a "lurker". The greater part of my observations were directed by the most popular and current threads, which the website tracked and updated as members contributed to them. Upon locating analytically compelling themes, I used the website's search function to see how common these themes were; how forum members participated in discussions about these themes, especially noting dissenting voices; and to situate these themes in various contexts. I used a similar coding method for these websites as I did for interviews with practitioners, which I describe later in this chapter in the section "Coding and Analysis".

My observations of male enhancement forums inform some of the building blocks of this research, including the interview questions I asked male enhancement practitioners. For example, section five of my interview guide explicitly states that the questions contained therein were inspired by my observations of online support sites like *Enhancement Forum* (see the "Semi-Structured Interview Guide" in the Appendix). Some of the questions I crafted based on my initial observations of male enhancement forums—such as inquiries about the relationship between pornography and physicians' medical practices in the materialization of cis men's bodies—did not survive past the first several interviews as they failed to generate much of a response from practitioners. Notable conflicts between patient desires and expectations expressed on *Enhancement Forum* and practitioner policies and practices also characterized my interviews with doctors. As one example, a large number of *Enhancement Forum* members wanted access to genital technologies as a means to secure multiple sexual partners, to which several practitioners such as Dr. Tabibi were vocally opposed (see Chapter 6).

However, other themes I originally identified within male enhancement forums are central to the analysis of this manuscript, including the suffering that characterizes cis men's 'origin stories' explaining why they became interested in genital technologies (see Chapter 4), discourses that racialize genitals (see Chapters 5 and 6), and themes related to the 'monster cock' (see Chapter 6). While I may have arrived at similar discourses about suffering and the racialization of sexed bodies without observing cis men's talk on male enhancement forums, it is unlikely that Chapter 6 about 'monster cocks' would exist without this pilot study.

Research Field

This project joins the ongoing conversation amongst many somatechnicians (Gill-Peterson 2018a, 2017, 2014; Alm 2013; Garner 2011; Sullivan 2008b, 2007) and gender scholars (Davis, Dewey, and Murphy 2016; Campo-Engelstein and Johnson 2014; Fujimura 2006; Green 2005; Dreger 1998; Martin 1991) who have taken up medical discourse of gender, sex, and/or race construction as their conceptual object, critiquing the role of psychology

and the medical establishment for defining bodies and identities in a way that privileges essentialist and bioreductive models of gender, sex, and race. Following in the footsteps of feminist theorists who have taken the clinical context as the specific site of their analysis of these discourses (Whitehead et al. 2015; Whitehead and Thomas 2013; Whitehead et al. 2012; Kessler 1990), this investigation looks at the medical practices of male enhancement physicians, investigating how they naturalize the cis 'male' body and normative whiteness in the process of opening and closing the gate to male enhancement technologies, while (de)naturalizing the bodies of trans folks, cis women, and Black cis men.

Sampling and Recruitment of Male Enhancement Practitioners

At the time of recruitment, eligible participants included anyone who legally performed male enhancement procedures in Canada and the United States, including penile length and girth enhancements, procedures on the scrotum, and adult circumcisions.[2] I initially identified potential participants and obtained their contact information through three avenues: examining publicly-available websites that profile and provide patient reviews of medical professionals; reading online support sites like *Enhancement Forum* where cis men shared their experiences with particular male enhancement practitioners, or asked other forum members for recommendations of doctors in the field; and searching for physicians' professional websites where they advertise their services. Through an e-mail recruitment script (see the "Recruitment Email" in the Appendix), I invited doctors who perform male enhancement procedures to participate in this research. If I did not receive a response within a week, I sent a follow-up email. Occasionally I called doctors' offices to confirm their receipt of the original email, as I discovered later in the recruitment process that email filters often directed my research invitation to spam folders.

After conducting each interview, I employed a chain-referral recruitment method as a tactic for accessing participants who may not have as much of an online presence,

[2]Three participants who exclusively perform adult circumcisions—Doctors Trotter, Grassa, and Wilson—are still represented in aggregate descriptions about practitioner responses (i.e. "the majority of doctors claim..."), but otherwise are largely absent from the analysis of this dissertation because the research focus shifted more towards penile length and girth augmentations. As a result, the questions pertinent to these doctors' expertise are not centered in this analysis.

and who may feel more inclined to participate after their colleagues vouch for me (Penrod et al. 2003). From this additional recruitment method, I received the names of just three physicians, but only secured one additional interview. Chain-referral recruitment posed a significant challenge, because unlike my previous experiences interviewing mental health professionals who are incredibly networked, male enhancement practitioners often claimed they did not know other physicians in their field. While this is possible, it seems unlikely given that many male enhancement practitioners perform revision procedures to reverse enhancements carried out by other doctors, whereby they become aware of their colleagues and the procedures they perform through their common patients. Moreover, several of the physicians I interviewed attend professional conferences where they network with other specialists in the field.

What is more likely is that practitioners refrained from providing referrals because they hold deep disagreements with how other physicians manage their practice and do not want the opinions of those doctors to be represented in a germinal study about male enhancement (see Robinson (2008), Luciano (2002), and Haiken (2000) for the few historical and social analyses of male enhancement). This seemed to be the case for a handful of physicians who explicitly stated during our interviews that other male enhancement practitioners were unprofessional or primarily motivated by profit rather than patient care, and that I should exercise caution about who I include in this research. Additionally, the male enhancement industry generally, and the private medical practices of physicians specifically, may be more competitive than I originally anticipated, potentially explaining why collaborative relationships between male enhancement practitioners may be much less common than for the mental health professionals with whom I previously conducted research.

After three months of active recruitment, of the seventy-two practitioners I invited to participate, twenty-six agreed to an interview, and twenty fulfilled the interview process.[3] All of the doctors who participated in an interview are cis men. I am aware of a handful

[3]Four practitioners requested to reschedule the interview, but did not respond to follow up emails; one physician passed away in the course of this research; and I chose not to interview the final doctor.

of women who perform male enhancement procedures, but they did not respond to my invitation to participate in the research. Two practitioners in my sample are racialized men, which seems proportional to the number of male enhancement doctors of colour from which I recruited participants; all other participants were white. I did not formally ask physicians to share their ages during our interviews, but based on their online profiles, their ages ranged between forty and eighty years. I estimate that most doctors were in their fifties or sixties, which is congruent with the typical level of experience and number of years most practitioners had accrued as practicing physicians. Only three participants in my sample were located in Canada, which limited my ability to draw conclusions about how the different health care systems in Canada and the United States oriented physician's medical practices; the remaining practitioners worked in the United States, with every region represented in my sample. California was the location in which most doctors from my sample practiced medicine. Some physicians performed male enhancement procedures at multiple offices in different regions of the United States, and a couple of doctors practiced medicine in other countries throughout the world in addition to their US location. All practitioner names used in this manuscript are pseudonyms that I selected.

The practitioners in my sample who gave informed, expressed consent to participate have different kinds and degrees of medical training, and wide-ranging levels of experience performing male enhancement procedures. Practitioners' formal training as they described it included urology; plastic, cosmetic, reconstructive, and general surgery; family medicine; anesthesiology; and several other specialties. The most common training doctors in this sample completed was in plastic surgery. Every participant was a doctor except one who performed male enhancement procedures as a clinical cosmetic specialist. The procedures that participants perform and that qualify for this analysis are various penile and testicular enhancements including, but not limited to, suspensory ligament release for penile elongation, penile and testicular implants, autologous fat injections—meaning fat that comes from patients' bodies—dermal fillers of the penile shaft, Scrotox to smooth out the wrinkling of scrotal skin, suprapubic fat removal, and revision procedures of prior enhancements. Participants' other surgical expertise that to

varying degrees falls under the purview of this analysis includes surgeries to 'correct' buried penis syndrome, intersex surgeries, and gender confirmation surgeries for trans patients (described by most practitioners as 'Female-to-Male' [FtM] and 'Male-to-Female' [MtF] genital procedures).[4]

Experience performing male enhancement procedures specifically ranged between about two to forty years, with a mean duration of seventeen years. However, several doctors had been practicing physicians much longer than they had been offering male enhancement procedures. The estimated number of male enhancement patients that practitioners had worked with also varied considerably, between ten and ten thousand patients. Operating on more than ten thousand patients was a notable outlier; the second highest number of patients on which a doctor in this sample had performed male enhancement procedures was two thousand. Excluding the surgeon with the most prolific experience, the mean number of male enhancement patients with whom participants had worked was four hundred. The six physicians in my sample who—in addition to performing male enhancement procedures—had a range of experience between four and forty years of specializing in gender confirmation surgeries, with a mean duration of about twenty-two years.[5]

Conducting Interviews

Congruent with the critical constructivist orientation of this research, I employed an active interviewing approach that treats the participant as a colleague in knowledge production, rather than as an object for knowledge extraction (Holstein and Gubrium 2004). During interviews I utilized an inductive, modified grounded theory approach with open-ended, semi-structured interview questions so as to draw out rich qualitative themes (Charmaz 2014, 2004; Strauss and Corbin 1991; Glaser and Strauss 1967). Crafting

[4]This dissertation does not use the language of 'male-to-female' (MtF) or 'female-to-male' (FtM) except when quoting male enhancement practitioners. While trans folks can and do use this language for self-identification, it is not language that is more useful to this research than the umbrella term 'trans', which is more reflective of the range of bodies and subjectivities contained under the purview of this project.

[5]Unfortunately, I did not anticipate early in the interview stage of this research the centrality of practitioners' comments about gender confirmation surgery to this project, and as a result, did not record the estimated number of trans patients with whom these physicians previously worked. However, I am familiar enough with their medical practices that I am able to make general claims about their level of experience working with trans patients.

interview questions was an iterative process based on emerging theoretical considerations, observations of virtual homosocial spaces for cis men seeking to enhance their genitals, as well as the experience and knowledge I gained after completing each interview with male enhancement practitioners. Questions in the interview protocol (see the "Semi-Structured Interview Guide" in the Appendix) addressed physicians' qualifications and experience; the logics they use for accepting or rejecting a prospective patient for male enhancement, affording careful consideration to negative cases; and their expert understanding of their patients' bodies, paying particular attention to discourses about sex, race, and other markers of the body.

One of the most successful strategies for soliciting theoretically compelling data was derived from the analytical methods of somatechnics described by cultural studies scholar Nikki Sullivan (2009b) (which I present in the section "Coding and Analysis"). As part of this method, I regularly invited doctors to consider and juxtapose male enhancement procedures and patient cases in relation to other forms of somatic transformation, embodiment, and subjectivity. This included trans bodies and gender confirmation surgery, intersex bodies, the 'monster cock', 'genital mutilation', 'body dysmorphic' cis men, and the bodies of patients' sexual partners (almost exclusively discussed by physicians as cis women).

The interview guide located in the appendix of this dissertation presents a sample set of the questions I asked participants. However, in practice, the lines of inquiry and delivery of the questions were customized for each participant—including their expertise and the procedures they perform—and our conversations regularly went 'off-script'. Moreover, this sample guide contains more questions than I regularly asked in each interview; since some practitioners limited their responses to just a few short sentences, I wanted to ensure I had follow-up questions prepared to solicit more about their medical practices and expertise. Other physicians spoke at such great length about their practices in male enhancement (and gender confirmation surgery) that I was compelled to limit my questions to those that—based on previous interviews and the unfolding of the current conversation—I anticipated would solicit the most theoretically engaging responses. On the other hand, sometimes

the questions that received little engagement in previous interviews would glean the most surprising responses in subsequent interviews.

I originally planned as part of my research design to organize in-person interviews with male enhancement practitioners, as well as immersive observations of their clinical appointments with cis men. I was partially successful, having conducted a handful of in-person interviews with physicians. It is uncommon for social science research to proceed without the need for adaptation and improvisation, however. This research is no exception. After only one month of active recruitment, I needed to leave Los Angeles, so I adapted my project to center virtually-mediated interviews with physicians. From these adaptations I may have lost the experiential and embodied richness that typically comes from in-person interviews, observations, and ethnographic immersion, but in my estimation, using mediated interviewing increased participation in this research because it offered flexibility for doctors' busy schedules (Deakin and Wakefield 2014). Some practitioners only agreed to an interview because they could accommodate our virtual conversation during a flight layover, in-between patient consultations, or after arriving home from work before cooking dinner.

As other qualitative research has confirmed (Jenner and Myers 2019; Deakin and Wakefield 2014), I was still able to build rapport with my participants and generate in-depth research through mediated interview contexts such as Skype, contrary to some of the concerns raised previously by other scholars (Seitz 2016; Weinmann et al. 2012). While call quality issues occasionally required participants and me to engage in mitigating strategies—such as slowing and clarifying our comments and remaining open to repeating questions and answers (Seitz 2016)—the majority of interviews benefited from these strategies.[6] It is also possible that some of the 'exceptional disclosures' (Jenner and Myers 2019) made by practitioners like Dr. Perry that I detail elsewhere in this chapter (see the section "Situating Myself") could have resulted in part from the physical separation made possible by virtual interviews (Weller 2017).

[6]My interview with Dr. Schneider created unique challenges, as he was able to hear me without call interference, but on my end, the call was characterized by persistent speech delay and feedback echoing my every word. This did have a notably negative impact on our rapport.

Most interviews took place in the fall of 2014; over the years I conducted a few additional interviews, culminating in the winter of 2017, mostly as follow-up discussions aimed at clarifying physicians' former comments. Interviews either took place in-person at medical practitioners' offices, over the phone, or via Skype. During virtually-mediated interviews, I was in my apartment and physicians were located in their offices, homes, at the airport, or driving their car during their commute. Our in-depth, qualitative interviews lasted between forty-five minutes and two hours forty minutes, with a mean interview duration of about one-and-a-half hours.

Coding and Analysis

Consistent with a critical constructivist paradigm, I favoured a modified grounded theory approach in this research out of recognition that the codes I construct and the analysis I produce are my interpretation of the data (Charmaz 2014, 2004; Strauss and Corbin 1991; Glaser and Strauss 1967). Instead of working through distinct phases, the generation, coding, and analysis of the data overlapped throughout this project. Building an interview guide by drawing from my coded observations of online support sites; analyzing data during the interview moment; memo writing throughout the transcription, coding, and analysis of the research; and continuously reconceptualizing and contextualizing practitioners' comments during the writing process reflect my iterative approach to the data.

After transcribing and organizing the audio data and my written notes for the first initial interviews, my approach consisted of identifying and managing emergent themes grounded in the data and emphasized by participants. By 'emergent' here I am not suggesting that they exist a priori and I simply encounter them; rather, "emerging data" refers to the co-constructive process whereby I actively conceptualize and contextualize the content of practitioners' comments and the work accomplished by their discourses (Charmaz 2014, 115). After coding these first few interviews, I revisited and revised my interview guide to reflect what I learned from our conversations.

During the initial rounds of open coding, I used the comments function of LibreOffice—an open-source, Linux-based word processor similar in functionality to

MicrosoftWord—to organize and conceptualize my codes and memos. After I had developed an initial but flexible coding scheme, I returned to the interviews using NVivo software to continue extensive memo writing and multiple waves of focused coding. At the peak of code identification, practitioner interviews contained anywhere from 30 to 71 different themes, with a mean of 53 different themes. Coding for those themes produced between 54 and 550 references per interview, with a mean of 213 references of those themes. Interviews that contained more themes and references—such as Dr. Fray (71, 550), Dr. Tabibi (65, 301), and Dr. Rosenburg's (63, 262) interviews—tend to be represented more often in the analysis compared to interviews that contained the fewest themes and references—such as the interviews with Dr. Lieberman (46, 118), Dr. Trotter (32, 70), and Dr. Grassa (29, 58). On the other hand, Dr. Allen's interview contained some of the fewest themes and references (30, 54), yet this dissertation contains and analyzes several of his quotes.

During analysis, I aimed to juxtapose practitioners' discourses about different bodies and subjectivities. Largely eschewing isolationist, analogical, and categorical approaches to understanding body projects in favor of a somatechnological one (Sullivan 2009b), this project brings male enhancement in relation to other bodies and bodily practices so as to locate similarities, resonances, divergences, and intersections between them. In particular, I was able to juxtapose codes for male enhancement surgery with codes for other somatic practices. Sullivan (2009a) describes this comparative method as

> juxtaposing various modificatory procedures, the justifications that inform their practice or its prohibition and the ethico-political lived effects of such, in the hope that in so doing, questions, issues, and insights associated with one particular practice may cast new light on others. This may in turn engender more-nuanced understandings of and critical responses to the complex and multifaceted technés in and through which embodied being(s) comes to matter in situated contextually specific ways. (317)

Interpreting genital procedures through and against each other, I compare cis male enhancement to other somatic practices like gender confirmation surgery for trans folks. This strategy brings into sharp relief the ontological assumptions informing each of these practices. Through this comparative analysis, I determined the focus of this project.

Practitioner responses fit within a general typology of themes that were best epitomized by the case examples shared within this dissertation. While the greater number of the quotes I analyze in this manuscript are representative of the primary themes that emerged during interviews, a few quotes that I examine in this project contain relatively unique responses. I included these singular responses because they marked the boundaries of doctors' logics about sexed and racialized bodies (such as Dr. Rosenburg's quote in the section "Denaturalizing the 'Big Black Dick'" in Chapter 6), or because they serve as examples of resistance to dominant discourses (such as Mr. Charles Bennett's quote in the section "Resisting Discourses of Trans Regret" in Chapter 5). In the section that follows, I detail how I examined physicians' discourses.

Discourse Analysis

Foucault has been credited with saying that "People know what they do; they frequently know why they do what they do; but what they don't know is what what they do does" (Dreyfus and Rabinow 1983, 187). Upon learning that male enhancement is the general focus of this project, many people assumed the aim of this research is to uncover why cis men are interested in augmenting their genitals, meaning why they do what they do. While some cis men are uncertain about why they do what they do (see the section "Monster Cocks" in Chapter 6), and medical practitioners are fairly clear why they perform male enhancement procedures, neither are as clear as to what what they do does, which is a matter of discourse. The purpose of this research is to trace what male enhancement discourses do in the materialization of particularly-sexed and racialized bodies. This section briefly lays out how Foucault understands discourse and how his work influences my own.

Foucault employed two methodological approaches to analyzing discourse: archaeology and genealogy. The tools of an archaeological analysis trace the vertical production of discourse—meaning the set of statements that direct what counts as 'truth'—as it operates among various layers of institutional and social contexts (Foucault 1994). Archaeology does not ask 'what is truth?', but rather, "how is it that one particular statement appeared rather than another?" (Foucault 2002, 30). Archaeology, therefore, attends to the conditions in the formation of some statements, and not others; and the

construction of objects of knowledge—such as the 'male body' or 'race'—through the productive capacity of power. The field that enabled the formation of statements and the rules that produced objects of knowledge are the focus of archaeology.

Foucault's (1990) genealogical method, on the other hand, maps the horizontal production of discourse by inciting a rereading of history to unsettle the underlying presuppositions and conditions of knowledge that comprise history. As a history of the present, a genealogical approach poses a question about the here and now and then looks backwards in history to map the power relations that form what counts as 'truth'. Foucault (1984) clarifies that genealogy does not conduct a linear search through history for an origin, design, or foundation upon which the present rests; instead it "disturbs what was previously considered immobile; it fragments what was thought unified; it shows the heterogeneity of what was imagined consistent with itself" (82). A genealogy of the 'male' body, for example, would render visible how maleness is mutable, fragmented, and heterogeneous.

This research deviates from Foucault's genealogical and archaeological methodology, as I do not engage in an historical or textual analysis. However, I follow the example of somatechnicians (Garner 2011) and ethnographers (Whitehead 2012; Moon 2004) who adopt Foucault's conceptualization of discourse to the extent that they can with the data they have generated. Since somatechnics understands discourse and materiality as inextricable—that discourse is constitutive of the contours of our bodies—it is compatible with a Foucauldian conceptualization that affords discourses material existence. Instead of employing an historical analysis to identify the ruptures and fissures between different discursive formations, I use a somatechnic method resembling the research of Fox and Thomson (2009b) and Sullivan (2009b) which juxtaposes similar somatic practices around which different discursive systems form. To borrow Garner's (2011, 45) astute observation, I do not have to analyze the past to "reveal the relations of power through which the body is materialised" because a somatechnic method allows me to examine, for example, the discourses of gender confirmation surgery alongside "the

other real possible statements, which are contemporary to it" in male enhancement discourse (Foucault 1994, xvii).

While I could have conducted a discourse analysis of male enhancement using various texts—including surgery journals or content published online—these texts do not necessarily demonstrate the ways discourses operate at the level of everyday life. Sociologist of gender and sexuality, Dawne Moon (2004) contends, "if we want to look at how people go about reproducing power in the capillaries of everyday thought and interaction, there is a paradox in looking at something so fixed as a text" (12). She suggests that ethnographic methods—including interviews and observations—"add to Foucault's theory of power from a perspective that more closely reflects his theory, by examining the micro-level interactions in which he sees power inhering" (12).

Feminist sociologist Jaye Cee Whitehead (2012) makes a similar argument that interview and observational data enriches an analysis of power.

> Textual analysis cannot uncover how discourses can be forged, appropriated, and locally adapted in particular moments that may never leave an historical trace. [...] Interactive methods allow researchers another lens to study the "capillary" effect of power to bleed its way into seemingly insignificant slices of everyday life and fleeting moments of individual's feelings and thoughts. (20)

Given that some of the discourses physicians invoked in our interviews do not exist in texts, and therefore, "may leave only a thin and ambiguous historical residue for genealogical or archaeological analysis", research like this present manuscript is unique in mapping out their operation, including how practitioners employ or disrupt these discourses in their everyday practices (Whitehead 2012, 21).

Mirroring Nikki Sullivan's (2009) acknowledgement that any intervention into debates about bodies further brings those bodies into being through discourse, I too recognize that "my contribution is no less an effect of the operation of power" (314). My contribution to the generation of knowledge through this research is shaped in part by my situated position. True to a feminist epistemology, which calls for a transparent accounting by the researcher to situate themself in relation to their research, I discuss my positionality in the following section.

Situating Myself

In this section, I offer a necessarily incomplete accounting for how my situated position is reflected in the generation of knowledge for this dissertation. My relationship to the land is one of the conditions that made the production of knowledge in this research possible. I began this investigation while living and working on the unceded, traditional, and ancestral land of the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Səl̓ilwətaʔɬ (Tsleil-Waututh), kʷikʷəƛəm (Kwikwetlem), Qayqayt, and Stó:lō Nations in what is now referred to as British Columbia, Canada.[7] In the territory of the Chumash, Tongva, and Kizh peoples, what is now known as Los Angeles, is where I conducted the majority of my in-person and virtually-mediated interviews. The greater part of my writing this dissertation took place in—to the best of my knowledge—Chinook and Stl'pulmsh (Cowlitz) territory in the Portland metro area.

As a white settler to these territories, and an immigrant to Canada, I was able to accomplish this research due to my general access to and mobility through the world that the privilege of whiteness, access to economic support through my family, and US citizenship affords me, in part as an outcome of the US and Canadian theft of Indigenous Land. While Indigenous Peoples are not at the center of this project on male enhancement, I hope that this manuscript begins to effectively situate the social and historical processes of gender, the sexed body, and race within white settler colonialism as one way of unsettling 'western' history and troubling naturalized categories that continue to shape the lives of Indigenous Peoples today.

In congruence with a constructivist and grounded theory approach, I similarly recognize that the results of this research are not independent of my own epistemological and ontological assumptions—some of which are inevitably unconscious—nor my former education, experiences, and political commitments. In agreement with feminist reflexivity, who I am, what my relationship is to the research, and my commitments to feminist social

[7] The spelling of the Indigenous names listed here reflects the best of my knowledge of these names as well as my ability to use diacritics and other special characters within the limits of the LaTeX program I used to code this dissertation. See native-land.ca for the full spelling of these names. This website also contains continually-updated maps of Indigenous territories, languages, and treaties primarily in North America.

justice organizing guide the kinds of questions that I think merit investigation, the tools I select to answer those questions, as well as the results I co-generated and share in this manuscript. The very act of, for example, selecting male enhancement as my primary field and gender confirmation surgery as a comparative medical practice is an extension of my previous research projects about cis men's body work and the logics of mental health professionals who gatekeep trans folk's access to appropriate medical care (Whitehead and Thomas 2013; Whitehead et al. 2012).

Investigating the 'natural male body', thinking through cisnormativity and trans oppression, and deconstructing racializing discourses—particularly of the Black 'male' body and Asian 'female' body—enable me to locate gendered and racialized operations of power from a relative position of ontological safety. After all, as a woman, it is not my own social location that I am unsettling (however, that project is on the horizon). And as a white cis person, I have the privilege to withdraw, at least to some degree, from the violence of the racializing and trans-antagonistic discourses I analyze in this notably academic text. Whereas for Black and trans communities, the struggle against anti-Black racism and trans oppression is not something they could simply elect to opt out of. So my outsider position in relation to this project is constitutive of the knowledges that I co-created within it, in many ways from a shifting location of systemic advantage.

Both my ethical and political commitments, as well as how my social position was read by participants, shaped every aspect of this research. As an 'undercover' feminist researcher working to end white supremacy, I remained vigilant about how white physicians perceived and interacted with me in ways related to our whiteness, especially during conversations that were explicitly about race and people of colour. Many practitioners such as Mr. Bennett, Dr. Rosenburg, Dr. Lieberman, and others regularly prefaced their comments about race by saying they "do not want to sound racist" or they "in no way mean to be racist", often before making racist comments, as if their intentions are more important than the impacts of their claims.

Whiteness studies sociologist Robin DiAngelo (2018) argues that statements like these demonstrate white fragility: "a state in which even a minimum amount of racial stress

[...] becomes intolerable [for white people], triggering a range of defensive moves" (103) such as anger, guilt, argumentation, silence, leaving the stressful situation without addressing the problem, and—in this particular case from practitioners—fear of being read as racist and a 'bad person'. Statements like "I do not want to sound racist" prioritize protecting whiteness and centering white people's feelings and moral reputations, rather than prioritizing the safety of people of colour from exposure to racist oppression. White fragility is "an outcome of white people's socialization into white supremacy and a means to protect, maintain, and reproduce white supremacy" (DiAngelo 2018, 113). By prefacing their comments about race by assuring me that they are not racist, they are thus positioning me to trust that they are not racist before they are able to speak about race; I understand this as a tactic to solicit white solidarity from me in order to minimize a challenge against their statements, and therefore, against having to reflect on their complicity as white men in upholding white supremacy.

Establishing white solidarity with me during interviews also took the form of jokes that diminish historically-oppressed groups. For example, practitioners' consistent claims about the existence of the 'big Black dick' as a biological, material reality of Black men's bodies coexisted alongside physicians' diminution of the 'threat' of Black men's bodies and sexualities. While speaking about the "shrinkage" that happens to any person's penis as a result of disuse and aging, Dr. Wexler concluded with a chuckle, "Black don't crack, but it does melt". The saying "Black don't crack" is a 'positive' stereotype and refers to the idea that Black people show less signs of aging like wrinkles than other people, namely white people. This assumption is supported by popular (Brinkhurst-Cuff 2016) and racializing medical discourses (Vashi, de Castro Maymone, and Kundu 2016) that Black people as a group have more melanin, natural oils, collagen, and/or a 'thicker' dermis that protect their skin from the wrinkle-inducing rays of the sun and other environmental stressors. So when a white physician like Dr. Wexler jokes that "Black don't crack, but it does melt" he is suggesting that even Black cis men—whose skin may defy wrinkling or "cracking"—are still victim to the aging or "melt[ing]" of their penises; that despite his assumption that Black men have larger penises on average compared to other racial groups, that racially-

determined 'benefit' eventually 'shrinks'. In a society and medical system structured by white supremacy and anti-Black racism like that of the United States where Dr. Wexler operates his private medical practice, it is difficult to read his 'humor' here as if he is not aiming to 'shrink' the cultural value imbued in the 'big Black dick', and solicit white solidarity from me in the form of laughter. Had I not been white, physicians may not have been as comfortable in reproducing racist stereotypes and jokes during our interviews.

The range of possible responses I have at my disposal as a white woman researcher during these moments are still delimited by the operation of power. A tension exists between upholding my ethical commitments to anti-racism and acting in solidarity with people of colour on one hand, and maintaining rapport with participants on the other—not simply to protect my access to the research field, although I predict that would have become a problem had I challenged them repeatedly—but rather, because damaging our rapport would likely have resulted in doctors sublimating oppressive discourses. Reflecting on her ethnographic field research with long-haul truckers in British Columbia, Canada, feminist sociologist Amie McLean (2017) insists that

> immediately and always challenging participants' oppressive talk, and/or consistently and immediately identifying my own anti-racist feminist sensibilities in the face of participants' racism or sexism would likely have silenced participants on those topics, or ended the research encounter altogether. I was increasingly concerned that such self-disclosures, although they would make me feel good about myself, would effectively extend oppressive protections on racist and sexist speech acts and lead to an empirically weak analytics of power by obscuring dynamics of oppression in the industry. (110)

Remaining mindful of this tension, I relied on other tools to navigate practitioner's oppressive discourses. For example, in the course of our conversations, I sometimes framed my challenges to practitioners' claims as positions taken by other male enhancement physicians I had interviewed previously—even when that was not necessarily the case—so that I could still confront oppressive discourses without directing the "range of defensive moves" identified by DiAngelo (2018) against me as a researcher (103). In practice, however, this tactic was only moderately successful. And moreover, I had to be strategic in selecting the moments when I used such artifice. I am not alone in conducting research

with a thin veneer of deception, both for the sake of maintaining rapport, and for generating a richer critique of power through those who experience multiple and overlapping forms of social advantage (Kolysh 2019). Nevertheless, this tactic of using prior interviews as a strategic device for 'talking back' is admittedly inadequate for a larger project of emancipatory politics.

As readers can witness in the quotations I share from practitioners in this manuscript, physicians also regularly erased the existence of gay or queer patients seeking male enhancement, instead referring to all of their cis men patients as heterosexual and only having vaginally-penetrative sex with cis women. This is despite the fact that at the beginning of the interview, many participants identified gay men as a sizable portion of their male enhancement patients.[8] Doctors' exclusion of gay men from our conversations prompted me to include a direct question in my interview guide asking practitioners to discuss their work with gay patients (see the "Semi-Structured Interview Guide" in the Appendix). Undeterred, physicians consistently redirected the conversation back to their heterosexual patients or otherwise evaded my questions. While I pushed back against this pattern of responses, I regret not developing additional interviewing tools to address doctors' assumptions of heterosexuality.[9]

This regret extends to when Dr. Fray (quoted in Chapter 6) assumed that because I am a woman, I have circlusive sex with cis men: "if you were dating somebody and you got in the sack and realized that 'I can't take this guy's penis', the ability to procreate possibly just went out the window". This statement carries a series of other assumptions, including that as a woman, I must have a vagina and the ability to conceive and carry a baby. Feeling uneasy by a research participant talking about and sexualizing my body, I fell silent. Again, 'talking back' against medical experts' statements risked sacrificing the at times shaky rapport I had worked so hard to cultivate with them, and as the quotes in my analytical chapters affirm, there was no shortage of problematic assumptions for me to

[8]For example, Dr. Tabibi, Dr. Lieberman, and Dr. Harris estimated that about 30% of their patients are gay, and Charles Bennett reported that about 50% of his patients are gay or queer. Other physicians, like Dr. Fray, said they could not accurately provide estimates.

[9]See Chapter 6 for an example of how I challenged physicians' heteronormative assumptions.

confront in our interviews. As others have noted (Gailey and Prohaska 2011), to a certain extent, a researcher's comfort is subordinate to the participants' during an investigation—especially when social hierarchies such as gender shape the interview process—because we are dependent upon their participation for the completion of our degrees and for the quality of our data in future publications.

How other people outside of this project perceived and interpreted this research was also filtered through a sexualized, gendered, and racialized lens in reference to my partner. At social gatherings, for example, upon discovering the focus of my dissertation, strangers subjected my partner's body to repeated and invasive questioning centered around the broad assumption that my selection of this research topic necessarily meant something about my partner's genitals. In addition to generally being inappropriate, their assumptions also unwillingly opened up conversations that racialized the sexed body of my Latinx partner. Luckily, my partner's learned, dead-pan rejoinder "why do you want to know about my genitals?" was followed by uncomfortable laughter that usually shut down their interrogation. Nonetheless, these patterned experiences speak to how both my subjectivity, and the embodiment of those relationally connected to me, came to bare on this research.

Like other women researchers whose conceptual object relates to the lives of men and masculinity, I navigated different manifestations of sexism throughout the research process. In many ways, the part I play in this research was assumed to be "inadequate or impoverished because as a woman investigating a male-dominated social arena, I [would] not be able to achieve adequate access or participation" (McLean 2017, 102). Contrary to this assumption, the gender(s) of researchers and participants can shape the process in a number of variable, yet patterned, ways. It is true that the knowledge we co-generated is different because of our respective social locations; if a man or nonbinary person had conducted this research, for example, the knowledge they would have generated with doctors would be different—not because it would necessarily be a more accurate or complete representation of the medical practices of male enhancement physicians—but because it would be just as situated as their claims presented here.

Below, feminist political scientist Cynthia Enloe describes in an interview how her gender and the gender of her participants enabled and circumscribed her scholarship on gender and militarism, and moreover, how the research process would have been different had a man conducted the research instead.

> I think many men were much more willing to talk with me, to answer my "dumb," naive questions with great openness, both because of a kind of genuinely chivalrous generosity and because it was in a sense "normal" for a female to be asking such basic questions. Also, it was relatively easy for me personally to deal with being in the "nonexpert" position. A male colleague who also did interviews with powerful nuclear decision makers told me somewhat ruefully that he and the men he was interviewing would sometimes get into a kind of competitive "who's-the-bigger-expert-here?" deadlock. It was probably quite productive that my relationships with these men did not provoke that kind of dynamic in either one of us! (Cohn and Enloe 2003, 1188)

In many ways, my research benefited from male enhancement doctors reading me as a "naive little lady" (Cohn and Enloe 2003, 1189) rather than as an expert, albeit in different ways than Enloe experienced in her research.

Evidenced in part by my framing of the research in my interview guide preamble, where I state that "[s]ome of these questions may sound really basic or have obvious answers", I had to devise strategies to negotiate how practitioners read my gender as it overlapped with my age during interviews.[10] To quote Dr. Wexler, "you're not that old", he laughed, "I can tell". Armed with several strategies, I aimed to reduce the likelihood that I was read as inexperienced and incompetent, while consciously choosing to not disabuse practitioners of my perceived youthful and gendered innocence, because it seemed to position them as experts who could 'educate' me. Even though it was off-putting for a participant to explain to me what 'intersex' means after I already demonstrated through how I contextualized my question that I am knowledgeable of the concept, doctors' perception of me as not understanding the terminology I use opened up the interview moment in a productive way; physicians assumed a position of "generous chivalry" that resulted in nuanced descriptions of their medical practices, and therefore, theoretically

[10]I conducted the majority of interviews at the age of 26.

rich data that I likely would not have obtained had they read me as an expert (Cohn and Enloe 2003, 1188). Even though it was frustrating when doctors repeatedly interrupted me, referred to participating in this dissertation as "helping [me] with a class paper" or "little project", or instructed me on what questions I *should* be asking or topics I *should* be researching (which is similar to Arendell's (1997) experiences),[11] on the other hand, their treatment of my youth and white femininity as green naivete also seemed to orient their responses to be patient with me and to excuse my 'basic' questions.

At times, my femininity and presumed heterosexuality served as a resource for some practitioners' enactment of (heterosexual) masculinity. This both facilitated my access to the field, and necessarily foreclosed some research opportunities. For example, Dr. Perry confided in me that he had performed his male enhancement procedure on himself. After the augmentation he said it was "kinda weird to look in the mirror and go 'wow, you probably could be a porn star'" and "I've only seen two penises bigger than mine in all the stuff [procedures] I've done [on patients]". While I was uncomfortable with the abrupt shift in our conversation towards a more intimate (and extended) discussion of Dr. Perry's genitals and sex life—neither of which I ever invited—the moment of his 'exceptional disclosure' (Jenner and Myers 2019) was also characterized by vulnerability that my gendered embodiment and perceived heterosexuality likely made possible. Dr. Perry was the only participant in this sample who disclosed that he had enhanced his own genitals; however, he was one of several practitioners to talk about their penis during our interview.[12]

My age, gender, and perceived sexuality functioned in other ways during the recruitment and interviewing processes that did not benefit the research, nor me. As one example, a retired doctor I invited to participate stated that he would only agree to an

[11]For example, Dr. Schneider told me I should do "a study on female genital aesthetic surgery" only to acknowledge immediately afterwards that it "has been done, okay", but that men who pursue male enhancement are "wacky" and "nuts" so "I don't know why you're doing a study on [male enhancement] to be honest". He also told me "It would be more interesting for you to do a study on the psychology of the doctors that do the surgery than it is on the results. Okay cause there's a lot of psychopathology in the doctors that do the surgery."

[12]Even Mr. Bennett who self-identified as a gay man felt the need to convince me that he has a sizable penis: "I mean, I'm not- I don't have anything- any insecurities with the size of my penis. I haven't- *I assure you I have a big penis*, I mean you don't care, but I mean I'm not- I'm not- I don't have a huge penis um but I'm not insecure about it" [emphasis added].

interview if I joined him at his farm where he would "enlighten" me about male enhancement by *personally* "show[ing]" me the results of his enhancement procedures. Suffice to say I declined his proposition, and therefore, the interview.

Negotiating Vulnerability

My social location as a woman who has experienced sexual violence from cis men is not something I can remove from my history or from my everyday reality in some unrealistic effort to be 'objective'. It is unsurprising that those experiences inform the ways in which I read practitioners' comments about such violence in Chapter 6. Those experiences also play an important part in shaping what considerations and precautions I felt were necessary to undertake when deciding how to conduct this research. This project was originally approved by the SFU Research Ethics Board (REB) to include interviews with cis men interested in male enhancement, but I elected not to conduct those interviews—either in person or virtually—not because there proved to be an imminent threat, but because I was not provided any tools to effectively navigate the risks if participants did become violent.

In contrast to other projects overseen by the SFU REB approval procedure, where a cis woman researcher's safety while alone with men who work in the long-haul trucking industry was a point of concern for the institution (McLean 2017), the only populations considered by the SFU REB to be vulnerable and in need of safeguarding in my work were my participants. This caught me by surprise as my ethics application made clear that I planned to be alone with cis men in secluded spaces that offered a high degree of privacy while talking about their genitals and erotic practices. The total absence of any discussion from the REB reviewers about my safety from men's violence, compared to their apprehension about protecting another woman researcher from the presumed violence of working class men specifically, is fraught with problematic assumptions that frame working class men as particularly dangerous, and men *in general* as innocent of sexual and other forms of violence.

This is despite the fact that some of the men active on the male enhancement forums I observed echoed the same sentiments and aggrieved entitlement to women's bodies

espoused by misogynist networks domestic to the United States and Canada like incels (see Chapter 4 for more context). While I cannot and would not suggest that all men generally—or all men seeking male enhancement specifically—are violent or would otherwise pose a danger to me, that does not efface the patterned directionality of gendered violence by cis men against cis women and others (see Berns 2001). Moreover, there is a wealth of evidence that women researchers are exposed to violence due to their close proximity to, dependence on, and vulnerability to men during their field research (Schneider 2020; Huang 2016; Gailey and Prohaska 2011; Sharp and Kremer 2006; Arendell 1997; Moreno 1995; Green et al. 1993). In fact, women researchers' exposure particularly to sexual violence is an entrenched problem that Sharp and Kremer (2006) suggest is pervasive in social science research. Why were these social and material facts not foregrounded when evaluating the risks of conducting this research and considering how to institutionally support me as a woman researcher?[13]

In part, the violence McLean (2017) could have been exposed to during her long-haul trucking ride-alongs and truck stop visits may have seemed to the SFU REB to be explicitly physical and immediate compared to the dangers of conducting my research. I largely disagree with that characterization. However, even if we were to assume that physical or sexual violence would have been less likely in the private and secluded spaces where I had planned to conduct this research (out of concern for participants' privacy), those are not the only forms of possible violence. Doxxing, for example, is the practice of searching publicly-available internet content and social media websites, hacking personal electronic devices, and engaging in social engineering to obtain, use, and publicly broadcast private

[13]Anthropologist and ethnographer Luisa Schneider (2020) identified a multi-step process her institution required for receiving research ethics clearance, which included systematic considerations for the primary investigator's safety. However, Schneider largely identified this process as "academic bureaucracy" reflecting the neoliberal university's aim for researchers to be "'risk assessors' and 'risk takers'" while protecting the institution from liability: "If a difficulty cannot be resolved successfully this is attributed to a researcher's risk susceptibility, lack of preparation, faulty management strategy, or flawed professionalism, while institutions wash their hands of responsibility. [...] I expected questions along the lines of: how can we better prepare researchers for these scenarios and respond to them? But I was asked how dangerous, on a scale from 1-10, did I think Sierra Leone was for women, and whether women should be restricted from carrying out fieldwork there. Their solution seemed to be 'restrict to protect'. Rather than learning to navigate unpredictability, which is an essential part of human interaction anywhere, they attempt the impossible: its erasure" (178).

and identifying information such as work and home addresses. Critical academics generally, but feminist women specifically, are increasingly subject to doxxing (Kelley and Weaver 2020; Sarkeesian and Cross 2015) and other online harassment (DeGroot and Carmack 2020; Vera-Gray 2017). Conducting research with cis men connected to and supported by like-minded men from virtual homosocial spaces like male enhancement forums seemed to only make those risks more probable.

Unfortunately, in lieu of receiving institutional support, the advice offered to women researchers—if it is ever offered at all—reads much in the same way as behavioral adjustments women must make to 'avoid getting raped': do not enter into dangerous situations and topics with men participants, especially related to emotional or sexual themes; always meet during the day in public places; interview participants in pairs; become aware of your surroundings by familiarizing yourself with the interiors of buildings, exits, and nearby streets; avoid carrying something that will weigh you down if you need to escape; program your cell phone with emergency numbers; dress conservatively and wear minimal makeup; on and on ad nauseam (see Gailey and Prohaska 2011; Sharp and Kremer 2006).

After a man sexually assaulted her during her field work, social anthropologist Luisa Schneider (2020) reflected on these suggestions for women's behavioral adjustment:

> These 'prevention strategies' adopt a rhetoric which makes women directly responsible for violence endured and complicit in their own discrimination and victimization. It not only assumes that women can somehow foresee all eventualities, but have themselves to blame in case they can't. (188)

In preparation for recruiting cis men participants, I thought through similar forms of "safety work" (Vera-Gray 2017), such as modifications to my comportment and embodiment in the absence of institutional support. For example, from my key ring, I removed a rewards card key tag to a local grocery store specific to my neighborhood so that if participants happened to see my keys, they would not be able to easily locate the neighborhood where I live—or at the very least—identify where I buy my weekly groceries. With my own resources, I contracted a professional to search the internet for private information about me using content participants would obtain from the standard consent form, such as my name, email,

telephone number, and university affiliation.[14] He not only located a wealth of information about me, but was able to connect it to my family. There were too many possible risks, and I could not foresee or manage them all on my own.

While I am not looking to invite more bureaucratic micromanaging of research projects from ethics boards who are positioned to protect the neoliberal university against liability moreso than to protect researchers (Schneider 2020; Huang 2016), I would be remiss if I did not comment on how my graduate education and the process of gaining research ethics approval left me unequipped to handle the potential risks of conducting the research I originally proposed. That is why I elected in this project not to interview cis men interested in male enhancement; I did not have the necessary tools and institutional support to navigate the potential, but very real risks to my safety that other women academics have faced while conducting research in the field (Schneider 2020; Huang 2016; Moreno 1995), especially with men participants (McLean 2017; Sharp and Kremer 2006; Arendell 1997), and while discussing sexual themes (Gailey and Prohaska 2011; Green et al. 1993). I join others in calling for institutional accountability for supporting academics who face gendered and other forms of systemic violence in the field (Schneider 2020; Huang 2016), recognizing that the absence of such support impacts every aspect of research, including if that research is even carried out.

In the remainder of this dissertation, I map the invocation of the 'natural' and the 'unnatural' in medical discourse across practitioners' private practices. In the next two chapters, I start with a comparative discourse analysis of male enhancement for cis men and gender confirmation surgery for trans people, demonstrating how various discourses operate to naturalize one's sex assignment at birth. Then I transition into the second thematic section of this dissertation, which examines how male enhancement practitioners selectively invoke the trope of the 'monster cock' in ways that naturalize heterosexuality, the 'reproductive body', whiteness, and the male body while (de)naturalizing the bodies

[14]The SFU library requires investigators to remove all contact information from the consent form before publishing it in the dissertation.

of cis women and the sexed bodies of people of colour. By attending to the norms, histories, and discursive regimes attendant to these clinical contexts, I demonstrate how medical discourses are a technology of the natural through which particularly-sexed and racialized bodies and subjectivities are constituted, and how the 'natural' and 'unnatural' are leveraged against historically-oppressed groups.

Chapter 4

Authenticity and Suffering: Juxtaposing Gender Confirmation Surgery and Male Enhancement Discourses

> *"How do you know you want rhinoplasty, a nose job?" he inquires, fixing me with a penetrating stare.*
> *"Because," I reply, suddenly unable to raise my eyes above his brown wingtips, "I've always felt like a small-nosed woman trapped in a large-nosed body."*
> *"And how long have you felt this way?" He leans forward, sounding as if he knows the answer and needs only to hear the words.*
> *"Oh, since I was five or six, doctor, practically all my life."*
> *"Then you have a rhino-identity disorder," the shoetops state flatly. My body sags in relief. "But first," he goes on, "we want you to get letters from two psychiatrists and live as a small-nosed woman for three years...just to be sure."*
>
> —Riki Anne Wilchins,
> *Read My Lips: Sexual Subversion and the End of Gender*

The absurdity of the epigraph above critically illustrates the differential treatment of cis people seeking medical interventions like 'cosmetic' surgery to alter their anatomical structures, compared to the gatekeeping of trans people pursuing 'gender confirmation' surgeries in Canada and the United States. A growing number of scholars are comparing the prohibitions and justifications of cosmetic surgeries elected by cis people with 'transition' surgeries elected by trans folks, taking up one of four different comparative

approaches identified by Heyes and Latham (2018). Some social critics like Jeffreys (2014) argue that both of these sets of surgeries are medically unnecessary and ethically problematic, where both trans and cis patients are capitulating to normative gender. On the other hand, some trans advocates make claims described by Heyes and Latham (2018) as "trans exceptionalism", where gender confirmation surgeries are framed as medically necessary, but cosmetic surgeries for cis people are not (174). For example, bioethicists Ashley and Ells (2018) suggest that, at least in most cases, cis people do not experience oppression based on a "core aspect of the self" such as gender, so procedures for cis people are not "morally necessary" like those elected by trans folks, and therefore, cis people have no ethical claim for health insurance to cover cosmetic procedures (25). Other trans/gender scholars (see Latham 2017; Garner 2011) have analyzed discursive devices similar to those employed by participants in this research, who—as I demonstrate below—argue that cosmetic genital surgeries elected by cis people are acceptable somatic interventions for self-improvement compared to gender confirmation surgeries, which are marked as 'unnatural' interventions into the sexed body.

I enter into this ongoing conversation, joining trans/gender studies scholars (Whitehead and Thomas 2013; Whitehead et al. 2012; Garner 2011; Stryker and Sullivan 2009; Spade 2003; Wilchins 1997) whose analytical approach is characterized by Heyes and Latham (2018) as "fruitfully" comparing cosmetic surgeries for cis people with gender confirmation surgeries for trans folks "without either being judged negatively" (176). My purpose in this analysis is not to frame medical interventions into the body—like gender confirmation surgery or 'male enhancement' procedures—as liberatory or oppressive; but rather, to understand what the discourses in each of these medical contexts 'do' in terms of the materialization of particularly-sexed and racialized bodies, gender identities, and the relationship between them.

In this and the subsequent chapter, I underscore the contradictory medical management of trans and cis patients who are seeking access to genital technologies by analyzing the (de)naturalization techniques of various discourses as they emerge within the medical contexts of male enhancement procedures for cis men and gender confirmation

surgeries for trans people. In many ways, these medical contexts overlap. Of the twelve practitioners quoted in this chapter and the next, five dedicate the majority of their practice to gender confirmation surgeries while also performing male enhancement procedures; one physician previously worked with trans patients as a medical student, but now works only with cis men in his private practice; and the remaining doctors perform genital interventions exclusively for cis patients.

The aim of this chapter is to trace various discourses that naturalize the 'male' body while rendering trans bodies unnatural. I locate these discourses in part when medical practitioners are screening a new trans or cis patient by evaluating patient *authenticity* and *suffering*. In the subsequent chapter, I continue this analysis, unpacking the discourses that operate in relation to performing each procedure (by assessing *harms* to the patient) as well as the discursive devices employed during the post-operative evaluation of somatic interventions (such as patient *regret vs. dissatisfaction*). Taken altogether, these discourses serve as naturalizing techniques of the sex assigned to bodies at birth. As I demonstrate in this and the next chapter, these naturalization techniques pathologize particular racialized somatic practices alongside the subjectivities and post-surgical bodies of trans people, marking them as unnatural constructions, while naturalizing cis bodies and subjectivities, both before and after going under the proverbial knife.

These two analytical chapters most closely resemble, confirm, and build on many of the arguments in T. Garner's (2011) analysis in their dissertation chapter "Chest Surgeries of a Different Nature". Garner analyzed in part the ontological presuppositions underlying gynecomastia[1] surgery for cis men with unwanted breasts, compared to chest surgery for trans folks with unwanted breasts. Their critical work in the scholarly tradition of somatechnics examined how the discourse of harm—understood through conceptions of disorder, regret, authenticity, and bodily integrity—operates in codified

[1] Gynecomastia is a medical diagnosis of "excess" tissue in the chests of mostly cis men, thought to be caused by a hormonal "imbalance" (Johnson and Murad 2009, 1012; see also Longhurst 2005). However, mental health professionals in the US have also used the diagnosis of gynecomastia so that trans folks—particularly trans men who also have unwanted chest tissue—can gain access to appropriate medical care.

medical texts about gynecomastia for cis men, compared to medical texts on chest surgery for trans patients. They ground their analysis in clinical guidelines, influential articles from surgery journals, and historical approaches to medical intervention. Garner's insightful work persuasively contends that the discourse of harm in the context of gynecomastia surgery naturalizes cis men's bodies, yet harm operates in the context of gender confirmation surgery to denaturalize the post-surgical trans body.

I did not predict that male enhancement practitioners would echo so closely the discourses Garner located in medical texts. I anticipated a wide range of responses to the open-ended question I posed to them, and which informs the majority of the analysis for this and the subsequent chapter: "in your professional opinion, why do you suppose transgender patients need to get letters from mental health professionals[2] in order to access genital surgeries, whereas your cisgender patients do not?" Male enhancement physicians employing similar medical discourses found in codified texts on gynecomastia and trans chest surgeries speaks to the stranglehold of (de)naturalization techniques within medicine, the embeddedness of male enhancement practitioners in the medical establishment, as well as their investment—or at the very least their involvement—in upholding the status quo of medicine and the notion of the 'natural' gender and sex binary.

With that said, my research design and analysis within this chapter and the next depart from Garner's work in four significant ways. First, analyzing discourses about genitals instead of breasts anchors my research in different locations of the sexed, gendered, and racialized body, thereby expanding and complicating our understanding of bodily meanings. Second, I foreground medical discourses and practices within the clinic, rather than in codified texts, enriching our understanding of how these two may overlap or diverge. Third, the texts Garner selected were specific to each medical procedure; no

[2] 'Mental health professionals' may include clinical psychologists, medical doctors who specialize in psychiatry, licensed family therapists, and counsellors who are able to write letters in support of gender transition, as outlined in the "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7" (2012). Many trans folks seeking access to somatic technologies experience their pursuit of these professional letters as compulsory, whereas cisgender patients do not need to obtain anyone's approval except the surgeon's for genital intervention (Latham 2017).

single text was attendant to both gynecomastia surgery for cis men and chest surgery for trans folks. My interviews with physicians were attendant to both male enhancement and gender confirmation surgery at the same time because, as I stated previously, many of the doctors who participated in this research specialized in both procedures. Practitioners whose medical practices bridge these two contexts enabled me to bring these two procedures in relation to each other during interviews.

Finally, Garner's work foregrounds many of the specific, technical elements of each surgical procedure, deconstructing, for example, how medical texts bring into being 'proper' placement of the nipple on trans and cis bodies. My research takes a broad approach, focusing less on the specificity of each male enhancement procedure (of which there are many represented in my sample) compared to different genital interventions for trans patients (of which there are many and I do not describe any in detail). The analysis in this and the following chapter centers on physicians' medical practices, particularly how they decide to accept a new patient, as well as their justifications for gatekeeping trans patients' access to genital technologies while constructing very few barriers for cis men. Moreover, male enhancement practitioners did not always make identical claims as those Garner found in codified medical texts, and I call attention to those differences throughout my analysis, especially in the subsequent chapter.

My analytical method oscillates between two approaches. At times I present evidence that contradicts the assertions made by medical practitioners. However, the strength of my argument comes from my primary analytical approach of somatechnics, which allows me to explicate what physicians' discourses of authenticity, suffering, harm, and regret vs. dissatisfaction 'do' in the incarnation of bodies. Similar to Garner's (2011) conclusions, the discourses employed by medical practitioners in this research do particular work that shapes people's life chances, namely naturalizing cis men's bodies, while marking post-surgical trans bodies as unnatural, thereby lending legitimacy to the violence enacted against trans people in service of the 'natural' body. The following two chapters are interventions into tracing the work of these discursive devices and the operation of power.

Authenticity

Under a cisnormative society in Canada and the United States that assumes one's assigned sex at birth will—by 'nature's design'—'match' one's gender identity, authenticity for cis people is an ontological presupposition, whereas trans people are positioned within both clinical and broader social contexts to prove themselves authentic. In many ways, being read as authentic is essential to the life chances of trans folks. The everyday violence of deadnaming trans people—using given birth names instead of gender-affirming chosen names—as well as misgendering trans folks serves as a threatening reminder of cisnormativity that casts doubt on trans authenticity. So-called 'bathroom bills' in Canada and the United States mark and exclude trans people from social life by legislating when, how, and if trans folks can use the restroom. These bills criminalize especially trans women as not authentic women, as 'males' who are deceptive about who they 'really' are as a means to gain access to 'women's spaces' to harm innocent (which is racially inflected as white) cis women and girls (Phipps 2019; Travers 2018). Trans folks—particularly Black and Brown trans women—are systematically made vulnerable to people who target them with violence; new records are set each year in the United States for the number of trans lives taken through racist and cis-sexist violence (see Gill-Peterson 2018a). The inaction of police and the broader community to prevent these murders; hold perpetrators accountable; let alone accurately report about these murders without deadnaming, misgendering (Strangio 2018), or whitewashing victims (Lamble 2008) demonstrates the degree to which trans people of colour are dehumanized in Canada and the United States. Vulnerability to or security from this violence can, in many ways, hinge on whether trans folks are read as authentic or not.[3]

At the same time, trans people have gained more visibility in Canada and the United States, prompting particular strategies to emerge for managing and integrating trans people into existing institutions, social structures, normative practices, and sets of social relations. Prevailing strategies include the liberal humanist politics of tolerance

[3]Authenticity does not refer to 'passing' as cis. It refers to being recognized as one's gender and/or sex.

(Gressgård 2010), which at once calls for trans acceptance, while also circumscribing trans normativity—or what it means to be acceptably, and therefore, authentically trans—through normative investments in whiteness, heteronormativity, and middle class respectability politics (Vipond 2015; Skidmore 2011; Beauchamp 2009). Tolerance and acceptance are, at least provisionally, afforded to trans folks largely through established narratives of authenticity under the objectifying gaze of psychology and medicine; in such an asymmetrical relationship between gatekeeping authorities and trans individuals, gender experts seek to authenticate if someone is—to borrow sociologist Spencer Garrison's (2018) terminology—'trans enough' to gain access to hormone therapy and gender confirmation surgeries. 'Trans-positive'[4] mental health professionals work to establish trans authenticity, requiring patient narratives to largely confirm practitioners' theories of gender as binary, immutable, innate, and therefore, aligned with particularly sexed bodies (Whitehead et al. 2012).[5]

Being read as authentic can produce a ripple effect in the life chances of trans people. According to the Standards of Care (version 7, 2012), which outline the best practices in the treatment of Gender Dysphoria, mental health professionals can write letters of support for trans patients to access surgeries that 'confirm' their gender as authentic through somatic transformation.[6] However, in the majority of cases, the trans patient must go through what is colloquially referred to as the 'real life test' to prove themselves authentic by living in their affirmed gender, sometimes waiting years to receive letters of support from mental health professionals while paying them large sums of money in order to gain access to somatic

[4]The term 'trans-positive' as it is used here describes mental health professionals and/or surgeons who support trans individuals' rights to self-determination. I place this term in quotation marks because this is not my label, and it is politically contentious.

[5]For examples of alternative approaches to mental health treatment for trans patients, see the section 'Queering Gender' in Whitehead et al. (2012), which describes the practices of mental health professionals who grant trans folks access to hormone therapy despite patients not conforming to the diagnostic criteria in the DSM. These practitioners understand gender as a larger power structure, rather than as a natural binary that stems from an unchanging and essential core.

[6]According to a report authored by the American Society of Plastic Surgeons, gender confirmation surgeries are not divided by type of procedure, but by the binary, with "Male to Female patients" numbering 3,359 and "Female to Male patients" totaling 7,626 in 2019. Combined, these figures demonstrate a fifteen percent increase in surgeries from 2018 to 2019.

technologies. While not all trans people want these surgeries, for those who do, accessing them can not only produce comfort in one's body and gender euphoria (Ashley and Ells 2018; Benestad 2010; Spade 2003), they can also enable social and legal recognition and the ability to change gender markers on official identification like passports and driver's licenses, all of which can lead to a degree of harm reduction (see Travers 2018).

However, many feminist and trans/gender scholars (Sadjadi 2019; Garrison 2018; Simon 2015; Hird 2002) critique authenticity narratives as reflections of social expectations of gender, rather than a sincere sense of oneself.[7] Sociologist Meagan Simon's (2015) treatise on the oppressive demands of authenticity narratives—particularly for trans children and youth—demonstrates how tolerance and acceptance of trans people are

> routinely substantiated through the idea of 'true self' – gender identity is innate and unalterable; therefore, we should accept young trans people as 'who they are.' Justifying trans acceptance through the idea of 'true self' in many ways demands an untenable permanence [....] Trans truth or 'authenticity' becomes characterized as a stubborn and heroic fixity [...] an "inner truth" (Gressgård 2010, p. 544) separate from a variously hostile or tolerant society [....] [T]hese 'true self' narratives restrict and normalize the meaning of trans to an individualized and permanent gendered reality, which erases and partially negates years of trans/gender activism and scholarship denaturalizing the essentially autonomous subject and theorizing gender as a system of power. (2-3) [reference in original]

As I detail in the following section, trans authenticity continues to operate within medical contexts as an inherent, immutable, 'inner truth' irrespective of social conditions, as well as the master criterion for determining whether psychiatric and medical practitioners will give trans people access to appropriate health care like genital technologies. Cis authenticity, on the other hand, is taken for granted as grounded in their sexed bodies, serving as a technique to naturalize one's sex assigned at birth.

[7] I hesitantly cite Sadjadi's work here since trans scholars and activists like bioethicist Florence Ashley (2019b) have serious concerns about Sadjadi and her work. In particular, Ashley notes that Sadjadi's scholarship imagines gender acquisition as "internally constituted", criticizes the use of puberty blockers among trans youth, and "has been cited favourably by anti-trans and conservative outlets".

"Weed Out the Real Ones": Skepticism of Trans Authenticity

No participant in this research was as loquacious as Dr. Fray, whose responses throughout our nearly three-hour interview were particularly telling about the differential medical management of trans and cis patients. Dr. Fray is a US practitioner who formerly worked with trans patients as a medical student, but now exclusively works with cis men, including performing the Priapus-Shot for a handful of years, and the Man Shot over the last several months.[8] The Man Shot procedure aims to augment penile girth by injecting stem-cell-enriched autologous fat—meaning enriched fat coming from one's own body—subdermally outside of the corpus cavernosum and corpus spongiosum, the erectile tissue of the penis. Dr. Fray is confident that the Man Shot that he administers can increase the circumference girth of a man's penis by over an inch.

Multitasking during our interview, Dr. Fray was lounging at home on a Saturday watching wrestling matches on TV. In between matches, he replied to my question as to why trans folks must go through counseling and receive approval to access genital technologies, but his cis male enhancement patients do not.

> [T]here's intended discrimination by the medical and insurance establishment against adults who feel trapped in their own gender for the purpose of trying to *weed out the real ones and the ones who are in a flux*. My guess is that if there was one surgery done out of a hundred that resulted in reassigning someone who- either was for the wrong reasons- or somebody who *recanted their intent* and maybe there was a lawsuit. [emphasis added]

Practitioners' trepidation about "real" trans people versus those who may be confused, undecided, "in a flux", or otherwise 'fake' was common throughout my interviews with physicians, and reflects how authenticity is not limited to autonomous, self-authorization. Dr. Fray's statements reveal the 'intercorporeality' of trans identification (Sullivan 2006), where trans people's claims to identity must align with an established array of criteria, often decided by cis authorities on gender, to gain access to appropriate medical care (Whitehead and Thomas 2013; Whitehead et al. 2012). As we see in Dr. Fray's response, just "one surgery

[8]In some cases, I elected to omit the number of years a physician has been offering male enhancement or gender confirmation surgeries to maintain confidentiality. Reported years of performing particular procedures reflect physicians' experience at the time of our interview.

done out of a hundred that resulted in reassigning someone who- either was for the wrong reasons- or somebody who recanted their intent" is one surgical and social reassignment too many for practitioners, demonstrating an exceptionally high requirement or threshold of certainty in a trans patient's identity out of speculation about potential lawsuits. Such a threshold of certainty is not required for cis patients, despite the possibility that they might pursue postoperative litigation as well.

While Dr. Fray expressed his unease about the possible legal ramifications for medical practitioners performing gender confirmation surgeries on patients who might later "recant their intent", Dr. Schneider voiced his apprehension about patients who are not "true transsexual[s]" obtaining gender confirmation surgeries, resulting in a "total change of identity". Dr. Schneider is a US surgeon who has more than twenty years experience specializing in gender confirmation surgeries, having performed hundreds of procedures for trans patients. He also performs 'corrective' procedures for 'buried penis syndrome',[9] as well as revision surgeries for 'failed' penile enhancements performed by other doctors. He previously performed both girth and length enhancements for cis men, but within a year of offering these procedures to patients, he quickly stopped the practice. After abandoning most male enhancement surgeries over twenty years ago when he realized the procedures resulted in "high complication rates" and poor outcomes, he now only occasionally performs penile length enhancements for cis men. These length enhancements sever the suspensory ligament that keeps the penis tucked up under the pubic arch and into the body. Releasing this ligament hypothetically allows the penis to extend outward from the body and—according to some physicians—can result in up to two inches gained in length; however, Dr. Schneider is not confident in such a good outcome, and therefore, tries to convince all of his patients who want length enhancements not to pursue the procedure.

[9]Urologists Ho and Gelman (2018), describe buried penis syndrome as it relates to the 'normal': "A buried penis refers to a normal sized phallus encompassed by either skin, subcutaneous tissue, and/or fat in the prepubic area. Due to reduced visible and functional length of phallus, this condition is often associated with patient dissatisfaction related to cosmetic, hygienic, voiding, and sexual dysfunction" (618). During interviews, medical practitioners—most notably Dr. Schneider—characterized cis men with 'buried penis syndrome' as the cis patients most deserving of access to male enhancement technologies.

During our interview, while he was waiting at the airport to board an international flight, I strained to hear Dr. Schneider over the poor cell reception echoing my every word, the cacophony of sounds—from travelers at the airport, to overhead speakers announcing flight times—and Dr. Schneider's congested voice as he was recovering from a terrible cold. After finding a more secluded lounge in the airport, Dr. Schneider responded as to why "we have a shrink with transsexuals".[10]

> [W]hen you do transgender surgery, you're taking their testicles off and you don't want to do that on somebody *unless you're one hundred percent sure that they're a true transsexual* and whether or not they can handle it emotionally. So what we're talking about, there's a much more *dramatic surgery* and a *total change of identity* [....] [Y]ou're cutting off testicles, you know you're turning a male to girl or vice versa and *that's a major change, that's not improving someone's aesthetic appearance. That's making a major change in their identity.* So the *severity* of that kind of procedure is is much more. And that's why there's standardization that's done by an organization to make sure that patients who undergo this are good candidates. [emphasis added]

Here Dr. Schneider distinguishes trans operations from cis male enhancement by claiming that cis men are merely "improving [their] aesthetic appearance" through penile augmentation, rather than making a "major change in their identity" through a "dramatic surgery". It seems as though Dr. Schneider frames male enhancement as less "dramatic" than gender confirmation surgeries—not because it is less physically invasive, but rather—because he assumes that identity change is necessarily difficult to "handle it emotionally". Perhaps in part due to expectations of stoic masculinity, and due to expectations of cis authenticity, Dr. Schneider assumes that male enhancement is not (as)

[10]This project does not use the language of 'transsexuality'; however, it has been common language amongst trans scholars and activists (Namaste 2000; Prosser 1998), as well as the medical practitioners who participated in this research, especially amongst the doctors who specialize in gender confirmation surgeries. Many trans folks reject the classification 'transsexual'—both as an adjective and as a noun—because it is a medicalized discourse that objectifies, pathologizes, and dehumanizes trans people (Gill-Peterson 2018a). According to trans somatechnician Jules Gill-Peterson (2018a), the term 'trans' marks "a political distinction from medical or pathological meanings that have accrued to the term 'transgender' in recent years, many of which have been borrowed from the earlier term 'transsexual'" (8). Transsexuality invokes a particular "medical discourse and biopolitical aparatus, a colonial form of knowledge with racializing and disenfranchising effects" (Gill-Peterson 2018a, 8-9). This present manuscript understands and employs the term 'trans' as encompassing more bodies and identities than 'transsexuality'.

emotionally difficult as gender confirmation surgery, an assumption common amongst most physicians in this research.

The suggestion that trans folks are undergoing a "total change of identity" through bodily transformation implies that the sexed body assigned at birth—particularly based on one's gonads—is the origin of identity, and that somatic intervention necessarily changes one's 'core' sense of self. I challenged Dr. Schneider's notion that identity is rooted in the sexed body, as well as his presupposition that bodily intervention through gender confirmation surgeries is the singular and most pivotal moment of identity change for his trans patients (rather than any other point(s) throughout a trans person's life, rather than an ongoing fluid process of gender play and accomplishment). Upon doing so, Dr. Schneider became noticeably vexed by my questions. While he conceded that, for trans patients who had been living as their affirmed gender for years, access to genital technologies merely "finishes up the identity", he immediately doubled down on his reasoning that "it's a total change of identity too. Instead of an improvement it's a total change." Dr. Schneider's position on gender confirmation surgery prioritizes the sexed body as the natural source of gender. And for this reason, he concluded that mental health professionals as well as medical doctors need to establish the authenticity of trans identities before cautiously opening the gate to gender confirmation surgeries.

Dr. Fraser echoed similar assumptions during our interview in his office. A Canadian physician, Dr. Fraser specializes in gender confirmation surgeries, but has recently started performing suspensory ligament releases, fat injections for girth enhancement, and scrotal reduction for cis men in the last few years. In the professional opinion of Dr. Fraser, male enhancement procedures merely improve one's embodied masculinity, a sense of masculinity that Dr. Fraser believes cis men already "have". Alongside these assumptions, Dr. Fraser articulated a cautious approach to working with trans patients seeking gender confirmation surgeries out of concern that trans identification may be a "phase", reflecting a medical approach that casts doubt on trans identities as authentic. When I asked Dr. Fraser why cis men are not required to go through counseling, but trans patients must see mental health professionals in order to access genital technologies, he hesitated at first, saying:

> I I really don't know [....] I think that the perception is that if you want to change your gender, they want to make sure that you're really of sound mind and body. Sometimes it's just tabled off as '*oh they're going through a phase'* or *'they really don't know what they want.'* They want to establish that they know exactly what they want, they know the risks and benefits, they're making an informed decision, and I mean that's different—switching sexes versus just wanting to *improve what you have*. [emphasis added]

Like Dr. Schneider, Dr. Fraser differentiates between male enhancement as an intervention for cis men to "improve what [they] have", and gender confirmation surgery as "different", as "switching sexes", as requiring a higher threshold of proof that trans patients "know exactly what they want". In other words, Dr. Fraser plainly articulates that the body provides the material truth of gender identity.

In both Dr. Schneider and Dr. Fraser's characterizations that contrast trans and cis genital interventions, they invoke the ideas of cis fixity alongside trans movement through transition. The use of genital technologies on cis men, according to practitioners, results in the maintenance, improvement, or restoration of one's body and one's self, which doctors describe as a minimal change to an otherwise fixed reality, rather than a radical gender and sex transition. Drawing on Garner's (2011) somatechnic comparison between trans chest surgery and cis men's gynecomastia surgery, they write "the distance between the pre-surgical body and the post-surgical body [of cis men] is figured as minimal through the absence of any preparatory requirements for the shift from one to the other" (135). Comparatively, gender confirmation surgeries are medically

> 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 [of trans people] as far from each other, across an almost impassable border, and serve to strengthen the sexual divide. (Garner 2011, 135)

Like gynecomastia surgery, male enhancement is regarded as a minor improvement, from a male body with a small or 'average' penis, to a male body with an 'average' or large penis. There is no discussion of cis men going through a 'real-life test' of having a larger penis—resembling the satirical psychotherapy session illustrated by Wilchins (1997) at the beginning of this chapter—to prove they are ready for life as men with larger cocks. Gender

confirmation surgeries, on the other hand, are characterized as traversing a somatic crossing from one sexed body to its 'opposite', and trans folks are required to provide mental health professionals with convincing evidence that they are truly ready for this movement between sexes.

Similar to Garner's (2011) analysis, I found that male enhancement practitioner's comments demonstrate how their differential conceptualization of the distance between pre and post-surgical bodies for cis and trans folks serves to naturalize cis identification, the sex assigned to bodies at birth, and the gender/sex binary. This is accomplished by framing gender confirmation surgeries as a dramatic, major somatic and identity change; by treating male enhancement—not as a gender or sex 'transition'—but as an improvement of one's sexed body as a 'natural' fixity, despite bodily intervention; and by imagining femaleness and maleness as mutually exclusive (and exhaustive) opposing categories separated by a great expanse of territory.

In all of these cases, where physicians cite concerns about trans authenticity, medical practitioners make two interrelated assertions: the assumption that healthy identity is innate, immutable, and located within the sexed body; and metaphysical skepticism, that is a doubt about the authenticity, stability, and permanence of trans identity, because it culturally 'contradicts' the sex they were assigned at birth. This skepticism about trans authenticity reflects both medical and wider social anxieties that there are fakes—people who are confused, undecided, or otherwise "in a flux" and not 'really' transgender—who will change their minds after a surgery. Practitioners' anxieties about 'fake' trans people are compounded by a perceived threat to a physician's medical practice if a patient later decides they are not trans, and seeks to hold their doctors accountable for a permanent bodily intervention. Yet, as I discuss in greater detail in Chapter 5 under the section "Regret vs. Dissatisfaction", research demonstrates that people who have received gender confirmation surgeries are extremely unlikely to "recant their intent" as Dr. Fray speculated, or to have been just "going through a phase" as Dr. Fraser surmised.

Physicians' skepticism about trans people's authenticity does not seem to stem from their past experiences with trans patients actually expressing regret, and thus demonstrating that there is sufficient cause to doubt trans patients' authenticity. After all, Dr. Fraser specializes in gender confirmation surgery, yet his answer to my question shows he does not readily know from working with trans patients why they are gatekept access to genital surgeries. In fact, Dr. Fraser formulates his answer based on what the medical "perception" is about the trustworthiness of trans people's claims to authenticity.

Instead, physicians' skepticism about trans authenticity seems to be based on their assumption that if patients regard both gender and sex to be mutable, then through normative discourses on bodies and identities, those patients must be confused, that they "really don't know what they want". And if a trans patient is so confused about something (culturally regarded) as core and foundational as gender identity (at least in the contemporary west), then why should a medical practitioner trust that trans patients are not also confused about their desires for bodily transformation? In other words, physicians assume that trustworthy patients—those who are authentic—have a fixed gender identity. So it is not surprising that skepticism about the authenticity of identity is not leveled at cis men seeking male enhancement; medical practitioners assume cis men's identities are inherent, unchanging, and rooted within the sexed body they were assigned at birth. Physician's perception of cis men's authenticity is the theme I turn to in the following section.

"I've Got the Anatomy and I Want To Do Something About It": Anatomy as Cis Authenticity

Cis men seeking male enhancement are treated in fundamentally different ways by physicians who do not question their authenticity. I arrived at this determination in part by asking doctors how they decide who is an ideal candidate for the penile augmentation procedures they perform. In general, practitioners stumbled through the interview while trying to answer my questions about ideal cis men candidates. As the primary way in which they decide if a cis patient is a good candidate for a procedure, doctors often mentioned patient's overall health—such as whether the patient had medical and/or

mental health conditions that would make the procedure more risky, or would interfere with the results of the procedure. Otherwise, practitioners often responded as though it was readily evident who are ideal candidates; some physicians—namely Dr. Schneider and Dr. Midden—became frustrated with my line of questioning for what they viewed had obvious answers prima facie. Only through my insistent follow up questions did physicians really begin to reflect on and articulate their process of accepting or rejecting a new cis patient for male enhancement.

Most of the doctors who participated in this research report that they largely rely on cis men's self-selection for male enhancement procedures as evidence that they are "really male", and therefore, eligible for and deserving of genital interventions. From the account of Dr. Wexler, we can see this process whereby he accepts new patients through their own, 'bottom up' self-selection. Dr. Wexler is a US physician who formerly performed penile girth enhancements using dermal fillers and polymethyl methacrylate (PMMA) injections, but has recently replaced that part of his medical practice with the Man Shot for mild girth augmentation, having performed a few dozen of these procedures on cis men within the last few years.

Fitting our interview into his busy schedule between work and cooking dinner for his family, we rushed through my pages of interview questions. When I asked Dr. Wexler how he evaluates who is a good candidate for the girth enhancement he performs, he replied with a warm and jovial tone.

> Usually they come in *preselected* [....] They're coming to me because they have something they want to do. They either want to be *better at what they're doing or at what they have*. Or they have an issue that they feel they need to have treated. So they're *preselected* in terms of you know "*I've got the anatomy and I want to do something about it*". [emphasis added]

In other words, alongside patient desire, the "anatomy" of the sexed body—the supposed site of gender identity for medical practitioners—was evidence enough for physicians like Dr. Wexler to believe in cis patients' masculine identities and 'male' bodies as legitimate, real, and stable. Compared to the gatekeeping of trans patients seeking gender confirmation surgery that I outlined earlier in this chapter, Dr. Wexler assumes that his cis patients

pursuing male enhancement are responsible consumer subjects of somatic technologies whose bodies and identities are stable and authentic, despite the patient's desire to "do something about" "an issue" with their anatomy.

Dr. Martin gave a response similar to Dr. Wexler's. Dr. Martin is a Canadian physician who, for the last few years, has administered the Priapus Shot and Scrotox on cis men. According to Dr. Martin, the Priapus Shot is essentially platelet rich plasma (PRP) injections to "heal" the "damaged" vasculature of the penis for mild girth enhancement.[11] Scrotox is a recently trendy procedure that injects Botox into the cremaster muscles so as to relax the scrotum for "enhanced sexual pleasure".[12] When I asked Dr. Martin in our interview "how do you decide if someone is a good candidate for the procedures you perform?" he said that, apart from ruling out any notable health concerns like cardiovascular disease or bleeding disorders, he performs these procedures based on "just *patients' desire* and *I'm not going to question their desire*" adding that "if the *anatomy* is fine, there's really no reason [to reject the patient]" [emphasis added].

In contrast with the quotes from physicians above expressing doubt in their trans patients identities and desires for their bodies, from Dr. Martin we see an example of how male enhancement doctors readily trust the desires held by cis men patients for their bodily being, because their anatomy—their sexed body—represents the 'truth' of their gender identity. Throughout the course of my interviews with medical practitioners, in fact, they never once expressed doubt about the authenticity of the bodies and identities of their cis men patients, including when their bodies failed to fit the narrow confines of the gender and sex binary.

[11] Practitioners who administer the Priapus Shot and Man Shot talk about them as healing the vasculature of the penis. For example, Dr. Martin claims that "the P-Shot works with platelet rich plasma therapy which relies on inducing inflammation to rejuvenate and repair" what he calls "damage" from smoking or Peyronie's disease, which forms scar tissue that curves the penis and causes pain and erectile dysfunction. It is outside the purview of this research, however, to assess the scientific veracity of these claims.

[12] According to Dr. Martin, Scrotox allows for easier manipulation of the testicles and enables the scrotum to hang lower, thereby increasing sexual pleasure because the testicles are now free to "flap up against the recipient". Other medical practitioners interviewed for this research—like Charles Bennett—suggest that Scrotox is exclusively used to improve the appearance of the scrotum by smoothing out the wrinkling of scrotal skin. Both Mr. Bennett and Dr. Martin described the purpose of Scrotox based on patient experience with the procedure's results, rather than based on medical evidence of the procedure's 'function'.

Core vs. Surface, Parts vs. Wholes: Defending the Authenticity of Male Bodies That Fail

In recognition of doctors' insistence on the sexed body as the site of one's 'true' gender identity, I decided to raise the possibility of bodily ambiguity to see how physicians would respond. In particular, I asked medical practitioners if it is possible that any of their male enhancement patients who believe their penises are 'too small' may be intersex. Witnessing the quotes below, it becomes clear that despite being confronted with the possibility of bodily ambiguity, practitioners like Dr. Rosenburg reasserted the authenticity of their cis patients' 'male' bodies and masculine identities.

Dr. Rosenburg is a US physician who, at the time of our interview, had performed gender confirmation surgeries for almost three decades, and temporary girth enhancements for cis men using dermal fillers for more than twenty years. Our phone interview took place during his evening commute. Over the baritone hum of his sports car accelerating in the background of the phone call, Dr. Rosenburg reflected on my question as to whether any of his male enhancement patients could be intersex. Speaking about his patients, Dr. Rosenburg stated matter-of-factly, "There are people who are classified as intersex, *but they're really male*, but they have streak gonads and *underdeveloped penises*. [Streak gonads are] a form of *testicular feminization*" [emphasis added].

Despite a medical diagnosis of an intersex condition, where the body has a mixture of traits (like hormones, gonads, chromosomes, and secondary sex characteristics) that are culturally deemed both/neither 'female' and 'male'—and therefore, incongruent according to binary logics—Dr. Rosenburg's faith in his patients' discrete maleness was unyielding. Locating the intersex condition in parts (gonads and the penis) of a whole ('male' body), Dr. Rosenburg is able to rescue the maleness of his patients' bodies from the feminization of its parts. Even through the use of the term "testicular feminization", for example, Dr. Rosenburg isolates that feminization from the rest of the body, while suggesting that the gonads are by *essence* still testicles. Similarly, as opposed to using a term like 'large clitoris' (which can imply a female sex designation) or 'tumescent tissue' (which does not imply a particular sex designation), Dr. Rosenburg's use of the term "underdeveloped penises"

reaffirms this part as male while distancing its shortcomings of underdevelopment from the whole of the rest of the body. Containing the intersex condition within body parts performs the discursive work of naturalizing the maleness of the body as a whole to release his patients from an intersex designation.

When some sexed traits are ambiguous or contradictory according to social expectations for binary sexed bodies—such as "underdeveloped penises" and "streak gonads"—presumably other sexed traits 'compensate' for their limitations (see Sanz 2017) so that practitioners like Dr. Rosenburg can confidently claim that his intersex patients are "really male" despite "feminization". On the other hand, perhaps Dr. Rosenburg's assignment of the 'male' sex to the bodies of his patients who have been diagnosed as intersex is actually based on his patients' (presumed) gender. This seemingly 'inverted' process of assigning a sex based on one's gender reflects a broader pattern of the medical management of intersex bodies observed by gender scholars whereby social categories determine the materialization of sexed flesh (Davis, Dewey, and Murphy 2016; Westbrook and Schilt 2014; Meadow 2010; Fausto-Sterling 2000; Kessler 1990). In other words, gender does not emerge from the sexed body, rather it is the cause. In either case, Dr. Rosenburg fortified the gender and sex binary by minimizing his patients' sex ambiguity. In cases like these, physicians took for granted that cis men's maleness was stable, legitimate, and real even if their sexed traits were "underdeveloped" or otherwise ambiguous, and therefore, wavered in representing male embodiment.

Other practitioners, like Dr. Fray, seemed to complicate processes that naturalize the sexed body. When I asked him why trans folks require letters from mental health professionals, but his cis patients do not in order to access genital technologies, he qualified some of his former responses (shared above in the section "'Weed Out the Real Ones': Skepticism of Trans Authenticity") by comparing access to genital surgeries versus chest surgeries. In his response, genitals served as the most important indicator of one's 'true' sex and gender, but he denaturalizes breasts in both cis boys, as well as adult cis women who have cancer.

> *Breast augmentation is not a trans procedure.* That's not a transgender procedure, because like in my kid's wrestling team there are some- there's a lot of *estrogen* in the water out there- there's about three or four boys that are over two-hundred pounds that probably have D-cups. And these boys have the boobs. They don't want the boobs, and *they're not trying to be girls*, but I think that if you're talking about breast mod, breast augmentation, mammaplasty um I I think that's an incorrect- *that's not a gender reassignment surgery.*[13] Because there are plenty of women out there that have mastectomy, that doesn't have no breast at all. *That doesn't make them less of a woman or a female.* So it just depends on what you throw at me. If you say "cock-to-vagina, vagina-to-cock", okay that's a different argument than somebody's *adjunctive* [procedure] uh "I wanna look *more female*", you know that's different for me. [emphasis added]

The discourses in Dr. Fray's quote overlap considerably with those found in Garner's (2011) reading of gynecomastia within medical discourse. Despite that breast development is a common occurrence for about fifty to sixty percent of adolescent boys and up to seventy percent of adult men aged fifty to sixty-nine years (Johnson and Murad 2009, 1010; see also Longhurst 2005), note how Dr. Fray frames breast development in cis boys as unnatural. He denaturalizes breasts on cis boys by citing their body fatness of "over two-hundred pounds" to imply a weight-based 'abnormality'. He further compounds the unnaturalness of breasts on boys by attributing exogenous estrogen—coded by binarist science of the sexed body as 'female' (Fausto-Sterling 2000; Oudshoorn 1994)—as responsible for producing feminized parts in the male bodies of boys. Even the use of the phrase "these boys have the boobs" dissociates breast tissue as a part/apart from the whole of the boys' male bodies. To

[13]The term 'gender confirmation surgery' has largely replaced the less preferred terminology 'gender reassignment surgery' (GRS) or 'sex reassignment surgery' (SRS) as well as the even more outdated term 'sex change operation' within spaces and institutions characterized as 'trans-friendly'. However, I would be remiss if I did not note that, terms such as 'gender confirmation surgery' (as well as 'transition surgery' or 'gender affirmation surgery') are no less politically imbued than former terminology like that used here by Dr. Fray. As Heyes and Latham (2018) point out, "To obtain a GD [Gender Dysphoria] diagnosis, someone seeking trans services must describe themselves as already belonging to an alternative sex-gender category. Thus the surgeries or other services a trans person receives are not positioned in themselves as trans-gendering (or sex changing) but gender confirming. That is, instead of saying, 'I want to become a man,' a trans man is expected to explain himself by saying (in the GD vernacular articulated by the DSM), 'I was always a man inside and I need my body to match'" (180). Thus, the term 'gender confirmation surgery' continues to constrain trans self-descriptions to fit the narrative (especially of suffering) outlined under the Gender Dysphoria diagnosis in the DSM-V as a means for trans folks to gain access to surgeries and hormones. I continue to employ the term 'gender confirmation surgery' within this dissertation, but while critically acknowledging its political alignments.

paraphrase Garner (2011), "boobs" on boys are conceived as part of the body, something that the body *has*, but is not *of* the body (120).

Medical framings of gynecomastia have linked "boobs" on cis men and boys to a handful of intersex conditions (Nieschlag 2013). Yet Dr. Fray never ascribes an intersex diagnosis to these breasted boys, demonstrating how their masculinity and maleness are rescued from threats of ambiguity that could render inauthentic their cis identity and embodiment. Since these boys are "not trying to be girls", their breast development is not a "transgender procedure" either. Implied in Dr. Fray's remarks above is that "breast mod" surgeries that would remove unwanted "D-cups" are not a "transgender procedure", but rather, a gynecomastia surgery to bring male bodies back into alignment with 'natural' male physiology.

Similarly, Dr. Fray claims that breast modification is not a "transgender procedure" because cis women have mastectomies (most often due to cancer or 'potentially diseased' tissue)[14] resulting in "no breast at all". As Heyes and Latham (2018) point out, cis women can only access breast removal surgeries if they have a medically-warranted reason for needing a mastectomy. The breast is a feminized part, but its removal specifically due to disease does not change the essence of the whole, presupposed to be the female body. Dr. Fray concludes that when women remove their breasts due to disease, that "doesn't make them less of a woman" nor does it make these women trans. So according to Dr. Fray, it follows that mastectomies elected by cis women, as well as the unwanted breast growth ("breast augmentation") and the surgical removal of unwanted breasts in the case of cis boys, are not trans procedures.

Within these three distinct medical contexts—cis boys with gynecomastia, cis women with breast cancer, and trans folks seeking gender confirmation surgeries—Dr. Fray identifies the 'diseased part' in distinct locations. The 'diseased part' for breasted cis boys as well as cis women with breast cancer is located within the body, namely the breast and breast tissue respectively. On the other hand, I demonstrate in the next section

[14]See Nye's (2012) treatise "Cancer previval and the theatrical fact" on prophylactic treatments to "preempt a future breast cancer diagnosis" (105).

that practitioners' framings of trans identity as a "psychological problem" of instability locates the 'disorder' for trans folks seeking gender confirmation surgeries, if not in their identities, then in their minds. Containing the 'disorder' in different locations (body versus mind) produces the effect of naturalizing male and female bodies without breasts, alongside the naturalization of the sex assigned at birth of the pre-surgical trans body. So while Dr. Fray's response above is not about male enhancement or genital interventions specifically, he does indirectly answer my original question about the differential management of cis and trans people regarding mental health services. Ultimately, Dr. Fray claims that disorders of the body in the case of breasted cis boys and cis women with cancer have no need for psychotheraputic interventions, whereas disorders of the mind in the case of trans people do require mental health support in order to receive access to genital technologies.

Dr. Fray's differentiation between trans and cis procedures appears to 'protect' cis women who have removed their breasts against threats to their 'female' designation or femininity, as well as 'defend' cis boys with unwanted breasts from threats to their 'male' sex assignment or masculinity. Embedded in this defense, however, Dr. Fray (re)produces a hierarchy of the sexed body at the expense of trans (as well as intersex) people. Drawing on Hirschauer and Mol's (1995) conceptualization of different bodily markers taking on "supremacy" (373), whereby particular variables of sex are medically regarded as the best determinants of the sexed body at different points throughout history, Dr. Fray argues that chest surgery is not a "trans procedure", implying that breasts—in the current social imaginary—are surface and genitals are core to one's gender and sex identity. According to Dr. Fray's logic, breast tissue—whether it is a young boy with D-cups or an adult woman with(out) breasts—is superficial to a person's claim to cis identity.

This line of argumentation is deployed in support of cis authenticity. For example, instead of resorting to sexist and bioreductive assumptions that breasts are essential to a woman's claim to womanhood, and therefore, that removing one's breasts is akin to losing one's 'natural' identity as a woman, Dr. Fray does not fix womanhood to breast tissue. His claim that mastectomy is not a trans procedure is useful for shoring up the boundaries of

cis authenticity for adult women without breasts. Similarly, this line of argumentation is useful for defending against threats to cis boys' and men's masculinity when they present with 'excess' breast tissue. Rendering breast tissue unnatural in the bodies of cis boys and men is not new, nor particularly surprising given the social embeddedness of physicians within the medical establishment; denaturalizing breast tissue as pathological enables medical practitioners to naturalize the male body without breasts.

> 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. (Garner 2011, 115)

Processes that denaturalize breasts on cis boys and men make it so that—compared to trans folks—"psychotheraputic management is never considered as a treatment [for cis men] or even an eligibility requirement for surgery" (Garner 2011, 116). As a result, breasted cis boys and men can access surgical technologies as the best treatment options for gynecomastia without having to navigate mental health gatekeepers seeking to prove that they are authentically 'cis enough'.

While it may appear as though Dr. Fray is problematizing processes of naturalization—after all, he is pushing back against essentialist narratives that claim cis women's identities are grounded in sexed body parts such as breasts—in actuality, he is perpetuating techniques that naturalize cis identification and embodiment. Treating breasts as surface and genitals as core to one's gender identity reproduces binary and bioreductivist logics that defend the authenticity of cis identities and bodies when the body is unreliable in citing the regulatory norms of binary gender. The hierarchy of the body (core versus surface) that Dr. Fray manifests is deployed at the expense of trans folks subordinated by an essentialist, bioreductive ideology of the sexed body that reasserts—beyond birth assignment—the supremacy of genitals as core to one's identity, thereby rendering trans folks inauthentic.

From the responses of practitioners like Dr. Fray and Dr. Rosenburg, we see that metaphysical skepticism about the authenticity, stability, and permanence of gender

identity does not apply to cis men. While all physicians in this research regularly follow up with their cis patients for post-operative care that focuses on their physical healing, none of the male enhancement practitioners in this research reported following up with their cis patients to gauge how they feel about their sense of self after penile augmentation, if they regret the procedure, much less whether or not they are "really male". Concerns about authenticity—informed by logics of biological essentialism—thus act as a technique of naturalization that expresses doubt about trans identity, resolute faith in the assigned sex of the body, and certainty in the cis subjectivities that are culturally congruent with that binary sex assignment.

Authenticity is just one discursive technique of naturalization employed by physicians in their medical practices. In the section that follows, I share excerpts from my interviews with practitioners that point to suffering as additional evidence that one's sex assignment at birth is natural and normal. Cis men's suffering is treated by practitioners as a normal response to living in a body that fails to cite the regulatory norm of masculinity, and therefore, serves as an ideal justification for accessing genital technologies. The suffering of trans people, on the other hand, is regarded by the practitioners—including those who specialize in gender confirmation surgery—as a sign of mental illness for failing to accept cis identification, and therefore, often served as evidence that doctors should close the gate to surgical technologies.

Suffering

Suffering is often regarded in the west as a predictable and understandable effect of living in a non-normative or 'abnormal' body. Indeed, suffering from abnormality serves as one of the most prevailing justifications for seeking relief through biomedical interventions, particularly cosmetic and elective procedures (Pentney 2012; K. Davis 2009; Heyes 2009b; Blum 2003). Yet which bodies and identities are classified as 'abnormal', and what kind of suffering is regarded as a 'mentally healthy response' is circumscribed by medical, legal, and mainstream framings of 'the normal', and by extension, 'the natural'. Building on the work of somatechnicians (Cadwallader and Murray 2007) and critical disability scholarship

(Siebers 2017, 2008), I identify suffering—not as an expected and unquestionable experience sheltered from examination—but rather, as a productive site for tracing the operation of power.[15]

This analysis ought not be understood as reducing the differences between the suffering experienced by some trans people seeking gender confirmation surgery, and the suffering experienced by some cis men pursuing male enhancement procedures; not all suffering is the same. But rather, how (and whose) suffering is normalized or pathologized renders visible how suffering is a technique of biopower that naturalizes some bodies and identities, while marking others as unnatural constructions.

Over time, the suffering of trans folks has taken on different meanings in psychology and psychiatry in Canada and the United States. Others have detailed trans history in the west in far more depth (Stryker and Sullivan 2009; Meyerowitz 2002). But briefly, throughout the 1960s into the 1990s mostly cis psychologists and psychiatrists theorized that gender non-conformity was an individual mental disorder (Meyerowitz 2002), resulting in the formal diagnosis of Transsexualism in 1980, and later Gender Identity Disorder (GID) in 1994 outlined in the American Psychological Association's *Diagnostic and Statistical Manual* (*DSM*) *of Mental Disorders* (versions III and III-R, IV and IV-TR respectively). Under these diagnoses, suffering was an effect of mental illness for failing to accept cis identification.[16]

[15]Disability scholar Tobin Siebers (2017, 2008) persuasively argues that the suffering of disabled people directs attention to the operation of power by revealing the architectural 'blueprint' of ableist oppression within the socially constructed environment.

[16]In the *DSM-III* (APA 1980) under "Associated features" of transsexualism, there is a summary of potential patient suffering, including "considerable anxiety and depression, which the individual may attribute to inability to live in the role of the desired sex" (262). Under "Impairment and complications", the *DSM-III* lists "Frequently social and occupational functioning are markedly impaired, partly because of associated psychopathology and partly because of problems encountered in attempting to live in the desired gender role. Depression is common, and can lead to suicide attempts. In rare instances males may mutilate their genitals" (263). For comparison across newer versions of the *DSM*, under "Associated descriptive features and mental disorders" in the *DSM IV-TR* (APA 2000), it lists that children with GID may experience anxiety and depression, and "[a]dolescents are particularly at risk for depression and suicidal ideation and suicide attempts. In adults, anxiety and depressive symptoms may be present" (578). The final diagnostic criteria (out of four) for GID in the *DSM IV-TR* indicates patient suffering as "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (581).

Yet clinical research and practice with trans patients often departed from codified texts; mental health professionals were abandoning the reparative, deterrent models against transsexualism that largely characterized the treatment of trans folks before the 1990s, primarily adopting instead a 'trans-positive' approach to self-determination of one's 'true' gender identity in order to resolve or mitigate trans suffering from distress (Ehrensaft 2012).[17] Only after a fourteen-year process of expert consultation and revision were codified treatment and diagnostic texts amended to begin to reflect these changes in clinical research and practice; culminating in 2013, GID was finally replaced in the *DSM-V* with the diagnosis of Gender Dysphoria. With this new diagnosis, gender non-conformity is no longer expressly classified—at least at an institutional level—as a pathology of the mind.[18] Instead, Gender Dysphoria refers to the ways in which trans folks can suffer from distress when forced to live in a manner 'inauthentic' to their experienced or expressed gender.[19]

Suffering then, has historically been—and continues to be by definition of Gender Dysphoria—central to the psychological diagnosis of trans people, and the key symptom to be ameliorated through gender confirmation surgery (Standards of Care version 7 2012). Yet as I demonstrate via the following vignettes from physicians, despite trans folks' suffering being the raison d'etre of gender confirmation surgery and the key criterion for Gender Dysphoria (which again is not a pathology), it continues to be pathologized and individualized by the doctors who participated in this research, serving as a primary indication to practitioners that they are reasonable to gatekeep trans peoples' access to genital technologies. By comparison, cis men's suffering from "genital ridicule" was

[17]See also Whitehead et al. (2012) for examples of different mental health practices that fall under the 'trans-positive' designation.

[18]Gender Dysphoria in the *DSM-V* (APA 2013b) "is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se" (para. 3).

[19]Suffering, in effect, serves as one of the two diagnostic criteria for Gender Dysphoria in the DSM-V (APA 2013b) "[t]he condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning" due to a "marked incongruence between one's experienced/expressed gender and assigned gender" (452). Moreover, "[a]dolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides" (454). In addition to suicide, other "[i]mpairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria" (455).

normalized, rendered predicable and acceptable, considered in some cases the clearest qualification to indicate to physicians that the patient deserves access to male enhancement procedures.

Suffering as Instability: Constructing Trans Suffering as Errant

Dr. Rosenburg expressed a high degree of caution when deciding whether or not to grant his trans patients access to gender confirmation surgeries. When I asked Dr. Rosenburg why cis men are not required to go through counseling to access genital surgery, but trans folks are, he replied by describing trans people and their suffering as psychologically unhealthy and deviant.

> Up until very recently, I'm talking in the last five or six years, the transgender community has been [an] unsupported population [of] people who were *psychologically stressed. This is a psychological problem* that has not been recognized by mainstream at all, has been shunted aside and has been under-appreciated [....] [transgender people are a] *stressed population* that has never had support, it's an *errant thread in society.* And they are smokers, and they don't have good relationships with other people, and they may have had schisms with their families, and they can't hold jobs, and they haven't gotten higher education because their *whole being has been stressed by their transgender inner selves*, and they're unidimensional in their quest for body transformation, and they're often *unsuccessful and unhappy in society.* When you have a *stressed population*, they need help [....] Um, my personal perspective on it is irreversible gonadal surgery, I need to have somebody else involved and I want to make sure that you're committed to this process. If nothing else, you having the wherewithal to go get a therapist to get you a letter tells me you're committed. As is walking in here, a little depressed because *mommy didn't breast feed you long enough.* [emphasis added]

Consider how Dr. Rosenburg reduces trans experience to suffering, eliding any discussion of trans people's experiences of contentment or trans folks who are generally happy. In contrast to Dr. Rosenburg's assessment of his trans patients, trans folks (Ashley and Ells 2018; Spade 2003)—some of whom are family therapists, sexologists, and medical doctors themselves (Benestad 2010)—report experiencing gender euphoria. Trans activist and legal scholar Dean Spade (2003) describes gender euphoria as the "joyful affirmation of gender self-determination" (21). Characterizing gender euphoria as "the positive homologue of gender dysphoria", bioethicists like Ashley and Ells (2018) attest that gender euphoria "speaks

to a distinct enjoyment or satisfaction caused by the correspondence between the person's gender identity and gendered features associated with a gender other than the one assigned at birth" (24). One of the ways in which trans folks can experience gender euphoria is through gender confirmation surgery and other forms of creative transfiguration, described by Ashley and Ells (2018) as "the manifold ways in which we may assert ownership over our bodies, transforming them into an art piece that is truly ours out of previously alienating flesh" (24).

While some trans people certainly experience gender dysphoria, wholesale erasure of gender euphoria perpetuates a cisnormative assumption that trans people are "errant" that functions to rationalize gatekeeping access to somatic technologies (see Ashley and Ells 2018). Dr. Rosenburg's portrayal of the trans population as a homogeneous group of "unsuccessful" and "unhappy" people contributes to this cisnormative rationale. And while social researchers have observed elevated incidences of depression, anxiety, and self-harm among trans people (Travers 2018; Duncan and Hatzenbuehler 2014; Mustanski and Liu 2013), it is irresponsible to reduce trans people's suffering to an "inner", "psychological problem" simply caused by "mommy [not] breast feed[ing] you long enough"—a problem that is merely "under-appreciated" and "unsupported" by society—rather than a direct result of experiencing systemic oppression in the violently trans-antagonistic, cisnormative cultures of Canada and the United States.

From Dr. Rosenburg's comments, he renders suffering as necessarily constitutive of trans experience. As Heyes and Latham (2018) have argued, "the more that suffering comes to define the trans narrative, the greater the purchase of a political psychology that disallows transformative self-descriptions and action" (175). In other words, the more that trans experience is reduced to suffering, the the less likely that institutions responsible for trans folks' care will accept euphoric self-descriptions and creative transfiguration as sufficient evidence of trans identity or reason to access somatic technologies. Such a limiting political psychology "individualizes gender and disallows critique of the systems that contribute to trans people's suffering in the first place" (Heyes and Latham 2018, 183). Indeed, reducing 'trans experience' to suffering from oppression creates a

> paradoxical attachment of the socially marginal to the very wounded identities they claim to want to surpass. [...] [D]istress will come to signify the essence of the trans individual—and ultimately, for those who take a biomedical perspective to its logical conclusion, the meaning of their bodies. (Heyes and Latham 2018, 182)

If one were to cede broader ethical commitments to transgender justice and accept—however provisionally so that trans folks can access appropriate medical care—that suffering is necessarily constitutive of trans experience, the physicians who participated in my research would—as their comments demonstrate—still gatekeep access to gender confirmation surgery precisely because of that suffering.

Almost all of the doctors who responded to my question asking why trans folks require a letter before undergoing surgery were exceedingly circumspect, and suggested that trans suffering is a sign of mental and emotional instability. Dr. Fray was no different; he discussed the suffering of trans people by directly comparing it to the imagined mental and emotional status of cis people. Through this comparison, Dr. Fray attempts to justify why trans people's access to genital technologies must be managed closely, whereas cis men do not require such management.

> If you asked a hundred physicians "do you think a transgender person is more mentally, emotionally stable? Or less emotionally stable? Or the same as someone who is not a transgender? [*sic*]" I think you would have an overwhelming majority [of physicians] say that [*trans people*] *were more unstable*. [emphasis added]

It is unclear how Dr. Fray arrived at this conclusion that trans people are more unstable than cis people; the focus of the conversation shifted abruptly after he made this statement, and I was not able to follow up to ask how he made this determination. However, at a different moment during our interview, he does provide insights into how he understands the instability of cis men, whom he claims are more mentally and emotionally stable compared to trans people. Examining these insights can help elucidate Dr. Fray's claim here about trans people.

Practitioners like Dr. Fray invest heavily in the bioreductive model that reduces human behaviour to our biological bodies. When discussing possible side-effects of penis

augmentation—such as the impact of male enhancement on the sexual practices of patients who have circlusive sexual partners—Dr. Fray suggested that cis men would not care about their partner's safety (who he referred to as cis women) because testosterone is a "warrior" hormone that makes men actually "want to hurt" cis women. Acting as a ventriloquist for his patients and their partners, Dr. Fray used a deep yet excited tone when trying to convey cis men's desires in the following quote. While speaking for cis women—the imagined sexual partners of his male enhancement patients—Dr. Fray switched his tone to an exaggerated higher pitch.

> Look if you tell a man that "gee well you're probably going to *hurt your wife* cause you're [your penis is] going to be bigger", [my patient's response] it's usually "*well that sounds good!*" rather than "oh, my poor wife I don't want to hurt my wife!" It's like, "well *I'll make it fit*". So *men are not the most considerate, compassionate-* in some respects- they're in some ways kind of *sadistic and barbaric* when it comes to those kinds of things. [...] I think a woman would be like "oh I wouldn't want to hurt you!" and the guy's like "oh yeeaahh *I want to hurt her*". [...] I think men are in general very *dominating and very warrior-like*. And *they don't care. Men don't care. They don't care about their partner's feelings*. They just don't. [emphasis added]

When I asked Dr. Fray what he thought about men not caring about their partner's feelings, he chuckled through his response.

> Um it's all called *estrogen. Estrogen makes you sensitive*. In fact when I give testosterone to [a cis man], I try not to [...] limit the conversion of testosterone into estrogen, because [otherwise] they become very *insensitive, and harsh, and hardened, and almost mean*. And estrogen tends to be cardio-protective. [...] If the estrogens get too high, then we get untoward effects of competition of estrogens that get in the testosterone receptor with testosterone. And then [my cis men patients will get] the *dreaded man boobs. And nobody wants that*. So it's all a very *carefully orchestrated*, almost symbiosis. So that would be the reason that men would be *not giving a shit about their partners* when they get very *high T[estosterone]* levels and their *estrogens are low*; *they're not a lot of fun to be around*. And they can get *really angry*. [emphasis added]

From the quote above, Dr. Fray takes up a bioreductive explanation of human behaviour—that is, an explanation that reduces complex human behaviour to our physiology, genetics, or in this case, hormonal chemistry (Lancaster 2006). According to Dr. Fray, human behaviour can be explained by our biological and binary natures as

'female' and 'male'. Dr. Fray understands cis men's aggression through the problematic science of binary 'sex hormones' that often functions to naturalize cis men's violent behaviours. In this formulation, estrogen—which is sexed as 'female'—is the "sensitive", "considerate", "compassionate" hormone, whereas testosterone—sexed as 'male'—is the "mean", "angry", "warrior" hormone. Due to Dr. Fray's assumption that 'male' bodies by design naturally have limited estrogen and high testosterone levels, and that hormones are responsible for cis men's behaviours, he contends that cis men "are not the most considerate, compassionate" people, "[t]hey don't care about their partner's feelings", and they "are in general very dominating and very warrior-like". Dr. Fray describes cis men as "sadistic" and "barbaric" as a natural result of their biology, and he normalizes these forms of violent instability, rather than as grounds to gatekeep their access to genital technologies. Yet Dr. Fray frames trans folks as "more unstable" than cis people for wanting access to somatic technologies that in many cases enable them to be more comfortable, if not euphoric in their bodies (Ashley and Ells 2018; Benestad 2010; Spade 2003), as well as socially and legally-recognized as their gender(s), which can lead to a degree of harm reduction (see Travers 2018).[20]

Many of the physicians in this research gave similar responses as Dr. Fray and Dr. Rosenburg, characterizing trans folks as "errant" and "unstable". In all of these cases, doctors used trans peoples' mental and emotional support needs—their suffering—as justification for enforcing mandatory counseling before granting them access to gender confirmation surgeries. Latham (2017) summarized it best by saying:

> Treating trans patients as though they inherently and necessarily require their competency to be approved by "mental health professionals," when this is not standard clinical practice for all other patients, constitutes trans patients as necessarily psychologically suspect because they are trans. (50)

Even though suffering and distress are central to the diagnosis of Gender Dysphoria, as well as the basis upon which trans folks should—according to current standards of

[20]To be clear, underscoring the potential somatic comfort, euphoria, and reduction of harm related to gender confirmation surgeries does not imply that these interventions result in trans people "finally feel[ing] at home in his/her body, to become whole" (Sullivan 2006, 553), thereby inscribing non-surgical trans existence as necessarily tragic or characterized by suffering.

care—receive access to somatic technologies, the suffering of trans people is used as evidence by the doctors in this research to distrust trans folks' identity claims, and therefore, as evidence that they should strictly gatekeep access to gender confirmation surgery. Through this gatekeeping, practitioners re-entrench cisnormativity and trans oppression in their medical practices. The institutional requirement that trans people receive approval from mental health professionals before undergoing genital surgery *compared* to the majority of cis patients who—as I demonstrate in the next section—do not have the same requirement and are in fact institutionally *enabled* to get genital surgeries, is a technique that naturalizes the sex assigned to bodies at birth.

Suffering as Eligibility: Ideal Candidates for Male Enhancement

In the course of conducting this research, I often reflected on how the topic of male enhancement was received by others. Upon learning the focus of my interviews, for example, complete strangers at social events would commonly ask me inappropriate questions about my partner's body (see Chapter 3) or divulge their sexual experiences to me without consent. Upwards of six different women I had never met before confided in the group—without invitation and often through inebriated laughter—that they are not satisfied sexually by their partners. Many of these women typically understood their sexual dissatisfaction as a result of their partner's penis size, which they characterized as small, often expressing that they are considering leaving their partners because of their genital size.

This behavior reduces the penis to pleasuring others as its teleology. Public critiques of their partners' genitals as sexually inadequate perpetuate narrow, unrealistic expectations for cis men's bodies, and simultaneously police the morphology of intersex and trans people's genitals according to binarist and cisnormative demands. After experiencing or simply witnessing genital mockery, cis men may seek to shore up their masculinity by securing *patriarchal dividends*—or the social and material rewards cis men receive for the subordination of others (Connell 1995, 79)—in this case through the reassertion of their physical dominance through phallic masculine embodiment, sexual control, and violence (which I discuss in Chapter 6).

Stories of genital humiliation were commonly reported by cis men in online forums and support sites like *Enhancement Forum*; however, suffering characterized their narratives rather than laughter. Most often cis men expressed grief, pain, and anger about a former or current sexual partner (always discussed as women) laughing at the size of their genitals; refusing to have sex with them because they have small penises; stating that they "only sleep with guys who wear Magnums"; expressing that they are sexually unsatisfied, which forum members often assumed was a problem of penis size, rather than of intimacy or sexual knowledge; ending their relationship because they have "inadequate cocks"; or sexual partners being "an unfaithful slut" for cheating on them with other men. Forum members frequently disclosed anxieties about being "cuckolded by a bigger man". Often cis men on forums would denigrate their partners as 'size queens'[21] for valuing a big dick over other characteristics of a sexual partner. While genital shaming is painful, oppressive, and reproduces constraining, impossible standards for peoples' bodies (effects that should not be minimized), heterosexual women alone are neither responsible for creating nor maintaining these expectations, much less structurally positioned within the field of gender relations to undo the problems of patriarchy.

Some may view the use of the epithet 'size queens' simply as men's retort for having their feelings hurt, but it is also an expression of cis men's aggrieved entitlement (Hayes and Dragiewicz 2018) to women's bodies. Women do not owe men relationships, sex, or orgasms—either women's own orgasms or men's.[22] Yet women who do not give men relationships, sex, or orgasms are often vilified and sometimes subjected to violence by men in these online support forums. According to some cis men's accounts in the male enhancement forums online, they harassed, abused, or assaulted women when they refused their sexual or romantic advances. So it is important to remember when thinking through cis men's discourses of suffering and practitioners' receptivity to these discourses, that suffering

[21] The term 'size queens' originally comes from gay and queer men's communities as a critique of men who prioritize genital size in their sexual partners above all other personal traits (Snider 2009). Cis, heterosexual men on male enhancement forums adopted/co-opted this language to disparage women as shallow.

[22] See Chadwick and van Anders (2017) for an analysis of how men feel entitled to women's pleasure because it makes them feel more masculine.

frames men as victims of an unfair sexual economy, a discourse steeped in misogyny that is central to violent networks like incels.[23]

Given the centrality of these discourses of suffering to cis men making sense of their experiences, it is not surprising then that male enhancement practitioners were privy to cis men's 'origin stories' for how they became interested in male enhancement.[24] Almost all of the medical doctors in my sample shared grievances that they often felt as though—in the course of being a physician and seeing patients for physical alterations—they were positioned as counselors and mental health supports for suffering cis men, without having the appropriate and adequate training to fulfill that role. Despite this, all but one practitioner (Dr. Midden) who participated in this research accepted cis men's suffering to some extent as a legitimate reason to grant them access to male enhancement technologies. This contradiction—where physicians recognize they are not qualified to evaluate patients' suffering, yet in practice they generally accept cis men's suffering and reject trans people's suffering—reveals the shaky foundation of their claims that trans folks have problematic, unmet psychological needs that cis men allegedly do not.

Cis men's suffering was handled in strikingly dissimilar ways by physicians in this research compared to how they treated the suffering of trans folks. Practitioners often discussed cis men's suffering as "embarrassment", "insecurity", "inadequacy", "shame", "worthlessness", and "feel[ing] less of a man", but doctors rarely framed cis men's

[23]The term 'incels' is a blending of the words 'involuntary' and 'celibates', and refers to an extremist network of people—largely white, heterosexual men—who have been unsuccessful at finding sexual or romantic partners despite desiring these relationships. In online activity, as well as in-person interactions, incels espouse misogyny, racism, and an entitlement to sex to the extent that they advocate for the legalization of sexual violence as a means to 'redistributing' sexual access. Incels are known for endorsing and enacting violence, including sexual violence and (mass) murder, against people they perceive to be more sexually active and successful than them. While not all incels engage in body projects, or "looksmaxing" to use incel terminology, recent news reports (Dickson 2019; A. Hines 2019; Cook 2018) suggest there is considerable overlap between incels and those who engage in genital work. See Srinivasan (2018) for an incisive explanation and analysis of incel ideology.

[24]Not every member writing on male enhancement support sites like *Enhancement Forum* attributes sexual humiliation from women as their reason for seeking out penile augmentation; however, it was such a common theme that dominated forum threads for me to report these stories here. These 'origin stories' were particularly common from new members or "long time lurker[s], first time poster[s]" introducing themselves to other forum members.

suffering as a "psychological" or "inner problem", to borrow Dr. Rosenburg's language. One male enhancement practitioner, Dr. Russo, even claimed that cis men's suffering from genital shame and "low self-esteem" should be recognized as a disability caused by social humiliation.

In many cases—such as in Dr. Harris' medical practice—suffering served as the ideal reason for granting cis men access to genital technologies. Dr. Harris is a US physician who has been performing suspensory ligament releases, dermal grafts for girth enhancements, as well as penoscrotal webbing resections for about fifteen years. Doctors generally describe penoscrotal webbing as an "excess amount of scrotal skin which interferes with aesthetics" so they surgically remove the scrotal skin to make the penis appear larger. During our interview, when I asked Dr. Harris who would be an ideal candidate for his male enhancement procedures, he said "the people that I try to encourage are patients who[se penis sizes] really are small or average and have some event in the past that has *scarred* them" [emphasis added]. He characterizes these patients as having "a true need." Scarring events "which *reduced their self-esteem*" [emphasis added] include:

> [E]ither somebody has said something in the shower [or] locker room when they were younger as athletes, [or] more commonly one of their partners has said something about the length of their penis in the flaccid or in the erect state, especially during intercourse. [...] I don't think that their partners are nefarious or malicious. It just happens when they're making love and Sue says to Sam "Is that all you got? Can you give me some more? I can't feel you." You know and really I think probably a benign comment but then that goes on his hard drive and can never be erased.... And it's significant because that's what happens with a new partner, they develop what's called *performance anxiety*, and when that happens, adrenaline is released from the adrenal glands, the blood supply is diminished to the penis so now they've got a *secondary problem*. They have *difficulty getting and maintaining an erection* because they're concerned about the size of their penis. [emphasis added]

The suffering highlighted by Dr. Harris is two-fold and interrelated: emotional suffering and physical suffering. According to Dr. Harris, emotional scarring and "reduced self-esteem" caused by cis men feeling as though they cannot stimulate or satisfy their sexual partners results in a "secondary problem" of "performance anxiety", and therefore, sexual impotence.

"[D]ifficulty getting and maintaining an erection" only compounds his patients' reduced self-esteem, framed as a vicious cycle of emotional trauma. According to Dr. Harris, the ideal role of his medical practice is

> to provide those men who were born with short penises in terms of length or girth a way to become average or slightly above average so that you would *restore their self-esteem*, and it has *significant ramifications in their entire life*. [emphasis added]

For this reason, Dr. Harris suggests that patients who have been "scarred" are ideal candidates for his male enhancement procedures. Across my interviews with other physicians, the majority made similar claims as Dr. Harris that suffering was sufficient evidence that cis men deserved access to male enhancement procedures, rather than a need for mental health support.

Dr. Russo was an adamant proponent of performing male enhancement procedures for cis men who are suffering. As the most prolific surgeon in my sample, Dr. Russo has performed over ten thousand male enhancement procedures over the course of more than twenty years in the United States. He specializes in suspensory ligament releases, fat injections for penile girth enhancements, testicular augmentation, penoscrotal webbing reductions and fat pad removal to make the penis visually appear longer, as well as revision surgeries to correct prior enhancements performed by other doctors. I began our interview by asking Dr. Russo to describe the patients who come to see him for male enhancement procedures. He explained that most men have a common trauma that leads them to his office. While he initially suggested that "genital ridicule" from other men in homosocial spaces was a common experience amongst his patients, and a good reason to get the procedure, he was especially sympathetic to patients who had suffered "self-esteem" issues from "genital ridicule" by the "opposite sex" who do not feel sexually satisfied by his cis men patients.

> Most of the time it's something they have *suffered* with for many many years. Usually since high school or shortly thereafter the age of puberty where it has prevented men from enjoying social life, enjoying sports, you know locker room situations, also avoiding joining the military. And just a *fear of ridicule*, and there's *nothing worse for a man's self-esteem than genital ridicule*, especially by

> members of the opposite sex usually you'll find. I've seen many men who are getting divorced or recently divorced, and they're ready to go out into a new social atmosphere, and are either unaware or made aware of the *demands on them socially* by sort of the liberated female. [...] And they just have come to the point where they want to free themselves from this *burden that society has placed [on] them*. [...] It's very common for me to hear "well my girlfriend or my current wife, her ex boyfriend or her ex husband was you know hung like a horse" and so this immediately puts this person on a defensive. So as I've said, there's nothing more *damaging to male self-esteem* than *genital ridicule* by the opposite sex. [emphasis added]

Compared to how Dr. Rosenburg pathologized and individualized trans folks' suffering, observe how Dr. Russo characterizes cis men's suffering as a result of social burdens that he frames as unjustly "preventing men from enjoying social life". Ideal candidates, according to Dr. Russo, are patients who he estimates can begin to enjoy a social, romantic, and sexual life after undergoing his male enhancement procedures. The patients Dr. Russo is most likely to give a penile augmentation to are those whose self-esteem he can help restore after they have suffered from years of "genital ridicule". In fact, practitioners like Dr. Russo and Dr. Harris agreed that the ideal role of medicine is the restoration of men's self-esteem through male enhancement. Therefore, success of a penile augmentation is assessed by physicians, to a great degree, by the alleviation of suffering, which remains largely unquestioned by the doctors who participated in this research. And yet, as I demonstrated previously, the alleviation of trans patients' suffering through genital technologies is rebuked by medical practitioners on the presumption that trans suffering is a sign of a psychological disorder, not eligibility for somatic intervention.

Cis men's suffering stems from particular social contexts, according to practitioners. Initially, Dr. Russo identifies a handful of homosocial spaces in which men's bodies are visible—and presumably evaluated and ridiculed—by other men. Homosocial spaces like sex-segregated sports and locker rooms, as well as the military are particular sites where the genital ridicule begins, according to Dr. Russo. This is not surprising as the organizing institutional logics that undergird these mostly homosocial spaces are rooted in sexism, queer and trans-oppression (Travers 2006), colonialism, racism, and patriarchal violence (Spade 2015). Since sport is a central institution to the successful enactment of masculinity (Messner 2007; Pronger 1999, 1990) and the military is deeply coded as a masculine space

(Enloe 2004), social and relational exclusion from these spaces and the inability to enact appropriately embodied masculinity can understandably result in suffering.[25] Yet, similar to Dr. Harris, Dr. Russo broadly glosses over these forms of violence perpetuated by men against other men, choosing to focus instead on the genital ridicule from the "opposite sex" as the most "damaging to male self-esteem". Yet unlike Dr. Harris, who framed women vocalizing their sexual dissatisfaction as "probably a benign comment", Dr. Russo frames the "demands on them socially by sort of the liberated female" as a "damaging" "burden that society has placed [on] them" that men seek to "free themselves from".

When I asked Dr. Russo to elaborate on what he means by a "liberated female", he began to stumble over his words: "I I I think it's just uh a uh modern woman who is probably also independent, uh also works outside the home" adding that liberated females "demand" sexual pleasure from their partners. Setting aside the obvious sexism in this remark, Dr. Russo's comment points to something even more consequential about male enhancement discourse. First, cis men's suffering is rendered a normal response to the "genital ridicule" men experience from women who want equitable access to sexual pleasure, which is largely unquestioned by medical practitioners. Second, cis men's suffering diagnoses feminism—including cornerstone goals of financial and sexual equity—as the problem, rather than the limiting, unrealistic, patriarchal gender expectations for men and their bodies. Finally, physicians in this research treat cis men's suffering as an ideal justification for enhancing both men's penile dimensions, and phallic masculine embodiment through augmentation procedures. Discourses of suffering therefore point to—if not generate—male enhancement as the solution to men's suffering, instead of calling for gender revolution.

In many ways, then, discourses employed in the medical context of male enhancement serve as a defense against threats to patriarchal power. Patriarchy no doubt generates benefits for cis men over historically-oppressed others. However, these benefits, or patriarchal dividends—as well as the violence enacted in the name of patriarchy—are not distributed equally among men; some men benefit from patriarchy more (Pascoe 2007; Connell 1995). Thus, male enhancement cannot simply be classified as patriarchal violence

[25]Notably, some male enhancement practitioners offer discounts to men in the military or veterans.

directed against cis men's bodies and subjectivities, nor can it be merely cast as emancipatory. Rather, patriarchy is productive of particular, masculine subjectivities through male enhancement; this subjectification serves as a defense against evolving challenges to patriarchal power, such as feminist movements enacting social change. Evidenced by the discursive devices employed in the medical context for penis enlargement, male enhancement is one of the currently accepted answers to the problem of the legitimacy of patriarchy.

Dr. Russo and Dr. Harris were not alone in their assessment of cis men's suffering; Dr. Tabibi agreed that suffering made cis men particularly eligible for male enhancement. Over the course of more than twenty years, Dr. Tabibi has performed over two thousand penile and testicular implants that he created and patented with the United States Food and Drug Administration. Seated in Dr. Tabibi's assistant's office, a large poster advertisement hovered over my shoulder depicting a white woman and man from the neck down in their bathing suits embracing each other. This image of a happy, heterosexual, white couple stands in for images of the enhanced penis itself, with a promise of how undergoing the procedure could shape one's sexual and romantic life. Their tanned, slender but toned bodies take up the entire frame of the image, save for a list of surgeries performed by Dr. Tabibi located at the bottom of the poster.

Gesturing to this list of male enhancement procedures, I ask Dr. Tabibi to describe under what circumstances he has declined to perform these operations, and rejected a new patient. He responded:

> I tell them "you are not a candidate unless you have a special reason, unless your girlfriend, or your friend, or your partner, or somebody really *hurt you or hurt your feelings*," [...] because this procedure really really boost their self-confidence. That is very important. [...] [W]e have a patient [...] his wife was cheating with one of his friend[s] and later on he find out, [he] said "why?" [she] said "oh because your penis is so small, so I went [and had sex] with [him]". And they got *divorced* and then with a girlfriend, the same situation happened with somebody else. This guy has been *attacked* two times by two different girls just because of his size, so he's on the verge of *committing suicide*. So [I gave him] a discounted price. [...] definitely this guy has been *insulted*. [...] [I]t's in his mind that "my size is small so I cannot satisfy anybody, going out with any girl". Unless [I] do something for him, [he's] *not going to be happy for the rest of his*

> *life*. So you have to do something. These are the group of people who definitely they need [male enhancement]. [emphasis added]

Dr. Tabibi was equally as emphatic as Dr. Russo that suffering genital ridicule—being "attacked" and "insulted" by "girls" (adult women)—makes cis men decidedly qualified to receive male enhancement procedures. We can see from Dr. Tabibi, Dr. Russo, and Dr. Harris' comments how cis men's suffering is normalized, rendered predicable and acceptable, and a clear indication that the patient is entitled access to genital technologies, rather than a clear sign that they need mental health support. Hurt feelings, a lifetime of unhappiness, and suicidal ideation were not indications that Dr. Tabibi's patient was too unstable for any kind of procedure on his genitals, and instead needed access to mental health services, but rather, that he was the best candidate for male enhancement. Dr. Tabibi's patient even received a discount on the cost of the procedure because his suffering made him so deserving of increased access to genital technologies.

The cases I presented above demonstrate that the discourse of suffering operates very differently within the medical management of trans folks compared to cis male enhancement patients. Suffering works to denaturalize trans people's dysphoria as a "psychological problem" of "their transgender inner selves", rendering their "quest for body transformation" illegitimately "unidimensional" and their mental and emotional states "more unstable" than cis people. Physicians' logic appears to suggest that internal, psychological problems cannot be ameliorated by external, medical interventions into the soma. Doctors seem to imply that even if a trans person undergoes gender confirmation surgery, they will still suffer from internal problems of instability.

On the other hand, suffering from a body that fails to cite the regulatory norm of cis masculine dominance is an external problem of "genital ridicule" stemming from "the liberated female", cheating girlfriends and wives, or broader "burden[s] that society has placed [on] them" that are "damaging to male self-esteem", pushing cis men to be "on the verge of committing suicide" because they are "not going to be happy for the rest of [their] life" without access to genital technologies. Getting a male enhancement, according to practitioners' logic, will enable cis men to fulfill broader social expectations, including

those of potential sexual partners. Thus, cis men's suffering is not only a normal response according to most physicians, but it is also sufficient cause for somatic transformation of cis men's bodies. So even though both trans folks and cis men suffer, it only makes sense to practitioners to alter the body to ease social suffering in the case of cis men, but not to ease the so-called "inner", mental anguish of trans people.

There are rare circumstances under which physicians did not accept cis men's suffering as a reasonable justification for granting them access to male enhancement procedures. In these cases, doctors were concerned about making any kind of medical intervention out of concern for perpetuating *harm* against cis men who (might) suffer from Body Dysmorphic Disorder. I analyze these cases, alongside other invocations of the discourse of harm, in the next chapter "Harm, Regret, and Dissatisfaction: A Somatechnic Analysis of Trans and Cis Genital Interventions".

Chapter 5

Harm, Regret, and Dissatisfaction: A Somatechnic Analysis of Trans and Cis Genital Interventions

> *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.*
>
> —T. Garner
>
> *Stitching Up the Natural: 'Manboobs,' Pregnancy, and the Transgender Body*

Continuing to unpack the (de)naturalization techniques that operate through the medical management of both male enhancement patients as well as trans folks seeking gender confirmation surgery, in this chapter I critically examine *harm* as well as *regret* versus *dissatisfaction* as discursive devices that differentially materialize sexed and racialized bodies, gender identities, and the relation between them. As I demonstrate in my analysis of physicians' comments below, these discourses pathologize particular racialized somatic practices as well as the identities and post-surgical bodies of trans people, marking them both as unnatural constructions, while normalizing and naturalizing cis men's bodies and subjectivities, both prior to and succeeding medical intervention. Understanding through a comparative somatechnic method (Sullivan 2005a, 2009a, 2009b) how the discourses of *harm*, *regret*, and *dissatisfaction* work in each medical context renders visible the materialization of cis men's bodies and identities.

Harm

Seated across from Dr. Fraser in his sun-filled office, I conclude our interview by asking him "if you could share anything with the general public about the work that you do performing gender confirmation surgeries and male enhancement, what would it be?" Dr. Fraser paused to think, rocking quietly in his office chair. After a protracted silence, he perches his elbows on his desk, interlacing his fingers in front of him as if to center himself in preparation for his answer. I lean in ready to hear the secret he is about to share with me. "Sometimes making someone whole" he says calmly, "is taking off a part of them." How do physicians like Dr. Fraser determine if a procedure will make their patients "whole" or harm them? Why are some somatic interventions thought to be corrective, restorative, or augmentative, while others are thought to cause harm? The ways in which differently-sexed and racialized bodies materialize through conceptions of harm will comprise the focus of my analysis in this section.

One of the foundational principles of contemporary medical care in Canada and the United States is 'above all do no harm'. Despite its widespread usage, the interpretation and application of the edict to 'do no harm' is contested by both physicians and mental health practitioners, particularly regarding the care of trans patients. As the Standards of Care (version 7, 2012) make clear under the section "Ethical Questions Regarding Sex Reassignment Surgery", some health professionals object to gender confirmation surgeries as a treatment for trans folks experiencing gender dysphoria. They make these objections on the basis that genital surgeries (among others) for trans people do not treat "pathological tissues", concluding instead that they perpetuate harm against trans bodies by "altering anatomically normal structures" (55).[1] Interpreting the medical principle to 'do no harm' in this way results in an uneven application of this edict, since cosmetic procedures like male enhancement also intervene upon bodies medically-deemed "anatomically normal", yet those procedures (mostly) escape accusations of perpetuating harm (see Pentney 2012).

[1]This section of the SOC (version 7, 2012) also contrasts gender confirmation surgeries with "ordinary" surgical interventions "made to body features to improve a patient's self image" (55), suggesting that gender confirmation surgeries are, mystifyingly, somehow unrelated to the "image" one has of themself, including their gender.

Such an uneven interpretation and application of the ethic of care positions the pre-surgical bodies of trans people as natural, thereby casting the post-surgical trans body as unnatural, constructed flesh.

Even though I did not explicitly ask physicians how genital interventions could potentially harm trans or cis patients, practitioners elected to discuss potential harms in response to other questions I posed about a variety of topics. The doctors who participated in this research frame trans folks as experiencing harm on the basis of altering "normal" anatomy with permanent consequences for the naturalness of their bodies, while under mental and emotional duress from gender dysphoria. And according to practitioners, gender confirmation surgeries also allegedly create permanent repercussions for trans peoples' gender identities, as we saw in the previous chapter, "Authenticity and Suffering", from physicians like Dr. Schneider, whose theory of gender acquisition locates the origin of gender identity within the sexed body.

Practitioners emphasized that trans people are likely to experience harm to the sex and gender assigned to them at birth, to the exclusion of all other potential harms trans folks could experience from medical intervention. While both cis and trans patients can experience harm as a result of post-operative medical complications, for example, practitioners only discussed negative outcomes in the context of cis men's medical interventions. Similarly, both US physicians and Canadian doctors—despite operating under differently-regulated healthcare systems—discussed how cis men could experience harm as a result of inadequate or reckless medical care under capitalist systems that prioritize profit accumulation over human well-being. This is a rare moment of critical resistance that physicians demonstrated. However, this form of resistance is limited; again, while both cis and trans people can experience harm from inadequate or reckless medical care, practitioners never included trans patients in this discussion, only cis men. It is unclear why doctors did not include trans folks in these conversations; however, by effect, it makes it appear as though the only harm trans patients can experience from gender confirmation surgery is harm to their 'natural' sex and gender.

By comparison, cis men could experience harm from male enhancement in multiple ways. In addition to the harms to cis patients identified by practitioners above, physicians established two other means by which cis men can experience harm from genital technologies: first, due to "unorthodox" genital procedures, and second, if they underwent a procedure while suffering from Body Dysmorphic Disorder (BDD). In terms of cis men receiving "unorthodox", "unusual", or "psychologically dangerous" medical interventions, physicians generally framed racialized genital interventions that challenge normative conceptions of masculinity and whiteness as causing cis men harm. For example, through the politics of transgression (Cadwallader and Murray 2007), bead or nodule insertions into the skin of the penis as well as penile reductions were "weird" and "unhygienic", according to male enhancement practitioners.

Most of the doctors in this research also claimed that if a cis man has BDD, he can experience harm as a result of *any* cosmetic intervention, including procedures as minimally-invasive as Priapus Shots for mild girth enhancement. Here we see a rare overlap between the gatekeeping of trans patients and the gatekeeping of body-dysmorphic cis men, both of whom medical practitioners frame as having internal, psychological problems that cannot and should not be ameliorated through physical interventions. From the case examples below, I illustrate how physicians—in the course of practicing medicine—mobilize harm as a discursive device that naturalizes whiteness, phallic masculine embodiment, and cis identification, while pathologizing particular racialized somatic practices alongside the identities and post-surgical bodies of trans people.

"Swimming Against the Stream of Nature": Harm to the Cis Body

Many physicians who participated in this research cautioned against opening the gate to gender confirmation surgeries because they allegedly result in "a total change of identity" as Dr. Schneider claimed, or because trans patients might be "going through a phase" as Dr. Fraser surmised in Chapter 4. In each of these statements, it is possible that doctors were alluding to concerns about perpetuating harm through permanent physical changes that have implications for both identity and the body. But few practitioners so explicitly discussed harm in the context of trans healthcare as Dr. Fray, who was unequivocal in his

concerns about gender confirmation surgery causing harm to trans patients. While Dr. Fray's private medical practice is geared towards procedures for cis men, recall that he regularly worked with trans patients during medical school, so his comments do not stem from a lack of experience treating trans patients. After describing trans folks as more mentally unstable than cis people (in Chapter 4 under the section "Suffering as Instability"), Dr. Fray went on to say:

> I think that whether [the medical establishment and insurance companies are] electing to discriminate against [trans people], or to protect them, or simply to give them a filtering system of making sure that *they're not doing any harm to them, which is part of the Hippocratic Oath*, or whatever the reasons—good, bad, or indifferent—there's the reasons. The reasons are there. [emphasis added][2]

Notice how Dr. Fray frames his response: it is unimportant—"good, bad, or indifferent"—whether gatekeeping access to genital surgeries will "discriminate against [trans people]" or "protect them" if the intention and result of gatekeeping is the prevention of harm. Yet the very real harm from such discrimination—or more accurately, the harm from oppression[3]—against trans people in cisnormative societies like Canada and the United States is not given the same ethical consideration compared to the potential harm caused by gender confirmation surgeries. To be clear, when Dr. Fray invokes the idea of harm as a result of these surgeries, he is specifically referring to harm against the sex of the 'natural' body.

> Look *you're swimming against the stream of nature on this one*. Because *nature said* penis and you're saying vagina. And so it's not like we're enhancing penis, we're actually having *to go against nature*. I actually do understand that, I think that something that's *non-reversible* that could cost a lot of money that the person is not going to pay for and could also lead to either malpractice or a wrongful injury [lawsuit] as a result of claiming mental health issues.[4] I just

[2]The Hippocratic Oath, despite popular belief, is not required of modern medical students and does not explicitly state 'above all do no harm'. Medical institutions in the United States for example, have adopted their own versions of medical ethics that suit contemporary medical and cultural values (North 2002).

[3]Oppression is the systematic marginalization and erasure of a group through power. It negatively shapes the life chances of groups of people, bringing them in closer proximity to precarity, suffering, and death. Oppression and discrimination are historically and materially distinct; while discrimination can be hurtful, it is not historically entrenched nor institutionalized like oppression.

[4]Dr. Fray's remarks here about broader institutional bodies—such as insurance companies, public bodies who cover gender confirmation surgeries, and the medical establishment—may or may not reflect how they

> think [mandatory mental health assessments are] just there to *protect* all the parties and it's still best in [the patient's] *well-being*. And *if all it does* is require the [trans] recipient to have to prove their intention to approve to prove to prove uh some mental you know uh stability in their decision look like you [*sic*] say, *you're going against nature on that one*. [emphasis added]

Here Dr. Fray is raising alarms about harming the 'nature' of the sexed body. In addition to Dr. Fray claiming authority over reading nature's intentions ("*nature said* penis" [emphasis added]), as well as emphatically naturalizing cis embodiment, he also explicitly pathologizes post-surgical trans embodiment as "swimming against the stream of nature". Dr. Fray's concern for the 'natural' sex of the body is heightened by the fact that genital surgeries on trans folks are largely "non-reversible", meaning that gender confirmation surgery would—according to the ethic of body modification espoused by practitioners like Dr. Fray—permanently mark trans bodies as unnatural constructions.

To quote trans somatechnician Jules Gill-Peterson (2014), who has analyzed logics like those perpetuated here by Dr. Fray, "[t]he use of technology to modify the body can be deployed against its authenticity, as a means of devaluing the trans body by measuring only its resemblance to the presumed natural cisgender body" (406). Despite somatic intervention into the bodies of cis men, they emerge after male enhancement procedures with the 'nature' of their sexed bodies unharmed, because physicians like Dr. Fray construct cis men's genital projects as merely "enhancing" or "improving" the genitals they already 'have' within a narrow range of plasticity (i.e. from a penis to a larger penis), rather than a transformation that "go[es] against nature" of the sex they were assigned at birth.[5]

Dr. Fray downplays the consequences of delaying trans peoples' access to appropriate medical care when he remarks "*all it does* is require the [trans] recipient to have to prove their intention" [emphasis added]. From this comment, Dr. Fray

do in fact operate in the world; I am not conducting an institutional analysis here. However, it is important to stress that the discourses taken up by Dr. Fray and other medical practitioners about institutional bodies informs how they make sense of, justify, and gatekeep access to genital technologies that would transform bodies of flesh in their medical practices. For physicians like Dr. Fray, aiming to avoid potential harms directed at institutional bodies is a justifiable reason for delaying trans peoples' access to medical care until they can "prove their intention." Harm is therefore not the property of naturalization techniques alone.

[5]For a genealogical analysis of gender and sex plasticity within endocrinology, and how reversibility operates as a stand-in for plasticity, see Gill-Peterson (2017).

demonstrates that he either does not understand the impact that gender confirmation surgery can and often has in the lives of trans people in terms of social and state recognition, in terms of survival, and in terms of reducing harm (see Spade 2015), or he subordinates these positive outcomes in an attempt to protect the supposed 'nature' of the sex assigned to bodies at birth. Absent from my interviews with practitioners (except for one that I detail in the section "Resisting Discourses of Trans Regret") was any mention of the harms from forcing trans folks to live through daily violence under a cisnormative, trans-oppressive society. Pointing to what was not said in my conversations with physicians is consistent with the analytical method of deconstruction at the centre of this project, but is complicated by the character of qualitative data given my co-creative role in guiding the interview discussion, and therefore, my ability to point to those absences during the conversation. Nonetheless, practitioners' silence on the harms to trans people living under social oppression—especially when contrasted with how vocal they were about the "burden that society has placed [on cis men]"—was nevertheless a particularly painful absence.

While scholars like Lane (2018) and Garner (2011) have both noted a tension between the harm health practitioners assume will result from surgery, and the harm associated with gender dysphoria—with the opening or closing of the gate to access surgery relying on the significance doctors attribute to each—the male enhancement and trans healthcare physicians who participated in this research do not report this tension. Only the harm to the 'natural' body and cisgender self as a result of gender confirmation surgeries was reported by medical practitioners in our interviews. Thus, the discourse of harm was mobilized against trans people as a naturalizing technique of the sex assigned to bodies at birth. How the discourse of harm operated in the context of male enhancement for cis men is the theme I turn to in the next section.

"Unorthodox Procedures" and Harm to Whiteness

When practitioners discuss harm in the context of cis men's genital enhancement, they often frame these harms as resultant of "unorthodox", "unusual", or "psychologically dangerous" medical interventions. Procedures that physicians deemed unorthodox include

bisecting a penis, surgery to have more than one penis, penile augmentations whose size makes penetration either impossible, or causes the partner unwanted pain (which I discuss in Chapter 6), the insertion of beads or other nodules under the skin of the shaft of the penis, as well as penile reduction surgery. In general, doctors refused to talk with me much about bisecting a penis or surgery to have more than one penis, claiming that they are "ridiculous" or "isolated requests" that do not reflect their medical practices.[6] However, some physicians briefly spoke about bead or nodule insertion, and many practitioners discussed penile reduction surgeries with me at length, even though requests for either of these procedures are relatively rare within the medical practices of the doctors who participated in this research.

The insertion of beads or nodules underneath the skin of the penile shaft is practiced in some societies—often in Asian countries—in order to create texture that men allege increases their sexual partners' pleasure (Hull and Budiharsana 2001).[7] Physicians' outright rejection and pathologization of bead and nodule insertion in our interviews demonstrates how they demarcate acceptable, normalized genital practices of male enhancement and circumcision,[8] from dangerous, 'unnatural' genital practices of mutilation. The politics of somatic acceptability and of bodily transgression are not naturally self-evident, but rather, always filtered through and materializing from power. In this particular case, whiteness as a somatechnology (Sullivan 2012, 2007; Pugliese and Stryker 2009) casts bead and nodule insertion practices as transgressive through processes of racialization.

Physicians will often gesture to other(ed), racialized cultures—most commonly from Africa—where they say cis men of colour have been stretching and hanging weights

[6]For example, Dr. Lieberman, a physician practising in the United States, cut our interview short because he said my questions about unorthodox procedures did not represent his practice in urology, and he was not going to respond to those questions.

[7]See Fischer et al. (2010) for a broad overview of the literature dedicated to penile nodule implantation, which concludes that the majority of these procedures take place in "Asian and Slavic countries", adding that they have "occasionally emerged in Western society" (3570). While white people from Canada and the United States may be inserting beads into the skin of their penises, these practices continue to be racialized.

[8]Notably, physicians like Dr. Lieberman suggested in our interview that not engaging in genital practices like circumcision is a reflection of racialized ignorance, neglect, and poverty, and recommended "mass circumcision there [in China] too just like Africa". See Gilman (1999) for a historical analysis of the racialization of the foreskin.

from their penises for more than a century. They make these gestures as a way to legitimize the male enhancement procedures they perform in Canada and the United States. For example, Dr. Allen, made appeals to unnamed African cultures' genital practices in order to defend the male enhancement procedures he performs. Dr. Allen is a US physician who has specialized in gender confirmation surgery for about forty years, but has also performed suspensory ligament releases and penile girth enhancements with fat injections for cis men. During our interview, while discussing post-operative care for cis patients who have undergone his lengthening procedure (who must maintain tension on the penis with weights and stretching to prevent retraction), he abruptly pivots to discuss other groups of people who engage in similar penile elongation techniques.

> Some islanders in the south seas in *Africa* lengthen the penis simply by wearing weights. By wearing weights for varying lengths of time during the day, they construct the different materials to hold onto the penis and wrap the penis around and add weights to it, gradually increasing the weight and increasing the length of the penis. And I have no experience using only that technique of lengthening the penis, but I've seen pictures and it works. [...] I know that's done in certain *African tribes* and I think maybe in the *South Pacific Islands* they might do that too. I forget where they they did that, but I know *Africa is one country* [*sic*] *where it's done. In certain tribes.* [emphasis added]

By broadly referring to unnamed, racialized tribal cultures in the South Pacific Islands as well as tribes from a nationally and regionally-undifferentiated Africa, Dr. Allen attempts to legitimize his male enhancement procedures in the United States by framing them as existing beyond the contemporary west. The logic is, if other people—particularly tribal cultures—engage in similar bodily practices as 'us'—presumably before 'they' had exposure to 'our' values, customs, beliefs, or medical technologies—then it is more likely that these genital practices are not just strange behaviours unique to our culture, but rather, they are closer to our bodily practices as human beings (at least for those who have penises). In other words, Dr. Allen mobilizes racialized others as evidence of the universality of penile augmentation practices.

Like Dr. Allen, Dr. Rosenburg made a similar appeal to racialized groups engaging in comparable genital practices, stating matter-of-factly:

> I recommend [a vacuum pump]. And I usually prescribe two ten-minute sessions a day, and within six months your penis will be enormous. Um *this is nothing new.* The *Ubangis* [*sic*] put plates in their lips, gaugers put dishes in their ears. [...] There are *tribes* that you can find *dating back again over a hundred years* where they tie stones to their penises. And they get giant long penises and they actually have regional competitions. How much weight can you drag around with your penis? Those *tribes* have done remarkable things with penile lengthening. [emphasis added]

Through these vague appeals to other(ed), unnamed, racialized cultural practices that have allegedly existed in Africa before or outside of the use of vacuum pumps, western medicine, and 'modernity', physicians like Dr. Allen and Dr. Rosenburg are attempting to validate and normalize contemporary male enhancement practices in Canada and the United States. By associating male enhancement with African tribal cultures—imagined historically in the west as 'closer to nature' (see S. Hall 1990), as "humanity in its most primitive state" (Bello-Kano 2005, 37)—practitioners constitute penile enlargement as not unnatural, and therefore, as more socially acceptable. While various cultures throughout the world have allegedly engaged in penis stretching and elongation—from Africa (Lemperle and Elist 2015), to the Middle East (Wylie and Eardley 2007), to Indonesia (Oktavian, Diarsvitri, and Dwisetyani Utomo 2011) to Brazil, Peru, and India (Talalaj and Talalaj 1994, cited in Wylie and Eardley 2007)—the utterance from white, male enhancement doctors in the west claiming that penis enlargement is "nothing new" is not a neutral fact; it is part of a broader discursive regime in which somatic practices from other cultures are removed from their socio-historical context for the purpose of defending the current male enhancement industry in contemporary Canada and the United States.

Yet, physicians are quick to pathologize other genital practices common amongst racialized groups, like bead or nodule insertion under the skin of the shaft of men's penises, characterizing these practices as harmful. For example, Dr. Schneider and Dr. Wexler both discouraged the use of bead insertion in the penis. When I asked Dr. Schneider if he has ever seen patients who have received procedures that he would characterize as psychologically dangerous, he stated: "I've had [patients who] *inserted beads* and take really *tiny beads like BB's.* [...] *really really weird* stuff" [emphasis added]. When I asked Dr. Wexler if there are people he would not accept as patients, he responded that he accepts almost all patients,

even those who make "unorthodox requests" because "it may be *better to put a little bit of fat in a phallus* than it is to send them to a tattoo parlour where they may or *may not have good hygiene* and have them put *metal beads* up and down the shaft" [emphasis added]. In other words, expanding the dimensions of a penis through a girth enhancement is a form of harm reduction, because girth enhancements are normalized and considered safer compared to practices like bead insertion that Dr. Wexler characterizes as unhygienic, Dr. Schneider considers "really really weird", and both construct as harmful.

What the practitioners I interviewed constitute as "weird" is not race-neutral; the "weird" is fully informed by particular norms, contexts, histories, and discursive regimes about the body, as well as the situated positions of the doctors who participated in this research, the vast majority of whom were white. From physicians' comments, we see how the privilege of whiteness plays in the politics of transgression. Despite the racialization of very large penises as Black,[9] whiteness as a somatechnology casts length and girth augmentation as safe, normal, predictable, and acceptable, while marking genital interventions like bead inserts as "unorthodox" and harmful through normalized, yet veiled processes of racialization.[10] In the next section, I further analyze how medical practitioners close the gate to "unorthodox" genital procedures, but in this case, they close the gate based on their conceptions of harm to normative masculinity.

"Unorthodox Procedures" and Harm to Normative Masculinity

Another "unorthodox" genital practice that male enhancement physicians framed as harmful was penile reduction surgery. According to sociologists and psychologists Lever, Frederick, and Peplau (2006) who studied women's and men's views on penis size, 0.2% or 51 heterosexual men in their sample (N = 25,594) desire a smaller penis (135), whereas 2% or 529 heterosexual women in their sample (N = 26,437) wished their cis men sexual partners had smaller penises (139). Grov, Parsons, and Bimbi (2010) report that among a

[9]See the section "The 'Big Black Dick'" in Chapter 2 and the section "Denaturalizing the 'Big Black Dick'" in Chapter 6.

[10]See Heyes (2009a) insightful article "All cosmetic surgery is 'ethnic': Asian eyelids, feminist indignation, and the politics of whiteness" for a discussion of how all cosmetic procedures are racialized somatic interventions.

sample of 1,065 men who have sex with men, 1.4% or about 14 men desire a smaller penis size (790). While both of these studies drew from non-representative samples, and therefore, cannot be generalizable, what their findings do reveal is that, while wanting a smaller penis may be rare, it is not 'unthinkable'[11] despite what practitioners like Dr. Tabibi may claim.

Dr. Tabibi's medical practice was built on increasing penile length and girth and testicular size using implants. The sizes of his implants range from large to extra extra large, because as he explains, "we don't call the penis or testicles small". I asked Dr. Tabibi how he would respond if a patient requested a procedure to shorten, narrow, or otherwise reduce his penis size, to which he responded forcefully:

> You can't do that. [...] We cannot do that, because you know I cannot decrease the size of the penis. You know I cannot decrease the girth of the penis also. Let's say the patient has a fat injection [enhancement], when I remove his fat [through a revision surgery], definitely his penis gets narrow because all this bulge, bumps, and lumps and everything was removed so his penis gets narrow. When you cut the suspensory ligament [for enhancement], there's a chance of retraction of the penis so the patient['s penis] gets shorter. All the patients who had—independent [of me]—suspensory ligament cut, they got shortening of the penis, okay. But I don't think anybody in *just and the right mind and natural and healthy thinking* [would] think about shortening their penis or narrowing their penis. Nobody wants to do that okay. *It's it's it's against you know the natural situation of mind.* Because *everyone wants bigger.* [emphasis added]

To be clear, penile reduction surgeries are possible and have been performed successfully (Martinez et al. 2015). So when physicians like Dr. Tabibi say they "cannot" perform them, it is not as though male enhancement doctors are unable to reduce a man's penis size due to the constraints of medical techniques or technologies, or the material limits of the body, but rather, physicians are *unwilling* to perform penile reductions. To further clarify Dr. Tabibi's remarks, while the intention of a suspensory ligament release is to elongate the penis by allowing the 'inner penis' to extend outside of the body, there is always a risk of

[11]It seems as though wanting a smaller penis is regarded as so unthinkable that medical researchers like Bjekić et al. (2018) did not even design their study in a way that allowed participants to say if they wanted a smaller penis, assuming that their participants were either satisfied with their penis size or wanted a larger size (314). Grov et al. (2015) also limited participant responses with regards to penis size satisfaction, reporting only one option, "wishes penis was larger", effectively erasing penis size satisfaction and wanting a smaller penis (229).

penile shortening as an adverse outcome. Dr. Tabibi claims that all of the men who get a suspensory ligament release from other practitioners (but not from him) will experience penile shortening as a negative outcome. According to Dr. Tabibi's logic, it is acceptable if a revision surgery that removes the "bulge, bumps, and lumps" of a poorly-executed enhancement results in a smaller or shorter penis, precisely because it works to reverse the harm from 'penile deformity'.

However, beyond these examples of unintentional shortening, Dr. Tabibi claims it is pathological for a man to willingly desire and pursue a penile reduction. From his comment, we see how practitioners regard "unorthodox" procedures like a penile reduction as unnatural, unhealthy, and unthinkable because it "goes against the natural situation of the mind" since "everyone wants bigger." Dr. Tabibi continued to make his point about the impossibility of penile reduction surgeries by using an analogy, this time with a chuckle punctuating his remarks.

> [Shortening or narrowing the penis is] like to say [to a] billionaire "how bout if he get hundred million dollars from you and threw it in the fire?" [The billionaire would] say "why why? Why you want to, why why you want to do that when I can keep the money?" You know? "Do something else, okay? *I might lose in the business transaction, but I don't want you to put it on the fire*". [emphasis added]

Unpacking Dr. Tabibi's analogy, he is claiming that patients take on an acceptable level of risk of harm when they undergo male enhancement procedures from which they might lose length or girth as a result of surgical complications (they "might lose in the business transaction"). Risking harm to your penis through male enhancement for the post-operative possibility of a large cock is acceptable, according to Dr. Tabibi, but to waste a large penis by purposefully shortening or narrowing it is comparable to winning the jackpot (a "hundred million dollars"), and burning it. And in a patriarchal, capitalist society like the United States (where Dr. Tabibi practices medicine) that values physical, social, sexual, as well as economic dominance grounded in social inequality, what is more 'natural' than coveting a big dick and millions of dollars?

Body Dysmorphic Disorder and Harm to Normative Masculinity

The medical management of trans and cis patients seeking genital interventions is not without some overlapping commonalities; like the gatekeeping of trans patients, doctors in this research gatekept cis men when they suspected that these patients suffered from an internal, diagnosable, psychological problem. In fact, the only cases of suffering that medical practitioners did not regard as a reasonable justification for granting cis men access to genital technologies, was if they suspected that the patient had a mental disorder such as schizophrenia, but most commonly Body Dysmorphia.

Dr. Midden was particularly vocal about gatekeeping body-dysmorphic cis men. He is a physician who has been performing various penile length and girth augmentations, as well as scrotal enhancement procedures for about twenty years in the United States. When I asked Dr. Midden why trans folks require letters from mental health practitioners before receiving access to genital surgeries, but cis patients do not, he made a distinction between most cis patients and cis people with BDD.

> [I]f you want to get your nose done or your eyes done do you need to see a mental health professional first? I don't know, I don't think so. Are there people with Body Dysmorphic Syndrome? Absolutely. Again is a plastic surgeon better able to ascertain that than a urologist? Absolutely.

Dr. Midden added that he is best-equipped to filter out patients with BDD because of his training and experience working in plastic surgery, closing the gate to genital technologies. Unlike Dr. Midden, most doctors in this research admitted that they did not feel qualified to diagnose mental health disorders or appropriately counsel psychologically-distressed patients. Yet out of the twenty doctors who participated in this research, only Dr. Midden and four other physicians said they have referred patients to mental health professionals. The fifteen practitioners who do not direct cis male enhancement patients to professional counselors might delay a procedure, but more commonly, they refer patients they believe are suffering from BDD to other physicians who may be willing to take them on as patients.

BDD is catalogued in both the World Health Organization's *International Classification of Diseases* as well as the American Psychiatric Association's *Diagnostic*

and Statistical Manual of Mental Disorders (DSM). As outlined in the DSM-V, the diagnostic criteria for BDD includes a preoccupation with perceived physical flaws that others do not see as flaws (such as a small penis),[12] repetitive behaviours or thoughts in response to these perceived flaws, and "clinically significant distress" (237). BDD is set apart from "normal appearance concerns", because disordered appearance concerns under the BDD diagnosis are "excessive", "repetitive", "time-consuming", and "difficult to resist or control" (241).[13]

When I asked physicians how they identify who has BDD, most mirrored the diagnostic criteria for the disorder. For example, Dr. Schneider answered that he suspects cis men have BDD when their preoccupation with their bodies is excessive and difficult to control, when "they're very focused on their penis to the point of a total obsession. They may transfer all their insecurities to their penis". For this reason, Dr. Schneider says that he does not refer cis men to seek counseling because "even if I asked, they won't go. And if I asked, then I probably would have refused [to operate on] them anyhow". Dr. Midden, on the other hand, diagnoses patients with BDD and refers them to professional mental health support when their appearance concerns are repetitive, time consuming, and cause clinically-significant distress.

> If they've had a number of procedures throughout their body or on their system because they can't quite get it right, that's certainly a way. If they came to be dissatisfied with other [procedures] they've had in the past. If they have a lot of anger, that's sort of a clue [they might have BDD].

Like Dr. Midden who relies on his training in plastic surgery to identify BDD, Dr. Rosenburg says that he has a "coherent narrative" about referring patients to see mental health professionals because of his experience working with trans patients. He says that a preoccupation with perceived physical flaws that others do not see as flaws is his first clue that a patient might have BDD and needs a referral to mental health support.

[12]Phillips et al. (2010) report that compared to women with BDD, "males are more likely to have genital preoccupations" (cited in DSM-V, APA 2013a).

[13]The DSM-V diagnosis of Body Dysmorphic Disorder (APA 2013a) specifies one more diagnostic criteria: "The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder" (236).

> [M]y first line of defense against Body Dysmorphic Disorder is do I see what the patient sees? If I see what the patient sees, the first level has been achieved and I move onto the next level, which is do they understand what I'm telling them and is their expectation realistic?

According to retrospective medical outcome studies, it is in part because BDD patients have unrealistic expectations that they typically do not find relief from distress after undergoing cosmetic interventions (see Crerand and Sarwer 2010; Crerand, Franklin, and Sarwer 2006). However, feminist philosopher Cressida Heyes (2009b) calls attention to how both advertisements for cosmetic surgery, as well as interactions with cosmetic surgeons themselves, introduce patients to novel ways of seeing their bodies as abnormal or marred by imperfections, which may better explain why the distress from BDD is not improved—and in fact often becomes worse—after consulting with doctors and undergoing cosmetic procedures. In either case, both mental health professionals and the physicians who participated in this research agree that bodily transformation through cosmetic interventions like male enhancement is not appropriate for patients with BDD.

Many of the physicians who participated in my research echoed this justification for closing the gate to genital technologies on body-dysmorphic cis men, but few were as explicit as Dr. Rosenburg that performing a male enhancement on a man with BDD would cause him harm. During my conversation with Dr. Rosenburg, I told him that another practitioner I had interviewed would rather offer a minor male enhancement procedure to a patient who might have BDD than reject him, because otherwise he is likely to seek out illegal or unsafe procedures to enhance his penis.[14] When I asked Dr. Rosenburg what his thoughts were on such a "harm-reduction" approach with patients who could have BDD, he replied with a frustrated sigh:

> The idea of doing something small to save them from something else, I just don't see that as an argument. I think that once you have made a diagnosis of Body Dysmorphic Disorder, you are actually *obligated not to do anything*. You're actually *obligated* to teach them that *anything is wrong, is harmful*, because if you do a little bit, *you're reinforcing an unhealthy behaviour*. So I think that argument is spurious, I don't like it. [...] [Male enhancement

[14]I quote Dr. Wexler in the section "'Unorthodox Procedures' and Harm to Whiteness" in this chapter.

> practitioners] get paid to do things- we navigate *shoals of moral hazard*. We must gird ourselves *against the temptation to convince ourselves that we're doing something for the patient's good, but we're really just rationalizing* because we want to sell a procedure. So you have to be doubly steeled against that and when you tell me [...] "do something small just to keep them from doing something big. I'm going to save them from themselves" that just rubs me the wrong way, because I'm overly sensitive to the marketeering aspect of what we do. [emphasis added]

Here Dr. Rosenburg claims that any cosmetic procedure on patients with BDD would be "wrong" and "harmful". In his response, he uses the language of moral obligation as a doctor to reject cis men patients with BDD who are seeking male enhancement, framing this rejection as a way to avoid harm. In fact, Dr. Rosenburg contrasts the rejection of a potential patient with the "moral hazard" of "selling a procedure", of "marketeering" at the expense of a "patient's good". Profiting from a procedure, in other words, is subordinated by the more noble ethic to 'do no harm'. The harm in this case is located in "reinforcing an unhealthy behaviour" of BDD patients, namely an excessive preoccupation with his appearance that causes clinically-significant distress.

In some important ways, gatekeeping cis men with BDD is similar—although categorically not equal—to gatekeeping trans folks with Gender Dysphoria. Again, the raison d'etre of gender confirmation surgery is to relieve trans peoples' suffering, but as I illustrated in Chapter 4, it is precisely trans people's suffering that informs doctors decisions to close the gate to somatic technologies. Similarly, the broadly-recognized function of cosmetic surgery is to relieve patients' emotional suffering (Pentney 2012; K. Davis 2009; Heyes 2009b; Blum 2003), but that suffering—if perceived to be BDD by physicians—can quickly disqualify a cis man's access to male enhancement, which doctors defend as protecting him from harm.

So when confronted with possible cases of BDD, many medical practitioners like Dr. Rosenburg refer cis men patients to mental health professionals, similar—although by no means identical—to trans patients who are institutionally required to see psychiatrists or counselors prior to gaining access to genital technologies. Physicians' logics are surprisingly consistent in these cases across their medical practices with trans and cis patients alike; external modifications to a patient's genitals are inappropriate interventions for addressing

internal, diagnosable, psychological problems that doctors view as defying the 'natural' body or mind. In the case of trans folks, medical practitioners frame them as defying the nature of their sexed bodies and assigned gender. And as I demonstrate below, in the case of cis men, physicians frame them as defying the nature of their gender identities as masculine men through persistent bodily dissatisfaction.

Even if cis men are initially dissatisfied with their penises, all of the medical practitioners who participated in this research expected cis men to be satisfied with their bodies after undergoing male enhancement. Most physicians' criteria for accepting a new patient included the likelihood of a patient's post-operative bodily satisfaction. Heyes (2009b) postulates that one of the functions of psychological diagnoses like BDD is to enable cosmetic surgeons to pathologize patients who are dissatisfied with the outcome of their procedure(s). It is not a coincidence that bodily dissatisfaction—one of the hallmarks of BDD—is also arguably one of the risks of a cosmetic medical practice that doctors most want to avoid in order to limit legal repercussions. After reviewing the psychological literature that is tailored for advising cosmetic surgeons about their practices, Heyes (2009b) remarks "[a]t the end of reading this literature one is left with the clear impression that the ideal, psychologically appropriate candidate for cosmetic surgery expects little of the surgeon" (87).

In my interviews with male enhancement practitioners, in fact, they confirmed that ideal candidates for their procedures are patients who not only pay their bill on time and in full, but also have "reasonable expectations" by accepting outcomes deemed satisfactory by the physician, would be satisfied with a moderate and normative change to their penis size, are not overly anxious about the size of their penis, and would not file a lawsuit against their doctor, even if they experience adverse outcomes. "The cosmetic surgery industry needs us to be distressed about our aesthetically inadequate bodies and works to develop this distress" concludes Heyes (2009b), "creating surgical subjectivity at the same time as it tries to control the less manageable, profitable or normative consequences of this subjectivity" like post-operative dissatisfaction (88).

While Heyes (2009b) argues that medical practitioners' profile of an ideal candidate for surgery "picks out a distinctively feminine comportment" of deference, adding that "men are so often described as less likely to be psychologically appropriate candidates for cosmetic surgery because, among other things, they are 'too demanding'" (87), the doctors I interviewed assumed a different perspective, perhaps because they specialize in cosmetic procedures 'for men'. Physicians' expectations that their patients would eventually become satisfied with their bodies seems to be tethered to doctors' notions of normative masculinity, whereby men should not be 'overly' concerned with their bodily appearance (Weber 2006; Haiken 2000). This may help to explain in part why cis men with BDD are uniquely gatekept by practitioners compared to other cis men. Take for example, Dr. Fray's comments where he genders bodily (dis)satisfaction.

> [O]ne of the reasons I actually prefer to work with men over women [is] because women do tend to... just have a lot more issues. Let's say you were going to do testosterone replacement in a woman. If she had breast tenderness, or she got a migraine, or she got a pimple! Or she had a little bit more hair on her face, or she was losing hair, you would hear about it at one in the morning! Because she would call and would be *freaking out* and just get herself *worked into a tizzy*. With men, you give them testosterone, the penis works great, you never hear about it until the penis doesn't work great, and then they're back in wanting another shot. And so in terms of the maintenance requirement, *men are naturally low maintenance*, *women tend to be*, not always, but tend to be *higher maintenance*. And if you have a busy practice [...] it's kind of a *turn off* when the majority of the people that you treat are going to be calling you and you're going to be *counseling them extensively*. [...] So I'm much more interested in men's health because of that reason. [emphasis added]

From Dr. Fray's comments, we see how bodily dissatisfaction—especially after a medical intervention—is gendered by some of the doctors in this research. Dissatisfaction with a medical procedure, according to physicians like Dr. Fray, is "higher maintenance". Women, he claims, are allegedly higher maintenance for allowing symptoms from medical interventions to get them "worked into a tizzy"—a particularly gendered and disparaging expression—as if breast tenderness, migraines, acne, unwanted facial hair, and hair loss do not warrant medical advice. Men, on the other hand, are supposed to be "naturally low maintenance" and stoic in the face of negative symptoms or adverse outcomes. Practitioners like Dr. Fray consider it a "turn off" to have to be "counseling [patients]

extensively" about their dissatisfaction with their medical procedures. So if a cis man has BDD—characterized by a "repetitive", "excessive" "preoccupation" with their bodily appearance, as well as persistent dissatisfaction with the results of cosmetic procedures—practitioners like Dr. Fray are less inclined to work with them for failing to live up to normative expectations of stoic masculinity. After a male enhancement, men are supposed to be satisfied with their bodies and physicians should "never hear about it until the penis doesn't work great" anymore, not because men are "freaking out" about how their penises look post-operatively.

While it may not appear on the surface as though patient cases of BDD are in any way related to techniques of (de)naturalization, when we consider the comments of physicians like Dr. Rosenburg and Dr. Fray together, we see how gatekeeping body-dysmorphic cis men may be important to male enhancement practitioners to filter out those who would not simply annoy them, but would violate normative, stoic masculinity through persistent bodily dissatisfaction. Men with BDD are thus imagined by male enhancement practitioners as excessively concerned about their appearance beyond what is 'natural' for men, reflecting broader patterns within cosmetic medicine (see Haiken 2000). Cis men who *suffer* from always being *dissatisfied* with their bodies should not receive access to genital technologies, because—according to physicians' logics—it would cause *harm* to normative, stoic masculinity as well as jeopardize their medical practices. As we can see from the case of BDD, the discourses of suffering, harm, and dissatisfaction (the latter of which I analyze in the next section of this chapter, "Regret vs. Dissatisfaction") are intimately entangled in medical discourse, and are therefore, co-constitutive of patients' bodies and subjectivities.

While both Body Dysmorphia and Gender Dysphoria are biopolitical somatechnologies, they do not contribute to the materialization of bodies, subjectivities, and the relations between them in the same way. One of the chief differences between them arises in their differential medical management; among the practitioners that I interviewed, physicians like Dr. Rosenburg assume all trans patients are a homogeneous group of "psychologically stressed", "errant" people and are never given the benefit of the

doubt that they might experience gender euphoria, or be particularly resilient despite living in a cisnormative, trans-antagonistic society like Canada and the United States. Instead, medical practitioners describe trans folks as internally disordered and unstable on the basis of seeking genital interventions that result in "a total change of identity", to borrow Dr. Schneider's words. On the other hand, cis men—by their "anatomy" (see Chapter 4) and 'nature' of stoic masculinity—are unquestionably eligible for male enhancement. Cis men are only disordered when they persistently seek genital interventions that never satisfy their expectations, and thus violate normative, stoic masculinity.

From the comments above, doctors frame the potential harms cis men are exposed to through male enhancement as harm to normative masculinity and to whiteness, which are constitutive of the standard subjectivity and 'ideal' body against which all others are compared in the contemporary western social imaginary. The practitioners I interviewed invoke concerns about harm to phallic masculine embodiment (through BDD and penis reduction surgery), and harm to whiteness (through "unorthodox", racialized somatic interventions). In the case of BDD, body-dysmorphic cis men who are "excessively" preoccupied with their bodily appearance violate stoic masculinity, which dictates that men should be disinterested in focusing on their looks, especially after medical intervention. In the case of unorthodox procedures, they perpetuate harm against one's bodily integrity—and not just harm from possible infections from the bead insertion or unhygienic tattoo parlours—but harm to the social imaginary of the body as white and male. Physicians who close the gate to male enhancement when they suspect patients have BDD as well as when patients request "unorthodox" procedures, thus maintain normative conceptions of cis masculinity and whiteness as natural. In the medical management of trans patients, on the other hand, the discourse of harm was mobilized against trans people as "swimming against the stream of nature", serving as a naturalizing technique of the sex assigned to bodies at birth.

In the next section, I conclude this chapter—along with my somatechnic comparison of male enhancement and gender confirmation surgery—by focusing on the final set of

discourses—regret and dissatisfaction—that I identified from my interviews with physicians as part of the medical management of both trans and cis patients.

Regret vs. Dissatisfaction

Upon first glance, it makes sense for practitioners to be wary about post-operative regret amongst their patients, especially if the procedures they perform often result in permanent changes to the body. After all, most of the physicians in this research explicitly stated that one of the primary reasons they became doctors was to help their patients, not leave them feeling regretful about irreversible modifications to their bodies.[15] However, compared to the limited medical management of male enhancement patients, trans folks are subject to systematic policing of their embodiment projects under the assumption that they will inevitably regret irreversible transformations. This assumption is not borne out by clinical research, which shows the incidence of trans people's regret is incredibly rare. Moreover, gatekeeping gender confirmation surgeries on the basis that they are irreversible, while not gatekeeping male enhancement procedures—which are not always reversible, safe, or efficacious—demonstrates the asymmetrical treatment of these two groups of patients, and the shaky foundation upon which doctors justify closing the gate to genital technologies for trans patients, while keeping it open for cis men.

While doctors were apprehensive about trans patients regretting transition, they only expressed concern about cis men's potential dissatisfaction after undergoing a genital procedure. Departing from Garner's (2011) analysis—which understood regret in the context of trans chest surgery as a denaturalization technique, and the absence of regret in gynecomastia surgery for cis men as a naturalization technique—I distinguish between regret and dissatisfaction as discrete somatechnologies in the materialization of particular bodies and subjectivities. In the next few vignettes, I make the case that the discursive device of *dissatisfaction*—operating within the medical context of male enhancement—is located in the results of procedures for cis men, whereas *regret*—operating very differently

[15]Moreover, as Dr. Fray repeatedly emphasized throughout our interview, avoiding post-operative regret is good for doctors' businesses, as litigation can be very costly.

in the context of gender confirmation surgeries—is located in the 'core', bodily identity of trans people, thereby further casting doubt on the authenticity of trans identification.

In fact, associating regret with permanent changes to the trans body, but not the cis body, continues to express doubt in the authenticity of trans people's identities (which I discussed in greater detail in Chapter 4). This assumption stems from a broader perspective within medicine: that the site around which authentic gender identity naturally coheres is the sexed body, which most doctors in this research presumed will persist even after irreversible genital surgeries, resulting almost predictably in post-operative regret amongst trans patients. The cisnormative expectation of both the medical practitioners who participated in this research—as well as the (over)abundance of investigations examining post-operative regret amongst trans patients (see Zavlin et al. 2018; A. A. Lawrence 2003; Kuiper and Cohen-Kettenis 1998; Landén et al. 1998; Bodlund and Kullgren 1996; Pfafflin 1993; Blanchard et al. 1989; Lindemalm, Körlin, and Uddenberg 1986; McCauley and Ehrhardt 1984)—is that because trans folks "really don't know what they want" and are just "going through a phase", to borrow Dr. Fraser's words, they will regret their bodily transformations. Out of the twenty participants in this research, only one practitioner in my sample, Mr. Bennett, resisted against discourses of trans regret, and I share his comments alongside those of other practitioners in my analysis below.

In the section that follows, I analyze how post-surgical regret is invoked by physicians concerned about the irreversibility of gender confirmation surgeries—which obfuscates both the permanence of many male enhancement procedures and their complications, as well as the higher incidence of cis patients being dissatisfied with genital surgeries compared to trans patients—thereby maintaining the conceptual separation between regret and 'the natural' cis body. Such continued skepticism of trans authenticity, alongside medical practitioners' unwavering confidence in the stability of cis identification and embodiment despite somatic intervention, concomitantly work to naturalize one's sex assignment at birth.

"The Changing of a Mind": Regretting Somatic Transition

Most of the physicians in this research—with a few exceptions—did not explicitly use the word 'regret' when talking about trans folks' post-operative experiences. Instead, medical practitioners often emphasized the irreversibility of gender confirmation surgeries, or relied on euphemisms like trans people "recant[ing] their intent", to borrow Dr. Fray's words. This is not surprising as the entanglement of irreversibility and regret in the context of trans health care is not unique to my participants, but is reflective of a broader pattern in the medical management of trans patients (see Ashley 2019c). In his attempt to justify why cis men have very few barriers to obtaining penile augmentations, while trans folks must go through mandatory counseling in order to access genital technologies, Dr. Harris framed gender confirmation surgeries as an irreversible bodily and identity change.

> Well the transgender operations are basically *irreversible*. And you're going to remove or add something that may or may not meet their expectations. And you know they're going to *completely change their sexual perspective* with an operation. It's a difficult life they're trying to... acquire you know. I look at male enhancement much like breast implants. That's my approach, and if the [cis] man is reasonable and wants to have [male enhancement] done, there's no reason why he can't have it done as long as he understands the risk and expectations. [emphasis added]

The differential treatment of trans and cis patients illustrated here by Dr. Harris is glaring. He constructs cis men as more than capable of being responsible consumer subjects of genital technologies. Trans patients, on the other hand, are represented by Dr. Harris as less-than-capable of making reasoned choices, of understanding the risks of medical procedures, or of managing their expectations for surgical outcomes on the grounds that gender confirmation surgery makes "irreversible" "change[s to] their sexual perspective". The framing of a procedure as "irreversible" is key to many doctor's claims about trans people regretting gender confirmation surgery. In the words of Dr. Harris, if one were to "change their sexual perspective" and it does not "meet their expectations", then they cannot reverse the alterations to their genitals. Emphasizing the irreversibility of trans operations while obfuscating the irreversibility and permanent consequences of many male enhancement procedures (which I discuss in greater detail in the section

"Managing Cis Men's Dissatisfaction with Results") performs the discursive work of disconnecting male enhancement from regret.

Dr. Harris' language of changing one's "*sexual* perspective" [emphasis added] may initially seem ambiguous. After all, many medical practitioners in this research conflated and confused gender, sexuality, and the sexed body, often misusing these terms interchangeably. However, in the context of this conversation with Dr. Harris, I interpret his statement about trans folks changing their "sexual perspective" to mean that trans people are changing their gender identities and sexed bodies, not necessarily their sexuality, erotic practices, or sexual relationships. In other words, the context of our conversation does not seem to lend itself to interpreting this statement as a caution against sacrificing identity coherence as cisgender, in exchange for having different erotic practices after gender confirmation surgery has transformed one's genitals. With that said, male enhancement physicians did discuss in our interviews how they gatekeep access to technologies of the sexed body on the basis of patient sexuality, erotic practices, and relationship structures, but this analysis falls largely outside of the focused purview of this dissertation.[16]

Instead, Dr. Harris' use of the language "change their sexual perspective with an operation" seems to yoke gender identity (one's "sexual perspective") to anatomy (through "an operation"). Tethering gender identity to the material body implies—as other practitioners like Dr. Schneider established in previous quotations about authenticity[17]—that physical transformation through gender confirmation surgery necessarily results in a permanent change to one's 'core' sense of self as a gendered subject. Regret, therefore, is not located merely in the *results* of gender confirmation surgeries failing to "meet their expectations"; the seat of regret in this context rests in the permanent changes made to trans people's 'core identities' as gendered subjects through "irreversible" modifications to the 'natural' sex of the body.

[16]In Chapter 6, I discuss how for Dr. Tabibi, monogamous marriage unlocks the gate to genital technologies. Other practitioners medicalize sexual inactivity, pathologize solosexuality as well as polyamory, and render partnered sex compulsory. Even though this data on sexuality are not central to the arguments of this dissertation, they make rich stories worth telling in other publications.

[17]See the section "'Weed Out the Real Ones': Skepticism of Trans Authenticity" in Chapter 4.

Dr. Fray mirrors Dr. Harris' language in our interview, arguing that gender confirmation surgeries are not reversible, and reasoning that if a trans patient changes their mind after receiving surgery, the consequences are much more damaging and grave than the consequences of male enhancement procedures.

> When you compare [male enhancement] with the potential of *changing a gender*, where you're creating a *non-reversible* surgical treatment, where *the changing of a mind* could result in a potential lawsuit or litigation against the perpetrator or the surgeon, and the person could say "well you should have known that I was mentally unstable" or "I was going through a lot of stress", I think that you're just dealing with a more egregious treatment. [emphasis added]

From doctors' comments, we receive a glimpse as to how the notion of regret dominates medical discourse in the practice of trans healthcare. Physicians' insistence that gender confirmation surgeries risk post-operative regret from trans patients because they are "non-reversible" with potentially "egregious" outcomes is striking, because—while some very minimally-invasive male enhancement procedures are temporary and/or reversible (such as platelet rich plasma injections or Scrotox)—many of the penile augmentations these and other doctors perform are not *reliably* reversible and regularly result in permanent complications.

Girth augmentations with polymethyl methacrylate (PMMA) injections, for example—which essentially consist of inserting several rounds of an acrylic substance around the corpus cavernosum and corpus spongiosum, the erectile tissue of the penis—are not reversible without aggressively removing an extensive section of penile skin (Casavantes, Lemperle, and Morales 2016). One follow-up investigation by Casavantes, Lemperle, and Morales (2016) reported that half of patients who received PMMA injections developed irregularities in the form of unwanted indentations, ridges, and nodules on the penis. Other studies on the use of PMMA throughout the body report similar negative outcomes (Park et al. 2012; Salles et al. 2008). And despite positive reflections from Casavantes, Lemperle, and Morales in their study on the use of PMMA in the penis, serious questions remain about patient satisfaction with the augmentation results due to a low respondent rate to the doctors' follow-up with patients (28%), and

low patient turn out to receive the second and final PMMA injection in the study (33%) (Alter 2016).

Only one practitioner from my interviews, Dr. Wexler, has reported performing PMMA injections. Soon after providing this enhancement to patients, he stopped offering the procedure in his medical practice due to the unknown, long-term consequences for cis men's bodies. In fact, doctors do not know what will happen to men's penises with PMMA in the future (Alter 2016), especially beyond 18 months (Kim et al. 2015).[18] Despite the uncertainty surrounding PMMA's potential impact on men's health, at the time of this writing, there are other doctors—especially in the United States—who continue to perform PMMA injections for permanent girth augmentation.

In addition to the irreversibility of PMMA injections, cutting the suspensory ligament is not reversible either. Seven of the physicians I interviewed for this project had previously performed, or continue to perform this suspensory ligament release to lengthen cis men's penises. As I described earlier in this manuscript, a suspensory ligament release severs the ligament that keeps the penis tucked up under the pubic arch and into the body. The 'inner' penis tucked into the body can be longer in some cis men than others. Releasing this ligament aims to allow the 'inner' part of the penis to extend outward from the body and—according to some physicians—can result in up to two inches gained in length. However, if post-operative care is mismanaged, physicians tell me that it is common for the ligament to reattach causing retraction and loss of not just the length that was gained from the procedure, but *original length* of the penis.

In addition to being irreversible, cutting the suspensory ligament has a history of producing a whole set of complications. To varying degrees, these complications can be ameliorated with additional revision surgeries, but there is no guarantee the complications will resolve. Synthesizing various medical studies, feminist historian Elizabeth Haiken's

[18]For example, Kim et al. (2015) state "long-term follow-up of injections of these materials has not been reported to date. Long-term follow-up is especially important for permanent fillers, since fatal adverse effects can occur, as with silicone" (207). The study by Kim and colleagues monitored patients up until 18 months post-operatively.

(2000) germinal article on male enhancement summarized some of the complications from lengthening procedures, including:

> "[P]enile deflection" (a penis that heads off in the wrong direction), significant scarring, a "hair-bearing penile hump" (because hair-bearing skin from the pubic region is advanced to cover the released "root" of the penis), formation of "dog-ears" (hanging flaps of hair-bearing skin bracketing the penis), "scrotalization" (the flaccid penis is surrounded by and partially or completely disappears into the scrotum), shortening, and decreased sexual function. (401)

While lengthening procedures and PMMA injections are not reversible—and often result in both physical and emotional pain—fat injections and tissue grafts can be reversible, in theory, but they too have a history of resulting in adverse outcomes. Six of the practitioners I interviewed previously performed or continue to perform penile girth augmentations with fat injections or grafts, procedures that have historically resulted in a

> "poor cosmetic appearance" at best, and at worst, painful nodules of fat that required surgical removal; chronic inflammation; spontaneous rupture; irregular resorption of fat (producing, in one case, "a bizarre mushroom shaped penis"); necrosis (literally, "death") of grafted or injected fat (with consequent risk of infection, bacterial contamination, and gangrene); and decreased sexual function. (Haiken 2000, 401)

The first patient to have died as a result of a penile girth augmentation using fat injections passed away in 2017; the fat traveled from the veins in his penis to the blood vessels in his lungs causing a fat embolism (Zilg and Råsten-Almqvist 2017). While this is certainly a rare outlier case, it nevertheless speaks to the potential risks and irreversible harms of fat injections for penile girth enhancement.

Soon after Dr. Harold Reed imported Dao-chou Long's (1990) suspensory ligament release technique from China in 1991, and Dr. Ricardo Samitier Jr. began performing autologous fat injections a few years later (Haiken 2000), the American Urological Association (AUA) announced in a policy statement in 1994 not to support urologists who perform the division of the suspensory ligament for increasing penile length in adults, nor the subcutaneous fat injections for increasing penile girth, because neither have "been shown to be safe or efficacious" (AUA 2018). Since the AUA is one of the most influential scientific and regulatory bodies of urology, this policy has broader implications

for urologists who perform male enhancement; without the support of the AUA, urologists can lose board certification in urology, and medical malpractice insurance companies can nullify physicians' liability coverage. Several surgeons have lost their medical licenses as a result of adverse outcomes and surgical complications from penile augmentations after performing botched procedures (Haiken 2000). Some physicians faced litigation, such as urologist Melvyn Rosenstein who was confronted with upwards of fifty lawsuits from patients, one of whom claimed to suffer from "disfigurement, shortening and loss of use of his penis" (cited in Bannon 1996). Due to the death of one of his patients, Dr. Samitier was sentenced to prison for manslaughter (Bannon 1996).

The risks and complications listed above are the reasons why Dr. Tabibi no longer offers the procedure to cut the suspensory ligament,[19] and why Dr. Schneider and Dr. Allen stopped performing most male enhancement procedures altogether. However, many other doctors in my sample who perform the Man Shot with autologous fat transfer, as well as most physicians who perform the suspensory ligament release, spoke in defense of their procedures citing advancements in medical technologies and significant improvements made to the process. For example, Dr. Fray spoke about the improvements in using much smaller, micronized fat enriched with platelet rich plasma to reduce the likelihood of "dead necrotic fat, lumpiness, oil cysts", and other negative outcomes. Dr. Perry was so confident in the Man Shot procedure, he performed it on himself. Dr. Midden, Dr. Harris, Dr. Fraser, and Dr. Russo spoke positively of their results performing suspensory ligament release. However, the AUA maintains as recently as October 2018 that as a policy they do not support either of these procedures (AUA 2018). The AUA has reaffirmed their policy statement on subcutaneous fat injection and division of the suspensory ligament every one to five years, meaning that they may reaffirm or reevaluate this statement within the next three years.

Practitioners' anxieties about the permanence of gender confirmation surgery and the potential for trans patients to regret these interventions—compared to physicians' relatively limited concerns about the irreversibility of male enhancement procedures and

[19]Dr. Tabibi still performs implant lengthening and girth procedures that, according to multiple members of *Enhancement Forum*, have resulted in permanent complications.

their complications—erase the very real and "egregious" outcomes from somatic interventions as unreliable as penile augmentation. Diminishing the likelihood and severity of adverse outcomes from male enhancement also conceals the processes that (re)naturalize post-surgical cis bodies and subjectivities, so that a cis man regretting a poor outcome from penile augmentation is explained away as 'worth the risk' for the possibility of having a bigger penis.[20]

Resisting Discourses of Trans Regret

Occasionally, the male enhancement practitioners I interviewed resisted dominant discourses. The only practitioner to resist discourses of trans regret, as well as the pathologization of trans folks' bodies and subjectivities, was Charles Bennett. Mr. Bennett is a clinical cosmetic specialist with seven years of experience treating both cis men and trans patients in the United States under the medical guidance of a physician.[21] Mr. Bennett specializes in administering the Priapus Shot for mild girth augmentation and has performed this procedure on more than one hundred patients over the last seven years. Within the last year, he also started offering Scrotox injections to smooth out the rugae, or the wrinkling of the skin of the scrotum, having performed this procedure on less than twenty cis men. While I did not specifically ask about practitioners' sexualities, erotic practices, or relationship structures in interviews, Mr. Bennett explicitly volunteered the information that he is a gay man. He was also the only participant who was not a medical doctor.[22] It is not clear if Mr. Bennett's position in relationship to medical institutions,

[20] Dr. Tabibi's analogy presented earlier in this chapter (under the section "'Unorthodox Procedures' and Harm to Normative Masculinity") speaks to this idea that the risks of male enhancement are 'worth it'. His analogy essentially communicated that one "might lose in the business transaction" by experiencing negative outcomes from male enhancement, but getting an augmentation is still worth the risk for the possibility of having a larger penis. Members of *Enhancement Forum* echoed Dr. Tabibi's sentiment. At the time of my observations of the forum, PMMA was attracting a lot of attention. Forum members frequently claimed that they would sacrifice their penis for the chance of enlarging it with PMMA even if medical professionals determine in the future that the material used in the enhancement causes irreparable damage, because it would be worth the risk for the handful of years of having an enhanced penis.

[21] Different states in the US have different regulations as to who can perform medical procedures and under what supervision. In Mr. Bennett's state, it was legal to perform the Priapus Shot on a patient without a medical license.

[22] All other participants had a medical license at the time of the interview. Only a few physicians in this research abstained from mentioning anything readily recognizable as pertaining to their sexuality. Most

his lack of immersion in certain forms of medical discourse, or his sexuality as a gay man are individually or collectively responsible for informing his perceptions of trans people, but he seemed to suggest throughout our interview that they did. Mr. Bennett did not have any more trans patients than the other participants who specialize in gender confirmation surgeries, but he certainly worked with more trans patients than those practitioners who only specialize in male enhancement.

When I mentioned to Mr. Bennett that the physicians I had already interviewed were concerned about the irreversibility of gender confirmation surgeries and the possibility of trans patients regretting transition, he was initially very confused, as this did not reflect his experiences working with trans people. As a fast-paced speaker accented by a southern drawl and vocal fry, [23] Mr. Bennett responded:

> I treat almost every transgendered [*sic*] person in [the city]. I mean every single transgendered [*sic*] person in [the city] knows who I am. All the therapists recommend me, all the drag queens at all the drag bars scream my name out whenever I go into a bar. They all know who I am. I treat a lot of transgendered [*sic*] patients. Male-to-female, female-to-male and *I've never had one person tell me that they had any regrets.* [...] You could have had a practitioner who was a very conservative republican that you asked that question to that thinks that we're all fucked up in the head, and in their mind everyone who [had gender confirmation surgery] made a mistake and they should have gone to transformation camp or whatever those straight camps are [that] they used to send kids to to make them straight. I mean *I have never ever had someone tell me that they regretted it. Never.* [emphasis added][24]

practitioners mentioned they were married to women; of course this does not necessarily mean they identify as heterosexual or that they do not engage in sexual activities with other people.

[23]Vocal fry refers to "the lowest register (tone) of your voice characterized by its deep, creaky, breathy sound" (Akst and Pietsch n.d.), and is often attributed to women's and gay men's speech patterns.

[24]Mr. Bennett's moment of resistance is significant, although limited. While conservative legislation put forward by republican politicians has aimed to erase, pathologize, criminalize, and dehumanize trans identity, experience, and existence, trans oppression is not unique to the right of the political spectrum. 'Trans-positive' liberals—including mental health professionals—have also been leading proponents of gatekeeping trans access to appropriate medical care out of concern that trans folks might regret gender confirmation surgeries (Whitehead et al. 2012). In both cases—through trans erasure often purported by conservatives and conversion therapists, as well as processes of self-actualization most often supported by liberals through the humanist politics of tolerance (Gressgård 2010)—concerns about regret operate to naturalize cis bodies and identities.

Out of all my interviews with practitioners, this moment of critical resistance to dominant discourses is rare. While Mr. Bennett's experiences are anecdotal, they are supported by scientific inquiry. Clinical research demonstrates it is extremely rare for trans patients to regret gender confirmation surgery—with the incidence calculated at about 1% (N = 232) (A. A. Lawrence 2003) to 1.5% (N = 40) (Zavlin et al. 2018) depending on the study. By comparison, cis patients are up to twenty-three times more likely to regret genital surgery.[25] Which begs the question why trans patients are gatekept out of concern about regret, yet the barriers for cis patients are comparatively low.

I must underscore that presenting these statistics as a challenge to dominant discourses is a limited form of resistance. Despite providing these statistics as a counter-argument, the discursive work accomplished by the notion of regret in the materialization of trans bodies remains mostly unaffected. As A. A. Lawrence (2003) remarked in a study about regret from "male-to-female" (MtF) trans people after 'sex-reassignment surgery' (SRS),

> Superficially, the results of MtF SRS appear to be so uniformly good that looking for factors predictive of satisfaction or regret might seem a pointless exercise. However, because existing beliefs concerning putative predictors of satisfaction or regret continue to affect the lives of candidates for MtF SRS and continue to influence the Standards of Care, such an investigation is warranted. (309)

In other words, conducting research to measure predictors of trans people's post-operative regret is not warranted on the basis that trans folks do in fact regret their surgeries in any way that should meaningfully impact their care as a class of people—they do not. But rather, that this research on regret is only meaningful insofar as people expect it to be meaningful, and those expectations impact the lives of trans folks through the institutions responsible for managing their care. The Thomas theorem (Thomas and Thomas 1928) captures this dynamic well: things that are defined as real—that trans people's post-operative regret is a

[25] Cis patients regret genital surgeries such as orchiectomy—or removal of one or both testicles—at an incidence of 23% (N = 201) (Clark, Wray, and Ashton 2001) and colpocleisis—or closure of the vagina—at 10.7% (N = 84) (Ubachs, Van Sante, and Schellekens 1974) or 9.3% (N = 32) (Wheeler et al. 2005) depending on the study. These articles did not distinguish between dissatisfaction and regret in the *language* they used as I have; however, the *meanings* and *implications* behind such a distinction—that the unhappiness of trans folks is rooted in their identities whereas the unhappiness of cis people is rooted in the results of their procedures—were consistent between their usage and how I employ them here.

meaningful concern—are real in their consequences—such that regret continues to exercise discursive power in the lives of trans folks. The discursive work accomplished by the notion of regret is the persistent denaturalization of trans bodies and identities at the level of institutional health management as well as the everyday lives of trans people.

Bioethicist trans activist Florence Ashley (2020) does not use the language of regret or dissatisfaction, but captures much of my argument about the different treatment of trans and cis embodiment.

> It is a sad reality that in a lot of ways, trans bodies can disappoint us. Yet if I say that, I know cis people will jump to forget just how disappointing cis bodies are. The prime difference is that cis bodies get to be disappointing. Society lets them be disappointing. When bodies that flow from transition-related interventions disappoint us, it's taken as evidence against those bodies (and interventions). Yet no one takes disappointment with cis bodies as evidence against cis bodies. (personal communication)[26]

Ashley illuminates how trans bodies that disappoint are leveraged against transition-related procedures, trans people, and their sense of self as gendered subjects, whereas cis bodies that disappoint do not cast doubt on the cis body or subjectivity. Across all of the cases in which practitioners in this research invoked regret in the context of trans healthcare, it marked the sex assigned at birth of the pre-surgical trans body as natural, constituting the post-surgical trans body as an unnatural construction. As the epigraph quoting Garner (2011) at the beginning of this chapter suggests, this denaturalization process only lends legitimacy to the cisnormative violence enacted against trans people in service of 'the natural'.

Managing Cis Men's Dissatisfaction with Results

Due to the way in which cis men's bodies and identities are naturalized both before and after male enhancement, regret does not take on much salience in this particular medical context. As Garner (2011) observed in the case of gynecomastia surgery on cis men's chests, "It is not simply that it is taken for granted that there is no regret associated with the post-surgical [cis] body", they write. "[I]t 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

[26]Social media post on Facebook, October 4, 2020.

of regret" (138). The absence of regret in the medical context of male enhancement is one of the ways through which cis bodies and identities are (re)naturalized. In this section of analysis, I demonstrate how regret is reserved almost exclusively for describing trans patients' sense of self as a gendered subject and their feelings about medical procedures post-operatively, while a different discursive device of patient *dissatisfaction* is used in the context of male enhancement to describe cis men's disappointment in the results of somatic intervention. The difference between these discursive devices is that regret casts doubt on trans authenticity, working to naturalize one's sex assignment at birth, while cis men's dissatisfaction—excluding rare cases of Body Dysmorphia—does not disrupt the nature of cis embodiment.

This claim may appear to contradict my earlier arguments in this chapter about cis men's persistent bodily dissatisfaction in the case of Body Dysmorphic Disorder and harm to normative masculinity. The primary difference between the two is the extent to which male enhancement practitioners pathologize dissatisfaction or not. While framing cis men as dissatisfied instead of experiencing regret from somatic transformation operates to naturalize the cis body, *persistent* dissatisfaction functions through the medical management of BDD as harm to normative masculinity. BDD denaturalizes the *gendered behaviour* of cis men who are persistently disappointed in having what they perceive to be a small penis, whereas the case of dissatisfaction with male enhancement *results* segregates cis men's post-operative bodies from the unnatural—rendering 'dissatisfaction' an agile and durable discourse in the materialization of sexed bodies and gender subjectivities.

While Dr. Allen was discussing the autologous fat injection and suspensory ligament release operations that he formerly performed before abandoning both procedures, he recalled how both he and his patients were "unhappy" with the "unsatisfactory", "poor results" of his now discontinued procedures.

> [Y]ou'll never know what the final *result* will be. Not only that, you never know exactly how much [girth] is going to stay, and you could easily lose half of [the fat]. But in addition to that, the fat that does remain that does become vascularized can remain as lumps, lumpy masses. Which can be uncomfortable and unsightly. And uncomfortable to the point where the patient is *unhappy* with that, with either the appearance or the discomfort of it, and wants to have

> the lumps removed. So we frequently had to go back and do surgical excision of those fatty lumps. Um... because this was a common problem, and because some significant percentage of patients lost length of the penis from the lengthening part of the procedure, I stopped doing the procedure[s]. Cause *I wasn't happy with the results*. It seemed to me that it was a very high percentage of cases—either the patients were *unhappy* because they lost the length that we created originally, or had problems with absorption of fat and remaining uncomfortable lumps of fat under their skin—that I had to address and re-operate on the patient. That to me it's just the rate of those *poor results* and *complications* were *unsatisfactory*, and so I decided at one point to stop doing them. [emphasis added]

From Dr. Allen's account, he stopped performing the suspensory ligament release for length enhancements as well as girth augmentations with fat injections—not because cis patients "recanted their intent" as Dr. Fray has described trans folks, and not because the poor results of the procedure did not meet the patients' expectations of their newly changed "sexual perspective" as Dr. Harris claimed about trans patients—but because Dr. Allen's cis patients were "unhappy" with the "unsatisfactory" "poor results". That Dr. Allen agrees with his patients' dissatisfaction with the results renders it an acceptable response to adverse outcomes, rather than a case of BDD and harm to normative masculinity. In this vignette, Dr. Allen's attention to "lost length", "unsightly" "fatty lumps", and the "appearance" and "discomfort" of the penis directs our focus onto patient dissatisfaction with the procedure's results, rather than regret located in a 'core', bodily identity change as we see with the medical management of trans patients.

Other practitioners, such as Dr. Tabibi, also discussed cis men's dissatisfaction with the results of a procedure—not due to regret of a 'core' identity change, nor due to "complications" or "poor results" as we saw with Dr. Allen—but rather, due to unrealistic expectations for what male enhancement procedures could realistically accomplish in cis men's lives. In the next quote, Dr. Tabibi recounts a patient case he identified as a possible instance of Body Dysmorphia where he refused to perform a male enhancement surgery in order to prevent patient dissatisfaction with the results of the procedure.

> I refused to do the surgery. I told him "I'm not going to do the surgery". Because I know this guy, I know *he's never satisfied with anything.* He has a larger size penis. I know that he has- and he is *not satisfied*. I'm sure when he gets [a] 10 [inch penis] he's also *not satisfied*. So no matter what I do- because most of these

> people they have some kind of wrong conception of the procedure. They think the larger they go from 8 to 10 [inches] he thinks he can go and pick up ten girls at the bar. So that's the problem they have. And I don't want to be part of that wrong conception. [...] At some point they get *disappointed*. The guy gets *disappointed* because then he goes and says "Oh I can do this and that" and nobody wants to pick him up because his personality, position, financial situation, attitude does not change. [emphasis added]

Take note of how Dr. Tabibi limits the transformative power of male enhancement. Unlike gender confirmation surgeries—which physicians like Dr. Schneider frame as necessarily causing a "total change in identity"—male enhancement does not impact one's "personality, position, financial situation, [or] attitude"; that would be a "wrong conception of the procedure". Cis men's expectations that male enhancement will have a broader impact on their sense of self in relation to others (like potential sexual partners) will only result in patients becoming "disappointed", according to physicians like Dr. Tabibi. Limiting the transformative power of penile augmentation is one of the devices through which male enhancement is conceptually separated from regret, and any unhappiness that may stem from these physical interventions is instead located in the procedures' *results not satisfying* patients' expectations, whether those patients can be diagnosed with BDD or not.

Practitioners' concern about post-operative results for cis men, rather than concern about their sense of self *as men*, was common throughout all my interviews with physicians. Dr. Fray adopted a similar approach as Dr. Tabibi to screen out prospective patients with unrealistic expectations. When I asked how he decides who is an ideal candidate for male enhancement compared to those he would not accept as a patient, Dr. Fray replied that he tries to "weed out" people that will only be "let down" and "dissatisfied" by the procedure's "results".

> I try to have [patients] envision what the most optimal *results* could be [...]. It gives me an idea about whether or not they have healthy realistic expectations, or if I'm dealing with someone who maybe does not have realistic expectations and is likely to be *let down* by any *procedure result*. In those cases, I think as a physician if you do come across people like that you just kindly say "I just don't- I think there's probably other physicians out there who probably would be a better match for you. I just don't know if I'm going to be able to really achieve the kinds of *results* that you want". [...] But you have to put out possible

> scenarios of either *negative outcomes*, *adverse outcomes*, what the potentials are, and keep it real. And if somebody only has rosy glasses we know what happens, it's just *a big let down*. And I don't want a *dissatisfied* patient. I would rather under-promise and over-deliver and also have people have appropriate expectations about what I'm doing. [...] Part of it is that you want people to be *satisfied* and you don't want somebody having unrealistic expectations where even in the best case scenario, you would be failing. So I think... 95 percent of the people out there are just fine. Five percent of the people are more likely to either want to sue you, or would write horrible reviews about you, or just would create a huge fuss, those are the ones you want to weed out before you treat them. [emphasis added]

Like Dr. Allen and Dr. Tabibi, Dr. Fray focuses on "negative" and "adverse outcomes" as well as "realistic expectations" for the "procedure results". Nowhere does he mention that his procedure could result in irreversible changes to a cis man's penis, let alone how this transformation would result in a permanent change in a cis man's identity. Physicians' concerns about cis patient dissatisfaction with a procedure's results are compounded by anxieties that cis men might sue their doctors, or "write horrible reviews" that damage their reputations, or otherwise "create a huge fuss", not because their cis men patients would regret an irreversible and "total change of identity", to borrow Dr. Schneider's words. Comparing multiple cases like these, we see how trans folks are institutionally required to seek counseling in great part to avoid regret, whereas male enhancement practitioners simply mitigate cis men's dissatisfaction and disappointment with the results of penile augmentation. By claiming that cis patients may become dissatisfied, but trans folks will regret their procedures, practitioners naturalize the sex assigned at birth of pre-surgical trans bodies, thus casting post-surgical trans bodies as artificial constructions.

The fine line between dissatisfaction and regret is not politically neutral, and not without real material consequences in the formation of bodies and identities. Some may suggest that both trans and cis people—albeit for separate reasons—are denied access to surgery, so the effect on the incarnation of sexed bodies is in some ways equitable. But the key injustice is that cis men's expectations *can be* and *are* successfully managed by male enhancement practitioners—either their original doctors, or subsequent physicians like those who Dr. Fray claims "would be a better match" for the patient. But doctors believe that 'core' identities like gender and sex are naturally rooted in the body and immutable—and

therefore, not manageable—so gatekeepers prevent trans folks from undergoing surgeries to prevent post-operative regret.

In the very rare cases that doctors expressed concern about their cis patients potentially regretting a penile augmentation because they have not carefully considered the ramifications of the procedure, doctors' responses are much less cautious, and certainly less pathologizing than how they talk about trans patients seeking gender confirmation surgeries. For example, Dr. Midden explains that he has recently changed the policies of his medical practice so that his cis men patients are less likely to undergo male enhancement on a whim.

> [Male enhancement] surgeries [are] performed anywhere from a month to a day because some of them come in from out of town. Have interviews one day and surgeries the next. Although I've made that much less frequent than it used to be, because I really don't want to do this as an *impulse buy* on the part of the patient. So generally it's a two to four week process from the time we talk to them, to the time they have surgery. [emphasis added]

Instead of granting cis men access to genital surgery the day after their initial intake interview, Dr. Midden has started to delay the process to two to four weeks in order to mitigate the likelihood of his cis patients undergoing the procedure on an "impulse" without carefully considering their options, and therefore, potentially experiencing regret after the surgery. Compare this to the majority of trans patients who—following the Standards of Care (version 7, 2012) that outline the best practices in the treatment of Gender Dysphoria—have to go through the 'real life test' living in their affirmed gender, sometimes waiting years to receive letters of support from mental health professionals while paying them large sums of money in order to gain access to gender confirmation surgeries.

Some may argue that it is precisely because trans patients have to submit to such a strict gatekeeping process that clinical research reports such a low incidence of trans regret, that without medical gatekeeping, more trans people would deeply regret undergoing gender confirmation surgeries. My research cannot speak to that. What my and Haiken's (2000) research on male enhancement does show, is that there are no standards of care implemented across physicians' medical practices, no formal guidelines,

and no institutionalized requirements for cis men to see mental health professionals before getting genital surgery. Cis men are rarely and inconsistently referred to mental health supports by the physicians who participated in this research. Moreover, there is evidence from my participants' testimonials that their cis men patients do have gender identity and mental health struggles, and they do second guess their genital procedures afterwards. Despite this, cis men are currently granted access to genital technologies with limited gatekeeping to a great degree because their bodies and identities are rendered natural. And because we culturally naturalize the sex assigned to bodies at birth, appropriate healthcare for trans folks is often delayed or denied, which does cause real material harms in trans peoples' lives (see Travers 2018; Seelman et al. 2017; Brown 2010).

The only other time a physician in this study, Dr. Schneider, even hinted in our interview that his cis men patients might regret an operation, it was not about male enhancement; he expressed concern about cis men regretting a procedure that—as I demonstrated previously (in the section "'Unorthodox Procedures' and Harm to Normative Masculinity")—all doctors who participated in this research were quick to pathologize: penile reduction surgery. Although Dr. Schneider had relocated to a lounge at the airport, he said he could not speak very loudly "because of what we're talking about" in such a public place. When I asked him "Have you ever received a request from a patient to make his penis smaller?" Dr. Schneider responded in a hushed and hoarse voice:

> I get 'em on the internet and I tend to ignore them. [...] I would say probably they're nuts. Okay, probably. I can make it smaller, but I'm not going to unle- I'm not- I don't want to go through the whole psychological aspect of dealing with it. [...] I would tend to think that these guys, it could be a *situational thing* with their partner. In which case I'm not going to do it. Their partner should get taken care of. And if it's not a situational thing [with] the partner, like I told you at the start, a lot of these guys are wacky. [emphasis added]

For Dr. Schneider, interest in getting a penile reduction either indicated that cis men were mentally unstable, or they were making a decision to get a permanent procedure based on situational—in other words, temporary—reasons, suggesting that these patients would likely regret their decision to get a penile reduction surgery after those reasons no longer hold importance in their lives. It is not a mistake that Dr. Schneider assumed that a

penile reduction surgery would be done for "situational" reasons, as this reflects a broader assumption shared by the practitioners in this research: that no man would ever in his "right mind" want his penis to be smaller, and "everyone wants bigger", to borrow Dr. Tabibi's words. So from Dr. Schneider's account, he essentially stated that if desire for a penile reduction is not situational—and therefore, not subject to concern about regret—then it is a sign the men are "wacky" or "nuts".

Technologies of the Natural

The purpose of this and the preceding chapter is not to suggest that the patient experiences, medical practices, surgical risks, institutional structures, or historical contexts of male enhancement and gender confirmation surgeries are the same, and therefore, should be subject to identical practices and codified regulations. To be clear, I am not recommending explicitly or by implication that cis men undergo mandatory counseling—identical to the process trans folks currently undergo or otherwise—before gaining access to genital technologies. Nor am I, as a cis researcher, dictating whether or not trans patients must undergo required counseling to access gender confirmation surgeries as currently outlined by the Standards of Care (version 7, 2012). Trans activists and advocates have been doing this work for a long time to make their own recommendations about how the medical management of trans patients should change and what other practices should emerge (see Ashley 2019a, 2019c; Ashley and Ells 2018; Heyes and Latham 2018; Winters 2018; Latham 2017; Cavanaugh, Hopwood, and Lambert 2016; Bourns 2015; Lev 2013; Hale 2007).

Rather, the purpose of this and the previous chapter, "Authenticity and Suffering", is to bring into relation the norms, histories, and discursive regimes attendant to each of these overlapping medical contexts in order to demonstrate that medical discourse does not merely describe the reality of bodies; it further brings those bodies into being. Medical discourses are a technology of the natural through which particularly-sexed and racialized bodies and subjectivities are constituted. Unpacking and juxtaposing discourses that arise in each of these medical contexts enables us to see the seams and sutures—the ways in

which cis men's bodies and identities materialize through medical discourse—rendering visible their incarnation through somatechnologies of (de)naturalization like *authenticity*, *suffering*, *harm*, and *dissatisfaction* versus *regret*. Equipped with this knowledge, we can attempt to disrupt the violence enacted against trans people and historically-oppressed others in service of cis masculinity, whiteness, and 'the natural'.

Chapter 6

"Too Big Doesn't Mean Anything": 'Monster Cocks', the 'Reproductive Body', and the Racialization of Genitals

...biology is politics by other means.

—Anne Fausto-Sterling

Sexing the Body: Gender Politics and the Construction of Sexuality

The somatechnic analysis that I conducted in the preceding chapters comparing male enhancement and gender confirmation surgery is distinct from the style of analysis that I present here. Instead of bringing particular somatic transformations in relation to each other to emphasize how, despite their similarities, they are discursively framed in contrasting ways, this chapter brings multiple bodies in relation to each other using the figure of the 'monster cock'. In the section below, I offer a more detailed explanation of this term as it appears in the language of *Enhancement Forum* members, but briefly, a monster cock refers to a penis whose size—often after an enhancement—hinders a person from being able to penetrate a circlusive sexual partner, or causes the partner pain. My examination in this chapter of how the discourse of the monster cock operates in relation to the 'female reproductive body', the 'Asian female body', and the 'Black male body' is not a somatechnic analysis in the sense of comparing two or more forms of somatic transformation. However, I bring the insights of the theoretical tradition of somatechnics with me into the analysis of this chapter—for example, the inextricability of technology and

the body, the materialization of the body through discourse, and the relational comparative analysis between bodies and somatic practices—to demonstrate the underlying assumptions, justifications, and prohibitions for particular forms of bodily being.

Two of the questions that I posed to physicians generated the majority of the quotes that I analyze in this chapter. First, I asked what male enhancement practitioners generally think about the monster cock. Second, I asked if there is anything as a medical doctor that they could do to help a cis man who wants to have penetrative sex, but currently cannot without causing pain to his sexual partner. In practitioners' responses, they referred to cis men's sexual partners exclusively as cis women, despite my use of gender-neutral language.[1] I pushed back against physicians' heteronormative assumptions in my interviews by consistently asking how their claims about the body and sexuality relate to their gay patients, with little effect.

I imagine that had I developed different interview tools to challenge physicians to consider even further how monster cocks might be painful during anal or oral penetration—with partners of any gender or sexed body—that framing would have generated rich responses and a valuable contrast in the data. In particular, I anticipate that this contrast would help to demonstrate the parameters of practitioners' understanding of monster cocks, sexed and racialized bodies, sexual practices, and 'the natural'. I doubt physicians, for example, would naturalize one's anal or oral capacity to "accommodate" a monster cock, as neither fit as neatly with existing discourses that naturalize reproductive sex, heterosexuality, or racialize the sexed body. Nevertheless, the analysis of this chapter is limited to and by physicians' talk about male enhancement patients who doctors believe engage in vaginally-penetrative sex with cis women.

Below I share a portion of my exchange with Dr. Rosenburg because it accomplishes two tasks. First, it serves as an example of how I challenged physicians' assumptions of heterosexuality, and second, it is a primer for understanding doctors' reaction to the monster

[1]When defining and explaining monster cocks to practitioners, I carefully and purposefully described them as causing pain to "sexual partners", rather than using gendered language like 'husbands' or 'girlfriends'.

cock as interfering with the "purpose" of the male body. When I asked Dr. Rosenburg what his thoughts were about the average size penis, he responded

> Dr. Rosenburg: My criteria for discussing lengthening of a penis with anyone is if they're less than 4 inches erect because that makes intercourse difficult due to the size of our pelves and the way that we thrust. So anybody who is more than four inches erect is normal and beyond that it's a broad spectrum, I don't quote anybody a number beyond that. I tell them if you're more than four inches erect you are a-ok.
>
> Jennifer: Okay and so if their penis is less than four inches erect would you say that you're more inclined to perform the surgery on them?
>
> Dr. Rosenburg: Yes because then they actually carry a diagnosis of microphallus and again it's a functional problem, it's hard to impregnate a woman if you are three inches when you're erect. The uh the penetration is not adequate. [...] I think the purpose of a penis is to function [...] obviously it has to have erectile potential and if they're interested in procreating it has to have ejactile potential. [...]
>
> Jennifer: You mentioned that part of the function or purpose [of the penis] is procreation, and you talked about [for] men who have a[n erect] penis smaller than three inches it can be really difficult to perform in terms of penetrating a vagina [...] What is the function of your gay patients' penises?
>
> Dr. Rosenburg: Um really to me it looks about the same as a heterosexual conversation. [...] I try to look at it from an individual's perspective. What are your needs? [...] Um everybody has a very different need and desire, and we have that for the way we comb our hair, and we have that for our genitalia if we're trapped in the wrong body, or we're trapped in an adequate body. So I don't really speak to a gay, queer, lesbian, trans person any differently than I would speak to anybody else.

I attempted to restate my question a second time, but rather than responding to my question about the 'purpose' of gay men's penises, Dr. Rosenburg replied that his gay patients were more interested in scrotal lifts than penile lengthening, thus bypassing the importance of length to gay men's ability to "thrust". Dr. Rosenburg's response above demonstrates an evasion and resistance against questions about gay patients that I commonly faced from physicians during interviews, despite gay men accounting for a sizable proportion of most practitioners' patients in their medical practices.

But Dr. Rosenburg's quote is also analytically compelling for considering how physicians think about the purpose of the penis and the 'male' body in terms of (particularly heterosexual) penetrative practices and reproduction. Comments like Dr.

Rosenburg's response above were not characteristic of the majority of my interviews, but they were not unique either. A quarter of the practitioners in my sample identified a cis man's inability to penetrate a cis woman and/or their infertility related to penile length as a failure of the (function of the) male body. As my analysis within this chapter demonstrates, one of the ways in which the male body is reasserted as male is through penetrative heterosexual practices and the naturalization of the 'female reproductive body'.

When discussing monster cocks with me, physicians naturalized the 'female reproductive body', claiming that cis women's bodies are capable of "taking" any size penis due to the alleged biological "design" and "natural" capacity of "the vagina [to] adjust and accommodate the head of the baby". Practitioners often deflected criticism that a man's penis could ever be "too big" or could cause someone genital pain—much less unwanted genital pain[2]—by medicalizing and denaturalizing cis women's inability to "accommodate" *any* size penis through vaginal penetration, for example, due to dyspareunia—a medical diagnosis of "persistent or recurrent genital pain that occurs just before, during or after intercourse" (Mayo Clinic 2018). Framing these women's bodies as having "anatomical issues", "postmenopausal dryness", "scar tissue" or otherwise needing "to be examined by the gynecologist", constructs cis women's bodies as 'unnatural' for failing to "fit"—much less sexually enjoy—a 'monster cock', given the allegedly "natural" capacity of the vagina to stretch, seemingly with few limitations.

Several practitioners attempted to reconcile how cis women could possibly experience unwanted vaginal pain from monster cock penetration. One doctor suggested that genital pain could be a result of a different body build between, for example, a "petite female dating a basketball player". Other doctors racialized the mismatch between genitals. For example, one doctor conceded that a penis could be "too big" when there is a size mismatch between differently-racialized genitals. Invoking the racializing discourse of

[2]I want to draw readers' attention to how most physicians did not even address that this pain could be unwanted, choosing to argue instead that cis women cannot, by biological "design", experience pain *in general* from vaginal penetration. As a result, my language in this analysis oscillates between merely emphasizing that this pain is possible, and stressing that this pain is often unwanted.

the 'tight Asian pussy', this doctor naturalized an Asian cis woman's inability to "take" a monster cock because her genitals are "small by nature". Similarly, another doctor acknowledged that, in particular cases, a penis might be too large for (pain-free) vaginal penetration by invoking the racializing discourse of the 'big Black dick' and the genital swelling caused by sickle cell anemia (which is a disease commonly racialized as Black). He claimed that Black cis men are the only people whose penises could be as large as a monster cock to cause cis women unwanted pain from penetration.

My aim in this chapter then is to map out both the erasure and selective invocation of the monster cock within the medical context of male enhancement. I build the case that for cis men on *Enhancement Forum*, acquiring a monster cock through penile augmentation helps them accomplish phallic masculine embodiment—as a social, relational, and somatechnological process—in relation to other male bodies, and through sexual dominance over female bodies. This is in part because heterosexual dominance is central to contemporary conceptualizations of masculinity (Pascoe 2007). However, given that monster cocks—by definition—impede penetration due to their size relative to the sexed bodies of circlusive sexual partners, monster cock dominance competes with physicians' understandings of the "purpose" of the male body. This chapter illustrates how doctors' discourses of reproduction and 'successful' heterosexual penetrative practices are technologies of the natural that work to reaffirm the body as naturally male.

Physicians' discourses work to frame the 'female reproductive body' as naturally capable of "accommodating" *any* size penis, thereby confirming patients' bodies as male through heterosexual penetration. Dyspareunia functions within male enhancement discourse as a 'failure' of the female reproductive body for undermining heterosexual penetration, and therefore, it places the 'problem' of pain on the female body in order to shore up the boundaries of male bodies. Given that physicians construct Asian cis women's bodies as uniquely vulnerable to experiencing pain from penetration, and frame Black cis men's sexed bodies as uniquely capable of causing cis women pain through vaginal penetration, the 'big Black dick' and the 'tight Asian pussy' function discursively to normalize the sexed bodies of white people. To set the stage for this analysis, I begin by

providing an exegesis for the term 'monster cock', situated within the language of *Enhancement Forum* members.

Monster Cocks

Figure 6.1: Micha Stunz pictured at Folsom Street Fair in Berlin displaying his silicone-enhanced penis (Reprinted with permission from VICE Media; modifications to blur the image background are mine).

The term 'monster cock' is language often used by members of penis augmentation websites like *Enhancement Forum*. A monster cock is a penis whose size—in many cases after male enhancement—impedes a person from being able to penetrate a circlusive sexual partner or causes the partner pain. Offering a contemporary example of a monster cock is Micha Stunz, a cis German man pictured above at a gay leather and fetish street fair in Berlin (see Figure 6.1). In the mini cockumentary[3] *This Is What Life Is Like with a Gigantic Penis: Monster Meat,* Vice Media (2015) interviews Micha about his enhanced penis. After Micha augmented his penis with several rounds of silicone injections, he reports that it now

[3]Cockumentaries are documentaries about cocks, most notably their size. Recent cockumentaries have titles such as *My Penis and I* (2005), *My Penis and Everyone Else's* (2007), and *Unhung Hero: Does Size Matter?* (2013). My use of the term 'cockumentary' should not be confused with the 2011 documentary about cock-fighting roosters called *The Cockumentary.*

weighs up to nine-and-a-half pounds (or about four-and-one-third kilograms); his penile dimensions are about nine inches in length and three-and-a-half inches in diameter (or about twenty-three by nine centimeters). However, these penile measurements are not what necessarily determines his monster cock status; a penis can be much smaller than Micha's and still be a monster cock in accordance with the definition employed by *Enhancement Forum* members, among others. In the course of his Vice Media interview, Micha did not claim to have a monster cock; however, he also did not refute such a label. That Micha reports it is impossible for him to penetrate his sexual partner(s) with his penis because of its large size is—according to many members of *Enhancement Forum*—the hallmark of a monster cock.

By *Enhancement Forum* members' definition, the status of a penis as a monster cock is necessarily relational to the bodies that interact with that penis.[4] Monster cock status as it is defined online and in this dissertation is not a fixed characteristic nor universal 'truth' about the body determined by a specific penis size, but rather, a changing social and relational status of the body. For example, in an *Enhancement Forum* thread asking fellow members interested in male enhancement "How big should we go?", one member writing about his desire for his penis to be a monster cock defined it in relation to sexual partners.

> Why do I WANT to have *unsuccessful sex*??? What I mean here is... I have yet to find a girl that [penetrative] *sex simply wont work with because of my girth*... why in the hell is the thought of that potentially happening a *turn-on for me*? [emphasis added]

This quote foregrounds the social and relational character of monster cocks. For example, "unsuccessful sex" refers to the inability of this cis man to penetrate a "girl" (adult woman?)

[4]Given the social, relational, and interactional character of monster cocks, their incidence is difficult to determine; however, we can infer from cis women's reported experiences of pain from vaginal penetration (see Herbenick et al. 2015; Elmerstig, Wijma, and Swahnberg 2013) that monster cocks exist, as well as cis men's qualitative accounts of causing their circlusive sexual partners pain. The online forum *Large Penis Support Group*—while regarded by some of the site's more than 660 thousand members as an ironic name—is treated by other forum members as an actual place to find community support. Forum members offer each other advice about where to find condoms that fit, how to conceal their genital bulge with clothing, and how to have penetrative sex without hurting their sexual partners. While I referenced the *Large Penis Support Group* in my interviews, it was not part of my online observations of male enhancement forums.

because—*in relation* to her vagina, anus, or mouth—his penile girth would be too large for 'successful' penetration. Like the quote above, most *Enhancement Forum* members spoke about monster cocks in terms of their impacts on cis women's bodies, with one forum member saying "Heck, some men *enjoy seeing a woman struggle* to accommodate a [monster cock] size, which in effect can be a *complaint by the woman, but not necessarily a complaint by the man*" [emphasis added]. Monster cocks are therefore not measured by their absolute dimensions or weight, but by how circlusive sexual partners—in this case cis women—physically experience often unwanted pain during penetration.[5] When I use the phrase 'unwanted pain' I am distinguishing it from consensual pain play in order to signal that monster cock penetration can be sexually violent. Sexual violence refers to *unwanted*, and therefore, *non-consensual* sexual conduct, either completed or attempted.[6]

Cis men interested in getting an enhanced monster cock, however, do not merely define them in relation to and through dominance over cis women's bodies through vaginal penetration; they also define monster cocks in relation to the penis sizes of other men. For example, one *Enhancement Forum* member posted the following in response to the prompt "How big should we go?":

> The bottom line is I don't trust women at all, and *until I was so big that I [my penis] could literally not fit inside her, I would assume she's had [sexual partners with] bigger [penises] and that she loved it way more than me* and she's just lying to protect my feelings. Well, the problem with that is that *I'm not going to think I'm big until I don't fit,* and if I don't fit then what's the point[?] [emphasis added]

In these "women-as-objects stories" (Curry 1991, 128), women serve as a conduit through which cis men gauge their penis size and phallic masculine embodiment compared to other men. Another forum member explained it succinctly when he stated that he wanted a

[5]Because 'circlusion' implies *active* participation, I do not refer to potential acts of sexual violence against cis women as 'vaginal circlusion'; that could be interpreted as if women are *actively* partaking in—and thus somehow consenting to—the violence directed against them. Throughout this manuscript, I use the phrase 'vaginal penetration' rather than 'vaginal circlusion' when I am referring to possible acts of sexual violence.

[6]I use the term 'sexual violence' instead of 'rape' due to the social and historical limitations of this term. As one example of many, rape was originally regarded in Canada as a property crime for 'stealing' the 'sexual purity' of a man's daughter or wife (Keough and Campbell 2014). Because of this history and narrow, particularly legal definition of the term 'rape', I largely avoid using it in this manuscript.

monster cock because "I want to know I am [my penis is] *bigger than the next dude. I want to be the one she measures everyone else against*" [emphasis added].

So as we consider monster cocks throughout this chapter, it is important to remember that—at least in practice—cis men often define monster cocks in comparison to the penises of other cis men, as well as in relation to circlusive sexual partners' bodies—particularly how monster cocks can cause cis women unwanted pain—as a testament to a cis man's phallic masculine embodiment. In other words, monster cocks often serve cis men to feel dominant over cis women and their bodies, as well as physically and sexually superior over other cis men.[7]

After I shared forum members' definition of the term 'monster cock' with practitioners—including how in practice cis men often describe them relationally—I asked physicians for their professional opinion of monster cocks. I thought perhaps the doctors who participated in this research would discuss the logics they would use to grant or deny requests made by cis men seeking a monster cock enhancement—offering different justifications for opening or closing the gate to these augmentations—which at times physicians did provide. I also expected practitioners to discuss the importance of limiting the length and girth dimensions of penile augmentations because of their investments in enabling their patients to engage in penetrative sex, which doctors did discuss, but often indirectly. I originally devised this question to see if physicians would consider offering cis men penile reductions in order to enable penetrative sex, but as I demonstrated in Chapter 5, every doctor denounced reducing a man's penis size.

Finally, I imagined that some practitioners might regard monster cocks as 'unnatural', and therefore, not part of their medical practices since the majority of my participants insisted that they aim to achieve a "natural-looking aesthetic" through male enhancement. However, with the exception of one case shared by Dr. Rosenburg that I detail below (in the section "Denaturalizing the 'Big Black Dick'"), none of the doctors in

[7]To be clear, the (hetero)sexual practices normalized by our culture may require a transformation, not necessarily the dimensions of our bodies, 'enhanced' or not. Micha affirmed in his interview with Vice Media (2015) that there are more ways to have sex than using one's penis to penetrate a partner: "if you're prepared to take other paths, and to try out new ideas, then you might even have a new field [of sexual practices] you can discover".

this research explicitly referred to monster cocks as 'unnatural'. What I did not anticipate was for physicians to declare that monster cocks—penises so large that penetration is either impossible or causes circlusive sexual partners pain—simply do not exist.

The 'Reproductive Body' and Heterosexuality

"Nobody's penis is bigger than a baby's head": Naturalizing the 'Reproductive Body'

The doctors in this research accomplished such an erasure of monster cocks by consistently (re)framing the discussion to focus so acutely on the 'nature' of cis men's sexual *partners*. All of the physicians in this research denied the existence of monster cocks—at least initially—because they defy the 'reproductive body'. In the subsequent quotes that I share, observe how techniques that naturalize vaginally-penetrative heterosex and sexual reproduction enable doctors to deny the importance of—much less the existence of—monster cocks and their ability to cause cis women unwanted pain as circlusive sexual partners. Like the gendered stories told by medical science about the 'active' sperm and 'passive' ovum during human reproduction (see Campo-Engelstein and Johnson 2014; Martin 1991), notice how physicians project gender and heteronormativity onto biology through the naturalization of the 'reproductive body'.

When I asked Dr. Rosenburg if there is anything he could do as a physician to help a cis man who wanted to have penetrative sex—but currently could not because penetration hurt his partner—I thought we might discuss the possibility of offering this man a penile reduction. Instead, Dr. Rosenburg communicated that monster cocks do not exist by the definition I gave him because of cis women's 'natural' reproductive capacities to birth babies. Instead of acknowledging that cis women can experience pain—much less *unwanted* pain—from vaginal penetration with a monster cock, Dr. Rosenburg suggested that his male enhancement patients and their sexual partners can eventually "fit together" if they simply practice

> patience [during sex]. [...] And patience during the relationship. *We're all born of women* and *nobody's penis is bigger than a baby's head.* So *virtually any female could, with enough stretching, take virtually any erect penis.* If the couple is in a

> loving, caring relationship and has patience, *you can fit together*. So I think you start with patience. [emphasis added]

Dr. Rosenburg insists that monster cocks are not real and neither is the pain cis women can experience from vaginal penetration because cis women's bodies naturally stretch to accommodate a baby's head, so eventually one can make any penis that is smaller than a baby's head "fit". The expectation that women and men will no doubt fit together through circlusive/penetrative sex is grounded in heteronormative and binarist assumptions about their respective 'natures', particularly cis women's alleged 'reproductive nature'. Rather than suggesting that his patients engage in alternative sexual practices that do not center penetration—especially after undergoing a male enhancement procedure—notice how Dr. Rosenburg speaks about heterosexual penetration as if it is compulsory (see Rich 1980, 2004), that heterosexual couples just need to have "patience" and do "enough stretching" of cis women's vaginal introitus or opening in order to make the couple('s genitals) "fit together". The discourse of reproduction, in tandem with references to heterosexual love and care, work to rescue the male body in interaction with the female body from the threat of penetrative failure.

Dr. Rosenburg was not alone in his disbelief in the existence of monster cocks and his erasure of cis women's unwanted pain. In addition to mirroring Dr. Rosenburg's statements about cis women's 'nature', physicians like Dr. Fray also erased the existence of monster cocks by suggesting that if they did exist, they would interfere with the ability to "procreate". Struggling to finish his sentences, Dr. Fray cast suspicion on the existence of monster cocks—again defined as penises whose size renders penetration impossible or causes circlusive sexual partners unwanted pain.

> I think it is impossible for someone['s penis] to be too large for all potential partners because when you consider the fact that a *woman having birth is passing shoulders of a ten-pound baby through her, there's nobody [with a penis] that big.* So I just don't- I don't believe that. [...] *the vagina was naturally designed-* with appropriate silicone lubrication- I still think that there is um... Well let's put it this way, if you were dating somebody and you got in the sack and realized that "I can't take this guy's penis", *the ability to procreate possibly just went out the window,* unless there [was] gonna be some *artificial insemination.* I just can't imagine that something like this would be the case because I I I just don't believe it. I don't believe it. [emphasis added]

Some may argue that a close examination of Dr. Fray's comments would indicate that he responded as though monster cocks are defined as so large that penetration would be impossible for "*all* potential partners" [emphasis added]. However, as Dr. Fray articulates his argument, it becomes clear that he is not concerned about the probability of at least one woman existing who could be a "potential partner" to a man with a monster cock by physically accommodating his large penis size. Instead, he demonstrates his assumption that cis women generally have a biological capacity to birth babies, so therefore, cis women generally should be able to physically "take" *any* size penis because "there's nobody [with a penis] that big" as the body of a "ten-pound baby" (equivalent to four-and-a-half kilograms). According to Dr. Fray's logic, cis women should be able to vaginally "take" a penis the size of Micha's silicone-enhanced monster cock that I pictured at the beginning of this chapter (see Figure 6.1), because it weighs less than a ten-pound newborn.[8]

Dr. Fray's disbelief in the existence of a penis so large that vaginal penetration is painful or impossible simultaneously relies on the naturalization of human reproduction and heterosexuality. He reasons that because "the vagina was naturally designed" for penetration by a penis, as well as for "passing shoulders of a ten-pound baby", it is "impossible for someone['s penis] to be too large" for vaginal penetration. The threat of penetrative failure is neutralized by grounding the nature of the male body in interaction with the 'female reproductive body'. Yet notice the slippage in Dr. Fray's argument when he begins to say that—in addition to the 'natural design' of the vagina—"appropriate silicone lubrication" can also help facilitate vaginal penetration. In other words, Dr. Fray's comment about silicone lubrication begins to concede that not all cis women can, by the 'natural design' of their bodies alone, "take" any size penis.[9]

Dr. Fray reasserts that if monster cocks as I defined them in our interview were real, if cis women could not vaginally "take" any size penis, then 'natural' modes of

[8] In Canada and the United States, the average birth weight of a newborn infant is about seven-and-a-half pounds (or three-and-a-half kilograms). A ten-pound (or four-and-a-half kilogram) infant is at the upper limit of 'normal' birth weight (Government of Alberta 2019).

[9] As a somatechnician, I understand silicone lubrication—not as a substance 'unnatural' to sex—but as beginning to break down the false dichotomy of the 'natural' and the 'artificial' in human sexual relations.

reproduction (as opposed to "artificial", technologically-assisted insemination) would be impossible. It seems that Dr. Fray imagines the body to be naturally reproductive, that procreation is a particularly natural process of binary bodies and heterosex, concluding therefore, that a penis could never be too large to hinder vaginal penetration because that would mean a loss of fertility without the assistance of artificial insemination. Of course, not all bodies are reproductive, including those that are socially and medically sexed as "female" under the binary. If we understand sexual reproduction and pregnancy—not as 'natural' processes made possible by the 'complementary' and 'dimorphic' 'natures' of sexed bodies—but rather, as somatechnologies, we come to see that all reproduction is not quite 'natural' (see Garner 2011).

Practitioners like Dr. Rosenburg and Dr. Fray—physicians with years of medical training, official accreditation, and expertise as practicing doctors in the field of sexual health—were comparing vaginal penetration to giving birth, thereby erasing the pain of childbirth. A penis does not have to be larger than a newborn human being for it to cause a circlusive sexual partner pain. Veritably, most people who engage in circlusive vaginal sex do not want it to feel like childbirth. Giving birth is still incredibly painful despite several months of changes in the body, multiple hours of contractions, and a flood of hormones that prepare the body to give birth that "stretching" during vaginal circlusion cannot quite mimic. The body has limits; it is common for the perineum—the flesh between the vaginal opening and anus—to tear during childbirth or require an episiotomy.[10] Sometimes a C-section is required for the health of the gestational parent because they are unable to pass the baby through their vaginal or genital canal,[11] all of which is fairly common knowledge within

[10]The National Health Services (2017) of the UK describes an episiotomy as "a cut in the area between the vagina and anus (the perineum) during childbirth [....] [that] makes the opening of the vagina a bit wider, allowing the baby to come through it more easily. [...] In some births, an episiotomy can help to prevent a severe tear or speed up delivery if the baby needs to be born quickly". The rate of episiotomy in Canada as of 2007 was 17% of births, and in the US as of 2012 was 11.6% of deliveries (Clesse et al. 2018).

[11]I include the term 'genital canal' alongside 'vaginal canal' out of respect for and acknowledgement of pregnant trans folks who do not use the term 'vagina' to refer to their bodies. The term 'vagina' is further exclusionary since its Latin translation means "scabbard" or "sheath", defining the vagina by and in relation to the penis (Merriam-Webster, s.v. "vagina (n.)," accessed September 18, 2019).

and outside of medicine.[12] Comparing vaginal penetration to birthing a baby subordinates the comfort, health, and safety—much less the pleasure—of the majority of cis women, thereby reducing them to sexual objects.

In the section that follows, I outline one of the ways in which physicians attempted to make sense of how cis women could possibly experience genital pain from penetration. The vignettes below demonstrate how male enhancement practitioners render cis women's bodies as ill, aging, or otherwise responsible for unwanted vaginal pain. I argue that dyspareunia functions discursively as a 'failure' of the female body for disrupting heterosexual penetrative practices; physicians' invocation of dyspareunia works to confirm the boundaries of cis men's bodies as male by medicalizing and denaturalizing the female body.

"It May be a Female Problem": Denaturalizing Cis Women's Genitals

In 1593 a German surgeon, Guilhelius Fabricius Hildanus, encountered a woman who experienced infertility and declining health. Chief among her problems was "recurrent genital pain associated with sexual activity, experienced during and after inter-course" (Kompanje 2006, 604), which in present-day allopathic medicine in Canada and the United States is commonly diagnosed as dyspareunia. Hildanus advised her to abstain from any form of vaginal penetration while she treated the ulcers on her vagina with ointments. Instead of treating his patient as if she were the source of her unwanted pain, Hildanus redirected his medical attention onto her husband. Hildanus determined that the cause of his patient's vaginal pain was "the exceptional length of her husband's penis in the fervent embrace" (cited in Kompanje 2006, 604). As a curative, Hildanus invented a device he termed a "masculine shield" that was fashioned out of cork and placed on the man's pelvis in order to "prevent the deep penetration of the penis" (cited in Kompanje 2006, 604). According to records containing Hildanus' medical observations, his invention worked: "This shield he put on, making the art well: even she felt no pain, and she even fancied it" (cited in Kompanje 2006, 604). In assessing Hildanus' treatment plan,

[12]From 2005 to 2014, doctors medically recommended about fifty percent of all cesarean deliveries in the US because it was not favourable for the health of the fetus and/or pregnant person to give birth through the vaginal or genital canal (Hehir et al. 2018). The remaining fifty percent were elective cesarean births.

contemporary medical ethicist Erwin J. O. Kompanje (2006) expresses surprise that Hildanus "gave the male partner a device as part of the treatment, rather than treating the woman as a sole source of the problem", which he called a "common error" even in present-day medical practices (605).

The male enhancement practitioners who participated in this research almost exclusively assign responsibility to cis women (to the exception of blaming racialized cis men)[13] for the unwanted pain they experience from vaginal penetration. Dr. Tabibi's remarks, for example, direct the "problem" of pain onto cis women's bodies. Repeating much of the language of Dr. Fray and Dr. Rosenburg's responses in the previous section, Dr. Tabibi rejects the existence of monster cocks altogether, particularly by denying the possibility that women could experience unwanted pain from vaginal penetration. Rocking back and forth in his plush leather office chair causing it to creak each time he reclined, Dr. Tabibi commented on the alleged nature of cis women's bodies, medicalizing those who fail to vaginally "accommodate" a penis.

> *Too big doesn't mean anything.* Too big for women is—unless they have some kind of *medical or sexual problem*—uh is unusual- *not natural* because remember that *the vagina can adjust and accommodate the head of the baby. There's no penis the size of the head of the baby.* Cause I haven't seen that one. What's the head of the baby? Seven inches? Eight inches [in diameter]? [...] So the largest penis is not even close to that. So it's not comparable. *So the vagina has this capacity of expansion.* And actually the body, the skin is expandable, that's the reason why I put the [penile] implant under the skin, [the implant] expands [the skin]. So our body has this *capacity naturally*, it expand[s]. So I don't think big is something- unless somebody had a *previous surgery [on] her vagina* and the *scar tissue* [causes] *narrowing* or something, so of course that one's painful. Or some women have *dyspareunia* when they get older and their *hormone balance* changes so they have that issue. So those are the things that are exceptions to this *rule.* But usually *I don't think any woman asks her husband or her boyfriend to make him [his penis] smaller.* [emphasis added]

[13]The only other ways in which physicians from my sample imagined that cis women could experience vaginal pain was from brutal sexual violence with inanimate objects, "gang rape"—which the doctor claimed is enacted exclusively by men from racialized countries—or from being penetrated by a cis Black man afflicted with genital swelling who has a monster cock as an effect of his 'race'. I discuss the latter case in this chapter.

From Dr. Tabibi's framing of the issue, we are led to believe that the skin's "capacity of expansion" is so natural to the human body, that if the vagina cannot "adjust and accommodate" a monster-sized penis like it can "the head of the baby", then that person must "have some kind of medical or sexual problem" that is "not natural". While "a previous surgery on her vagina", "scar tissue", "narrowing" of the genital canal, "dyspareunia", or a change in one's "hormone balance" may contribute to many cis women's pain during vaginal penetration, those "exceptions to this rule" of 'natural' vaginal expansion do not vindicate monster cocks as incapable of causing cis women unwanted pain. It is not as though the skin's capacity for expansion does not have limits, and that pushing past those limits cannot result in pain.[14]

Physicians disregarding the possibility that a cis man's penis could cause cis women unwanted vaginal pain—while at the same time pointing to other hypothetical, medicalized causes of that pain—is a deflection technique that rescues the maleness of cis men's bodies—accomplished through penetrative heterosexual practices—from critique. By using the language of 'technique' here I am not arguing that Dr. Tabibi and practitioners like him knowingly deflected criticism, nor am I necessarily claiming that physicians are wholly unaware that they transfer the "medical or sexual problem" onto cis women's bodies. Intentions are not necessarily important in the operation of discourse or when analyzing the consequences of those discourses.[15] This derailment tactic—whether physicians use it intentionally or not—also helps practitioners evade answering warranted questions about the ramifications of the male enhancement procedures they perform, particularly the ramifications experienced by circlusive sexual partners.

Dr. Tabibi was not alone in rendering cis women responsible for the unwanted pain they can experience from monster cock penetration. Several other physicians, including Dr.

[14]Consider how stretch marks—tears in the dermis caused by rapid growth of fat and/or muscle, from pregnancy, or childhood growth spurts—are a testament to the limits of the skin's capacity to expand.

[15]In *The History of Sexuality*, Foucault (1990) explains "Power relations are both intentional and nonsubjective [...] there is no power that is exercised without a series of aims and objectives. But this does not mean that it results from the choice or decision of an individual subject" (95). In their analysis of Foucault's work, Dreyfus and Rabinow (1983) suggest that even though "[w]ill and calculation were involved", the consequences of power's operation "escaped the actors' intentions" (187).

Schneider, made similar deflections. I asked Dr. Schneider if there is anything that he could do as a physician to help cis men who cannot have penetrative sex because their penis size hurts their sexual partners. Dr. Schneider responded matter-of-factly:

> No, no... Except *treat the woman*. [...] Well it may be a *female problem, post-menopausal dryness, some anatomical issues in the females* and those need to be addressed. [...] If it's a *dryness issue*, the woman may need to be on *estrogens* or some of these new lasers that are out where they can *laser the vagina down* and increase the *health* of the vaginal lining and increase *natural* lubrication. If there's an issue with the [female] partner, the next step is usually for the partner to be examined by the gynecologist. [emphasis added]

Dr. Schneider's comments denaturalize cis women's bodies at the expense of their comfort and physical safety. Instead of acknowledging that it is possible for a penis to be "too big" for (pain-free) vaginal penetration—much less pleasurable sex—Dr. Schneider deflected critique away from monster cocks by medicalizing cis women's bodies as having a "female problem" that needs to be "examined by a gynecologist".

Adding to the potential causes for vaginal pain that Dr. Tabibi surmised above, Dr. Schneider suggested to "laser the vagina down" to address assumed "anatomical issues" that may cause pain during vaginal penetration. Monster cocks, on the other hand, do not pose an "anatomical issue" because they do not exist according to practitioners like Dr. Schneider. He also recommended to "treat the woman" for "post-menopausal dryness" by prescribing estrogen—a hormone molecule deeply coded by binarist science of the sexed body as 'female' (Fausto-Sterling 2000; Oudshoorn 1994)—thereby reaffirming the need to bring 'female' bodies back into alignment with 'nature' to enable heterosexual sex. Dr. Schneider's treatment recommendations aim to "increase the *health* of the vaginal lining" as well as "increase *natural* lubrication" [emphasis added], meaning that pain from vaginal penetration indicates to Dr. Schneider that the vagina is not as 'healthy' nor responding to vaginal penetration as it 'naturally' should, rather than demonstrating, for example, that a couple's chosen sexual practices may need to adapt and diversify, especially after a penile augmentation.

Practitioners' repeated medicalization of cis women's bodies, denaturalization of cis women's unwanted pain, alongside their insistent denial that cis men's penises could

ever be too large for pain-free, vaginal penetration demonstrates physicians' perpetuation of—if not investment in—medical sexism, compulsory heterosexuality, and the maleing of cis men's bodies through penetrative heterosexual practices. Feminists who study the medicalization of sexuality (Cacchioni 2007; Tiefer 2004) persuasively illustrate that diagnosing cis women as having a sexual problem—especially if they do not enjoy vaginal penetration—is often motivated by a heteronormative, phallocentric, and unrealistic sexual ideal. Pharmaceutical companies and cosmetic surgeons are also capitalizing on this narrowly-defined sexual ideal in the hopes of expanding their patient base by medicalizing cis women's bodies and sexualities. For example, in the case of 'female sexual dysfunction'—often characterized by a lack of sexual response, desire, or orgasm from vaginal penetration—the pharmaceutical and surgical 'cures' preexisted and are what drove the creation of a medical diagnosis (Canner 2009; Tiefer 2004). The production of commodity 'solutions' is what led to the manufacturing of a physical 'problem'.

However, to be clear, the transformation of cis women's bodies through genital technologies as a means to accommodate monster cocks does not necessarily render cis women as passive objects of heteronormativity and phallocentrism. Contrary to much feminist scholarship—which frames the surgical creation of "designer vaginas" as the surrendering of one's identity and body to the mandates of the male gaze (see Braun 2010, 2009, 2005; Green 2005)—a somatechnic lens teaches us that the liberatory / oppressive dichotomy assigned to somatic practices "negates the political potential" of these procedures—not in terms of what the subject *intends* bodily transformation to signify—but in terms of the possible intercorporeal meanings created in relation to others (Sullivan 2006, 556). Somatic interventions generally regarded as 'conformist' or 'normative' carry more meanings than what is strictly intended. Just as somatic practices that are intended to be transgressive and radical can carry multiple, often contradictory meanings, practices constructed as normative are also multiple in their effects, and those who engage in practices like "laser[ing] the vagina down" or taking hormones should not be foreclosed as 'cultural dupes'.

Physicians who participated in this research such as Doctors Rosenburg, Fray, Tabibi, and Schneider largely did not respond to my questions about monster cocks as I originally expected. Meaning, to the exception of one case that I share below, they did not place limits on the penile dimensions that result from their enhancement procedures as a means to preserve the possibility that their patients can penetrate a partner. Instead, they defend phallocentric sex by denying the possibility that vaginal penetration can become painful; regardless of a cis man's penis size, he cannot—by the "function" of the male body and the reproductive 'nature' of cis women's bodies—cause them unwanted pain through vaginal penetration. Shoring up the boundaries of the male body, practitioners suggest that one of the very few ways in which cis women can experience pain from vaginal penetration is if she has a medicalized problem as a result of illness or aging. Male enhancement practitioners direct the "problem" of pain from monster cock penetration onto cis women's bodies, whereby dyspareunia functions as a 'failure' of the female body for disrupting heterosexual penetration. Cis women are assigned responsibility for the unwanted pain they experience from monster cock penetration, and are largely rendered acceptable casualties of sexual violence.

Contrary to his comments above, Dr. Tabibi did attempt to understand—beyond medicalizing cis women's sexed bodies—how the monster cock could cause circlusive sexual partners unwanted pain. While the majority of the practitioners who participated in this research "don't believe" that a cis man's penis could ever be "too big" so as to cause a cis woman pain through vaginal penetration, Dr. Tabibi reluctantly believed some women and their reports of unwanted pain when he suspected that there was a biologically-determined size mismatch between racialized genitals. Despite the singularity of his response, I share Dr. Tabibi's comments as they provide a valuable contrast in the data for how practitioners make sense of cis women's unwanted pain. Moreover, racializing Asian cis women's vaginas as "small by nature" works to render the monster cock a result of racialized difference in genital size. According to physicians' typology of racialized genitals, which I present later in this chapter, this discursive move naturalizes and normalizes the particularly white male body.

"I'm small by nature": Naturalizing the 'Tight Asian Pussy'

During our two-and-a-half-hour interview, Dr. Tabibi was called away by his staff on several occasions for patient consultations. While Dr. Tabibi was on a conference call with a patient complaining of pain, I stayed in his office passively listening to top 40 soundtracks playing down the hall at his receptionists' desk. Glancing around Dr. Tabibi's office, I observed his ornate wooden desk and filing cabinets strewn with printed medical journal articles and copies of his patents from the FDA. In addition to housing medical texts, his shelves served as temporary storage for tubes of cream, Tubigrip bandages, and boxes of antibiotics placed haphazardly among decorations, family photos, and awards. On the shelf nearest me is a four-by-five postcard with a photo of Laura and George W. Bush. The former First Lady and US President are pictured posing in a field of grass with blurred figures of deciduous trees in the background on their 1,600 acre Prairie Chapel Ranch home in Texas.[16] Wearing button-up shirts with a matching hue of cornflower-blue, the pair are smiling at the camera embracing each other. This postcard—ostensibly depicting marital bliss—is propped up against leather-bound religious texts, supported at the base by a model replica of a white, opaque, testicular implant.

During my interview with Dr. Tabibi, I learned that the Bush family postcard was an illustrative anecdote from my research in the field, reflective of some of Dr. Tabibi's political views that carried over into his medical practice. Legislation from the second Bush administration—such as "The Healthy Marriage Initiative"—sought to promote marriage in ways that privileged heterosexual, particularly monogamous couples (Whitehead 2012) as the foundation of US society at the expense of other family structures (Heath 2013, 2009)—a platform that I learned was congruent with Dr. Tabibi's investment in heterosexual monogamy in his medical practice. Without prevarication, Dr. Tabibi made clear during our

[16]For a peek at a copy of the Bush family postcard that was displayed in Dr. Tabibi's office, visit: https://web.archive.org/web/20190801231755/https://www.architecturaldigest.com/story/laura-and-george-w-bush-prairie-chapel-ranch-texas-article

interview that he prioritized heterosexual patients in long-term, committed, monogamous relationships when granting cis men access to male enhancement technologies.[17]

The purpose of male enhancement procedures, as Dr. Tabibi describes them, is to help couples "enjoy better, so together they can work with each other." The best candidate for male enhancement, according to Dr. Tabibi, is a man who is married or has a long-term girlfriend on the track to marriage, is sexually and romantically monogamous, and is not looking to "pick up people" on the "market". Prioritizing monogamous men, Dr. Tabibi wants his male enhancement patients to have a woman partner who can "use" his enhanced penis. In Dr. Tabibi's medical practice, heterosexual monogamy unlocks the gate to genital technologies.

In very rare cases, however, heterosexual monogamy also justifies the removal of Dr. Tabibi's penile implants. Despite declaring elsewhere in our interview that "Too big doesn't mean anything", Dr. Tabibi did share patient cases where "too big" meant a lot to his patients' partners. Despite insisting elsewhere in our interview that "I don't think any woman asks her husband or her boyfriend to make [his penis] smaller", the long-term girlfriends looking to marry some of Dr. Tabibi's male enhancement patients have asked him to reverse their partners' penile augmentations so as to return their penises to a smaller size. In some cases, Dr. Tabibi has acquiesced and reduced the size of or removed patients' penile implants. Recounting a patient case while discussing monster cocks in our interview, Dr. Tabibi shared the following experience about a patient and his partner.

> [T]he physician should be smart enough you know to adjust [the implant size] based on the patient's skin, patient's desire, and sometimes partner. *I removed some of the implants after patients got married* because they got married to the *Chinese girl and she was very small*. So I have to change or decrease the size. So I went from extra large to large. [...] Which she said "*I cannot have it, I cannot enjoy sexual activity with my boyfriend. If I were to get married to him, [his penis] is too big*". So they decided, with a lot of sorrow and crying and everything to remove it. And I did. [...] The user of this product, she has the

[17] Dr. Tabibi's preference to perform male enhancement procedures on married men is reflective of broader patterns within cosmetic medicine. For example, Gorney and Martello (1999) developed the SIMON criteria, an acronym that refers to Single, Immature, Male, Over-expectant, and Narcissistic. The authors of this criteria encourage practitioners to avoid performing cosmetic surgery on patients with these characteristics.

> right also at some point to [decide his penis size]. So we have to be very very careful, very very careful. My position in this situation is very tough. Because the guy says "*make it as big as possible*" and she says "no please be careful, I cannot adjust [to] that [implant] because *I'm small by nature*". I have to go between [his] and [her desires]. I have to be very careful to manage this situation. [emphasis added]

Alongside framing gender as relational opposites in the quote above, Dr. Tabibi also perpetuates a heteronormative project that requires 'female' and 'male' bodies to fit together through vaginally-penetrative sex and monogamous relationships. For example, Dr. Tabibi says his patient's girlfriend "cannot enjoy sexual activity with [her] boyfriend. If [she] were to get married to him, [his penis] is too big", suggesting that his penis is too big for their sexual relationship—and by implication their future marriage—to survive. Dr. Tabibi expresses that it is important for him to consider "[t]he user of this product", meaning his patients' wife or long-term girlfriend who he says "has the right" to decide what size penis her sexual partner can have. The permanence of physical incompatibility—meaning a mismatch in genital size—between married or long-term, monogamous, heterosexual couples convinces Dr. Tabibi to remove a patient's implant that the impermanence of a casual girlfriend may not.

While it may seem as though Dr. Tabibi is supporting a woman in the case cited above by deciding "to change or decrease the size" of her partner's penile implant with the hope that she can "enjoy sexual activity with [her] boyfriend", Dr. Tabibi suggests he is reversing his implant in order to support their path to marriage by helping them overcome a mismatch in genital sizes that he believes is biologically-determined by race. Dr. Tabibi only believes that a penis can be "too big" when he estimates there is a size mismatch between differently-racialized genitals. At another point in my interview with Dr. Tabibi (see the section "The 'Genetics of Race' and the Racialization of Black Men's Genitals" below), he exclusively spoke about Black men with enhancements as capable of having monster cocks that could be "too big" for penetration. In this quote, however, he constructs the vagina

of one patient's partner as "small by nature" *on the basis* of her being a "Chinese girl" (woman).[18]

Discourses that naturalized cis Asian women's vaginas as small were also common in online support sites like *Enhancement Forum*.[19] For example, cis men interested in penis augmentation regularly advised each other to seek out cis Asian women as sexual partners.

> The cheapest, easiest and quickest way to feel you have a larger penis is to go out with a woman with a small pussy or young women who have no children. *Asians have small vaginas by design.* Try it, you will never go back. [emphasis added]

As I have identified throughout this manuscript, cis women's bodies are often used by cis men as a conduit through which they gauge their masculinity and accomplish phallic masculine embodiment. Cis men interested in male enhancement often conceptualize their own sense of masculinity and of having a large penis in relationship to bodies they perceive to be smaller or softer.

These cases demonstrate how cis women's bodies are understood through a racial hierarchy, in this case marked by 'yellow fever'. Feminist philosopher Robin Zheng (2016) describes 'yellow fever' as a "racial fetish" or an objectifying and otherizing sexual preference for Asian people, commonly women (401). The term centers the racism of the concept 'yellow peril', but emphasizes how that racism is sexually objectifying. 'Yellow fever' is partially an effect of the racializing stereotype perpetuated by Dr. Tabibi that the morphology of genitals is 'naturally' determined by race. Drawing on the concept of 'yellow fever' helps us to understand that the stereotype of cis Asian women's "small vaginas" offers cis men who are anxious about their penis size the "cheapest, easiest and quickest way" to calm their anxieties and make them feel like masculine men.

Racialized stereotypes of Asian women as small, subservient, and sexually exotic are not new; they are socially and historically-rooted in institutionalized racism. Early

[18] After male enhancement physicians told me that penis size is determined by race, I asked them if the vagina also varies in size by race; however, unlike Dr. Tabibi, most practitioners declined to comment on the vagina generally, saying that it was outside of their expertise.

[19] At the time of my virtual observations, upwards of one hundred posts eroticized Asian women as small, hyper-feminine, or having "tight pussies".

nineteenth century immigration law in the United States, for example, prevented independent Asian women from immigrating, thereby foreclosing many of the labour opportunities of those who were allowed to enter the country. As a result, Asian women immigrants commonly laboured as indentured servants or in sex work (Jiwani 2005; Võ and Sciachitano 2000), contributing to the stereotype that Asian women are passive and sexually available. In the twentieth century, when US soldiers invaded several Asian countries such as the Philippines, Japan, and Vietnam, they sexually exploited local women as the "spoils of war" (Patel 2008, 119). Under the conditions of war and the threat of sexual violence, the women who were compliant (but still not consenting) were read by US soldiers as submissive and child-like (Patel 2008). The exotification of the 'Asian pussy' as object, as commodity, as available particularly to white men thus has roots in structural, anti-immigrant racism and imperialist sexual violence. Stereotypical portrayals of cis Asian women being hypersexual, exotic, and docile are made flesh in the figure of the 'tight Asian pussy'.

The concept of Orientalism (Said 1978) is particularly germane to thinking about cases of 'yellow fever' and the racialization of the 'Asian pussy'. *Orientalism* is a form of cultural imperialism that constructs the Oriental Other—who is particularly feminized—as essentially exotic, erotic, and sexually available. The racialized representations of the 'Asian body' perpetuated by both forum members and physicians like Dr. Tabibi—particularly the naturalization of Asian people's vaginas being small "by design" or "by nature", respectively—are, according to Orientalism, a means to dominate and control othered, racialized populations. The 'tight Asian pussy', much like the discourse of the 'big Black dick' that I discuss in the next section, functions discursively within male enhancement practice to render the monster cock a result of racialized difference in genital size. Working together, these discourses normalize and naturalize the particularly white male body.

Dr. Tabibi's comments also work to address the dilemma created by the monster cock, namely, the tension between successful heterosexual penetrative practices that confirm the body as male, and phallic masculine embodiment that confirms a man's masculinity.

He elects to prioritize the male body's "purpose" within heterosexual monogamy. In other words, Dr. Tabibi shores up the male body of his patient by prioritizing its "function" (to borrow Dr. Rosenburg's term) of successful heterosexual penetrative practices instead of reaffirming phallic masculine embodiment by maintaining the size of the monster cock. Notably, Dr. Tabibi was the only physician in my sample to do this; the majority of doctors in my sample prioritized maintaining the size of a cis man's enhanced penis.

In the next section, I analyze practitioners' discourses that identify the 'genetics of race' as *the* determinant of penis size in order to contextualize the other way in which male enhancement practitioners attempted to make sense of cis women's unwanted vaginal pain from penetration; namely, by essentializing the bodies of cis Black men with sickle cell anemia (an often racialized disease) for having 'unnaturally' large penises as an effect of their 'race'. In the following sections, I foreground how physicians' conceptualization of race as a biological reality—rather than a social product—inform their understandings of who could be physically equipped with a monster cock, and therefore, who could even be capable of causing cis women vaginal pain through penetration.

The 'Genetics of Race' and the Racialization of Black Men's Genitals

In the case that dyspareunia and the 'tight Asian pussy' do not sufficiently explain cis women's pain from vaginal penetration—meaning, when rendering cis women responsible for vaginal pain does not effectively defend the contours of cis masculinity and male bodies—physicians discursively gesture to racialized male genitals. As I demonstrated in the previous section, 'female' genitals racialized as Asian are constructed as "small by nature"; in this section, I show how 'male' genitals racialized as Black are framed as unnaturally 'excessive', as the only possible monster cocks that are responsible for cis women's pain from penetration. These discourses of the 'big Black dick' and the 'tight Asian pussy' function to normalize and naturalize particularly the white male body, defending its contours as incapable of causing cis women pain.

Before I share the practitioner's remarks that (de)naturalized racialized genitals, however, it is important to first set the stage for how these comments fit into the overarching discourses on race and penis size mobilized by the male enhancement practitioners with whom I spoke for this project. A few physicians in my sample challenged the common perception that penis size is related to—if not determined by—race. For example, Dr. Harris disrupted racializing discourses when he remarked "I've seen as many white men with long penises as I've seen Black men. I don't think there's a racial difference frankly." Offering alternative explanations for different size penises that seem to move beyond race, Dr. Allen and Dr. Fraser proposed that penis size is related to height and overall "body habitus" or build.[20]

Dr. Fraser acknowledged that a size mismatch between the genitals of his male enhancement patients and their sexual partners might cause pain through penetration. I asked Dr. Fraser if there is anything he could do to help cis men who would like to have penetrative sex with their partners, but currently cannot because the monster cock size of their penises causes their sexual partners pain, to which he responded cautiously, pausing between sentences:

> I can't think of what would help other than using toys on the partner to perhaps *loosen the sphincter or the vaginal introitus*... That would be my only recommendation... But also *sometimes you may have size mismatch* just because of the body habitus of one person to the other. So say that you have a petite female dating a basketball player. *So there's only so much she's going to be able to handle.* [emphasis added]

Like Dr. Schneider and Dr. Tabibi, who claimed that vaginal pain from penetration was a "female problem", Dr. Fraser also began his answer by rendering cis women's bodies responsible for the unwanted pain they can experience from monster cock penetration. Cis women's vaginal introitus may be 'tight', according to Dr Fraser's framing. His only

[20]Doctors Harris, Allen, and Fraser were not able to reference any scientific evidence in support of their claims accounting for differences in penis size. The anecdotal confirmations they provided from their medical practices are not representative of the general population; they are selective of the men who are not only concerned about their penis size, but are also interested in, and can afford out-of-pocket expenses for medical appointments and elective interventions. In other words, anecdotal evidence of the variance in penis sizes from physicians' medical practices offers a narrow snapshot of the population, and therefore, cannot be representative.

suggestion to help a cis man who is causing his partner unwanted vaginal pain is for him to use toys "on the partner to perhaps loosen the sphincter". Notably, Dr. Fraser did not recommend alternative sexual practices that do not center penetration.

By the end of his response, however, Dr. Fraser reluctantly admits that "sometimes you may have size mismatch just because of the body habitus of one person to the other". Unlike Dr. Tabibi and Dr. Rosenburg who racialize this mismatch in genital size, Dr. Fraser communicated that significant differences in height between a "petite female" and her "basketball player"-sized partner can account for a "size mismatch" in genitals. Acknowledging the limits of the vagina's "capacity for expansion" (to borrow Dr. Tabibi's words), Dr. Fraser finally concedes at the end of his comment that "there's only so much she's going to be able to handle", a point that every other practitioner in this research did not confirm.

Dr. Allen's explanation appears to move beyond race, at least initially. To complicate his response, however, he suggested that while penis size is related to a person's height, he claimed that one's height is determined by their race. In response to my question "in your professional opinion, is there anything that accounts for differences in penis size?" Dr. Allen said:

> Well supposedly the African Americans- or just Africans have a larger penis. I think some ethnic groups have larger or smaller penises, *Africans [are] maybe in general taller than white Caucasians. Asians have smaller penises, but most Asians are smaller men, they're smaller people, and so they would have smaller penises too.* [...] but I'm not sure about what medical statistics [say]. [emphasis added]

While Dr. Allen cites height as a determinant of penis size, he racializes height as determined by race categories (or what he terms "ethnic groups"),[21] whereby "Africans [are] maybe in general taller than white Caucasians" and "most Asians are smaller men, they're smaller

[21]Practitioners regularly conflated terminology during our interviews—not just about gender, sex, and sexuality as I demonstrate in Chapter 5—but also language about race and ethnicity. The terms 'African', 'Asian', and 'white Caucasian' do not refer to ethnicities, but rather, racial classifications tethered to regionally undifferentiated geographies that include heterogeneous groups of people. My suspicion is that, because conversations about race in Canada and the US are particularly contentious, using the language of 'ethnicity' functions to defuse tension and shelter white fragility (DiAngelo 2018).

people", thereby reaffirming by the transitive property that genital size is related to—if not determined by—race. In many ways, the medical field of male enhancement coheres around this notion of the 'average' penis size as a reference to help determine which patients are deserving candidates of penis augmentation, and what are realistic, post-enhancement goals in terms of penile dimensions. Thus, male enhancement specifically materializes a set of social relations that Foucault (1999) described as "a type of power [...] that can only function thanks to the formation of a knowledge that is both its effect and also a condition of its exercise" (52).

Similar to Dr. Allen—and as a result of racializing penis size—the majority of the male enhancement practitioners who participated in this research invoked the stereotype of the "big Black dick" (Lemons 1997, 38; see also Poulson-Bryant 2006) as if it were a material, biological reality of Black cis men's bodies. For example, in the next vignette, Dr. Martin estimates the 'average' penis sizes according to different race categories, claiming that men from "African countries" have the largest median penile length.

> There have been a lot of studies and ninety percent of the population fall between five inches and seven inches [in penile length]. [...] [Penis size] varies from *ethnicity to ethnicity* [...] I think in North America those [five to seven inches] are pretty much I guess what would be considered average *versus Africa versus Asia*. [...] And then for different cultures [their penis size] was *bigger or smaller* or whatever. I think like *South Korea and North Korea was on the smaller side*, maybe about four-and-change [inches] as their median [penile length] and I think there was some *African countries* where the median [penile length] was about seven, seven-and-a-half or so [inches]. But I think in North America it was pretty much around five-and-a-half [inches in penile length]. [emphasis added]

Like other male enhancement practitioners who I quote below, Dr. Martin seems to confuse race (or "ethnicity") with geography—specifically conflating whiteness with "North America"—when he describes the average penis length of cis men in North America "versus Africa versus Asia". Rather than a mere accident, it is an effect of whiteness that people exclude Mexico—a country that has a large population of people who are not white—from North America. Moreover, conflating "North America" with whiteness erases the growing communities of people of colour in Canada and the United

States,[22] as well as the existence of Indigenous Peoples on this land for thousands of years before white settler colonists violently claimed it as their/our own.

At any rate, other doctors' assessments of the 'average' race-based penile length differed numerically from Dr. Martin's estimations; however, the racial hierarchy remains intact. Dr. Tabibi approximated that the lowest value within the range of penis sizes starts with Asian men having three-and-a-half inches in penile length, which he characterized as "below average". The highest value Dr. Tabibi calculated within the range of penis sizes according to race categories is among Black men having "at least four-and-a-half" inches in penile length. White men's penile average was located somewhere in the middle of those two figures. Notably, the penis sizes of other groups were largely absent from physicians' talk mapping out penis size according to race categories. The estimated penile measurements practitioners cited in our interviews are mostly anecdotal from their medical practices, not from peer-reviewed studies.[23]

More importantly, physicians' talk about median race-based penile length carries with it the assumption that there is more inter-group variability between 'races' than intra-group variability in terms of penis size. In other words, male enhancement practitioners like Doctors Allen, Martin, Tabibi—and as I share below, Dr. Rosenburg too—assumed there is more variability in penis length *between* race categories (i.e. Asian, Black, white, etc.) than *within* them. In concert with physicians' racialized hierarchy of penis sizes that I described above, most of the doctors who participated in this project—including Dr. Rosenburg—insisted that penis size was determined by the 'genetics of race', which as I demonstrate

[22]See Franklin (2014) for evidence of the changing demographics in the United States. See Statistics Canada (2017) for the growing number and proportion of the visible minority population in Canada from 1981 projected until 2036.

[23]Four of the twenty practitioners from my sample did not provide estimates for the race demographics of their patients. Out of the sixteen who did provide race demographics, most physicians' practices have 10-40% Black or African American patients; Latinx or Hispanic men typically make up 10-30% of doctors' patient base; and Asian men typically number between 5% and 25% of physicians' patients. White men—or what most practitioners referred to as "Caucasian" men—typically formed the largest group, making up 50% or more of patients in a doctor's medical practice. However, in rare cases white patients were not the single largest group; in Dr. Russo's practice, for example, about 40% of patients are African American, 40% are "Caucasian" (of which 10% are Latinx), and 20% are Asian. Notably, Mr. Bennett could not recall having Black or Asian patients. Only Dr. Midden disambiguated broader racial categories to identify patients according to countries of familial origin.

in Chapter 2, is unsubstantiated by current medical science—and may not be possible to substantiate—despite the persistent social energy dedicated to 'finding' racialized difference in genital dimensions.

When Dr. Rosenburg talks about race in the context of our interview, he oscillates between treating race as a proxy to mean, as he formally defined it, "restricted gene pools", but in the context of our conversation, he also treats race as a meaningful label for understanding 'natural' differences between *social* groups of human beings. For example, when I asked Dr. Rosenburg, "is there anything that accounts for different penis sizes in men?" he answered that size is resultant from "genetic triggers" and "racial traits". "Well different gene pools have different size penises" Dr. Rosenburg asserted. "I I I I in no way mean to be racist or insult any ethnic group, but Asian men have smaller penises than western men." In this comment, Dr. Rosenburg spoke about race as "gene pools", but then also treated "Asian men" as a homogeneous group of people (despite having heterogeneous "gene pools"), whose categorization is meaningful in order to understand them as separate and different—especially in terms of penis size—from other 'races'.

When I asked Dr. Rosenburg to clarify what he meant by "western" in his comment, he explained "if I had ever been born in China, I'd still have a bigger penis than most Chinese men. I mean not me personally, but somebody with my genetic background. I think it is racial." Like Dr. Martin—who conflates whiteness with "North America"—when Dr. Rosenburg refers to "western" men like him, it is clear that he is referring to them as white, not in terms of "western" genes, but by flattening whiteness with culture and geography. Like Dr. Martin, perhaps Dr. Rosenburg conflates the two because he imagines the west as white, as belonging to white people. Nevertheless, Dr. Rosenburg formally defines race in terms of gene pools, but employs race according to *socially-produced* categories of difference such as "Asian" or "North American". Later in our interview, Dr. Rosenburg recognized that "People that intermarry, okay all bets are off"[24] in terms of predicting the penis size

[24]Instead of framing racist oppression as a consequence of inequality making some differences matter politically by allocating benefits to whiteness, Dr. Rosenburg's complete quote conceptualizes racist oppression as an inevitable outcome of diversity and difference: "People that intermarry, okay all bets are off. That's what we should all do, we should all be forced to marry somebody of a different gene pool. Think of the world peace that would result." Here I am reminded of Ta-Nehisi Coates's (2015) words:

of their children, meaning that when "gene pools" are not "restricted", "racial traits" are not clearly defined. Yet despite recognizing that race categories are not mutually exclusive, Dr. Rosenburg applies race categories as if they are. Dr. Rosenburg's conceptualization and deployment of race imposes rigid classifications upon a continuum of physical traits that cannot be neatly organized into discrete categories.

Dr. Rosenburg's conflicting usage of the term 'race' was apparent throughout his other statements during our interview, which I share here to help contextualize his remarks that denaturalize the penises of Black cis men. For example, below Dr. Rosenburg oscillates back and forth between commenting on the genetics of observable traits (like body fat distribution within a restricted gene pool), and social categories of 'race' (such as "Hottentots") as if these groupings are biologically meaningful and scientifically accurate, rather than categories that are socially-produced through white supremacy and colonialism. When I asked Dr. Rosenburg to explain what he means by 'race' after he clarified his usage of the term 'western', he replied with such conviction in the genetics of race categories that he laughed at the absurdity of anyone claiming otherwise.

> In fact there are *genetic groups*, the *Hottentots have gigantic steatopygia, rumpty dumpty, they have these huge butts* that you could put a glass on top of. And those are a *genetic trigger*, it's a *racial trait. Can't call me racist for knowing that lumpty dumpty* or *steatopygia is a biological phenomenon restricted to a certain race of people*, it just is. [emphasis added]

Dr. Rosenburg's assertions about the biology of race cannot be dissociated from the scientific racism and histories of colonialism that inform his understanding of racialized bodies. Overlapping referentially with the fat-oppressive language in Dr. Rosenburg's quote above is the racist, colonialist language of the Dutch word "Hottentots"—meaning "stutterers" (Hughes 2006)—which was historically forced upon the Khoikhoi Indigenous group of South Africa by Dutch colonists (Gilman 1999).

"'race' itself is just a restatement and retrenchment of the problem. You see this from time to time when some dullard—usually believing himself white—proposes that the way forward is a grand orgy of black and white, ending only when we are all beige and thus the same 'race.' But a great number of 'black' people already are beige. And the history of civilization is littered with dead 'races' (Frankish, Italian, German, Irish) later abandoned because they no longer serve their purpose—the organization of people beneath, and beyond, the umbrella of rights" (115).

The image of the "Hottentot" was introduced to the British public through ethnological show business—the exhibition of people of colour to 'educate' and scintillate white audiences for a profit. In one of these exhibitions from 1810, a British man and a Dutch colonist of South Africa caged and abused a San woman named Saartjie Baartman while displaying her body to white audiences in London. They gave her the stage name "Hottentot Venus" as a joke to highlight the incompatibility of European ideals of beauty with Black bodies (Lindfors 1996). Historiographer of African literature Bernth Lindfors (1996) explains the contemporary purchase of the term 'Hottentots'.

> Because [Saartjie Baartman] was displayed, treated, and conceptualized as little better than an animal, the Hottentot Venus remains *even today* a potent symbol of Africa's supposed degraded backwardness. Cuvier [a French naturalist] compared her to a monkey or an orangutan, scientifically dehumanizing her and her kind. It was this sort of biological slur that reinforced European beliefs that Africans were closer to the lower order of brutes than to human beings. (210-211) [emphasis added]

What Lindfors demonstrates is that the nomenclature 'Hottentot' continues to elicit racist, dehumanizing understandings of Black bodies that positions white bodies as normative, and white people as superior knowers of the 'natural' world through white supremacist, western 'science'. Indeed, sexological and anatomical literature written by white scholars describes the dissected pelvises and—as Dr. Rosenburg calls them—the "huge butts" of the Hottentots as "sufficiently well marked to distinguish [them] [...] from those of any of the ordinary varieties of the human species" (cited in Snorton 2017, 23). Shortly after Saartjie Baartman died, her genitals were cast in wax molds and her body in plaster; up until 1982, these molds were displayed to the public as a means of distinguishing the genitals and bodies of Black people from those of white bodies as the norm (Lindfors 1996).

In addition to Dr. Rosenburg's use of the Dutch name 'Hottentots' and the histories of racist, colonialist violence that it carries, he also employed the medical term "steatopygia",[25] defined as "an *excessive* development of fat on the buttocks that occurs chiefly among women of some African peoples especially the Khoisan" [emphasis added].

[25]Merriam-Webster, s.v. "steatopygia (n.)," accessed September 18, 2019, `http://www.merriam-webster.com/dictionary/steatopygia`.

This term already contains within it the racist, sexist, and fat-oppressive assumption that the bodies of Black women are in *excess* of the normative body, defined in the western imaginary as white, male, and thin. As historian Sander Gilman (1999) noted, "beginning with the expansion of European colonial exploration, describing the form and size of the buttocks became a means of describing and classifying the races. The more prominent, the more primitive" (212). Dr. Rosenburg's preoccupation with the size of the "butts" of this group—much like fixating on the size of Black men's penises—thus reinforces a colonialist history of scientific racism. Dr. Rosenburg's understanding of race categories—particularly Black men's bodies as having 'unnaturally' large penises—extends from the knowledge claims of scientific racism and colonialist science.[26]

That Black men supposedly have the largest median penis size compared to the median penile length of other 'races' meant to some male enhancement practitioners that the only monster cocks that could possibly exist would be those of Black men. For example, while discussing monster cocks in our interview, Dr. Tabibi implied that those who have undergone male enhancement procedures—"especially" Black patients with penile augmentations—could have a monster-sized cock.

> [W]ith some of the sizes that we put, definitely the penis is very large. I've seen that also. Especially when we have a few *Black patients* that originally were large and they would like to get larger. So [one Black patients' penis was originally] five [inches], we change it to seven-and-a-half [inches] in girth. You know *the girth [is] so big that that's unusual.* [emphasis added]

[26]While explicitly racist claims were not characteristic of all my interviews with physicians (Dr. Fraser was a notable exception), the majority of my participants did perpetuate racist stereotypes, white supremacist ideologies, and/or phrenological ideas presented as objective science. For example, Dr. Wexler uses what he calls a "human assessment technology" as part of his patient evaluation process to develop a tailored treatment plan for each patient. This technology is "not a normal psychometric exam that identifies who you are," explained Dr. Wexler. "This one identifies *what you are*, and by going back to the basis of *what you are and being true to your nature* as you go through life, you have less stress. [...] a person's *physical presentation* is a direct relationship to *what they are*. So [this assessment has] questions like "are your *features angular or rounded*?" [...] "are your *eyes this colour*?", "did you have uh *premature receding hairline*?" "are you *heavier around the middle*, are you *athletic*?" [emphasis added]. Measuring one's physical traits—including facial features, eye colour, fat and muscle distribution—as a means to predict one's abilities, personalities, and "what they are" is awfully reminiscent of phrenology: a debunked field of study that measured the physical dimensions of the skull to *construct* the mental abilities of different 'races', and justify structural racism (see Stein 2015; Fausto-Sterling 2000).

Like Dr. Schneider, who marked bead inserts into men's penises as "really really weird" (see Chapter 5), Dr. Tabibi's characterization of Black men's augmented penises as "unusual" in size is not race-neutral. What doctors in Canada and the United States deem "weird" and "unusual" is instructed by the norms, contexts, histories, and discursive regimes about the body within contemporary allopathic medicine in the west. However, it would be an interpretive leap to argue that Dr. Tabibi's ambiguous characterization denaturalized Black men's penises; he did not invoke discourses that unequivocally refer to the nature of the sexed body, biology, medicalization, or pathologization, etc.

Dr. Rosenburg was the only male enhancement practitioner from my sample who explicitly denaturalized Black men's genitals. I conclude this chapter by examining his remarks in the following section. Despite the singular character of Dr. Rosenburg's statements, I share them below because—in terms of discursive strategies structured through whiteness—his remarks overlap considerably with other practitioners' arguments about Black men's genitals and with other physicians' claims about racialized men's sexual behaviours.

Denaturalizing the 'Big Black Dick'

After a short intermission in my conversation with Dr. Rosenburg—who after arriving home from his commute had dinner with his wife—he returned to our interview to continue discussing monster cocks, particularly the penises of men racialized as Black. While attempting to make sense of how cis women could possibly experience unwanted pain from monster cock penetration, Dr. Rosenburg suggested that the only men who truly have monster cocks are Black men who have an illness that is highly racialized, framing their bodies in contrast with the natural. When I asked Dr. Rosenburg if he has seen any monster cocks in his medical practice, he explained:

> I haven't seen any *naturally*- the only *freakishly large* [penises of] men I have seen who are *so large that penetration is impossible* are [the penises of] *Black men with sickle cell anemia* who have reoccurring bouts of *priapism* who become *horribly disfigured and distended*. [emphasis added]

Based on the context of the conversation, it seems as though Dr. Rosenburg begins to say that he has not seen any "naturally" large penises like monster cocks. Before finishing his sentence, however, he abruptly redirects his remark seeming to suggest that, *in contrast with the natural*, "the only *freakishly* large [penises of] men [that he has] seen who are so large that penetration is impossible are [the penises of] Black men with sickle cell anemia" [emphasis added]. By marshaling the spectre of the 'freak' in this comment—which has historically been racialized (see Bogdan 1996; Cook Jr. 1996; Lindfors 1996) as well as constructed as a corruption or failure of nature (see Garland-Thomson 1996)—Dr. Rosenburg underscores his framing of Black, ill, monster cocks as unnatural. Dr. Rosenburg's techniques of denaturalization are equally apparent when he describes the effects of priapism—the persistent and painful erections caused by sickle cell anemia—as making Black cis men's penises "horribly disfigured and distended", lacking the "natural contours" of the penis that he otherwise described in our interview.

Based on his remarks above, Dr. Rosenburg is able to characterize the penises of ill, Black, cis men as "freakishly large" due to two co-occurring constructions of race. First, Dr. Rosenburg's (problematic) conceptualization of race as a biological reality structures the manner with which he understands Black bodies generally—and Black men's penises specifically—through whiteness as the norm. Like other physicians in this project, Dr. Rosenburg relies on and perpetuates the scientifically unsubstantiated assertion that on average Black cis men have larger penises compared to other groups divided by race. While some may view Dr. Rosenburg's claim as positive or as a compliment to Black men—especially given the way Canadian and US cultures value large penises—to borrow from critical race scholar Yasmin Jiwani (2006), even "'[p]ositive' representations, like their negative counterparts, still serve the function of reinforcing the superiority of whites by re-inscribing the inferiority of peoples of colour" (273). In this case, the reinscription of inferiority onto Black men's genitals is inferentially linked to primitivism, which imagines Black bodies as 'closer to nature' (see Bello-Kano 2005; Gilman 1999; S. Hall 1990).

The 'big Black dick' invoked by Dr. Rosenburg and other male enhancement practitioners is rendered non-normative by centering whiteness as the invisible norm (see Lehman 2006). Like a racist Goldilocks parable, Black men are allegedly hypersexual and have exceptionally large penises, Asian men according to this formulation are effeminate and—as Dr. Rosenburg claimed himself—have small penises, whereas white men's sexuality and penis size are supposedly 'just right'. By centering whiteness as the invisible norm, not only are Asian men subordinated and rendered less-than-men, the racist stereotype of the 'big Black dick' reduces Black men to their bodies—a technique whose legacies trace back to pro-slavery ethnology in the United States[27]—while also reinforcing the dangerous stereotype that Black men are sexually insatiable, violent (hooks 2004), and perverse (Stein 2015).

According to gender and race scholar Melissa Stein (2015), the contemporary construction of the Black "sexual menace" (218) is rooted in racialized gender, constructed in late nineteenth century sexology as a codified sexual disorder 'furor sexualis', which white scientists of race manufactured as a lack of self control alongside "abnormal passions" (223) that were innate to the biology of Black men. As Stein (2015) points out, 'furor sexualis' constructed Black men as "simultaneously too much man and not man enough. That is, they embodied brute masculinity without the manly restraint and rationality of civilization" (223).

At the heart of Dr. Rosenburg's claims, intended or not, is the figure of the sexually-threatening Black man. This figure relied on the biologization of Black men as naturally sexually violent, grounded particularly in the sexed body. At the time, the foreskin of the penis and its "secretions", for example, were constructed as "stimulating" for any man, but for Black men allegedly created an "over-exuberant and impatient virility" that—according to white scientists of race—was compounded by the large size of Black men's penises (cited in Stein 2015, 228). By locating the 'propensity to rape' in the genitals of Black cis men, white scientists of race generated the "distinctly genital [...]

[27]For example, "[e]thnological proslavery arguments generally presented [...] that the very bodies of African Americans were designed for labor whereas the bodies of (male) Caucasians were more suited for intellectual pursuits" (Stein 2015, 73-74).

solution" of castration (Stein 2015, 218), justifying various genital procedures on Black cis men—including circumcision, removal of the testicles, and mutilation of the penis[28]—as a means of protecting white women who were framed as vulnerable to Black men's allegedly uncontrollable and "abnormal" sexuality (223). White scientists of race reasoned that genital surgery on Black men "could curtail sexual aggression among the most savage", and dovetailing with the rise of eugenics in the United States at the end of the nineteenth century, white scientists of race celebrated that genital surgery would also render Black men sterile (cited in Stein 2015, 219).

Throughout history, then, the construction of Black cis men and boys' genitals as 'overly-endowed'—or "freakishly large" as Dr. Rosenburg claimed—has contributed to the white perception of Black cis men's sexualities as 'abnormal'; both Black cis men's genitals and sexualities were framed as responsible for sexual violence, and have operated as a justification to mutilate, sterilize, and lynch Black cis men and boys as a result of centering whiteness as both 'civilized' and the norm. To quote Scott Poulson-Bryant (2006) "once upon a time we were hung from trees for being, well, hung" (7). The racialization of sexual violence and the threat these racist stereotypes pose to boys and men of colour are not relics from the not-so-distant past. The figure of the 'Black rapist' continues to be mobilized by white people in contemporary Canada and the United States, including by white feminists.[29] We continue to see the threat of violence play out in contemporary racist encounters; white women and girls weaponize their white femininity, claiming vulnerability to the alleged sexual aggression of boys and men of colour, especially Black boys and men (Dodd 2016). The stereotype of the 'big Black dick' invoked by Dr. Rosenburg and other practitioners

[28]At the turn of the century, white scientists of race intended for castration to become an alternative to lynching; however, castration was already a concomitant practice of the lynching spectacle. According to Stein (2015), the act of "unsexing" (243) Black cis men during lynchings served as an initiation of white boys into white supremacy whereby a "young white boy became a man by literally taking the manhood of an African American" (238). Among other objects that served as mementos, white participants in the lynchings of Black cis men and boys collected their severed genitals as postmortem souvenirs. Whether castration was a understood at the time as a 'progressive' suggestion made by medical scientists seeking authorial control over what the US should do to resolve the growing 'race problem', or an act carried out by a lynch mob, the specter of castration in both scenarios functioned as a means of controlling and subjugating Black people.

[29]For just one example of many, see Susan Brownmiller's (1993) *Against Our Will: Men, Women and Rape.*

continues from its historical legacies to justify anti-Black racism, creating the conditions that place Black boys and men in direct danger of police surveillance and state-sanctioned violence, incarceration, and death (see Stein 2015; Jiwani 2011; Patton and Snyder-Yuly 2007; hooks 2004; A. Davis 1983).

The second way in which Dr. Rosenburg racializes and denaturalizes the penises of Black cis men is by mobilizing sickle cell anemia as a racialized disease. A blood condition characterized by the crescent shape of one's red blood cells, sickle cell disease[30] developed as a way for the human body to resist the malaria parasite. As a result, sickle cell disease affects people in regions with high rates of malaria (CDC 2018b), and is common among those whose ancestors came from Central and South America, the Caribbean, Mediterranean countries, sub-Saharan Africa, Saudi Arabia, and India (CDC 2019). The Centers for Disease Control and Prevention (CDC) report that in the United States, for example, sickle cell disease occurs most often in Black populations with about "1 in every 365 Black or African-American births",[31] and to a lesser extent in "Hispanic-American" populations, occurring "among about 1 out of every 16,300 Hispanic-American births" (CDC 2019).

Sickle cell disease, in both popular imagination and medical expertise, is often constructed as a 'Black disease' (Bediako and Moffitt 2011). Contrary to this belief, however, sickle cell anemia is not a race-specific disease, much less a 'Black disease'; the association between sickle cell anemia and Black people is actually representative of geographical location and (ancestral) exposure to malaria (see Bediako and Moffitt 2011), not 'race' as a biological reality. Anyone, including white people, can have sickle cell anemia and its associated symptoms, such as the swelling and distension of one's penis from priapism.[32] Yet Dr. Rosenburg did not claim that anyone with priapism would be

[30]'Sickle cell disease' is an umbrella term for various manifestations of the disease. The term 'sickle cell anemia' refers to "the most common and most severe type of sickle cell disease" (NIH 2019).

[31]The CDC (2019) also reports that about "1 in 13 Black or African-American babies is born with sickle cell trait (SCT)", meaning they have inherited one sickle cell gene rather than the two copies that result in severe symptoms.

[32]However, places that have high populations of white people (such as Canada, the United States, Europe, Russia, and Australia) have also had the resources and political support to eliminate (see CDC 2018a; WHO 2016a) or considerably reduce the incidence of malaria in their territories (see Government of Canada 2016; NSW Government Health 2016; WHO 2016b). With the significant reduction or elimination of malaria in

unable to penetrate a partner (by definition of the term monster cock); he specifically identified cis Black men with priapism as having "freakishly large" monster cocks in contrast with the natural. Invoking this highly racialized disease, therefore, further enables Dr. Rosenburg to essentialize cis Black men at the level of 'race' as the only people with monster cocks capable of causing cis women unwanted pain through penetration.

Denaturalizing cis Black men's penises on the basis of 'race' (in terms of genetics and disease) places Black men and boys in danger, largely leaves unaddressed cis women's unwanted pain from monster cock penetration, and conceals other men's sexual violence. After all, the racialized framing of monster cocks in Dr. Rosenburg's comments renders invisible the sexual violence enacted by white men particularly, as well as non-Black men of colour who—according to this formulation—do not have a racialized disease, nor the necessary race-based genetics—and therefore, genital size—to even possess a monster cock that would ostensibly enable them to enact this kind of violence against circlusive sexual partners.

Like the 'tight Asian pussy', the 'big Black dick' functions discursively to normalize the sexed bodies of particularly white cis men. If the "purpose" or "function" of the penis is heterosexual penetration and reproduction, as some physicians suggest, and failure to successfully engage in heterosexual penetrative practices threatens the maleness of the body, then framing the Black male body as uniquely incapable of vaginal penetration without causing cis women unwanted pain discursively constitutes the Black male body as essentially, biologically different at the level of sex. This only reinforces the histories of scientific racism that framed Black bodies as failing to embody sex according to white standards (Snorton 2017; Stein 2015; Gill-Peterson 2014; Magubane 2014). On the other hand, if phallic masculine embodiment—as a practice of dominance over others—is accomplished through the monster cock, and Black cis men are framed within medical discourse as the only people capable of having a monster cock at the level of genetics and a racialized disease, then Black men's subjectivities are reinscribed as

these regions, therefore, sickle cell anemia does not develop in their populations, which helps explain why relatively so few white people have developed the condition.

"embod[ying] brute masculinity without the manly restraint of rationality and civilization" (Stein 2015, 223).

Naturalizing the White Male Body

Between *Enhancement Forum* members' discourses about the monster cock, and male enhancement practitioners' discourses about the "purpose" of the male body, the figure of the monster cock produces a tension between phallic masculine embodiment practices that shore up cis men's masculine dominance on the one hand, and successful heterosexual and reproductive practices that confirm the body as male on the other. Within this chapter, I presented how physicians attempt to reconcile this tension. Through this analysis, I demonstrate that together the 'reproductive body', dyspareunia, the 'tight Asian pussy', and the 'big Black dick' function discursively as technologies of the (un)natural that reassert cis masculinity and the sex of particularly white male bodies as natural through their relation to female and racially-marked bodies. By juxtaposing different bodies in relation to the monster cock I was able to locate the seams and sutures for how cis men's bodies are constructed as natural through heterosexuality, reproduction, medicalization, and race.

Practitioners invoked the 'female reproductive body' by naturalizing cis women's "capacity of expansion" to vaginally "accommodate" any size penis to shore up cis men's bodies as male through heterosexual penetrative practices, thereby denying the existence of a monster cock that causes cis women vaginal pain. The threat of penetrative failure posed by the monster cock is neutralized by grounding the nature of the male body in its penetrative and reproductive "function" in relation to the 'female reproductive body'. In physicians' limited attempts to acknowledge and explain cis women's unwanted pain from penetration, they cited dyspareunia, the 'tight Asian pussy', and the 'big Black dick'. Redirecting the "problem" of pain from monster cock penetration on to cis women's bodies, physicians invoke dyspareunia, which functions discursively as a 'failure' of the 'female reproductive body' for undermining heterosexual 'success'. Thus framing cis women's sexed

bodies as ill, aging, and otherwise responsible for vaginal pain from penetration shores up the naturalness of the male body.

Racializing Asian cis women's vaginas as "small by nature", and racializing Black cis men's penises as "freakishly large" both work to render the monster cock a result of racialized difference in genital size while naturalizing and normalizing particularly white men's bodies. Both reinforce histories of racism that framed Asian cis women as passive, hypersexual, and exotic; and Black bodies as aggressive, hypersexual, and perverse for failing to embody sex according to white standards. (De)naturalization techniques have historically been effective means for justifying the status quo and for absolving ourselves of changing oppressive social arrangements. We can begin to transform oppressive social arrangements by deconstructing the discursive devices that capture our bodies within binary logics of the 'natural' and 'unnatural'.

Chapter 7

Conclusion

The bodies of particularly white cis men are regularly centered in everyday life, but often in ways that go un(re)marked. That there has been an abundance of feminist and sociological research about medical interventions into the genitals of peoples who have historically faced oppression, but there is such limited research about cis men's genital practices is in many ways reflective of the absent presence of the male body accomplished through masculine disembodiment. This disembodiment is interlocking with the unmarked categories of whiteness and cisness. By refocusing on male enhancement, this research works to locate the seams and sutures that stitch the particularly white male body together before and after genital transformation.

Given that minimal social science research has been conducted on male enhancement generally, and that the extant somatechnic research comparing genital transformations has largely focused on medical interventions into historically-oppressed peoples bodies and not 'male' bodies, this investigation is unique in mapping out both the incarnation of the male body through medical discourse, and its differential materialization compared to other bodily becoming. Moreover, the existing bodies of scholarship that investigate historically-oppressed peoples' genital practices tend to approach body 'modification' to evaluate the liberatory potential or oppressive pitfalls of somatic transformation while also often maintaining a false dichotomy between nature and technology. Departing from that scholarship, in this manuscript I examine cosmetic genital procedures for cis men—not to ask if these body projects are good or bad, or if they

produce 'artificial' bodies, or what these body projects necessarily *mean*—but to ask what male enhancement *does* in the incarnation of bodies.

In many ways, this project about cis men has always, necessarily also been about those who are othered. I demonstrate through this research how medical discourse renders the particularly white male body as natural and normal, while (de)naturalizing the bodies and/or identities of trans folks, cis women, and people of color in ways that work to justify inequitable social arrangements. This dissertation focused on some of these inequities, including gatekeeping trans folks' access to appropriate medical care and denaturalizing their post-operative bodies, lending legitimacy to the violence enacted against them; erasing cis women's pain from sexual violence, if not rendering their bodies responsible for this pain through processes of racialization and medicalization; and racializing the sexed bodies of Asian cis women and Black cis men in ways that contribute to their construction as sexually docile or threatening, respectively, further entrenching how they are socially made vulnerable to racist violence. As such, this project joins others in deconstructing 'the natural' as a site through which power operates, and through which so many justifications for inequity in Canada and the United States are fortified.

By comparing male enhancement with gender confirming genital procedures, I traced the operation of various technologies of the natural within male enhancement that suture cis men's bodies together as naturally male. Male enhancement practitioners' theory of gender acquisition posits that the male body is the site from which masculinity naturally emanates, making cis men unquestionably eligible according to physicians to receive male enhancement. Their authenticity as 'real men' was largely unquestioned, even when their bodies failed to cite the regulatory norms of sex. This work demonstrates how medical discourse constructs genital surgeries elected by cis men as an acceptable somatic intervention for self improvement of their 'natural male bodies', and a reasonable and predictable option to address suffering from social burdens like genital ridicule (particularly by the 'opposite sex'). For many male enhancement physicians, cis men's suffering served not as an indication that they needed access to mental health supports, but that they were ideal candidates for male enhancement.

Cis men's suffering becomes a potential problem, according to practitioners, when it is characterized as persistent dissatisfaction with their bodies, signaling a potential case of Body Dysmorphia. In this case, most physicians agreed that any medical intervention would cause harm to cis men's identities as masculine. Other potential harms include penile reduction surgeries or racialized interventions into the body which indicated to practitioners that cis men were "really really weird" if not unstable, causing harm to whiteness and cis masculinity. Compared to physicians' concern about trans people regretting irreversible surgical interventions, practitioners framed male enhancement as unlikely to cause cis men regret, even if they may feel somewhat dissatisfied with the end results; the seat of regret therefore rests in a permanent change to what physicians see as a 'core' identity of gendered subjects, not a 'minor' change to their embodiment.

Gender confirmation surgery, on the other hand, is constructed by medical discourse as a procedure that needs to be highly gatekept in case patients are "just going through a phase" and are not actually trans, and as a somatic transformation that will not change trans people's inner problem of suffering from psychological instability. Doctors construct transition surgeries as harmful and irreversible procedures to the nature of the sex trans people were assigned at birth, concluding that trans people's regret over somatic intervention is inevitable because the nature of their sexed body will persist even after surgical transition. Practitioners naturalize the sex both cis men and trans folks were assigned at birth, so only cis men's body projects are constructed as leaving their sexed bodies intact, thus casting post-surgical trans bodies as artificial constructions.

Closing the gate to gender confirmation surgeries on the basis that they are irreversible, while largely not gatekeeping male enhancement procedures—which are not always reversible, safe, or efficacious—demonstrates the asymmetrical treatment of these two groups of patients. Moreover, this differential gatekeeping reveals the dubious foundation upon which doctors justify closing the gate to genital technologies for trans patients, while keeping it open for cis men. Comparing multiple cases like these, we see how trans folks are institutionally required to seek counseling in great part to avoid regret,

whereas male enhancement practitioners simply mitigate cis men's dissatisfaction and disappointment with the results of penile augmentation.

Garner's investigation (comparing gynecomastia with trans chest surgeries) and my own shared considerable overlap in terms of the theoretical perspectives that oriented our research, and our objects of analysis. Both of our projects were grounded in similar bodies: of scholarship, of trans people, and of cis women and men. Both of our investigations used a somatechnic method, and both produced similar conclusions. However, our respective projects drew from different sets of medical experts, employed distinct methods (textual analysis versus interviews), and analyzed separate locations of the body (chests versus genitals) that carry with them discrete processes of pathologization (of chest tissue versus body dysmorphia). The procedures involved (on cis men's bodies) are also constructed in contrasting ways: as correcting a medical pathology (gynecomastia) versus an elective cosmetic procedure (male enhancement).

That the conclusions I drew from my comparative analysis largely corroborate the arguments Garner produced—despite these dissimilarities—indicates the embeddedness of doctors within medical discourse, and the consistency with which medical discourse enables and constrains the differential materialization of trans and cis bodies and subjectivities across distinct medical fields and within medical *practice*, not just codified texts. Because not all of the discourses physicians invoked in our interviews exist in texts, and therefore, "may leave only a thin and ambiguous historical residue" for textual analysis (Whitehead 2012, 21), this investigation makes a valuable contribution to mapping out their operation, including how doctors employ and disrupt these discourses in their everyday practices. Sharing practitioners' dominant discourses alongside disruptions to these discourses—such as Mr. Bennett's unequivocal statement that his trans patients have never regretted somatic transformation—offered a means of 'talking back' within medical discourse.

The ways in which Garner's and my conclusions depart from one another are also meaningful. That physicians—including those who work(ed) with trans people—do not report a tension between weighing the potential harms related to gender dysphoria with the potential harms from transition surgeries—only considering the latter—is a consequential

finding in the materialization of bodies at the level of medical practice that was not captured in codified texts. Moreover, that most practitioners recognize that they are not trained nor qualified to evaluate patients' suffering—much less the harms that are associated with that suffering—yet in practice they largely accept cis men's suffering and reject trans people's suffering undermines doctors' claims that trans people have unstable psychological problems that cis men do not. While the gatekeeping around male enhancement may be problematic for a number of reasons, it reveals that there are other possibilities for how trans people's access to surgery could be managed—not as pathology, but as aesthetic surgery—thus cracking open a fissure in medical discourse.

Both of our analyses demonstrate that physicians pathologize trans people largely due to practitioners' theories of gender acquisition—that gender is the effect of sex, rather than its cause—which lies at the heart of their doubt in trans authenticity and their concern about trans regret. Unlike the majority of gynecomastia patients in Garner's analysis, however, since male enhancement patients can also be pathologized with Body Dysmorphic Disorder—albeit in different ways and to different degrees than trans patients with Gender Dysphoria—this project also contributes to the literature by identifying a rare overlap between the pathologization of trans and cis patients. While large bodies of scholarship have investigated these two sites separately, bringing them in relation to each other through a somatechnic method renders visible the boundaries and logics of doctors' medical practices. Physicians were surprisingly consistent in their logics that internal, diagnosable, psychological problems cannot be ameliorated through physical interventions. In the case of trans patients, closing the gate to somatic transformation maintains the sex they were assigned at birth as natural, and in the case of cis male enhancement patients, closing the gate maintains normative conceptions of masculinity.

By examining physicians' assessments of patient suffering, this project also maps out the differential attribution of social burdens versus psychological problems to different bodies and subjectivities, reflecting the discursive battlefield in the medical management of trans and cis patients. In Garner's (2011) analysis of gynecomastia, they found that cis men conceptualized their conditions as having "robbed" them of their 'natural' bodies, signaling

"a deep sense of injustice at what has been taken away, so that gynecomastia surgery [...is...] imagined as giving back what is rightfully theirs [...] not a construction" (281). Similarly in my own investigation, cis men and physicians imagined male enhancement not as a somatic transition and not as construction, but as a remedy to their aggrieved entitlement to sexual access—particularly to women's bodies—that they were otherwise denied due to what they imagine to be a result of their penis size, rather than, for example, their disinterest in giving reciprocal sexual pleasure.

While I was unfortunately not the investigator to conduct interviews with cis men, future research of cis men's framing of suffering as though they are victims of an unfair sexual economy merits deeper examination. That practitioners' explanations for their patients' interest in male enhancement diagnose feminism as the problem for cis men's suffering—rather than the limiting, patriarchal gender expectations for men's bodies under capitalism—closely mirrors incel discourse (Srinivasan 2018), and demonstrates how male enhancement is one of the currently accepted answers to the problem of the legitimacy of patriarchy (Connell 1995). Men and masculinities scholars researching the looksmaxing practices of extremist networks like incels may find significant overlap with cis men enhancing their genitals (Cook 2018, see). Because of the potential risks researchers face in terms of harassment, doxxing, and (sexual) violence associated with conducting this kind of investigation, I join others (Schneider 2020; Huang 2016) in calling on universities and institutional review boards to support scholars who take up this research so they have institutional assistance to navigate potential vulnerabilities to cis men's—and potentially incel—violence.

By tracing physicians' erasure and selective invocation of the monster cock and the sexual violence perpetuated through monster cock penetration, I analyzed how physicians attempt to resolve a tension between sexual practices that male the body, and dominance practices—what I call phallic masculine embodiment—that accomplish masculinity. Reading the monster cock in relation to discourses of the 'female reproductive body', dyspareunia, the 'tight Asian pussy', and the 'big Black dick', I trace how male enhancement discourse works to shore up the contours of whiteness, cis masculinity, and the male body through

their relation to and dominance over female and racially-marked bodies. Only by analyzing the monster cock relationally was I able to identify the seams and sutures of the natural male body, and to understand the assumptions and prohibitions for monster cock bodily being.

As one of the few somatechnic investigations into the male body (see Garner 2011; Fox and Thomson 2009a, 2009b for a few exceptions), this research helps bridge men and masculinities scholarship and somatechincs. Men and masculinities studies would benefit from using a somatechnic method and theoretical approach to understand the social materialization of the male body. While men and masculinities studies often relies on non-male masculinity scholarship to disentangle masculinity from the male form, and maps out the incarnation of the male body by identifying moments when the body fails to cite the regulatory norm of sex—often by examining processes of medicalization—the comparative analysis enabled through a somatechnic orientation would strengthen men and masculinities scholarship by not having to rely on bodily failure as a necessary analytical entry point. Somatechnics can specifically aid men and masculinities studies by identifying the assumptions and justifications for particular forms of male embodiment when juxtaposed with other forms of bodily being.

This research also makes a novel contribution to the literature by analyzing male enhancement discourse from cis men's online support sites like *Enhancement Forum*. While previous research has examined cis men's talk about their penises as 'short' in online forums (Del Rosso 2011), there is no equivalent nor similar analysis of cis men's talk about their practices to augment their genitals. My analysis of *Enhancement Forum* discourse was mostly limited to a pilot study to center existing discourses about male enhancement in my interviews with physicians, and as supportive evidence in my analysis of the monster cock. Future research on male enhancement would benefit from a more in-depth analysis of cis men's online talk, including about do-it-yourself genital practices.

This manuscript contains some undertheorized elements that warrant further research. For example, while Dr. Tabibi racialized cis Asian women's genitals as "small by nature", most male enhancement physicians in my sample did not respond to questions

about the racialization of cis women's bodies, claiming that the vagina was outside of their area of expertise. As a result, the data I co-generated with practitioners was insufficient to support a line of argumentation that the monster cock—as a representation of a racialized mismatch between genitals—signaled practitioners' investment in anti-miscegenation. However, this could prove an important line of inquiry for future research on male enhancement. Another undertheorized element in this present research that would benefit from further investigation is gay men's participation in male enhancement practices. A comparative examination of how medical discourse constitutes their bodies would enrich this analysis. Finally, as Karioris and Allan (2017) point out, the testicles are often forgotten when considering the construction of masculinity and the male body. While scrotal enhancements were technically included under the purview of this research, they were sidelined both in my conversations with male enhancement practitioners, and in this present analysis, and merit a closer examination.

I cannot predict how this dissertation and its descriptions, analysis, and conclusions will be taken up by others. It is certainly possible that practitioners may change some of their practices by referring cis men patients to mental health supports, screening them for sexual violence, or tracking the incidence of regret after male enhancement. Given that this is one of the few examinations of male enhancement from a social science perspective, it is also possible that this research may contribute to how cis men fashion their narratives to gain access to augmentation surgeries. After all, trans folks are not unique in tailoring their statements to access medical knowledge and somatic transformation.

I have written this dissertation largely as a response to the ways in which the 'natural' and 'unnatural' operate within medical discourse, with the understanding that (de)naturalization techniques are not benign descriptions of reality, but bring into being particular formations of sexed and racialized bodies and relations between them. I acknowledge, as poststructuralist feminists insist, that this project on male enhancement further brings bodies into being in unpredictable ways. To borrow Nikki Sullivan's (2009) words,

> I recognize that my contribution is no less an effect of the operations of power particular to a given time and place—the somatechnologies, if you like—than the work with which I engage. In other words, I acknowledge that the critical practice I perform itself contributes to the formation and transformation of bodies (of flesh, knowledge, politic) in heterogenerative and unpredictable ways. As such, the intervention I make should not be understood in terms of a definitive answer to a set of identifiable universalizable problems but as a necessarily delimited offering that is open to ongoing (re)evaluation and modification. (314)

My contribution to the materialization of sexed and racialized bodies is also necessarily delimited. That I am an outsider to the populations largely represented in this investigation only confirms that my claims in this manuscript should be read as partial, a reflection of my whiteness and social location as a cis woman, and held as cispicious[1] until corroborated by others.

What I hope, however, is that this research begins to locate the seams, cracks, fissures, and ruptures in discourse. After all, Foucault suggests that the revolutionary potential of discourse analysis is not in attempting to move beyond or outside of discourse, but in identifying the alternative possibilities contemporary to current arrangements. The significance of discourse analysis is its potential to open up new geographies of thought, action, resistance, embodiment, and subjectivity. By studying male enhancement for its discontinuities, I hope that the contents of this manuscript open up space for different forms of bodily being and subjectivity. My aim was to trouble the binary between the 'natural' and 'unnatural' body in an effort to show how no bodily being is (un)natural, and to therefore, not only disrupt the justifications that naturalize inequity by grounding them in our bodies, but to make an intervention into how bodies might come to matter differently.

[1] 'Cispicious' is a portmanteau of 'suspicious' and 'cisgender'.

Bibliography

Adamczak, Bini. 2016. "On 'Circlusion'." Mask Magazine. http://web.archive.org/web/20190709125520/http://www.maskmagazine.com/the-mommy-issue/sex/circlusion.

Akst, Lee, and Kristine Pietsch. n.d. "Is Vocal Fry Ruining My Voice?" Johns Hopkins Medicine. https://web.archive.org/web/20190405200256/https://www.hopkinsmedicine.org/health/conditions-and-diseases/is-vocal-fry-ruining-my-voice.

Alm, Erika. 2013. "Somatechnics of Consensus: Situating the Biomedicalisation of Intersex." *Somatechnics* 3 (2): 307–328. doi:10.3366/soma.2013.0100.

Alter, Gary J. 1995. "Augmentation Phalloplasty." *The Urologic Clinics of North America* 22 (4): 887–902.

———. 2016. "Editorial Comment on 'Penile Girth Enhancement With PMMA-Based Soft Tissue Fillers'." *The Journal of Sexual Medicine* 13 (9): 1423. doi:10.1016/j.jsxm.2016.07.011.

APA. 1980. "Transsexualism." In *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed. Washington, DC: American Psychiatric Association.

———. 2000. "Gender Identity Disorder." In *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed., text revision. Washington, DC: American Psychiatric Association.

———. 2013a. "Body Dysmorphic Disorder." In *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. Arlington, VA: American Psychiatric Association. doi:10.1176/appi.books.9780890425596.

———. 2013b. "Gender Dysphoria." In *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. Arlington, VA: American Psychiatric Association. doi:10.1176/appi.books.9780890425596.

Arendell, Terry. 1997. "Reflections On The Researcher-Researched Relationship: A Woman Interviewing Men." *Qualitative Sociology* 20 (3): 341–368. doi:10.1023/A:1024727316052.

Ashley, Florence. 2019a. "Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising." *Journal of Medical Ethics:* 1–3. doi:10.1136/medethics-2018-105293.

Ashley, Florence. 2019b. "McGill University's Hiring of Sahar Sadjadi." Medium. http://web.archive.org/web/20190627112341/https://medium.com/@florence.ashley/mcgill-universitys-hiring-of-sahar-sadjadi-e98f72b2bc6c.

———. 2019c. "Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth." *Clinical Child Psychology and Psychiatry* 24 (2): 223–236. doi:10.1177/1359104519836462.

Ashley, Florence, and Carolyn Ells. 2018. "In Favor of Covering Ethically Important Cosmetic Surgeries: Facial Feminization Surgery for Transgender People." *The American Journal of Bioethics* 18 (12): 23–25. doi:10.1080/15265161.2018.1531162.

ASPS. 2019. *Plastic Surgery Statistics Report.* American Society of Plastic Surgeons. https://www.plasticsurgery.org/documents/News/Statistics/2019/plastic-surgery-statistics-full-report-2019.pdf.

Atkinson, Michael. 2008. "Exploring Male Femininity in the 'Crisis': Men and Cosmetic Surgery." *Body & Society* 14 (1): 67–87. doi:10.1177/1357034X07087531.

AUA. 2018. "Penile Augmentation Surgery." American Urological Association. https://web.archive.org/web/20190423145916/https://www.auanet.org/guidelines/penile-augmentation-surgery.

Bannon, Lisa. 1996. "How a Risky Surgery Became Profit Center in Los Angeles." Wall Street Journal. https://web.archive.org/web/20171216130825/https://www.wsj.com/articles/SB834019376802886000.

Barrett, James R., and David Roediger. 1997. "Inbetween Peoples: Race, Nationality and the 'New Immigrant' Working Class." *Journal of American Ethnic History* 16 (3): 3–44.

Beauchamp, Toby. 2009. "Artful Concealment and Strategic Visibility: Transgender Bodies and U.S. State Surveillance After 9/11." *Surveillance & Society* 6 (4): 356–366. doi:10.24908/ss.v6i4.3267.

Beauvoir, Simone de. 1989. *The Second Sex.* Vintage Books ed. Translated by Howard Madison Parshley. New York: Vintage Books.

Bediako, Shawn M., and Kimberly R. Moffitt. 2011. "Race and Social Attitudes about Sickle Cell Disease." *Ethnicity & Health* 16 (4-5): 423–429. doi:10.1080/13557858.2011.552712.

Bello-Kano, Ibrahim. 2005. "Representations of Africa in Western Writing: A Bibliographic Essay." *Journal of Cultural Studies* 6 (1): 36–66. doi:10.4314/jcs.v6i1.6275.

Benestad, E.E.P. 2010. "From Gender Dysphoria to Gender Euphoria: An Assisted Journey." *Sexologies* 19 (4): 225–231. doi:10.1016/j.sexol.2010.09.003.

Berdahl, Jennifer L., Marianne Cooper, Peter Glick, Robert W. Livingston, and Joan C. Williams. 2018. "Work as a Masculinity Contest." *Journal of Social Issues* 74 (3): 422–448. doi:10.1111/josi.12289.

Berns, Nancy. 2001. "Degendering the Problem and Gendering the Blame: Political Discourse on Women and Violence." *Gender & Society* 15 (2): 262–281. doi:10.1177/089124301015002006.

Billings, Dwight B., and Thomas Urban. 1982. "The Socio-Medical Construction of Transsexualism: An Interpretation and Critique." *Social Problems* 29 (3): 266–282. doi:10.2307/800159.

Birke, Lynda. 1986. *Women, Feminism and Biology: The Feminist Challenge.* Brighton: Wheatsheaf Books.

Bjekić, Milan, Sandra Šipetić-Grujičić, Hristina Vlajinac, and Ivana Dunić. 2018. "Does Penis Size Influence Sexual Behaviour of Men Who Have Sex with Men?" *Acta Facultatis Medicae Naissensis* 35 (4): 311–319. doi:10.2478/afmnai-2018-0033.

Blair, Peggy. 2005. *Rights of Aboriginal Women On- and Off-Reserve.* Scow Institute. http://scow-archive.libraries.coop/library/documents/RightsofWomenFacts.pdf.

Blanchard, Ray, Betty W. Steiner, Leonard H. Clemmensen, and Robert Dickey. 1989. "Prediction of Regrets in Postoperative Transsexuals." *The Canadian Journal of Psychiatry* 34 (1): 43–45. doi:10.1177/070674378903400111.

Bleier, Ruth. 1984. *Science and Gender: A Critique of Biology and Its Theories on Women.* Athene Series. New York: Pergamon Press.

Blum, Virginia L. 2003. *Flesh Wounds: The Culture of Cosmetic Surgery.* Berkeley: University of California Press.

Bodlund, Owe, and Gunnar Kullgren. 1996. "Transsexualism—General Outcome and Prognostic Factors: A Five-Year Follow-up Study of Nineteen Transsexuals in the Process of Changing Sex." *Archives of Sexual Behavior* 25 (3): 303–316. doi:10.1007/BF02438167.

Bogaert, Anthony F., and Scott Hershberger. 1999. "The Relation Between Sexual Orientation and Penile Size." *Archives of Sexual Behavior* 28 (3): 213–221. doi:10.1023/A:1018780108597.

Bogdan, Robert. 1996. "The Social Construction of Freaks." In *Freakery: Cultural Spectacles of the Extraordinary Body,* edited by Rosemarie Garland-Thomson, 23–37. New York: New York University Press.

Bordo, Susan. 1993. *Unbearable Weight: Feminism, Western Culture, and the Body.* Berkeley: University of California Press.

———. 1998. "Pills and Power Tools." *Men and Masculinities* 1 (1): 87–90. doi:10.1177/1097184X98001001005.

Bourns, Amy. 2015. *Guidelines and Protocols for Hormone Therapy and Primary Health Care for Trans Clients.* Sherbourne Health Centre.

Brace, C. Loring. 2002. "The Concept of Race in Physical Anthropology." In *Physical Anthropology: Original Readings in Method and Practice,* edited by Peter N. Peregrine, Carol R. Ember, and Melvin Ember. Upper Saddle River, NJ: Prentice Hall.

Braun, Virginia. 2005. “In Search of (Better) Sexual Pleasure: Female Genital ‘Cosmetic’ Surgery.” *Sexualities* 8 (4): 407–424. doi:10.1177/1363460705056625.

———. 2009. “‘The Women Are Doing It for Themselves’: The Rhetoric of Choice and Agency around Female Genital ‘Cosmetic Surgery’.” *Australian Feminist Studies* 24 (60): 233–249. doi:10.1080/08164640902852449.

———. 2010. “Female Genital Cosmetic Surgery: A Critical Review of Current Knowledge and Contemporary Debates.” *Journal of Women’s Health* 19 (7): 1393–1407. doi:10.1089/jwh.2009.1728.

Brennan, Joseph. 2017. “Porn Penis, Malformed Penis.” *Porn Studies* 6 (3): 316–331. doi:10.1080/23268743.2017.1388191.

Brickell, Chris. 2005. “Masculinities, Performativity, and Subversion: A Sociological Reappraisal.” *Men and Masculinities* 8 (1): 24–43. doi:10.1177/1097184X03257515.

Briggs, Laura. 2002. *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico.* Berkeley: University of California Press.

Brinkhurst-Cuff, Charlie. 2016. “A Dermatologist Explains the Science Behind the ‘Black Don’t Crack’ Stereotype.” *Vice Media.* https://web.archive.org/save/https://www.vice.com/en_us/article/mgmzva/a-dermatologist-explains-the-science-behind-the-black-dont-crack-stereotype.

Brown, George R. 2010. “Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder.” *International Journal of Transgenderism* 12 (1): 31–39. doi:10.1080/15532731003688970.

Brownmiller, Susan. 1993. *Against Our Will: Men, Women, and Rape.* 1st Ballantine Books ed. New York: Fawcett Columbine.

Brubaker, Sarah Jane, and Jennifer A. Johnson. 2008. “‘Pack a More Powerful Punch’ and ‘Lay the Pipe’: Erectile Enhancement Discourse as a Body Project for Masculinity.” *Journal of Gender Studies* 17 (2): 131–146. doi:10.1080/09589230802008899.

Brunner, Laura A. K. 2010. “‘How Big Is Big Enough?’: Steve, Big, and Phallic Masculinity in *Sex and the City*.” *Feminist Media Studies* 10 (1): 87–98. doi:10.1080/14680770903457170.

Burkowicz, Jakub. 2016. “Peripheral Europeans: The History of the Racialization of Slavs in Canada.” PhD diss., Simon Fraser University.

Butler, Judith. 1990. *Gender Trouble: Feminism and the Subversion of Identity.* Thinking Gender. New York: Routledge.

———. 1993. *Bodies That Matter: On the Discursive Limits of “Sex”.* New York: Routledge.

Cacchioni, Thea. 2007. “Heterosexuality and ‘the Labour of Love’: A Contribution to Recent Debates on Female Sexual Dysfunction.” *Sexualities* 10 (3): 299–320. doi:10.1177/1363460707078320.

Cadwallader, Jessica. 2007. "Suffering Difference: Normalisation and Power." *Social Semiotics* 17 (3): 375–394. doi:10.1080/10350330701448702.

Cadwallader, Jessica, and Samantha Murray. 2007. "Introduction." *Social Semiotics* 17 (3): 259–261. doi:10.1080/10350330701448538.

Cameron, Deborah. 1992. "Naming of Parts: Gender, Culture, and Terms for the Penis among American College Students." *American Speech* 67 (4): 367. doi:10.2307/455846. JSTOR: 455846.

Campo-Engelstein, Lisa, and Nadia L. Johnson. 2014. "Revisiting 'The Fertilization Fairytale:' an Analysis of Gendered Language Used to Describe Fertilization in Science Textbooks from Middle School to Medical School." *Cultural Studies of Science Education* 9 (1): 201–220. doi:10.1007/s11422-013-9494-7.

Canner, Liz, ed. 2009. *Orgasm Inc.* First Run Features. DVD.

Casavantes, Luis, Gottfried Lemperle, and Palmira Morales. 2016. "Penile Girth Enhancement With Polymethylmethacrylate-Based Soft Tissue Fillers." *The Journal of Sexual Medicine* 13 (9): 1414–1422. doi:10.1016/j.jsxm.2016.06.008.

Castro-Vázquez, Genaro. 2013. "The 'Beauty' of Male Circumcision in Japan: Gender, Sexuality and the Male Body in a Medical Practice." *Sociology* 47 (4): 687–704. doi:10.1177/0038038512453794.

Cavanaugh, Timothy, Ruben Hopwood, and Cei Lambert. 2016. "Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients." *The American Medical Association Journal of Ethics* 18 (11): 1147–1155. doi:10.1001/journalofethics.2016.18.11.sect1-1611.

CDC. 2018a. "Elimination of Malaria in the United States (1947-1951)." Centers for Disease Control and Prevention. https://web.archive.org/web/20180618035757/https://www.cdc.gov/malaria/about/history/elimination_us.html.

———. 2018b. "Where Malaria Occurs." Centers for Disease Control and Prevention. https://web.archive.org/web/20190616004126/https://www.cdc.gov/malaria/about/distribution.html.

———. 2019. "Sickle Cell Disease (SCD): Data and Statistics." Centers for Disease Control and Prevention. https://web.archive.org/web/20190807094051/https://www.cdc.gov/ncbddd/sicklecell/data.html.

Chadwick, Sara B., and Sari M. van Anders. 2017. "Do Women's Orgasms Function as a Masculinity Achievement for Men?" *The Journal of Sex Research* 54 (9): 1141–1152. doi:10.1080/00224499.2017.1283484.

Chang, Harry. 1985. "Toward a Marxist Theory of Racism: Two Essays by Harry Chang." Edited by Paul Liem and Eric Montague. *Review of Radical Political Economics* 17 (3): 34–45.

Charmaz, Kathy. 2004. "Grounded Theory." In *Approaches to Qualitative Research: A Reader on Theory and Practice,* edited by Sharlene Nagy Hesse-Biber and Patricia Leavy, 496–521. New York: Oxford University Press.

———. 2014. *Constructing Grounded Theory.* 2nd ed. Introducing Qualitative Methods. Thousand Oaks, CA: Sage.

Choi, SU, SH Park, BS Lee, and JH Han. 1999. "Erect Penile Size of Korean Men." *Venereology* 12 (4): 135–139.

Chu, Andrea Long, and Emmett Harsin Drager. 2019. "After Trans Studies." *TSQ: Transgender Studies Quarterly* 6 (1): 103–116. doi:10.1215/23289252-7253524.

Clark, Jack A., Nelda P. Wray, and Carol M. Ashton. 2001. "Living With Treatment Decisions: Regrets and Quality of Life Among Men Treated for Metastatic Prostate Cancer." *Journal of Clinical Oncology* 19 (1): 72–80. doi:10.1200/JCO.2001.19.1.72.

Clesse, Christophe, Joëlle Lighezzolo-Alnot, Sylvie De Lavergne, Sandrine Hamlin, and Michèle Scheffler. 2018. "Statistical Trends of Episiotomy around the World: Comparative Systematic Review of Changing Practices." *Health Care for Women International* 39 (6): 644–662. doi:10.1080/07399332.2018.1445253.

Coates, Ta-Nehisi. 2015. *Between the World and Me.* 1st ed. New York: Spiegel & Grau.

Cohn, Carol, and Cynthia Enloe. 2003. "A Conversation with Cynthia Enloe: Feminists Look at Masculinity and the Men Who Wage War." *Signs: Journal of Women in Culture and Society* 28 (4): 1187–1107. doi:10.1086/368326.

Connell, R. W. 1995. *Masculinities.* Berkeley: University of California Press.

Connell, R. W., and James W. Messerschmidt. 2005. "Hegemonic Masculinity: Rethinking the Concept." *Gender & Society* 19 (6): 829–859. doi:10.1177/0891243205278639.

Conrad, Peter. 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders.* Baltimore: Johns Hopkins University Press.

Cook Jr., James W. 1996. "Of Men, Missing Links, and Nondescripts: The Strange Career of P.T. Barnum's 'What Is It?' Exhibition." In *Freakery: Cultural Spectacles of the Extraordinary Body,* edited by Rosemarie Garland-Thomson, 139–157. New York: New York University Press.

Cook, Jesselyn. 2018. "Inside Incels' Looksmaxing Obsession: Penis Stretching, Skull Implants And Rage." *HuffPost.* https://web.archive.org/web/20190623220905/https://www.huffpost.com/entry/incels-looksmaxing-obsession_n_5b50e56ee4b0de86f48b0a4f.

Craven, Julia. 2020. "Please Stop Making Protest Signs That Reference 'Black Dick'." *Slate.* https://web.archive.org/web/20200610172040/https://slate.com/news-and-politics/2020/06/please-stop-making-protest-signs-that-reference-black-dick.html.

Creese, Gillian. 2007. "Racializing Work/Reproducing White Privilege." In *Work in Tumultuous Times: Critical Perspectives,* edited by Vivian Shalla, 192–226. Montreal: McGill-Queen's University Press.

Crerand, Canice E., Martin E. Franklin, and David B. Sarwer. 2006. "Body Dysmorphic Disorder and Cosmetic Surgery." *Plastic and Reconstructive Surgery* 118 (7): 167e–180e. doi:10.1097/01.prs.0000242500.28431.24.

Crerand, Canice E., and David B. Sarwer. 2010. "Cosmetic Treatments and Body Dysmorphic Disorder." *Psychiatric Annals* 40 (7): 344–348. doi:10.3928/00485713-20100701-07.

Curry, Timothy Jon. 1991. "Fraternal Bonding in the Locker Room: A Profeminist Analysis of Talk about Competition and Women." *Sociology of Sport Journal* 8 (2): 119–135. doi:10.1123/ssj.8.2.119.

Da Ros, C., C. Teloken, P. Sogari, M. Barcelos, F. Silva, and C. Souto. 1994. "Caucasian Penis: What Is the Normal Size?" *Journal of Urology* 151 (2): 323A–325A.

Davis, Angela. 1983. *Women, Race & Class.* 1st Vintage Books ed. New York: Vintage Books.

Davis, Georgiann, Jodie M. Dewey, and Erin L. Murphy. 2016. "Giving Sex: Deconstructing Intersex and Trans Medicalization Practices." *Gender & Society* 30 (3): 490–514. doi:10.1177/0891243215602102.

Davis, Kathy. 2009. "Revisiting Feminist Debates on Cosmetic Surgery: Some Reflections on Suffering, Agency, and Embodied Difference." In *Cosmetic Surgery: A Feminist Primer,* edited by Cressida J. Heyes and Meredith Jones, 35–48. Burlington, VT: Ashgate.

Deakin, Hannah, and Kelly Wakefield. 2014. "Skype Interviewing: Reflections of Two PhD Researchers." *Qualitative Research* 14 (5): 603–616. doi:10.1177/1468794113488126.

DeGroot, Jocelyn M., and Heather J. Carmack. 2020. "Unexpected Negative Participant Responses and Researcher Safety: 'Fuck Your Survey and Your Safe Space, Trigger Warning Bullshit'." *Journal of Communication Inquiry* 44 (4): 354–375. doi:10.1177/0196859920921752.

Del Rosso, Jared. 2011. "The Penis as Public Part: Embodiment and the Performance of Masculinity in Public Settings." *Sexualities* 14 (6): 704–724. doi:10.1177/1363460711420461.

Delgado-Echeverría, Isabel. 2007. *El Descubrimiento de Los Cromosomas Sexuales: Un Hito En La Historia de La Biología.* Estudios Sobre La Ciencia 41. Madrid: Consejo Superior de Investigaciones Científicas.

DeVun, Leah, and Zeb Tortorici. 2018. "Trans, Time, and History." *TSQ: Transgender Studies Quarterly* 5 (4): 518–539. doi:10.1215/23289252-7090003.

DiAngelo, Robin J. 2018. *White Fragility: Why It's so Hard for White People to Talk about Racism.* Boston: Beacon Press.

Dickson, EJ. 2019. "Stretching the Truth: How Incels Are 'Jelqing' for a Bigger Penis." *Rolling Stone.* https://web.archive.org/web/20190629154819/https://www.rollingstone.com/culture/culture-features/jelqing-penis-size-increase-length-841045/.

Dodd, Jayy. 2016. "Why I'm Scared Of White Women." Medium. https://web.archive.org/web/20180903182543/https://medium.com/the-establishment/why-im-scared-of-white-women-89bcdce25959.

Dorr, Lisa Lindquist. 1999. "Arm in Arm: Gender, Eugenics, and Virginia's Racial Integrity Acts of the 1920s." *Journal of Women's History* 11 (1): 143–166. doi:10.1353/jowh.2003.0094.

Dreger, Alice Domurat. 1998. *Hermaphrodites and the Medical Invention of Sex.* Cambridge, MA: Harvard University Press.

Dreyfus, Hubert L., and Paul Rabinow. 1983. *Michel Foucault: Beyond Structuralism and Hermeneutics.* 2nd ed. In collaboration with Michel Foucault. Chicago: University of Chicago Press.

Duncan, Dustin T., and Mark L. Hatzenbuehler. 2014. "Lesbian, Gay, Bisexual, and Transgender Hate Crimes and Suicidality Among a Population-Based Sample of Sexual-Minority Adolescents in Boston." *American Journal of Public Health* 104 (2): 272–278. doi:10.2105/AJPH.2013.301424.

Ehrensaft, Diane. 2012. "From Gender Identity Disorder to Gender Identity Creativity: True Gender Self Child Therapy." *Journal of Homosexuality* 59 (3): 337–356. doi:10.1080/00918369.2012.653303.

Elmerstig, Eva, Barbro Wijma, and Katarina Swahnberg. 2013. "Prioritizing the Partner's Enjoyment: A Population-Based Study on Young Swedish Women with Experience of Pain during Vaginal Intercourse." *Journal of Psychosomatic Obstetrics & Gynecology* 34 (2): 82–89. doi:10.3109/0167482X.2013.793665.

Enke, Anne, ed. 2012. "The Education of Little Cis: Cisgender and the Discipline of Opposing Bodies." In *Transfeminist Perspectives in and beyond Transgender and Gender Studies,* 60–78. Philadelphia: Temple University Press.

Enloe, Cynthia. 2004. "Wielding Masculinity inside Abu Ghraib: Making Feminist Sense of an American Military Scandal." *Asian Journal of Women's Studies* 10 (3): 89–102. doi:10.1080/12259276.2004.11665976.

Fausto-Sterling, Anne. 2000. *Sexing the Body: Gender Politics and the Construction of Sexuality.* 1st ed. New York: Basic Books.

Feinberg, Leslie. 1996. *Transgender Warriors: Making History from Joan of Arc to Dennis Rodman.* Boston: Beacon Press.

Ferber, Abby L. 2000. "Racial Warriors and Weekend Warriors: The Construction of Masculinity in Mythopoetic and White Supremacist Discourse." *Men and Masculinities* 3 (1): 30–56. doi:10.1177/1097184X00003001002.

Firestone, Shulamith. 1970. *The Dialectic of Sex: The Case for Feminist Revolution.* New York: W. Morrow.

Fischer, Nicolas, Stefan Hauser, Olivier Brede, Christian Fisang, and Stefan Müller. 2010. "Implantation of Artificial Penile Nodules—A Review of Literature." *The Journal of Sexual Medicine* 7 (11): 3565–3571. doi:10.1111/j.1743-6109.2009.01659.x.

Flowers, Paul, Darren Langdridge, Brendan Gough, and Ruth Holliday. 2013. "On the Biomedicalisation of the Penis: The Commodification of Function and Aesthetics." *International Journal of Men's Health* 12 (2): 121–137. doi:10.3149/jmh.1202.121.

Foucault, Michel. 1984. *The Foucault Reader.* 1st ed. Edited by Paul Rabinow. New York: Pantheon Books.

———. 1990. *The History of Sexuality, Vol. 1: An Introduction.* Vintage Books ed. Translated by Robert Hurley. New York: Vintage Books.

———. 1994. *The Birth of the Clinic: An Archaeology of Medical Perception.* New York: Vintage Books.

———. 1999. *Abnormal: Lectures at the Collège de France, 1974-1975.* Edited by Valerio Marchetti and Antonella Salomoni. Translated by Graham Burchell. New York: Picador.

———. 2002. *Archaeology of Knowledge.* Routledge Classics. London: Routledge.

Foucault, Michel, and Colin Gordon. 1980. *Power/knowledge: selected interviews and other writings, 1972-1977.* 1st American ed. New York: Pantheon Books.

Fox, Marie, and Michael Thomson. 2009a. "Foreskin Is a Feminist Issue." *Australian Feminist Studies* 24 (60): 195–210. doi:10.1080/08164640902852415.

———. 2009b. "Sexing the Cherry: Fixing Masculinity." In *Somatechnics: Queering the Technologisation of Bodies,* edited by Samantha Murray and Nikki Sullivan. Farnham, UK: Ashgate.

Frankenberg, Ruth. 1993. *White Women, Race Matters: The Social Construction of Whiteness.* Minneapolis: University of Minnesota Press.

Franklin, Rachel S. 2014. "An Examination of the Geography of Population Composition and Change in the United States, 2000-2010: Insights from Geographical Indices and a Shift-Share Analysis." *Population, Space and Place* 20 (1): 18–36. doi:10.1002/psp.1744.

Friedan, Betty. 1963. *The Feminine Mystique.* New York: W. W. Norton & Company.

Friedl, Ernestine. 1975. *Women and Men: An Anthropologist's View.* Basic Anthropology Units. New York: Holt, Rinehart and Winston.

Fujimura, Joan H. 2006. "Sex Genes: A Critical Sociomaterial Approach to the Politics and Molecular Genetics of Sex Determination." *Signs: Journal of Women in Culture and Society* 32 (1): 49–82. doi:10.1086/505612.

Gailey, Jeannine A, and Ariane Prohaska. 2011. "Power and Gender Negotiations during Interviews with Men about Sex and Sexually Degrading Practices." *Qualitative Research* 11 (4): 365–380. doi:10.1177/1468794111404315.

Garcia Dauder, Silvia, and Nuria Gregori. 2009. "Designing the Margin of Feasible Bodies." Translated by Ruth Collins. *eurozine.* https://web.archive.org/web/20130918215505/https://www.eurozine.com/articles/2009-09-28-garciadauder-en.html.

Garland-Thomson, Rosemarie, ed. 1996. "Introduction: From Wonder to Error–A Genealogy of Freak Discourse in Modernity." In *Freakery: Cultural Spectacles of the Extraordinary Body,* 1–19. New York: New York University Press.

Garner, T. 2011. "Stitching up the Natural: 'Manboobs,' Pregnancy, and the Transgender Body." PhD diss., Simon Fraser University.

Garrison, Spencer. 2018. "On the Limits of 'Trans Enough': Authenticating Trans Identity Narratives." *Gender & Society* 32 (5): 613–637. doi:10.1177/0891243218780299.

Gill-Peterson, Jules. 2014. "The Technical Capacities of the Body: Assembling Race, Technology, and Transgender." *TSQ: Transgender Studies Quarterly* 1 (3): 402–418. doi:10.1215/23289252-2685660.

———. 2017. "Implanting Plasticity into Sex and Trans/Gender: Animal and Child Metaphors in the History of Endocrinology." *Angelaki* 22 (2): 47–60. doi:10.1080/0969725X.2017.1322818.

———. 2018a. *Histories of the Transgender Child.* Minneapolis: University of Minnesota Press.

———. 2018b. "Trans of Color Critique before Transsexuality." *TSQ: Transgender Studies Quarterly* 5 (4): 606–620. doi:10.1215/23289252-7090073.

Gilman, Sander L. 1997. "Decircumcision: The First Aesthetic Surgery." *Modern Judaism* 17 (3): 201–210. doi:10.1093/mj/17.3.201.

———. 1999. *Making the Body Beautiful: A Cultural History of Aesthetic Surgery.* Princeton, NJ: Princeton University Press.

Glaser, Barney G., and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* 4th ed. New Brunswick, NJ: Aldine.

Gorney, Mark, and Jeannette Martello. 1999. "Patient Selection Criteria." *Clinics in Plastic Surgery* 26 (1): 37–40.

Government of Alberta. 2019. "Physical Growth in Newborns." MyHealth Alberta. http://web.archive.org/web/20200813045317/https://myhealth.alberta.ca/Health/Pages/conditions.aspx?hwid=te6295&lang=en-ca.

Government of Canada. 2016. "Surveillance of Malaria." Government of Canada. https://web.archive.org/web/20190113220023/https://www.canada.ca/en/public-health/services/diseases/malaria/surveillance-malaria.html.

Green, Fiona J. 2005. "From Clitoridectomies to 'Designer Vaginas': The Medical Construction of Heteronormative Female Bodies and Sexuality through Female Genital Cutting." *Sexualities, Evolution & Gender* 7 (2): 153–187. doi:10.1080/14616660500200223.

Green, Gill, Rosaline S. Barbour, Marina Barnard, and Jenny Kitzinger. 1993. "'Who Wears the Trousers?'" *Women's Studies International Forum* 16 (6): 627–637. doi:10.1016/S0277-5395(08)80007-6.

Greenberg, Zoe. 2018. "What Happens to #MeToo When a Feminist Is the Accused?" *New York Times.* https://web.archive.org/web/20180820130300/https://www.nytimes.com/2018/08/13/nyregion/sexual-harassment-nyu-female-professor.html.

Gregor, Thomas. 1985. *Anxious Pleasures: The Sexual Lives of an Amazonian People.* Chicago: University of Chicago Press.

Gressgård, Randi. 2010. "When Trans Translates into Tolerance - or Was It Monstrous? Transsexual and Transgender Identity in Liberal Humanist Discourse." *Sexualities* 13 (5): 539–561. doi:10.1177/1363460710375569.

Grosz, Elizabeth A. 1995. *Space, Time, and Perversion: Essays on the Politics of Bodies.* New York: Routledge.

Grov, Christian, Jeffrey T. Parsons, and David S. Bimbi. 2010. "The Association Between Penis Size and Sexual Health Among Men Who Have Sex with Men." *Archives of Sexual Behavior* 39 (3): 788–797. doi:10.1007/s10508-008-9439-5.

Grov, Christian, Lena D. Saleh, Jonathan M. Lassiter, and Jeffrey T. Parsons. 2015. "Challenging Race-Based Stereotypes about Gay and Bisexual Men's Sexual Behavior and Perceived Penis Size and Size Satisfaction." *Sexuality Research and Social Policy* 12 (3): 224–235. doi:10.1007/s13178-015-0190-0.

Grov, Christian, Brooke E. Wells, and Jeffrey T. Parsons. 2013. "Self-Reported Penis Size and Experiences with Condoms Among Gay and Bisexual Men." *Archives of Sexual Behavior* 42 (2): 313–322. doi:10.1007/s10508-012-9952-4.

Guba, Egon G., and Yvonna S. Lincoln. 2004. "Competing Paradigms in Qualitative Research: Theories and Issues." In *Approaches to Qualitative Research: A Reader on Theory and Practice,* edited by Sharlene Nagy Hesse-Biber and Patricia Leavy, 17–38. New York: Oxford University Press.

Guglielmo, Jennifer, and Salvatore Salerno, eds. 2003. *Are Italians White? How Race Is Made in America.* New York: Routledge.

Gurevich, Maria, Nicole Cormier, Usra Leedham, and Amy Brown-Bowers. 2018. "Sexual Dysfunction or Sexual Discipline? Sexuopharmaceutical Use by Men as Prevention and Proficiency." *Feminism & Psychology* 28 (3): 309–330. doi:10.1177/0959353517750682.

Gutmann, Matthew C. 1997. "Trafficking in Men: The Anthropology of Masculinity." *Annual Review of Anthropology* 26 (1): 385–409. doi:10.1146/annurev.anthro.26.1.385.

Habous, Mohamad, Alaa Tealab, Ben Williamson, Saleh Binsaleh, Sherif El Dawy, Saad Mahmoud, Osama Abdelwahab, et al. 2015. "Erect Penile Dimensions in a Cohort of 778 Middle Eastern Men: Establishment of a Nomogram." *The Journal of Sexual Medicine* 12 (6): 1402–1406. doi:10.1111/jsm.12894.

Haiken, Elizabeth. 2000. "Virtual Virility, or, Does Medicine Make the Man?" *Men and Masculinities* 2 (4): 388–409. doi:10.1177/1097184X00002004002.

Halberstam, Jack. 1998. *Female Masculinity.* Durham, NC: Duke University Press.

Hale, C. Jabob. 2007. "Ethical Problems with the Mental Health Evaluation Standards of Care for Adult Gender Variant Prospective Patients." *Perspectives in Biology and Medicine* 50 (4): 491–505. doi:10.1353/pbm.2007.0047.

Hall, Matthew. 2015. "'When There's No Underbrush the Tree Looks Taller': A Discourse Analysis of Men's Online Groin Shaving Talk." *Sexualities* 18 (8): 997–1017. doi:10.1177/1363460715583603.

Hall, Stuart. 1990. "The Whites of Their Eyes: Racist Ideologies and the Media." In *The Media Reader,* edited by Manuel Alvarado and John O. Thompson, 9–23. London: British Film Institute.

Hamer, Dean H., Stella Hu, Victoria L. Magnuson, Nan Hu, and Angela M. L. Pattatucci. 1993. "A Linkage between DNA Markers on the X Chromosome and Male Sexual Orientation." *Science* 261 (5119): 321–327. doi:10.1126/science.8332896.

Haraway, Donna Jeanne. 1991. *Simians, Cyborgs, and Women: The Reinvention of Nature.* New York: Routledge.

Harding, Richard, and Susan E. Golombok. 2002. "Test-Retest Reliability of the Measurement of Penile Dimensions in a Sample of Gay Men." *Archives of Sexual Behavior* 31 (4): 351–357. doi:https://doi-org.proxy.lib.sfu.ca/10.1023/A:1016276310371.

Harding, Sandra G., ed. 2004. *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies.* New York: Routledge.

Hausman, Bernice L. 1995. *Changing Sex: Transsexualism, Technology, and the Idea of Gender.* Durham, NC: Duke University Press.

Hayes, Rebecca M., and Molly Dragiewicz. 2018. "Unsolicited Dick Pics: Erotica, Exhibitionism or Entitlement?" *Women's Studies International Forum* 71:114–120. doi:10.1016/j.wsif.2018.07.001.

Heath, Melanie. 2009. "State of Our Unions: Marriage Promotion and the Contested Power of Heterosexuality." *Gender & Society* 23 (1): 27–48. doi:10.1177/0891243208326807.

———. 2013. "Sexual Misgivings: Producing Un/Marked Knowledge in Neoliberal Marriage Promotion Policies." *The Sociological Quarterly* 54 (4): 561–583. doi:10.1111/tsq.12042.

Hehir, Mark P., Cande V. Ananth, Zainab Siddiq, Karen Flood, Alexander M. Friedman, and Mary E. D'Alton. 2018. "Cesarean Delivery in the United States 2005 through 2014: A Population-Based Analysis Using the Robson 10-Group Classification System." *American Journal of Obstetrics and Gynecology* 219 (1): 105.e1–105.e11. doi:10.1016/j.ajog.2018.04.012.

Henne, Kathryn. 2014. "The 'Science' of Fair Play in Sport: Gender and the Politics of Testing." *Signs: Journal of Women in Culture and Society* 39 (3): 787–812. doi:10.1086/674208.

Herbenick, Debby, Vanessa Schick, Stephanie A. Sanders, Michael Reece, and J. Dennis Fortenberry. 2015. "Pain Experienced During Vaginal and Anal Intercourse with Other-Sex Partners: Findings from a Nationally Representative Probability Study in the United States." *The Journal of Sexual Medicine* 12 (4): 1040–1051. doi:10.1111/jsm.12841.

Hesse-Biber, Sharlene Nagy, and Patricia Leavy. 2004. "Distinguishing Qualitative Research." In *Approaches to Qualitative Research: A Reader on Theory and Practice,* edited by Sharlene Nagy Hesse-Biber and Patricia Leavy, 1–15. New York: Oxford University Press.

Heyes, Cressida J. 2009a. "All Cosmetic Surgery Is 'Ethnic': Asian Eyelids, Feminist Indignation, and the Politics of Whiteness." In *Cosmetic Surgery: A Feminist Primer,* by Cressida J. Heyes and Meredith Jones, 191–205. London: Routledge.

———. 2009b. "Diagnosing Culture: Body Dysmorphic Disorder and Cosmetic Surgery." *Body & Society* 15 (4): 73–93. doi:10.1177/1357034X09347222.

Heyes, Cressida J., and J. R. Latham. 2018. "Trans Surgeries and Cosmetic Surgeries." *TSQ: Transgender Studies Quarterly* 5 (2): 174–189. doi:10.1215/23289252-4348617.

Hines, Alice. 2019. "How Many Bones Would You Break to Get Laid? 'Incels' Are Going under the Knife to Reshape Their Faces, and Their Dating Prospects." *The Cut.* https://web.archive.org/web/20190626210649/https://www.thecut.com/2019/05/incel-plastic-surgery.html.

Hines, Sally. 2006. "What's the Difference? Bringing Particularity to Queer Studies of Transgender." *Journal of Gender Studies* 15 (1): 49–66. doi:10 . 1080 / 09589230500486918.

Hird, Myra J. 2002. "For a Sociology of Transsexualism." *Sociology* 36 (3): 577–595. doi:10.1177/0038038502036003005.

Hirschauer, Stefan, and Annemarie Mol. 1995. "Shifting Sexes, Moving Stories: Feminist/Constructivist Dialogues." *Science, Technology, & Human Values* 20 (3): 368–385. doi:10.1177/016224399502000306.

Ho, Tammy S., and Joel Gelman. 2018. "Evaluation and Management of Adult Acquired Buried Penis." *Translational Andrology and Urology* 7 (4): 618–627. doi:10.21037/tau.2018.05.06.

Hoffman, Kelly M., Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver. 2016. "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites." *Proceedings of the National Academy of Sciences* 113 (16): 4296–4301. doi:10.1073/pnas.1516047113.

Holliday, Ruth, and Allie Cairnie. 2007. "Man Made Plastic: Investigating Men's Consumption of Aesthetic Surgery." *Journal of Consumer Culture* 7 (1): 57–78. doi:10.1177/1469540507073508.

Holmes, Brooke. 2019. "Let Go of Laqueur: Towards New Histories of the Sexed Body." *Eugesta* 9:136–175.

Holstein, James A., and Jaber F. Gubrium. 2004. "Active Interviewing." In *Qualitative Research: Theory, Method and Practice,* 2nd ed, edited by David Silverman. Thousand Oaks, CA: Sage Publications.

hooks, bell. 1997. "Representing Whiteness in the Black Imagination." In *Displacing Whiteness: Essays in Social and Cultural Criticism,* edited by Ruth Frankenberg, 165–179. Durham, NC: Duke University Press. doi:10.1215/9780822382270-006.

———. 2004. *We Real Cool: Black Men and Masculinity.* New York: Routledge.

———. 2015. *Feminist Theory: From Margin to Center.* New York: Routledge.

Huang, Mingwei. 2016. "Vulnerable Observers: Notes on Fieldwork and Rape." *The Chronicle of Higher Education: Advice.* http://web.archive.org/web/20200816021735/https://www.chronicle.com/article/vulnerable-observers-notes-on-fieldwork-and-rape/.

Hubbard, Ruth. 1990. *The Politics of Women's Biology.* New Brunswick, NJ: Rutgers University Press.

———. 1995. "In a Science Restructured Along Feminist Lines, Would the Laws of Gravity No Longer Hold?" In *Profitable Promises: Essays on Women, Science, and Health,* edited by Ruth Hubbard. Monroe, ME: Common Courage Press.

Hughes, Geoffrey. 2006. "Hottentot." In *An Encyclopedia of Swearing: The Social History of Oaths, Profanity, Foul Language, and Ethnic Slurs in the English-Speaking World,* 241–243. Armonk, NY: M.E. Sharpe.

Hull, Terence H., and Meiwita Budiharsana. 2001. "Male Circumcision and Penis Enhancement in Southeast Asia: Matters of Pain and Pleasure." *Reproductive Health Matters* 9 (18): 60–67. doi:10.1016/S0968-8080(01)90091-6.

Hunley, Keith L., Graciela S. Cabana, and Jeffrey C. Long. 2016. "The Apportionment of Human Diversity Revisited." *American Journal of Physical Anthropology* 160 (4): 561–569. doi:10.1002/ajpa.22899.

Hyde, Janet Shibley. 2005. "The Gender Similarities Hypothesis." *American Psychologist* 60 (6): 581–592. doi:10.1037/0003-066X.60.6.581.

Ignatiev, Noel. 1995. *How the Irish Became White.* New York: Routledge.

Inhorn, Marcia C. 2007. "Masculinity, Reproduction, and Male Infertility Surgery in the Middle East." *Journal of Middle East Women's Studies* 3 (3): 1–20. doi:10.1215/15525864-2007-4001.

"Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7." 2012. *International Journal of Transgenderism* 13 (4): 165–232. doi:10.1080/15532739.2011.700873.

Jamison, Paul L., and Paul H. Gebhard. 1988. "Penis Size Increase between Flaccid and Erect States: An Analysis of the Kinsey Data." *Journal of Sex Research* 24 (1): 177–183. doi:10.1080/00224498809551408.

Janzen, Caitlin, Holly Randell-Moon, Iris van der Tuin, and Melisse Vroegindeweij. 2020. "On the Intersection of Somatechnics and Transgender Studies." *TSQ: Transgender Studies Quarterly* 7 (3): 374–382. doi:10.1215/23289252-8553020.

Jeffreys, Sheila. 2006. *Beauty and Misogyny: Harmful Cultural Practices in the West.* London: Routledge.

———. 2014. *Gender Hurts: A Feminist Analysis of the Politics of Transgenderism.* New York: Routledge.

Jenner, Brandy M., and Kit C. Myers. 2019. "Intimacy, Rapport, and Exceptional Disclosure: A Comparison of In-Person and Mediated Interview Contexts." *International Journal of Social Research Methodology* 22 (2): 165–177. doi:10.1080/13645579.2018.1512694.

Jiwani, Yasmin. 2005. "The Eurasian Female Hero[ine]: Sydney Fox as Relic Hunter." *Journal of Popular Film and Television* 32 (4): 182–191. doi:10.3200/JPFT.32.4.182-191.

———. 2006. "Race(ing) the Nation: Media and Minorities." In *Mediascapes: New Patterns in Canadian Communication,* 3rd ed, edited by Paul Attallah and Leslie Regan Shade, 305–312. Toronto: Nelson.

———. 2011. "Mediations of Race and Crime: Racializing Crime, Criminializing Race." In *Diversity, Crime, and Justice in Canada,* edited by Barbara J Perry. Don Mills, ON: OUP Canada.

Johnson, Ruth E., and M. Hassan Murad. 2009. "Gynecomastia: Pathophysiology, Evaluation, and Management." *Mayo Clinic Proceedings* 84 (11): 1010–1015. doi:10.1016/S0025-6196(11)60671-X.

Jones, Nikki. 2009. "'I Was Aggressive for the Streets, Pretty for the Pictures': Gender, Difference, and the Inner-City Girl." *Gender & Society* 23 (1): 89–93. doi:10.1177/0891243208326676.

Jordan-Young, Rebecca M. 2010. *Brain Storm: The Flaws in the Science of Sex Differences.* Cambridge, MA: Harvard University Press.

Jordan-Young, Rebecca, and Katrina Karkazis. 2012. "Some of Their Parts." *Anthropology News* 53 (6). doi:http://onlinelibrary.wiley.com/doi/10.1111/j.1556-3502.2012.53601.x/epdf.

Karioris, Frank G., and Jonathan A. Allan. 2017. "Grow a Pair! Critically Analyzing Masculinity and the Testicles." *The Journal of Men's Studies* 25 (3): 245–261. doi:10.1177/1060826516671307.

Keller, Evelyn Fox. 2000. *The Century of the Gene.* Cambridge, MA: Harvard University Press.

Kelley, Brit, and Stephanie Weaver. 2020. "Researching People Who (Probably) Hate You: When Practicing "Good" Ethics Means Protecting Yourself." *Computers and Composition* 56:102567. doi:10.1016/j.compcom.2020.102567.

Kennedy, Amanda. 2015. "Masculinity and Embodiment in the Practice of Foreskin Restoration." *International Journal of Men's Health* 14 (1): 38–54. doi:10.3149/jmh.1401.38.

Keough, Willeen G, and Lara Campbell. 2014. *Gender History: Canadian Perspectives.* Don Mills, ON: Oxford University Press.

Kessler, Suzanne J. 1990. "The Medical Construction of Gender: Case Management of Intersexed Infants." *Signs: Journal of Women in Culture and Society* 16 (1): 3–26. doi:10.1086/494643.

Khanna, Nikki. 2010. ""If You're Half Black, You're Just Black": Reflected Appraisals and the Persistence of the One-Drop Rule." *The Sociological Quarterly* 51 (1): 96–121. doi:10.1111/j.1533-8525.2009.01162.x.

Kihika, Maureen. 2019. "Negotiating Borders: The 'Everyday' Encounters of Black African Immigrant Caregivers in Vancouver, British Columbia." PhD diss., Simon Fraser University.

Kim, Ma Tae, Kyungtae Ko, Won Ki Lee, Sae Chul Kim, and Dae Yul Yang. 2015. "Long-Term Safety and Longevity of a Mixture of Polymethyl Methacrylate and Cross-Linked Dextran (Lipen-10®) after Penile Augmentation: Extension Study from Six to 18 Months of Follow-Up." *The World Journal of Men's Health* 33 (3): 202–208. doi:10.5534/wjmh.2015.33.3.202.

Kolysh, Simone. 2016. "Transgender Movements in the United States." In *The Wiley Blackwell Encyclopedia of Gender and Sexuality Studies,* edited by Angela Wong, Maithree Wickramasinghe, renee hoogland, and Nancy A Naples, 1–5. Singapore: John Wiley & Sons, Ltd. doi:10.1002/9781118663219.wbegss759.

———. 2019. "Everyday Violence: Catcalling and LGBTQ-Directed Aggression in the Public Sphere." PhD diss., The City University of New York.

Kompanje, Erwin J. O. 2006. "Painful Sexual Intercourse Caused by a Disproportionately Long Penis: An Historical Note on a Remarkable Treatment Devised by Guilhelmius Fabricius Hildanus (1560–1634)." *Archives of Sexual Behavior* 35 (5): 603–605. doi:10.1007/s10508-006-9057-z.

Kuiper, AJ, and Peggy T. Cohen-Kettenis. 1998. "Gender Role Reversal among Postoperative Transsexuals." *International Journal of Transgenderism* 2 (3).

Kupers, Terry A. 2005. "Toxic Masculinity as a Barrier to Mental Health Treatment in Prison." *Journal of Clinical Psychology* 61 (6): 713–724. doi:10.1002/jclp.20105.

Lamble, Sarah. 2008. "Retelling Racialized Violence, Remaking White Innocence: The Politics of Interlocking Oppressions in Transgender Day of Remembrance." *Sexuality Research and Social Policy* 5 (1): 24–42. doi:10.1525/srsp.2008.5.1.24.

Lancaster, Roger N. 2003. *The Trouble with Nature: Sex in Science and Popular Culture.* Berkeley: University of California Press.

———. 2006. "Sex, Science, and Pseudoscience in the Public Sphere." *Identities* 13 (1): 101–138. doi:10.1080/10702890500535707.

Landén, M., J. Wålinder, G. Hambert, and B. Lundström. 1998. "Factors Predictive of Regret in Sex Reassignment." *Acta Psychiatrica Scandinavica* 97 (4): 284–289.

Lane, Riki. 2009. "Trans as Bodily Becoming: Rethinking the Biological as Diversity, Not Dichotomy." *Hypatia* 24 (3): 136–157. doi:10.1111/j.1527-2001.2009.01049.x.

———. 2018. "'We Are Here to Help': Who Opens the Gate for Surgeries?" *TSQ: Transgender Studies Quarterly* 5 (2): 207–227. doi:10.1215/23289252-4348648.

Laqueur, Thomas Walter. 1990. *Making Sex: Body and Gender from the Greeks to Freud.* Cambridge, MA: Harvard University Press.

Latham, J. R. 2017. "Making and Treating Trans Problems: The Ontological Politics of Clinical Practices." *Studies in Gender and Sexuality* 18 (1): 40–61. doi:10.1080/15240657.2016.1238682.

Lawrence, Anne A. 2003. "Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery." *Archives of Sexual Behavior* 32 (4): 299–315. doi:10.1023/A:1024086814364.

Lawrence, Bonita. 2003. "Gender, Race, and the Regulation of Native Identity in Canada and the United States: An Overview." *Hypatia* 18 (2): 3–31. doi:10.1111/j.1527-2001.2003.tb00799.x.

Lehman, Peter. 2006. "A 'Strange Quirk in His Lineage': Walter Mosely, Donald Goines, and the Racial Representation of the Penis." *Men and Masculinities* 9 (2): 226–235. doi:10.1177/1097184X06287757.

Lemons, Gary L. 1997. "To Be Black, Male and 'Feminist'–Making Womanist Space for Black Men." *International Journal of Sociology and Social Policy* 17 (1/2): 35–61. doi:10.1108/eb013291.

Lemperle, Gottfried, and James J. Elist. 2015. *A Matter of Size: What Men Have Always Wanted to Know, But Could Never Ask.* IMD Inc. Kindle.

Lev, Arlene Istar. 2013. "Gender Dysphoria: Two Steps Forward, One Step Back." *Clinical Social Work Journal* 41 (3): 288–296. doi:10.1007/s10615-013-0447-0.

Lever, Janet, David A. Frederick, and Letitia Anne Peplau. 2006. "Does Size Matter? Men's and Women's Views on Penis Size across the Lifespan." *Psychology of Men & Masculinity* 7 (3): 129–143. doi:10.1037/1524-9220.7.3.129.

Levin, Roy J. 2005. "The Involvement of the Human Cervix in Reproduction and Sex." *Sexual and Relationship Therapy* 20 (2): 251–260. doi:10.1080/14681990500113195.

Lewis, Diane. 1973. "Anthropology and Colonialism." *Current Anthropology* 14 (5): 581–602. doi:10.1086/201393.

Lewontin, R. C. 1972. "The Apportionment of Human Diversity." In *Evolutionary Biology,* edited by Theodosius Dobzhansky, Max K. Hecht, and William C. Steere, 381–398. New York: Springer US. doi:10.1007/978-1-4684-9063-3_14.

Lindemalm, Gunnar, Dag Körlin, and Nils Uddenberg. 1986. "Long-Term Follow-up of 'Sex Change' in 13 Male-to-Female Transsexuals." *Archives of Sexual Behavior* 15 (3): 187–210. doi:10.1007/BF01542412.

Lindfors, Bernth. 1996. "Ethnological Show Business: Footlighting the Dark Continent." In *Freakery: Cultural Spectacles of the Extraordinary Body,* edited by Rosemarie Garland-Thomson, 207–218. New York: New York University Press.

Long, Dao-chou. 1990. "Elongation of the Penis." *Chinese Journal of Plastic Surgery and Burns* 6 (1): 17–9, 74.

Longhurst, Robyn. 2005. "'Man-Breasts': Spaces of Sexual Difference, Fluidity and Abjection." In *Spaces of Masculinities,* edited by Bettina van Hoven and Kathrin Hörschelmann, 152–165. New York: Routledge.

Lorde, Audre. 1984. *Sister Outsider: Essays and Speeches.* The Crossing Press Feminist Series. Trumansburg, NY: Crossing Press.

Luciano, Lynne. 2002. *Looking Good: Male Body Image in Modern America.* New York: Hill and Wang.

Maddison, Stephen. 2009. "'The Second Sexual Revolution': Big Pharma, Porn and the Biopolitical Penis." *TOPIA: Canadian Journal of Cultural Studies* 22:35–53. doi:10.3138/topia.22.35.

Magubane, Zine. 2014. "Spectacles and Scholarship: Caster Semenya, Intersex Studies, and the Problem of Race in Feminist Theory." *Signs: Journal of Women in Culture and Society* 39 (3): 761–785. doi:10.1086/674301.

Manion, Jen. 2018. "The Performance of Transgender Inclusion." Public Seminar. https://web.archive.org/web/20190628224416/http://www.publicseminar.org/2018/11/the-performance-of-transgender-inclusion/?fbclid=IwAR1Grmq-FY5d_iYBjn_s6rEUI5ivQB3fsm0rn33TVMX7J2ZgwQBEGOw1s8o.

Martin, Emily. 1991. "The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles." *Signs: Journal of Women in Culture and Society* 16 (3): 485–501. doi:10.1086/494680.

Martinez, Daniel R., Neil J. Manimala, Arash Rafiei, Tariq S. Hakky, Chris Yang, and Rafael Carrion. 2015. "The Reduction Corporoplasty: The Answer to the Improbable Urologic Question 'Can You Make My Penis Smaller?'" *The Journal of Sexual Medicine* 12 (3): 835–839. doi:10.1111/jsm.12767.

Mayo Clinic. 2018. "Painful Intercourse (Dyspareunia)." Mayo Clinic. https://web.archive.org/web/20180728020201/https://www.mayoclinic.org/diseases-conditions/painful-intercourse/symptoms-causes/syc-20375967.

McCauley, Elizabeth, and Anke A. Ehrhardt. 1984. "Follow-up of Females with Gender Identity Disorders." *The Journal of Nervous and Mental Disease* 172 (6): 353–358. doi:10.1097/00005053-198406000-00006.

McLean, Amie. 2017. "'We Used to Be Kings of the Road': Negotiations of Ethics, Embodiment, and Subjectivity in the BC-Based Long Haul Trucking Industry." PhD diss., Simon Fraser University.

Meadow, Tey. 2010. "'A Rose Is a Rose': On Producing Legal Gender Classifications." *Gender & Society* 24 (6): 814–837. doi:10.1177/0891243210385918.

Messing, Karen. 1983. "The Scientific Mystique: Can a White Lab Coat Guarantee Purity in the Search for Knowledge about the Nature of Women?" In *Woman's Nature: Rationalizations of Inequality,* edited by Marian Lowe and Ruth Hubbard, 5–88. The Athene Series. New York: Pergamon Press.

Messner, Michael A. 2000. "Barbie Girls Versus Sea Monsters: Children Constructing Gender." *Gender & Society* 14 (6): 765–784. doi:10.1177/089124300014006004.

———. 2004. "On Patriarchs and Losers: Rethinking Men's Interests." *Berkeley Journal of Sociology* 48:74–88.

———. 2007. "When Bodies Are Weapons: Masculinity and Violence in Sport." In *Out of Play: Critical Essays on Gender and Sport,* 91–106. Albany: State University of New York Press.

Meyerowitz, Joanne J. 2002. *How Sex Changed: A History of Transsexuality in the United States.* Cambridge, MA: Harvard University Press.

Moon, Dawne. 2004. *God, Sex, and Politics: Homosexuality and Everyday Theologies.* Chicago: University of Chicago Press.

Moreno, Eva. 1995. "Rape in the Field: Reflections from a Survivor." In *Taboo: Sex, Identity, and Erotic Subjectivity in Anthropological Fieldwork,* edited by Don Kulick and Margaret Willson. New York: Routledge.

Morgensen, Scott Lauria. 2011. *Spaces between Us: Queer Settler Colonialism and Indigenous Decolonization.* Minneapolis: University of Minnesota Press.

Murji, Karim, and John Solomos, eds. 2005. *Racialization: Studies in Theory and Practice.* Oxford: Oxford University Press.

Mustanski, Brian, and Richard T. Liu. 2013. "A Longitudinal Study of Predictors of Suicide Attempts Among Lesbian, Gay, Bisexual, and Transgender Youth." *Archives of Sexual Behavior* 42 (3): 437–448. doi:10.1007/s10508-012-0013-9.

Namaste, Viviane K. 2000. *Invisible Lives: The Erasure of Transsexual and Transgendered People.* Chicago: University of Chicago Press.

National Health Services. 2017. "Episiotomy and Perineal Tears: Your Pregnancy and Baby Guide." National Health Services. http://web.archive.org/web/20181106192946if_/https://www.nhs.uk/conditions/pregnancy-and-baby/episiotomy/.

Nechas, Eileen, and Denise Foley. 1994. *Unequal Treatment: What You Don't Know about How Women Are Mistreated by the Medical Community.* New York: Simon & Schuster.

Nieschlag, Eberhard. 2013. "Klinefelter Syndrome: The Commonest Form of Hypogonadism, but Often Overlooked or Untreated." *Deutsches Arzteblatt International* 110 (20): 347–353. doi:10.3238/arztebl.2013.0347.

NIH. 2019. "Sickle Cell Disease." National Heart Lung and Blood Institute. https://web.archive.org/web/20190627185809/https://www.nhlbi.nih.gov/health-topics/sickle-cell-disease.

North, Michael, trans. 2002. "Greek Medicine: The Hippocratic Oath." National Institutes of Health and National Library of Medicine. https://web.archive.org/web/20200217204815/www.nlm.nih.gov/hmd/greek/greek_oath.html.

Nota, Nienke M., Baudewijntje P.C. Kreukels, Martin den Heijer, Dick J. Veltman, Peggy T. Cohen-Kettenis, Sarah M. Burke, and Julie Bakker. 2017. "Brain Functional Connectivity Patterns in Children and Adolescents with Gender Dysphoria: Sex-Atypical or Not?" *Psychoneuroendocrinology* 86:187–195. doi:10.1016/j.psyneuen.2017.09.014.

NSW Government Health. 2016. "Malaria Fact Sheet." NSW Government Health. https://web.archive.org/web/20190621033646/https://www.health.nsw.gov.au/infectious/factsheets/pages/malaria.aspx.

Nye, Coleman. 2012. "Cancer Previval and the Theatrical Fact." *The Drama Review* 56 (4): 104–120. doi:10.1162/DRAM_a_00217.

Oktavian, Antonius, Wienta Diarsvitri, and Iwu Dwisetyani Utomo. 2011. "Cultural Practices and Beliefs of Penis Enlargement and Implant in Papua, Indonesia." *Journal of Epidemiology & Community Health* 65 (Suppl 1): A368–A368. doi:10.1136/jech.2011.142976m.61.

Oudshoorn, Nelly. 1994. *Beyond the Natural Body: An Archaeology of Sex Hormones.* London: Routledge.

Owen, Craig, and Christine Campbell. 2018. "How Do Men's Magazines Talk about Penises?" *Journal of Health Psychology* 23 (2): 332–344. doi:10.1177/1359105317745333.

Park, Tae Hwan, Sang Won Seo, June-Kyu Kim, and Choong Hyun Chang. 2012. "Clinical Experience with Polymethylmethacrylate Microsphere Filler Complications." *Aesthetic Plastic Surgery* 36 (2): 421–426. doi:10.1007/s00266-011-9803-z.

Parsons, Talcott. 1954. *Essays on Sociological Theory.* New York: Free Press.

Pascoe, C. J. 2007. *Dude, You're a Fag: Masculinity and Sexuality in High School.* Berkeley: University of California Press.

Patel, Neesha. 2008. "Racialized Sexism in the Lives of Asian American Women." In *Benefiting by Design: Women of Color in Feminist Psychological Research,* edited by Chemba Raghavan, Arlene E. Edwards, and Kim Marie Vaz. Newcastle: Cambridge Scholars Pub.

Patton, Tracey Owens, and Julie Snyder-Yuly. 2007. "Any Four Black Men Will Do: Rape, Race, and the Ultimate Scapegoat." *Journal of Black Studies* 37 (6): 859–895. doi:10.1177/0021934706296025.

Peele, Jordan, ed. 2017. *Get Out.* Universal City, California: Universal Pictures. DVD.

Penrod, Janice, Deborah Bray Preston, Richard E. Cain, and Michael T. Starks. 2003. "A Discussion of Chain Referral As a Method of Sampling Hard-to-Reach Populations." *Journal of Transcultural Nursing* 14 (2): 100–107. doi:10.1177/1043659602250614.

Pentney, Beth Ann. 2012. "Shaping Embodiment in The Swan: Fan and Blog Discourses in Makeover Culture." PhD diss., Simon Fraser University.

Pfafflin, Friedemann. 1993. "Regrets After Sex Reassignment Surgery." *Journal of Psychology & Human Sexuality* 5 (4): 69–85. doi:10.1300/J056v05n04_05.

Phipps, Alison. 2019. "The Fight Against Sexual Violence." *Soundings* 71 (71): 62–74. doi:10.3898/SOUN.71.05.2019.

Pieper, Lindsay Parks. 2019. "Athletes, Trans and Intersex." In *Global Encyclopedia of Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) History,* edited by Howard Chiang. Farmington Hills, MI: Charles Scribner's Sons.

Ponchietti, Roberto, Nicola Mondaini, Massimiliano Bonafè Filippo Di Loro, Stefano Biscioni, and Lorenzo Masieri. 2001. "Penile Length and Circumference: A Study on 3,300 Young Italian Males." *European Urology* 39 (2): 183–186. doi:10.1159/000052434.

Porter, Tom. 2008. *And Grandma Said–Iroquois Teachings: As Passed down through the Oral Tradition.* In collaboration with Lesley Forrester and Ka-Hon-Hes. Philadelphia: Xlibris Corp.

Potts, Annie. 2005. "Cyborg Masculinity in the Viagra Era." *Sexualities, Evolution & Gender* 7 (1): 3–16. doi:10.1080/14616660500111081.

Poulson-Bryant, Scott. 2006. *Hung: A Meditation on the Measure of Black Men in America.* New York: Harlem Moon.

Pronger, Brian. 1990. *The Arena of Masculinity: Sports, Homosexuality and the Meaning of Sex.* Toronto: Summerhill Press.

———. 1999. "Outta My Endzone: Sport and the Territorial Anus." *Journal of Sport and Social Issues* 23 (4): 373–389. doi:10.1177/0193723599234002.

Prosser, Jay. 1998. *Second Skins: The Body Narratives of Transsexuality.* Gender and Culture. New York: Columbia University Press.

Pugliese, Joseph, and Susan Stryker. 2009. "The Somatechnics of Race and Whiteness." *Social Semiotics* 19 (1): 1–8. doi:10.1080/10350330802632741.

Pyle, Kai. 2018. "Naming and Claiming." *TSQ: Transgender Studies Quarterly* 5 (4): 574–588. doi:10.1215/23289252-7090045.

Rabinow, Paul, and Nikolas Rose. 2006. "Biopower Today." *BioSocieties* 1 (2): 195–217. doi:10.1017/S1745855206040014.

Rasool, Amira. 2018. "Some White Influencers Are Being Accused of 'Blackfishing,' or Using Makeup to Appear Black." *Teen Vogue.* https://web.archive.org/web/20191230072542/https://www.teenvogue.com/story/blackfish-niggerfish-white-influencers-using-makeup-to-appear-black.

Raymond, Janice G. 1994. *The Transsexual Empire: The Making of the She-Male.* Athene Series 39. New York: Teachers College Press.

Reeser, Todd W. 2010. *Masculinities in Theory: An Introduction.* Chichester: Wiley-Blackwell.

Rich, Adrienne. 1980. "Compulsory Heterosexuality and Lesbian Existence." *Signs: Journal of Women in Culture and Society* 5 (4): 631–660. doi:10.1086/493756.

———. 2004. "Reflections on 'Compulsory Heterosexuality'." *Journal of Women's History* 16 (1): 9–11. doi:10.1353/jowh.2004.0033.

Richardson, Sarah S. 2013. *Sex Itself: The Search for Male and Female in the Human Genome.* Chicago: University of Chicago Press.

———. 2014. "Y All the Hype?: A Study about Sexual Similarity Gets Framed as a Major New Finding of Sex Difference." *Slate.* https://web.archive.org/web/20190414153702/https://slate.com/human-interest/2014/05/sex-difference-findings-in-human-genome-studies-be-very-skeptical.html.

Richters, Juliet, John Gero, and Basil Donovan. 1995. "Are Condoms the Right Size(s)? A Method for Self-Measurement of the Erect Penis." *Venereoiogy* 8 (2): 77–81.

Robinson, Thomas Christopher. 2008. "The Sticking Out Parts: A Content Analysis of Print and Website Advertisements on Breast and Penis Augmentation." MA Thesis, Georgia State University.

Rodriguez, Clara E. 2000. *Changing Race: Latinos, the Census, and the History of Ethnicity in the United States.* New York: New York University Press.

Rosenfeld, Dana, and Christopher A Faircloth. 2006. "Medicalized Masculinities: The Missing Link?" In *Medicalized Masculinities,* edited by Dana Rosenfeld and Christopher A. Faircloth. Philadelphia: Temple University Press.

Sadjadi, Sahar. 2019. "Deep in the Brain: Identity and Authenticity in Pediatric Gender Transition." *Cultural Anthropology* 34 (1): 103–129. doi:10.14506/ca34.1.10.

Said, Edward W. 1978. *Orientalism.* New York: Pantheon Books.

Saint-Aubin, Arthur. 2002. "A Grammar of Black Masculinity: A Body of Science." *The Journal of Men's Studies* 10 (3): 247–270. doi:10.3149/jms.1003.247.

Salles, Alessandra Grassi, Priscilla Helena Lotierzo, Rolf Gemperli, Júlio Morais Besteiro, Luís Carlos Ishida, Rodrigo Pinto Gimenez, Jorge Menezes, and Marcus Castro Ferreira. 2008. "Complications after Polymethylmethacrylate Injections: Report of 32 Cases:" *Plastic and Reconstructive Surgery* 121 (5): 1811–1820. doi:10.1097/PRS.0b013e31816b1385.

Sanders, A. R., E. R. Martin, G. W. Beecham, S. Guo, K. Dawood, G. Rieger, J. A. Badner, et al. 2015. "Genome-Wide Scan Demonstrates Significant Linkage for Male Sexual Orientation." *Psychological Medicine* 45 (7): 1379–1388. doi:10.1017/S0033291714002451.

Sanz, Veronica. 2017. "No Way Out of the Binary: A Critical History of the Scientific Production of Sex." *Signs: Journal of Women in Culture and Society* 43 (1): 1–27. doi:10.1086/692517.

Sarkeesian, Anita, and Katherine Cross. 2015. "Your Humanity Is in Another Castle: Terror Dreams and the Harassment of Women." In *The State of Play: Creators and Critics on Video Game Culture,* First edition, edited by Daniel Goldberg and Linus Larsson. New York: Seven Stories Press.

Savic, Ivanka, Alicia Garcia-Falgueras, and Dick F. Swaab. 2010. "Sexual Differentiation of the Human Brain in Relation to Gender Identity and Sexual Orientation." In *Progress in Brain Research,* 186:41–62. Elsevier. doi:10.1016/B978-0-444-53630-3.00004-X.

Schiebinger, Londa. 1986. "Skeletons in the Closet: The First Illustrations of the Female Skeleton in Eighteenth-Century Anatomy." *Representations,* no. 14: 42–82. doi:10.2307/2928435.

———. 1993. *Nature's Body: Gender in the Making of Modern Science.* Boston: Beacon Press.

Schilt, Kristen, and Laurel Westbrook. 2009. "Doing Gender, Doing Heteronormativity: 'Gender Normals,' Transgender People, and the Social Maintenance of Heterosexuality." *Gender & Society* 23 (4): 440–464. doi:10.1177/0891243209340034.

Schneider, Luisa T. 2020. "Sexual Violence during Research: How the Unpredictability of Fieldwork and the Right to Risk Collide with Academic Bureaucracy and Expectations." *Critique of Anthropology* 40 (2): 173–193. doi:10.1177/0308275X20917272.

Scully, Diana, and Pauline Bart. 2003. "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks." *Feminism & Psychology* 13 (1): 11–16. doi:10.1177/0959353503013001002.

Seelman, Kristie L., Matthew J.P. Colón-Diaz, Rebecca H. LeCroix, Marik Xavier-Brier, and Leonardo Kattari. 2017. "Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults." *Transgender Health* 2 (1): 17–28. doi:10.1089/trgh.2016.0024.

Seitz, Sally. 2016. "Pixilated Partnerships, Overcoming Obstacles in Qualitative Interviews via Skype: A Research Note." *Qualitative Research* 16 (2): 229–235. doi:10.1177/1468794115577011.

Selod, Saher. 2015. "Citizenship Denied: The Racialization of Muslim American Men and Women Post-9/11." *Critical Sociology* 41 (1): 77–95. doi:10.1177/0896920513516022.

Serlin, D. H. 1995. "Christine Jorgensen and the Cold War Closet." *Radical History Review* 1995 (62): 137–165. doi:10.1215/01636545-1995-62-137.

Shapiro, Judith. 1991. "Transsexualism: Reflections on the Persistence of Gender and the Mutability of Sex." In *Body Guards: The Cultural Politics of Gender Ambiguity,* edited by Julia Epstein and Kristina Straub. New York: Routledge.

Sharp, Gwen, and Emily Kremer. 2006. "The Safety Dance: Confronting Harassment, Intimidation, and Violence in the Field." *Sociological Methodology* 36 (1): 317–327. doi:10.1111/j.1467-9531.2006.00183.x.

Sheff, Elisabeth. 2006. "Poly-Hegemonic Masculinities." *Sexualities* 9 (5): 621–642. doi:10.1177/1363460706070004.

Siebers, Tobin. 2008. *Disability Theory.* Corporealities. Ann Arbor: University of Michigan Press.

———. 2017. "Disability and the Theory of Complex Embodiment: For Identity Politics in a New Register." In *The Disability Studies Reader,* Fifth edition, edited by Lennard J. Davis, 272–291. New York: Routledge, Taylor & Francis Group.

Simon, Meagan Elizabeth. 2015. "Trans/Gender Sincerities: A Dialogic Analysis of Four Young People's Embodied Subjectivities." Master's thesis, Simon Fraser University.

Skidmore, Emily. 2011. "Constructing the 'Good Transsexual': Christine Jorgensen, Whiteness, and Heteronormativity in the Mid-Twentieth-Century Press." *Feminist Studies* 37 (2): 270–300.

Smith, Anthony M A, Damien Jolley, Jane Hocking, Kim Benton, and John Gerofi. 1998. "Does Penis Size Influence Condom Slippage and Breakage?" *International Journal of STD & AIDS* 9 (8): 444–447. doi:10.1258/0956462981922593.

Smith, Linda Tuhiwai. 2012. "Research through Imperial Eyes." In *Decolonizing Methodologies: Research and Indigenous Peoples.* London: Zed Books.

Snider, Stefanie. 2009. "Fat Girls and Size Queens: Alternative Publications and the Visualizing of Fat and Queer Eroto-Politics in Contemporary American Culture." In *The Fat Studies Reader,* edited by Esther D. Rothblum and Sondra Solovay, 223–230. New York: New York Unviersity Press.

Snorton, C. Riley. 2017. *Black on Both Sides: A Racial History of Trans Identity.* Minneapolis: University of Minnesota Press.

Spade, Dean. 2003. "Resisting Medicine, Re/Modeling Gender." *Berkeley Women's Law Journal* 18 (1): 15–37.

———. 2015. *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law.* Revised ed. Durham, NC: Duke University Press.

Spyropoulos, Evangelos, Dimitrios Borousas, Stamatios Mavrikos, Athanasios Dellis, Michael Bourounis, and Sotirios Athanasiadis. 2002. "Size of External Genital Organs and Somatometric Parameters among Physically Normal Men Younger than 40 Years Old." *Urology* 60 (3): 485–489. doi:10.1016/S0090-4295(02)01869-1.

Srinivasan, Amia. 2018. "Does Anyone Have the Right to Sex?" *London Review of Books* 40 (6). https://web.archive.org/web/20190504085446/https://www.lrb.co.uk/v40/n06/amia-srinivasan/does-anyone-have-the-right-to-sex.

Statistics Canada. 2017. "Number and Proportion of Visible Minority Population in Canada, 1981 to 2036." Statistics Canada. https://web.archive.org/web/20191129030249/https://www.statcan.gc.ca/eng/dai/btd/othervisuals/other010.

Stein, Melissa N. 2015. *Measuring Manhood: Race and the Science of Masculinity, 1830-1934.* Minneapolis: University of Minnesota Press.

Stephens, Elizabeth. 2007. "The Spectacularized Penis: Contemporary Representations of the Phallic Male Body." *Men and Masculinities* 10 (1): 85–98. doi:10.1177/1097184X07299332.

Strangio, Chase. 2018. "Deadly Violence Against Transgender People Is on the Rise. The Government Isn't Helping." American Civil Liberties Union. https://web.archive.org/web/20190614150030/https://www.aclu.org/blog/lgbt-rights/criminal-justice-reform-lgbt-people/deadly-violence-against-transgender-people-rise.

Strauss, Anselm L., and Juliet M. Corbin. 1991. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* 3rd ed. Newbury Park, CA: Sage.

Stryker, Susan. 2006a. "(De)Subjugated Knowledges: An Introduction to Transgender Studies." In *The Transgender Studies Reader,* edited by Susan Stryker and Stephen Whittle. New York: Routledge.

———. 2006b. "My Words to Victor Frankenstein Above the Village of Chamounix: Performing Transgender Rage." In *The Transgender Studies Reader,* 1st ed., edited by Susan Stryker and Stephen Whittle, 244–256. Seal Studies. New York: Routledge.

Stryker, Susan. 2008. *Transgender History.* Berkeley: Seal Press: Distributed by Publishers Group West.

Stryker, Susan, and Aren Z. Aizura. 2013. "Introduction: Transgender Studies 2.0." In *The Transgender Studies Reader 2,* edited by Susan Stryker and Aren Z. Aizura. New York: Routledge.

Stryker, Susan, Paisley Currah, and Lisa Jean Moore. 2008. "Introduction: Trans-, Trans, or Transgender?" *WSQ: Women's Studies Quarterly* 36 (3-4): 11–22. doi:10.1353/wsq.0.0112.

Stryker, Susan, and Nikki Sullivan. 2009. "King's Member, Queen's Body: Transsexual Surgery, Self-Demand Amputation and the Somatechnics of Sovereign Power." In *Somatechnics: Queering the Technologisation of Bodies,* edited by Nikki Sullivan and Samantha Murray, 49–63. Queer Interventions. Burlington, VT: Ashgate.

Subbaraman, Nidhi. 2018. "Some Called It 'Vigilante Justice.' But An Anonymous Campaign Triggered A Real Investigation Into A UC Santa Cruz Professor." *BuzzFeed News: Science.* https://web.archive.org/web/20190107135508/https://www.buzzfeednews.com/article/nidhisubbaraman/gopal-balakrishnan-sexual-harassment-investigation.

Sullivan, Nikki. 2005a. "Integrity, Mayhem, and the Question of Self-Demand Amputation." *Continuum* 19 (3): 325–333. doi:10.1080/10304310500176487.

———. 2005b. "Somatechnics, or, The Social Inscription of Bodies and Selves." *Australian Feminist Studies* 20 (48): 363–366. doi:10.1080/08164640500280274.

———. 2006. "Transmogrification: (Un)Becoming Other(s)." In *The Transgender Studies Reader,* 1st ed., edited by Susan Stryker and Stephen Whittle, 552–564. New York: Routledge.

———. 2007. "'The Price to Pay for Our Common Good': Genital Modification and the Somatechnologies of Cultural (In)Difference." *Social Semiotics* 17 (3): 395–409. doi:10.1080/10350330701448736.

———. 2008a. "Dis-Orienting Paraphilias? Disability, Desire, and the Question of (Bio)Ethics." *Journal of Bioethical Inquiry* 5 (2-3): 183–192. doi:10.1007/s11673-008-9097-2.

———. 2008b. "The Role of Medicine in the (Trans)Formation of 'Wrong' Bodies." *Body & Society* 14 (1): 105–116. doi:10.1177/1357034X07087533.

———. 2009a. "The Somatechnics of Intersexuality." *GLQ: A Journal of Lesbian and Gay Studies* 15 (2): 313–327. doi:10.1215/10642684-2008-140.

———. 2009b. "Transsomatechnics and the Matter of 'Genital Modifications'." *Australian Feminist Studies* 24 (60): 275–286. doi:10.1080/08164640902852472.

———. 2012. "The Somatechnics of Perception and the Matter of the Non/Human: A Critical Response to the New Materialism." *European Journal of Women's Studies* 19 (3): 299–313. doi:10.1177/1350506812443477.

Sullivan, Nikki, and Samantha Murray. 2009. "Introduction." In *Somatechnics: Queering the Technologisation of Bodies,* edited by Nikki Sullivan and Samantha Murray, 1–10. Queer Interventions. London: Ashgate.

Sutherland, Ronald S., Barry A. Kogan, Laurence S. Baskin, Robert A. Mevorach, Felix Conte, Selna L. Kaplan, and Melvin M. Grumbach. 1996. "The Effect of Prepubertal Androgen Exposure on Adult Penile Length." *Journal of Urology* 156 (2S): 783–787. doi:10.1016/S0022-5347(01)65814-2.

Szymczak, Julia E., and Peter Conrad. 2006. "Medicalizing the Aging Male Body: Andropause and Baldness." In *Medicalized Masculinities,* edited by Dana Rosenfeld and Christopher A. Faircloth, 89–111. Philadelphia: Temple University Press.

Talalaj, Janusz Joseph, and Stanisław Talalaj. 1994. *The Strangest Human Sex Ceremonies and Customs.* Melbourne: Hill of Content.

Thomas, Drew M. 2011. "A Critical Review of Richard Lynn's Reports on Reaction Time and Race." *Journal of Biosocial Science* 43 (1): 113–123. doi:10.1017/S002193201000057X.

Thomas, William Isaac, and Dorothy Swaine Thomas. 1928. *The Child in America: Behavior Problems and Programs.* New York: A. A. Knopf.

Thompson, Craig J., and Douglas B. Holt. 2004. "How Do Men Grab the Phallus?: Gender Tourism in Everyday Consumption." *Journal of Consumer Culture* 4 (3): 313–338. doi:10.1177/1469540504046518.

Tiefer, Leonore. 2004. *Sex Is Not a Natural Act and Other Essays.* Boulder, CO: Westview Press.

Tiger, Lionel. 2004. *Men in Groups.* New Brunswick, NJ: Transaction Publishers.

Tlapoyawa, Kurly. 2019. "Can We Please Stop Using 'Latinx'? Thanx." *Medium.* https://humanparts.medium.com/can-we-please-stop-using-latinx-thanx-423ac92a87dc.

Towle, Evan Baird, and Lynn M. Morgan. 2002. "Romancing the Transgender Native: Rethinking the Use of the 'Third Gender' Concept." *GLQ: A Journal of Lesbian and Gay Studies* 8 (4): 469–497. doi:10.1215/10642684-8-4-469.

Travers. 2006. "Queering Sport: Lesbian Softball Leagues and the Transgender Challenge." *International Review for the Sociology of Sport* 41 (3-4): 431–446. doi:10.1177/1012690207078070.

———. 2018. *The Trans Generation: How Trans Kids (and Their Parents) Are Creating a Gender Revolution.* New York: New York University Press.

Treggiden, Katie. 2014. "Naomi Kizhner's Jewelry Collection Harvests Energy from the Human Body." *Dezeen.* https://web.archive.org/web/20141022124820/https://www.dezeen.com/2014/08/06/naomi-kizhner-energy-addicts-jewellery-human-electricity-production/.

Ubachs, J. M. H., Th. J. Van Sante, and L. A. Schellekens. 1974. "Partial Colpocleisis by a Modification of Le Fort's Operation." *Obstetrical & Gynecological Survey* 29 (5): 364. doi:10.1097/00006254-197405000-00029.

Upchurch, Meg, and Simona Fojtová. 2009. "Women in the Brain: A History of Glial Cell Metaphors." *The National Women's Studies Association Journal* 21 (2): 1–20.

Valone, David A. 2002. "Review of 'Eugenics: A Reassessment' by Richard Lynn. Human Evolution, Behavior, and Intelligence. Westport, Conneticut: Praeger, 2001." *Isis* 93 (3): 534. doi:10.1086/374143.

Vashi, Neelam A., Mayra Buainain de Castro Maymone, and Roopal V. Kundu. 2016. "Aging Differences in Ethnic Skin." *The Journal of Clinical and Aesthetic Dermatology* 9 (1): 31–38.

Vera-Gray, Fiona. 2017. "'Talk about a Cunt with Too Much Idle Time': Trolling Feminist Research." *Feminist Review* 115 (1): 61–78. doi:10.1057/s41305-017-0038-y.

Vice Media. 2015. "This Is What Life Is Like with a Gigantic Penis: Monster Meat." https://www.youtube.com/watch?v=h-IXx4tkTF0.

Vidal-Ortiz, Salvador. 2009. "The Figure of the Transwoman of Color Through the Lens of 'Doing Gender'." *Gender & Society* 23 (1): 99–103. doi:10.1177/0891243208326461.

Vipond, Evan. 2015. "Resisting Transnormativity: Challenging the Medicalization and Regulation of Trans Bodies." *Theory in Action* 8 (2): 21–44. doi:10.3798/tia.1937-0237.15008.

Võ, Linda Trinh, and Marian Sciachitano. 2000. "Introduction: Moving beyond 'Exotics, Whores, and Nimble Fingers': Asian American Women in a New Era of Globalization and Resistance." *Frontiers: A Journal of Women Studies* 21 (1/2): 1–19. JSTOR: 3347027.

Volken, Thomas. 2003. "IQ and the Wealth of Nations. A Critique of Richard Lynn and Tatu Vanhanen's Recent Book." *European Sociological Review* 19 (4): 411–412. doi:10.1093/esr/19.4.411.

Warner, Michael. 1993. *Fear of a Queer Planet: Queer Politics and Social Theory.* Edited by Social Text Collective. Vol. 6. Minneapolis: University of Minnesota Press.

Weber, Brenda. 2006. "What Makes the Man? Television Makeovers, Made-Over Masculinity, and Male Body Image." *International Journal of Men's Health* 5 (3): 287–306. doi:10.3149/jmh.0503.287.

Weinmann, Tobias, Silke Thomas, Susanne Brilmayer, Sabine Heinrich, and Katja Radon. 2012. "Testing Skype as an Interview Method in Epidemiologic Research: Response and Feasibility." *International Journal of Public Health* 57 (6): 959–961. doi:10.1007/s00038-012-0404-7.

Weller, Susie. 2017. "Using Internet Video Calls in Qualitative (Longitudinal) Interviews: Some Implications for Rapport." *International Journal of Social Research Methodology* 20 (6): 613–625. doi:10.1080/13645579.2016.1269505.

Wessells, Hunter, Tom F. Lue, and Jack W. McAninch. 1996. "Penile Length in the Flaccid and Erect States: Guidelines for Penile Augmentation." *Journal of Urology* 156 (3): 995–997. doi:10.1016/S0022-5347(01)65682-9.

West, Candace, and Sarah Fenstermaker. 1995. "Doing Difference." *Gender & Society* 9 (1): 8–37. doi:10.1177/089124395009001002.

West, Candace, and Don H. Zimmerman. 1987. "Doing Gender." *Gender & Society* 1 (2): 125–151. doi:10.1177/0891243287001002002.

Westbrook, Laurel, and Kristen Schilt. 2014. "Doing Gender, Determining Gender: Transgender People, Gender Panics, and the Maintenance of the Sex/Gender/Sexuality System." *Gender & Society* 28 (1): 32–57. doi:10.1177/0891243213503203.

Wheeler, Thomas L., Holly E. Richter, Kathryn L. Burgio, David T. Redden, C.C. Grace Chen, Patricia S. Goode, and R. Edward Varner. 2005. "Regret, Satisfaction, and Symptom Improvement: Analysis of the Impact of Partial Colpocleisis for the Management of Severe Pelvic Organ Prolapse." *American Journal of Obstetrics and Gynecology* 193 (6): 2067–2070. doi:10.1016/j.ajog.2005.07.010.

Whitehead, Jaye Cee. 2012. *The Nuptial Deal: Same-Sex Marriage and Neo-Liberal Governance.* Chicago: University of Chicago Press.

Whitehead, Jaye Cee, Kath Bassett, Leia Franchini, and Michael Iacolucci. 2015. "'The Proof Is in the Pudding': How Mental Health Practitioners View the Power of 'Sex Hormones' in the Process of Transition." *Feminist Studies* 41 (3): 623. doi:10.15767/feministstudies.41.3.623.

Whitehead, Jaye Cee, and Jennifer Thomas. 2013. "Sexuality and the Ethics of Body Modification: Theorizing the Situated Relationships among Gender, Sexuality and the Body." *Sexualities* 16 (3-4): 383–400. doi:10.1177/1363460713479755.

Whitehead, Jaye Cee, Jennifer Thomas, Bradley Forkner, and Dana LaMonica. 2012. "Reluctant Gatekeepers: 'Trans-Positive' Practitioners and the Social Construction of Sex and Gender." *Journal of Gender Studies* 21 (4): 387–400. doi:10.1080/09589236.2012.681181.

WHO. 2016a. "From Over 90,000 Cases to Zero in Two Decades: The European Region Is Malaria Free." World Health Organization Regional Office for Europe. https://web.archive.org/web/20180716112623/http://www.euro.who.int/en/media-centre/sections/press-releases/2016/04/from-over-90-000-cases-to-zero-in-two-decades-the-european-region-is-malaria-free.

———. 2016b. "Russian Federation." World Health Organization Regional Office for Europe. https://web.archive.org/web/20190927101434/http://www.euro.who.int/en/health-topics/communicable-diseases/vector-borne-and-parasitic-diseases/malaria/country-work/russian-federation.

Wilchins, Riki Anne. 1997. *Read My Lips: Sexual Subversion and the End of Gender.* Ithaca, NY: Firebrand Books.

Winters, Kelley. 2018. "What's Needed in the WPATH SOC8, Part 1: A Wish for Wings That Work*." Trans Policy Reform Blog. http://web.archive.org/web/20190702223946/https://transpolicyreform.wordpress.com/2018/09/26/whats-needed-in-the-wpath-soc8-part-1-a-wish-for-wings-that-work/?fbclid=IwAR2CLGFMEgFVv0YYuXwGXWlAgSiadd9GB0O7q4MX-IKJpnkRyKpFVPGNx3Q.

Wrangham, Richard, and Rachel Carmody. 2010. "Human Adaptation to the Control of Fire." *Evolutionary Anthropology* 19 (5): 187–199. doi:10.1002/evan.20275.

Wylie, Kevan R., and Ian Eardley. 2007. "Penile Size and the 'Small Penis Syndrome'." *BJU International* 99 (6): 1449–1455. doi:10.1111/j.1464-410X.2007.06806.x.

Yagoda, Maria. 2017. "I Ate Myself Out Using My iPhone, and It Was Pretty Good." *Vice Media.* https://web.archive.org/web/20190724020807/https://www.vice.com/en_us/article/ywmv8x/i-ate-myself-out-using-my-iphone-and-it-was-pretty-good.

Younging, Gregory. 2018. *Elements of Indigenous Style: A Guide for Writing by and about Indigenous Peoples.* Indigenous Collection. Edmonton, AB: Brush Education.

Zavlin, Dmitry, Jürgen Schaff, Jean-Daniel Lellé, Kevin T. Jubbal, Peter Herschbach, Gerhard Henrich, Benjamin Ehrenberger, Laszlo Kovacs, Hans-Günther Machens, and Nikolaos A. Papadopulos. 2018. "Male-to-Female Sex Reassignment Surgery Using the Combined Vaginoplasty Technique: Satisfaction of Transgender Patients with Aesthetic, Functional, and Sexual Outcomes." *Aesthetic Plastic Surgery* 42 (1): 178–187. doi:10.1007/s00266-017-1003-z.

Zheng, Robin. 2016. "Why Yellow Fever Isn't Flattering: A Case Against Racial Fetishes." *Journal of the American Philosophical Association* 2 (3): 400–419. doi:10.1017/apa.2016.25.

Zilg, Brita, and Petra Råsten-Almqvist. 2017. "Fatal Fat Embolism After Penis Enlargement by Autologous Fat Transfer: A Case Report and Review of the Literature." *Journal of Forensic Sciences* 62 (5): 1383–1385. doi:10.1111/1556-4029.13403.

Appendix A

Semi-Structured Interview Guide

Thank you for joining me for this interview. How much time do we have set aside today?

As I described in the consent form, I am studying how medical practitioners make decisions in consultation with their patients about elective male genital procedures. The questions in this interview will focus on your experiences performing [procedures] . Do you perform any other procedures that might qualify for this study?

Have you had a chance to review the consent form? Do you have any questions? Do you consent to participating in this interview?

Some of these questions may sound really basic or have obvious answers, but I've received a lot of different and surprising responses from practitioners, so I'm interested in hearing what you think. I'll start the audio recorder now.

Warm-Up Questions

1. To start, can you briefly tell me how you became interested in [male enhancement] ?

- How many years have you been performing [procedures] ?
- Over the years, about how many patients have you performed these procedures on?
- Without disclosing sensitive information, can you tell me about the demographics of the patients who come to see you? (Race, sexuality, socioeconomic status)

2. Who is an ideal candidate for these procedures? How do you decide if someone is ready for them?

- What do realistic expectations for your procedures look like? What are unrealistic expectations?
- Do you refer to any professional guidelines or publications when deciding whether to take on a patient for these procedures?

- What kinds of things can someone say or do that tell you it is not a good idea to take them on as patients / to perform a procedure on a patient?
- Do patients have any common experiences related to their decision to get these procedures? If someone has these experiences, does that help inform your decision to accept them as a patient?
- Do you consult with a patient about the impact the procedure will have on their sex lives / partners / future partners? Do you ever consult with patients' partners?
- You mentioned earlier that you perform these procedures on gay men as well. Can you also tell me about your work with them?
- How would you react to a patient who wants this procedure in part so that they can get a sexual partner? Or many sexual partners?
- Have you ever reversed a procedure that you (or another doctor) performed? Can you tell me about those cases?

3. What is your professional opinion about research looking for the "average penis size"?

- If they use these figures in their practice: What is the average penis size? Where do these figures come from?
- What accounts for different penis size in men? Do these numbers vary across different groups of people? Why is that the case?
- Is there a relationship between body fat and penis size?
- Have you ever seen a patient who had a very large penis and wanted to augment their penis with your procedures? Can you tell me more about this?
- Is it possible that any of your patients seeking a genital augmentation are intersex?

4. Can you think of a patient who did not fit the general description of who you typically see? Can you tell me more about this experience?

- Have you ever decided to not perform an elective genital procedure on a prospective patient? Can you tell me about this?
- Have you ever received unusual requests from patients?
- Are there patient requests that you would consider not anymore physically risky than the procedures you normally perform, but are otherwise dangerous?
- Have you ever received requests from a patient to make his genitals smaller? Softer or harder? Ribbed or textured? Curved? Differently proportioned? If requested by a patient, would you perform any of these procedures?
- What does a natural-looking penis look like?

- One doctor I spoke with has adopted a 'harm reduction' approach to patients who request 'unusual' genital procedures by giving them a mild enhancement. What are your thoughts on that?
- Have you ever seen a patient who had body dysmorphia? How can you tell if someone has body dysmorphia?

5. The next few questions are inspired by some of the male enhancement forums I've seen online and may seem a bit out of the ordinary. Feel free to take your time with them.

- A common question in these forums is "how big is big enough?" In terms of penis size for your patients, how big is big enough?
- Some men on these forums talk about wanting, and sometimes receiving procedures for what they call a "monster cock"—a penis so big that penetrative sex with their partners is impossible or really painful. What are your thoughts on that?
- There is a forum for men who want to have penetrative sex, but cannot without hurting their partners because their penises are very large. Is there anything you could do as a doctor to help them?
- Some men online compare male enhancement procedures to genital mutilation. What are your thoughts on that?

6. Have you ever asked a patient to seek professional counseling (before undergoing a procedure)? Do you require patients to see a professional counselor?

- Why do you suppose that transgender people require counseling and a professional letter written on their behalf to receive elective genital procedures and your cisgender patients do not?

Cool-Down Questions

7. What do you think is the ideal role of medicine in terms of male enhancement?

- What is the most fulfilling aspect of your job?
- If you could share something about the work that you do with the general public, what would you like them to know?
- Is there anything else that you would like to share with me?

8. Are there other doctors you can think of who are eligible to participate in this research?

Appendix B

Recruitment Email

Hello [participant's name] ,

My name is Jennifer Thomas; I am a PhD student working with Dr. Travers in the Department of Sociology and Anthropology at Simon Fraser University in Burnaby, BC Canada. Starting in October 2014 I am conducting interviews via Skype with medical practitioners who perform elective male genital procedures. I would like to invite you to participate in my dissertation research exploring how medical practitioners make decisions in consultation with their patients about elective genital procedures.

You are eligible to participate in this study if you perform elective procedures on male genitalia, including, but not limited to penile length and girth enhancement, penile or testicular implants, and adult circumcision. By participating, you will have the opportunity to share your expertise and perspectives on elective male genital procedures. Most interviews last about one hour.

Participating in this study does not pose many risks. I will keep your responses confidential and your name, contact information and other identifying information private to the greatest extent permitted by the law. I will not ask you to share information that would identify your patients during our conversation. If you share identifying information, I will not include it in my study. Please see attached for a sample of the consent form.

Please let me know if you have any questions. I look forward to hearing from you.

Jennifer Thomas
PhD Candidate, Sociology
Department of Sociology and Anthropology
Simon Fraser University
8888 University Drive,
Burnaby, B.C. Canada V5A 1S6

Appendix C

Consent Form

1. Study Title

An Ethnography of Male Genital Enhancement

2. Study Personnel

Principal Investigator	Faculty Advisor	Department Chair
Jennifer Thomas	Dr. Travers	Dr. Dany Lacombe
The Department of Sociology and Anthropology at Simon Fraser University		

3. Study Invitation and Purpose

You are invited to participate in a study on how medical practitioners and men seeking male genital enhancement make decisions about surgical and do-it-yourself genital enhancement procedures. The results of this study will be used to inform our understanding of male genital enhancement. You will only be asked to engage in one interview which typically lasts for about one to two hours. The study will take place throughout Canada and the United States from August 2013 through August 2018. This research is being conducted for my PhD dissertation in Sociology at Simon Fraser University in Burnaby, BC Canada.

4. Participant Characteristics and Exclusionary Criteria

You are eligible to participate in this study if you are a medical surgeon or medical staff person who performs or assists elective male genital surgeries, including, but not limited to penile length and girth enhancement, penile or testicular implants, adult circumcision, foreskin restoration, scrotal shaping, or penoscrotal webbing excision. You must be 19 years or older to participate in this research.

5. Voluntary Nature of Participation

During the interview, I will record our conversation with a digital audio recorder and by taking written notes. You may decline to have your voice recorded and notes taken during the interview. If you decide to participate, you may decline to answer any question or withdraw at any time without negative consequences. If you withdraw early, *I will not delete or shred any data already gathered unless specifically requested by you*.

6. Anticipated Benefits to Participants

There are no direct benefits or monetary reimbursement for participating in this research. By participating, you will have the opportunity to share your expertise and perspectives on elective male genital surgery.

7. Anticipated Risks to Participants

Potential risks in this study are very limited and will not exceed risks you would otherwise experience in your everyday life. If at any time during the interview you feel uncomfortable, at your request, I will stop the digital audio recorder, set aside my notes and ask if you would like to continue. You may stop the interview at any time without negative impact to your relationship with me or with Simon Fraser University.

8. Promise of Privacy

I will keep your responses confidential and your name, contact information, and other identifying information private to the greatest extent permitted by the law. The records of this study will be kept private. No information that would identify you or your patients personally will be solicited during the interview. If you share information that will make it possible to identify you or your patients, I will not include this information in any of the transcriptions, written reports, or oral presentations. Descriptive details of the interview and our interaction may be recorded. In order to protect your privacy, I will transport the audio file, my notes and this consent form in a secure lock-box. All research materials will remain at the private residence of the principal investigator. Notes and audio files will not be connected with your name, but with a code only known by the principal investigator. I will keep the data in a secure location for up to 15 years. I have taken great precautions to protect your privacy and keep your information confidential.

9. Organizational Permission

Permission to conduct this study at your organization may or may not have been obtained. Please ask the primary investigator for the updated status on organizational permission. The risk of your participation without the organization's consent is very minimal. I will keep your participation in this research confidential, which means I will not inform *anyone*, including anyone from your organization, that you have participated in this research.

10. Contacts and Questions

Please contact the principal investigator, Jennifer Thomas if you have questions about the research or if you are interested in obtaining the final research results. Complete contact information for the research team is noted on the first page of this form.

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact Dr. Jeffrey Toward, Director, Office of Research Ethics.

10. Statement of Consent

I have read and understand the above. All my questions have been answered. I am 19 years of age or older. I agree to participate in this study. I have requested a copy of this form.

Participant's Printed Name	Signature	Date

Investigator's Printed Name	Signature	Date