The Pathological Production of Antagonism

On the Institutionalization of Violence Against Trans People

Cello Latini Pfeil; Bruno Latini Pfeil

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Abstract

Our main concern in this essay is to analyze how the invention of transsexuality as a diagnostic category, from a cisgender and heteronormative perspective, has led to systems of control, surveillance and oppression against trans people. In order to discuss institutional violence and control directed against trans people, an anarchist lens of analysis appears — insofar as anarchism produces blunt criticism of the very existence of the State and its institutions, and not only of its structuring possibilities — as well as a decolonial one — insofar as violence against trans people is the outcome of a colonial regime.

Keywords: institutional violence; transsexuality; cisnormativity; decoloniality.

Introduction

In considering how violence is constituted, one ought to analyze not only its perpetrators and reinforcers, but furthermore the structures of oppression that enable it to be perpetuated. It is from the angle of institutionalization that we analyze the cisgender, heterosexual and white standard of being. Our main hypothesis is that the institutionalization of violence allows it to be perpetuated on a massive scale. Thus, we focus on the violence directed at transgender people, direct targets of cisnormativity, and as lens of analysis we rely on anarchism, for the denial of authority, and decolonial thinking, for denoting epistemicide as part of all Westernized and institutionalized dynamics of knowledge production.

Transsexuality emerged as a diagnostic category in the late 20th century, as the antagonism of something that had not yet been named: cisgenderity. Since its epistemological invention, the diagnosis of transsexuality has rested in the hands of doctors, psychiatrists, psychoanalysts, psychologists, university professors, religious authorities; it has been in the hands of men in positions of power, protected by the institutions that legitimized their sayings.

Behind institutional walls, the exploitation of marginalized people was performed without hindrance, with the aim of producing knowledge that reiterated cisgender, heteronormative and white patriarchal norms, without which the violence that traverses our lives could not be as extensive as it is. It is therefore essential to embrace an anarchist lens of analysis. For, unlike the individualist freedom defended by liberal philosophy, the anarchist conception of freedom is collective, rejecting the discrimination and persecution of those considered "others": people of color, indigenous people, LGBTQIA+ people, rebels, dissident communities in general, those who do not conform to the colonial norms and do not submit to the position they have been assigned.

By analyzing the pathologization of transsexuality, the main issue that motivated our writing is the following: would it be coherent to take institutions as potential ways of social emancipation for trans people? Would it be possible to defend a State that, while assisting us, marginalizes us? In order to address these concerns, our approach to this article has been organized into two sections, arranged as follows: in the first section, we explain the emergence of the notion of "transsexuality" in the latter 20th century. The classification and determination of who would be a "real transsexual" outlined the way in which transsexuality is currently treated by medicine, psychiatry and psychology. The invention of transsexuality through a cisgender lens produced specific power relations between cisgender doctors and transgender patients, and annulled any

possibility of self-determination for the latter, as well as creating trans narratives through cisnormative lenses.

Transsexuality, having been institutionalized, is in a subordinate position to cisgenderity. Government institutions are deeply involved in the operationalization of violence against trans people and in the dichotomous production of abnormal/trans/subject groups and normal/cis/subject people, which forces trans people to adhere to cisnormative narratives about themselves. In general terms, trans people are imbued to model themselves according to narratives that delegitimize them.

In the second topic, we consider the production of trans subjectivities — subjected subjectivities — through mechanisms of culpability, segregation and infantilization (GUATTARI; ROLNIK, 1996). Our focus turns to infantilization as a tool of control. The State that marginalizes trans people is the same one that offers us welfare policies. However, this assistance figures as patronage, masquerading as welcoming, insofar as access to health services is given to trans people who reproduce cisnormative narratives and convince doctors that they are "truly trans". Thus, it is not our contention that health facilities for trans people should be abolished, because their existence is necessary for us to have basic access. What we aim to argue is that there are only trans clinics because other clinics, hospitals and health facilities are geared towards cis people and don't acknowledge the existence of our bodies.

The perspective we are using is that of health, as the first conceptions of transsexuality originated from the pathological, as a perversion, a disease, a deviation, an incongruity. To think about transsexuality and health is to return to the cradle of our pathologization and to the development of policies of control directed at us. Since health itself is institutionalized, is it possible to think about the emancipation of trans people by institutional means?

The institutionalized invention of transsexuality

For quite some time there has been a tendency in the Social Sciences to be driven by knowledge that does not accept alternative, popular and dissident concepts as legitimate; a tendency that aims to keep hegemonic knowledge in its place of hegemony and "subaltern" knowledge in "its place" of subalternity. It is a monoculture of knowledge (SANTOS, 2014), in the sense that the cultivation of certain beliefs and ideologies nullifies the possibility of other ways of thinking being validated. The monoculture of knowledge produces epistemicide, "the murder of knowledge" (SANTOS, 2014, p. 149). The academically legitimized studies on transsexuality are based on the same premise: the monoculture of knowledge, which offers certain [cisgender] figures institutional protection so that they can determine what it means to be trans.

In relation to transsexuality, its emergence as a sociological category occurred as a pathology, a disorder that could be diagnosed. The pathologization of trans individuals takes place through the eyes of cisgender physicians, holders of epistemic privilege (GROSFOGUEL, 2016), never considering the self-determination of the individuals referred to as "patients". The antagonism of epistemic privilege is epistemic inferiority, epistemic racism/sexism. Grosfoguel (2016, p. 30) defines epistemic racism/sexism as "the inferiority of all knowledge coming from human beings classified as non-western, non-male or non-heterosexual", and to this we add non-cisgender, dissenters from the cis and heterosexual norm. The "transsexual" category was formulated within North American and European universities, by the hands of "intellectuals" and whose scientific

production did not encounter any barriers to being disseminated, as it was already embedded in the institutional apparatus responsible for legitimizing it as scientific. This invention was responsible not only for the current way in which physicians approach transsexuality, but furthermore for the way in which other institutions — legal, educational, academic etc. — exclude, historically erase and violate trans people. Therefore, in order to better understand this process and its consequences, a brief historical review of the institutionalized invention of transsexuality is in order.

Reiterating Grosfoguel's assertion that the predominant knowledge in our global system, in our schools, universities, hospitals and clinics, derives from five countries — France, Germany, England, the United States and Italy -, the hegemonic understanding of transsexuality comes especially from the United States and Europe. The first mentions of "transsexuality" date back to the beginning of the 20th century: in 1919, the term "transsexualism" was used by the german physician Magnus Hirschfeld; in 1949, the american sexologist David O. Cauldwell used it again in the paper Psychopatia Transexuallis, in which he analyzed the life of a transfeminine person. But the earliest medical records concerning transsexuality — and which underpinned the way gender is currently diagnosed — emerged in the 1950s in the United States, based on the studies of endocrinologist Harry Benjamin (BENTO & PELÚCIO, 2012), one of the forerunners in the establishment of a *cisgendered trans subjectivity*. According to this logic, the only possible 'treatment' for 'real transsexuals' would be transgenital surgery. No therapy could reverse the transsexuality of a 'true transsexual'.

In contrast to Benjamin, the north-american psychiatrist Robert Stoller, professor at the University of California, refuted the practice of surgery or any procedures that could be considered 'social transitions'. For him, trans people should be convinced that in fact they needed psychiatric treatment (BENTO & PELÚCIO, 2012). Another important personality was the north-american physician John Money, from Johns Hopkins Hospital. For him, children would already have their sexual identity defined by the age of 3, which encouraged him to advocate transgender surgeries. In 1966, the Johns Hopkins Hospital opened the Gender Identity Clinic, one of the first to cater for transgender people.

Throughout the 1960s and 1970s, Benjamin's efforts influenced the performance of surgical procedures relating to the medical veracity of transsexuality. In 1973, John Money coined the term 'gender dysphoria' to designate a symptom determining transsexuality and, in 1977, the Harry Benjamin International Gender Dysphoria Association was founded, an institution responsible for publishing and updating the Standards of Care (SOC) and legitimized as a world reference for the care of trans people (BENTO, 2006). Along with the SOC, the International Code of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) constitute the main documents that pathologize transsexuality.

In 1980, transsexuality was included in the ICD. During this period, Leslie Lothstein, a professor at Yale University, contributed to structuring the diagnosis of transsexuality by carrying out a study with ten adult trans people. In 1994, the DSM-IV replaced the diagnosis of 'Transsexualism' with 'Gender Identity Disorder', breaking down the diagnoses by age and creating yet another category, 'Gender Identity Disorder Not Otherwise Specified', aimed at people who did not meet the requirements of the previous diagnoses.

There are constitutive differences regarding 'trans identity' in the three documents — SOC, ICD and DSM — and with each new edition the diagnostic definitions are reviewed. For example, the DSM-IV focuses on identifying the traits of the 'disorder' in childhood, briefly addressing

the issue of surgery. In its fourth version, gender, sexuality and sex are used arbitrarily in the qualifications of the 'disorder'. Sex and gender would be synonymous. In the tenth version of the ICD, transsexuality was included in the section entitled "Personality Disorders of Sexual Identity", characterized by the "desire to live and be accepted as a person of the opposite sex", and this 'sexual identity' could only be validated if the patient had presented it for at least two years. Although these concepts have been updated over the years and have differed from one another, SOC, DSM and ICD perpetuate the same pathologizing perspective in the academic and medical fields.

The ICD-11 no longer conceives of transsexuality as a "gender identity disorder", as the ICD-10 had previously proposed, and places it in the "conditions related to sexual health", as "a marked and persistent incongruence and persistent incongruence between the gender experienced by the individual and their assigned sex". The DSM-V, in turn, defines gender dysphoria as a "marked incongruence between a person's experienced/expressed gender and their assigned gender, lasting for at least six months", and argues that the best diagnostic method is the observation of child behavior, the child's preference for 'boy' or 'girl' toys, the desire of 'boys' to wear 'feminine clothing' and 'girls' to wear 'masculine clothing'. It does not fail to mention the importance of identifying, as a diagnostic trait, a "strong dislike of one's own sexual anatomy".

The influence of Stoller on the DSM, with its psychoanalytic discourse, and that of Benjamin on the SOC, with its endocrinological and physiological roots, can be found. As endocrinology seeks to discover the biological origins of transsexuality and is responsible for delivering the final decision on transgenital surgery, the psychological sciences (psychology, psychiatry and psychoanalysis) attempt to understand one's desire to undergo the surgical procedure, as the demand for surgical interventions is perceived as an essential requirement for a 'true transsexual'. The commonly asked questions by physicians, psychiatrists, psychologists and psychoanalysts take the trans person's word almost as a lie: do you really want to do this? Are you sure you want to make such drastic changes? Will you not regret it? For someone to be 'truly' trans, they would have to prove that they are not compulsively lying. The decision is never made by the trans patient, but by the holders of epistemic privilege, of the power to legitimize or delegitimize the patient's narrative. Despite the theoretical differences, both fields — endocrinology and psychiatry/psychoanalysis/psychology — fear the same situation: being deceived by 'lying transsexuals'. Health services for trans people in Brazil, for instance, promote 'gender asepsis', a categorization of trans people into those who are 'truly trans' and those who are 'untruthfully trans' (BENTO, 2006).

The most significant feature of the aforementioned documents lies not in their differences, but in their similarities. Whether from the perspective of Benjamin or Stoller, Bento & Pelúcio understand that the elaboration of the concept of transsexuality by medicine occurred in such a way that trans people were "conceived as having a set of common indicators that position them as disordered, regardless of historical, cultural, social and economic variables" (BENTO & PELÚCIO, 2012, p. 572). The 'truth' of transsexuality is to be found in discourses about rejecting one's own body, in dysphoric suffering, in necessarily conflicting family relationships, in a traumatic childhood. Any life experience that doesn't fit in with these dictates immediately casts doubt on the legitimacy of the person's own transsexuality and prevents them from accessing the health services they need. After reviewing the various pathologizing documents and movements regarding transsexuality, Bento (2011, p. 96) reveals her surprise at realizing that "so little so-called scientific knowledge has generated so much power".

The common assertion of axiological neutrality, which psychiatry uses to justify its diagnoses, aims to annul its social position, to neutralize the perspective of the subject who produces knowledge, as if it were possible to assume a position of total neutrality. Neutrality becomes a farce when we consider precisely which beings hold and have held the places where knowledge is produced and which have never been able to enter a university as students or professors. Not only does it apply to a gender perspective, but also to race and class. The holders of epistemic privilege, who devised the diagnostic category of "transsexuality", relied on a cisheteronormative perspective to list, name, categorize, subordinate and humiliate the trans people who came to them in search of assistance, but who found — and still find — an environment of control, tutelage and humiliation: if one wishes to access health devices, from routine care to surgical procedures, one must be evaluated according to the symptoms set out in the ICD, DSM or SOC. These documents, drawn up by North American and European institutions, are considered valid regardless of where they are operated on. A cisnormative and eurocentric scientific paradigm is imposed, one that does not dialogue with the self-determination of trans subjectivities or with gender identities from non-Westernized cultures — which, by the standards of this science, are furthermore considered pathologies.

The pathologization of trans identities is far from granting access to health institutions, on the contrary. Jaqueline Gomes de Jesus (2016, p. 198) perceives a generalization of the medical care given to trans people by health professionals, who end up "disregarding their particularities, or considering, ubiquitously, that all their health demands are restricted to the process". Only if we replicate medical discourses about what it means to be trans, if we report suffering from dysphoria since childhood, and express our anguish over being born in the 'wrong body', are we legitimized as 'real' trans people, and especially if we urgently expose our repulsion towards our genitals and the need to have transgenital surgery.

As trans people's autonomy over their own identities is scrutinized; as bureaucracies are created so that we can access trans clinics, hormonization processes and surgeries, the situation for intersex people is, in a way, the opposite. Surgeries on their bodies are encouraged, even if against their will. Investigating the records from 1990 to 2003 of a brazilian pediatric surgery clinic for intersex children, Machado (2005, p. 62) noted the repetition of "expressions such as "genitalia with a good aesthetic or cosmetic aspect"". The doctor's "gaze" would be decisive in judging the "good aspect" of a genitalia, which would decide whether the child should undergo genital modification surgery, according to the sex assigned to them by the medical team. Heteronorm is present even in the details of surgical procedures.

This contradiction between how trans and intersex people are treated in medicine conveys a message: what matters to the "health" institution is not really the well-being of those people, but the reproduction of a norm that must be kept operative. Why are trans people systematically denied hormone therapies, surgeries, cosmetic procedures, civil registration changes, access to public restrooms, schools and spaces of empowerment? For what ends there are, for intersex people, pediatric surgery clinics — that is, surgeries on children — that encourage physical genital changes in infants, without them even being able to decide for themselves about their own identity? Why are physicians responsible for determining the sex of the child, and why are the surgeries performed with a heterosexual and cisgender bias?

Trans people are constantly put to the test. Our behavior, the way we speak and the way we dress are analyzed and questioned: in the case of a transmasculine person, for example, sitting cross-legged can lead to doubts on the part of the medical team: "Are you really trans? If you

wanted to be a man, you'd act like a man". These conflicts are referred to by Bento as an 'invisible protocol', present in the strange looks from the medical team, the insults, the whispers and all the attitudes that remind the trans person of their deviant place. The relationship between the medical team and the patients continues through the "essentialization of relations of power […] by which the medical know-how doesn't leave alternatives to the patients" (BENTO, 2006, p. 61).

This essentialization is not limited to relations of power, but extends to the standardization of a trans identity through the correlation of certain symptoms, in order to diagnose gender dysphoria, gender identity disorder, gender nonconformity or any other term that points to one's incompatibility with cisgender norms. As anarchism includes in its fundamentals the defense of self-determination, then the control regime over trans people, erected by pathologization, is contrary to any and all principle that follows the anarchist logic of emancipation, because in pathologization there is no possibility of self-determination. By annulling the self-determination of trans people, the colonialist and institutional way of annihilating non-normative cultures and subjectivities is reproduced. Decolonial and anarchist ideas take a stand against this process.

If the legitimization of our identities by government institutions depends on the deepest submission to cisgender normativities, from the detailed elaboration of our narratives to the affirmation of our desires, then, in this and other contexts, the State constitutes itself as the ultimate denial of the freedom of its governed. This denial worsens as the individual distances themself from the colonial epistemological standard. For this reason, from an anarchist perspective, we defend the impossibility of any State to perform a favorable role for trans people, as well as for black, indigenous and insubmissive beings. Anarchist political theory is not static; it undergoes changes and adaptations according to the context in which it is inserted (WOODCOCK, 1998), but anarchist principles should not be abandoned, as they advocate the need for constant change.

In its transformations, anarchist philosophy consistently rejects any kind of authority, which means, politically, denying any form of government and, economically, denying any form of exploitation; and we can infer, in a medical sense and, more broadly, in any institutional sense, the denial of any authority figure that has the power to control a body, to impose rules upon it, to subject it to humiliation and behavioral protocols, to regulate its desire and its identity.

Thinking of "transsexuality" as a category created in a place of power, immersed in the concept — still not widely accepted by cisgender academics — of cisnormativity, we can see how, from Harry Benjamin's studies to the present day, the defense of self-determination is something poignant among trans movements and remains necessary in the defense of every marginalized group. In general terms, even if we say we are trans and elaborate a narrative of self-hate, of 'I was born in the wrong body', the truth about who we are will be in the hands of a medical authority. Even if we remain in a transsexualization program for two years, with psychiatric and endocrinological monitoring, the medical team's opinion may be negative. In other words, they may decide that we are not trans and that we cannot undergo physical modifications in relation to gender self-affirmation. The truth of gender and sex is in institutionalized hands.

Institutional dynamics of control

Production of cisnormative narratives

While transsexuality is institutionalized by taking trans people as incapable of self-determination, cisgenderity is institutionalized as being part of "human nature". A certain

authority model is constructed — the cis, straight, white man — to the detriment of which trans epistemologies are delegitimized. This particular model is not only present in hospitals and clinics, but within non-institutional environments as well. Violence does not only exist inside institutions. There are differences between the imposing forces of the State and those of society (BAKUNIN, 2021). State authority is violent, imperative and formalized, it operates through institutionalized mechanisms and uses legal and bureaucratic methods; the authority of society, based on culture, is even stronger, since even though it does not rely completely on institutions, it permeates social relations. That does not mean that both forces don't feed off each other. What we see in relation to transsexuality is the production of a violent and exclusionary norm, imposed culturally *and* institutionally.

There are larger forces behind the walls of institutions which reinforce exclusion, discrimination and violence against trans people; which [re]produce the delegitimization of trans identities and defend the cisheteronorm; which take away the ability of trans people to assert themselves. When institutional forces act in favor of these factors, it becomes almost impractical to imagine emancipation without also considering the abolition of the State, of the sacredness of its laws and orders, and of the institutions considered necessary for the organization of a society.

These dynamics of power must be analyzed more closely. Guattari and Rolnik (1996) propose two ways of conceiving groupings: there are subject groups, creators and administrators of the law, who are clearly the protagonists of their narratives; and there are subjected groups, submitted to the laws of the subject groups. While the former produce the laws that privilege them, the latter are subjected to them and justify them. For example, the idea that trans people are unable to speak for themselves instantly reflects the ability of cis people to not only produce their own narratives, thinking only in terms of cisgenderity, but also to produce ours — in the sense that cisgender narratives about trans people are created before we even begin to situate ourselves socially.

When we enter a general hospital, our bodies change. The questions "Should I say I'm trans? Should I introduce myself with my civil or social name? Should I pretend I'm cis? Should I say I'm hormonized?" hover like hammers that measure "How far can I go? How far would you let me go?". Because there is a pre-discursivity (VERGUEIRO, 2016) in operation, something that establishes who we are before we can even present our demands. We are determined before we are able to speak, and when we believe we have acquired the capacity for self-determination, we find ourselves immersed in narratives from which we are not allowed to stray: the criteria for classifying transsexuality shape the criteria for determining citizenship, once, in order to be able to access healthcare, rectify one's name and gender in civil registration, and enter the formal labor scene, one must pass through the yoke of authorities who carry the same pathologizing perspectives shared by both Benjamin and Stoller.

Until 2018, for instance, changes to the civil registry had to be made through a judicial process in Brazil. The success of the cases depended on the approval of a judge, who required proof that the applicant was a "real" trans person. In other words, the applicants had to present psychological and psychiatric reports, evidence that they had undergone surgery or intended to do so — in most cases, surgery was a determining factor -, witnesses who could prove that the person had been trans for more than two years, photographs in which the person was dressing and behaving in a way that was socially consistent with their gender identity (in other words, in a cisheteronormative way). The trans individual should construct an entire life narrative to prove their transsexuality. With narratives, we are not limited to the level of diagnoses, to what we

write and say about ourselves, but we encompass our bodily construction, since it is not only our discourse, but our social coding that legitimizes or not our belonging to the sphere of masculinity or femininity. The two major systems of hierarchical domination in capitalist societies that Santos identifies can be found in these dynamics: the *systems of inequality* reflect the near absence of trans people in the formal labor scene, which pushes them into the informal sector, almost always into prostitution; while the *systems of exclusion* reflect the invisibilization, historical erasure and expulsion of trans people from the dynamics of social determination and political organization. A body that is both subalternized and excluded cannot be free.

Considering, for example, that having their documents rectified represents the possibility of coming and going with their name, a trans person's "freedom" is not determined by themselves, as it should be, but is decreed by a third-party authority over which they have no ability to interfere. Defending freedom is not compatible with defending government institutions, as it opposes the relationship between governors and governed. When the judicial system denies a person the right to have their name recognized by the State, it is denying that this person exists, delegitimizing their identity, and confirming the main characteristic of the State — to liquidate the "other".

It is evident, in this way, that culture imposes itself on us, the social organism shapes us according to its own structuring laws. We are born with only our motor, sensory and psychological capacities, devoid of innate notions about how the world functions. The notions we acquire about what should or shouldn't be performed, reproduced or desired are introjected into us by the environment in which we live, and our future positions are built around these notions, regardless of being contrary to them (BAKUNIN, 2021). Our bodies are not something given *a priori*, for the concept of a body does not only encompass the arrangement of tissues, organs and biological structures: it extends to all the historical, territorial, political and economic meanings it holds. For Letícia Lanz (2014), the body is the manifest materiality of a gendered society and is therefore the target of cisheterosexual hegemony, be it to the detriment of clothing, behavior or aesthetics.

Rodovalho (2016, p. 25) adds: "[trans people] know that they are first and foremost their bodies. They know that society won't let them forget this at any time", insofar as the body "is always something that has to do with the mode of insertion into the dominant subjectivity" (GUATTARI; ROLNIK, 1996, p. 278–279). Subjected bodies are produced for the margins, for not being able to self-determine, to build their own territories.

The terms 'trans' and 'cis', in the context of gender identities, appeared at different historical moments: the former emerged in the 1920s, but it was only in the 1950s that transsexuality gained notoriety in scientific circles, while the latter only appeared seventy years after the appearance of the antonym that gave rise to it. According to Rodovalho (2017, p. 366),

> [cisgender people] use the word "trans" all the time, the same people who refuse to use "cis", and they use it because they believe it says something, even if we don't know exactly what. They use it because they believe we exist and they are no longer capable of not seeing us, of not recognizing us in the crowd.

Cisgenderity rejects its own naming as it compulsorily names that which does not reflect itself, and epistemologically invents transsexuality over the incapacity for self-determination and social exclusion, all of which are expressed in the processes of culpability, infantilization and segregation demonstrated by Guattari and Rolnik (1996).

Culpability functions through the formation of a dominant image, a standard of reference that ought to reflect our own. Be it based on religion or science, guilt inevitably produces violence. The academy that produces knowledge based on cisgender normativity is the same academy that works towards a segregated social organization that puts the "blame" on trans people. It is something that Santos refers to as a crisis of hegemony, concerning the university as the only institution capable of producing scientific knowledge. There can be no democratization of knowledge if the only legitimized knowledge is the one that originates institutionally.

How many trans people have historically produced knowledge about themselves? And if they have, to what extent has this knowledge been decisive in the elaboration of ICDs, DSMs and SOCs, as well as in the drafting of any regulation on transsexuality? If we are unable to say who we are, how would we be able to produce science about ourselves? Scientific knowledge operates for its own protection, behind the institutional walls that guarantee its tyranny, because "that which is true of scientific academies is also true of all constituent and legislative assemblies" (BAKUNIN, 2009, p. 18).

One cannot situate the production of trans subjectivities solely on dichotomous individual or social levels, as these are in no way separate; there is no point in centralizing subjectivity in the individual, since it "is essentially fabricated and shaped in the social register" (GUATTARI; ROLNIK, 1996, p. 31). Therefore, the making of this cisgendered trans subjectivity, of the social imaginaries of dysphoria, dangerousness and marginalization of trans people, is closely connected to the exercise of hegemony, of legitimized knowledge. Faced with the creation of a dominant image, processes of identification and disidentification arise: who am I in that image? What does this distance produce? This reference model is not limited to aesthetic ideals and socialization, but to the level of humanity. We don't just think about segregation on a geographical level; we think about social exclusion, unemployment rates in certain social groups and the targeting of State violence; who do they target, if not the bodies that are distant from the reference of humanity?

In short, segregation is reflected in the indicators of violence, employability, schooling and the marginalization of trans people — for whom opportunities in the formal labor scenario are rare. Culpability is interspersed in medical discourses that demand from our narratives stories of self-hate, born-in-the-wrong-body and farce. The search for the benjaminian "real transsexual" has spread to such an extent in medicine that they not only want someone who is 'really' trans, but someone who, as well as being trans, hates being trans as a requirement for being trans. As much as we mold our behavior to a coerced heteronormativity, as much as we internalize signs and symbols of cisnormativity, we will never be cis; therefore, we will never be part of the dominant elites (GUATTARI; ROLNIK, 1996).

The practice of infantilization, on the other hand, deprives us of the possibility of self-determination, placing us in a position of tutelage. Infantilization is the driving force behind tutelage, something similar to intellectual oppression, so criticized by Bakunin as an oppression from which one cannot evade easily. One either has the knowledge or not, and what decides who has it or not is an established power, as is what decides whether an individual is transsexual or not. Among the mechanisms of subjected subjectivities — culpability, infantilization and segregation -, we find infantilization to be something that should be further explored in the context of transsexuality, in the sphere of pathologization.

Infantilization as a tutelary mechanism

Infantilization is the mechanism that most interests us and receives the most attention from Guattari and Rolnik. It removes all possibility of self-determination from the individual, as they are not considered capable of thinking on their own and organizing themselves socially.

By cumulatively centralizing all political functions, the State deprives individuals of these same functions, so that they are no longer able to determine their own lives. The State attributes to itself the ultimate authority over the lives of every individual, which makes popular revolt intuitive, since the presence of State authority is notable, aggressive and violent. Guattari and Rolnik (1996, p. 147) understand the State as a "set of ramifications, [...] a rhizome of institutions that we call 'collective equipment'", namely health institutions, educational institutions, journalistic institutions; in short, discourse producers. While it can protect and cultivate an entire subjective structure, the institution can also stratify it, harden it and annihilate other possibilities of subjectivation. It is through these mechanisms that the State not only marginalizes and geographically segregates dissident beings, but also produces representations of subjugation. An example of this is Operation Tarantula, which occurred between February 27 and March 10, 1987, in the center of São Paulo (Brazil). With neither reports nor evidence, police forces flooded the streets to arrest travestis on the pretext that they were committing the crime of venereal transmission of HIV. More than 300 travestis were arrested. AIDS became a targeting tool. The operation was covered by newspapers as a police strategy to protect the rest of the population from HIV, as a clean-up of the streets.

The State, through its police forces, not only produced this idea, but also mobilized violently to justify its veracity. The operation ended after pressure from social movements. Hence, it can be inferred that, as a central characteristic of every government, murder is a common practice. The essence of any State is the annihilation of figures who threaten its existence, who do not submit to it. To be trans is, in fact, to be insubmissive. Despite the blatant persecution of trans people by the police, in some [brazilian] cities we find government initiatives to provide care, such as the opening of trans ambulatories, which offer psychological, endocrinological and psychiatric care — rarely, some offer gynecologists and urologists, dermatologists, among other services.

If the State provides these services, why accuse its institutional apparatus of producing violence if there is violence everywhere, whether in institutionalized environments or not? Is the State not remedying conflicts? These questions are part of the two currents of revolutionary thought identified by Kropotkin (2020): on the one hand, there are the anarchists, who understand the State as something essentially negative, both in organization and in the arguments that justify its existence, and who advocate the abolition of the State and its institutions, as well as the establishment of a society without hierarchies of oppression; and on the other hand, there are those who intend to revolutionize through the State, using its administrative apparatus, its institutions and its strength for revolutionary purposes — the State would not be at fault for being LGBTphobic, racist and classist, as society would be to blame. From this second perspective, if the State reflects the social organism, change should be aimed at society, not institutions; if institutions are run by people, it is the ideals of those people that should change, not the State's power. However, these arguments crumble once we consider the justification for the existence of the State.

In other words, the State would be justified on the basis that individuals' freedom and security — as well as property, from a liberal perspective — should be guaranteed. To this end, conflicts,

to the extent of their significance, would need to be remedied in such a way as not to interfere with individual freedoms or collective well-being. If there are no equitable conditions for all individuals to have decent living conditions, governments must respond in some way. The "care" initiatives, such as the construction of trans clinics and transsexualization processes, reflect this line of thought. As Bakunin comprehends, even if the State imposes a good, as long as it's an imposition, it is harmful as it fails to respect the other person's freedom.

It is clear that these social initiatives come at a price, in line with the institutional violence mentioned above. Instead, we are faced with State welfare: first, segregating, then saving us from the violence that comes from segregation and, furthermore, selecting who deserves salvation, who can cross over to the other side and belong — falsely — to the dominant group. This salvationist and infantilizing perspective would enable particularized cultural manifestations, so that the subjected groups feel they belong to the dominant sphere: only trans people who are, by benjaminian standards, 'truly trans', those who demonstrate a desire to reinforce cisnormativity and manage to do so perfectly, can be approved in the transsexualizing processes.

Although a number of trans people are selected in these processes, many are not, especially black and indigenous people. Health institutions claim to legitimize trans identities, offer transsexualizing care and services, but at what cost? Under what conditions? There is concrete segregation within these institutions, which distances people who are increasingly dissident from cisnormativity from access to proper healthcare.

The State's institutional apparatus forces us to tolerate the norm that segregates us. The power dynamics between cisgender hospital personnel and trans patients are constant, and the infantilization of trans people by cis people is the pivot of the pathology, to the extent that "the routines and obligations to which [trans people] must submit are justified in the name of their well-being, thus taking away the transsexual's decision-making capacity and power over their body and actions" (BENTO, 2006, p. 58). The laws and regulations whereby trans people are inserted into institutional systems are based on the three mechanisms mentioned by Guattari and Rolnik: they condemn us for our social nonconformity; they segregate us to "clean up" the streets; and they infantilize us when, for example, in medical clinics, we are demanded to fit into historically constructed cisgender models of what a true trans identity is.

As Bakunin stated, the imposition of a certain good is invariably harmful. From a libertarian perspective, laws that are seen as natural are in fact legitimized through very specific cultural and historical lenses. It is the human being who produces natural laws, by establishing what is natural and what is not, what is normal and what is an aberration. Therefore, an individual's freedom consists of their ability to determine their own enactments, freeing themselves from the authority of violent and institutionalized knowledge.

For Rodovalho, the pathologization of transsexuality led trans people to be perceived as

> […] insane people and perhaps, because of the very impossibility of existing and the very repression we were subjected to all the time, we really were: society made us ill and perhaps it's time that society recognized its share of the blame for our madness, its responsibility for not being able to make us according to what it created us to be. (RODOVALHO, 2017, p. 367)

Insofar as these health institutions are governed by cisgender people, we understand that trans clinics are the ultimate laboratory for studying gender roles. Trans clinics are laboratories

of the cisnorm. In these environments, we can identify quite clearly which femininities and masculinities are institutionally legitimized or disapproved of, and how the dysphoric veridicality of transsexuality is constructed.

Conclusion

Medical institutions are a reflection of the cisnorm — and not only because ambulatory clinics demand that our performances conform to cisgender molds, but also because all spaces that are not specifically designated for trans people are veiled as being designated for cis people, with racial, class and various bodily segregations. Trans clinics are not exempt from this. The people who apply for the transsexualization processes and usually undergo the various stages of evaluation, as Bento has shown, are those who, to some extent, fit into a cisgender social reading, or — truthfully or not — claim to desire it. Medical authorities do not give up their place as authorities. The institutional walls continue to protect the determinations of what is or is not 'being trans', of how we should or should not be treated, of what access we can or cannot have. The annihilation of trans subjectivities falls under the concept of epistemicide, insofar as any possibility of self-determination and knowledge production about transsexuality by trans people is annulled.

Since the early 2000s, with the insurgence of trans social movements in Brazil — such as the National Association of Travestis and Transsexuals (ANTRA) or the Brazilian Institute of Transmasculinities (IBRAT) -, popular pressure on pathologization has been strong, but only achieved results by the end of the first decade. The ICD-11 and DSM-V have modified its sections on transsexuality. However, they continue to catalog trans identities as something-not-quite-right, whereas cisgenderity remains unnamed. We still depend on medical approval to access surgery and hormone therapy. The authority of "scientific opinion" remains, even after changes to the ICD and DSM. This shows us how institutions operate: not without authority, not without hierarchy, not without a clear dynamic of subjection.

The government-regulated trans clinics express the materialization of cisgender norm. The means by which we can access health care are the same ones that force us into a violent normativity. And these are the same forces that compel us to introject cisnormative trans subjectivities, based on the dynamics of culpability and segregation (GUATTARI; ROLNIK, 1996). In general terms, there is no possibility of social emancipation that passes through institutional hands, whether it be the government's so-called 'assistance' of dissident people, affirmative policies aimed at marginalized groups, or the provision of minimal services that seek to protect trans people from violence. The monoculture of knowledge (SANTOS, 2014) is a constant that underpins different institutionalized spaces. Even though these ambulatory policies and institutional initiatives of "care" can be fruitful, it cannot be denied that every institutional apparatus, once it represents the arms of the State, operates to maintain segregation. The "care" provided by trans clinics translates into epistemic violence, the erasure of subjectivities and the imposition of the cisnorm. The name change protocols offered by registry offices and the judicial system cause embarrassment, inaccessibility and vexatious situations.

One cannot fight for freedom except from it and using it as the main instrument (BAKUNIN, 2021); one cannot defend the emancipation of dissident bodies through institutions, as this would be the same as striving for freedom by means of the very same instruments that produce impris-

onment. Only through libertarian means — that stand against the authoritarianism of institutionalized scientific knowledge — can we glimpse emancipation.

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