Challenging a sacrosanct tradition?

Analysing the governing of gender through policies for trans healthcare.

by

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Statement of Originality

To the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes. I declare that the intellectual content of this thesis is the product of my work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Rebecca Louise Howe, 6.10.2023

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As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements above are correct.

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Abstract

Depathologisation in trans health exists because of sustained, polyvocal opposition to the structural violence of imposing psychiatric classifications upon people seeking access to gender-affirming medical technologies. Concentrating on approaches to depathologisation in trans health, this thesis considers how the regulation of access figures in the colonial mechanisms of maintaining populations on stolen Indigenous lands. It argues that challenging the current illness model and evaluating a proposed alternative model of rights requires sustained critical interrogation of the liberal and colonial governing that a trans health policy relies on and is producing.

This thesis uses Carol Bacchi's What's the Problem Represented to be? (WPR) approach to compare the World Professional Association of Transgender Health (WPATH) *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, version 7 (the SOC-7) to the *Best Practices Guide to Trans Health Care in the National Health Care System* (the Guide), created by the Spanish Network for Depathologization of Trans Identities. Since access to medical technologies hinges on the external, professional judgement of whether a person's gender-related distress qualifies them for treatment, the analysis demonstrates how the SOC-7 advances a logic of medicalisation for governing access and enacting depathologisation. The SOC-7 undermines attempts to rework a gatekeeping position by pressing people into status relations established and maintained by psy-professions, Western medicine, law, and citizenship. In contrast, the Guide problematises the entire illness-based paradigm arguing that the Western, medico-scientific model of sexuality, the body, and gender has colonially conditioned trans health. It demands access without illness diagnosis, autonomy, and accompaniment in decision-making, improving knowledge about medical technologies, and state-funded healthcare. It offers an alternative policy for the Spanish health system and a proposal to formulate multiple responsive, place-based, non-pathologising protocols through an alternative yet liberal logic of rights. The analysis shows how the Guide's approach could disrupt the state-securing colonial conditions governing gender highlighting limitations of a liberal reconfiguring of practices, relations, and structures of governing access.

This thesis argues that without ongoing critical scrutiny of the colonial power that operates within the existing approaches, the possibility of total depathologisation of gender self-designation and the realisation of positive transformation in trans health policy is politically limited. This critical engagement with trans health policy in international and national contexts contributes to continuing scholarship, activism, and healthcare practice by showing how policy can generate productive uncertainty about strategies to depathologise and disturb the operations of colonial power.

Dedication

“I want to ask what it is to live an intelligible and admirable life—what the structures of subjectivity look like from perspectives other than those of normalizing privilege. The question is an explicitly transcendental one: It starts from what I take as the fact that such lives are lived, hence livable, and asks after the conditions of that possibility.”
—Naomi Scheman, 1997.

For you, with tenderness and poetry, a paisley shirt, and cherry docs.
For you, with fiery comments and a fierce heart that knows what belongs in the bin.
For you, gesturing the ropes of connection with strength in knowing.
Your lives have shaped my politics and purpose. I offer this in honour of you.

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List of Abbreviations

The following is a list of abbreviations used in this thesis.

APA:	American Psychiatric Association
CPATH:	Canadian Professional Association for Transgender Health
DSM-III:	Diagnostic and Statistical Manual of Mental Disorders, Third edition
DSM-IV-TR:	Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, Text Revision
DSM-5:	Diagnostic and Statistical Manual of Mental Disorders, Fifth edition
HBIGDA:	Harry Benjamin International Gender Dysphoria Association
ICD:	International Classification of Diseases, with eleven editions
NGO:	Non-governmental organisation
The Guide:	Best Practices Guide to Trans Health Care in the National Health Care System
SOC-6:	Standards of Care for Gender Identity Disorders, Version six
SOC-7:	Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7
SOC-8:	Standards of Care for the Health of Transgender and Gender Diverse People, Version 8
STP:	Spanish Network for Depathologization of Trans Identities
WPATH:	World Professional Association for Transgender Health
YPs:	The Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity
YP plus 10:	The Yogyakarta Principles Plus 10: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics to Complement the Yogyakarta Principles

List of Tables

The following is a list of boxes and tables used in this thesis.

Chapter 1
Concerning Governing

The governing of gender involves many activities, from allocations within educational, health, sporting, and carceral institutions to its coding in data management platforms, making travel arrangements, using honorifics, entering public facilities, and more. This thesis is concerned with the governing that takes place when particular bodily configurations and healthcare approaches are regarded as sacrosanct and immutable. Recognising that the corresponding practices have deeper colonial purposes, this thesis focuses on the governing that occurs when people seek to modify their bodies using gender-affirming medical technologies. Despite perceived achievements, a half-century of referring to some gender identities and expressions in mental illness terms has far-reaching effects. Movements for depathologisation in trans health exist because of sustained, polyvocal opposition to the imposing of psychiatric classifications on people who request access to care. It is from within these complex webs of interconnected practices that this thesis sets out to analyse and compare the approaches to depathologisation in an established set of professional standards and an alternative best practices guide. If the goal of depathologisation is to no longer conceptualise gender self-designation as a mental illness, how does it apply when responding to requests for access to gender-affirming medical technologies? How does relinquishing psychiatric classifications form into governing within trans health policy? Going further, how do these shifts figure in existing colonial mechanisms?

I explore these questions by analysing and comparing the World Professional Association of Transgender Health (WPATH) *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, version 7 (the SOC-7) (Coleman et al., 2012) to the *Best Practices Guide to Trans Health Care in the National Health Care System* (the Guide), created by the Spanish Network for Depathologization of Trans Identities (2010). I use the critical What's the Problem Represented to be? (WPR) approach to policy analysis, developed by Canadian-Australian feminist political theorist Carol Bacchi (2009), to examine a contested illness-based paradigm and an

alternative, rights-based model for care as two ways of approaching depathologisation in trans health, with the purpose of scrutinising different strategies to bring about the end of pathologisation. I examine these approaches not only because pathologisation in trans health policy structures harmful practices and relations, but also because it helps secure colonial state power that maintains populations on stolen Indigenous lands. I argue that dismantling an illness model and establishing a proposed replacement model of rights necessitates sustained critical interrogation of the liberal and colonial governing that a trans health policy rests upon and produces.

My position and responsibilities

I examine approaches to depathologisation because I noticed this term kept appearing to describe improvements in access to gender-affirming medical technologies, despite the ongoing presence of many harmful pathologising practices. I worked in the youth homelessness sector for nearly two decades, primarily in case management roles and coordinating social support programs at a specialist service for young people with diverse bodies, genders, and relationships, their families and communities. Many young people turned up at the service to find out how they could access gender-related support. I regularly discussed ways of accessing medical technologies and participated in conversations about "care" with young people as they shared their expertise with one another.

I was working during a time of intensive activism sparked by the revisions of the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR) (American Psychiatric Association, 2000) and the Harry Benjamin International Gender Dysphoria Associations Standards of Care for Gender Identity Disorders, version six (SOC-6) (Meyer et al., 2002). I became aware of depathologisation struggles through reading the critiques and proposals concerning diagnoses in the DSM-IV-TR chapters on Paraphilias and Sexual and Gender Identity Disorders that included "Transvestic Fetishism", "Autogynephilia", "Gender Identity Disorder of Children" (GIDC), and "Gender Identity Disorder Not Otherwise Specified" (GIDNOS) (see Appendix, Policy Overview).

I was further politicised when I situated the policy critiques and commentary alongside the experiences young people shared of psy-professionals mobilising diagnostic criteria for regulating their access to "care". I began thinking deeply about approaches to depathologisation and asked myself, "does saying it make it so". By questioning whether a professional association can say it is depathologising while maintaining an orientation toward mental illness diagnosis and treatment, I found myself wondering what it would look like to redesign non-pathologising systems of healthcare. What if people could voice a desire to modify their bodies within a healthcare system designed to meet that request? What if there was a relinquishment of the current system focused on restriction and, more trenchantly, supporting health practitioners to mitigate against its perceived risks? These questions sparked others about paternalism, constructions of scarcity, understandings of agency, the inducements of racial capitalism, and the structures that fix colonial societies in place.

Based in the US, critical scholar Hil Malatino (2020) has spent their career dismantling the idea that biological sex is binary and theorises the exhaustion felt by trans people "in a culture that is alternatingly, depending on where you're at and who you are, either thinly accommodating or devastatingly hostile" (p. 5). After many years of working in an Australian community services sector equivalent to that culture, I returned to university to qualify as a professional social worker. I was then accepted into a PhD program to research trans health policy. Early on, a friend asked if my research would help trans people access hormones and surgeries. Asking this question was necessary because of where I am and who I am. I research from within overlapping structures of privilege and disadvantage because I am a white settler living on unceded Country, a queer cis woman, a precarious contract worker with social mobility, and an adopted person who has been living with diabetes since early childhood. When I went to answer my friend, I came up short. I struggled to see how this research could contribute much more than critical discussion and theorisation to the ongoing efforts for trans depathologisation on the ground. The composite parts of who I am present entry points for this research. Still, the fact remains that I am outside the we/us survival Malatino (2020) is pursuing when theorising "how we cultivate arts of living that make us possible" (p. 5). The efforts I make in

response to my social location are ongoing. I am regularly reminded that situating where I am and who I am is only one of many ways of understanding that I have responsibilities and limits in my actions. As a cis person researching trans health policy in a set of interlocking structures that disproportionately benefits people who are racialised as white, I am responsible for researching in a non-extractive manner. That is to say, I am responsible for asking and negotiating how I may be of use to the people involved in the struggles for just relations. It is from this location and with these responsibilities that I took up a poststructural methodological approach that included researching reciprocally with practitioners who work in support of people with self-designated genders.

As I began to shape my observations and questions about depathologisation into a research project, I began to think deeply about the directions First Nations scholars and activists make available to confront the foundations of colonial society. Reflecting on how pathologisation is part of colonisation, I began seeking the connections between anti-pathologisation and anti-colonial activism. In their published correspondence, Robyn Maynard, a Black Canadian writer and scholar, and Leanne Betasamosake Simpson, a Michi Saagiig Nishnaabeg scholar, writer, and artist (2022), discuss the complexities of recognition in contemporary abolitionist anti-colonial activism. From these conversations, I began noticing how the settler colonial state requires constant recognition of itself through identity documentation and citizenship processes established and maintained in the face of First Nations sovereignty and refusal (Maynard & Simpson, 2022). These artefacts and practices are part of the conditions of settler colonialism that, as Koenpul Indigenous studies scholar Aileen Moreton-Robinson (2006/2020) shows, interact with sustained assertions of sovereignty by Aboriginal and Torres Strait Islander people, "demonstrating that colonisation is a living process" (p. 2). Prompted by these lessons and the work of non-native settler scholar and political theorist Kevin Bruyneel (2021), I began appreciating the depths of settler disavowal. I wondered what it would look like to abolish pathologisation as part of dismantling the colonising mechanisms that attempt to maintain populations within set limits. In pursuing these lines of thinking, I began noticing how First Nations make clear the moral demands of Indigenous sovereignty and reciprocity in multiple ways.

I was taught Indigenous theory in the context of the academic field of social work (e.g. Bennett, 2019b; Muller, 2014b). At the same time, I was given opportunities to build relationships and work in culturally responsive ways by a Torres Strait Islander colleague and a broader network of Sistergirl, Brotherboy, and Aboriginal and Torres Strait Islander LGBT people, working culturally within and for the wellbeing of their communities. Through this learning, which included negotiating and failing tests that I only later realised were being set, I began to appreciate when I was invited into specific knowledge and spaces and that those invitations came with certain responsibilities. One imperative can be understood through the argument offered by Kānaka Maoli feminist scholar Maile Arvin, Unangax̂ urban education and Indigenous studies scholar Eve Tuck, and Klamath feminist scholar Angie Morrill (2013). It is that "settler colonialism must be understood as a multi-fronted project of making the First Peoples of a place extinct; it is a relentless structure, not contained in a period of time" (Arvin et al., 2013). Appreciating the extensive and enduring processual violences of colonial projects clarifies the scope of this inquiry. A further task appears in the forewarning from another Kānaka Maoli critical scholar, J. Kēhaulani Kauanui (2016), that to focus on the settler-colonial without any meaningful engagement with Indigenous polities is another form of elimination of the alternative, prior First Nations presences. It means that my position as a cis person researching trans health policy entails relational and ethical obligations, as does my position as a settler living on stolen land. These involve developing skills through repeated practice, locating my position and limits, and noticing the lessons that help me appreciate what is required. My obligations and these invitations to responsibility are far from onerous; they are energising in that they set out a path for action.

Research context and scope

This research is situated within an ongoing challenge to the use of mental illness diagnosis in regulating access to gender-affirming medical technologies. This objection is part of a broader struggle for choice over the use of medical technologies that are tethered to multiple forms of social and state recognition. Attention to its politics remains a crucial part of this struggle, particularly an awareness of how recognition functions to acknowledge the existence, legitimacy, and legality of

being. Psychotherapist Y. Gávriel Ansara and psychology researcher Peter Hegarty (2014) clarify one of its essential elements, arguing that because "authorities in English language contexts typically assign 'permanent' gender at or before birth … people's own descriptions of their genders and bodies are treated as invalid unless they are typically associated with their assigned sex designations" (p. 259). Identifying this practice of negation and its place in Western medical understandings of gender and bodily configurations was a crucial starting point for the critical literature surrounding trans health.

Foundations and histories

Over fifty years, multiple concepts have been incorporated within the prevailing diagnostic manual for mental disorders, disease classification system, and professional standards that establish a "care" protocol for health practitioners. The practices of external assignation and authoritative diagnostic, classificatory, and procedural texts combine to produce a powerful system of governing gender. Yet, for generations, people have used multiple means to counter this knowledge disqualification and resist the "disordered" classification of gender self-designations that differ from an external attribution. Examples of such refusals and negotiations include novels with canonical status and a clarion call to liberation (Feinberg, 1993, 2003; Hall, 1928, 1990), field inaugurating dispatches (Stone, 1991; Stryker, 1994), principles for research and writing (Hale, 1997), rigorous empirical research (Namaste, 2000), philosophy (Bettcher, 2007, 2009), and a challenge to its prevailing whiteness (Koyama, 2003) and disablism (Clare, 2015; Withers, 2014). These are components of the crucially resistive foundations for the current field. Yet, medical sociology, gender, inequality, and social movements scholar stef m. shuster (2021) also demonstrates that these contributions remain vital because the authority over access to medical technologies and the expectations of those who request them has only increased over time. Another is because of the sustained and often vitriolic anti-trans discourse that emanates from multiple quarters in numerous countries (see Vincent et al., 2020).

As the scrutiny of English-language authority implies, scholars have also disputed these knowledge

practices as grounded in deeper colonial histories. As queer theory, transgender studies, transnationality and immigration, political economy, and labour scholar Aren Aizura (2018) explains, "colonial and racial violence set the scene for knowledge production about transgender subjects" (p. 10). These include the violent imposing of French, English and Spanish as languages of power in colonised places and declaring some gender identities and expressions as illegitimate, justifying their elimination. Wiradjuri anti-colonial scholar Sandy O'Sullivan (2021) skilfully identifies how the colonial project of gender requires persistent erasure of multiplicity and complexity because it is about rendering only some formations of bodies, genders, and relationships visible for governing. Lohana Berkins (1995/2019) of the Kolla nation was a prominent travesti activist based in Argentina who carefully explained "that framework, that worthlessness, society imposed that on me. This is a bruisingly violent society" (p. 12). Persistent rejection of these governing practices by First Nations peoples occurs in varying forms of every day and organised resistance. For O'Sullivan (2021), insisting on the complexities of gender is a position against the reductive representations that are the marker for First Nations peoples' "continued management within the colonial project, through the colonial structures and restrictions still held in place" (p. 8). As Berkins (1995/2019) argues so powerfully:

> It's not that the only thing I am is travesti … I insist on the question of our struggles. I believe we need to rethink it completely and be inclusive. I'm also struggling for people without land, I am absolutely devastated by poverty, I fight against the rich, I fight against every kind of oppression. (pp. 17-18)

The lesson I take from O'Sullivan and Berkins is rejecting the limited inclusion produced by racial liberalism, as those efforts to absorb complexity and multi-issue struggle into advocacy and activist movements are too often left unchallenged. Offering intricacy and contestation in response to the question of struggle is partly how such expansive academic and community-based literature has emerged. It variously critiques and condemns the pathologisation of people with self-designated genders within diagnostic manuals, medical classifications, and professional standards while

challenging the colonial conditions that sustain their use.

The current context

It is against this backdrop of anti-pathologisation and anti-colonial efforts that this thesis analyses and compares the SOC-7 and the Guide. Centring attention on the biopolitics of settler colonialism within its theoretical framework, this research uses the interconnected forms of questioning in the WPR approach to consider the approaches to depathologisation in each policy in light of their underpinning assumptions, histories, surrounding contexts and colonial conditions. This research builds upon considerable literature analysing and condemning the SOC and the accompanying DSM and International Classification of Diseases (ICD) for their pathologisation of people with self-designated genders. Austin H. Johnson is a sociologist whose scholarship aims to understand how gender operates as an axis of inequality in health, healthcare, and medical contexts. At this broad level, Johnson (2015) contends that a medical logic that simultaneously legitimises and restricts access to gender-affirming medical technologies via "continued psychiatric diagnoses" has developed into "a hegemonic medical model for understanding transgender people's experiences of gender over the life course" (p. 804). In this fraught space, there is an extensive analysis of how people with self-designated genders who request access to gender-affirming medical technologies experience the SOC-7 and its predecessors, alongside an analysis of how practitioners use these protocols. Sociologists Jodie Dewey and Melissa Gesbeck (2017) set their focus on provider experiences using DSM-IV-TR diagnostic criteria to meet requirements for access to medical technologies in the SOC-6. Confirming previous findings at a more granular level, their interviews with service users and health professionals in the US show how the diagnosis that purportedly legitimates gender self-designation in medical systems permits and works against access to "care" (Dewey & Gesbeck, 2017). Australian sociologist Riki Lane (2018) examined how the debates about and changes in the DSM-5 and SOC-7 translate into practice at a prominent Australian gender clinic. Drawing upon relevant literature, interviews with practitioners and observation of clinical review meetings, Lane (2018) discusses an ongoing shift from gatekeeping to a more collaborative model in "care". Findings of practice adjustment in this

context demonstrate that activism, increasing numbers of practitioners with self-designated genders, and "the declining influence of explicitly pathologising "old guard" clinicians" have increased access to different technologies (Lane, 2018, p. 208). Ruth Pearce is a social researcher and activist specialising in transgender studies and community development who used a different approach in her research. Pearce (2018) uses a seven-year, internet-based ethnography on trans healthcare in the UK to illustrate how discourses and practices of trans health involve constant negotiation of position, requirements, provision, experience, and temporality on a range of personal, collective, and political levels. Pearce (2018) extends her research beyond the effects and uses of policies to examine negotiations and challenges for change. This inquiry occurs alongside multiple analyses of how depathologisation is proceeding. For example, Zowie Davy, whose sociological research centres on medico-legal constructions of gender and sexuality in healthcare, undertook a meta-narrative review with legal scholar Anniken Sørlie and social anthropologist Amets Suess Schwend (2018) that revealed an uneven engagement with a depathologisation perspective. There was less engagement with anti-pathologisation critiques at the policy development level and more at localised levels of direct service provision (Davy et al., 2018). In many ways, the research elaborates on what Lane (2018) identifies as "the defining tension in the clinical relationship between access (to treatment and insurance coverage) and pathologisation" that informs revisions to existing policies (p. 208). This seemingly inescapable imperative for policy change is underscored by a consensus from historians who examine the development of the field. The position, sharply articulated by trans historian Jules Gill-Peterson (2022), is that "transgender medicine was deliberately intended by its architects to prevent and limit as many trans people as possible from transitioning" (para. 1). These tensions and realities result in calls to develop approaches to address gender complexity in the context of people's survival (see, Diamond & Kirby, 2014; Elkin et al., 2022; Hines et al., 2018).

The current context of research in the field of trans health is primarily sociological. There is a notable lack of social work scholarship considering the emphasis on practices and power in clinical relations between practitioners and people requesting access to "care". There is increasing critical attention to institutional and service provision change (e.g. Kia et al., 2021). Yet, coming to this analysis from a

place of practice with a limited base for theorisation means this analysis necessarily works across multiple disciplines and fields of study.

Questions of politics

In trans health, there is an almost exclusive focus on the provision of gender-affirming medical technologies, often to the exclusion of other forms of healthcare. However, as Chinese American genderqueer psychologist Sand C. Chang (2016) argues, rigorous analysis requires attention to and rejection of the pervasive assumption that a person can only genuinely affirm their self-designated gender through the use of medical technologies. While adhering to the current emphasis, this thesis upholds the rigour Chang demands by broadening the scope of the analysis to consider the conditions surrounding medical technologies. It is what I understand Canadian philosopher Cressida J. Heyes and feminist theorist J.R. Latham (2018) to convey when they ask, by what means can "we make possible a politics of self-transformation (and access to medical services) that allows for being trans in more ways?" (p. 175). This question also expresses the political impetus for this research.

An emphasis on that which allows for being is crucial because there are so many apparatus involved in regulating access to medical technologies. For example, sociologist and practising psychotherapist Michelle O'Brien (2013) shows the connections between her use of oral and intramuscular hormones, several multinational pharmaceutical manufacturers, the US insurance-based healthcare system and the companies that exclude this "care" from coverage, the transnational free trade agreements between Mexico, Canada and the US that allow her to "shop around" for affordable alternatives, and the criminalisation and regulation of access to injecting equipment. This access to medical technologies occurs within a mixture of state-subsidised and privately owned healthcare systems shaped by the DSM, ICD, and SOC in conjunction with a vast array of extraneous legal and legislative processes. Thus, as O'Brien (2003) asserts, "healthcare is a major site in defining, and transforming, what race

and class domination mean in our day to day lives" (p. 11). US-based philosopher and queer theorist Jasbir Puar (2017) identifies this as a further tension since "many trans bodies are reliant on medical care, costly pharmacological and technological interventions, legal protections, and public accommodations from the very same institutions and apparatuses that functionalize gender normativities and create systemic exclusions" (p. 35). It prompts Puar (2017) to ask: "How do people who rely on accessing significant resources within a political economic context, where the possessive individual is the basis for rights claims—including the right to medical care—disrupt the very models on which they depend?" (p. 35). Cultural theorist C. Riley Snorton and sociologist Jin Haritaworn (2013) situate this tension in an "uneven institutionalization" of the political imperatives of women's, gay, and trans social movements that "produces a transnormative subject, whose universalized trajectory of coming out/transition, visibility, recognition, protection, and self actualization largely remains uninterrogated in its complicities and convergences with biomedical, neoliberal, racist, and imperialist projects" (Snorton & Haritaworn, 2013, p. 67). This investigation is thus informed by literature that delineates and examines the effects of these apparatus and their location in dense webs of power. It contributes to ongoing scholarship and activism by clarifying how multiple fields — particularly transgender studies, critical Indigenous studies, and settler colonial theory — can link to trans health and critical policy analysis.

Situating this analysis

The existing literature thoroughly examines changes in established protocols and practices, situating them in the context of entrenched medical authority, overall progress narratives, constant negotiation over access, and to a certain extent, racial capitalism and its colonial conditions. Examining the different approaches to depathologisation in trans health is crucial because the proposed alternatives for this "care" receive much less critical engagement. Informed consent receives substantial attention because it is the most prominent alternative and emphasises processes of decision-making in "care". Sarah L. Schulz (2018) is a mental health, medical sociology and gender studies scholar and

psychiatric social worker who provides an overview and evaluation of the emergence and use of informed consent. Under some of these models, access is granted based on an ability to consent to care rather than discerning whether a person meets psychiatric diagnosis criteria (Schulz, 2018). Consent is presented as part of the necessary shift "to remove the distress narrative from the center of the transgender experience, and allow for a more nuanced understanding of gender variance than what the diagnostic model offers" (Schulz, 2018, p. 88). Florence Ashley, a transfeminine academic and activist, Colton M. St. Amand, a physician, and G Nic Rider, a psychologist and coordinator of transgender health services, provide a concise overview of the range of informed consent models in Canada and the US. They argue for attentiveness to the diversity of this proliferation to better account for their use and efficacy in responding to pathologisation (Ashley et al., 2021). A touchstone for the analysis in this thesis is the critical comparison of the SOC-6 and the Guide by science and technologies studies scholar Esther (Mayoko) Ortega Arjonilla (2014), who shows how the Guide is a pivotal policy for analysis, not because it contains a proposal for informed consent but because it offers a stand-alone alternative to existing policies that is neither a reform nor an addition—it is unique in the field. This thesis contributes knowledge at this point in the rapidly changing and embattled field of trans health. It maintains the relevance of the Guide's approach to depathologisation by comparing it to the subsequent SOC-7.

This thesis asks two key questions that follow from the dedication quote from feminist philosophy scholar Naomi Scheman (1997), who presses home the fact that trans lives are lived in multiple ways that precede and exceed a request for body modification. Philosopher C. Jacob Hale (1997) and colleagues, who offer *Suggested Rules for Non-Transsexuals Writing About Transsexuals, Transsexuality, Transsexualism, or Trans* invite scholars to begin any work from a premise that "lives are lived, hence livable" (Hale, 1997, para. 9). This foundation supports research that "asks after the conditions of that possibility" for a livable life (Scheman, 1997, p. 132). This research asks two questions about the forms of governing in trans health policy:

1. How does the governing of gender through the governing of access to gender-affirming

medical technologies operate in the SOC-7 and the Guide?

2. How is this governing connected to settler colonialism?

Terms of analysis

This research examines approaches to depathologisation at the point in the literature between significant critiques of existing policy and the scant critical engagement with proposed alternatives. It offers a critical comparative analysis of two policies that uses specific terms and phrases in conjunction with a poststructural sensibility and a particular politics of citation. It also discusses the problem representations within the policies under examination as part of conversations. Consequently, these distinct components of the analysis are described from the outset.

Phrasing

Some terms and phrases that appear in this writing warrant an explanation. By way of context, Aizura (2006) explains that the diversity of terms across multiple spaces "reflects the reality that people engage in many different kinds of practices to negotiate the bodies they are born with, and the possibilities for modifying, re-signifying or living with those bodies" (p. 296). I am taught through my relationships that it is not for me to tell someone else's story. Accordingly, there is a certain discomfort in using the word trans as an umbrella term that encompasses transgender, transsexual, non-binary, gender diverse, gender non-conforming, and more. Nevertheless, I do appreciate historian, author, filmmaker, and theorist Susan Stryker's (2017) explanation of trans as "the movement across a socially imposed boundary away from an unchosen starting place, rather than any particular destination or mode of transition" (p. 1). Considering the attempts at universalising the word in the 30 years following its reclamation as a tool for activism, Aizura (2006) argues that it is crucial to remain sensitive to the likelihood that many embrace a term that some people disavow. I take up his request to read all the identity categories that I use in this thesis, "under erasure" (Aizura, 2006, p. 291).

On these grounds, I adopt the language practice of Ansara and Hegarty (2012), who use the phrase "people with self-designated genders" to de-naturalise external, binary gender assignation (p. 141). I use this phrase alongside the terminology used by the scholars, activists, and participants who appear in this research. This language practice aligns my writing with obligations that stem from my social position to attend to First Nations Peoples' sovereign assertions of languages, cultures, and complex relational identities (Barker, 2017; O'Sullivan, 2019). In this thesis, I also use the term affirmation to describe particular ways a person may move across a socially imposed gender boundary. I use the terms medical gender-affirmations and gender-affirming medical technologies to describe the means of body modification. The details of a specific technology are included where relevant. In this language practice, I consider surgical procedures as technologies to communicate complexity. Trans health researcher Shoshana Rosenberg, practitioner Elizabeth Duck-Chong, and advocate Teddy Cook (2021) explain that the term "gender affirming surgery" often obscures how many of these exist and that they "happen in phases, require revisions, and are often the result of several individual procedures combined" (p. 1). I also use the phrase medical technologies classified as gender-affirming to signal critical interrogation of such governing practices. These terms and phrases are not intended to forgo the utility and politics of current terminology. Instead, I use this language practice to situate myself within those politics per the intentions of those who seek to develop, transform, and reawaken language that resists pathologisation while engaging the diversity of human gender identities and expression.

A poststructural sensibility

The analysis in this thesis is driven by a poststructural sensibility that interrogates the representations of "problems" in policies to understand how particular ways of thinking become privileged over others and how they shape and are shaped by practices and influence change. A WPR approach views policies as governmental texts (Bacchi, 2012). Consequently, this research into the governing of gender and access consists of a primary data set that applies its questions to each policy and additional

data generated through facilitated group policy analyses using an abbreviated WPR approach. Bacchi and her colleague sociologist Susan Goodwin (2016) argue that policies are not only "the activities of state institutions" but also those of "other agencies and professions involved in maintaining social order" (Bacchi & Goodwin, 2016, p. 17). For this reason, I recruited members of a community of practice for counsellors and psychologists to inform this critical comparative analysis of policies developed by a professional association and a network of activists.

Paraphrasing Bacchi and Goodwin (2016), the WPR approach helps me reflect critically on governing practices, theorise my location within these, and resist those that cause harm. Some of this sensibility is demonstrated in how I have located my social position and responsibilities and introduced the research context, scope, and questions. It also permeates the text through quotations, which signal that the assumed fixed status of a particular term or concept is contestable. It can be enticing to liberally (pun intended) deploy quotation marks. However, this visual indication that a term is contested requires some justification for its placement. Historian and settler colonial scholar Patrick Wolfe (2011) has cautioned against the use of what he termed "exculpatory quotation marks" and their work to relieve an author of a deeper analysis; particularly as he points out, in attempts to de-naturalise terms such as "race" (p. 274). Given this warning, I deploy quotations in this thesis just as the WPR approach is deployed: as an analytic strategy.

I place quotations around "Gender Dysphoria" to signal objections to its construction and imposition as a psychiatric diagnosis, not to question its use by people with self-designated genders to describe their experiences. I also use quotations to challenge assumptions of the fixed status of "care". These efforts are influenced by Dutch ethnographer and philosopher Annemarie Mol. In *The logic of care: Health and the problem of patient choice*, Mol (2008) contributes "to theoretical repertoires" that face, rather than turn away from experiences of ill-health and upset presumptions of mutually exclusive categories (p. 13). In the context of this research, these are inter- and extra-disciplinary assemblages that trouble categories in "care" (patient/practitioner) and in knowledge production (participant/researcher). Crucially, Mol (2008) draws upon the minutiae of interactions between

people with diabetes and medical professionals to "gradually flesh out" the notion of "good care" that is "silently incorporated in practices and does not speak for itself" (p. 2). These are interactions about externally managed bodily functions — testing blood sugar levels and injecting insulin — which I embody. Another influence is an argument by sociologist Aryn Martin, settler-Canadian anthropologist Natasha Myers, and Portuguese sociologist Ana Viseu (2015) for consideration of care as a critical practice. One that expands attention beyond actions to consider the conditions of its possibility; "exploring care's potentialities before it has latched onto an object" so that "care is not only a practice and an outward action but also a willingness to respond" (Martin et al., 2015, p. 634). Situating and extending "care" in these ways supports a poststructural sensibility and aligns with my responsibilities in this research and beyond.

Politics of citation

There is a particular politics of citation in this thesis that has three parts. The first is that it provides an introduction for every referenced author. It is a practice modelled on the messy, inconsistent introductions offered by Vikki Reynolds (2013), a community activist, instructor and therapeutic supervisor who works and lives on unceded Musqueam, Squamish, and Tsleil-Waututh territories, in the place now known as Canada. These often-clumsy statements are intended to draw attention to what can be taken for granted about an author's position and ideas. As Reynolds (2013) points out, an "absence of locating information" can often, but should not always, "be taken as indicating dominant locations" (p. 2). The information I use to introduce authors is gathered from the publicly available author biographies via a google search at the time of writing. Noticing the particularities of absence is crucial. For example, though I prioritise scholarship by people with self-designated genders in this thesis, this location may not appear in an author's bio. Reynolds (2013) argues that an absence can more effectively point to the "complex and multifaceted" nature of identities, along with the limitations of dominant social and linguistic norms "in making space for people" to express them (p. 2). The introductions in this thesis offer another way to connect with those whose work is referenced. The second component is the use of citation to recognise the lineage of ideas. In this thesis, citations

are a written practice of acknowledgement that honours those who have given ideas before us. The third is an attempt to bring forward through writing the people to whom I owe a debt of knowledge. These people, collectives, and movements have offered lessons academically and through being in practice together. These writing practices can be understood as a way of thinking about critique and what can be built from it.

Problem representations as conversations

This thesis understands the making of "problems" in "care" as speaking in conversations. In other words, I frame problem representations themselves as part of conversations; those within the SOC-7 and the Guide or other policies, not the words of policymakers, activists, or scholars (see Bacchi & Goodwin, 2016, p. 21). This frame expresses practical and theoretical ideas that deepen this examination of the governing of gender through the governing of access and how it connects to settler colonialism. In practical terms, Hale (1997) and colleagues caution people who are writing about gender self-designation to:

> Be aware that our words are very often part of conversations we're having within our communities, and that we may be participating in overlapping conversations within multiple communities, e.g., our trans communities, our scholarly communities (both interdisciplinary ones and those that are disciplinarily bounded), feminist communities, queer communities, communities of color. Be aware of these conversations, our places within them, and our places within community and power structures. Otherwise, you won't understand our words. (para. 6)

Awareness of multiple, overlapping conversations thus compels attention to complex networks of power for a greater understanding of nuance and what's at stake in depathologisation efforts. In a theoretical sense, feminist technoscience scholar Katie King (1994) uses conversations as an analytic category to recognise contingent overlapping and layering forms of political agency in feminist disputes about difference. Ethnographer and historian of social movements Scott Lauria Morgensen

(2011b) builds on this work by interpreting the relations between non-Indigenous and Indigenous queer people and cultures in the US as conditioned by settler colonialism. Crucially, politics in spaces produced by settler colonialism "formed by telling different kinds of stories about the meaning of indigeneity to queer people, which entered them into power-laden conversations that nevertheless remained open to creative transformation" (Morgensen, 2011b, p. x). This attention to conversations has influenced how I situate the problem representations under analysis in a dynamic set of exchanges. I emphasise the presence of conversations at various points in the text to recognise and examine its multiple functions and effects within trans health.

Thesis overview

Within the title of each chapter, gerunds indicate a specific analysis. By engaging the field of trans health, chapter two offers a review of the literature and an outline of the theoretical framework that provides the structure for this thesis. This literature situates trans health policy within a field that, despite sustained activism, is structured by normative, racialised, and constantly contested power differentials. Connecting the literature to the theoretical framework makes the case that critical attention to how biomedical theorisations of "care" function within the biopolitics of settler colonialism can help broaden the narrow scope of the field. Approaching a comparative analysis of trans health policy, chapter three outlines the methodology, methods, and ethical considerations for data collection and analysis in this research. It describes how a WPR approach is used in conjunction with reciprocal research as a strategy for problematising the governing of gender that also encourages crucial scrutiny of the politics and relationships inherent in knowledge production. Chapters five, six, and seven report findings from applying the questions in the WPR approach. These chapters are named and arranged according to the terms Bacchi (2012) uses to explain how these questions work together to create an analytic strategy. Namely, how the WPR questions *clarify* the implicit problem representation within the policy or its proposals, encourage *reflection* on its underlying premises, *consideration* of contingent practices and processes that have shaped this understanding of the "problem", careful *scrutiny* of limitations potential alternatives, assessment of the ways that problem

representations limit was is seen as relevant, shape understandings, and materially impact people's lives, and finally, awareness of the surrounding contestation (see, Bacchi, 2012, p. 22).

Chapter four begins the analysis of the SOC-7 and the Guide by clarifying problematisations. It provides a detailed overview, then works backwards from each policy's proposals for "care" to spell out what the SOC-7 and the Guide represent the "problem" to be. It shows that in representing distress to be a diagnosable health "problem", the SOC-7 is governing access through professional judgement for "treatment". In contrast, representing the entire illness-based model to be a "problem", the Guide proposes a governing of access that suspends a logic of medicalisation. Chapter five moves from clarifying the policy problem representations to reflecting on the underpinning logics. It describes the presence of and interactions between logics, how they are utilised in the concepts that appear in each policy, and how these signal different elements of liberal governing. It argues that the SOC-7 advances a logic of medicalisation for governing access and achieving depathologisation, whereas the Guide offers an open-ended proposal for the formulation of any number of responsive, place-based, non-pathologising protocols through a logic of rights. Chapter six is considering how these problem representations came about by genealogically considering critical moments in "care". With the emergence of the pathologising conditions and their contestation as the driving concern, this genealogical examination looks at 12 critical moments in "care" across time. Considering these moments shows how "care" has been foundational in enforcing a colonial white supremacist binary system of gender. Also, how "care" secures, authorises, and protects hegemonic medical authority and state power. Crucially, though, considering critical moments in "care" shows how these opposing problem representations are formulated through all sorts of tactics for constructing and governing access. Representations of "Gender Dysphoria" and an illness-based model as "problems" thus emerge from a complex interplay of historically contingent, colonially inflected conceptualisations of gender and coexistent practices of governing access to gender-affirming medical technologies.

Chapter seven shifts from responding to a single WPR question to combining three. Scrutinising implications of problem representations brings together scrutiny, assessment, and awareness of what

occurs as a consequence of governing that is configured through the problem representations in the SOC-7 and the Guide. This chapter argues that despite sustained attempts to rework and disrupt gatekeeping relations, the SOC-7 is a continuation of the medical management of appropriate modes of living by maintaining the link between "treatment" and diagnosis. In contrast, the Guide affords the possibility that depathologisation can help reshape the recuperative, obscuring, and settler state-securing colonial conditions governing gender by demanding a transformation of practices, relations, and structures of governing access. Chapter eight discusses the findings from this WPR analysis as forms of preservation and potential abolition. I contend that ongoing critical attention to the models for "care" is imperative for depathologisation in trans health policy. I suggest that understanding the governing that a trans health policy relies upon and is producing is crucial for contesting how the SOC-7 preserves, legitimates, and expands existing illness-based and colonial systems. Further, that such an understanding helps to engage with the productive uncertainty the Guide offers about how to achieve its potential for abolition. Chapter nine concludes this thesis by drawing together the insights from this comparative analysis and comments on the contributions an argument for sustained critical attention on the models for "care" has for the development of trans health policy.

Chapter 2
Engaging the field of trans health

Critically engaging the field of trans health involves understanding it as a convergence of at least two constituent and political elements: namely, the delivery of clinical diagnostic, therapeutic, rehabilitative, preventative, and palliative services for people with self-designated genders; and an academic enquiry into their health and healthcare needs. While the terms health and medicine are often used interchangeably, historian Beans Velocci (2021) notes that "trans medicine" is used as a referent for "the clinical apparatus" that has taken form "around hormonal and surgical interventions for trans people" (p. 477). I adopt the term trans health because it encompasses both the apparatus and the relevant populations. This choice is itself political. Writing as a coalition of Australian cis and trans researchers, Newman and colleagues (2021) see trans health as a field "waiting to be seen" as legitimate inside a context of intensifying contestation; whereas Hanssmann (2016) highlights the importance of the historical narrative that saturates trans health practices, politics, and scope from his location in the US. That is, an historical account of a pathologising sexological classification system that created a foundation for a field of transsexual medicine whose presiding psychiatric authority was consistently disputed by trans people who, through community formation, fragmentation, and bitter struggle, shaped it into the stand-alone field of trans health (Hanssmann, 2016). Noticing how reliably this type of progress narrative was repeated, Hanssmann (2016) began to consider the possibilities of mapping this field in ways that both exceed and extend dominant theorisations of "care" and biomedicine. Hanssmann (2016) is one of many trans scholars who critically engage with this narrative and who offer increasingly detailed, localised maps of the field of trans health. Notably, b. binaohan (2014), a transpinay ladyboy philosopher and writer, argues that the prominent trans health narrative is an inherently white formation; and in alignment with cultural and linguistic anthropologist David Valentine (2007), situates it within a particular social imaginary of trans "community". The two policies under scrutiny in this research are situated very differently within the historical narrative and its social imaginary. The political context of trans health with its multiple points of contention

determines the critical approach that I take to the literature. I argue that despite sustained depathologisation activism, the field struggles to mobilise insights from feminist scholarship, queer theory, and transgender studies toward critical research and theorisation.

In this chapter, I review the literature in this field through a critical project of unmapping trans health and sketching a series of overlays that correspond to its key features. Using this review, I then detail a poststructural theoretical framework used in this thesis – one that is centred on examining the biopolitics of settler colonialism that creates and naturalises the conditions through which the governing of gender self-designation occurs. Based on this critically engaged literature review, I locate trans health policy within a field that is structured by racialised, normatively gendered, and continually contested power differentials. I suggest that directing attention to how the dominant biomedical theorisations of "care" function as part of the biopolitics of settler colonialism is an approach to policy analysis that broadens the narrow scope of the existing field.

Unmapping trans health

Adding the prefix un- to the verb map denotes an interrogatory position from which to approach the relevant literature. I offer an unmapping of the field of trans health in which I situate a selection of historical and psy-literatures alongside critical scholarship to illuminate the maintenance and contestation of a hierarchy of social relations. The notion of unmapping was put forward by human geography scholar Richard Phillips (1996, 2013) as a critical project of denaturalising geography and, consequently, calling into question the world views that rest upon it. Feminist critical race scholar Sherene Razack (2002b) uses unmapping to reveal how the organisation of settler colonial spaces and places maintains unequal social relations through systems of domination, then further shows how these social relations also give shape to spaces. Unmapping thus denaturalises ideas of white settler innocence which characterises European colonisers as simply settling upon and developing land by foregrounding the various systems and practices of conquest and control that enabled settling (Razack, 2002b, p. 5). In order to consider the multiple systems that constitute trans health as a space,

requires – as Razack (2002a) argues – attention to "the dialectical relationship between spaces and bodies" and to "how the symbolic and the material work through each other to constitute a space" (p. 8). I thus unmap the field of trans health by examining some of its preliminaries; a selection of its medical literature; and the spaces created for knowledge production by the subjects upon whom it was built. I argue that each of these three areas contributes to the organisation of trans health as a conceptual and tangible space that maintains a profoundly racialised power differential between professional knowledges and lived expertise of people with self-designated genders for sanctioning and providing "care".

Preliminaries

I begin with preliminaries because discussion of how gender self-designation came to be represented as a psychiatric "problem" in the late nineteenth century often circumvents assertions from Indigenous scholars, such as binaohan (2014), that "prurient, cis interest" in nonnormative genders "did not start in white countries focused on white bodies" (p. 105). Razack (2000) argues that unmapping requires historicisation by asking what is being imagined or projected onto specified spaces and bodies and what actions occur in those spaces and upon those bodies. I unmap the preliminaries by highlighting what is being imagined about and projected onto colonised bodies in colonised spaces and what bodily classifications are occurring in colonising places. I suggest these actions prepare the way for a pathologising medical literature to flourish in Europe and North America.

A Spanish Jesuit priest named Francisco Ignacio Alcina is a key figure whose writing highlights what is imagined about and projected onto spiritual spaces and bodies during the Spanish colonisation of the Philippines in the late sixteenth and early seventeenth centuries. Gender studies scholar Carolyn Brewer (1999) offers an account of the conclusions reached about bayog and asog (highly respected religious figures of the Tagalog and Visayan areas in the Philippines) based on the writings of Spanish colonial missionaries, explorers and administrators. Brewer (1999) describes how Alcina reported in 1668 that he had "located a genuine shaman as a research subject" an asog who maintained ancestral

spiritual practices yet in the presence of "the 'new world' of the Spaniards … modified their behaviour accordingly" (para. 16). Alcina's report appears in the context of notorious Inquisitional investigations — the violent suppression, surveillance, and violation of Indigenous peoples — that imposed Catholicism partly because the pre-existing gender systems were "incomprehensible within the binarist and patriarchal gender system" (binaohan, 2014, p. 105). Thus, any examples of behaviours that did not conform to established Spanish Catholic norms induced speculation regarding not simply "their 'defective' anatomy and possible links to sexual preference" (Brewer, 1999, para. 13), but also "satanic spirits" (para. 37). Alcina had a particular "curiosity regarding the 'deficient' genitals of the *asog"* that "remained unfulfilled" since he admitted this person maintained boundaries prohibiting physical contact and intimate observation (Brewer, 1999, para. 18, emphasis in original). Even as Alcina lacked verification to substantiate the claims in his report, "it is undeniable that Catholicism itself had a huge impact in regendering" Indigenous peoples "to conform to Hispano/Catholic sex/gender congruence" (Brewer, 1999, para. 24). For binaohan (2014), "these spanish colonialists literally were incapable of comprehending the existence of bayog or asog without reducing us to our bodies. Without speculating on our genitals [and] seeking to violate our consent with their white gaze" (p. 105, non-capital letter in original). Thus, "it was, at first contact, the way that our bodies were rendered inert and inhuman, as objects of study … [that] we became dehumanized and deviant" (binaohan, 2014, p. 106). The impossibility of these Spanish colonisers imagining bodily ways of being outside their religiously driven relations of domination is an example of how it was possible to create a position for unintelligible, non-conforming bodies as an object outside of what they regarded as human.

The Swedish naturalist Carolus Linnaeus is a prominent historical figure whose writing in the early to mid-eighteenth-century highlights how a specific taxonomic action bolstered the social hierarchies created in European places that were actively colonising "other" places. History of science scholar Londa Schiebinger (1993/2000) investigated the implications of Linnaeus's 1758 introduction of *Mammalia* — a Latin term for "of the breast" — as one of the six "classes" of animals in his zoological taxonomies (p. 11). Schiebinger (1993/2000) notes that Linnaeus' choice of *Mammalia*

over non-gendered terms "such as *Aurecaviga* (the hollow-eared ones) or *Pilosa* (the hairy ones)" was a political act that did two important things (p. 12, emphasis in original). First, it signalled that a concern to construct "universally comprehensible" notions of "nature" was saturated "with middle-class European notions of gender" (Schiebinger, 1993/2000, p. 24). The consequence of relegating a "class" of animals to a subordinate gender was that it legitimated a position for propertied European white men at the top of a system of social ordering. An argument it was "natural" for "females both human and nonhuman – to suckle and rear their own children" was used to bolster an argument for denying upper-class European women political power by confining them to tasks of child rearing (Schiebinger, 1993/2000, p. 24). Such statements had ripple effects for multiple racialised and class-based forms of social control within and beyond the colonies established by Sweden in Africa, Asia, and the Americas. Second, it signalled "that neither the dominant theory of race nor of [bodily] sex in this period applied to women of non-European descent" (Schiebinger, 1993/2000, p. 25). This indeterminate position thus "doubly determined" that the study of Black, Brown, and Indigenous women by Linnaeus' peers would focus on their sexuality and become one of the foundations of scientific racism (Schiebinger, 1993/2000, p. 26). Identifying differences in "race" bolstered a constructed white ideal, and these were ranked according to a gendered taxonomic hierarchy of human, animal, plant, and non-living things. This was one of the many violences of what Argentine feminist philosopher and activist María Lugones (2010) calls a colonial system of gender that associates white "woman" with "natural" and categorises all those who were being colonised as not "properly human". Linnaeus' choice of Mammalia highlights how this political act justified and reinforced an explicitly gendered and racialised ranking system projected onto differently identified bodies in specific spaces.

Medical literature

I continue to unmap by historicising the emerging medical literature that shaped trans health and highlighting some classifications projected onto bodies by psychiatrists, psychologists, and sexologists in colonising places. A key figure in this clinical space is Austro-German psychiatrist

Richard Freiherr von Krafft-Ebing. His book *Psychopathia Sexualis: Eine Klinisch-Forensische Studie* (A Medico-forensic Study) was published in 1886 and reached twelve editions. It used case studies to outline a complex taxonomy of sex practices and gender expressions. Krafft-Ebing (1939) aligned with the dominant position at the time, which asserted anyone whose sexual interests deviated from heterosexual procreation had a mental or physical illness. By the turn of the twentieth century, however, Krafft-Ebing (1939) announced that he no longer regarded "contrary sexuality" and "contrary sexual sensation" simply as a disease or degeneration but rather a form of "biological anomaly" (p. viii). Importantly for what was to become the field of trans health, Krafft-Ebing characterised "contrary sexuality" as more of a gender-related "problem" than one of erotic or romantic expression. That is to say, he "considered a man who loved a man to be more like a woman" and "a woman who loved a woman to be more like a man" (Stryker & Whittle, 2006, p. 21). Introducing the term "inverted sexuality", Krafft-Ebing (1939) categorised homosexuality as an "anomaly of psycho-sexual feeling" either "having the force of a congenital phenomenon" or appearing "as an *acquired* anomaly" (p. 285, emphasis in original). He also introduced the term "metamorphosis sexualis paranoica" to categorise "the delusion of a transformation of sex" (Krafft-Ebing, 1939, p. 328). The notions of paranoia and delusion appear in this term so that it would register as the ultimate "degree" of deviance, or rather, the final stage in the "disease-process" (Krafft-Ebing, 1939, p. 328). As Stryker and Whittle point out (2006), while these terms have disappeared, their "highly specific forms of subjectivity" have endured to the point that they "are readily identifiable in current terminology" (p. 21). I suggest categorising in-born or "natural" phenomena in a hierarchy above "anomalies" of expression and identity that develop over time has also endured in ways that are less readily recognised. Thus, it is not that Krafft-Ebing's "inverted sexuality" category contained elements of what today would be considered gender self-designation. Instead, sexual expressions considered "abnormal" were explicitly connected to the contravention of gender norms within a disease model.

British psychologist and sexologist Havelock Ellis is another key figure whose six volumes of *Studies in the Psychology of Sex* contributed significantly to Krafft-Ebing's work. In the General Preface of

Vol. 1 Sexual Inversion, Ellis (1897) suggests that because the "problems" of religion and labour had now been addressed, "the question of sex—with the racial question that rests on it—stands before the coming generations as the chief problem for solution" (p. x). He asserts: "Sex lives at the root of life and we can never learn to reverence life until we know how to understand sex" (p. x). Ellis (1897) then provides an overview of various "sexual inversion" phenomena. These appear in order of animals, "the Lower Human Races", a list of specific cultural, social, class, and institutional contexts in which they appear, a theory of the "barbarously hybrid" term Homosexuality, and finally, "The Racial Factor" (Ellis & Symonds, 1897, p. 1). This nexus of sex, race, and life demonstrates how the conditions for Linnaeus' zoological taxonomy in the mid-eighteenth century remain at the turn of the twentieth. Later in his prolific career, Ellis (1913) introduced the term "sexo-aesthetic inversion" to widen its scope beyond sexual activity to include a person dressing and expressing themselves as per a self-determined gender. Pearce (2018) suggests that Ellis is more affirming of gender self-designation because he regards this "inversion" as a "natural difference" (p. 23). Perhaps so, when his classifications are contrasted with Krafft-Ebing categorising people with self-designated genders as "profoundly disturbed, and … their desire for self-affirming transformation to be psychotic" (Stryker & Whittle, 2006, p. 21). Nevertheless, as cultural theorist C. Riley Snorton (2017) eloquently argues, the overlap of "gender and sexual aberrance" in Ellis' concepts "require that one does not read "the question of sex" as exclusively concerned with sexual acts or object choice but as also indicative of gendering practices and trans ways of being" (p. 4). Together, Schiebinger (1993/2000), Snorton (2017) and feminist theory, queer studies, and American literature scholar Siobhan B. Somerville (2000) draw critical attention to the foundation of scientific racism upon which both the term "natural" and the sexological texts of this period are built. Ellis' representation of "the question of sex" at the turn of the twentieth century thus continued to combine bodily differences, participation in particular sexual activities, and gender self-designation into a problem category opposed to cisnormative heterosexual procreation.

German Sexologist Magnus Hirschfeld is a crucial figure in the medical literature whose work created a slightly different shape for trans health. Hirschfeld's (1910, 2006) book *Die Transvestiten:*

Untersuchung Über Den Erotischen Verkleidungstrieb (Transvestites: The Erotic Drive to Cross-dress) broke with his predecessors by considering the behaviours and requests for body modifications that affirm a person's self-designated gender as distinct from but with some connections to sexuality. For historians, Rainer Herrn (2005) and Michael Tomas Taylor (2008), Hirschfeld making a clear distinction between homosexuals and transvestites was a radically innovative move formulated in response to the protests and demands of those consigned to the existing medical (disease) categories. Hirschfeld (1910/2006) introduced a purportedly scientific principle of "sexual intermediaries" and used the term Transvestite to characterise this phenomenon on a scale of gender between the poles of a supposedly "complete womanly and 'absolute' woman" and "an 'absolute' man" (p. 35). He emphasised that these representative characterisations are "abstractions, invented extremes" to differentiate between the expected and "these mixed forms" (Hirschfeld, 1910/2006, p. 35). The argument in *Die Transvestiten* is that the "intermediaries" are both independent from and more complex than the "absolutes". Pearce (2018) points out that the term "Transvestite" signalled "a range of subject conditions that might – according to patient need or desire – be affirmed and/or cured" (p. 24). Using "Transvestite" to indicate such a range is crucial because it emphasises responding to a person's requests rather than what the doctor considers necessary in their specific circumstances. Hirschfeld enabled this shift in many ways by making a strategic alliance with the "patients" who came to see him (Taylor, 2008). Even as a disease model remained in place, this attempt to shift the emphasis from studying people with self-designated genders as objects of medical inquiry to responding to requests for access to gender-affirming medical technologies effectively reshaped what would later become trans health.

Hirschfeld was a gay Jew and a socialist who opened the Institut für Sexualwissenschaft (Institute for Sexual Science) that employed people with self-designated genders and facilitated some of the first documented gender-affirming surgeries (Stryker & Whittle, 2006). This combination led Adolf Hitler to denounce him as "the most dangerous man in Germany", one of the consequences of which was the infamous public burning of the Institute's archives and Hirschfeld's exile from Germany (Stryker & Whittle, 2006, p. 28). Hirschfeld's terms indicated a "persisting unsettledness" throughout his career

that, according to Taylor (2008), demonstrates his difficulties "understanding and treating" the people who sought his assistance (p. 313). Indeed, it "exemplifies the overall instability characterizing the nineteenth-century project of medically identifying, classifying, and treating "deviating" forms of sexuality and gender— with the consequence that categories such as gender, sex, and sexuality themselves became unmoored" (Taylor, 2008, p. 313). The medical field of trans health emerged out of this project, which, as Alex Bakker, along with Herrn, Taylor, and Annette Timm (2020) point out, also "developed out of eugenic discourse … tainted with racialized logics" (p. 24). While some of the "progressive sexologists", such as Hirschfeld, did not agree with their methods and were denounced by the Nazis, they still "embraced eugenic thought as the very foundation of their dreams of progressive social change" (Amin, 2018, pp. 600, introduced below). It may have been contradictions in this project that caused Hirschfeld difficulty and confusion about his categorisations, yet identifying, classifying, and "treating" differences dovetails with the explicitly gendered and racialised conditions of domination underpinning the medical literature's preliminaries.

German-born American endocrinologist and sexologist Harry Benjamin is recognised as a key figure directly shaping trans health, even though Hirschfeld is recognised as one of the earliest supporters of people with self-designated genders. In his book *The Transsexual Phenomenon*, Benjamin (1966) distinguishes between sex, sexuality, and gender (the implications of this innovation are discussed in the following section and chapter six). He also offers one of the most enduring metaphors in trans health, positing that "more or less perfect *symphony of the sexes* is the rule" and recognising "those in whom nature or life (nature or nurture) have created a dissonance … are frequently condemned and ostracized" (Benjamin, 1966, p. 10, emphasis in original). In making these distinctions, Benjamin suggested that people with self-designated genders stood to benefit from access to gender-affirming medical technologies and thus, it was the responsibility of a doctor to help "people live fuller and happier lives in the gender they identified as their own" (Stryker, 2017, p. 96). Benjamin's position was geared toward surgical and hormonal "management" rather than "cure", which coincided with the establishment of several hospital-based clinical research and "treatment" programs in the US from the mid-1960s. Arjonilla (2014) points out that there was only the occasional use of surgical technologies

in other places until this time, “and surgeons performed them under patient petition” (p. 33). American academic theorist, media theorist, author, and performance artist Allucquére Rosanne “Sandy” Stone argues that Benjamin’s book became “the standard reference” for these clinics (p. 288). There was a substantial increase in opportunities for access, mainly because those who qualified as research participants could obtain care for free in some clinics (Stryker, 2017). However, it soon became apparent that these research programs “were far more concerned with restabilizing the gender system” than facilitating conditions that make for a livable life for people with self-designated genders (Stryker, 2017, p. 118). As American sociologist Henry Rubin’s (2003) examination of published case studies from the 1950s to 80s demonstrates, psychologists justifications for denying access to “care” reflected the prevailing class-based, patriarchal, conservative gender norms. Velocchi’s (2021) analysis of correspondence between Benjamin and his colleagues suggests that denying access was also “a regime of anticipation” premised on practitioners’ fears of backlash and more (p. 475). Indeed, internationally recognised standard diagnostic criteria and “treatment” recommendations for “Transsexualism” did not appear until the first Harry Benjamin International Gender Dysphoria Association (HBIGDA) standards of care were published in 1979 (Coleman et al., 2012) and the third edition of the DSM (APA, 1980). As the sexological categorisations from the medical literature began to sediment into a foundation for the institutionalisation of transsexual medical “care”, the trans health space was now to be “shaped by the health professionals who oversee gender identity services” (Pearce, 2018, p. 5).

Outside the medical literature

I unmap trans health further by historicising knowledge produced outside the academic fields of medicine and sexology. I attend to actions occurring in spaces created by people with self-designated genders, in a dynamic relationship with what was imagined and projected onto their bodies. There are examples from the mid-nineteenth century of people creating spaces in self- and traditionally published texts for a general audience, personal communication with friends and doctors, and overtly radical political action. Bakker, Herrn, Taylor, and Timm (2020) contend that it was people in these

spaces, “rather than the scientists and doctors who studied them”, who were most active in changing the story of how it became possible “to accept that the gender one is assigned at birth should not be considered definitive or unchangeable” (p. 1). In a pamphlet published anonymously in 1864 by German lawyer and journalist Karl Heinrich Ulrichs, the term “Urnings” and the Latin phrase *anima muliebris virili corpore inclusa* — generally translated as womanly psyche or soul — was used to inform the public about others like him (Somerville, 2000; Stryker, 2017). Ulrichs is among the key figures that shaped what was to become trans health because his self-published works and his later published personal correspondence emerged decades before Krafft-Ebing’s *Psychopathia Sexualis*. Stryker (2017) argues that the terms in Ulrichs’ correspondence with Karl Maria Kertbeny (the German-Hungarian credited with coining the term homosexual in 1869) are an early form of trans activism. Emerging here are collective efforts for change “based on the idea that people we would now probably label gay or transgender were not by definition sinners or criminals but simply different kinds of people who were equally entitled to full participation in society” (Stryker, 2017, p. 53).

Historical research has long recognised the regulatory politics of “sexual science”, particularly the relegation of people’s responses to the imposition of pathologising labels to other stigmatising categories. Bakker, Herrn, Taylor, and Timm (2020) contribute to this recognition by investigating how medical knowledges developed by Hirschfeld, Benjamin and others, travelled the Atlantic in the mid to late twentieth century. These scholars meticulously traced personal correspondence and photographs to understand burgeoning peer networks and mutually beneficial knowledge transfers between “patients” and doctors. Exchanging letters and photographs created spaces for those seeking and receiving gender-affirming medical “care”, just as it helped doctors and scientists increase their expertise and professional standing. Indeed, it “was trans individuals who approached experts and publishers to ask that their stories be told, their images be shown, or that the doctors change or modify their categories to better describe trans individuals’ experiences and self-understandings” (Bakker et al., 2020, p. 18). Just as some people were open about and prolific in their correspondence, many more were scrupulously private about their gender history. Sharing personal experiences and images thus functions as more than an “interplay of agency and authority” in twentieth century “care” (p. 18).

It acts as part of a "history in which trans individuals often create their own experts and instrumentalize them as mouthpieces for self-articulation – precisely because this path of medicine or science was the only path available to them" (Bakker et al., 2020, p. 18). What is produced by people with self-designated genders outside of but connected to the medico-scientific literature demonstrates an effort to create conditions to become more than objects of study and regulation.

White women and white people who designated their gender as feminine appeared to dominate the strategising for self-articulation in the mid-twentieth century. Yet, it did not mean they were the only ones to create spaces for action and knowledge production in response to the emerging field of trans health. As Bakker, Herrn, Taylor, and Timm (2020) explain, there are very few people of colour represented in the correspondences they investigated because most "did not have the material or social capital to appear in doctors' offices" (p. 22). They suggest this absence is the result of dominant European and North American social norms creating ideals of beauty and gender expression that determined "who was socially visible or invisible and on what terms" (Bakker et al., 2020, p. 23). Going further, sociologist Salvador Vidal-Ortiz (2014) argues these constructions of whiteness are the "structuring and structured form of power that … crystallizes inequality while enforcing its own invisibility" (p. 266). Thus, it appears that most people in these spaces "aspired to living within the prevailing standards of white, Western, middle-class heterosexual comportment" precisely because these standards functioned as "a prerequisite for access to treatment" (Bakker et al., 2020, p. 24). While this was a necessary condition for "care", historian Emily Skidmore (2011) demonstrates how media representations of a "good transsexual" that became "possible through the subjugation of other gender variant bodies" in the 1950s and 60s also made it a condition for access to proper recognition (p. 271). Thus, "as the subject position of the transsexual was sanitised in the mainstream press and rendered visible through whiteness, other forms of gender variance were increasingly made visible through nonwhiteness" (Skidmore, 2011, p. 271). It further demonstrates that normative gendering practices, anti-Blackness, and disavowal of Indigenous presences are not merely contained within the provision (and denial) of "care" but constitutive of broader conditions that maintain this social ordering.

Nevertheless, English literature scholar and documentary filmmaker Jennifer Worley (2011) details the activities of a little-known radical social and political organisation called Vanguard in San Francisco's Tenderloin district between 1965 and 1970. Vanguard was a group of assumed "bad transsexual" young people who, with their peers on the fringes of respectable society — homeless and often street-based sex workers — were creating spaces that responded to how racialisation, class status, police violence, incarceration, and discrimination were making their lives unliveable. Worley (2011) argues that Vanguard functioned to provide a material home space by hosting meetings and social events and "a sort of literary "home" that circulated, like its readers and writers, on the streets of the Tenderloin" (p. 51). Vanguard magazine denounced and gave practical advice on what to do when experiencing discrimination and harassment, giving "readers a framework into which they could place their own experiences" (Worley, 2011, p. 52). Vanguard's framework highlighted the collectivity of each reader's experiences in that it simultaneously identified these as institutional oppression and as something they were entitled to protest (Worley, 2011). Among Vanguard's political projects was radical community organising to gain state recognition of the economic marginalisation of their neighbourhood and subsequent federal anti-poverty funds for affordable housing (Worley, 2011). Such efforts complimented Vanguard's picketing, rioting, street theatre, and networking activities for economic justice because being able to appear in doctors' offices also meant having a home to return to. Stable housing remains a pivot on which access to gender-affirming medical technologies revolves.

I have briefly unmapped these spaces outside academic literature to highlight how people shaped and spoke back to a medical paradigm and responded to the system of social ordering upon which it rested. Vanguard is just one example that demonstrates how the terms created to pathologise and contain people with self-designated genders and regulate access to gender-affirming medical "care" were also used for agency and self-determination to create a more livable life.

Conclusion

In this section, I have unmapped the field of trans health by introducing key figures in what led up to, what is contained within, and situated outside of the medical literature that forms the foundation of what is known today as trans health. I historicise to discuss how the representation of gender self-designation as a psychiatric "problem" started with its representation as a colonial "problem" of invading and occupying other people's lands. The key figures and their work I have introduced from the late sixteenth to the mid-twentieth century create contour lines for unmapping. They mark how interlocking knowledges and actions created conditions whereby people whose understandings and desires for their bodies were incomprehensible to those in positions of power became objects of study for containment. A series of political acts produced an array of diagnostic categories and medical experts (in clinics or otherwise) that maintained an established hierarchy of social relations. I argue that unmapping the field of trans health reveals both liminal and tangible spaces organised by normatively gendered, racialised, and continually contested power differentials for the provision of gender-affirming medical "care". The following section offers a sketch of further scholarship that overlays this unmapping of trans health.

Sketching Overlays

In this second section, I sketch out five areas of academic scholarship as a set of overlays to the field of trans health. I use this term to indicate the transparent sheets placed over maps to allow additional features of a particular space to be factored into the analysis. I sketch overlays of feminist scholarship, queer theory, transgender studies, social work theory for practice, and analysis of trans health policy. I introduce some key figures and formative works in these areas of study. Each overlay varies in thickness and complexity, yet each contributes critical counterpoints to the medical and psychological literature that effectively reduced consideration of the lives of people with self-designated genders to their desires for body modification. I sketch overlays to show how this thesis will contribute to theoretically informed social work scholarship at a point where the literature on trans health is most attenuated. Finally, I use the unmapping of the field together with the sketching of layers to identify

the point at which this thesis will contribute to debates about the rationales and specific strategies for approaching depathologisation and de-medicalisation of "care".

Feminist scholarship

The sketching begins with a dense overlay of feminist scholarship. Scholar-activist Janice G. Raymond and critical theorist Bernice Hausman are two key figures from within gender essentialist and radical feminisms whose refusal to recognise the legitimacy of people with self-designated genders has profoundly affected trans health. Raymond (1979) invokes an image of Frankenstein's monster in *The Transsexual Empire: The Making of the She-Male* to claim that transsexuals are merely constructed through medical categories and technologies because gender is the expression of chromosomal sex that is fixed from birth. Raymond (1979) sees the availability of medical technologies and the deployment of diagnostic criteria by psychiatrists as what makes it possible for people who modify their bodies in ways that affirm their self-designated genders to disavow, or worse, appropriate (an imagined formation of) legitimate "womanhood". Sociologist and interdisciplinary gender studies scholar Sally Hines (2014) illustrates how Raymond magnifies this position by insisting "female biology" or "female socialization" is what makes someone a feminist, to the point where "the place of trans people within feminist communities became disputed" (p. 84). Going further, Stryker (2017) argues that *The Transsexual Empire* consolidated numerous strands of discourse disputing the possibility of gender self-designation "into one grand narrative", simultaneously becoming "a sourcebook for antitransgender opinion" and "a goad for transgender countertheorizing" (p. 132). Raymond's polemic against gender self-designation is seen as contributing to a drastic decrease in access to "care" because it aligned so well with the conservative neoliberal withdrawal of funding for so many government health and social services under Nixon and Reagan in the 1970s and 1980s (Stryker, 2017). Almost fifteen years later, Bernice Hausman (1995) moved from a grand narrative to a Foucauldian analysis in *Changing Sex: Transsexualism, Technology, and the Idea of Gender.* Hausman (1995) is now infamous for arguing "that transsexuals are the dupes of gender" who reproduce stereotypes that harm women and therefore undermine

feminism (p. 140). Writer, cultural critic, and scholar, Jay Prosser (1997) identifies in Hausman's work an "uncritical dependence" on a Foucauldian approach based on her "glaring failure to examine how transsexuals are not simply constructed but constructing subjects" (p. 202).

As will be discussed, the critical response to these texts firmly establishes a position that people with self-designated genders are actively shaping as much as they are being shaped by medico-scientific knowledges, practices, and technologies. Moreover, various feminisms sustain a tradition of nuanced frameworks for understanding and challenging not only the impact of gendering on people's lives but also racialisation, ableism, capitalism, colonialism, and more. This legacy includes the Boston-based group of Black feminist lesbian socialists who produced the Combahee River Collective Statement (1984), American lawyer Kimberlé Williams Crenshaw's (1989) use of a traffic metaphor to mobilise the analytic framework of intersectionality, and the articulation of transfeminism by multi-issue social justice activist and writer Emi Koyama (2003, 2006). So, while Raymond and Hausman set a standard for reactionary feminist accounts of people with self-designated genders, these were far from monolithic and formed only a tiny, but influential, part of the dense layer of feminist critique that informs the field of trans health.

Queer theory

The sketching of overlays continues with an account of how queer theory forms a substantial and uniquely connective layer over trans health. Queer theory emerged as critical thinking about the structures that create and stabilise normativities that include but are not limited to sexuality and gender. Some scholars mobilised queer theory to denaturalise the category of "woman" in theories underpinning feminist activism in the 70s and 80s. For example, Italian cinema, literature, and psychoanalytic theory scholar Teresa De Lauretis (1987) put Foucault's conceptualisation of power to use in theorising gender. For De Lauretis (1987), "the movement in and out of gender as ideological representation … is a movement back and forth between the representation of gender … and what that representation leaves out or, more pointedly, makes unrepresentable" (p. 26). Many more scholars

used queer theory to respond to white supremacy and the elision of colonialism—especially that which circulated in critical scholarship and healthcare practices. For example, the first appearance of queer theorising from poet, writer, and cultural theorist, Gloria Anzaldúa appeared in the collection *This Bridge Called My Back*, which she co-edited with Chicana writer, feminist activist, poet, essayist, and playwright Cherríe Moraga (1981). Importantly, Anzaldúa (1987) used a mix of up to eight dialects of Spanish and English throughout her writing as a refusal to make herself legible and bend herself to colonial, positivist standards of what it means to produce "valid" knowledge. This refusal and many others became a foundation for queer theorising. In her later writings, Anzaldúa's (2009) struggles with diabetes and its disabling complications contributed to a wariness that marginalised groups who are excluded from access to resources could become locked into "a position of reclaiming power from the sources that produced a sense of powerlessness in the first place" (p. 302). Literary critic Eve Kosofsky Sedgwick (1994) is another key figure in the field who illuminated not only the contradictions but the loss of life that occurs when "the irreducible multilayeredness and multiphasedness of what queer survival means" is consigned to binary categories within a hierarchy (p. 2). Elsewhere, Judith Butler (1990) offered their theory of gender performativity in *Gender Trouble: Feminism and the Subversion of Identity*. Despite many, often oppositional interpretations, Butler (1990, 1993, 2004) generatively uses performativity to theorise the becoming of gender and name the ways that social realities can change over time. The purpose is to create a political convergence of theorisations that can "participate in whatever network or marginal zones … spawned from other disciplinary centers and that, together, constitute a multiple displacement of those authorities" (Butler, 1990, p. xxxii). Queer theory thus structures an explicit problematisation of the terms not just of feminist but all modes of inquiry. It questions these limitations by attending to the negotiation of bodies, identities, relations, and knowledges with a poststructuralist-informed queer sensibility. The linking-layer queer theory forms over the field of trans health — between feminist scholarship and transgender studies — extends poststructural understandings and deepens the analysis of systems of interlocking oppression.

Transgender studies

Transgender studies forms a crucially thick overlay of embodiment and agency over the field of trans health. Much like the unmapping of spaces that shaped trans health from outside the medical literature, transgender studies takes an explicitly non-medical approach to consider transgender phenomena and the lives lived by people with self-designated genders. Transgender studies is closely related to queer theory, not least because they each rest on the institutionalisation of pejorative terms reclaimed for liberatory purposes. It is a testament to the achievements of activists who reclaimed "transgender" as part of a strategy to collectively speak back to rigid medical terminology while attempting to build a coalition among those with disparate social positions and experiences of oppression. The emergence of the field was strongly influenced by possibilities anticipated in Donna Haraway's (1991) cyborg feminism for "both building and destroying machines, identities, categories, relationships, spaces, stories" (p. 37). However, Sandy Stone's (1991) rebuttal to Raymond's *The Transsexual Empire* is credited with its instigation. In *The Empire Strikes Back*: *A Posttranssexual Manifesto*, Stone (1991) drew on poststructuralist, feminist, and postcolonial thinking not only to critically engage with Raymond's (1979) relentlessly totalising assertion: "All transsexuals rape women's bodies" (p. 104) but also the diagnostic practices occurring within gender identity clinics. For Stone (1991), transsexuals are not a category or problem but rather "a set of embodied texts whose potential for productive disruption … has yet to be explored" (p. 291). Stone (1991) calls for transsexuals "to be consciously "read", to read oneself aloud – and by this troubling and productive reading, to write oneself into the discourses by which one has been written" (p. 292). Susan Stryker (1994) responded to this call in her canonical essay *My Words to Victor Frankenstein above the Village of Chamounix: Performing Transgender Rage.* The essay was a reworking of a performance piece Stryker (1994) created during her participation in the radical direct action group Transgender Nation's disruption of the 1993 annual meeting of the APA to protest the imminent replacement of "Transsexualism" with "Gender Identity Disorder" in the DSM–IV. Stryker (1994) claims the figure of Frankenstein's monster for theorising both her experience as transsexual and her rage that emanated partly from invisibility and partly from "the necessity of existing in external circumstances

that work against my survival" (p. 244). The philosopher Talia Mae Bettcher (2009) named this experience "the Basic Denial of Authenticity", where identification occurs "in ways that are contrary to or even hostile to our own self-identifications" (p. 99). The emergence of transgender studies thus emphasised particular embodied expertise in relation to feminist theories and the extensive medical literature on gender self-designation.

Butler's (1990; 1993) innovative work has played an important role in that it saw feminist, queer and transgender theories operating at close quarters, creating profound divisions while also generatively reconfiguring their relations (Stryker, 2004; Whittle, 2006). English and Gender Studies scholar Heather Love (2014) argues that as a result of this tumult, transgender studies centred itself around "accounting for material experience and making space for new forms and experiences of embodiment" (p. 176). For scholars such as Canadian feminist Viviane Namaste (2011), a poststructural understanding of power and an interest in the becoming of gender helped focus attention on the lives lived by people with self-designated genders, especially the effects produced by particular policies and concomitant health practices. Transgender studies scholar and advocate Ben Singer (2013) argues that by centring "transgender scholarship, trans-identified scholars, trans people's lives and related social phenomena as the subjects of inquiry", the field is able "to look at how all phenomena, objects, social relations, and social worlds might be analyzable through a transgender optic" (para. 2). Stone (2014) recognises "the quixotic effort of articulating structure while refusing closure and insisting on situation" (p. 92). Yet this effort is crucial given that current health research in Australia details adverse conditions across the entire range of social determinants of health that undermine the potential for people with self-designated genders to flourish (Callander et al., 2019; Hill et al., 2020). This research details continuing, multilayered experiences of discrimination, stigma, marginalisation, and harm. These are not just interpersonal experiences; they encompass marginalisation within services, strategies, and policies. Artist and scholar Micha Cárdenas (Boellstorff et al., 2014) reflects on Namaste's (2000) trailblazing theoretical and empirical research on the erasure of people with self-designated genders across a range of institutional and cultural settings. Cárdenas (Boellstorff et al., 2014) emphasises Namaste's crucial insight into how

"scholarship can be "reflexive"—that is, ways that scholarship can be accountable to transgender communities instead of merely talking about us without improving our lives" (p. 426). Transgender studies is thus a field of inquiry where relations between theory and action are contested, politically fraught, and demonstrate a complex engagement with the lives, bodies, and experiences of people with self-designated genders. Its operation as a layer over the field of trans health continues to challenge and extend poststructuralist-informed theorising and critical investigation while prioritising the agency and expertise of people with self-designated genders.

Social work theory for practice

I offer a sketch of social work theory as a thin yet instructive overlay to the field of trans health. Feminist frameworks have been pivotal to social work theory for practice in multiple places for decades. Yet, there appears only a gradual increase in the use of queer theory and its underpinning poststructuralist approach by some critical social workers. Canadian-American philosopher Stephen Hicks and social work scholar Dharman Jeyasingham (2016) argue that much of social work theory and research neither mentions nor engages the field; if it does, social work appears "merely to assimilate queer into otherwise unchanged perspectives" (p. 2362). Despite a genuine interest from social work in supporting people with self-designated genders, there is scant academic engagement with trans health and even less with the field of transgender studies. The main focus of theoretically informed social work scholarship appears to be a unidirectional evaluation of how it might use feminist, queer, or transgender theory in ways that improve practice with or "outcomes" for people with self-designated genders. The social work profession is only beginning to consider how critical theory and contributions of people with self-designated genders might reconfigure the perspectives of the profession itself and how this might, in turn, improve practice at multiple levels (e.g. Kia et al., 2021). Consequently, social work theory for practice contributes a tenuous layer through which to view the field of trans health. As the following examples show, many of the theoretically informed recommendations for social work contain normalised assumptions and power/knowledge hierarchies that appear to undermine its efforts to address subjugation experienced by people with self-designated

genders.

Beverly A. McPhail (2004) is a social work educator and scholar who argues that engaging a paradigm of poststructuralist queer theory, contemporary sex research, and embodied expertise is a necessary challenge to social work. Social work practitioner and scholar Barb J. Burdge (2007) takes a firmer stance by arguing that the values, ethics, and commitments of the profession culminate in a responsibility for social work to incorporate postmodern, and specifically queer, social constructionist theorisations into practice for the deconstruction of the gender binary as an oppressive system. Without devaluing the call for such a deconstruction, Valentine (2003) identifies a series of nested binary categories — homosexual/heterosexual, masculinity/femininity, sexuality/gender — that renders people whose articulation of their desires and understandings of themselves "cannot be labelled", or "require different kinds of labels at different times" as incoherent or confused (p. 132). Such a dismissal corresponds to Stryker's (1994) explanation from twenty-five years earlier of what it means to "live daily with the consequences of medicine's definition of my identity as" linked to "an emotional disorder" (p. 244). Valentine's (2003) ethnographic research and Namaste's (2000) institutional ethnography (discussed below) are two early studies that implicate social work in interlocking systems that produce such oppression. Such research and theorisation present a further challenge and a responsibility for social work to increase critical analyses of what is normalised within the profession (e.g. Chapman & Withers, 2019).

Julie Nagoshi and Stephan/ie Brzuzy (2010) are two social work scholars who present transgender theory as a framework that provides the profession with relevant critical principles, methods, and practices. Nagoshi and Brzuzy (2010) argue that transgender theory is instrumental in encouraging "social workers to think and practice" in innovative ways that emphasise embodiment "for understanding and empowering individuals with multiple, intersectional oppressed identities" (p. 440). However, presenting this theory without recognising its emergence from within the academic field of transgender studies adheres to a hierarchisation of accepted disciplinary knowledges that brings social work's basis of engagement into question. In a subsequent review of literature informing

Australian social work with people with self-designated genders, social work scholars Miff Trevor and Jennifer Boddy (2013) express concerns about a lack of trans-specific, social work-specific research, the dominance of medical and psychiatric literature, and the absence of "a transgender voice" (p. 566). Trevor and Boddy (2013) recommend that social work "investigate the applicability of transgender theory" while seeking "to expand upon the current theoretical knowledge base" by merely "incorporating feminist, queer, and critical social work perspectives" (p. 566). This recommendation belies the warning offered by Vidal-Ortiz (2005) that positing "social work research as the only kind of research that offers results to those it serves" is a stance that "gives social work unnecessary authority" (p. 90). By implicitly affirming a knowledge hierarchy that ranks feminist, queer, and critical social work above trans theory, Trevor and Boddy's (2013) recommendation also undermines their argument that knowledge-sharing — for empowerment, social change, and awareness — is the way forward for social work with people with self-designated genders. I provide a sketch of this scholarship because it forms an important backdrop for my practice experience in the Australian community services sector, and it is the academic discipline from which my PhD research is undertaken. However, social work scholarship is of small use to this research because it appears to have difficulty mobilising insights from feminist scholarship, queer theory, and especially transgender studies outward toward the "care" of people with self-designated gender and inward toward the profession itself.

An ever-broadening contemporary Australian literature attempts to counterbalance the dominance of medically focused literature and an ongoing need for trans-specific, social work-specific research. Necessary trans-focused research on health and well-being issues has informed a large amount of practice and policy change (Hill et al., 2020; Strauss et al., 2017). Of particular significance is *The 2018 Australian Trans and Gender Diverse Sexual Health Survey* (Callander et al., 2019). It is the first study that not only openly declares it was developed and guided by trans and gender diverse community members but that most of the paid research team were people with self-designated genders. In addition to literature with content specific to social work practice (e.g. Howe et al., 2019; McEwan, 2017) and content specific to sites where social work occurs (e.g. McNair et al., 2017),

there is also consideration of contemporary social perspectives on trans health (Newman et al., 2021). Further, there is a proliferation of theorisation of transgender phenomena (e.g. Aizura, 2006; Latham, 2017; Nicholas, 2019; Povinelli, 2015). Although not all of the contemporary literature takes an explicitly critical approach, it offers a uniquely Australian contribution to existing knowledges relevant for the academic field of social work to widen its frame of critical analysis.

This thesis will contribute a theoretically informed comparative policy analysis to this literature. It incorporates feminist scholarship's recognition that gendering is a component of multiple systems of interlocking oppression, queer theory's challenge to pervading normative structures and representations, and transgender studies' emphasis on embodied expertise and its provocations for expansive, reflexive, and accountable research. As discussed in the following theoretical framework section, it follows the generative lines of Foucault's (1978) thinking on interventions for regulating and managing populations to scrutinise dominant forms of governing through policy alongside counter-dominant possibilities.

Analysis of trans health policy

The final area of scholarship is the thickest, most detailed overlay formed by the analysis of trans health policy. I sketch this layer in light of the discussion in chapter one of how a WPR approach sees policies as governmental texts. I suggest the contested categorisations from the medical literature create a foundation for governing trans health through illness classifications, diagnostic criteria, "treatment" guidelines, and professional "care" standards. Although people with self-designated genders actively shape these texts and the conditions of trans health, the DSM, ICD, and SOC constitute three governmental texts pivotal to the field. I follow Bacchi and Goodwin's (2016) assertion that "policies are contingent historical creations, human constructions, that produce effects" and that thinking about "policy" as a concept is a valuable way to conceptualise and symbolise social relations (p. 7). Thus, while the bulk of analysis within this overlay may not characterise itself as policy analysis, these contributions orient the central debates within trans health by scrutinising its

effects and social relations.

Centring the lives lived by people with self-designated genders has been crucial for analysing what is produced by the policy texts central to trans health. Namaste's (2000) *Invisible Lives: The Erasure of Transsexual and Transgendered People* is among the most influential analyses in this overlay because it focuses on people's everyday lives and experiences "as a point of entry into the quotidian administration of the social world" (p. 186). Namaste was among the first to combine theoretical and empirical methods to research the lives of her peers. However, it should be noted that Australian sociologist, sex worker and transgender rights activist Roberta Perkins (1982) published findings from her in-depth survey, *The 'Drag Queen Scene': Transsexuals in Kings Cross*, almost two decades earlier. Extending Perkins' (1982) observation that marginalised women were articulated as a kind of "non-person" (p. 58), Namaste (2000) demonstrates how people with self-designated genders "are produced through erasure" (p. 265). Namaste illuminates a now-familiar effect of contemporary neoliberal social and organisational policy where the "problem" becomes individualised. Participants in Namaste's (2000) research experienced abuse, noncooperation, judgement, conditional "care" facilitated through information on gender self-designation, poverty-based exclusion, and denial of identity in health and social services contexts, that included alcohol/drug recovery programs, housing providers, primary healthcare and more. An absence of social policies in these contexts "shifts the focus from one of an agency delivering appropriate services to a client (e.g., shelter, primary medical care, or information) to one of a TS/TG [transsexual/transgender] client finding an agency that will deal with them" (Namaste, 2000, p. 188). Erasure occurs not only when people with self-designated genders experience outright and indirect institutional exclusion, but also when they are reduced "to the merely figural" and rendered into conceptual frameworks where gender self-designation is almost inconceivable (Namaste, 2000, p. 265). This analysis forms a crucial part of an overlay through which to view additional features of the field of trans health. There is a wealth of contemporary scholarship that creates even more detail. For example, independent audio producer, writer, and researcher Cassius Adair (2019) examined the administrative violence perpetrated through race and sex categories on drivers licences in the US from the nineteenth through to the early twentieth century.

Elsewhere social media software, gender, and journalism scholar Rena Bivens (2017) illuminated the profits generated by the binary gender coding of Facebook user information despite the company's declarations of "authenticity" and its provision of custom gender options. This research demonstrates an interplay between health, organisational, and social policy with a ripple effect that extends across the breadth and depth of a person's life, irrespective of any desire to access gender-affirming medical technologies.

Medicalisation and pathologisation are distinct but overlapping practices whose effects are of principal interest in analysing trans health policy. In the lead-up to the publication of the DSM-5, sociologist Mary C. Burke (2011) used a combination of interviews, participant observations, and textual analysis to examine the diverse and sometimes contradictory positions trans activists in the US took on proposed changes to the "Gender Identity Disorder" diagnosis. In that context, Burke (2011) identified a de-medicalisation position as activism for the complete removal of any diagnosis related to gender self-designation from authoritative medical texts. It remains a prominent activist position even though, for many, it is seen to delegitimise some people's need for "medically based body-altering technologies" and jeopardise access to both "care" and legal recognition (p. 189). This activism is counterposed with a dominant depathologisation position Burke (2011) identifies as advocating for reform of diagnoses. For participants in Burke's (2011) study, a reform position seeks to redesign a diagnosis so that it does not pathologise people with self-designated genders while preserving existing systems of access to and payment for medical technologies. A depathologisation position has taken on far greater depth and nuance in the last decade. Social anthropologist and trans depathologisation scholar Amets Suess Schwend (2020) analysed its emergence and developments in a European context, illuminating a reciprocal influence between this perspective and a human rights framework that offers an important contribution to the trans health space. Suess Schwend (2020) argues the collaborative strategies needed for developing a new model for "care" in the trans health space require an explicit "focus on depathologization, gender non-binarism, decolonialization, children's human rights and legal gender recognition, questioning pathologizing practices and language use in the clinical and research context" (p. 13).

As will be examined in chapter five, calls to establish a new model emerge because a direct link is found between the DSM and ICD classifications and violence, stigma, criminalisation, and discrimination perpetrated against people with self-designated genders (Kara, 2017) As Johnson (2015) theorises, these classifications function as "a normative accountability structure that influences transgender people's experiences of doing gender in multiple institutions of social life" (p. 803). Significantly, Johnson (2015) illuminates that no matter the stance taken on "care", the existing diagnostic manuals, disease classifications, and care standards are non-binding and non-mandated. One implication is that whether a health professional actively upholds the latest version of a given guide or protocol, they retain the power to determine access to gender-affirming medical technologies (Johnson, 2015). Lane (2018) clarifies that gatekeeping, through its codification in authoritative texts, "institutionalised the view of gender variance as a psychological disorder", thus generating "the defining tension" between access to medical technologies and pathologisation in "care" (p. 208). Contestation over removing or rewriting diagnoses, an influential human rights discourse, and an overarching normative structure anchored to an entrenched gatekeeper position show how pathologisation and medicalisation converge in the trans health space. The result is fierce debate about trans health policy that uses distinct but overlapping terms. Crucially, in such conversations, a call to abolish pathologising "care" practices does not always extend to the de-medicalisation of "care".

Revision processes are often a focal point for analysing the effects and social relations produced by trans health policy. The knowledge contribution of this thesis occurs at this point in the overlay that focuses on the revision processes of the three central texts. Dewey and Gesbeck (2017) provide a summary of changes to diagnoses related to gender self-designation from their first appearance in 1980 in the DSM-III up until 2013 in DSM-5, and a detailed comparison of SOC-6 and SOC-7 (see Riggs et al., 2019, for a comprehensive summary of all the relevant changes in both texts). Interviewing service users and health professionals who use an earlier DSM diagnosis with the previous SOC led Dewey and Gesbeck (2017) to argue the most recent changes "may not be sufficient to alter the underlying structure of social control and power that diagnostic categories have over

transpeople and their providers" (p. 41). WPATH's (2010) formal statement recognising gender diversity and acknowledging that gender self-designation is not an illness was a change welcomed by many in the trans depathologisation movement. However, Schwend (2020) points out that even as WPATH included this statement in the SOC-7, trans depathologisation activists continue to challenge its preservation of professional gatekeeping, psychiatric diagnoses and language (especially concerning people with intersex variations) and verification of a person's gender identity. Davy, Sørlie, and Schwend (2018) analysed claims and declarations of the European and South/Central American trans depathologisation movement. Reviewing its input into both DSM and ICD revision processes revealed that despite social movements generating research and demanding increased participation in revision processes, there was a curtailing of meaningful involvement by trans activists and their networks (Davy et al., 2018). Consequently, "trans authors and allies have been able to contribute critiques on the participation process and the proposed and final content, but have no guarantees that their critiques were heard or taken into consideration" (Davy et al., 2018, p. 27). Even though these high-level policies in trans healthcare were only minimally affected, Davy, Sørlie, and Schwend (2018) found that the trans depathologisation movement has made a significant positive influence on localised health service provision. The research in this overlay highlights that efforts to address medicalisation and pathologisation in trans health policy mobilise different rationales and entail specific strategies to shore up, erode or abolish the current Western medical model approach to "care".

This thesis builds upon the findings of Davy, Sørlie, and Schwend (2018) in that it compares the proposals for "care" practices framed by a medical model in the SOC-7 to a localised alternative model of rights in the Guide. The following chapter outlines how I use Bacchi's (2009) WPR approach to compare these policies. What makes the Guide crucial for this analysis is that trans depathologisation activists within the STP (2010) network submitted revisions to the SOC-6 by creating an entirely new policy guiding the provision of "care" for people who request access to gender-affirming medical technologies in a Spanish context. As mentioned in chapter one, the gap that I address in this research is the scant analysis of proposed alternatives beyond models of informed

consent. One of the most relevant policy analyses in this overlay is, therefore, Arjonilla's (2014) analysis of how the Guide takes a theoretical position that rejects "the authority, knowledge, and practices of mental health professionals in the definition of the gender identity of trans people" by equalising the elements, steps, and relationships within "care" (p. 40). Critical analyses exist of the medicalised position taken on "care" in versions 6 and 7 of the SOC and the activist positions on its changes. However, there is less attention to the positions taken in stand-alone alternative policies such as the Guide. Considering the SOC-7 and the Guide as governmental texts, this thesis questions the forms of governing each policy relies upon and is producing. The theoretical framework for this thesis is structured around Foucault's (1978) concept of biopolitics and it responds to Morgensen's (2011a) call for attention to the biopolitics of settler colonialism. It considers colonial projects as established mechanisms for the governing of gender and, as a consequence, creating the conditions of trans health. This thesis thus compares an established and an alternative trans health policy to illuminate how the governing of gender occurs through governing access to gender-affirming medical technologies.

Conclusion

In this section, I have sketched overlays of feminist scholarship, queer theory, transgender studies, social work theory for practice, and analysis of trans health policy to highlight what this literature contributes to the field of trans health. I offer this sketch recognising these five areas of scholarship operate alongside and in relationship with numerous fields of study. This sketch does not address the compelling scholarship emerging from within the antipsychiatry movement (Burstow et al., 2014), crip studies, disability justice, and critical disability (Withers, 2014; Mingus, 2015; Puar, 2017), and bioethical inquiry by people with variations in sex characteristics (Carpenter, 2018). These areas add further detail to the nuanced opposition to the narrow approach in much of the medical and psychological literature. I have discussed how reactionary accounts of gender self-designation from within feminist scholarship form part of a dense overlay over trans health. Also, how queer theory forms an important connective layer between many feminisms and transgender studies in ways that

extend a critical poststructural analysis of systems of interlocking oppression. I have discussed how transgender studies is a substantive overlay because it attends to embodied gender self-designation in ways that had been inadequately or problematically addressed by feminist and queer scholarship. I have suggested that currently, social work theory for practice is a thin overlay to the field of trans health. I have discussed how this thesis will contribute a theoretically informed policy analysis to a field that struggles to mobilise insights from feminist scholarship together with queer theory, and transgender studies for outward- and inward-facing critical research and theorisation. In sketching analysis of trans health policy as the thickest and most detailed overlay, I have identified the DSM, ICD, and SOC as three policies pivotal to the field of trans health and outlined key areas of policy analysis. I discussed how this thesis contributes knowledge by comparing the SOC-7 to the Guide and questioning the forms of governing each policy relies upon and is producing. The following section details a poststructural approach, specifically a critical application of Foucault's concept of biopolitics, as the theoretical framework for the analysis undertaken in this thesis.

Detailing a Foucault-influenced theoretical framework

In this third section of the chapter, I move from unmapping and sketching the field of trans health to detailing the theoretical framework that guides this analysis of trans health policy. Using the WPR approach as the research methodology and method means engaging Foucault's analytical concepts of problematisation, discursive practices, governmentality, genealogy, and subjectification as part of a specific analytic framework. Foucault's understanding of power as both relational and productive underpins the entire WPR approach, even though the highly influential concept of biopower appears only briefly to highlight his conceptualisation of governmental regulation of the biological processes of populations that produce certain kinds of bodies and a particular social body (Bacchi & Goodwin, 2016). Scrutinising how power produces differently gendered bodies for regulating populations is central to my examination of the SOC-7 and the Guide. In this section, I provide an overview of Foucault's (1978, 2003) concept of biopolitics as the complex encounter between "politics" and "life"

whereby power takes hold of life (and sanctions death) through the body at the level of the population. I offer a brief account of critical scholarship within and alongside trans health that utilises and extends this concept for analysing the biopolitical function of governing gender self-designation and access to gender-affirming medical technologies. I then outline some shortfalls of biopolitics as an analytic in relation to race and colonisation to describe why I deliberately place the biopolitics of settler colonialism at the centre of the framework for this thesis. I argue that recognising colonialism as a primary condition of modern governing counters an elision and invites scrutiny of how "care" functions as part of the biopolitics of settler colonialism.

The concept and analysis of biopolitics

Foucault (1978) introduced the term biopolitics in *The History of Sexuality, Volume 1,* to conceptualise the organisation of Western sovereign power into state power as "the administration of bodies and the calculated management of life" (p. 139). It was through this complex process of "taking charge of life, more than the threat of death, that gave power its access even to the body" (Foucault, 1978, p. 142). Elaborating this theorisation in his *Society Must Be Defended* lectures, Foucault (2003) argued that "power's hold over life" is more specifically the power of a modern governmentality "to 'make' live and 'let' die" (p. 241). This taking charge of life through the administration and management of bodies established a new political right that Foucault (2003) conceptualised as "the *right* to make live and to let die" (p. 241, emphasis added). This regulation of bodies includes managing their biological components and capacities. Foucault (2009) historicised the concept of biopower in his *Security, Territory, Population* lectures to enable a thorough understanding of the term "governmentality" as a set of "institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has the population as its target" (p. 108). Thus, biopower operates within an analysis of biopolitics by highlighting how life becomes "integrated into techniques that govern and administer it" even as "it constantly escapes them" (Foucault, 1978, p. 143). Biopolitics structures this analysis because it supports scrutiny of the specific knowledges, mechanisms, and administrative structures used for

governing access to gender-affirming medical technologies. Stryker (2014) offers a biopolitical understanding of gender that clarifies this position. In this account, gender:

> Is a system filled with habits and traditions, underpinned by ideological, religious, and scientific supports that all conspire to give bodies the appearance of a natural inevitability, when in fact embodiment is a highly contingent and reconfigurable artifice that coordinates a particular material body with a particular biopolitical apparatus. (Stryker, 2014, p. 39)

When approached biopolitically, gender is seen as "an apparatus within which all bodies are taken up", thus making its structure "an integral part of the mechanism through which power settles a given population onto a given territory through a given set of administrative structures and practices" (Stryker, 2014, p. 39). In this thesis, I follow Stryker by considering gender as constitutive of and integral to the mechanism of biopolitics while continually slipping through it. As I elaborate below, I read the SOC-7 and the Guide as part of the administrative structures and practices that settle and maintain populations, not on a given territory, but as a part of a broader colonial project of settler futurity.

There is a wealth of critical scholarship from within the field of trans health and transgender studies that utilises Foucault's concept of biopolitics for analysis. Arjonilla (2014), for example, identifies medical logics as central to biopolitics because they produce non-normative bodies both "as pathological and as an object of medical intervention" (p. 32). A human rights approach is the most widely used strategy for mitigating the harm caused by the pathologisation of people with self-designated genders. However, Canadian-based trans scholar, academic, and activist Dan Irving (2008, 2013) identifies particular modes of trans rights activism epitomising a biopolitical formation by unintentionally legitimising established neoliberal governing relations. Irving argues (2013) that an invocation of trans rights together with human rights law makes the lives of people with self-designated genders "who are unemployed, impoverished, criminalized, struggling with addictions, or

do not have citizenship status more arduous" (p. 321). Stryker and curatorial activist, queer scholar, and writer Nikki Sullivan (2009) also recognise the increasing normalisation of transgender status within neoliberalism. Yet, they argue that mobilising pathologised categories of deviant identities, such as those unmapped in section one, already serves a biopolitical function through technologies of individual responsibilisation. Thus, Stryker and Sullivan's (2009) use of a biopolitical analytic opens space for critical interrogation of what legitimises and enables "certain modes or forms of bodily being, whilst denigrating or foreclosing others" (p. 60). The theoretical framework for this analysis of trans health policy takes shape through these investigations of a medical logic's regulatory function and the kinds of recognition sought through rights.

While critical scholarship highlights the biopolitical function of governing both gender self-designation and access to medical technologies for body modification, there is also a generative interrogation of biopolitics as a conceptual tool for analysis. Cameroonian political theorist Achille Mbembé (2003) interrogates the limitations of biopolitics by conceptualising necropolitics as the subjugation of life "to the power of death" (p. 39). Re-emphasising the prominence of both race and racism in a calculus of biopower, Mbembé (2003) enables critical interrogations of various projects of colonial occupation as "topographies of cruelty" that create the conditions for necropower (p. 39). As mentioned in chapter one, such interrogation enables Snorton and Haritaworn (2013) to examine the value derived from the deaths, but not the lives of people of colour who designate their own genders. Eva Hayward, a scholar of sensation, sexuality, and science, and Black non-binary femme writer Che Gossett (2017) have gone on to question the ontological implications of a bio- and necropolitical analytic. Hayward and Gossett (2017) offer a caution against reading trans as "necessarily a progressive mechanism for revealing cultures of violence" because the careful positioning of gender self-designation as a crisis of categories for being is effective in stabilising them as mechanisms of governing (p. 18). Going further, Kadji Amin (2020), a critical scholar whose research focuses on the disorienting effects of the queer and transgender past on politicised fields of study, encourages scholars to attend to the implications of how the terms of analyses themselves are "invested from the start by biopower" (p. 51). My application of biopolitics in this analysis is scaffolded by this trans-

specific interrogation of what is prominent within, what is stabilised by, and what constitutes a biopolitical analytic.

The biopolitics of settler colonialism

The extensive use and examination of Foucault's analytical concept of biopolitics necessitates a critical application in this thesis. Critical theorist Alexander Ghedi Weheliye (2014) is a scholar and teacher of Black culture, critical theory, gender and sexuality studies, social technologies, and popular culture. Weheliye (2014) illuminates how Foucault uses the terms colonialism, colonised, and re-colonised as metaphors in his articulation of racism as producing biopolitics but assumes that they are understood without delving into how they operate as a set of interconnected historical phenomena. Moreover, passing over prior colonial formations to position the Nazi regime as the ultimate expression of racist state biopower demonstrates an elision of the rich traditions of Black and ethnic studies that theorise the relations between colonialism, racial slavery, Indigenous dispossession, and genocide extending over the centuries (Weheliye, 2014). In this account, Foucault's theorisation of biopolitics is, at best, a miscalculation and, at worst, a disavowal of the extent to which race, racism and racialisation shape the modern idea of the human. Weheliye (2014) argues that if there is to be an engagement with the conceptual apparatus of biopolitics, "that race be placed front and center in considerations of political violence albeit not as a biological or cultural classification but as a set of sociopolitical processes of differentiation and hierarchization, which are projected onto the putatively biological human body" (p. 5).

As a leading figure in critical Indigenous studies, Moreton-Robinson (2015) observes that while many scholars acknowledge Foucault's limitations, particularly on colonisation, there is a failure to investigate the ramifications of these limitations on understanding issues of Indigenous sovereignty. Influenced by the work of fellow Indigenous scholars, Moreton-Robinson (2015) mobilises whiteness studies together with Foucault's work in *Society Must Be Defended* to call for investigation of "how white possession functions through a discourse of rights" and "manifests in regulatory mechanisms"

(p. 134). Moreton-Robinson argues that:

> Indigenous sovereignty is in a different relationship to the state as opposed to the way in which citizens have a relationship to the state. And that the relationship between citizens and the state is through the racial contract … but Indigenous sovereignty is different … that through citizenship, the subjectivity of white people is, at an ontological and epistemological level, possessive. And it emerged historically as an integral part of the new subject. (Kauanui, 2018b, p. 219)

It is Foucault's concept of biopower — specifically, a genealogical account of "race" that is tied to war and sovereignty through introducing the subject of rights — that, for Moreton-Robinson (2015), provides a valuable framework for analysis of relations between Indigenous sovereignty and state sovereignty. This is largely because such an approach is underpinned by whiteness studies' central concern to understand "how racialized knowledge works in power relations" (Moreton-Robinson, 2015, p. 135). While this thesis does not explicitly engage in whiteness studies, it shares some of its central concerns. It is also essential to clarify that while this thesis recognises the presence of Indigenous sovereignty (discussed further in chapter three), it does not analyse how the governing in trans health policy operates in relation to its presence. I am only just coming to a full awareness of my possessive subjectivity as a white settler researcher. For this reason, I do not follow the research agenda that Moreton-Robinson (2015) sets out. Rather, I see Weheliye and Moreton-Robinson's critique as necessary lessons for developing a responsive and ethical theoretical framework.

This analysis mobilises critical theory for analysis by placing the biopolitics of settler colonialism at the centre of its theoretical framework. Morgensen (2011a) focuses on the tension in Foucault's oeuvre that arises because there is no direct theorisation of colonialism creating the conditions for biopower. Foucault (1978) certainly pinpointed the second half of the nineteenth century as the point where "a whole politics of settlement (*peuplement*), family, marriage, education, social hierarchization, and property accompanied by a long series of permanent interventions at the level of the body, conduct, health, and everyday life, received their color and their justification" (p. 149).

Foucault (1978) also identified a politics of racism "exercised through the devices of sexuality" and premised on "the mythical concern" with preserving racial purity and maintaining white supremacy (p. 149). In his critique of what is missing from Foucault's analysis, Morgensen (2011a) points to both historical and contemporary settler societies that were produced by those specific processes of Western law that absorb "Indigenous peoples into the settler nation by simultaneously pursuing their elimination" (p. 53). This notion of elimination is central to Wolfe's (2006) theorisation of settler colonialism as "an inclusive, land-centred project that coordinates a comprehensive range of agencies" whose "operations are not dependent on the presence or absence of formal state institutions or functionaries" (p. 393). Prompted by Kauanui (2018b), Wolfe clarifies that "eliminating the alternative, prior Native presence" is something that "carries right on, right through colonial society" in "thoroughly legal, bureaucratic ways" (p. 350). Part of what makes Wolfe's theorisation so crucial to the study of settler colonialism is his insistence that it is an ongoing, active practice (Kauanui, 2018b). Mark Rifkin (2014), who is a queer Jewish settler and a critical literary studies scholar, uses the phrase "settler common sense" to identify how "the legal and political structures that enable nonnative access to Indigenous territories come to be lived as *given*, as simply the unmarked, generic conditions of possibility for occupancy, association, history, and personhood" (p. xvi, emphasis added). It is for these reasons that Morgensen (2011a) argues that "distinctions within present power relations must be specified" by denaturalising "how settler colonialism acts continuously within them" (p. 69). It is therefore necessary to examine the "specific biopolitics of settler colonialism as generalised tactics of late modern power relations, which proliferate by naturalising their settler colonial conditions" (Morgensen, 2011a, p. 69).

What is at issue here is a lack of explicit consideration of how the wealth extracted from colonised lands and bodies requires and produces knowledge, expertise, status quo, and the mundanities that maintain settler colonialism. The purpose of such an examination is to counter "a naturalisation and continuation of settler colonialism" within both a "theoretical apparatus and the horizons of critical theory" (Morgensen, 2011a, p. 70). The call for greater attention to the naturalising of settler colonial conditions of power relations contextualises Stryker's (2014) assertion that gender is integral to the

mechanisms through which power *settles*, and that a consideration of the biopolitical function of gender requires recognition of the broader biopolitics of settler colonialism. Thus, I use this analytical concept to evaluate how colonialism acts continuously within trans health policy. I do so in response to cultural studies scholars Aimee Carrillo Rowe and Eve Tuck (2017) identifying that settler-researchers are responsible for responding to the workings of settler colonialism, even if what links them appears tenuous. As Morgensen (2011a) argues, from his position as a settler, "we must confront our inheritance of settler colonialism as a primary condition of biopower in the contemporary world" (p. 52).

This thesis compares a policy intended for worldwide use with one designed for a specific local context. It scrutinises protocol for granting (and denying) access to medical technologies for body modification as a part of continuous efforts to naturalise the colonial conditions that govern gender self-designation. By recognising the overlaps and specificities of the colonial contexts of these policies, this thesis contributes another way of understanding how the multiple, interlocking forms of oppression that people experience are part of connected settler colonial projects. The generative critiques of Foucault's conceptualisation of biopolitics from Weheliye, Moreton-Robinson, and Morgensen provide crucial lessons in conjunction with the insights offered by trans-specific interrogations of this analytic. They support a critical reading of the rhetorical use of "given" in Stryker's (2014) account of gender as integral to the mechanisms "through which power settles a given population onto a given territory through a given set of administrative structures and practices" (p. 39). Since gender is instrumental in the regulation of bodies for the control of populations, it is crucial to understand its function in purposely dispossessing some in order to settle others on stolen territory. I follow Stryker by considering gender as both constitutive of and integral to the mechanism of biopolitics. But as Arvin, Morrill, and Tuck (2013) argue, recognising settler colonialism to be a gendered process means there is an intellectual and political imperative to address how gender and gendering operate as interlocking oppressions within settler colonial projects.

Conclusion

In this section, I have detailed the Foucault-influenced theoretical framework for this comparative policy analysis, which is based on the understanding that colonialism is a primary condition of modern governing that operates in part by attempting to make itself invisible. Recognising this process as part of the mechanism of settling helps to analytically grasp the lines of heteropatriarchal white supremacy that are revealed by unmapping the field of trans health and sketching its overlays. Further, to appreciate the ways these are constantly rejected and resisted, I have outlined the concept of biopolitics and justified its use as the theoretical framework in this thesis by demonstrating how it is utilised and interrogated within critical scholarship. Trans-oriented interrogations of a biopolitical analytic and the limits revealed by critical Black and ethnic studies and critical Indigenous and whiteness studies scholars sensitised me to the political landscapes of governing gender in ways my social position and lived experience cannot. These crucial lessons and analytical tools support this examination of governing in trans health policy to not only recognise but scrutinise colonialism as its primary context.

Conclusion

This chapter has reviewed the literature in the field of trans health, with the purpose of pushing at the limits of its established progress narrative. This literature review highlights multiple ways in which the field is racialised, normatively gendered, and continually contested. In view of the critically applied Foucault-influenced theoretical framework, I suggest that focused attention on how dominant biomedical theorisations of "care" function as part of the biopolitics of settler colonialism can extend the narrow scope of the field. I used unmapping to historicise what is imagined, projected, and enacted in spaces and onto bodies. By opening with examples of overtly colonising actions and choices as preliminaries to the medical literature, this chapter traced how they permeate the shaping of trans health through the work of key figures in psychiatry, psychology, sexology, and endocrinology. An analysis then followed, presenting how people with self-designated genders created liminal and locally specific tangible spaces from which to speak back to a medical paradigm and respond to the

system of social ordering upon which it rested. Unmapping reveals how intricately interwoven processes of colonialism, scientific racism, and the management of non-normative bodies, alongside the individual and collective efforts of people with self-designated genders, shape the conditions of trans health within their contexts. This chapter then continued its critical review of the literature by sketching a set of overlays that emphasise additional complexity and nuanced opposition to the narrow approach taken in much of the medical and psychological literature in this field. Sketching the dense, connective, substantive, instructively thin, and richly detailed layers of scholarship shows much of what is at stake within the debates and efforts to address medicalisation and pathologisation in the field of trans health; and by extension, in the current Western medical model approach to "care". I also outlined why this analysis scrutinises approaches to depathologisation in trans health as a function of the biopolitics of settler colonialism. Centring scrutiny of the processes whereby power takes hold of life (and sanctions death) through the body at the level of the population generates an important depth of critical analysis when comparing the SOC-7 to the Guide, as well as complementing the interconnected forms of questioning in the WPR approach that highlight the governing each policy relies upon and produces. The following chapter outlines my use of the WPR approach together with a reciprocal research approach as the methodologies and methods used for data collection and analysis in this thesis.

Chapter 3
Approaching a comparative analysis of trans health policy

Approaching a comparative analysis of trans health policy requires multiple yet connected components. More than twenty years ago, Viviane Namaste (2000) posed a series of questions for research relating to people with self-designated genders. On the surface, these questions responded to the limitations of applying poststructuralist thought to a chosen text. Implied more deeply was dissatisfaction with the apparent disregard for the everyday lives of people with self-designated genders inherent in both theory and research. Consequently, Namaste (2000) argued that a focus on the "relations between knowledge and action" necessitates a kind of "academic inquiry that is theoretically sophisticated, politically engaged, and practically relevant" (p. 9). Namaste's appeal for an explicit focus on these dynamic relations remains compelling for contemporary scholarship in the embattled field of trans health, which is beset by thoroughly discredited hypotheses about gender self-designation such as "rapid-onset gender dysphoria" (Ashley, 2020), the rise of an incoherent white supremacist "gender critical" feminism (Vincent et al., 2020), and conservative right-wing political organisations actively campaigning against trans health (Moore, 2021). Relations are the linchpin of my approach because they support an in-depth examination of how I gather data and hold together the various components necessary for analysing the governing of gender through policies governing access to gender-affirming medical technologies.

This chapter outlines the methodology, methods, and ethical considerations used for data collection and analysis in this thesis. Section one provides an overview of the WPR approach as a theoretically sophisticated and politically engaged methodology for this policy analysis. Section two describes the method I used to generate and then integrate two sets of WPR analyses as the data for this thesis. The primary data consists of a standard application of the questions in the WPR approach to both policy

texts. The supplementary data consists of two facilitated group sessions in which research participants used a condensed WPR approach to analyse the introductory statements in both policies. Section three describes reciprocal research as a methodology and a method of delivering something of benefit to participants that forms an additional part of this comparative policy analysis. This section also includes a discussion of how I understand reciprocity in terms of Indigenous sovereignty, and how I use its lessons for responsible research. I suggest that using the WPR approach to analyse trans health policy in conjunction with a reciprocal research approach invites attention to the politics and the relationships inherent in knowledge production.

The WPR approach

This section provides an overview of the methodology called What's the Problem Represented to be? (WPR), used in this thesis as the chosen approach for policy analysis. Based on an argument that we are all *governed through* constituted "problems", a WPR analysis concentrates its attention on policy proposals and their problematisations. The questions within the WPR approach offer an alternative to conventional forms of policy analysis that are concerned with using "evidence" of "what works" to generate proposed solutions to fix a given "problem" (Bacchi & Goodwin, 2016; Bacchi, 2009). The WPR approach is an analytic strategy that takes a contrary position that "policy is not the government's best effort to solve 'problems'; rather, policies produce 'problems' with particular meanings that affect what gets done or not done, and how people live their lives" (Bacchi, 2012, p. 22). Despite its reference to efforts made by an elected government, the WPR approach is not solely concerned with legislative institutions and public policy; instead, it invokes a poststructural understanding of government as an activity "that aims to shape, guide, or affect the conduct of people" (Bacchi & Goodwin, 2016, p. 5). Accordingly, Bacchi and Goodwin (2016) describe a WPR analysis as a way of using policy "texts as 'levers' to open up space for reflections on the forms of governing, and associated effects, instituted through a particular way of constituting a 'problem'" (p. 18). As mentioned in chapter one, I deliberately emphasise the governing of gender *through* the governing of access to discuss what happens within the space levered-open by analysing the SOC-7

and the Guide. I describe the theoretical stance and an application of this analytical strategy to show how the WPR approach aligns with Namaste's call for theoretically sophisticated and politically engaged research concerning people with self-designated genders.

As an explicitly Foucault-influenced poststructural approach, a WPR analysis directs critical attention to the *making* of problem representations. Working from a position "that a policy *represents* a 'problem' in a particular way" focuses on "how the 'problem' is *made to be* a particular kind of problem *within a specific policy*, with all sorts of effects" (Bacchi & Goodwin, 2016, pp. 17, emphasis in original). Crucially, it does not suggest that "problems" do not exist, nor does it reductively suggest that policies themselves produce things such as "ill health" (Bacchi, 2009). The WPR approach takes seriously the consideration of how "ill health", "poverty", and so on might *result* from some policies, and further, "that declared commitments in some policies are empty promises, that there was no *intent* to deliver on them" (Bacchi, 2009, xix, emphasis in original). Recall the discussion in chapter one of O'Brien's (2013) supply chain analysis. Locating her use of synthetic estrogens within a complex web of activities, O'Brien (2013) considers the multinational corporations that produce pharmaceutical hormone preparations; transnational trade agreements that make these available on the "free market"; and the varying degrees to which national insurance-based healthcare systems and insurance companies provide financial coverage for this "care", together with the localised regulation (including criminalisation) of access to injecting equipment. Depending on one's position as a citizen (economic subject) within this web of neoliberalism and racial capitalism, ill health and poverty are among the many results of this network of overlapping policies. The current Australian research mentioned in chapter two is relevant in this context as it confirms there is an array of adverse conditions that undermines the flourishing of people with self-designated genders (Callander et al., 2019; Hill et al., 2020). Specifying that the WPR approach is not questioning whether "problems" exist is crucial in light of sustained feminist contestation of the complex ways in which concepts associated with mental ill-health (such as "distress" and "trauma") are co-opted to normalise, individualise, and depoliticise interlocking forms of structural oppression (e.g. Tseris, 2019; Ussher, 2010).

Approaching an analysis of the SOC-7 and the Guide by asking how each policy governs through giving shape to "problems" offers a critical counter-reading and a challenge to conventional problem-solving forms of analysis. The WPR approach maintains a conviction that problem representations within policies constitute *political interventions* (Bacchi, 2014; Bacchi & Goodwin, 2016). To sustain critical attention on the political, problem representations "need to be contested at the level of what they produce" (Bacchi, 2016, p. 12). The theoretical approach in WPR is thus consistent with a poststructural theoretical framework and with much of the Foucault-influenced, cross-disciplinary, critical literature previously discussed in chapter two. Although the WPR approach is not widely used in the field of trans health, there are nevertheless many examples of critical analysis in this vein. These include Latham (2017) scrutinising the constitution of gender self-designation and people with self-designated genders in a medical context as clinical practice "problems" (p. 40); Dewey and Gesbeck (2017) examining the relationship between diagnostic processes and what legitimates gender identity; and applied linguistics scholar Rodrigo Borba (2019) analysing the interactional making of people with self-designated genders into "institutionally recognisable types of subjects" (p. 24). The WPR approach provides a practical and relevant methodology for deepening the ongoing analysis of how trans health policy gives shape to "problems" while remaining attentive to an array of interconnected local and transnational public, economic, and organisational forms of governing.

Box 1 — Questions in the WPR approach to policy analysis (Bacchi & Goodwin, 2016, p. 20)

Question 1: What's the problem (e.g., of "gender inequality", "drug use/abuse", "economic development", "global warming", "childhood obesity", "irregular migration", etc.) represented to be in a specific policy or policies?

Question 2: What deep-seated presuppositions or assumptions underlie this representation of the "problem" (problem representation)?

Question 3: How has this representation of the "problem" come about?

Question 4: What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be conceptualized differently?

Question 5: What effects (discursive, subjectification, lived) are produced by this representation of the "problem"?

Question 6: How and where has this representation of the "problem" been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?

Step 7: Apply this list of questions to your own problem representations.

Uniquely, analysis of problem representations begins with what a policy says it will do. To begin an analysis that scrutinises how governing takes place using the WPR approach, Box 1 above sets out the interrelated forms of questioning and analysis the WPR approach offers for scrutinising how governing takes place. Beginning a WPR analysis is "to 'work backwards' from a proposal to how a 'problem' is represented" so as "to 'read off' the problem representation from the proposal or proposed solution" (Bacchi & Goodwin, 2016, p. 17). It is a deceptively simple starting point. Using plain language, Bacchi (2014) clarifies that in policy — as in many everyday situations — what we say we will do about something also announces what we think needs to change; from there, it can be understood what we think the "problem" is. Bacchi (2014, 2018a) explains how to undertake this analysis by relating her experience of being inundated with email invitations to training sessions intended to boost her position as a "woman academic". Bacchi (2014) explains that if training programs are the solution to the lack of women in well-paid, high-status academic leadership positions, the problem is represented to be women's lack of training. This example shows how question one of the WPR approach, which asks what a "problem" is represented to be, is a clarification exercise (Bacchi, 2009). It sets the scene for using the remaining analytic questions to

consider what is happening beneath, surrounding, and as a result of a problem representation, an insight that supports extensive scrutiny and critique of a particular policy (Bacchi & Goodwin, 2016). That is to say, after clarification, a WPR analysis reflects on the assumptions and presuppositions underpinning a problematisation — such as women's assumed lack of leadership skills. Analysis considers how a representation came about and further scrutinises what's not being problematised, what the effects are, and how this problematisation is deployed and challenged in particular contexts. I use the WPR approach to analyse how the SOC-7 and the Guide set out parameters for "care" as proposals for how practitioners can respond to requests for access to gender-affirming medical technologies. I made this choice because the analytical depth of the WPR approach allows a scrutiny of how the biopolitics of settler colonialism functions in this form of governing. I use its modes of analysis to sort through, as Bacchi (2009) suggests, the various explanations presented for the political interventions presented in both the SOC-7 and the Guide. This overview demonstrates that the WPR approach is a methodology that uses theoretically driven concepts to facilitate an analysis that attends to the political while providing a practically relevant way to offer critical comments on the proposals put forward in the SOC-7 and the Guide.

Two sets of WPR analyses

This thesis offers a novel implementation of the WPR approach in that it uses two different applications of its modes of analysis to produce two sets of findings. In this section, I describe how I intentionally designed a method of analysing trans health policy that could be approached from a range of subject positions and practice experiences. It generated a set of primary findings by applying an entire WPR analysis to the two chosen policy texts. It also produced a set of supplementary findings where participants in two focus groups used WPR's first question to clarify problematisations in the introductory sections of the SOC-7 and the Guide. This novel implementation was not an attempt to improve the WPR approach. Instead, the description of methods in this section demonstrates how a poststructural sensibility supports an engagement with both sets of WPR analysis

to develop a rigorous comparison of both policies.

The primary WPR analysis

The primary data for this thesis was generated by responding to each question contained within the WPR approach (see Box 1). I printed copies of each policy, placed them in a two-ring binder for easy reference, and used coloured markers to annotate the pages. The accumulation of handwritten annotations over time was an important part of the analysis process. I began by asking what the problem is represented to be within the SOC-7 and the Guide (Question 1). The identified problematisations provided a focus for consulting explanatory texts (Bacchi, 2009; Bacchi & Goodwin, 2016; Bletsas & Beasley, 2012), recorded seminars (Bacchi, 2014, 2018a), and the Research Hub on Bacchi's blog, for the purpose of teaching me and those in the group policy analysis sessions how to utilise the approach. The constant referring back to this material over time was an essential part of the analysis; it helped to establish connections and discrepancies between the data sets, deepening the extent of the findings. After responding to Question 1, I used a genealogy of "care" to consider how each policy's problematisation came about (Question 3). I also facilitated, transcribed, and coded the group policy analysis sessions during this time. I then returned to reflect on the conceptual logics and attendant liberal governmental rationalities that underpin these policy problematisations (Question 2) and updated the responses to Question 1 with the supplementary data.

Findings from the first three questions supported concurrent scrutiny of the silences within the SOC-7 and the Guide (Question 4); the discursive, subjectification and lived effects of each mode of governing (Question 5); and how the problematisations of distress and an illness-based model have been deployed and resisted in particular contexts (Question 6). While the group analyses' primary focus was on Question 1, the extent to which the supplementary data significantly impacted the entire analysis was unexpected. This data intensified the illumination of what each "problem" was represented to be and indirectly consolidated the selection of critical moments in the genealogy of "care". As will be discussed in the findings chapters that follow, there were times when participant

comments and group discussion created an important direction for the remainder of the analysis that would not have otherwise been considered. In addition to this reflection on the research method, I report on the self-problematising application of the WPR questions (Step 7) in chapter nine.

The supplementary group WPR analyses

Eight participants across two focus groups generated the supplementary findings. This overview of the group WPR analyses describes the methods for participant recruitment and consent, along with a summary of participant demographics, followed by an explanation of how each group policy analysis was facilitated and an overview of the discussion questions. This data collection was conducted before the outbreak of the Covid-19 pandemic in Australia. Of the two facilitated analyses, the first was a face-to-face session with four participants, held in May of 2019 at a community service organisation in Sydney. A second group was held using the video conferencing platform Zoom, a choice that was made in response to feedback about making the session more accessible. This second group policy analysis was held in July 2019, with four participants joining from locations across Sydney and Melbourne.

Recruitment

The selection criteria for the group WPR policy analysis required that potential participants be practitioners with direct experience in supporting people with self-designated genders, irrespective of whether or not these service users are seeking access to gender-affirming medical technologies. In addition, potential participants were required to be in either paid or volunteer roles within community organisations or private practice. This requirement was based on the rationale that pre-existing support structures could be enacted in support of a participant who may experience distress during their participation. To recruit participants, I approached a long-established group that describes itself as a peer supervision community of practice for practitioners providing therapeutic support to trans and gender diverse people. Information about this group was available on the website of an Australian organisation operating in the LGBTIQA+ community health sector, verifying that it met the selection

criteria. Initial contact was made via email, followed up with e-introductions and a telephone conversation with core group members, hereafter referred to as core-group liaisons. I use the term "core" to distinguish between those members who support new member engagement and organise the peer supervision sessions and other members who interact as part of the group on the email list and in supervision sessions.

The participants for the facilitated group WPR policy analysis were recruited via the group's email list. The session options were formulated in discussion with the core-group liaisons based on their experiences convening peer supervision meetings. I created and sent the final invitation to the core-group liaisons, who then approved it and then forwarded it to members (see Appendix for Invitation to participate in research, Participant Information Sheet, Participant Consent form). After this initial mail-out for the first group session, one of the core-group liaisons maintained ongoing contact with me to communicate about recruitment. The second group session recruitment then consisted of re-contacting group members who had confirmed but were unable to attend the first session, followed by re-contacting group members who had expressed interest in participating in the first group session. Core-group liaisons then approved and emailed an amended invitation to participate in the second session to their list.

Consent

Obtaining full, prior, and informed consent from participants occurred at the outset and as an ongoing verbal iteration during each focus group. All those who indicated an interest in participating received an electronic copy of the Participant Consent Form via email (see Appendix), and completed a hard copy of this same form at the beginning of the face-to-face proceedings. Participants in the Zoom session completed an electronic copy of the document and returned it to the researcher via email before commencing the video proceedings. All potential participants were made aware in writing and by verbal instruction that their consent to the research was by free choice. The method of consent-as-process consisted of a verbal iteration of the written Participant Consent Form at the start of

proceedings and a verbal reminder at the start of the analysis component of the group. This method of consent provided the participants an additional opportunity to review their decision and withdraw from the study if they desired. Participant consent and withdrawal were recorded and transcribed as part of the audio recordings of the research. In accordance with the best practice Research Data Management standards outlined by the University's Research Data Management Policy 2014, hard copies of consent forms remain in a locked filing cabinet at the University of Sydney. Upon digitisation of hard copies, all consent forms and all electronic research materials are stored in encrypted folders with assigned security codes on a MacBook Air (M1, 2020), backed up on an external hard drive, and in a University of Sydney OneDrive cloud-based storage account.

Participant demographics

The characteristics of the eight research participants began to emerge at the beginning of each focus group as they introduced themselves according to the context of their work and what they bring to it (see Box 2). This introductory process was deliberately structured to set the tone for the discussion, as it allowed the participants to offer their demographic information in a way that created opportunities for critical, self-reflexive — or even self-problematising — comments about the complex layers of identification in their lives. Participants explicitly spoke about aspects of who they are and where they're at throughout the focus group when it was relevant to the topic under discussion. The information they provided during this part of the process included naming their sexuality (e.g., as gay or queer); identifying as belonging to a broader LGBTI community, or more specifically, the intersex community, identifying themselves as a peer; and identifying as someone with a self-designated gender. These details suggest that participants are simultaneously experiencing oppression and engaging in political struggles, not merely working as mental health practitioners who are "helping others". The introductory questions also prompted participants to reveal that they had been practising in therapeutic settings approaching or going beyond ten years. Notably, almost all participants worked to support access to subsidised counselling sessions by operating on a sliding-scale fee structure in private practice or working in Government or NGO settings that offered free counselling as part of

their overall services.

Participants reflexively introduced what they brought to the work. More than one expressed their frustration about their professional qualifications not being recognised across international borders. One participant mentioned a difficult upbringing in the northern part of Europe at the height of a conservative neoliberal regime as his inspiration to start training as a social worker and later as a psychologist. For this participant, "with all kinds of the underdog coming out as queer … and having a family member and friends transition, I really wanted to do something that was bigger picture". Another participant spoke of inspiration coming from a different direction – specifically, being inspired and "really stretched" by "a bunch of younger people" who access their services "who are very political"; and from this, cultivating a therapeutic practice of mutual knowledge sharing that includes a respect they could not depart from, even if they wanted to. Most participants described actioning their politics, such as one who described her responsive efforts to create material spaces for practitioners to address the misuse of power in therapy, and another who spoke of "giving a push" to certain systems to make federally funded services accessible. Another participant also declared:

> Certainly, I want what I say not in front of people's faces to be consistent and congruent with what I say to their face. Not just, "There, there, I understand you are having trouble with an oppressive system". But actually, I will be challenging that system with my professional colleagues. I will be challenging that with your psychiatrist, your GP, whoever.

This kind of active stance was acknowledged by another participant who said that for the people who are seeking them out for support, gender was only "one way that they identify, and they don't want that to be a hurdle for the rest of the support they receive". These comments demonstrated links between participants' political thinking and some of the political elements of their work, and also the stance that was taken by the peer supervision group to which they belong.

Box 2 — Introductory "go-round" Questions

1. Tell us about the context of your work.
This might be whether you work in private practice or as part of an NGO, the fee structure, who sees you, the setting where you work.

2. Tell us what you bring to the work.
This might be a perspective or a stance that you have. It might be your experience, your vision.

Focus group facilitation

The first group policy analysis was intended as a 120-minute face-to-face morning session broken up into four sections, with a food break in the middle. The session used a PowerPoint presentation that included an introduction and orientation; an explanation of the WPR approach; an analysis of excerpts of the SOC-7 and the Guide in small groups; and a report-back/discussion. Introducing a research methodology to a group of psychologists and counsellors in a limited time frame posed a challenge. Workshop recordings of Bacchi (2014, 2018a) introducing scholars to the WPR approach proved an invaluable resource. In the introduction, I explained the notion of policies as giving shape to problems; briefly outlined some of the key theoretical concepts; and gave a short overview of the WPR Chart (Box 1). I also facilitated a series of short activities on the notion of governing and being governed through policies; the WPR approach to analysing concepts; and practicing "the WPR thinking" with some example policy proposals. Small participant numbers meant that upon completion of the introductory section, the analysis proceeded as an all-in discussion. After a short break, participants took turns reading from the introductory sections of the SOC-7 and the Guide, and I used the discussion questions (Box 3) to facilitate their analysis of the text. The overly long lecture-style introductions of the WPR approach and a misunderstood ending time (which meant the session was only 90 minutes) constrained the analysis in this instance. A second group session was added to address these limitations and to provide another opportunity for participants who had notified the core-group liaisons that they were unable to attend, but were keen to contribute in the future if possible.

The second group policy analysis was advertised as a 90-minute morning session held via the Zoom video conferencing platform. A practice reflection on the first group session and the shift to an online format required a reworking of both the delivery of content and the engagement with participants for this second analysis. The format included the same introduction and orientation; an updated explanation of the WPR approach using the short activities; and due to the small group size, another all-in group analysis of the policy excerpts. Owing to a positive response from the first group when presented with opportunities to practice the WPR thinking before starting the analysis, the existing lecture-style explanation was replaced with a simplified, real-world example. I set the scene by asking participants to:

> Imagine for a moment that you manage a huge retail business with hundreds of stores across Australia. You receive word that the company will no longer provide plastic bags to customers. If you respond by making available some cardboard boxes that would otherwise be thrown out, in effect you are saying that it's part of the company's role to reduce waste. What you propose to do about something reveals what you think needs to change. If instead, you decide to tell your customers to bring their own bag or to buy one that you offer, you are saying that it is the customer's role to reduce waste.

I used this example in concert with Bacchi's (2014, 2009) description of a gym owner with an expensive water bill and with the example of "training programs for women" from the previous section for the group to practice identifying policy proposals. The group continued to practice the approach by analysing the general example of "crime" (Bacchi, 2014), the use of "resilience" in a 2012 South Australian drug policy (Bacchi, 2018a), and the description of Compulsory Income Management on the Australian Department of Social Services website (Bacchi & Goodwin, 2016). The reworking from a presentation to a practice-based format meant that when participants in the second focus group began their analysis of the SOC-7 and the Guide, they were equipped to produce a more in-depth analysis. Participants were so engaged in taking turns reading and analysing excerpts of the policies that they agreed to extend the session finishing time, and produced close to ninety minutes

of analysis.

Discussion questions

Rather than attempting to complete a full WPR analysis in a single focus group session, I created a series of discussion questions based on the key ideas within question one of the approach (See Box 3 below). These were based on discussion questions used by Bacchi (2014, 2018a) in her workshops and used as prompts for participants to discuss proposals, issues, and explicit and implicit references to "problems" that they identified in each policy text.

The first question emphasised proposals, asking participants to identify what each policy said needed to happen. The second invited participants to discuss what issues they saw included in the policy and the concepts they thought were associated with those issues. Question three focused attention on the overt references to "problems" and asked participants to consider whether these "problems" were presented as taken-for-granted "realities". Question four asked participants to move deeper into the analysis and consider implied problematisations in each policy's proposals. Participants were invited to consider whether these more subtle problematisations linked up or misaligned with overt problematisations, and in doing so, if they could detect a weighting of one problem representation over the others. The final two questions were formulated to be used if the group needed further prompts to generate discussion. Question five was posed because of WPR's emphasis on governmental rationalities; however, because the theoretical concept of governmentalities was given only a cursory introduction, asking participants to consider the styles of problematisation in each policy was considered less of a priority. Similarly, the explicit attempt at self-problematisation within question six was also de-prioritised. The rationale relevant to this decision was that participants might organically reflect on whether any of their underlying assumptions had come to light, whether the approach moved them toward thinking differently, whether it opened up things that might not have been on their agenda previously, and whether it would assist them in some way to think about governing.

Box 3 — Group Policy Analysis Discussion Questions

1. Look for the proposals in each policy. What is the policy saying that it will do?

2. How are the issues spoken about in each policy?

3. Look for the explicit references to "problems". How are the explicitly named "problems" represented?

4. How do the proposals represent the "problem"? Are they different from explicit representations?

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5. Look to find how governing is taking place: can you identify governmentalities?

6. Have a go at Step 7. Ask yourself, how am I representing the 'problem'?

While the first group session ambitiously asked participants to respond to six questions, time constraints resulted in covering only the first two. After the practice reflection on the first group session, a decision was made for second session participants to respond only to questions one, three and four, using the rationale that an emphasis on identifying the proposals supported the participants in discussing the explicit and implied problematisations in the Guide and the SOC-7. The practice-based format of the second session therefore supported a thorough discussion of all three questions and enabled an attempt at the content of the others.

Bacchi and Goodwin (2016) caution researchers that judgements based on additional research data must adhere to a poststructural sensibility and "remain open to disputation, variation and revision" (p. 23). Following a poststructural sensibility, I used the discussion questions in the focus group to facilitate a discussion that contests notions of single truths and knowledges. I use them in the analysis

that follows to cultivate an active engagement *between* the primary and supplementary WPR analyses and to develop a rigorous set of overall findings, which is demonstrated in the use of excerpts from the group policy analyses throughout the thesis. These excerpts create points of contention that help trouble an uncritical account of each policy's problematisations, meanings, effects, deployments, and resistance.

Conclusion

This section offers an overview of the WPR approach as a methodology. In particular, its focus on how we are governed through problematisations; clarifying the complex making of problem representations; and providing an understanding of the political function of problematisation. This section also offers an overview of the methods I used to generate two data sets through two different applications of a WPR analysis, with summaries of the two group analyses and a description of the methods of consent and recruitment, participant demographics, focus group facilitation, and discussion questions. A description of how I used the collective voices of the participants in the group WPR analyses to supplement the primary findings and to reflect critically on the comparative analysis of each policy are also covered in this section. Each overview demonstrates how this application of the WPR approach aligns with the first part of Namaste's call for research concerning people with self-designated genders to be theoretically sophisticated and politically engaged. The second section of this chapter responds to Namaste's call for focus on the relations between knowledge and action, specifically for ways to generate practically relevant research.

A reciprocal approach to research

This section describes how I utilised a reciprocal approach so that this research might benefit those for whom trans health policy is written. I have completed the formal processes set out for ethical research in Australia. This research project (No. 2018/948) received approval from the University of Sydney Human Research Ethics Committee from 14 January 2019 to 14 January 2023 (see Appendix for a

copy of the University of Sydney Human Research Ethics Committee approval). While this research is undertaken ethically and with integrity, I was concerned that the analysis had limited practical use for people working "on the ground" for the depathologisation of gender self-designation and increased access to requested gender-affirming medical technologies. Discussions about ethics are ongoing with my supervisors, other academics, research participants, and peer researchers. They have enabled me to rethink research processes more expansively and have opened space for considering this question of being useful. I have come to understand reciprocity in research as a method of producing knowledge in ways that can directly benefit participants and as a foundation of Indigenous polities. This mindset change has helped me to understand reciprocity as a way of unravelling settler colonial relations of domination and extraction.

This section details how Indigenous sovereignty informs this methodology even though the research does not engage directly with Aboriginal and Torres Strait Islander people. The method for this reciprocation comprises listening, liminality, and circularity, with each of these three components being in play during the entire research process. I describe two concrete activities to outline this approach: organising the focus groups that produced the supplementary findings, and my involvement in a working group that developed a set of practice guidelines for the broader community of practice. These reciprocation activities enabled me to contribute to the collective organising efforts of practitioners who are working in support of people with self-designated genders. Addressing questions about the benefit of this research through reciprocation and recognition of Indigenous sovereignty presents opportunities for me to carry out my ethical responsibilities. I suggest that a reciprocal approach addresses immediate ethical questions and provokes a deep consideration of how the settler colonial context and Indigenous sovereignty inform my research practice.

Research that is of direct benefit

A reciprocal research methodology is concerned with generating direct benefits for participants as a result of their participation in the research. This explicitly relational methodology is commonly

understood as an ethics of exchange. However, there are challenges inherent in articulating and deciding with participants what counts as beneficial beyond monetary payment. The *National Statement on Ethical Conduct in Human Research* (the National Statement) offers guidance for considering ethical issues that are associated with research design, participant recruitment and consent, research data and participant information, communication and dissemination of findings, and research completion (National Health and Medical Research Council, 2007). These associated issues are framed by five values: respect, research merit, integrity, and justice (NHMRC, 2007). The benefits of research specify an expression of justice that "involves a regard for the human sameness that each person shares with every other", which indicates underlying biomedical assumptions about human subjects that often emphasise the individual at the expense of surrounding conditions (NHMRC, 2007, p. 9). According to the National Statement, the resulting "benefit to humankind" is equivalent to the "benefits of research [that] are achieved through just means, are distributed fairly, and involve no unjust burdens" (NHMRC, 2007, p. 9). Emphasising the importance of the research process recognises the appropriateness of reimbursement for material costs and for the time involved, but reciprocity is only mentioned with regard to research with and about Aboriginal and Torres Strait Islander peoples (NHMRC, 2007).

Anchoring reciprocity to Aboriginal and Torres Strait Islander research is crucial because this organising principle that differs significantly from the conventional, biomedical, risk-based approach to research ethics. Reciprocity is one of the six core values in the *Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders* (the Guidelines), alongside spirit and integrity, cultural continuity, equity, respect, and responsibility (National Health and Medical Research Council, 2018). It is also specified among the responsibilities in the Australian Institute of Aboriginal and Torres Strait Islander Studies (2020) *Code of Ethics for Aboriginal and Torres Strait Islander Research* (the AIATSIS Code). This emphasis on integrity is consistent across all three guides for research. However, the AIATSIS Code (2020) connects the importance of integrity to the ways research contributes to Indigenous peoples' "ongoing experiences of colonisation, theft of lands and resources, disruption to societies and

families, and suppression of culture and identity, [that] is a denial of human dignity and respect" (AIATSIS, 2020, p. 11). Thus, reciprocity is a core value, and responsibility is a counterpoint to prevailing ethics. These proceed "from a presumption of Indigenous authority as self-determining peoples, and as rights holders, both proceeding "from a presumption of Indigenous authority as self-determining peoples, and as rights holders, whose knowledge and contribution to research must be recognised, respected and valued" (AIATSIS, 2020, p. 11). The stark contrast between the references to humanity in the National Statement and those in the AIATSIS Code is made clear by Steve Larkin (2020), a Kungarakany and Yanyula man, an executive leader of Indigenous tertiary education in Australia, and a scholar of critical race and whiteness studies in the areas of public administration and social policy. Larkin (2020) identifies the racial dimensions of the "human sameness" mentioned in the National Statement by pointing out how research carried out by white people on any population is thought to be done in the name of "humanity", whereas this claim to power is tacitly unavailable for people who are racialised as Indigenous Australians: "they can only speak for their race" (p. 172). Expressions of Indigenous sovereignty can instead "redefine and reorient what we do and what we know so that positive transformation may result" (Larkin, 2020, p. 177).

I began this research mirroring what is set out in the National Statement. I was wary of appropriating Indigenous research methods because I considered a comparative analysis of trans health policy to be outside the sphere of researching directly with Aboriginal and Torres Strait Islander people and communities. Thus, I investigated how other researchers worked with ideas of reciprocity and used those to inform how I invited participation in the group policy analysis in exchange for something that would be directly useful. My investigations included Eileen Pittaway, Linda Bartolomei and Richard Hugman's (2010) description of reciprocation for research on human rights abuses against refugees with the Shan Women's Action Network (SWAN), a community-based organisation responding to the needs of displaced Shan women on the Thai-Myanmar border. Pittaway, Bartolomei and Hugman have variously researched preventing and responding to sexual and gender-based violence experienced by refugee women, ethics of research with refugee communities,

professional ethics, community development, and international issues in social work and social development. Pittaway, Bartolomei and Hugman (2010) recount how, back in 2002, SWAN self-published their report on the systematic and brutal use of sexual violence against Shan women by the Burmese military. Through negotiation, SWAN agreed to share their experiences of human rights abuses in refugee camps in exchange for training from the research team on how to use their report in formal NGO and UN meetings to lobby for political change (Pittaway et al., 2010). Reciprocity was also used by prefigurative politics scholar-activist Sofa Gradin (2017), who reflected on the limitations of negotiating a labour exchange with two organisations who participated in their research on radical egalitarian alternatives to neocolonial and capitalist trade across North-South borders. A third example is an investigation by English and technical writing scholar Heather Noel Turner (2018) of how researchers interested in social justice use reciprocity in their practice. I began the reciprocal approach with these examples in mind. However, as I developed a relationship with core-group liaisons, I realised that I had stepped off the path of responsible action in my wariness of appropriating Indigenous knowledges. Cherokee poet, scholar, and activist Qwo-Li Driskill (2010) argues that when "a Native presence is made absent" in analyses of ongoing colonialism, it "brings us to question whether Native people, histories, and decolonial struggles are actually part of scholarly and political consciousness and imagination" (p. 78). Countering this un-seeing is not an argument for scholars to change the focus of their work, but an expectation that scholars "integrate Indigenous and decolonial theories into their critiques" (Driskill, 2010, p. 78). As Arvin, Morrill, and Tuck (2013) explain, the point of naming the un-seeing is to understand that people "who are generally supportive of Indigenous causes but feel that their research has nothing whatsoever to do with Indigenous issues may need to reassess what Indigenous theories are actually concerned with", since "such theories are much more expansive than many non-Indigenous peoples have been led to think" (p. 27). Prompted by such critiques, I began reconsidering how I recognised the presence of Indigenous knowledge and theory in the reciprocity I was undertaking.

There are over 500 hundred prior and ongoing nations in this place currently known as Australia, each with distinct culture, language, and law premised upon respect and reciprocity in relationship with

Country. I am learning this as a presence, part of which is deep collectively held knowledge that contains intricate layers of being and responsibility. This understanding is facilitated, in part, by Lorraine Muller (2014a), a Murri woman and a scholar of decolonisation and social health. Recognising difficulties in drawing on Aboriginal and Torres Strait Islander theory as an academic source, Muller (2014b) sought appropriate ways to make it available to Indigenous students, health workers, and interested non-Indigenous people. Muller (2014b) describes her research with cultural knowledge holders as a process of genuine two-way knowledge sharing that is grounded on mutual respect and understanding. This description helps me to appreciate my settler position and reinforces the reason that I am not permitted into so much cultural knowledge. A further dimension is added by Yugambeh writer and scholar Arlie Alizzi (2014) and his colleague Madi Day (2020), who identify how predictable debates about legitimacy and persistent myths about Aboriginal cultures are used to justify dispossession. Alizzi (2014) and Day (2020) emphasise the strategic decisions made about what to omit from discussions to make sure that it can be used by non-Indigenous audiences. Since my social position means that I am complicit in processes that attempt to eliminate and interrupt much more than cultural knowledge transfer, what does it mean for me to draw upon Indigenous understandings of reciprocity for my research? The Gay'wu Group of Women (2019), a deep ten-year collaboration between five Yolŋu women and three non-Aboriginal women, has helped me understand how protocol allows appropriate layers of knowledge to be shared strategically and teaches how to show proper respect; therefore, Indigenous theory is also an ethics for relations of respect. I now realise how these considered yet often exasperated explanations and prompts are consistently repeated across various modalities. By following the lessons that are offered, I can recognise Indigenous sovereignty as crucial in this methodology, even though the research itself does not directly include and may not have specific significance to Aboriginal and Torres Strait Islander peoples. In this reciprocal research methodology, such recognition presents an opportunity to practice what is required for building Indigenous settler relations in anti-colonial work. In the following section, I share reflections and lessons from a method of reciprocity.

A method of reciprocal research

I draw upon the responsibility and lessons of Indigenous sovereignty and the examples of reciprocation by non-Indigenous researchers to discuss how listening, liminality, and circularity function together as a method of reciprocity. Listening is a crucial component of this method. In an echo of the AIATSIS (2020) framework, Pittaway, Bartolomei and Hugman (2010) explain that to achieve reciprocity, "researchers need to return to the community something of real value, in forms determined by participants themselves" (p. 234). I approached a relationship with the core members of the community of practice who had agreed to participate in this research with the idea of figuring out a trade. I attempted to enquire about the meaning of "community" and what was held to be of value by those involved. The core-group liaisons responded thoughtfully but were confused by this approach. Changing tack, I asked directly about tasks that the group might delegate to an outsider. Talking in terms of trade seemed the simplest way to describe what I hoped to be doing, but something was off. It wasn't about changing the course of the conversation, it was about changing the terms. As I began connecting up the lessons offered by critical Indigenous scholars and peers, I realised the dimensions of extraction and domination within popular notions of trade. Ngāti Awa and Ngāti Porou, Māori critical scholar Linda Tuhiwai Smith (2021), explains that the assumption of a two-way transaction between someone who buys from someone who sells also assumes that places, people, and cultural items were available to be sold. These assumptions are ingrained into the settler colonial structures that Wolfe (2006) argues destroy to replace. Thus, the notion of trade is far from innocuous in the face of the sustained rejection of such assumptions and calls for treaty relations, truth-telling, and reparations by Indigenous Peoples. Understanding trade as part of the biopolitics of settler colonialism helps me to understand how it operates within the mechanisms of settling. It took special attention to listen out for the subtle ways that settler-colonialism shows up in my casting reciprocation as a trade and how it contributed to tension in the emergent relationship.

I had initiated a dialogue with the core-group liaisons by imagining a simplistic two-way transaction,

partly because I thought I could prove myself trustworthy by completing tasks the group asked of me before proceeding to the research. The core-group liaisons saw real value in analysing policies that directly influenced their work. They challenged my preconceived idea of how to go about a mutual exchange by suggesting we begin by arranging the group policy analyses. Gradin (2017) maintains that reciprocation carries the potential to ensure that traditional qualitative research methods are deployed in ways that are mutually beneficial to both researchers and participants. The discussions that occurred as part of arranging the group analyses helped the core-group liaisons to gauge me by my intentions, actions, and capabilities. It also created opportunities for all of us to get a better handle on where we could go with this reciprocation. Abandoning an imagined way of becoming trustworthy made it possible for me to listen to the core-group liaisons. All of us working together to bring about participation in the group policy analyses opened up possibilities in our reciprocation.

Liminality is another component of this reciprocation. Turner's (2018) consideration of social justice-based research found that reciprocity was possible when researchers structured opportunities for exchanges of knowledge, labour, and resources. The reciprocation dialogue with the core-group liaisons revealed how they spent time completing administrative tasks, convening workgroups, and orientating new members in addition to their existing workloads. Their decentralised approach to organising is situated in a liminal space between their professional counselling practice and a kind of grassroots community organising. However, conceptualising *what* took up their time and *where* core-group liaisons spent time was still linked to the fraught process of task identification. Shifting to discussing how core-group liaisons *experienced* this time went to the heart of their difficulties sustaining interest in peer-led supervision sessions and their struggles in addressing harmful interactions within the larger group e-list. Shifting the understanding of time helped clarify the core-group liaisons' experiences of tiredness and depletion from an ongoing focus on problems and conflict in the group. These experiences set us to structuring forms of affective reciprocity into the process, thus expanding the sorts of opportunities for exchange. These included additional informal meetings to discuss key issues and strategic approaches and also to share resources. Through discussion, the core-group liaisons identified an externally facilitated policy analysis session as an

opportunity to re-activate energy for the regular peer supervision meetings. Indeed, one participant commented that it was an unexpectedly positive reflective experience. Other participants echoed the sentiment that the analysis felt like another form of peer supervision that renewed their appreciation of the group.

After completing the group policy analyses, the core-group liaisons invited me to join a working group developing a set of Community of Practice Guidelines. Its purpose was to articulate a shared ethos that would improve group cohesion, build safety for trans and gender-diverse members, and increase shared responsibility for maintaining the group. My involvement in this working group included iterative editing and feedback and creating a glossary of key terms. The glossary, in particular, was an opportunity to funnel some of the academic literature into a practical resource for the group. Participating in the working group was time spent in another liminal space between research and community organising for relational work toward de-pathologisation at an interpersonal therapeutic practice level. Turner's (2018) conceptualisation of reciprocation as a practice of structuring opportunities for exchange connects to Gradin's (2017) suggestion that it is one of several important strategies to avoid extractive research practices and reduce the labour expected of research participants. The reciprocation dialogue, process, and liminal spaces that give it context show that tending to the experience of time was an indirect but no less important way of supporting people engaged in collective organising.

The final component that I discuss concerns the circularity of this reciprocation. Circularity expresses its intricacy while invoking a practice of revisiting learning for a deeper understanding of Indigenous sovereignty. I offer two tangible examples from within four years of an explicitly named relationship of reciprocation, of which many components existed before and have extended far beyond this research. As I deepen my learning of Indigenous sovereignty, coming back to the three studies that informed the method of this reciprocity helps me appreciate the implications of Driskill's (2010) description of un-seeing. I am able to notice the importance of respecting and supporting Indigenous knowledge production when Indigenous Shan women displaced in Myanmar's military-enacted

assimilation policies named that they wanted specific lobbying training in exchange for participating in Pittaway, Bartolomei and Hugman's (2010) refugee camp research. I can take lessons from Gradin's (2017) reflection on the limitations of their labour exchange with a non-profit co-operative in South Africa and an anarcho-syndicalist collective in Germany. Gradin (2017) attempted to develop a reciprocal research relationship with a German collective that also had a relationship with the Zapatistas in Mexico. Recognising a lack of language and farming skills and the extent of Zapatista knowledge production set a limit for Gradin (2017) to attempt reciprocation only with the German collective. This reflection helped me recognise the limits of my position, which led to a collaboration invitation from the core-group liaisons in this reciprocation. Turner's (2018) conceptualisation of reciprocal research as precarious helped me understand how to move toward a practice of continuously returning to reciprocity through actions. Theorising precarity as an interplay of personal power, agency and politics, Turner (2018) shows that reciprocation is not a guaranteed outcome of research but rather an opportunity to be directly useful to participants and their communities.

Literature by non-Indigenous scholars illustrates valuable practices and reflections, but it is the guidelines produced by Indigenous peak bodies and the contributions of critical Indigenous scholars that have significantly shaped this reciprocation. Returning to, reflecting on, and writing up this reciprocation has helped me appreciate Indigenous sovereignty as a presence that is too often un-seen and unacknowledged. Alissa Macoun (2016), a white scholar interested in the politics of race, colonialism, justice, and complicity, argues for "a more profound understanding that as white settler scholars we are always-already in political and knowledge relationships with Indigenous peoples—and these relationships are mostly not good" (p. 98). That I did not appreciate the significance of recognising Indigenous sovereignty until I had retraced the paths of my thinking and practice says as much about my learning as a settler researcher as it does about how settler colonialism works to make itself invisible. What I can do to take up my responsibilities without burdening Aboriginal and Torres Strait Islander people with my questions, uncertainty, and mistakes, is to use the resources Indigenous people make freely available while participating in and reflecting on the relationships that reciprocity

entails.

Conclusion

In this section, I introduced an ethical concern about whether this research output could directly benefit trans depathologisation efforts on the ground. I discussed the limits and racial dimensions of conventional ethics and the transformation that occurred through recognising expressions of Indigenous sovereignty. I also showed how listening, liminality, and circularity function as the methods of this reciprocation. This process required listening out for the ways settler colonialism shows up in my assumptions and imagination, being flexible in my understanding of time and the between-states of the work, opening space for multiple different opportunities for exchange, and the importance of returning to learning to strengthen its lessons. Through describing this reciprocation, I have shown how I have directly supported collective organising in ways that indirectly support efforts toward trans depathologisation in the context of therapeutic practice. Enacting reciprocity within the constraints of a research project also raises important questions for practice about the limits of a settler understanding of Indigenous knowledges and the implications of complicity in ongoing settler colonial elimination and invisibilisation. Recognising that Indigenous sovereignty is within this research practice of reciprocity redefines what I do in return for participants who contributed to this policy analysis and reorients my attention towards the relations needed in anti-colonial work.

Conclusion

This chapter has outlined the methodology, methods, and ethical considerations used for data collection and analysis in this thesis. It suggests that approaching this analysis of trans health policy using the WPR approach in conjunction with a reciprocal research approach encouraged crucial scrutiny of the politics and relationships inherent in knowledge production. This approach responds to Namaste's (2000) incisive call for research that is as theoretically sophisticated and politically engaged as it is practically relevant to the people it concerns. The stance of the WPR approach, that

governing occurs through problematisations in policy, creates a focus on the making of "problems" as types of political interventions with particular consequences. I have demonstrated the level of sophistication and political engagement in a WPR approach by providing an overview of the methods I used to generate two data sets. This approach has helped generate critical thinking for in-depth analysis while highlighting important layers of self-identification, positionality, political thinking and action. A reciprocal research approach has simultaneously helped address immediate ethical concerns about research benefits while provoking consideration of how settler-colonialism and Indigenous sovereignty can and should inform my research practice. This approach demonstrates how responding to each part of Namaste's appeal has a far-reaching influence, especially in the way this reciprocation draws attention to settler responsibilities in the relations between Indigenous knowledges and settler actions. The significance of approaching this comparative analysis of trans health policy with a WPR analysis and reciprocation is that it offers a counterpoint to the increasingly common double-move of co-opting and depoliticising opposition to normalise and individualise interlocking forms of oppression. In the following chapter, I begin articulating the findings of the WPR analyses by clarifying the problematisations in the SOC-7 and the Guide.

Chapter 4
Clarifying problematisations

Clarifying the problematisations within trans health policy is crucial for examining how its governing occurs. The analysis within a WPR approach is premised on Foucault's (1984) argument that governing occurs through problematisation, that "develops the conditions in which possible responses can be given" and "defines the elements that will constitute what the different solutions attempt to respond to" (p. 389). This chapter reports on findings from an application of question one in the WPR approach, which asks, "What's the problem represented to be?" within the SOC-7 and the Guide. Clarifying problem representations requires a close reading that first identifies what each policy says it wants to do, then "working backwards" and "reading off" from these proposals what they say needs to change, or what they say needs improvement, promotion, or reinforcement (Bacchi, 2009; Bacchi & Goodwin, 2016). This process of clarification thus addresses what Foucault (1984) describes as the "transformation of a group of obstacles and difficulties *into* problems to which the diverse solutions will attempt to produce a response" (p. 389, emphasis added). In other words, detailing the problematisations within the SOC-7 and the Guide sets the scene for the subsequent analysis of their underlying assumptions and rationalities, the emergence of problem representations, and the resulting silences, effects, deployment, and disruption. The findings in this chapter are spread over four sections, with sections one and two providing a general overview of the SOC-7 and describing its representation of "Gender Dysphoria" as the "problem". Section three provides an overview of the Guide, and section four describes its representation of a traditional, illness-based model as the "problem". It is important to note that throughout this chapter, I maintain the use of capital letters when directly quoting the source text. However, as mentioned in chapter one, I also use quotations and capitalise "Gender Dysphoria" in the analysis to signal contestation of its construction both as a psychiatric diagnosis and as an anchor point for "care" in the SOC-7. I argue that the SOC-7 is governing access through the verification of eligibility for and appropriateness of "treatment", whereas the Guide is proposing governing that divests itself of a logic of medicalisation.

An overview of the SOC-7

As previously noted, the full name of the SOC-7 is the World Professional Association for Transgender Health (WPATH) *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People* (Coleman et al., 2012). Importantly, as medical anthropologist Eric Plemons (2018) argues, its purpose is to "structure the processes by which people attain access to sex- and gender-altering medical care under the sign of transgender medicine" (p. 5). Therefore, the SOC-7:

> Provides clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. (p. 1)

In addition:

> The SOC are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria. (p. 2)

The SOC-7 defines gender dysphoria "as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (p. 2). The SOC-7 reiterates WPATH's position on de-psychopathologisation. Namely, that self-designated gender identities and expressions are not to "be judged as inherently pathological or negative" (p. 4). The term "gender dysphoric" appears throughout the text and refers to people who "experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder" (p. 5).

Consequently, the SOC-7 offers guidance for health professionals in what they can do to assist "gender dysphoric" children, adolescents, and adults (p. 1).

This guidance is separated into fifteen sections over one hundred and twelve pages. Sections one and two provide an overview of its purpose and global applicability, which includes articulating the core principles of the SOC-7 (pp. 1-3). When taken together, these elements express an expectation that health professionals are respectful to people with self-designated genders, either providing affirming "care" or referring people to knowledgeable professional peers and do not pathologise a person's gender identity or expression. These core principles also expect health professionals to become knowledgeable about the healthcare needs of people with self-designated genders beyond the benefits and limitations of gender-affirming medical technologies. The SOC-7 maintains a dual emphasis on affirming care that actively "reduces the distress of gender dysphoria" and recognises the "need for relief from gender dysphoria" (p. 3). Accordingly, its core principles expect health professionals to: Match their approach to a person's needs and goals; facilitate access; obtain informed consent; offer a "continuity of care"; and provide support and advocacy in a range of settings that include family, education, and the workplace (p. 3). Section three situates the position on de-psychopathologisation under the title *Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology* (p. 4). This statement differentiates between gender nonconformity and gender dysphoria as a move away from concentrating on a person's identity and toward focusing on their distress. These differentiations culminate in a statement that "a disorder is a description of something with which a person might struggle, not a description of the person or the person's identity" (p. 5). Drawing on a review of formal epidemiological research, section four offers considerations on the incidence and prevalence of particular gender designations "and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population" (p. 6). Section five briefly describes advances in gender-affirming medical care in North American and European contexts beginning in the middle of the twentieth century, and attesting to the medical necessity of gender-affirming medical care for those who request it. In describing the diversity of gender self-designation, this section also references high-profile scholar-activists such as Kate Bornstein, Sandy

Stone, Joan Nestle, Riki Anne Wilchins, and Leslie Feinberg, whose works are part of the Transgender studies canon. This section then presents an overview of the options proffered for psychological/therapeutic "care" and medical technologies (including voice and other communication therapies, hair removal, chest binding, and genital tucking), along with changes to identity documents and peer support and advocacy for people with self-designated genders, their family, and their friends (pp. 9-10).

The guidance presented in sections six through thirteen is more specific. Section six covers care for children and young people seeking access to gender-affirming medical technologies (pp. 10–21), whereas sections seven to thirteen pertain to adult-focused care. These sections cover "mental health"; administering hormone therapies; addressing reproductive health; providing voice and communication therapies; surgeries, postoperative follow-up, lifelong "preventative" healthcare, and primary healthcare (pp. 21–67). Section fourteen outlines the SOC-7's applicability for people held within "institutional environments such as prisons or long-/intermediate-term health care facilities" (p. 67). This section emphasises that people in these contexts should be provided with all the elements of care that are described in the SOC-7 and that such provision "should mirror that which would be available to them if they were living in a non-institutional setting within the same community"; and that it "should not be denied on the basis of institutionalization or housing arrangements" (p. 67). Section fifteen provides guidance on care for people born with intersex variations who request access to gender-affirming medical technologies (pp. 69–72). Despite acknowledging strong objections, this final section of the SOC-7 justifies its use of the category "disorder of sex development" by proclaiming that the term is used "in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses" (p. 69). The guidance in this section is based on the proposed changes in the DSM-5, which considers that people born with intersex variations who are seeking access to gender-affirming medical technologies "have a subtype of gender dysphoria" (p. 69). Uniquely, after the main body of text, the SOC-7 contains a list of references (pp. 72-94). Until now, no other version of the SOC had provided reference information for readers to trace the sources of "evidence" upon which it is based

(see, for example Levine et al., 1999; Meyer et al., 2002). The SOC-7 also has five appendices of related content. These include a glossary of terms; an overview of medical risks attributed to hormone and surgical technologies; a summary of each set of eligibility criteria; "evidence" from therapeutic clinical outcome studies analyses; and an outline of the SOC-7 development process (pp. 95–109).

The SOC-7 establishes its guidance according to the qualifications, competencies, roles, and common tasks required of health professionals. Crucially, the SOC-7 asserts that:

> The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. (p. 22)

The SOC-7 sets out "recommended minimum credentials" for professionals within these disciplinary fields, which include recognised professional qualifications, specific diagnostic abilities, documentation of supervised training, competencies, and ongoing education that includes "attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria" (p. 22). Within this framework, the SOC-7 constitutes "care" as assessment for eligibility and "risk"; providing information; diagnosis; making referrals; and assisting people in "making fully informed decisions and becoming adequately prepared" (p. 26), as well as with initiating, maintaining, undertaking, and monitoring particular medical gender-affirmations. The SOC-7 emphasises its various ethical positions by reiterating key terms and statements. One example of this approach is an emphasis on the responsibilities of health professionals, which include numbered lists relevant to specific areas of care, the duties of health professionals to provide encouragement, guidance, and assistance, to "obtain appropriate knowledge" (p. 41), and the shared

ethical and legal responsibilities for recommending and providing hormone-related and surgical technologies. A second example is found in the reiteration of an unequivocal statement that "it is unethical to deny availability or eligibility for" both hormone and surgical technologies "solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C" (p. 34 and 56). A third example comprises the emphasis on health professionals maintaining a functioning working relationship with people requesting access to medical technologies and a preference for care coordination that maintains close working relationships between healthcare professionals. The SOC-7's guidance is thus structured around an emphasis on what constitutes "care" and on what is required of health professionals to provide it.

What is the problem represented to be within the SOC-7?

To identify what the problem is represented to be in the SOC-7 it is necessary to work backwards from its stated intention to provide flexible standards for care and to offer guidance on "the treatment of people experiencing gender dysphoria" (p. 2). On first reading, the proposal to provide flexible standards appears to represent the "problem" to be the previous direction given to health professionals. Considering that this is the seventh iteration of clinical guidance, a SOC-7 proposal for an updated standard "for promoting optimal health care" (p. 2) is not unexpected. Further scrutiny was thus required of what it says needs improvement, promotion, and reinforcement. A second reading shows that its guidance on granting access and administering different types of medical "treatment" implicitly represents the "problem" to be a type of distress that can be diagnosed as "Gender Dysphoria".

As a group of practising psychologists and counsellors, participants in the group WPR analyses took a different route in their backwards reading of these proposals. Scrutinising the promotion of flexible standards and its guidance on "treatment" directed participant's attention to the proposal that health professionals are to assist "people with *safe and effective pathways* to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-

being, and self-fulfillment" (p. 1, emphasis added). This scrutiny also directed attention to the proposal for health professionals to "use the SOC to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression" (p. 2). One participant argued that on the surface, "of course those things are good, of course, we want those things", but was troubled to see that underneath the SOC-7 is "saying that the problem is located is within the person". A second participant saw the SOC-7 as taking a "very top-down approach", which implies that "if they get this assistance that they're provided, they will be fixed".

Crucially, another participant identified the representation of the "problem" within the person requesting gender-affirming medical technologies as "protecting an authority structure and an authoritarian system". This participant was speaking as a clinical psychotherapist recognised by the SOC-7 as qualified to verify the extent of a person's experience of distress and to provide referrals for gender-affirming medical technologies. He sees the SOC-7 as protecting "the authority of practitioners to make decisions about other people's lives, protecting them, or us, as the people who get to dictate who's in, who's out, who gets a yes, who gets the no". This insight is crucial in light of the SOC-7 no longer mandating a psychiatric diagnosis but rather requiring an assessment of distress in order to access gender-affirming medical technologies. Reading backwards from what it says needs to happen, the SOC-7 is representing gender dysphoria to be a *diagnosable* health "problem" with medical "treatment(s)" for which health professionals can — or not — provide assistance.

An overview of the Guide

Produced by the Spanish Network for Depathologization of Trans Identities (2010), the Guide's full name is *The Best Practices Guide to Trans Health Care in the National Health System*. The Guide is explicitly presented as:

> A proposal to improve the health care provided to trans persons by the Spanish public health system, and is intended not only for the general public but especially for professionals and policy-

> makers working in the government's public health care system. (p. 5)

The objective of presenting the Best Practices Guide is "to contribute tools to foster a change in the trans health care model from a depathologizing perspective" (p. 13). This emphasis on this perspective means "that no trans identity should any longer be considered as problematic, and that all identities should be considered a reflection of human diversity" (p. 17). The Guide aims to provide "analytical tools and reference points for developing alternative non-pathologizing trans health care protocols that have local and international applicability" (p. 5). Its stated purpose "is to align trans health medical practice with the diversity paradigm that informs today's understanding of trans identities" and to use its tools and reference points "to inspire better health care procedures for trans people in the future" (p. 15). However, the Guide makes clear:

> The aim of this proposal is not to establish a new universal model, and so it must be understood in the context in which we created it. We hope that our work leads to additional progress by means of similar projects being undertaken that are responsive to specific local political, cultural and social environments. (p. 16)

The Guide is a document in two sections spanning thirty two pages. Section one provides the context, and section two sets out the proposed alternative model of "care" and places it alongside the previous SOC-6 protocol for comparison. The first section analyses the diagnostic processes and other problems in contemporary Spanish healthcare for people with self-designated genders as the context for developing an alternative model (pp. 7-13). To analyse diagnostic processes, the Guide historicises pathologisation through Harry Benjamin's use of the term "transsexualism" and his development of the first protocol for its diagnosis and "treatment". It also historicises the effect of developing "specialized clinics to diagnose and monitor trans people through the psychiatric departments of selected public hospitals" and the gradual implementation of this model across many European countries during the 1970s and 1980s (p. 8). This historicisation is then linked to the revisions of the

DSM and the resulting significance of defining "the medical approach to trans people's health care treatment", especially the DSM's influence on the content of both the ICD and the SOC (p. 8). The Guide also associates this historicisation with the 2008 decision by the Spanish Department of Health to maintain specialist clinics — Unidad de Trastornos de Identidad de Género (UTIG) or Gender Identity Disorder Units — rather than integrating the provision of gender-affirming medical technologies into the services provided within the national health system. The Guide identifies the maintenance of separate, specialised UTIG as a problem in Spain because these clinics create geographical gaps in terms of access while perpetuating the problematic model of diagnosis and the systematic monitoring of identities. The Guide describes trans depathologisation activism as "a movement against pathologizing transsexuality" and one that "takes many of its cues from the anti-psychiatry movement" (p. 9). Thus, in the Guide, trans depathologisation activism "is a political movement that strives to reduce the impact of culture and oppressive gender norms on the construction of one's own body and identity" (p. 10). As a result of its analysis, the Guide identifies the overarching problem in contemporary Spanish healthcare to be "the scientific model developed in the West with regard to sexuality, the body, and gender" and the invention of the Western, medico-scientific category of "transsexuality". Crucially, the Guide argues that the pathologising Western, medico-scientific model "functions as an imperialistic colonizing mechanism" (p. 10).

After establishing the context, the Guide explains how its proposals are organised in response to the important work of "finding a way to escape the pathologizing model without sacrificing access to medical treatment" (p. 12). Recognising the intricacies of integrating "the body modification treatments needed by some trans people into the [Spanish] national health care system", the Guide argues for the promotion of "trans-specific health rights" concurrently with a move from a paradigm of illness toward a paradigm of rights (p. 12). The Guide underscores this argument with the emergent view of human rights in the Yogyakarta Principles (2007) and the Council of Europe's report *Human Rights and Gender Identity* (Hammarberg, 2009), "that recognizes people's free expression of gender as a fundamental human right" (p. 11). To achieve the aim of establishing a rights-based approach, the Guide puts forward the following four demands:

1. Transforming the health care model for trans people by exchanging the present judgmental model for one of autonomy and informed consent;
2. Support for the concept that body modification for trans people, when they request it, is a public health matter and should be covered by the public health system;
3. A system which permits body modification without a diagnosis of illness; and,
4. Improved medical knowledge (regarding the side-effects of hormone treatment, perfecting surgical techniques, etc.) in order to guarantee that trans people have access to the best quality health care available. (p. 12)

With these four demands as its basis, the second section of the Guide sets out "seven fundamental axes, each of which points toward a specific change in the traditional model of health care" for people requesting gender-affirming medical technologies (p. 15).

The seven axes of change in the second section of the Guide are as follows. The first axis, which concerns necessary intervention, declares "the objective of health care for trans people should be to create conditions that improve their quality of life", an objective that is achieved by a reconceptualisation of what constitutes "the health care system's purpose in being involved with trans people" (p. 1). The second axis, concerned with depathologisation, differentiates between psychopathologisation (psychiatrisation) and organic pathologisation (a biological basis) and the importance of centring the focus on de-pathologisation because a there is a "default tendency" in efforts to de-psychopathologise that result "in trans identities being re-pathologized" (p. 17). The third axis involves de-medicalisation, a change achieved by redefining a process of gender-related bodily modification "as one worthwhile and possible choice to which a person could have access", and by redefining specific medical technologies "as useful tools a trans person can request" in that process (p. 18).

The Guide asserts that a flexible, non-pathologising model of "care" is one "that allows an individual

to select from various available options" rather than a model that invokes set stages and different requirements for different people. In this context, it emphasises honouring requests from people with intersex variations to access gender-affirming medical technologies. This change is achieved in three parts. The first step challenges the traditional medical framework that endorses "a correlation between the socially-imposed duality of gender expression and its bio-medical counterpart" (p 19), with the second part challenging the use of this correlation to justify so-called urgent and medically necessary genital surgeries on infants with intersex variations. The third part then challenges the further use of this correlation to justify "a mental illness diagnosis of "Gender Incongruence" for a person who has not adjusted his or her [sic] behaviour to the gender role the medical professionals selected during that person's infancy" (p 19).

The fifth axis of change in the Guide concerns counselling and decision-making, calling for the removal of the "assessment function" of health professionals and replacing it with a collaborative counselling approach that "seeks to promote and respect an individual's autonomy rather than usurp it" (p. 20). The sixth axis involves counselling and local community support, with the Guide asserting that it is insufficient to take on a non-pathologising viewpoint. Instead, "the health care system must lay the groundwork for trans empowerment and self-worth", such as linking people "to existing community support resources"; providing "access to viewpoints and experiences that show trans identities as worthwhile"; and working to increase awareness of "supportive spaces and groups outside the formal medical system" (p. 20). This change is about decoupling gender self-designation "from a medicalized vision", facilitating the autonomy of people with self-designated genders, and honouring their requests to modify their bodies. The seventh and final axis concerns professional training (p. 20). To guarantee "a successful redesign of the trans health care system", it is necessary for health professionals to receive training in fields beyond what is expected "under the paradigm of illness" (p. 21). This change means that in addition to regular professional training, those involved in "care" for people with self-designated genders would be required to undertake training within a non-pathologising curriculum in fields such as sexology and gender studies, in order to foster further knowledge about and understanding of gender in and of itself.

The second section of the Guide also presents a set of sixteen principles that form the basis of its proposed best practices. These principles make clear the expectation that health professionals neither reject nor attempt to suppress or to modify a person's self-designated gender identity. These principles also reject requirements for people with self-designated genders to verify either their identity or expression through a process of testing "real life experience" (p. 23). Finally, the principles also reject care practices that involve expressing opinions, judgements, distinctions, and bias, or that show a preference for some aspects of a person's body, identity, expression, and sexuality while rejecting others. They distinctly articulate that:

> Every health care protocol and every medical treatment process should be aimed at the betterment of trans people's lives, so they can develop their own form of expressing their gender and giving meaning to their bodies, free of the stigmatization that befalls trans identities, gender expressions and bodies that are found at the frontiers of traditional concepts of women and men. (p. 23)

The Guide concludes by comparing the existing SOC-6 to its *Proposed Best Practices Health Care Protocol* by summarising the "treatment" process under the SOC and outlining ten key roles and a five-level qualification framework for healthcare professionals in its proposed alternative. It uses descriptions alongside flow charts, visually representing the protocol within each policy (see Appendix, Diagrams of Care Protocol in the Guide).

The new protocol contains two features that are significant for this analysis. The first is that in this model, the person requesting access "contacts a supervising health professional who sets the health care process in motion by enlisting the participation of a social worker (or, alternatively, a psychologist or sexologist)" (p. 29). Emphasising *participation* suggests a critical reworking of care practices, yet also implies such professions are somehow separate from psychiatry and the "Western" medical model that it relies upon. This potentially uncritical engagement with psy-professions indicates a limit to the extent of this approach to depathologisation. The second feature appears in the

new protocol situating an "absence of identity delusions" within its process of informed consent (p. 28), while its written description asserts more generally that the "existence of a prior psychiatric diagnosis should not constitute an impediment to accessing trans-related health care" (p. 29). This subtle contradiction hints at a further limit to the Guide's position on autonomy and self-determination, which are discussed in chapters four and eight. Even with these potentially limiting features, the comparison usefully shows how the Guide offers a non-pathologising alternative to the traditional medical paradigm that underpins "care" in the SOC-6.

What is the problem represented to be within the Guide?

The Guide explicitly states that the "problem" is the pathologisation of people with self-designated genders; it presents demands that are based on a representation of a "pathologising model" as an inherently problematic way of responding to requests for gender-affirming medical technologies (p. 16). Crucially, the Guide is a stand-alone alternative policy that was developed by a network of trans depathologisation activists for use in the Spanish healthcare system, and a comprehensive policy submission to the WPATH as part of the SOC-6 revision process. Attention to place and time is important here. The Guide constitutes an attempt to challenge the prevailing model of "care" in Spain, while also engaging in conversations about an authoritative, international, and entrenched policy problematisation, expressing the need for a drastic change in the use of mental illness diagnoses and associated practices. The Guide was published prior to the SOC-7 and DSM-5, which use the "Gender Dysphoria" diagnosis and its "Disorders of Sex Development" specifier, also the ICD-11, which uses the "Gender Incongruence" of childhood, adolescence, and adulthood categories (see Appendix, Policy Overview). For this reason, the WPATH, the APA and the World Health Organisation (WHO) are identified as prominent speakers in these conversations, because of the interrelated revision processes that have produced this suite of policies (p. 8).

An illness-based model is problematised because of the way that it conceptualises the reasons for requesting gender-affirming medical technologies. The Guide argues that "it's not a trans identity that

induces a person to seek medical care; instead, the impetus is the constellation of societal factors that makes the daily lives of trans people so difficult" (p. 16). It clarifies, "the problem is not transsexuality—it's transphobia" (p. 16). It is "when the medical system fails to recognize society's transphobia that the pathologization of individuals' identities begins" (p. 16). Thus, the Guide represents the problem to be the pathologisation of people with self-designated genders, and it locates this problem directly within the "prevailing medical paradigm" that forms the basis of current "Western" healthcare systems.

The Guide presents a non-pathologising alternative to a "traditional model of medical care, based on the international diagnostic classifications and protocols referenced by the Standards of Care … [that] designates transsexuality as a problem, such that a trans identity itself becomes the focus of intervention" (p. 16). It is an alternative to the model of "care" that is in the SOC-6 and influenced by the DSM-IV-TR and ICD-10. As a participant in the group WPR analyses suggests, "just in the fact that they're using the word "alternative", means that it's acknowledging that there is a baseline and there's something problematic about that". The Guide's non-pathologising model addresses what it problematises in the SOC-6 as an "imposition of a psychiatric diagnosis" and its judgment concerning "the identity of the individual" (p. 16).

In the wake of revisions to the DSM-5 and the move from the psychiatric label "Gender Identity Disorder" to "Gender Dysphoria", the SOC-7 declared a shift in focus from gender identity to distress. The notion of a shift as a strategy for change is discussed at length in subsequent chapters. Despite the removal of a requirement for a formal "Gender Dysphoria" diagnosis, STP's (2012) *Reflections on the SOC-7* oppose what it sees as a continuation within the policy of an "external assessment model" (p. 4). An example of this continuation is the SOC-7 requirement of referral letters from mental health professionals to verify that a person *fits* the diagnostic criteria for "Gender Dysphoria" before granting access to hormone and surgical technologies. Another example is requiring referral letters from mental health professionals verifying that a person has "12 continuous months of living in a gender role that is congruent with their gender identity" before granting access to genital surgery

technologies such as metoidioplasty, phalloplasty, and vaginoplasty (Coleman et al., 2012, p. 60). These two examples demonstrate that the SOC-7 maintains both a psychiatric diagnosis and a judgment of a person's identity. Working backwards from the Guide's problematisation of a traditional, illness-based and pathologising model of "care" identifies a further problematisation of judgement in this model. The Guide is thus presented as both an objection to and a solution for the SOC's "continued classification of gender transition processes" as treatments for a mental disorder (STP, 2012, p. 4).

Conclusion

This chapter has clarified what the problem is represented to be in the SOC-7 and the Guide. The close, backwards reading of each policy reveals that requests for access to and provision of gender-affirming medical technologies are represented to be different kinds of care-problems. Accordingly, I argue that the SOC-7 is governing access through an illness model that consists of professional judgement of a person's eligibility and appropriateness for "treatment", whereas the Guide is proposing governing that dispenses with a logic of medicalisation. The SOC-7 represents the distress constituted as "Gender Dysphoria" to be a diagnosable, individual health "problem" for which it provides health professionals clinical practice guidelines for its "treatment". Clarifying an implicit intention to protect an authority structure highlights a very particular role for health professionals in what the SOC-7 represents the problem to be. In contrast, the Guide represents a traditional, illness-based model to be a "problem" for which it provides a non-pathologising, human rights-based alternative from which to redesign both the Spanish healthcare system and its "care". Despite revisions to the key policies in this space, clarifying that the Guide is problematising the entire paradigm of "care" highlights an enduring objection to the pathologisation and judgement inherent to the external assessments of an illness-based model. Such clarification is significant because it opens space to further analyse how each problematisation institutes these different forms of governing gender *through* governing access to gender-affirming medical technologies. It is also significant because it supports a comparison of how the making of these divergent representations of "care-

problems" operates in conversation with one another. In the following chapter, I detail the conceptual logics, concepts, and rationalities that underpin the problematisations in the SOC-7 and the Guide.

Chapter 5
Reflecting on conceptual logics

Reflecting on the function of a conceptual logic is a way of thinking deeply about the accepted understandings circulating beneath what a "problem" is represented to be. This chapter reports on findings from an application of question two of the WPR approach, which asks, "What deep-seated presuppositions or assumptions (conceptual logics) underlie this representation of the "problem"?" (Bacchi & Goodwin, 2016, p. 20). This reflection is made possible by the previous chapter clarifying that the SOC-7 represents the problem to be the distress of "Gender Dysphoria", and the Guide represents the problem to be an illness-based model for trans healthcare. Mol (2008) uses the term logic in her book, *The Logic of Care: Health and the problem of patient choice,* to evoke how some things appear more comprehensible, tend to fit together, and share affinities more than others. The term also resonates with discourse, or how "words, materialities and practices hang together in a specific, historically and culturally situated way", and how these "'modes of ordering' make discourses multiple and mobile" (Mol, 2008, p. 11). The term logic is deliberately foregrounded in this chapter because it also supports analysis of the articulated "rationality, or rather the rationale, of the practices" under scrutiny (Mol, 2008, p. 11). The term has a similar focus in Wolfe's (2006) conceptualisation and Kauanui's (2018a) analysis of a logic of elimination as what underpins practices that establish and maintain the settler colonial state in Australia and Hawai'i, respectively. There is a similar urgency in theorising by radical scholars, activists, and organisers Eric A. Stanley and Nat Smith (2016) on the "dangerously unnamed" underpinning logics of the Prison Industrial Complex (PIC) that naturalise the violence experienced by people of colour with nonnormative genders and sexualities (p. 6). The insights from this critical literature and the group WPR analyses are the reason that I focus my attention on the logic of medicalisation and the logic of rights that underpin the problem representations in trans health policy.

This chapter reflects on how a conceptual logic of medicalisation underpins the SOC-7 and how a

conceptual logic of rights underpins the Guide to show how different features of a liberal governmental rationality within these logics operate toward different ends in each policy's representation of the problem. I argue that the SOC-7 advances a logic of medicalisation both for governing access and as a means to bring about depathologisation. In contrast, I suggest the Guide offers an open-ended proposal for the formulation of any number of responsive, place-based, non-pathologising protocols for governing access through a logic of rights. The structure of this chapter follows the goals set by Bacchi and Goodwin (2016) for question two of the WPR approach. First, it describes each conceptual logic and discusses the meanings that are in place for each problem representation to make sense. It also outlines how the Guide's problematisation of an illness model occurs through the interactions between these logics. This chapter then identifies how each policy constructs problems using concepts formed within a conceptual logic of medicalisation and rights by comparing how they appear within each policy's stated focus, changes, and intended use. Finally, this chapter identifies patterns in rationalities, discussing how each problem representation signals different features of a broadly liberal governmental rationality and how these operate toward divergent ends in the SOC-7 and the Guide.

Conceptual logics

Bacchi and Goodwin (2016) follow Foucault's (2013) delineation between discourse ("general knowledge" or knowledge that operates in the background) and discourses (knowledge that is deemed "scientific" or is socially produced within specific disciplines). This section identifies both the discourse and discourses that constitute a conceptual logic of medicalisation and a conceptual logic of rights. I utilise these Foucauldian understandings of discourse(s) to discuss knowledges, presuppositions, and assumptions that constitute the meanings that enable each policy's problem representations to make sense. I seek to show how a conceptual logic of medicalisation underpins the SOC-7 and interacts with a conceptual logic of rights that underpins the Guide. By focussing on this interplay, I suggest that both logics are necessary for the Guide's problematisation of an illness paradigm to make sense.

A conceptual logic of medicalisation

Medicine can be understood as a practice and a knowledge system concerned with maintaining and promoting "health" and "well-being". Ivan Illich (1975) and Peter Conrad (2007) are two canonical scholars in this area who use the term medicalisation to critique the process of using medical concepts for classifying non-medical states of being, so that they become identifiable and thus "treatable" as medical "problems". Informed by this critique, British sociologist and social theorist Nikolas Rose (2007) argues that medicine "makes us what we are through the role of medical expertise in governing the ways we conduct our lives" (p. 701). This expertise can be understood as part of broader projects that render the bodies, genders, and relationships of Indigenous peoples visible to colonisers in order to justify and serve specific forms of colonial governing. Bioethicist, intersex activist and researcher Morgan Carpenter (2020) points out that "medicalisation is, in part, intended to construct people with heterosexual and cisgender identities, with bodies that can fulfil normative heterosexual functions" (p. 521). An example in the context of trans healthcare policy is the use of medical, psychiatric and sexological expertise in constructing diagnostic categories such as "Transsexualism", "Gender Identity Disorder", "Autogynephilia", and "Gender Dysphoria", so that gender self-designation becomes identifiable, and thus "treatable" as a medical "problem". As I clarify in chapter four, the "care" in the SOC-7 is constituted as "care for gender dysphoria" (Coleman et al., 2012, p. 55). It is thus a conceptual logic of medicalisation that makes the SOC-7's representation of the distress of "Gender Dysphoria" understood as a distinct kind of psychiatric "health problem", for which the solution is to guide health professionals in granting access to and administering "treatment".

The medical discourses relevant to this analysis shape and are shaped by a presupposition that a person who requests body modifications classified as gender-affirming is a person who is mentally unwell. The pervasiveness of this assumption cannot be overstated. Anti-trans feminist scholar Bernice Hausman (1995) demonstrates its influence in her polemical suggestion that "the demand for sex change [sic] represents the desperation of the transsexual condition: after all, who but a suffering

individual would voluntarily request such severe physical transformation?" (p. 110). Hausman's (1995) question also demonstrates how this presupposition connects to commonly held opinions that, at the very least, it is unethical to alter, remove, or tamper with bodily systems deemed to be "healthy", particularly those involved in human reproduction. This discourse appears in several previous iterations of the SOC (see, Levine et al., 1999; Meyer et al., 2002).

With revised wording but the same focus, the SOC-7 asserts that the objections "on ethical grounds to surgery as a treatment" means it is "important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal [sic] structures" (Coleman et al., 2012, p. 55). The SOC-7 suggests:

> Resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments. (Coleman et al., 2012, p. 55)

Even though the SOC-7 (and its predecessors) suggests that a resistant practitioner engage in a dialogue with "patients themselves", the focus on psychological distress frames the interaction within a logic of medicalisation that presupposes the authority of medical expertise. Such interactions become part of what Dewey and Gesbeck (2017) identify as "the diagnostic processes and categories that legitimate gender in the medical system" (p. 39). The medicalisation and pathologisation of people with self-designated genders that underpins the SOC-7 are thus grounded upon the presumption that distress is evidence of pathology.

A conceptual logic of rights

Rights can be understood as fundamental principles that determine individuals, groups, and even ecosystems are entitled to freedom *from* certain things (abuse, harm, slavery, torture, degradation) and

freedom *to* certain things (life, expression, work, education, and health). These normative principles are premised upon commonly held liberal assumptions that rights "are universal, interdependent, indivisible and interrelated" and that all "human beings are born free and equal in dignity and rights" (Yogyakarta Principles, 2007, p. 6). Much is written about the development, purpose, promise, and use of such principles. Historian Lynn Hunt (2007) argues that human rights are made legible not only by "a doctrine formulated in documents" but also by "a set of convictions about what people are like and how they know right and wrong in the secular world" (p. 27). The location of such a process is crucial. Smith (2021) explains how the tenet of "humanity" itself functions within established, gendered, and hierarchical "systems of rule and forms of social relations which governed interaction with the Indigenous peoples being colonized", making it possible "to consider Indigenous peoples as not fully human, or not human at all", in ways that "enabled distance to be maintained and justified various policies of either extermination or domestication" (p. 99). Thus, as Irving (2013) points out, "rights discourses produce ontological categories that establish sex, sexual orientation, disability and race as historical and transcultural homogenous states of being" (p. 320).

Rights discourses operate according to an "inner logic" that Hunt (2007) contends has "developed a kind of conceivability or thinkability scale" that overlays these ontological categories (p. 150). Rights often produce a cascading effect, despite the situated yet abstract nature of their formation and the corresponding need for continual adjustment of hierarchies. In other words, the discourse(s) that make it possible to affirm one set of rights means that recognising and thus establishing the next set of rights becomes increasingly inevitable. This cascading effect is made possible because the making up of rights "depended—as it still does—on the interpretation given to what was "no longer acceptable"" (Hunt, 2007, p. 26). This interpretation leads to widespread contention about what constitutes either fundamental or merely aspirational rights, particularly when it comes to upholding or protecting rights through state action. Despite this friction, rights discourse often passes over the deep-seated presuppositions that homogenise and hierarchise disparate human and more-than-human states of being. As chapter four clarifies, the Guide problematises a prevailing medical paradigm based on the conviction that the pathologisation of people who request gender-affirming medical technologies is

unacceptable because it compromises their basic right to "free expression of gender" (STP, 2010, p. 11). As discussed in more detail below, the pathologisation inherent in an illness paradigm often compromises a person's quality of life. Therefore, a conceptual logic of rights makes the Guide's representation of an illness-based model understood as a distinct kind of "healthcare problem" because undermining a person's health by limiting access to "care" is becoming increasingly unacceptable.

Assumptions about bodily integrity and individual autonomy are central to the presupposition of universal human rights and the Guide's problematisation of an illness-based model. The term bodily integrity is widely used to invoke a person's right to determine what happens to their body. However, this invocation implicitly connects the body to liberal assumptions of individuality, such as an owner's privileged position in relation to their property. It is argued that this relationship is a legacy of colonial invasions and the waging of its wars over notions of ownership over land and bodies. Indian postcolonial feminist scholar Uma Narayan (1995) argues that the construction of a liberal rights discourse occurred at a time "when western countries were becoming increasingly interdependent with, unseparate from, and anything but disinterested in their unfree and unequal colonies" (p. 135). Narayan (1995) deftly shows how rights logics developed from a liberal ontology and epistemology and served as justifications for and as agents of colonial projects. In the context of treaty relations between First Nations and the United States in the mid-1800s, Nick Estes, historian and member of the Oceti Sakowin Nation is meticulous in outlining how "settlers and private property have always been the vanguards of invasion, and the sanctity of private property never applied to Indigenous peoples" (p. 46).

These liberal assumptions and their colonial capitalist foundations call attention to violence and the webs of complexity lurking within a logic of rights. For example, Stryker and Sullivan (2009) argue provocatively that integrity is a legitimising fiction that assumes the state of being unimpaired and the qualities of being complete and pure are essential to individuals and the dominant body politic. Stryker and Sullivan (2009) emphasise how integrity operates as a form of "bodily *integration*" that is

"predicated not on the organic *integrity* of the human organism, but rather on the body's suitability for *integration"* (p. 55, emphasis in original). Moreover, this integrity is about a body's "ability to be *integrated* as a biopolitical resource into a larger sociotechnical field, or into an apparatus such as the State" (p. 55, emphasis in original). The connections between integrity and bodies as biopolitical resources carry important implications for the Guide's representation of an illness-based model as the "problem" and its subsequent proposal for governing access through rights. Such a connection raises questions about whether a rights-based paradigm creates positive transformation or maintains processes for integrating bodies into existing conditions of colonial expansion, settler-state formation, and racial capitalism.

Liberal assumptions about the interrelationship between rights are similarly crucial for making the Guide's problem representation legible. In particular, the Guide emphasises the connection between health and citizenship rights in the demand for "a system that permits body modification without a diagnosis of illness" (STP, 2010, p 12). What makes the Guide's problematisation of an illness-based model understood as a "healthcare problem" within the Spanish system is an assumption that public health systems — financed entirely or partly by governments through taxation — are obliged to provide people with healthcare. This assumption connects to an understanding that most States have ratified one or more human rights treaties that recognise health, or "enjoyment of the highest attainable standard of health" among "the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 2020, p. 1). Comparing the Guide and the SOC-6, Arjonilla (2014) discusses the unique position of people with self-designated genders accessing citizenship and, as a result, accessing human rights. Arjonilla (2014) argues that "in many cases the non-correspondence between the legal documents and the gender presentation of the person in question limits enormously the possibility of exerting citizenship rights—for those who are granted citizen status" (p. 41). Citizenship rights in this context include access to state-funded social and welfare provisions, obtaining secure housing and employment, participation in elections, and so on. The inability of many people with self-designated genders to benefit from and even to secure citizenship in many places occurs because legislation

related to legal recognition of changes to name and gender on official documents requires both a DSM diagnosis and medical "treatment". Arjonilla's (2014) analysis highlights the connections between upholding health rights through the provision of publicly funded gender-affirming medical technologies and upholding citizenship rights of people with self-designated genders who request them, and further highlights how the governing of access to gender-affirming medical technologies also involves governing access to gender-affirming citizenship. Reflecting on these connections between upholding health and citizenship rights in light of the theorisation of integrity and bodies as biopolitical resources shows just what is at stake within the Guide's proposal for a rights-based paradigm of care.

An interplay between conceptual logics

The Guide's problem representation is made legible through interactions between the conceptual logics of medicalisation and rights. As the previous section shows, medicalisation, pathologisation, and the transgression of the rights of people with self-designated genders converge in practices. Schwend (2020) observes that despite the gains of non-pathologisation movements, pathologisation compromises human rights because people with self-designated genders in multiple world regions are compelled into psychiatric assessments and diagnosis, and this pathologisation is linked to shocking levels of anti-trans violence. A report created by GATE, an international human rights-based advocacy organisation working towards justice and equality for trans, gender diverse and intersex communities, explains how:

> Regional and international human rights mechanisms have drawn a direct link between discriminatory medical classifications and rights violations against trans individuals, including violence, stigma, criminalization and discrimination in the realization of economic and social rights, specifically naming pathologization as a "root cause" of abuses. (Kara, 2017, p. 18)

Pathologising practices are problematised in the Guide precisely because of a presupposition that a person who voices a desire to use medical technologies to modify their bodies in ways that affirm their self-designated gender is mentally unwell. Highlighting this way of responding to requests for access to "care" makes it possible to understand how the underpinning logic of medicalisation is implicated in perpetuating abuse and violence in a range of social contexts.

Another significant interaction between these logics occurs in strategies that seek to end pathologising practices by removing classifications that medicalise self-designated gender. Arjonilla (2014) explains how the Guide conceptualises gender self-designation as "other physical processes of the body, such as pregnancy, that require medical care" (p. 38). This attempt at normalisation is made legible by the Guide's assertion that "total depathologization of trans identities presupposes their removal from both the DSM and the ICD (at least in terms of psychological and organic pathologizing references)" (STP, 2010, p. 17). While the DSM is a manual for diagnosing so-called mental disorders, the ICD is an international medical coding classification system for everything within the purview of the illness paradigm. Medical coding is a process of transforming descriptions of medical diagnoses and procedures into standardised statistical codes. These codes represent both a health professional's diagnosis and a person's health status with various applications across an array of settings. Applications of particular interest are the role of codes in determining "medical necessity", billing processes, public funding allocations, and insurance claims (World Health Organisation, 2020a). As LGBTI rights consultant and co-founder of GATE Justus Eisfeld (2014) notes, the ICD forms "the basis for payments for health care in virtually all countries in the world. And therein lies the problem for trans* people" (p. 107).

Medical coding is thus a mainstay in conversations about de-medicalising gender self-designation, especially concerns that it jeopardises access to "care" (e.g. Burke, 2011). The primary strategy for maintaining access has been to create medical codes for gender-affirming medical technologies that

are separate from disorder or illness categories (Schwend, 2020; see also, GATE, 2012). Changes in the ICD-11 represent an important attempt at this kind of decoupling strategy. Pre-existing ICD-10 categories have been replaced with references to "Gender Incongruence" at different stages of the lifespan and moved from the "Mental and behavioural disorders" chapter into a new chapter on "Conditions related to sexual health" (World Health Organisation, 2020b). While this move was celebrated for ruling that gender self-designation is no longer considered a mental disorder, the ICD-11 has also been challenged to remove the normative and othering content from the "Gender Incongruence" category. For example, the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) (2018) argues that "Gender Incongruence of Childhood must be removed from ICD-11 … in favor of depathologizing gender diversity in childhood entirely and for good" (para. 4). The interaction between logics is further highlighted when the ICD-11's engagement with a decoupling strategy was criticised for falling short of the ultimate goal of "full depathologization grounded in human rights and, particularly, on universal access to healthcare" (ILGA, 2018, para. 4). Such criticism resonates with comments from a participant in the group WPR analyses who read the Guide as arguing that "care" is "a service that needs to be available to people to basically live their lives in a way that feels right to them". This interplay demonstrates an important distinction between a strategy that advances a logic of medicalisation for removing diagnoses and retaining access to "care" and a strategy that seeks to accomplish the same aims through a logic of rights. It further reveals the propensity towards liberal rationalities in both underpinning conceptual logics.

Conclusion

In this section, I highlight knowledges, presuppositions, and assumptions that constitute the conceptual logics of medicalisation and rights. Presupposing that people who request medical technologies that affirm their self-designated gender must be mentally unwell is part of an underpinning conceptual logic of medicalisation that makes the SOC-7's guidance on "treatment" legible as the *standard* for "care". Rejecting a representation of such medical technologies as "treatment" for a psychiatric "problem", the Guide draws upon an underpinning conceptual logic of

rights for its proposal for an alternative model for healthcare in the Spanish system. Presuppositions of universality, humanity, and bodily integrity appear in the Guide's demand for publicly funded gender-affirming medical technologies (based on a right to healthcare) that are accessible via a process of informed decision-making (based on a right to bodily integrity, autonomy, and self-determination) without a requirement for a diagnosis of illness (based on the interrelationship between health and citizenship rights). Reflections on these presuppositions emphasise important liberal assumptions and settler colonial capitalist foundations. It shows that a conceptual logic of medicalisation is in place for the problem representations in the SOC-7 to make sense, while both logics are in place for the problem representations in the Guide to make sense. An understanding of these underlying premises provides grounding for comparing concepts that each policy relies upon to construct their divergent problem representations.

Constructing problems with concepts

This section identifies and compares concepts that the SOC-7 and the Guide rely upon to construct their representations of the "problem". It looks at each policy's focus, comparing the SOC-7's use of "pathways" and "personal comfort" to the Guide's use of "analytical tools" and "reference points". It reflects on changes, comparing the SOC-7's use of "flexible" to the Guide's use of "autonomy" and "informed consent". Finally, it examines each policy's intended use, comparing the SOC-7's intention for "worldwide use" to the Guide's desire for "responsive" protocol. A visual representation of this comparison appears below in summary Table 1. I use these comparisons to reflect on how a logic of medicalisation and rights forms the basis for the concepts used in constructing each policy's problem representations. I argue that the SOC-7 uses concepts that reinforce an underpinning conceptual logic of medicalisation, whereas the Guide uses concepts in dynamic ways that signal the potential for radical approaches to "care".

Summary Table 1 — Comparison of concepts in the SOC-7 and the Guide

The SOC-7	Focus	Individual	“safe and effective pathways”
			“achieving lasting personal comfort”
The Guide		Paradigmatic	“analytical tools”
			“reference points”
The SOC-7	Changes	Departure	“flexible” clinical guidelines
The Guide		Redesign	“autonomy”
			“informed consent”
The SOC-7	Intended use	Adaptation	“worldwide use”
The Guide		Localised	“responsive”

Focus

The SOC-7's use of concepts with an individual-level focus and the Guide's use of concepts with a paradigmatic-level focus forms the first point of comparison.

The SOC-7 states its focus is on providing clinical guidance for health professionals assisting individuals with "safe and effective pathways" to achieve "lasting personal comfort" (Coleman et al., 2012, p. 1). These euphemistic concepts are used in its opening statement, whereupon the SOC-7 reverts to guidance in a strictly medical sense of assessment and treatment of "patients". A participant in the group WPR analyses pointed out how a concept of "pathways" indicates an assumption "that there is one, or a minimal number of safe and effective pathways and they are ones created by experts". While access is determined by assessing a person's experience of distress according to standard diagnostic criteria, this participant added that it is also "putting that judgement" on whether a person is "acting unsafely, if they're being irresponsible". Another participant extended this point by reflecting on how these concepts position people with self-designated genders as those who "need to be cared for; you're not caring for yourself". In light of the top-down approach identified in chapter four, this positioning indicates an assumption "that people don't have the resources", which this participant found to be "quite infantilising". These participant comments illuminate how a conceptual logic of medicalisation attributes authority to expert medical knowledges to judge what "safe" is. They also illustrate how this expertise responsibilises people with self-designated genders to become "safe" to gain access to gender-affirming medical technologies. The SOC-7 implies that an individual focus of health professionals assisting people with a "treatment" pathway is the way to achieve lasting comfort. However, participant analyses of how the SOC-7 relies on these concepts reveal that it also maintains a hierarchy of subject positions.

The Guide focuses on providing "analytical tools" and "reference points" to policymakers and practitioners for developing protocols that overturn a paradigm of illness in favour of rights. It uses these concepts to describe what is needed to develop healthcare policy and practices for people with

self-designated genders based on the premise that care should "improve their quality of life" (STP, 2010, p. 16). The Guide uses the concept of "analytical tools" to contextualise its proposed paradigm shift within a history of pathologisation of gender self-designation. It uses the concept of "reference points" to locate these practices in the Spanish healthcare system. This use of concepts is connected to an understanding entrenched within the conceptual logic of rights that scrutiny helps to hold state and non-state systems accountable for their responsibilities under international human rights treaties and conventions. The Guide problematises the dominant illness-based model of care at a paradigmatic level in order to promote responsibility for and accountability to human rights within trans health policy.

Changes

The SOC-7's departure and the Guide's redesign are presented here as the second point of comparison between different types of change within each policy.

Chapter four mentions that the SOC-7 are intended as "flexible clinical guidelines" that "allow for tailoring" by health practitioners to people's needs and the settings in which "care" occurs (Coleman et al., 2012, p. 35). This conceptualisation has been maintained across the SOC-5 (Levine et al., 1999) and the SOC-6 (Meyer et al., 2002). However, the SOC-7 links it to a "significant departure" from previous Standards in response to "significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise" for people with self-designated genders (Coleman et al., 2012, p. 1). Using flexibility to denote a change in direction gestures toward the permissibility of adjusting practices while emphasising the importance of preserving an underpinning logic of medicalisation.

The SOC-7 also uses the concept of "flexible" in connection with an individual/social binary in two distinct but interrelated ways. The first is a careful differentiation between *gender nonconformity,* as the extent to which individual gender identity, role, or expression differs from socially prescribed

cultural norms, and *gender dysphoria,* as an experience of discomfort or distress "caused by a discrepancy between" self-designated gender identity and externally assigned sex (Coleman et al., 2012, pp. 2, 5, 96). The underlying conceptual logic of medicalisation is what makes this distinction legible, and also underscores the tenuousness of WPATH's de-psychopathologisation statement that self-designated gender identities and expressions are not to "be judged as *inherently* pathological or negative" (Coleman et al., 2012, p. 5, emphasis added). This differentiation occurs within a set of "flexible" clinical guidelines. However, there appears to be little flexibility in the space between not judging *a person* based on their gender designation and diagnosing *a person's distress* regarding their gender designation.

Second is the SOC-7's differentiation between the psychiatric problem of the distress of "Gender Dysphoria" and a social problem of prejudice, discrimination, and other forms of harm brought about by "stigma attached to gender nonconformity" (Coleman et al., 2012, p. 4). The SOC-7 frames this stigma using the influential model of "minority stress" developed by social worker Winn Kelly (Virginia Rae) Brooks (1981), yet predominately attributed to psychiatric epidemiologist and public policy scholar Ilan H. Meyer (2003). The model that Meyer (2003) is known for suggests that the unique stressors experienced by members of stigmatised groups have an additive effect on more generally experienced stressors, increasing a person's vulnerability to mental distress. The SOC-7 identifies "prejudice and discrimination in society at large" and "abuse and neglect in one's relationships with peers and family members" as unique stressors experienced by people with self-designated genders. These constitute a set of "socially induced symptoms" that "are not inherent to being transsexual, transgender, or gender nonconforming" (Coleman et al., 2012, p. 4). Consequently, "Gender Dysphoria" is represented to be a psychiatric problem for which the SOC-7 provides guidance on "treatment", whereas the impact of stigma, prejudice, discrimination, abuse, and neglect is represented to be a "socially induced" psychiatric problem beyond the remit of its guidance. The SOC-7 subtly reinforces a psychiatric notion that discrete mental health "problems" with discrete "symptoms" require discrete "treatments". Making distinctions between a person and their distress and between individual and social "problems" reiterates the narrow view that people can only achieve

"lasting personal comfort" via individual, gender-affirming medical "treatment".

The Guide uses the concepts "autonomy" and "informed consent" in connection with its proposal for a "redesign of the trans health care system" (STP, 2010, p. 21). The Guide represents "the problem with the current informed consent model" to be the fact "that it's preceded by a phase of assessment and gatekeeping" (STP, 2010, p. 21). While the SOC-7's criteria for access to hormone and surgical technologies states that health professionals must assess whether a person's distress matches the diagnostic criteria for "Gender Dysphoria", it also requires an assessment of the person's capacity to make a fully informed decision and provide consent for "treatment" (Coleman et al., 2012). Participants in the group WPR analysis characterised the Guide's redesign as an objection to a unidirectional and regulatory role for health professionals responding to requests for access to gender-affirming medical technologies. The Guide challenges the hierarchy of relations between those seeking access and those with the power to grant it by "exchanging the present judgmental model for one of autonomy *and* informed consent" (STP, 2010, p. 12, emphasis added).

The Guide aligns the concept of "informed consent" with the right to autonomous decision-making by proposing a stand-alone "informed consent document that would grant the patient sufficient flexibility to be able to follow a self-designed path that can be modified as time goes by to adjust to the individual's life at each moment" (STP, 2010, p. 21). This proposal is premised on "an understanding of the concepts of 'informed consent' and an 'informed decision' as a continued process of information, optional counseling and professional accompaniment in the decision process" (Stop Trans Pathologization, 2012, p. 6). It emphasises that people with self-designated genders have the right to make autonomous decisions throughout the entire process of body modification, not only providing consent to receive particular "treatments". The Guide anchors the concept of "autonomy" to "informed consent" within an explicitly named rights paradigm, invoking the quintessentially liberal notions of bodily autonomy and self-determination within a contemporary logic of rights.

Intended use

The third point of comparison concerns the SOC-7's intention for worldwide adaption and the Guide's desire to develop responsive local projects for depathologisation.

The SOC-7 uses the concept of "worldwide use" to articulate an expectation that its clinical guidance can be adapted to fit any context. This concept follows a statement recognising that "most of the research and experience in this field comes from a North American and Western European perspective" (Coleman et al., 2012, p. 1). The SOC-7 equivocates by suggesting that it is impossible for its guidance to reflect the multitude of cross-cutting differences that shape "care". However, it makes explicit that "applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the SOC according to local realities" (Coleman et al., 2012, p. 4). A participant in the group WPR analyses reacted to the expected adaptation of such a perspective to some "other" cultural context, stating that it assumes "people living in that region wouldn't be First Nations people and have their own cultural backgrounds, and so in a sense, it's colonising even to people who do come from that particular geographical region". A second participant further critiqued the problematics of racialisation in the SOC-7:

> I think there is another implicit message in there. If you are an expert, you work from this way. You must be white, North American, or Western European, and then ... there are those people who are different. It kind of creates a different dilemma for people of colour or diverse people within this profession of where do I fit in? Am I part of the expert profession? Or am I part of the cultural people that things need to be adapted for?

The SOC-7 reiterates a more general statement that "WPATH recognizes that the SOC have grown out of a Western tradition and may need to be adapted depending on the cultural context" under the subheading "Other Tasks of the Mental Health Professional" (Coleman et al., 2012, p. 32). The critiques from participants in the group WPR analyses draw attention to colonialism and its

racialisation as the present context in which both the SOC-7 and the knowledges of an underpinning conceptual logic of medicalisation are produced.

The Guide uses the term "responsive" to encourage the development of any number of alternative models for "care" that implies a potential for disrupting the liberal universalism lurking within a conceptual logic of rights. In stark contrast to the SOC-7's intended use, the Guide insists that its proposal is understood within the Spanish context in which it was created and not as an attempt "to establish a new universal model" (STP, 2010, p. 16). It expresses the desire "that our work leads to additional progress" towards trans depathologisation "by means of similar projects being undertaken that are responsive to specific local political, cultural and social environments" (STP, 2010, p. 16). The Guide is thus proposing an alternative model for healthcare in Spain while "incidentally proposing features that can be utilized in non-pathologizing models elsewhere in the world" (STP, 2010, p. 8). It references research in Spanish by cultural anthropologist and activist Carsten Balzer/Carla LaGata, to explain:

> The study of anthropology has shown us that pathologization functions as an imperialistic colonizing mechanism that spreads the message that trans people in the West are treated with respect and that some countries even take responsibility for their hormonal and surgical treatment. This idea, though it may appear progressive, reveals little awareness in the West of the existence of other cultures and alternative ways of understanding trans issues, and it does nothing to negate the fact that trans people in many Western countries suffer extreme violence. (STP, 2010, p. 10)

The Guide uses this analysis as the basis for its argument that "the objective of health care for trans people should be to create conditions that improve their quality of life" (STP, 2010, p. 16). The Guide, therefore, develops its best practices by locating pathologisation within a colonising

mechanism and marking both as key conditions shaping the lives of people requesting access to gender-affirming medical technologies. It follows that localised non-pathologising models for "care" can become "responsive" by incorporating analyses of how hegemonic "Western", medico-scientific taxonomies of gender self-designation operate within specific colonising mechanisms. Becoming "responsive" is used to signal processes that recognise and address the governing of gender through a logic of medicalisation. Responsiveness carries the potential to extend beyond the liberal notions within a conceptual logic of rights and to disrupt settler colonial structures as the context for the development of non-pathologising models for "care".

Conclusion

In this section, I used each policy's stated focus, changes, and intended use as a heuristic for comparing how the SOC-7 and the Guide use concepts to construct their divergent problem representations and for reflecting on how these connect to underpinning conceptual logics. The SOC-7 relies on the concepts of "safe and effective pathways", "personal comfort", "flexible guidelines", and "worldwide use" in ways that reinforce an underpinning logic of medicalisation. Problematising distress at an individual level, the SOC-7 attributes authority to expert medical knowledges and judgement by health professionals in ways that reproduce a hierarchy of subject positions, maintains psychiatric assessment, and expects its application in any context of "care". In contrast, the Guide relies on the concepts of "analytical tools", "reference points", "autonomy", "informed consent", and "responsive" in dynamic ways that further reveal a lurking liberalism yet signals opportunities for potentially radical approaches. Problematising "care" at a paradigmatic level, the Guide promotes accountability to human rights and challenges the hierarchy of relations between those who seek access and those with the power to allow access. Critique within the Guide suggests the possibility of disrupting settler colonial structures, even if this potential is called into question by typically liberal notions of bodily autonomy and self-determination. Identifying how each policy uses concepts in relation to their underpinning conceptual logics makes possible the final part of this reflection, which identifies patterns within each policy's problem representations that signal particular rationalities.

Patterns that shape rationalities

This section identifies patterns in each policy's representations of the "problem" that signal a liberal governmental rationality. To use Bacchi and Goodwin's (2016) terms, it identifies patterns that signal "the rationales produced to justify particular modes of rule" (p. 42). For Mol (2008), logics are patterns that shape the rationale for the specific practices studied. The logics and concepts in the preceding sections outline the contours of a liberal rationale, broadly understood as encompassing a range of features. As Nikolas Rose and critical socio-legal scholars Pat O'Malley and Mariana Valverde (2006) argue, "rationalities are constantly undergoing modification in the face of some newly identified problem or solution, while retaining certain styles of thought and technological preferences" (p. 98). Ultimately, a liberal rationality belongs to "a broad family of ways of thinking about and seeking to enact government" that has, through "the rather contingent coalescence of a wide array of criticisms", ascended "into governmental prominence and even dominance" (Rose, O'Malley & Valverde, 2006, pp. 98-99). I describe different patterns of a liberal rationality in the SOC-7 and the Guide by reflecting on the modifications wrought by their diverging problem representations.

It is crucial to emphasise that an application of the WPR approach also involves a consideration of the ways that policies actively produce "problems" together with "subjects", "objects", and "places" (Bacchi & Goodwin, 2016). As a result, this section also describes the making (and also unmaking) of these components to deepen the reflection on how different features of a liberal governmentality combine within the SOC-7 and the Guide. I reflect on two different combinations of features that justify two particular modes of governing access to gender-affirming medical technologies. I argue that liberal governmental rationalities are pervasive in ways that leave uncertainty about how disruptions can be achieved and whether or not these will lead to positive transformation.

Governing via a logic of medicalisation

The first combination of features within a liberal rationality occurs via the underpinning logic of medicalisation. The preceding sections sketch a familiar and relatively straightforward operation of a liberal and neoliberal rationality within the SOC-7's problem representation. They also show how its features are combined with minimal modification for the SOC-7 to retain familiar styles of thought and technological preferences.

The familiarity is the SOC-7 providing clinical guidance in a narrow medical sense and maintaining a representation of the "problem" in medical terms. Accordingly, the SOC-7 retains a recognisable technological preference for diagnostic protocol because these provide the rationale that gender-affirming medical technologies are the "treatments" that alleviate the psychiatric "problem" of "Gender Dysphoria". Introducing the model of "minority stress" allows the SOC-7 to recognise the importance of social factors without shifting its individual focus and delving into the impacts of interlocking structural oppression and racism. Explaining the change of terms in the diagnosis also allows the SOC-7 to assert that people with self-designated genders "are not inherently disordered" which permits a claim that its guidance is now non-pathologising and can thus continue to be adapted to fit any context (Coleman et al., 2012, p. 6). Problem representations underpinned by liberal rationalities regularly focus on issues of exclusion and discrimination and offer "inclusion" and "diversity" as proposals within normative assimilatory frameworks, adjusting or removing components but retaining the existing mechanisms. The pattern in the SOC-7's focus, change, and intended use reveals a problem representation that, although framed as a "significant departure" in response to cultural changes, advancing knowledge, and a deeper appreciation of healthcare issues, nevertheless remains well within the existing paradigm. This problem representation can be understood through the underpinning logic of medicalisation as a particular approach to depathologisation that relies on a familiar liberal governmentality.

Identifying how the SOC-7 produces "subjects", "objects", and "places" extends this reflection. Reading backwards from the stated goal of guiding health professionals in providing assistance by first assessing (judging) a person's distress (also capacity and risk) clarifies how the SOC-7 represents "Gender Dysphoria" to be a psychiatric problem of distressed individuals. In other words, this reading illuminates how it produces the "gender dysphoric" subject it describes. The Canadian Professional Association for Transgender Health (CPATH) (2012) favourably referred to this as a major shift in tone whereby the SOC-7 provides guidance "on what health care providers can do … rather than what 'hoops' transgender individuals need to 'jump through' to prove that they are eligible to access treatment" (para. 4). Yet this change in tone is what signals the familiar, straightforward neoliberal rationality operating in the problem representation. Access to requested medical technologies still rests on people assuming the subject position of a child, adolescent, or adult whose experience of gender dysphoria can be verified against the criteria for a mental illness diagnosis.

The SOC-7 thus produces a "gender dysphoric" subject in the same way that it produces "informed consent" as an "object" in practices governing "care". That is, the SOC-7 makes a psychiatrically unwell-enough "subject" that is "governable" through practices of judgment and documentation of eligibility for "treatment" and capacity to provide "informed consent". This process, especially in the context of surgical technologies, means that "mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body" (Coleman et al., 2012, p. 55). Yet, these practices are precisely what prompts California-based critical historian Julian Carter (2014) to describe the path of access as a "trajectory through batteries of expert gatekeepers" (p. 235). Comments from participants in the group WPR analyses on this unidirectional approach already indicated the combining of a liberal with a neoliberal rationality in the SOC-7, illustrating how expertise responsibilises people through producing not only the psychiatrically unwell-enough "subject" but also the credentials that authorise the professional "subject" to verify distress, assess capacity to consent, and determine risk based on "complexity". Maintaining a premise of first illness then "treatment" enfolds gender self-designation into a logic of medicalisation that is,

as Dewey and Gesbeck (2017) point out, a logic within which hegemonic "medical and therapeutic systems create the problem they purport to solve" (p. 67).

Situating assessments as part of the assistance a person can receive to make informed choices about their "care", the SOC-7 interweaves the making of a "gender dysphoric subject" with the making of an "active subject" that provides informed consent for "treatment". As STP (2012) observes in its *Reflections on the SOC-7, "*this application of informed consent is reduced to making the trans person responsible for knowing the risks of treatment and signing the form" (p. 6). This is a type of containment with familiar styles of thought, broadly understood as liberal governing exercised over individuals constituted as both subjects of rights and economic actors. As Foucault explains (2008), "economic men, must be placed [in civil society] so that they can be appropriately managed" (p. 296). The SOC-7 thus produces a "subject" and an "object" that specify people with self-designated genders must first be verified as distressed enough and then safe enough (have the capacity and be risk-free) to become "active" decision-makers in their "care". This positioning connects to Puar's (2017) argument that "neoliberal mandates regarding productive, capacitated bodies entrain trans bodies to re-create an able body not only in terms of gender and sexuality but also in terms of economic productivity and the development of national economy" (p. 35). This making of subjects that are verified through "expert" assessment for "treatment" is, therefore "about trans bodies being recruited, in tandem with many other bodies, for a more generalized transformation of capacitated bodies into viable neoliberal subjects" (Puar, 2017, p. 35).

Consolidation of these features of a neoliberal responsibilisation within a liberal rationality supports reflection on how the SOC-7 produces "places" as part of the colonial biopolitics of these governmentalities. Carter (2014) extends the description of access as a trajectory through expert gatekeepers by arguing that "the sequence itself materializes the discomforting biopolitical requirement that trans-people must literally embody a particular set of psychiatric perspectives and medical practices" (p. 235). This has particular implications when viewed in light of the statement that

"acknowledges that much of the recorded clinical experience and knowledge … is derived from North American and Western European sources" that precedes the SOC-7's suggestions for "thinking about cultural relativity and cultural competence" (Coleman et al., 2012, p. 3, p. 1). Producing North America and Western Europe as "places" of research and clinical expertise (re)produces a particular relationship with the "other parts of the world" to which its guidance should be adapted (Coleman et al., 2012, p. 1). Identifying how the SOC-7 calls people with self-designated genders into relation with psy-practices and "the West" into relation with "other parts of the world" helps locate the biopolitical requirements of people with self-designated genders within the broader biopolitics of settler colonialism.

Governing through a logic of rights

The second combination of features within a liberal rationality occurs via the underpinning logic of rights. As indicated in the preceding sections, the lurking liberal assumptions within this logic and the interactions between underpinning logics generate a complex pattern of rationalities. This pattern reveals how rights, in and of themselves, operate as another feature of a liberal governmentality. It also reveals how rights can disrupt some of the expected styles of thought and technological preferences.

The Guide retains the familiarity of a liberal rationality because, as Irving (2013) points out, rights produce "individualized states of existence" (p. 320). Accordingly, Irving (2013) objects to its governing of "social subjects according to the hegemonic colonial, capitalist, nationalist, racialized and heteronormative logics" that are "obscured through such liberal democratic exercises" (p. 320). However, if the logics themselves are what shapes the rationale of practices, this distinguishing of components and means of ascendancy creates opportunities for disruption. Read in this way, the pattern in the Guide's focus, change, and intended use reveals a problem representation explicitly formulated to provide scope for developing any number of responsive, place-based, non-pathologising protocols. The opportunities for disruption are emphasised in the Guide problematising a paradigm

rather than an experience within a person, its proposal for a flexible model rather than flexible guidelines within an existing model, and offering its method for similar projects developing protocols in different contexts. It means there are multiple points at which it seeks to disestablish an illness-based model and numerous means of doing so. The underpinning logic of rights is how the Guide's problem representation can be understood, yet its liberal governmentality also creates significant limitations.

Identifying how the Guide produces "subjects", "objects", and "places" enhances this reflection on its governmental rationalities. Reading backwards from the proposal for the development of alternative, rights-based, non-pathologising protocols clarifies how the Guide represents the "problem" to be an illness paradigm. Its proposed alternative model allows "an individual to select from various available options" (STP, 2010, p. 19). Therefore, it produces "subjects" by challenging the problematisation of an individual's experience of distress for the purposes of regulating access to "care". Arjonilla (2014) explains how "the Guide breaks with this model of diagnosis and treatment … and substitutes it for a new one in which every single trans person is responsible for the process, because they are considered experts on their own processes" (p. 41). In other words, the Guide is unmaking the psychiatrically unwell "subject" constituted in the SOC-7 by making an autonomous, self-determining, rights-bearing "subject".

People with self-designated genders, therefore, assume the subject position of an individual whose relations with health professionals is a process "to access any medical techniques or procedures that might at some point be chosen" (STP, 2010, p. 20). The Guide achieves this by conceptualising informed consent as "a continued process of information, optional counseling and professional accompaniment in the decision process" (STP, 2012, p. 6). By explicitly situating a rights-bearing "subject" on an equal footing with health professionals as accompanying "subjects", the Guide renders both governable through rights. Arjonilla (2014) argues that contrary to an illness-based

model, this process is both “a democratization” of “the model of relations”, and “a democratization inside the medical treatment process” (p. 41). However, invoking notions of responsibility in contemporary healthcare comes perilously close to the neoliberal responsibilisation of people with self-designated genders that was highlighted in the previous discussion of the SOC-7. While the making of autonomous, rights-bearing, and accompanying subjects in the Guide facilitates democratisation, the presence of a neoliberal rationality raises concerns about uncritically mobilising rights as an alternative model.

Reflecting on this combination of features within a liberal rationality calls attention to an extensive critique of human rights as a liberatory proposal. Critical scholars highlight how a liberal rationality produces a rights-bearing “subject” by racialising, gendering, and sexing bodies via medico-scientific technologies that categorise attributes and affects according to sets of binary oppositions configured for hierarchical social ordering. Influential Peruvian sociologist Aníbal Quijano (2007) developed the concept “coloniality of power” to describe a mode of governing that “was conceived together with America and Western Europe, and with the social category of ‘race’” (p, 171). Quijano (2007) recognises coloniality as a system of knowledge that positions European culture as superior and also establishes and maintains a relation between “European culture” and “the other cultures” as “a relation between ‘subject’ and ‘object’” (p, 174). Lugones (2010) extends Quijano’s work, arguing for an examination of the governing — emergence, maintenance and enforcement — of race alongside the governing of gender and sexuality. As mentioned in chapter two, Lugones (2010) argues for the use of “the modern, colonial, gender system” as a critical “lens through which to theorize further the oppressive logic of colonial modernity, its use of hierarchical dichotomies and categorial logic” (p. 742). Taking this theorisation up in the field of transgender studies, Aizura, Cotten, Balzer/LaGata, Ochoa, and Vidal-Ortiz (2014) suggest Lugones’ conceptualisation supports thinking beyond a double bind “which produces the terms of recognition for trans subjects within medical governmentality and modern forms of self-making and citizenship” (p. 311). However, the Guide appears to grapple with this double bind of gender recognition by setting its protocol on a track that bypasses a medico-

scientific rationality. In doing so, it also avoids an engagement with a liberal rights rationality and its colonial conditions.

Further identification of how the Guide produces "objects" and "places" deepens the reflection on this complex interplay of thinking and technologies within a liberal rationality. As discussed, the Guide produces a rights-bearing "subject" that, in Bacchi and Goodwin's (2016) terms, also causes the "object" of "informed consent" to be "produced otherwise" (p. 87). The Guide's conceptualisation of "a continued process" goes beyond information transfer. Optional engagement with mental health practitioners helps recast the relationship with health professionals as an "accompaniment in the decision process" (STP, 2012, p. 6). Moreover, the Guide's analytical tools and reference points provide important context for a connection between a continued process of decision-making and a continued process of developing locally situated non-pathologising protocols. In a discussion about the consequences of an illness-based model's enduring focus on the "problem" with and in a person, a participant in the group WPR analysis noticed that there is nothing "in [either of] these guidelines to help providers to navigate oppressive systems". However, another participant identified the Guide's use of the personal pronoun "we" as an important component of its approach to depathologisation. The participant had noticed an assertion of "continuing to fight tirelessly against the violence, stigmatization and marginalization to which we've been subjected" (STP, 2010, p. 5). The participant characterised the Guide as wanting change through being part of that change, commenting that its use of concepts has "a very different feeling to it" than the policies she is used to. Indeed, the statement is a precursor to the Guide articulating a hope that it "will stimulate debate over alternative ways to implement a non-pathologizing health care model" (STP, 2010, p. 29). The anticipation of being part of a continued and contested process is underscored by the Guide's perspective on its proposal "as another turning point in a historic struggle", one that "gives voice to the trans community, which invites all to join us in crafting new alternatives that replace the customary pathologization of our lives" (STP, 2010, p. 29).

Accordingly, the Guide produces localised "places" of responsive protocol development. It calls attention to the colonial underpinnings of the SOC and so denaturalises the making of North America and Western Europe as "places" where clinical and research knowledges reside. There is a contribution to the unmaking of these "places", yet there is a concern that it focuses on "care" in the Spanish healthcare system without scrutinising Spain's position as a Western European colonising power or the genocidal consequences of dispossessing Indigenous peoples of their lands. The suggestion is that its analytical tools and reference points play a crucial but also a limited role in the Guide producing "subjects", "objects", and "places" otherwise. The Guide's problem representation generates an approach with the potential to disrupt the ongoing colonial function of an underpinning liberal governmental rationality but also uncertainty about how far and what sorts of transformations it will bring about.

Conclusion

In this section, I identified a familiar, straightforward operation of a liberal and a neoliberal governmental rationality in the SOC-7 and a more complex operation of a broadly liberal rights governmentality in the Guide. The SOC-7 is straightforward in the sense that it advances a logic of medicalisation by maintaining a premise of first illness, then "treatment". It produces responsibilised "subjects" and "objects" for "care" and "places" where expertise about "care" resides and should be adapted to. Its rationality calls people with self-designated genders into relation with psy-practice as necessary conditions that bring about depathologisation. The Guide is complex in that its (un)making of "subjects", "objects", and "places" breaks with established processes of grating access to gender-affirming medical technologies. Recasting relations between people with self-designated genders and health professionals indicates a rights governmentality that has the potential, despite its contradictions, to disrupt the logics a liberal rationality otherwise forecloses. The pervasiveness of liberal governmental rationalities, such as those maintained in the SOC-7 and the Guide, and their complex interactions leave uncertainty about how disruptions can be achieved and what sorts of transformation they will provoke.

Conclusion

This chapter reflects on two conceptual logics that underpin and are used in constructing the problem representations in each policy. It also reflects on how these logics and concepts have different liberal rationalities for governing access. I argue that the SOC-7 advances an underpinning logic of medicalisation for governing access and as a means to bring about depathologisation, whereas the Guide offers an open-ended proposal for the formulation of any number of responsive, place-based, non-pathologising protocols for governing access informed by an underpinning logic of rights.

Identifying and comparing these underpinning conceptual logics shows how problematisations in the SOC-7 reflect assumptions about suffering individuals and tampering with bodily systems that are contained within medicalised responses to requests for access to gender-affirming medical technologies. It also shows how problematisations in the Guide reflect assumptions about proprietary ownership, bodily integration, and citizenship contained within rights-based responses to the medicalisation and pathologisation of gender self-designation. While it is clear that a conceptual logic of medicalisation is circulating beneath the SOC-7, there is a degree to which the Guide relies on both a conceptual logic of rights and medicalisation for its problem representation. Identification of the concepts that appear in the SOC-7's focus (on the individual "problem" of distress and its "treatment"), its change (from a formerly problematic to a new type of flexible approach), and its intended (worldwide) use, reveal how a conceptual logic of medicalisation is bolstered through its representation of the "problem". Subsequent identification of concepts in the Guide's focus (on the systemic "problem" of pathologisation through an illness-based paradigm), its change (through redesigning both the premise and model of "care"), and its intended (localised) use, revealed the dynamic ways a conceptual logic of rights is used in its problem representation. The pattern of concepts used to construct the problem representation in the SOC-7 signals a straightforward combination of familiar liberal and neoliberal rationalities, whereas the pattern in the Guide indicates a liberal rationality complicated by a rights rationality. Participants in the group WPR analyses

offered important comments about what underpins these problem representations as a result of how their social positions combined with their experience of the different subject positions, objects, and places produced in the SOC-7 and those produced otherwise in the Guide. It is in this way that the supplementary findings continue to offer significant contributions to this analysis. The following chapter shifts the focus from what underpins the SOC-7 and the Guide by using a genealogy of "care" to consider how the representation of the "problem" in each policy came about. Considering key moments across time and space shows how they are interwoven in a tenacious struggle to maintain access to care, shift its attention, and also to dispute its assumed legitimacy. It is a consideration of what makes it possible to represent internalised experiences and overarching structures as "problems" in each policy.

Chapter 6
Considering critical moments in "care"

Considering critical moments in "care" highlights the conditions from which the problematisations in trans health policy have emerged. The SOC-7 and the Guide are professional standards and best practices for providing "care" for people who request body modifications classified as gender-affirming. In an overview of academic literature that emphasises the importance of "care" across theology, anthropology, sociology, and ethics, Mol (2008) points to an understanding of "care" as what "people shape, invent and adapt, time and again, in everyday practices" (p. 4). In this theorisation, "care" is as much "an intervention (or rather a style of intervening)" as it is an interaction (Mol, 2008, p. 100). Accordingly, Bacchi (2018b) argues that how "care" is spoken about and how it is theorised "reflects the changing political landscapes we inhabit" (para 3). Such a wide-ranging conceptualisation is a crucial part of this comparative analysis because, as Mol (2008) identifies, it occurs relationally "between people but also between people and materialities, i.e. technologies and bodies" (p. 100). This chapter reports on findings from an application of question three of the WPR approach, which asks, "How has this representation of the "problem" come about?" (Bacchi & Goodwin, 2016, p. 20). I build upon previous reflections on the underpinning medical and rights-based logics and their liberal governmentalities by considering how the problem representations of "Gender Dysphoria" and an illness-based model have come about. This is a genealogy concerned with the development of the conditions of "care" in trans health. The aim is to consider how people who request body modifications classified as gender-affirming become subjects of "care". This consideration requires attention to practices, struggles, and relations within, alongside, and seemingly far away from trans health. I suggest the problem representations in the SOC-7 and the Guide emerge from within this complex interplay of historically contingent ideas about and processes for governing gender.

This genealogy considers twelve critical moments in "care". The moments are nonchronological

because they emerge, in Foucault's (2008) terms, from within "a dense web" of power relations that transit "through apparatuses and institutions" and a "swarm of points of resistance" (p. 96). The profusion of moments is part of this analytic method. For Amin (2018), genealogy is important because it "acknowledges multiple, contingent origins rather than a singular, determining one; it understands historical time not as a causal, straight line but as a fragmented and tangled network of ruptures, continuities, reversals, and reconfigurations" (p. 602). Similarly, social work researcher Adrienne Chambon (1999) argues that genealogy identifies "continuities and discontinuities among the ideas and practices of a field. It highlights critical breaks, moments and departures" (p. 55). In the context of policy analysis, Bacchi (2009) asserts that "identifying specific points in time" that take "an issue in a particular direction" illuminates how problem representations under scrutiny are "contingent and hence susceptible to change" (p. 10). Following Amin (2018), Chambon (1999) and Bacchi (2009), I outline how twelve moments represent continuities, ruptures, possibilities, and reconfigurations in "care" for people with self-designated genders. This chapter proceeds across five sections that consider moments of change in "care", status relations, becoming "treatable", gatekeeping and access, and finally, recognition and self-determination. Below, summary Table 2 outlines the claims I make about what each moment contributes to the emergence of "care". This genealogy shows how the production of people with self-designated genders as subjects of "care" occurs within this complex array of practices and relations. This consideration of critical moments in "care" across time and place is important because it shows the ways in which "care" secures, authorises, and protects hegemonic medical authority and state power. This consideration revels the presence of the underlying logics of medicalisation and rights, sometimes implicit others overt. Considering the complexity of practices and relations in "care" develops an appreciation of how trans depathologisation efforts are formulated through all sorts of tactics to intervene in the constructions and governing of access.

Summary Table 2 — Overview of a genealogy of "care"

Section	Moment	Continuities, ruptures, possibilities, and (re)configurations
Changes in "care"	**2022** when revisions to the ICD11 come into effect	A possibility in "care" following a reformulation of the existing medical coding system.
	2013 changes to diagnostic categories in the DSM-5	A continuity in "care" occurs by renaming psychiatric diagnoses.
Status relations	**2007** Law 3/2007 regulating changes to a person's name and sex on the Spanish national registry	A continuity by reconfiguring activist demands into legislation that maintains governing through established status relations.
	1777 imposition of "civilisation" through treaty	A configuration of patriarchal white supremacist colonial status relations using mechanisms synonymous with "care".
	1897 "protection" as policy mediated dispossession	A configuration of colonial relations as "care".
Becoming "treatable"	**1930s** production of synthetic hormones discredits organotherapy (using extracts from animal organs as medical "treatments").	A rupture within white supremacist philosophies of "care" that underscore ongoing capitalist, carceral, and colonial mechanisms of power in "care".
	2012 A Starfish Model of codes classification for ICD proposed	A possibility in "care" through reorganising an entire medical coding system.
	1893 creation of the ICD	A configuration of "care" practices into surveillance practices for managing populations.
Gatekeeping and access	**1979** closure of the Johns Hopkins Gender Identity Clinic and the publication of the first Standards of Care	Continuity of health professionals as regulators of "care".
	2016 gender-affirming genital surgery skills development workshop	A rupture caused by an inability to transform increased access into realised "care".
Recognition, autonomy, and self-determination	**2017** Yogyakarta Plus 10	A reconfiguration of "care" through broadening the understanding of rights.
	Perpetually designating the	A rupture countered with an explicitly

	gender of new-borns	collective and relational politics of resistance.

Changes in “care”

A genealogy is an analytic that starts from a concern in the present. The concern in this instance is how requesting access to gender-affirming medical technologies has come to be tied to pathologisation. This genealogy considers critical moments when this linking and (attempted) de-linking occur. Gender and feminist studies scholar Maria Tamboukou (1999) argues that in the context of genealogy, a “present is not theorised as the result of a meaningful development, but rather as an episode, a result of struggle and relations of force and domination” (p. 203). Theorising the present as an episode within an ongoing struggle in power relations is crucial for articulating the importance of each critical moment within this genealogy. As a result, this section considers two critical moments associated with recent changes in “care”. First, it looks at a critical moment in 2022 when the ICD-11 revisions come into effect. Second, a moment in 2013 when the DSM-5 changes to diagnostic categories associated with gender self-designation were released. I suggest these changes represent a possibility in “care” following a reformulation of the existing medical coding system and a continuity in “care” that occurs by renaming psychiatric diagnoses.

2022 Revisions to the ICD11 come into effect

I start this consideration at a possibility in “care” that occurred when the 72nd annual World Health Assembly confirmed that the approved revisions to the ICD-11 would take effect on 1 January 2022 (World Health Organisation, 2019). According to the WHO (2020b), the “ICD-11 has redefined gender identity-related health” (para. 2). As noted in chapter five, existing diagnostic categories related to gender self-designation have been deleted from the ICD chapter “Mental and Behavioral Disorders”, while new trans-related categories have been introduced in a new chapter “Conditions Related to Sexual Health” (WHO, 2020b). Even as this reformulation of the ICD-11 is generally lauded as a positive move, the worldwide activist federation ILGA (2018) insists that more work

remains to be done. Examples include an ongoing review to ensure "gender incongruence" is replaced with a non-reductive and non-normative ICD code, removal of the harmful reference to "gender incongruence" in children, and the ultimate goal of achieving "full depathologization grounded in human rights and … universal access to healthcare" (ILGA, 2018, para. 4). The goal, clearly stated, is a human rights-based depathologisation of "care". Accordingly, ILGA (2018) also specifies that because "many people around the world have severely suffered the impact of pathologisation", there is work remaining so "as any other victim of human rights violations, they have the right to truth, to rehabilitation and to reparation" (para. 4). This list of the ongoing work for full trans depathologisation is also a list of what is possible in "care". It suggests that working toward "care" grounded in human rights can extend beyond challenging illness-based governing of access to challenging broader structures of harm and seeking justice. The ICD-11's descriptive account of gender self-designation as "gender incongruence" and relocating this new category for people with self-designated genders into a new chapter can be read as a set of possibilities produced by the ongoing struggle by activists for a shift in power relations.

2013 Changes to diagnostic categories in the DSM-5

I return briefly to the 2013 release of the DSM-5 to consider its changes to diagnostic categories as a critical moment of continuity in "care". Rather than repeat the changes described in chapter four, I consider this moment with a compelling examination of constructing pathology in the DSM and the SOC by Damien W. Riggs, Ruth Pearce, Carla A. Pfeffer, Sally Hines, Francis White, and Elisabetta Ruspini (2019). These authors are located in Education, Psychology, Social Work, and Sociology departments in Australia, the UK, North America, and Italy. This paper is significant because it contends that a normative "version of life for transgender people" is enforced by the psy disciplines through policies for diagnosis and treatment (Riggs et al., 2019, p. 3). It summarises changes to diagnoses concerning gender self-designation within the DSM and contextualises these within a dynamic of ongoing pathologisation and vocal resistance. It explains the logic of replacing the name of the principal diagnosis was "to shift the focus away from seeing gender diversity as a disorder, and

to instead focus on the distress arising from the experience of dysphoria" (Riggs et al., 2019, p. 13). Changing from "Gender Identity Disorder" to "Gender Dysphoria" is touted as a move to reduce the stigma surrounding trans identities (APA, 2013). However, refocusing medical attention (assessment, intervention, treatment) from the existence of gender self-designation to a particular experience of gender self-designation illustrates the continuity of a pathologising logic of medicalisation in responding to requests for access to gender-affirming medical technologies. Accordingly, Riggs and colleagues (2019) emphasise the necessity of considering "just who is given the power of diagnosis" (p. 14). They conclude that "the effect of displacing responsibility for responding to social injustice" is "diagnosing a targeted individual as disordered or ill rather than seeking to change the cisgenderist and heterosexist society or social system in which they are embedded" (Riggs et al., 2019, p. 17). The emergence of this "care" in response to requests for body modification is another way of organising and governing society according to dominant ideas about gender.

In this brief section on changes in "care", I suggest that the outstanding tasks for achieving full trans depathologisation remain possibilities even after the practices of re-categorisation and reallocation in the ICD-11. Also, that rigorous attention to histories of relations between psy professions and people with self-designated genders reveals continuity in the DSM-5, maintaining the focus on a disordered individual. The emergence of this "care" at these connected contemporary moments orients the remaining considerations of struggle and relations within and surrounding trans health policy.

Status relations

This section considers three critical moments associated with status relations. The first is a moment in 2007 when a new Spanish National Identity Documentation legislation was passed. The second and third are critical moments of settler colonial governing through notions of "civilisation" and "protection". I suggest that the status relations produced through these acts of governing are a continuity of "care" by reconfiguring activist demands into legislation and two configurations of "care" in which cisheteropatriarcy scaffolds the dispossession and ongoing regulation of Indigenous

peoples.

2007 Spanish Gender Identity Law

A consideration of status relations starts with a critical moment of the passing of The Organic Law 3/2007 to alter details in the primary Spanish identification document, the Documento Nacional de Identidad (DNI). This critical moment connects to changes in trans healthcare policy through a shared history of struggle to amend official documents such as birth certificates, driving licences, and passports without prior medical intervention. The passing of Law 3/2007 highlights a further continuity of "care" via reconfiguration. Trans-feminist activist and researcher R. Lucas Platero (2011; 2020) offers an extensive analysis of trans-related legislation and public policy in Spain. Platero (2011) explains how Law 3/2007 allows "adult Spanish citizens the right to change their legal name and sex marker in all documents" upon meeting the requirements of a "Gender Dysphoria" diagnosis, two years of "medical treatment" (with some exceptions), and "a clearly-gendered name" (p. 601). Law 3/2007 only addresses issues of identity documents, despite the Spanish trans movement campaigning for sweeping legislation covering publicly funded healthcare, material access to employment, and labour, anti-discrimination protections, provisions for asylum seekers, adding transphobia to the National Criminal Code, and reparations for those persecuted under Franco's fascist regime (Platero, 2011). Requirements within Law 3/2007 have mixed implications for people with self-designated genders because the DNI still "associates a person's geopolitical and ethnic origin with a number", "establishes kinship with a biological family", and "ties a person's image to a gender, for which there are only two possible options" (Platero, 2011, p. 600). This legislation thus works together with existing diagnosis and "treatment" protocols to maintain the status quo of governing citizens through the geopolitical, racialising, essentialising, binary apparatus that is the DNI. A further continuity of the pathologisation and medicalisation of gender self-designation occurs when multiple, overlapping activist demands are reconfigured into state legislation that uses established diagnosis and "treatment" protocols to maintain the status quo of governing citizens through a national identity apparatus.

1777 Imposition of "civilisation" through treaty

I now turn to a critical moment that began in 1777 that highlights a colonial configuration of status relations in the settler-occupied territories now known as the United States. This is a moment of colonial investment in "civilisation" that connects to changes in trans health through the policies, codes, and regulations that enforced a rigid patriarchal binary gender system. Suzan Shown Harjo (2014) is a Cheyenne and Hodulgee Muscogee writer, curator, and policy advocate involved in examining the history and present of over three hundred and fifty treaties negotiated between US State officials and tribal leaders between 1777 and 1868. Treaties can be understood as a means of establishing and maintaining relations between nations. At odds with the US colonial project, Shown Harjo (2014b) explains that for Native peoples, treaties are more than written and signed documentation of negotiations between sovereigns; they are also relations "of kinship, and the agreed upon duties and rights are recognized as both familial and national" (p. 132). However, the treaty requirements set by the US regularly referenced "the so-called arts of civilization" to justify confining Native peoples within reservations to gain access to vast swathes of their homelands (Shown Harjo, 2014, p. 4). One understanding Native people had of this "civilisation" terminology was in the benefits of learning "about non-Native ways, but not that the new ways would replace, or try to replace, Native values or knowledge systems" (Shown Harjo, 2014, p. 4). This "civilization" terminology produced material conditions for the management of Indigenous nations through the bodies of Indigenous people. It also generated a template for configuring the subordinated position of Indigenous nations in Indigenous settler state relations.

Philip J. Deloria is a history scholar and member of the Dakota Nation who, in an interview with Shown Harjo (2014a), identifies the consequences for Native peoples in how a treaty "crunches them down geographically into a smaller space, opens up all the surrounding land to white settlement, and then sets up the provisions for a colonial kind of structure" (p. 12). This crunching down of Native peoples to establish colonial governing involved coercing consent to sign treaties through threats and

overt acts of violence. It also involved transposing the "civilisation" terminology from treaties into regulations and codes that criminalised everything "that was traditional or customary", including matriarchal governance structures, ceremony, and even who was allowed long hair (Shown Harjo, 2014, p. 4). These manoeuvres are understood as an attempt to contain Indigenous peoples "within social and cultural boundaries" through "the same institutions and ideologies that made white citizens into subjects—schools, churches, wage labor, and literacy, among others" (Deloria, 2004, p. 28). This positioning also authorised punitive measures against those who refused the purported "gift of civilization" (Deloria, 2004, p. 28). These included starvation, imprisonment, and hostage-taking, including abducting children from their families and confining them in the now well-known, violent system of residential schooling (Shown Harjo, 2014). Such punishments were an integral part of an orchestrated attempt to impose a patriarchal colonial system of gender, family relations, and structures of governing onto pre-existing and enduring kinship relations. These practices instrumentalised cisheteropatriarchy to produce structures of population control for colonial land accumulation and settlement. This is one example of how a normative, rigid system of gender is pivotal to a set of structures that condition contemporary Indigenous settler relations and settler-state policies more generally.

1897 "protection" as policy mediated dispossession

I shift from the use of "civilisation" in the US to considering another episode of policy-mediated dispossession in the former British colony now known as Australia. This critical moment occurred on 15 December when the parliament of Queensland assented to the *Aboriginals Protection and Restriction of the Sale of Opium Act 1897*. It is another example of colonially configuring status relations, highlighting the importance of attending to the rationales and practices through which people come to be subjects of "care". The written purpose of this Act is "to make Provision for the better Protection and Care of the Aboriginal and Half-caste [sic] Inhabitants of the Colony, and to make more effectual Provision for Restricting the Sale and Distribution of Opium" (AIATSIS, 2022).

Badtjala artist and academic Fiona Foley (2020) contextualises the Act amid frontier labour shortages. In the late 1800s, white settlers turned to Aboriginal people, bereft and dispossessed from "successive waves of frontier and settler violence", to do unwanted "rough work" and were paying them opium dregs instead of wages, effectively addicting them as a free labour force (Foley, 2020, p. 77). As Foley (2020) explains, "their labour was sought and taken advantage of in a multifaceted arrangement … The newcomers achieved the subordination of a sovereign peoples and their culture. Over time, Aboriginal employees suffered the consequences of opium addiction" (p. 78). Crucially, the Queensland government was introducing legislation "to 'solve the problem' of opium-addicted Aboriginals" while continuing to earn a sizeable revenue from issuing opium licences (Foley, 2020, p. 1). No action was ever brought against a white man; instead, the Act served to prosecute Chinese men for selling opium and establish island missions to isolate "problem" Aboriginal people away from townships. Missions ostensibly provided care for "opium-addicted Badtjala people" and became "an open-door jail for all misbehaving types across the state" (Foley, 2020, p. 1). Its racism was, therefore, multilayered and multidirectional.

Implied in the Act was another "problem" of interracial sexual relations. Australian social historian and poet Raymond Evans (1999), describes public outrage and "demands for Aboriginal expulsions" from the towns as a result of "young white lads" sexually transmitted infections (p. 135). What Foley (2020) makes clear is that Aboriginal women experienced "sexual abduction, assault and infection" to the point where "there was no safe environment from marauding white males bent on sexual raids" (p. 80). The racism in the Act is thus a disavowal of the sexual violence enacted as part of settlement under a colonial system. As with "civilising" codes and regulations, this legislation confined Aboriginal people to reserves and missions to live in abject conditions. It shows that the provision for better "protection" and "care" was also a lawful "pursuit of eugenics through complete racial isolation", with a long-established mode of governing gender operating below the surface (Foley, 2020, p. 86). This Act is a formative part of what is referred to as the "protectionism" phase of Indigenous settler state relations; following the Frontier Wars, it set the precedent for attempting to conceal overt genocidal state violence through policies of assimilation (Strakosch, 2020). The

contents of the Act characterise the biopolitical regulation of Aboriginal peoples by the state in almost all aspects of their lives. As Gamilaraay mother and social work scholar Bindi Bennett (2019a) explains, the "protective" legislation that went on to be passed in all mainland states between 1860 and 1922 placed all Aboriginal people and their children under the "care" of the State. The Act was a foundational part of a racial order for the white settler occupation of north-eastern coastal Country and beyond (Foley, 2020). Its configuration of status relations sets a pattern by explicitly linking ideas of "protection" to practices of "care" and restriction.

In this section on status relations, I seek to show how allowing changes to national identity documents but retaining pathologising criteria is a continuation of governing gender self-designation and containing activist demands to maintain established status relations in contemporary Spanish society. Also, how a colonial investment in sweeping "civilisation" policy secured settlement and configured status relations through institutions and mechanisms such as schools, churches, wage labour, and English literacy. Further, how these arrangements, which are synonymous with well-being, self-fulfilment, and "care", served to disrupt the conditions for reciprocal relations in governing that Native Nations attempt to establish through treaty. I also show that "protection" legislation in the years preceding Britain granting independence to its colony of Australia set a pattern of racism, isolation, eugenics, and disavowal as practices represented as "care". This consideration suggests that "civilisation" and "protection" are not so distant from the "care" that is legislated in the DNI and that these are present as the enduring colonial conditions for multiple institutions. These critical moments, together with the preliminaries to unmapping the field of trans health in chapter two, constitute a foundational colonial enforcement of the gender binary. These foundations make clear the ways that "care" helps secure, authorise, and protect colonial state power. It is crucial to emphasise the centrality of returning Land and recognition of continuing sovereignty to Indigenous struggles for self-determination. Highlighting the parallels and important differences between Indigenous and trans struggles for self-determination reveals the imperative for ongoing critical attention to the different modes of constructing and governing access to "care".

Becoming “treatable”

This section considers three critical moments of becoming “treatable”. First is the mid-1930s and the production of synthetic hormones, second is late 2012 and a proposed “Starfish Model” for codes classification in the ICD-11, and third is 1893 and the creation of the ICD. Rubin (2006) uses the phrase “becoming treatable” to critically interrogate processes “whereby some [“deviant”] bodies are made treatable, and others are considered healthy and not treatable” (p. 496). I use it to consider how people seeking access to body modifications classified as gender-affirming are produced as “treatable” and un- “treatable”. I suggest these three critical moments represent a rupture within white supremacist philosophies of “care”, a possibility via reorganising an entire medical coding system, and a reconfiguration of “care” into colonial surveillance.

1930s Production of synthetic “sex hormones” discrediting organotherapy

The initial moment in this consideration of becoming “treatable” is a rupture in “care” that occurred in the mid-1930s when synthetic hormone production discredited organotherapy. Rubin (2006) explains that organotherapy was a technique whereby extracts from animal glandular organs were used to restore a youthful appearance, increase virility, and boost masculinity. Organotherapy gained widespread attention in the mid-1920s when Russian-born French physician Serge Voronoff began grafting material from chimpanzee testes into elite European men (Amin, 2020). Scientific communities, the press, and even speculative fiction writers at the time responded with outcry at “the possibilities of human-ape ontological and erotic proximity” (Amin, 2020, p. 49), or simply the perceived implications of “inter-species mixings” (Rubin, 2006, p. 486). Feminist Science and Technology Studies scholar Nelly Oudshoorn (2003) shows that organotherapy and the accompanying organ extract business have enjoyed some popularity since at least the 1890s. However, as the promise that animal extracts would restore “sexual performance” went unfulfilled, these practices were increasingly dismissed as medical quackery (Oudshoorn, 2003; Rubin, 2006).

The practice of organ extraction, however, received far less critical attention than organ implantation.

Voronoff was harvesting "rejuvenating" material for his organotherapeutic surgeries from Algerian apes amid the French colonial genocide of Algerian people and project of securing its colonial expansion across Northern Africa (Rubin, 2006, p. 485). Rubin (2006) argues that Voronoff's "colonialist stance toward Algerians" mirrored the prevailing racialising imaginary that "monkeys were 'almost human,' standing on the evolutionary scale below Western, white men" (p. 486). Indeed, Voronoff attempted to garner support for his testicular transplants by invoking the imperative to avoid "the fate of the Egyptian eunuch", a figure whose social position, lack of genitals, and thus lack of "vitality" was "represented the antithesis of the West's ideal man" (Rubin, 2006, p. 486). This figuration reveals how an "organotherapeutic logic of treatment" was premised on a false claim of science as "an unproblematic means of surpassing nature" that, in turn, "literalized the French colonization of the Algerian body politic" (Rubin, 2006, p. 486). This was not the only acceptance of such deep-seated assumptions that "Western" medical science can exceed and hold dominance over "nature". This presupposition forms the basis for multiple colonial projects.

Crucial to this consideration of becoming treatable are the links between organotherapy and the emerging field of endocrinology. Amin (2018) argues that a preoccupation with "the unique potencies" of genitals was a form of eugenic thought in which endocrinology "envisioned sex as at once the sign of racial (un)fitness and the easily manipulable means of improving the [white] race" (p. 601). Before synthetic manufacturing, pharmaceutical companies chemically isolated hormone preparations from urine collected from gynaecological clinics, pregnant horses, and populations of factory workers, soldiers, and prisoners (Oudshoorn, 2003). Pharmaceutical companies obtaining bodily fluids to be sold as drug treatments reveals how some (human and more-than-human) bodies are maintained in extractive colonial, capitalist, and carceral mechanisms to produce the material technologies for "care". The production and marketing of synthetic testosterone, oestrogen, and progesterone in the mid-1930s led to a further rejection of organotherapy. Making hormones more readily available also helped legitimise further experimentation for their various disciplining applications.

Hierarchies of "race" are thus (re)woven into the notion of who is "treatable" to govern access to gender-affirming medical technologies. Rubin (2006) argues that as endocrinology and its distinction between a person's sex (morphological and physiological), sexuality, and gender were legitimised, people with self-designated genders who requested body modifications could now become people with "treatable" bodies. Rubin (2006) credits Harry Benjamin, who was a proponent of organotherapy, with influencing this separation of sex, sexuality, and gender into categories "that organize our understanding of bodies and identities" (p. 483). As I unmap in chapter two, Benjamin's influence meant the reach of these categories extended beyond endocrinology to surgery and the psy-professions and influenced the creation of rigid criteria for which technologies can be used as "treatments" for what bodies.

Synthetic hormones spelled a rupture but not a change in white supremacist social ordering. As gender non-conforming performance artist Alok Vaid-Menon explains:

> Transness only became synonymous with the body, let alone genitalia, because of colonization, right? That actually, prior to the British conquest of South Asia, gender was not about your body [it] was about your social role within a community and in that way, gender was relational. It was not about identity; it was about community. And one of the first things that [the] British did is they defined eunuchs by their absence of genitalia, and overnight, gender became body became genitals. And so when we say that dysphoria is a prerequisite for being trans … that's another insidious way in which white supremacy operates because it delegitimizes millions of ways of being gendered across the world that were never, and are never, gonna be about the body. (Olave Talks, 2018)

Medical logics can produce some bodies as "treatable" because colonial logics have already produced "other" bodies un- "treatable", in this case, through absence and lack (defectiveness). The critical moment of synthetic hormone development represents a rupture that was reincorporated into "care". While some white supremacist techniques were abandoned, their rationales and practices persisted in

other ways.

2012 A Starfish Model of codes classification for ICD

This consideration of becoming "treatable" continues with a possibility for "care" that occurred during discussions of an alternative Starfish Model for reorganising the ICD. In November 2012, as part of their contributions to the review of the ICD-10, GATE (2012) convened a meeting of health experts, primarily people with self-designated genders, from fourteen different nations to collectively suggest "lines of work" for developing the ICD-11 (p. 3). The difficulty identified was the ICD's contradictory status as a gateway and gatekeeper for accessing different health rights (Eisfeld, 2014, p. 108). Despite this tacit criticism of the ICD as unworkable, I suggest that the transformative potential for disrupting practices of becoming "treatable" is in the meticulous attention given to addressing the complex layers of pathologisation in the current systems of "care" in trans health.

The discussion of an alternative, decentralised classification system emerged from a position that ICD references (any chapters, blocks, or codes) must not be illness-based yet be capable of creating "a path to health care, public or private insurance coverage, and legal recognition of trans* people's identities" (GATE, 2012, p. 9). In other words, codes must be broad enough to sustain access to "care" as it changes over time, but not too wide that it misses attention to a person's actual needs (Eisfeld, 2014, p. 108). A metaphoric Starfish Model was used because "an actual starfish has a decentralized nervous system. While all parts of the starfish work together, a chopped-off leg can exist on its own, and actually grow a new starfish" (GATE, 2012, p. 10). In contrast, a spider was used to describe the existing model that "has a centralized nervous system where the whole spider dies if the head is injured" (GATE, 2012, p. 10). These metaphors articulated how "combining different [ICD] chapters, blocks and codes (the starfishs' legs) could exponentially increase trans* people opportunities of accessing health care under very different circumstances without recurring to a single and potentially re-pathologizing diagnosis (a Spider Model)" (GATE, 2012, p. 10). Collective decision-making practices were key in this discussion of how health practitioners might mobilise

combinations of current codes with new "trans*-specific" and "neutral" codes across multiple health issues (GATE, 2012, p. 12).

The meeting limited itself to an exploration of a Starfish Model because there were concerns about continuing pathologisation that kept participants from reaching a consensus (GATE, 2012). The four main issues were "diagnosis as a need; usage of a decentralized model for change; placement of chapters, blocks, codes and diagnoses; how to best serve adolescents and children" (GATE, 2012, p. 20). The meeting report thus introduces the supporting arguments, challenges, and additional comments for the complex discussion on each specific ICD reference or set of references (GATE, 2012). The difficulty of generating a decentralised model for the ICD reflects the intricacies of listing and classifying all the illnesses, injuries, and health-related situations that require diagnosis, verification, and processing in a health system. The challenge is partly because of how the ICD operates despite the term classification in its name. As Bowker (1996, introduced below) explains, "the ICD is a nomenclature, not a classification" (p. 51). It has no "single organizing principle, rather etiological (disease origin), topographical (disease site), operational (test for disease) and ethical/political factors each play complex, frequently conflicting, roles in establishing the list" (Bowker, 1996, p. 51). While the Starfish Model was not put forward as a proposal, this process for developing a decentralised system of ICD coding was not a dead-end. It demonstrates how an effort to reorganise an established system of coding "care" can still challenge the governing of who is "treatable" through the active involvement and recognition of people with self-designated genders' expertise in articulating their healthcare needs.

1893 Creation of the ICD

I now consider a moment of becoming "treatable" that is an ongoing configuration of care practices that began in 1893 with the creation of the ICD. This is another consideration that may seem far away from "care" in trans health. However, as history and philosophy of science scholar Geoffrey C. Bowker (1996) argues, the complexity, negotiation, and history of the ICD is "infrastructural work"

(p. 50) that "has inscribed affairs of state onto its representation of the afflicted human body" (p. 54). Describing the ICD as infra-structural or as an essential part of a State's operations emphasises its crucial role in the development of the conditions of "care" in trans health. Its first iteration was a codification of specific causes of death developed by Jacques Bertillon, adopted at a meeting of the International Statistical Institute in Paris, promoted by the French International Office for Public Hygiene, and implemented by the statistical agencies of multiple governments (Bowker, 1996). Early editions of the ICD attained widespread international acceptance in the aftermath of World War 1 (Bowker, 1996). However, its commission, development, adoption, promotion, and implementation were a consequence of earlier cholera epidemics that followed one of Europe's most intensive periods of colonisation (Bowker, 1996). The operation of distinct yet connected French and English colonial projects is of central importance to considering this critical moment of counting bodies according to disease classifications.

Historian Alison Bashford (2003) describes how one of the major cholera outbreaks in Europe was attributed to annual Muslim pilgrimages from India to Mecca. Bowker (1996) explains how steamboat and rail technologies (driven by the colonial economic imperatives that opened the Suez Canal) increased the spread of cholera to pandemic proportions. Pilgrims now arrived home from Hajj while unwell and spread the cholera bacillus, whereas previously, those who returned on foot often died in the time it took to travel (Bowker, 1996). Concerns that outbreaks now impacted citizens of colonising rather than colonised nations resulted in a confluence of biopolitical state and commercial practices regulating infectious disease transmission, migration, and movement (Bashford, 2003). These practices generated increasingly racialised and eugenic distinctions between populations subject to different forms of inspecting, banning, quarantining, and confining under rationales of health and "hygiene" (Bashford, 2003). Regarding the ICD, Bowker (1996) argues that ultimately the French empire was imposing "its own classification scheme on its colonies—and other imperial powers followed suit" even as these efforts were regularly contested and rejected (p. 52). As chapter five explains, ICD codes represent diagnoses and health status, both of which are determined through healthcare procedures. Bowker (1996) argues that on one hand this scheme led to the development of

modern bureaucratic state structures to monitor the ill health and death of populations and, on another, the justification for population-level surveillance methods. Speaking to the making of un/countable and un/"treatable" subjects, Bashford (2003) argues that this process implicates "the whole mission of public health" in "larger modern projects of nation, of race and of colonisation" (p. 189). However, Bowker's (1996) reminder that not once "has the ICD been universally and consistently applied" calls attention to how these projects remain incomplete (p. 51). The unfinished work of inscribing state affairs onto a representation of an afflicted body holds potential for anti-colonial reconfigurations to make health, and thus the subjects of "care" otherwise.

In this section on becoming "treatable", I attempt to show how a rupture in colonial, white supremacist eugenic thought was reincorporated into "care" through producing and regulating the use of synthetic hormone technologies. I also show how there is a possibility for a challenge to a broader system of governing who is "treatable" in discussing the development and application of a decentralised coding system for "care". Further, how the counting of bodies according to disease classifications creates conditions for only some bodies becoming "treatable". Revealing histories and ongoing configurations of care practices as methods of making and surveilling populations also reveals it as unfinished work, suggesting there is potential for more radical, anti-colonial unmaking of this "care".

Gatekeeping and Access

The fourth section of this chapter considers critical moments that connect to gatekeeping and access. The first is 1979, when the Johns Hopkins Gender Identity Clinic was shut down, and the first SOC was published. The second is 2016, when a hands-on genital surgery skills development workshop was held in a hospital in the Midwest United States. I suggest these critical moments represent a continuity of health professionals as regulators of "care" and a rupture caused by an inability to transform increasing access into realised "care".

1979 Johns Hopkins Gender Identity Clinic closure and the first SOC

This consideration starts with a continuity in "care" that occurred in 1979 when the Johns Hopkins Gender Identity Clinic in Baltimore, United States, ceased operation and prompted the publication of the first set of professional care standards. An examination of the role of the Clinic and the reasons for its closure was undertaken by Charalampos Siotos and fellow professionals connected to various Johns Hopkins Medical Institutions, Paula M. Neira, Brandyn D. Lau, Jill P. Stone, James Page, Gedge D. Rosson, and Devin Coon (2018). Established in November 1966, the Clinic administered access to surgical and hormone technologies with the aim of "assessing the scientific, ethical, religious, and legal considerations" of "how to evaluate and care for transgender patients" and, further, to "identify and describe factors that could predict a satisfactory patient outcome after medical and surgical procedures" (Siotos et al., 2018, p. 2). It shows a complex interaction of interests that extended far beyond those of the medical professions and people with self-designated genders. However, the contribution of funds by millionaire trans man Reed Erikson that allowed the Clinic to open is one demonstration of the material investments of people with self-designated genders in institutionalising this "care" (Stryker, 2017).

Siotos and colleagues (2018) argue that the closure was the culmination of public outcry over a published program evaluation and the vitriolic antitransgender stance of Dr Paul McHugh, head of Psychiatry at the Hospital during this period (p. 2). Siotos and his colleagues (2018) contextualise the closure among a lack of stable funding, communication difficulties, administrative and medical staffing issues, and Clinic attendees lacking resources to pay for surgery (p. 2). However, McHugh's dissemination of Jon Meyer and Donna Reter's discredited Clinic evaluation certainly set the final direction. McHugh (2004) has declared his refusal to "be tacitly co-opted in encouraging sex-change surgery [sic] in the very department that had originally proposed and still defended it" and a desire to correct the "misdirection of psychiatry" allowing access to gender-affirming medical technologies (p. 1). Correspondingly, Meyer saw psychotherapy as "curative" and surgery as "subjectively satisfying" for people with self-designated genders but lacking an "objective advantage in terms of social

rehabilitation" (Siotos et al., 2018, p. 2). These views reflect a paternalistic reluctance of some US doctors to provide "care" because of a pervasive idea that operating or administering hormones would be "colluding with a deranged person's fantasy of "changing sex" or, "enabling a homosexual person to engage in perverse sexual practices" (Stryker, 2017, p.73).

Meyer and Reter's (1979) study claimed that because there was no meaningful improvement in participants' employment, education, intimate relationships and housing, they were neither better nor worse off as a result of their participation in the Johns Hopkins' program. Openly transgender physician Nick Gorton and queer- and genderqueer-identified psychiatrist Hilary Maia Grubb (2014) clarify that participants in the study who had surgery had the same or better outcomes in the areas measured than participants who were not offered surgery; it was the measures of "improvement" that had no statistical significance. This study continues to receive criticism for design flaws and negative bias in recruiting participants (Namaste, 2000; Siotos, 2018). Nevertheless, during the much-publicised debate on "the medical morality of gender-affirming surgery" fuelled by these findings, the Clinic was closed, and McHugh realised his vision to help end surgeries at Johns Hopkins (Siotos et al., 2018, p. 2).

Crucially, the discredited research at the centre of this debate was also used to justify the closure of almost all programs offering gender-affirming medical "care" in US academic-teaching hospitals (Gorton & Grubb, 2014). There was a drastic loss of access for people in the US because these closures coincided with the elimination of even the minimal health insurance coverage for gender-affirming medical "care" (Gorton & Grubb, 2014). The Johns Hopkins and other clinic closures reveal an important continuation of professional authority because, in the same year, the original SOC was created by a newly established Harry Benjamin International Gender Dysphoria Association (HBIGDA), which would later become the World Professional Association of Transgender Health (WPATH) (Coleman et al., 2012).

The SOC-7 Revision Committee cites health professionals' calls for "a standard for eligibility for sex

reassignment surgery" upon the closure of the Johns Hopkins Clinic as the impetus for the original Standards (Coleman et al., 2012, p. 107). These standards became the most widely acknowledged and applied, despite several accounts of and guides to "treatment" circulating before this point (see for example, Benjamin, 1966; Elbe, 1933; Hamburger et al., 1953; Hirschfeld, 1910, 2006). Calls for an eligibility standard are linked to the media controversy and public debate surrounding the Clinic closure because it portrayed associated health professionals as morally dubious and compliant with unreasonable (psychopathological) demands. Assuming there is a benefit to *any* public debate about the legitimacy of a person's request for body modification, let alone their gender, reveals the recurring struggle in relations of domination central to this genealogy's concern about how people with self-designated genders come to be pathologised subjects of "care".

The discursive positioning of health professionals in the late 1970s links to a professional outcry in reaction to the early 1950s news media surrounding the transformation of Christine Jorgensen from the figure of an "all-American soldier" into the figure of a "blond bombshell" (Stryker, 2017). The implications of decades of published commentary from psychiatrists criticising their peers for colluding with a form of sexual perversion extend beyond censure of practices within the medical professions, fuelling a sustained rejection, from multiple positions, of an idea of "completely unfettered on-demand" access to medical technologies (e.g. Fenway Health, 2015; Gupta, 2019; Heyes & Latham, 2018). The closure of university-based clinics with institutional power meant the "responsibility for ensuring that professional standards of care were being met devolved onto a second tier of psychotherapists in private practice who were members of HBIGDA" (Stryker, 2017, p. 112). In other words, a lack of institutional support created a seemingly heavy responsibility for medical professionals and a certain intensity of feeling about the impact of controversy and backlash on their status and livelihoods.

Writer, performer, activist, and biologist Julia Serano (2016) argues HBIGDA provided relief by formalising the position of psy-professionals as the first in a series of gatekeepers whose role it was to regulate those obtaining gender-affirming medical technologies. This is an important perception of

"care" sustained through the production of the gatekeeper over time. Velocci (2021) argues that prominent practitioners like Harry Benjamin "did not define transness by establishing solid criteria and then assessing people by how closely they matched them; rather, they constructed transsexuality as a space of uncertainty through their fear-based practices and used that uncertainty to maintain clinical control" (p. 464). The authoritative status of the SOC was thus achieved by distributing "responsibility and culpability for" what continues to be viewed by many as "radical medical procedures across a number of distinct clinical specialists" (Plemons, 2018, introduced below). Despite a steadfast declaration that the Standards were a safeguard against unsatisfactory clinical outcomes, Serano (2016) argues that it inculcated practices that limited access and sought to isolate and invisibilise those who were allowed through the gateway. The development of the first SOC suggests a political process of installing an eligibility standard *as* a care standard that continues as authorisation and protection for health professionals as regulators of access to gender-affirming medical technologies.

2016 Gender-affirming genital surgery skills development workshop

This consideration of gatekeeping and access continues with a rupture in "care", illustrated by a surgery skills development workshop that was held in 2016 at an inner-city hospital in the Midwest United States. Medical anthropologist Eric Plemons (2018) attended a WPATH-sponsored event with twenty surgeons that was a two-day "Transmale Genital Surgery" lecture and cadaver lab workshop demonstrating metoidioplasty (creating a penis and scrotum from existing genital tissue) and phalloplasty (constructing a "neophallus" using skin grafts from the person's forearm or thigh) (Plemons, 2018, p. 2). This is a critical moment of teaching because the advocacy practices that increased private and public insurance coverage of medical technologies are out of sync with the institutional and technical practices necessary for "turning expanded access into realized care" (Plemons, 2018, p. 1). This expanded access was brought about by a 15-year growth of private, employer-provided insurance coverage for gender-affirming medical "care" and a 2014 lawsuit that effectively ended the exclusion of surgery in the US Medicare system (Plemons, 2018). Ready access

to a “guaranteed payment for trans- genital reconstruction” is an enticing source of revenue that has rapidly increased hospital-based teaching fellowships and training programs (Plemons, 2018, p. 9). However, it also encroaches upon a small, competitive, international market that caters to those with the financial resources to pay for this “care” (Plemons, 2018). The surgical skills workshop responded to an increasing demand for and interest in providing genital surgeries. It also sought to address a situation where most surgeons within the US market were reticent to share the “technical expertise that had been their very lucrative trade secrets for decades” (Plemons, 2018, p. 3). The rupture in “care” is illustrated in the workshop organisers admitting that although the event “pulls back the shroud” on otherwise hidden procedural knowledge, it only provides familiarity and does not equip workshop participants with the necessary skills to carry out these surgeries (Plemons, 2018, p. 8).

What Plemons (2018) makes visible is that “the effects of the decades-long insurance exclusion of trans- surgery are not easily remedied through the event of their inclusion” (p. 5). Generating proficiency in complex genital surgeries cannot occur in a workshop setting. It requires “handwork skills of operating on particular tissues and structures, deep anatomical knowledge of the area of concern, and technical fluency of particular procedures” (Plemons, 2018, p. 6). It also requires hospitals willing to establish specialised clinics where surgeons can practice. A significant barrier to establishing these services is that the “unique clinical needs and the coordination required by WPATH Standards” do not correspond to “work practices that had been built for other kinds of surgical patients” (Plemons, 2018, p. 13). Difficulties in realising access to genital surgeries occur because the SOC-7 essentially dictates “the cooperation of distinctly credentialed specialists” across “multiple stages of authorization and permission” (p. 10) in ways that create “layered administrative responsibilities” (Plemons, 2018, p. 13). Here, the emphasis is not on how people with self-designated genders exceed the limits of current hospital and insurance systems; it is on how the requirements set out in the SOC-7 make a complicated situation more difficult. Increased insurance coverage affects how surgeons become proficient in particular procedures and how administrators (hospital and insurance) accomplish tasks to facilitate those surgeries. Plemons (2018) argues that the growth of insurance that helps pay for “care” is “moving trans- medicine into a different moment” (p. 6). Further

that:

> As the SOC is integrated into existing health care practice, it works not to only distribute ethical responsibilities but to materialize a series of technical ones: health care administration, document production and circulation, insurance coding, formulary revision, and the handwork of medical and surgical techniques … The operation event, so often imagined as literally and figuratively unfolding in the hands of the surgeon, requires the protracted and coordinated work of multiple parties inside and outside of the operating room. (Plemons, 2018, p. 6)

These shifts show how obtaining permission to access surgical technologies is only one in a series of events within a tightly regulated, economically oriented mechanism of "care" with fixed and moving parts. The challenges of "bureaucratizing trans- health care demonstrate the tangled and peculiar ways that trans- medicine has been imagined outside of these kinds of technocratic institutions" (Plemons, 2018, p. 13). Notwithstanding the messiness, these challenges demonstrate how this imagining has largely occurred inside a liberal framework of including trans health into the existing US economic-health system. The rupture illustrated by the surgical workshop compels attention not only to the institutional and technical practices but also to the imaginaries required to transform obtaining permission and increasing access into the use of medical technologies.

In this section on gatekeeping and access, I show how a set of material changes in access for people with self-designated genders in the US was part of a set of practices that entangled a conceptualisation of a health practitioner's responsibility *in* "care" as a fear of repercussions *from* "care". A moment of closure is also a moment that formalised gatekeeping (regulation) through judging a person's eligibility. I also show how a workshop revealing hidden procedural knowledge that familiarises but does not equip surgeons with the necessary skills is a rupture that compels attention to the material conditions and visions for realising access to "care".

Recognition, autonomy, and self-determination

The final section of this chapter considers critical moments that connect to ideas of recognition, autonomy, and self-determination. The first moment is 2017 when the Yogyakarta Plus 10 (2017) was launched. The second is somewhat unconventional; it is a recurring moment when the gender of a newborn baby is designated. I suggest these critical moments represent a reconfiguration of "care" through broadening the framework of understanding rights and a rupture countered with an explicitly collective and relational politics of resistance.

2017 Yogyakarta Plus 10

The consideration of recognition starts on 10 November 2017 with a reconfiguration of "care" that occurred when the Yogyakarta Plus 10 (YP plus 10) was formally launched in Geneva, Switzerland. Its full title describes its purpose; *The Yogyakarta Principles Plus 10: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics to Complement the Yogyakarta Principles*. The YP plus 10 (2017) thus contributes additional Principles and State Obligations to those asserted in its initial publication. Carpenter (2020) explains that the Yogyakarta Principles (YPs) were necessitated by "the absence of an UN process for a convention comparable to those on the rights of the child and of persons with disabilities" (p. 517). Created on the YPs tenth anniversary, the YP plus 10 (2017) cover rights whose expression emerged from where "developments in international human rights law" met "with the emerging understanding of violations suffered by persons on grounds of sexual orientation and gender identity" and combined with "recognition of the distinct and intersectional grounds of gender expression and sex characteristics" (p. 4). For example, the YP plus 10 specifically "elaborates a new ground of 'sex characteristics' and recognised rights to bodily integrity, truth and legal recognition" (Carpenter, 2020). Human rights lawyer, scholar, and consultant Andrew Park (2019) argues the YPs "anchored themselves in the assumption that sexuality and gender is a universal characteristic of all people" (p. 241). Taking this position was a way to resolve the disjuncture of describing rights held only by LGBTI people within a discourse that defines human rights as held by *all* humans. As a

result, both statements emphasise human characteristics over specific populations. The rationale is that all people have a sexual orientation, a gender identity, gender expression, and sex characteristics (SOGIESC). Likewise, all people can experience violations of their rights across any number of these characteristics. Together, the YP plus 10 (2017) and the YPs (2007) clarify a State's obligations as a signatory to human rights conventions to prevent and respond to human rights violations related to a person's SOGIESC.

The YP plus 10 takes a different position to the YPs on how a government should fulfil its obligations as a signatory of human rights conventions. Park (2019) describes how the YPs make a "demand for equal inclusion" (p. 247). It frames human rights violations experienced by people with non-normative relationships, genders, and bodies "in terms of inclusion in current legal norms" in ways that "do not seek structural reform of those norms" (Park, 2019, p. 248). Despite misgivings among its authors, a "palatable" tactical approach of "sameness" was chosen for the YPs to persuasively outline the application of international human rights obligations in the political landscape of the early 2000s (Park, 2019, p. 251). Doubts developed into a challenge to the liberalising notion of inclusion (e.g. Otto, 2016; Waites, 2009) and grew into a well-established critique of the inappropriate normative framings of sexual orientation and gender identity in the YPs (Park, 2019; Carpenter, 2020). It identified how these framings were a limitation in the applicability of the YPs; especially in creating human rights responses to violations against intersex people (Carpenter, 2020). The YP plus 10 responded by shifting to a demand for recognition. Park (2019) describes how it focuses on a State's obligation to develop an understanding of each characteristic in the SOGIESC acronym, the different kinds of SOGIESC, along with the lived realities, communities, and culture(s) of people with non-normative SOGIESC. The YP plus 10 intentionally emphasises intersectionality analyses of compounding oppression developed by critical race scholars, specifically Kimberlé Crenshaw (Carpenter, 2020). Meaning, "the YP plus 10 explicitly recognise the intersectionality of sexual orientation, gender identity, gender expression and sex characteristics, including on grounds of sex, gender, racialisation, religion, belief and disability" (Carpenter, 2020, p. 523). The difference between these two positions is the YPs asserts "each person should be equally valued because they have a

SOGIESC" whereas the YP plus 10 argues that states are obliged to apply "equal value to the different SOGIESCs" (Park, 2019, p. 253). Together, the Principles articulate a set of "escalating demands, from inclusion to recognition" through "a consensus that LGBTI people fit within the international human rights regime" (Park, 2019, p. 248). Despite their differing positions, the YP plus 10 and the YPs are presented as valuable tools for activists and advocates at both local and international levels. However, as Carpenter (2020) asserts, the YP plus 10 increases their effectiveness by broadening the "framework beyond matters of self-identification" to the fact of SOGIESC (p. 528). I suggest the YP plus 10 represents a reconfiguration of "care" based on this broadening of the framework and the stance that recognition of compounding oppression is key to states fulfilling their obligations as signatories to international human rights conventions through structural change.

Perpetually designating the gender of newborns

A consideration of autonomy and self-determination centres on a rupture in "care" that occurs when a medical professional designates the gender of a newborn child. A child's birth and gender designation occur so frequently that it contrasts with the more discrete moments and periods in this genealogy. However, at most contemporary "Western" hospital-based births, there is a perpetual practice of external attribution of sex that coincides with an external attribution of gender. The procedure usually involves the medical professional in attendance verifying the baby's external genitalia resembles established medical and social norms of either a female or male body and assigning sex according to the observed shape. Stryker (2017) explains that "midwives, ultrasound technicians, obstetricians, parents, family members, and innumerable others look at our bodies and say what they think our bodies mean to them"(p. 12). These practices converge because "gender is the social organization of different kinds of bodies into different categories of people" (Stryker, 2017, p. 14). The immanent power in external gender designations is emphasised by Vaid-Menon (2018) as they argue:

> Even if you accept the gender & sex you were assigned at birth, that doesn't mean that you

> shouldn't have been consulted in that decision. You deserve the right to come into your womanhood, manhood, non binary existence on your own terms. We deserve autonomy of our own bodies. Resisting this memo is about fighting for self-determination. (para. 2)

In making clear the connection between the right to autonomy and fighting for gender self-determination, Vaid-Menon (2018) also shows how external gender assignment creates a rupture in "care" because it overrides a person's own decision-making process.

While connected, the terms autonomy and gender self-determination also articulate multiple political positions in the context of "care" for people with self-designated genders. For Serano (2016), autonomy relies on the "public acknowledgement that all people have the right to self identify (even if that identity falls outside of the male/female binary)" (p. 158). Going further, Vaid-Menon (2019) weaves autonomy throughout their creative practice to frustrate efforts to present as natural and inevitable the systems that maintain oppressive consequences of external gender designations. Vaid-Menon (2019) is thus referring to autonomy when they assert that "what is natural isn't given, it's a political decision" (para. 1). There are hints of a liberal politics in Borba's (2017) characterisation of "trans autonomy" as a possibility for making the voices of people with self-designated genders heard in an institutional context (p. 343). However, Brazilian transfeminist activist viviane v. (translated in Borba, 2017) identifies how such expression is limited by the "privatization of autonomy" (p. 326). In its most simplistic form, it is the process where people with self-designated genders who are financially secure are capacitated to negotiate their choices and voice an opinion.

In contrast, critical scholar and filmmaker Eric A. Stanley (2014), situates gender self-determination within a human rights critique that rejects the substitution of a collective "self" for an individual or autonomous "self" as a necessary requirement for the maintenance of state power. Following this thinking, Irving (2014) locates autonomy within a neoliberal ideal that positions people as "personally responsible for honing themselves to be physically, spiritually, and emotionally fit to engage and excel in competitive free-market relations" (p. 51). Likewise, Mol (2008) suggests there are particular

consequences when a neoliberal, individualised notion of autonomy — particularly when it is tied to "choice" — is located within the "fuzzy" differentiation "between 'the West' and 'the Others'"(p. 3). Meaning the transformative potential of autonomy is limited when it is used to reinforce a dominant subject position; one that creates a "we" as "individualised and autonomous" and locates an "us" as "modern" and belonging to "the West" (Mol, 2008, p. 3). Elsewhere, Black non-binary femme writer and scholar Che Gossett (2014) highlights how "AIDS activist, black and queer liberationist and anti-prison activism" (p. 31) in the U.S. interlace within "the continuing struggle for trans and queer life in the face of carceral violence and policing" (p. 41). Together, Gossett (2014) and Stanley (2014) argue for a consideration of gender self-determination as inextricable from a broader self-determination practice and theory that operates across ongoing radical Black, anticolonial, and prison abolitionist movements. It is collective work that creates "the most space for people to express whatever genders they choose at any given moment" (Stanley, 2015). It is premised on acknowledging "these expressions might change and that this change does not delegitimate previous or future identifications" (Stanley, 2015, p. 19). This work and its political contexts articulate how gender self-determination constitutes a theoretical and embodied practice, a politics, and an ethic (Gossett, 2014; Stanley, 2015). It is how gender self-determination points away from "the fiction of the fully possessed rights-bearing subject of Western modernity" by collectivising responses to interpersonal and state-based violence that occur as a consequence of an external gender assignment at the time of birth (Stanley, 2014, p. 90). Whereas autonomy is often limited by liberal capitalist assumptions of personal power and entitlement, the "self" in this particular articulation of gender self-determination explicitly asserts a collective and relational politics that resist any conceptualisation of gender posited as "true" or appropriate for all contexts.

In this section on recognition, autonomy, and self-determination, I suggest that principles on a state's obligations as a signatory to human rights conventions were published by a human rights organisation in a way that reconfigured "care". These principles extended from a notion of including people into an existing state apparatus to clarifying the obligations a state has to address the compounding oppression of its mechanisms. Critiques of its normative framings certainly helped to broaden the

framework of understanding rights, but it is not certain that these escalating demands reverse its liberalising approach. I show how the multiple political positions articulated through struggles for autonomy and gender self-determination counter a rupture in "care". By making explicit the interrelatedness of the struggle for gender self-determination and radical traditions in activist movements, there is a direct challenge not only to the pathologisation of gender self-designation in "care" but also its underpinning neoliberal capitalist coloniality.

Conclusion

This chapter has considered twelve critical moments in "care" in an effort to destabilise established "truths" about granting and enabling access to body modifications classified as gender-affirming. The emergence of pathologising conditions and the possibilities of contesting this "care" in trans health are the driving concern of this genealogy. It shows there is no linear progression from previously pathologising to now non-pathologising "care". Instead, problem representations of "Gender Dysphoria" and an illness-based model emerge from historically contingent conceptualisations of gender that are overlaid with different strategies and tactics for governing access to gender-affirming medical technologies.

This genealogy considered critical moments of changes in "care" that include the relocation of new trans-related categories to a new chapter in the ICD-11 and the renaming of diagnostic categories in the DSM-5. The practices in these two contemporary moments – pursuing full trans depathologisation even after re-categorisation, reallocation, and refocusing medical attention onto a disordered individual – oriented the remaining considerations. This genealogy then considered critical moments of configuring the status relations of individuals, Nations, and peoples in relation to the state. It looked at legislation that enables a change of details on the Spanish DNI; treaty-initiated "civilisation" policies in the United States; and a specific Act that legislated "protection" as "care" in Australia. These moments reveal how minor alterations to legislation for changing national identity documentation and the enforcement of a patriarchal colonial system of gender and family relations

function as the structures of governing that secure settlement. It demonstrates that being a subject of "care" means that "care" is also defined and decided by some for an "other". Whether explicitly named or not, it constitutes a normative form of governing gender imposed as a requirement for or consequence of recognition by the state. This genealogy considered several more critical moments of becoming "treatable" and un- "treatable". These moments include the production of hormone technologies that brought discredit to eugenic organotherapy practices; a proposal for a decentralised model for organising ICD medical codes; and the creation of the ICD as "care" infrastructure for maintaining the state through surveillance. These moments show how medical logics and practices operate to manufacture, codify, and count material access to medical technologies as part of the incomplete and contested capitalist, carceral, and colonial mechanisms of power in "care". This genealogy also considered the closure of the Johns Hopkins Gender Identity Clinic; the subsequent publication of the first SOC; and a genital surgery skills development workshop as critical moments of gatekeeping and access. These moments show how installing a professional standard for "care" is also a continuity of authority and protection for health professionals and how a surgical workshop represents a rupture that compels attention to practices that can transform permission into the use of medical technologies. Finally, this genealogy considered the launch of the Yogyakarta Plus 10 (2017) and perpetually designating the gender of newborns as critical moments of recognition, autonomy, and self-determination. These moments show how broadening the framework of rights can reconfigure "care" and how an explicitly collective and relational politics of resistance can counter a rupture caused by external rather than self-designations.

The reverberations of these critical moments usefully draw attention to complex rationales and practices that emerge from theorising, analysis, critique, contestation, advocacy, strategising, and negotiation that both preserve and attempt to overturn structures of pathologisation in "care". Considering these moments in light of Mol's (2008) theorisation of "care" as a style of intervening highlights land, labour, revenue, cost, and coverage among the economic concerns of "care". "Civilisation", "protection", and surveillance bring to light the biopolitics of settler colonialism. Indeed, the management of populations through the body for securing and maintaining a settler state

threads its way through this genealogy. These moments in "care" not only connect to one another but also to practices of paternalism and to the consequences of colonial expansion and settlement. Yet, these practices are never fully accomplished. They illustrate a "care" that is in a state of flux that helps to destabilise what Bacchi and Goodwin (2016) refer to as the politics of "the firming up of particular social arrangements" and the "making of the taken for granted" (p. 4). The possibilities in this genealogy show the sorts of work undertaken by people constituted as subjects of "care" includes sustained international policy-level activism, maintaining treaty relations, sensitising people to the violence of colonial settlement and the demands of Indigenous sovereignty, devising alternatives for organising "care", sustained legal battles, and advocating for access. This work is illustrated in no small part by community-driven, collective attempts to refocus not only who is at the centre but also who is designing "care". Even with this illustration of "care" as contingent and in flux, it is vital to state that the purpose of considering the moments of colonial configuration through dispossession is to draw attention to the presence of Indigenous polities and their ongoing resistance to ongoing colonial projects. One of the lessons in the continuing struggles for Indigenous sovereignty and self-determination is how it stresses the importance of attending to the specificities of positionality and not conflating distinct political struggles. In the following chapter, I scrutinise what the SOC-7 and the Guide are silent on, what discursive, subjectification, and lived effects are produced by each policy's representation of the "problem", and how these problematisations are authorised and contested.

Chapter 7
Scrutinising implications of problem representations

Scrutinising the implications of problem representations is a way of turning meticulous attention to what occurs as a result of how governing is configured in trans health policy. The previous clarification of each policy's problem representations, the reflection on their conceptual underpinnings, and the consideration of critical moments in their development enables a close reading of the governing of access to gender-affirming medical technologies in the SOC-7 and the Guide. Scrutinising implications is crucial because problem representations themselves are seen as political processes in which some people benefit while some are harmed (Bacchi & Goodwin, 2016; Bacchi, 2009). Understanding that politics are enacted (come into existence) through practices and relations involves critically examining what can be inferred from, what becomes available, and what consequences emerge from policy problematisations (Bacchi & Goodwin, 2016). Johnson (2015) sets the scene by explaining that the arrangement of gender-affirming social relations, healthcare, and legal documents according to a medical model makes responding to this model a necessary part of day-to-day living for people with self-designated genders. Susan Stryker, in an interview with higher education researcher and administrator Petra Dierkes-Thrun (2014), reiterates the importance of recognising how race operates as a dividing line in the cultivation, investment, recognition, and enfolding of life into the biopolitical state or its consignment "to malignant neglect or lethal violence" (para. 34). Sensitivity to the multiple impacts of these arrangements propels an analysis that attends to relations amidst the apparatus, mechanisms, and operators of domination to show how they support, connect, converge, and reinforce one another or engage in a struggle to negate or annul them (Foucault, 2003).

This chapter examines what occurs as a consequence of how governing is configured through the problem representations in the SOC-7 and the Guide. It reports on an analysis that integrated questions four, five, and six of the WPR approach. These questions direct attention to "What is left

unproblematic in this problem representation? Where are the silences? Can the "problem" be conceptualized differently?" (Question 4), "What effects (discursive, subjectification, lived) are produced by this representation of the "problem"?" (Question 5), and "How and where has this representation of the "problem" been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?" (Question 6) (Bacchi & Goodwin, 2016, p. 20). This analysis mobilises all six WPR questions to probe deep into problematisations. The reflection on the logic of medicalisation and rights and their liberal governmentalities joins with the genealogy to help identify what is left unproblematic and draws attention to the defence, dissemination, and disruption of the problem representation in ways that emphasise contestation and helps destabilise accepted truths about "care". This chapter compares the implications of policy problematisations for governing access to gender-affirming medical technologies across two sections. Section one focuses on the point of entry for "care". It outlines the limits set on "care" by critically examining the silences and effects and the reproduction and reworking of the representation of the "problem" to be the distress of "Gender Dysphoria" in the SOC-7. Section two focuses on the Guide's four demands for the total depathologisation of gender self-determination. It outlines the conditions the Guide is creating for "care" by critically examining the defence and dissemination, the silences and effects, and the various disruptions of the representation of the "problem" to be an illness-based model of "care". I suggest that by maintaining the link between "treatment" and diagnosis, the SOC-7 is a continuation of the medical management of appropriate modes of living, and by demanding a transformation of practices, relations, and structures of governing access, the Guide affords the possibility that depathologisation can help reshape the settler colonial conditions governing gender.

The limits set on "care"

The release of the SOC-8 (Coleman et al., 2022) marks a decade since the proposals in the SOC-7 have been circulating as practices for "care". The WPR approach maintains the relevance of the present analysis of SOC-7 even as the release of another version of the standards supersedes it.

Findings from the previous clarification, discourse analysis, genealogy, and the group WPR analyses point me to the threshold of access to gender-affirming medical technologies as a site to scrutinise the implications of the problem representation in the SOC-7. By scrutinising the entry point, this section shows how "treatment", diagnosis, eligibility criteria, and an established hierarchy of power relations combine in the SOC-7 to set limits on "care". This focus reveals how discourse circulates within the field of trans health and helps offer a generative critique of an emerging shift towards the language of human rights. I argue that even with sustained attempts to rework and disrupt its gatekeeping relations, representing the problem to be the distress of "Gender Dysphoria" preserves a biopolitical function in the SOC-7.

There is a particular discursive legitimation of "treatment" in the SOC-7 representing the distress of "Gender Dysphoria" to be a diagnosable, individual mental health "problem". As chapter five has illuminated, the concepts within the stated focus of this policy are more than euphemisms for determining a person's eligibility for access to "care". They are part of an enduring discourse that ties "achieving comfort" to "treatment" for the maximisation of a person's health, well-being, and sense of personal fulfilment within a hierarchy of relations that maintains a gatekeeper at the entry point of "care". The overall "Treatment Goal" to achieve "lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment" repeats almost verbatim in the SOC-5 (Levine et al., 1999, p. 2), the SOC-6 (Meyer et al., 2002), and the SOC-7 (Coleman et al., 2012, p. 1). Interesting to note the trajectory in the SOC-8 that shifts to "assistance" and an aim of "optimising" a broader scope of health, well-being, and self-fulfilment (Coleman et al., 2022, p. S5). This repetition still echoes Benjamin's (1996) frequent use of "gender discomfort" in *The Transsexual Phenomenon* to assert that medical technologies — not reparative psychotherapy — bring about comfort, emotional balance, and relief (pp. 14-19). Carrying these concepts over half a century of established protocol accords "treatment" an authority that sets limits on what can be thought of as constituting "care" and narrows the possibilities of what can be thought of as constituting "healthy", fulfilling, and indeed "successful" participation in all levels of society.

There are particular discursive effects of representing the distress resulting from a discrepancy between a person's gender and the sex assigned at birth as a diagnosable and thus treatable individual health "problem". They can be read as a reproduction of Benjamin's (1996) "nutshell characterization" of "deviations" whereby: "The transvestite has a social problem. The transsexual has a gender problem. The homosexual has a sex problem" (p. 17). The Guide identifies the effects of the SOC-6 characterising transsexuality "as a problem to be treated and eliminated" in the ways it disallows "the possibility that a trans person could have a viable and dignified life" (p. 18). It argues this unwillingness is because a "traditional medical model dictates a single approach to understanding trans identities—that they are stages in a process of overcoming one's past and hypothetically assuming an eventual non-trans life" (STP, 2010, p. 18). Despite the SOC-7 replacing the "problem" of identity with the "problem" of distress and replacing the single approach with flexible tailored "pathways", anchoring "care" to the psychiatric diagnosis associated with gender-self designation still insinuates a kind of elimination. Even asserting the legitimacy and diversity of self-designated genders, the characterisation of "treatment" in the SOC-7 still implies a linear trajectory from distress (incongruence) to comfort (harmony). Consequently, granting access to "treatment" is one of both health professionals and institutions regulating (governing) specific modes of living. There is a discursive resonance between "treatment" and other governing processes. The manufacturing of synthetic hormones considered in chapter six shows how the medical logic that produced some bodies as "treatable" maintained colonial logics that produced "other" bodies through ideas of defectiveness together with practices of extraction. These governing processes also resonate with another kind of management at the level of the population. Namely, the management of a national story for overcoming an unfortunate (necessary although divisive) colonial past by absorbing (pursuing the elimination of) Indigenous peoples and polities for an imagined settler future. "Treatment" is legitimated through and discursively resonant with a futurity that connotes elimination, revealing how the biopolitical projects of settler colonialism act continuously within trans health policy by governing what constitutes a viable life.

Participants in the group WPR analyses illuminated how the SOC-7's use of "comfort", "treatment", and "successful" contains further discursive allusions regarding trans life. One exchange foregrounded that:

> P1: At the moment politically, we're getting really direct, explicit messages about it not being ok to have a chronic illness or be aged.
> Researcher: Why? Why can't we be like that?
> P1: Because they express it as a burden on society. Rather than everyone's got something to give.

The analysis moved from discussing how the notion of people as a "burden" on society imposes limits on both thinking and speaking to the effects this discourse generates for people with self-designated genders:

> P2: That you're not whole and complete. That you're unhealthy or need, I don't know... health.
> P1: ...and it's your responsibility to engage in these processes that will fit you back into that way of participating that's ok and then makes you have access to your rights again.

Another participant astutely points out, "there's a cost that isn't written in this". They clarify:

> It's a psychological cost of living out that narrative that there is something inherently wrong and needs medical intervention in order to change. And maybe some people are really good at wearing off that narrative and not internalising it, but I feel that it's so present within how we think about gender diverse and transgendered people. That this is the process that you are meant to go through, so that in deviating from it, so in not accessing hormones or not accessing surgery, then how do you fit within the community versus not fit within the community.

These exchanges help set the scene for deeper consideration of what the SOC-7 silences and the combined subjectification, discursive and lived effects and the attempts at reworking the representation of the "problem" to be psychiatrically distressed — and "treatable" — "gender dysphoric" subjects.

Diagnosis is an important site for scrutiny because of the particular limits it sets on care. The core principles in the SOC-7 promote the provision of care "that affirms patients' gender identities and reduces the distress of gender dysphoria, when present" (Coleman et al., 2012, p. 3). Accordingly, "care" is both constituted as and requires an "assessment of gender identity *and* gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers" (Coleman et al., 2012, p. 23, emphasis added). As Dewey and Gesbeck (2017) argue, the result is not that diagnosis leads to the medicalisation of gender self-designation; rather, a person's entire life "must be framed through a medicalized lens in order to prove, *through diagnosis*, that they have a legitimate claim to medical services" (p. 58, emphasis added). This process is a continuation of what the Guide identifies as psychiatrisation, or "the imposition of a psychiatric diagnosis" as justification for "the customary involvement of mental health professionals" in the provision of gender-affirming medical technologies (STP, 2010, p. 16). Indeed, when the formal requirements for practising medicine install the diagnosis of a mental disorder as a systematic practice, the effect is that "a diagnosis of disorder is a given, preordained even before the trans person seeks assistance" (STP, 2010, p. 17). The Guide characterises this effect as a burden of diagnosis that is intensified when enfolded into the legal requirement for a person to exercise their civil and political rights (STP, 2010). Diagnosis is used to evidence the presence of distress; thus, it establishes the threshold of "care" and a certain degree of rights.

The limits set by diagnosis have particular subjectification and lived effects for people with self-designated genders and practitioners involved in providing "care". The SOC-7 asserts that while an

"evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment", a mental health professional must be "reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses" (Coleman et al., 2012, p. 23). As illustrated in chapter five, the "problem" of distress calls people with self-designated genders into a kind of social relationship with psy-practices. The underpinning logic of medicalisation with its liberal rationality is instrumental in (re)producing the political subject of the "health professional" who is responsible for verifying that a "gender dysphoric" subject is psychiatrically distressed-yet-safe-enough to access gender-affirming medical technologies as "treatment". Recall how Dewey and Gesbeck's (2017) investigation of the perspectives held by US-based practitioners who evaluated people seeking gender-affirming medical technologies. Their analysis led to an important assertion that the ostensibly "progressive" policy changes appear insufficient to change entrenched "structures of social control and power" that mental illness categories hold over people requesting access to "care" (Dewey & Gesbeck, 2017). Similarly, Pearce's (2018) seven-year, internet-based ethnography on trans healthcare in the UK illustrates how both diagnosis and "treatment" maintain the position of health professionals as gatekeepers with the authority and obligation "to shape notions of what appropriate trans lives, trans bodies and transitions might look like" (p. 90). A discussion of how the assessment (judgment) of distress, capacity, and risk maps onto the lives of people who request access to gender-affirming medical technologies appears in an interview between Shaindl Diamond and Ambrose Kirby (2014), both of whom are involved in resistance to psychiatry as activists and psychotherapists in Ontario, Canada. Kirby describes how:

> There has been an increasing willingness by health centres and individual health providers across Canada to recognize trans identity as regular, normal, not pathological. However, while our identities are being normalized, our resistance to transphobia is increasingly being separated out from our identities and pathologized. Instead of being trans people who creatively survive transphobia, we are trans people with anxiety disorders, anger disorders, bipolar [disorder], schizophrenia. Our basic identities are less and less considered a "mental illness," but our strategies for surviving are being taken out of context and individualized as "mental illnesses".

(Diamond & Kirby, 2014, p. 163)

This account demonstrates that scrutinising the effects of policy problematisations is less about measurable "outcomes" than the political implications of specific problem representations (Bacchi & Goodwin, 2016). The delicate prioritisation of assessment above diagnosis in the SOC-7 is a move toward trans depathologisation that nevertheless preserves the established authority and hierarchy of psychiatric diagnoses, structures the discourse and practices of "care", and cements the relations between practitioners and people with self-designated genders.

The structuring force of psychiatric diagnoses sets discursive limits on how other forms of distress can be recognised. These limits appear in two main ways; the first is in the implications of the SOC-7 defending its standard eligibility criteria as a standard for "care". The SOC-7 contains a recurring set of criteria for access to hormone and surgical technologies with additional requirements depending upon a person's age and the specific medical technologies requested. In accordance with the assessment of distress described above, the principal requirement for adults is "persistent, well documented gender dysphoria", followed by a statement that any "significant medical or mental health concerns … must be reasonably well controlled" (Coleman et al., 2012, p. 34). Arguing that the requirement for documentation limits access for people who seek body modification without the prescribed feelings of discomfort or distress, STP (2012) shows how continuing this kind of assessment forces an adaptation of "personal experience to a prestablished medical narrative" (p. 6). A consequence embedded in both the diagnosis and its surrounding assessment practices is, as Heyes and Latham (2018) contend, an appeal "to suffering as constitutive of being trans" (p. 175). The SOC-7 producing a subject position of being simultaneously distressed- and safe-enough to access "care" leaves this appeal to suffering unproblematised.

This silence on the subject positions produced in the SOC-7 is significant, not least because neither an assessment nor a diagnosis guarantee access and, in many instances, impose further limits on "care"

(Dewey & Gesbeck, 2017). Chapter six details how the SOC-7 requirements exacerbate the complex hospital and insurance systems in the US as a material limit on access to medical technologies. At the same time, participants in the group WPR analysis discuss the subtle implications of continued attention on the "problem" with/in the person. One participant noticed that:

> There's nothing within these documents about how to protect gender diverse and trans individuals or gender variant people from professionals. Because there's… because it's more about… it's the other way around, it's like there's a health issue, and we need to fix it, as opposed to a societal issue. And if there is a health issue and we need to fix it, and people are going about "treating" that problem… I don't know…

This hesitancy sparked another comment about how the SOC-7 is potentially:

> Stopping people from… people are not critically thinking about the concepts or about the wider issues. Reducing it down to step, step, step, step, and people feel like they're doing the right thing by going through the steps. They're doing it… I don't know; I shouldn't make assumptions about how people are doing it. But if people are doing it thoughtlessly, if people are doing it as a way of not having to do any personal work, or work around [how] they're perpetuating certain, I don't know, certain stigmas, or perpetuating power dynamics within the system, then you're doing harm.

Chapter five identified the careful distinctions in the SOC-7 between a person's gender identity and their experience of distress, the psychiatric problem of "Gender Dysphoria", and a social problem of prejudice and discrimination. Participant analysis illuminates how these distinctions are replete with silences on what it means to undertake a normative diagnostic process. The process of assessment (verification) of the distress of "Gender Dysphoria" produces a silence around the lived effects of "care" itself.

The second way psychiatric diagnosis limits how distress can be recognised is the silence on what it means to be denied "care" when judged ineligible. The SOC-7's guidance on assessing, diagnosing, and discussing "treatment options for co-existing mental health concerns" lists what potentially "significant" is, yet it has little to say about what ensures something is "reasonably well controlled" beyond the mention of pharmacotherapy (Coleman et al., 2012, pp. 24-25). This elision likely occurs because the logic of medicalisation underpinning the problem representation in the SOC-7 regards the DSM and its "treatment" protocol as unproblematic. However, there are many alarming implications of the requirements for documentation of persistent "Gender Dysphoria" and the appropriate management of other mental health concerns. An example is Lane's (2018) research at a prominent Australian gender clinic that details how assessment processes are considerably longer for people with "more complex issues", specifically "psychiatric disorders like psychosis, dissociation, or autism; intellectual disability; history of trauma; unstable social circumstances; homelessness; and substance abuse" (p. 215). Crucially, a lengthy process for people with non-binary or fluid genders occurs because they present a "different complexity" that results from a lack of policy guidance and expertise (Lane, 2018, p. 215).

The appearance of homelessness and the notion of unstable social circumstances in this laundry list of "complex issues" recalls the detail in chapter two of Vanguard's radical community organising in the late 1960s. This example of activism by racialised young people is important because the nebulous notion of "instability" remains a primary reason for delaying and denying access to gender-affirming medical technologies. It also shows that appearing in a practitioner's office is one thing, whereas accessing requested body modifications requires that a person has both a home and a normative lifestyle to return to afterwards. Going further, Chang (2016) created a list of the problematic dynamics they have witnessed regularly in the provision of "care" in the US and the struggle they experience:

> When TGNC [trans and gender non-conforming] folks complain about the shitty care they're receiving and demand change, [and] providers point to their mental health diagnoses as a way to

> discount their concerns. This is a way of putting TGNC people in their place and making it known who has the power. It communicates that compliance is the only way to get ones needs met … We know we deserve better. (p. 52)

Compelling research by Canadian-based public and trans health scholars Kinnon R. MacKinnon, Daniel Grace, Stella L. Ng, Suzanne R. Sicchia, and Lori E. Ross (2020) found that people who were considered "complex" reported that they needed "to be in 'therapy' and 'doing everything they asked,' including taking medication, in order to show clinicians that any previously 'uncontrolled' mental health concerns were currently being 'well-controlled'" (MacKinnon et al., 2020, p. 65). In practice, the extensive work of assessing and the arduous job of presenting "as clinically ready to transition" undermined the SOC-7's claim that its guidance is not intended to limit access to care (MacKinnon et al., 2020, p. 67). Similarly, the Australian study found that while mental health professionals use the SOC-7 to varying degrees in their attempt to depathologise their practice and adopt a more collaborative approach, it did not address the way risk discourse — the perceived risk of regret after "treatment" and medico-legal risk for the clinician — continued to shape the relationship (Lane, 2018). These examples demonstrate how effective the dissemination of gatekeeping has been in trans health.

Even the attempt to disrupt relations with collaborative gatekeeping does not alter the role that psychiatric diagnosis plays in verifying the distress that grants access, and in discerning that which complicates the process. Dewey and Gesbeck (2017) argue that this seemingly unyielding arrangement of relations arises because assessing "mental stability" is not only about ensuring that a person is somehow free from the "complications" of other (more serious) "mental illness" diagnoses; "it extends beyond the DSM and incorporates subjective interpretations of patient competency and rationality" (p. 61). These interpretations illustrate the biopolitical function of assessing (recognising) distress. This function also appeared when a participant in the group WPR analysis expressed his dismay at seeing that his peers were "using these standards to try and weed out things" and to "make sure that people are the 'right' people" for body modification. Thus, it is unsurprising that the SOC-7

is entirely silent on what kind of political intervention is produced when "care" is delayed or refused because of a mental health concern that is "unmanaged" or when a person who is seeking gender-affirming medical technologies is considered to be unmanageable. These accounts of how the SOC-7 is used in practice highlight the combined effects of a problematisation that remains silent on how structures of social control and power are built into "care" through diagnosis.

The analysis of the SOC-7 that I have presented in this section is an integrated form of WPR analysis using questions four, five, and six of the approach. It demonstrates how the problem representation in the SOC-7 sets limits on what practitioners can draw upon for "care" and on what is made available for a person requesting body modifications to become. I set the scene for a critical examination of the silences and effects, and the reproduction and reworking of the representation of the "problem" to be the distress of "Gender Dysphoria" by illuminating an enduring legitimation of "treatment" and its resonance with a limited kind of futurity. I have also reported how participants in the group WPR analyses identified the cost that discursive allusions about "health" carries for people with self-designated genders. I began with "treatment" and the notion of a conditional futurity as a way of managing a renewed or continuing existence for people with self-designated genders because those elements reveal how the biopolitical projects of settler colonialism appear within the SOC-7. I have drawn from published research and participant discussions to contend that diagnosis is a pivotal site for scrutiny because it sets evidence of a particular kind of distress as the threshold for "care". Psychiatric diagnosis persists as a major structuring force in the SOC-7. Whether it is reordering its position in the process; defending eligibility criteria so their requirements and associated practices are left unproblematic; or silence on built-in social control and professional power, scrutinising the way "treatment" and diagnosis operate in the SOC-7 reveals how it continues to function biopolitically despite ongoing attempts to modify and break open its gatekeeping relations. The governing of "care" in the SOC-7 produces multiple silences, effects, defences, and replacements. The limits that are set on "care" indicate a point of overlap in the conversation between problematisations, a point where the Guide has already begun speaking about the problem representation, and the SOC-7 is speaking over

and around it. The following section reports on findings from scrutinising the representation of the "problem" in the Guide to be an illness-based model of "care".

Creating the conditions for "care"

It is possible to read the Guide as an analysis of the SOC-7 that responds to questions four, five, and six of the WPR approach. It offers an alternative proposal for a rights-based model for "care" in response to the representation of the "problem" as an illness paradigm. It provides reference points for scrutinising how a representation of gender-affirming medical technologies as "treatments" for the "problem" of the distress of "Gender Dysphoria" limits thinking, shapes practices, and materially impacts the lives of people with self-designated genders, as well as encouraging disruption and replacement of the problem representation by developing and supporting protocols honouring people's requests for body modification. I respond to questions about what sustains and occurs as a result of representing the "problem" to be an illness-based model for "care" by analysing the Guide's four interconnected demands for the total depathologisation of gender self-determination. These demands are a site for scrutiny because although this proposed rights-based model has been circulating for over a decade, it has still received, at best, only a partial application. This section shows how co-option, disputes, pushback, clashes, and subordination have followed the demands for autonomy in decision-making, access without illness diagnosis, improving knowledge about medical technologies, and state-funded healthcare. I suggest that the Guide attempts to create the conditions for a liveable life by asserting demands that change the function of "care" in multiple and overlapping ways.

The Guide situates its four demands for "care" inside the tension between rejecting an illness paradigm and providing gender-affirming medical technologies. Chapter four clarifies how the Guide uses its seven axes of change to negotiate this tension from the point at which a health care system intervenes in the lives of people with self-designated genders, arguing that "it's not a trans identity that induces a person to seek medical care; instead, the impetus is the constellation of societal factors

that makes the daily lives of trans people so difficult" (STP, 2010, p. 16). Chapter five reveals that the point of necessary intervention is not at the level of individual "treatments" for an illness. Rather, it is for the health system to create conditions that improve the quality of a person's life. Changing the focal point of intervention necessitates the reconceptualisation of the established medical paradigm (STP, 2010).

A human rights-based model for "care" is the proposed mechanism for creating and maintaining these conditions. A participant in the group WPR analyses tentatively articulated how they understood this level of change:

> I think for me, and maybe this is getting too big, but maybe … [its] even that the Standards exist. The fact that something's been written that states this needs to happen, as opposed to a societal acceptance that people are of all sorts of genders and maybe there doesn't need to be some type of step-by-step process.

This understanding illustrates the effect of the Guide discursively constituting gender-affirming medical technologies as part of a liveable life (upholding rights) for people who request them. A rights-based approach is used in a manner that enables thinking about state-funded health care as part of the necessary structure of trans health. That is to say, situating both the request for and the initiation of gender-affirming medical technologies as self-determined in the context of a state-funded health system redefines a medical gender-affirmation process "as one worthwhile and possible choice to which a person should have access"; that is, "medical treatments, whether endocrinological or surgical, are seen here as useful tools the trans person can request" (STP, 2010, p. 18). This de-medicalisation approach makes it possible for the Guide to defend "treatment" as a means of establishing conditions for a liveable life rather, than as a means of medically managing specific modes of living.

Scrutinising the implications of representing the "problem" to be an illness-based model involves a

critical examination of the effects of practices that emerge from the conditions that the Guide attempts to create. The Guide's opening demand is to exchange "the present judgmental model for one of autonomy and informed consent" (STP, 2010, p. 12). In chapter five, I detailed how the Guide replaces the illness-based practice of assessing (judging) whether a person is eligible to access medical technologies as a "treatment" for "Gender Dysphoria" with a practice that Arjonilla (2014) defines as practitioners accompanying people in a process of body modification. I also detailed how Arjonilla (2014) describes the Guide as implicitly rendering informed consent as part of a democratisation of both the model (structure) and practices of "care". Published after the Guide, the SOC-7 responds to a demand for the abolition of a prior "phase of assessment and gatekeeping" with what can be understood as the co-option of a proposed alternative, stand-alone "informed consent document" that grants "sufficient flexibility" for a person "to follow a self-designed path" (STP, 2010, p. 21). The SOC-7 recognises the use of informed consent protocol for accessing hormone technologies. These protocols — such as those developed in a peer-led context at the Callen-Lorde Community Health Center (2014) and Fenway Health (2015) in the US, and the Equinox Gender Diverse Health Centre (2020) in Australia — integrate existing practices whereby body modification proceeds after an eligible (non-complex) person certifies with their signature that they understand the risks and dangers of the chosen technologies. The benefits of these protocols for removing barriers to accessing hormone technologies are not in dispute; however, they do fall short of full autonomy in decision-making about *all* body modifications. Rather than making it possible to attest to one's own capacity and responsibility throughout the entire process, the SOC-7 disrupts autonomy and decision-making through a depoliticised understanding of consent that presupposes a conceptual logic of medicalisation and preserves its overarching structure. Used in the way, consent is tethered to an idea of protection for health professionals that was enshrined in the SOC since its inception.

The Guide's replacement of the "gender dysphoric" and the gatekeeping subject with a rights-bearing and accompanying subject demonstrates how it defends the demand for a model of autonomy in decision-making. The Guide disseminates a model for a care process that is set in motion by "enlisting the participation" of a health professional, who, instead of being concerned with eligibility or

"readiness", will help the person "engage with community support resources, consider various life choices including those that lie outside the conventional sexual binary, and decide whether or not to suppress his or her [sic] secondary sexual characteristics or undergo surgery" (STP, 2010, p. 29). The Guide disrupts existing processes with the notion of a health professional participating in, rather than directing the course of a person's "care". Although the Guide adds to this disruption by reiterating the importance of supporting people's involvement with existing community supports, there is also silence on the terms of their existence. The Guide argues that "awareness of supportive spaces and groups outside the formal medical system decouples the concept of transsexuality from a medicalized vision and facilitates the autonomy of trans people" (STP, 2010, p. 20). However, as the unmapping of trans health and the genealogy of "care" show, communities do converge, but they do not always cohere around a non-medicalised vision and do not necessarily respond to the ways racialisation, class or citizenship status, police violence, incarceration and discrimination make for an unliveable life. This silence constrains the Guide. It limits discussion about the possibilities, challenges, and the role of policy in supporting people and spaces outside existing medical systems to participate in a person's "care".

A model of autonomy in decision-making connects to another demand for a "system that permits body modification without a diagnosis of illness" (STP, 2010, p. 12). Disseminating a model for accompaniment, means that the Guide is attempting an outright discursive legitimation of the embodied experiences of people with self-designated genders. In its most general sense, Stryker (2006) discusses how such experiential knowledge is legitimated in complex relations with "other, supposedly more 'objective' forms of knowledge" because it necessitates scrutiny of "the political dynamics of the situation being analysed" (p. 12). The situation in the Guide is the unique context within which a person decides upon a course of action for using particular medical technologies to modify their body in specific ways. As Stryker (2006) clarifies:

> This is not the same as claiming that subjective knowledge of "being transgender" is somehow more valuable than knowledge of transgender phenomena gained from a position of exteriority,

> but is rather an assertion that no voice in the dialog should have the privilege of masking the particularities and specificities of its own speaking position, through which it may claim a false universality or authority. (p. 12)

The Guide's attempt to democratise the structures and practices of "care" creates conditions for responding to political dynamics, not just by replacing judgement with accompaniment in self-determination but also through a dynamic process of de-subjugating the experiential knowledges of people with self-designated genders.

The demand for a system that permits body modification without an illness diagnosis shows how the proposed practices that emerge from the Guide's problematisation of an illness-based model for "care" are radical in their practical application. Arjonilla (2014) explains that the Guide's explicit removal of "any reference to psychiatric attention to trans people" is remarkable because it implies altogether "redefining psychosocial practices related to trans identity" (p. 40). Unsurprisingly, the de-subjectification and liberatory effects of such a process are disturbing for those who regard these as a loss of position and power in regulating appropriate gender self-designation. The bitter contestation over children requesting gender-affirming medical technologies is an instructive example of how a dispute over redefining psy-practices is taking place.

The Guide's straightforward problematisation of an illness paradigm is the kind of response that people with self-designated genders have widely defended. A notable example is Gill-Peterson's (2018) argument that "trans children need … access to an enfranchised voice to articulate situated knowledge to which medical practice is held accountable"; it propels radical transformation "by actually *asking trans children what they want* and truly basing care on that knowledge" (p. 198, emphasis in original). Another example comes from a group of nine scholar-advocates in social work, family medicine, and education who critique influential medically-focused research on children with

self-designated genders emerging from Canada and the Netherlands (Winters et al., 2018). This critique is part of a conversation concerning the ways that "desistance" is represented to be the "problem" in "care" for children and young people with self-designated genders. These advocates clarify their concerns about the pervasive "desistance" stereotypes that are present in the relevant research, specifying the undue methodological focus on children's future genders rather than the affirming of current designations; the harm caused by the implicit disapproval of gender self-designation that is present in the studies; and the effects of clinical practices that create, rather than remove, obstacles to "care" (Winters et al., 2018). Crucially, even a reform-oriented approach to "care" for children with self-designated genders echoes a similar position: advising to ask children "but truly learn to *listen*" (Winters et al., p. 249, emphasis in original). A further example of the dispute appears in Schwend (2020), detailing the arguments of activists whose position on depathologisation calls for removing diagnostic classifications for children with self-designated genders from authoritative medical texts altogether. Activists emphasise that diagnoses lack health benefits and challenge the unwarranted defence of "Gender Incongruence of childhood" as helping to cover the costs of psy-services, justifying access to puberty-blocking hormone technologies, and promoting research and skills development (Schwend, 2020). Alternatively, efforts are directed toward "support and accompaniment" in context and against any discrimination they face; against pushing any particular affirmations; and "avoiding a medicalization of gender diversity" (Schwend, 2020, p. 11). Examples of changes to psychosocial practices that de-subjugate children's experiential knowledges highlight the counterarguments that demonstrate how contemporary practice, knowledge production, and justification often work together to reiterate rather than redefine the relations in "care".

Alarmingly, disputes within the field of trans health over redefining psy-practices are increasingly overshadowed by conservative groups in the US, UK, and Australia who focus on safeguarding children and young people from what they consider to be a harmful use of medical technologies. The intensity and consequences of these activities have motivated public statements from various medical

organisations. One example is provided by a longstanding medical journal, *The Lancet Child & Adolescent Health* (2021), that rebuked the framing of "gender-affirming care as child abuse and medical experimentation", as a stance that "wilfully ignores decades of use of and research about puberty blockers and hormone therapy" (p. 385). The increase in these kinds of accusations of harm to children has followed the unprecedented rapid increase in proposed and enacted legislation directed at children and young people in education, sports, and healthcare across 37 of the 50 states that make up the US (Levin, 2021). As an example, legislative representatives in the state of Texas that attempted to legislate punitive investigations of families by statutory government departments under the notion of "protecting" children from such harm (e.g. Aguilar, 2022; Salam, 2022), have now succeeded (Sharrow & Sederbaum, 2022), amid ongoing legal challenges from those who bear the brunt of this particular "weaponization of state agencies" (Nguyen, 2023, para, 27). These efforts reflect not only the tenor of epistemological conflict in the conversation between problematisations but also Foucault's (1978) suggestion that "power's condition of possibility … makes it possible to use its mechanisms as a grid of intelligibility of the social order" (p. 93). These effects of even the possibility of making "care" accountable to situated, embodied knowledges within a democratised dialogue reveals the power — or rather, the "complex strategical situation" (Foucault, 1978, p. 93) — of the Guide's proposed replacement paradigm.

The potential de-subjectification and liberatory effects of the Guide's problematisation of an illness-based model for "care" occur alongside the possible discursive effects of its demand for specific forms of knowledge production. The Guide's demand for improved medical knowledge expands the limits of what can be thought of as structuring "care" while also extending what is known about the medical technologies it incorporates. This expansion is in the demand for medico-scientific knowledge production to shift from the suffering of people with self-designated genders toward improving medical knowledge on the side-effects of hormone-related technologies, the improvement of surgical techniques, and so on (STP, 2010). This demand operates so that the Spanish health system can uphold a person's right to the highest attainable standard of gender-affirming healthcare (STP,

2010). A shift in the locus of knowledge production does not devalue inquiry into what conditions create suffering or into the practices and structures required for "care"; it adds the potential to expand thinking on what and how medico-scientific knowledges can be directed towards improving the technologies themselves.

The demand for improved medical knowledge in trans health is made in the context of the established authority and hierarchy of relations in medical research. Schwend's (2020) review of contemporary trans depathologisation scholarship summarises criticism of ongoing pathologisation within research via discriminatory conceptual, linguistic, and visual representations of gender self-designation, alongside ethnocentrism and an absence of specific ethics for consent and confidentiality practices. The criticism also reveals a conspicuous silence in the medical research about how people with self-designated genders are to be meaningfully included in processes of knowledge production beyond testimony, further exposing how the theoretical contributions of trans scholarship continue unrecognised (Schwend, 2020). This criticism is relevant for problematising how "Gender Dysphoria" remains within an illness paradigm because of the way that it resonates with several moments discussed in chapter six. These moments include maintaining normative categories of gender diversity in children; the co-option of trans depathologisation activist demands into Spanish legislation, and in contrast, an ongoing exploration of a decentralised model for ICD codes; and the intersectionality-informed stance on the need for regional-and national-level structural changes in the YP plus 10. These are but a few dynamic instances of what Pearce (2018) views as "an epistemic *clash of credibility*, in which the authority of medical knowledge is questioned in the context of … considerable collective achievements of activists in interpellating trans knowledges as authoritative, expert and *real"* (p. 194, emphasis in original). The reception (co-option and rejection) of sustained criticism and enduring strategic practices demonstrate that a complete upending of accepted "expert" knowledges and the function of "professional" practices is necessary to meet demands for the total depathologisation of gender self-designation in trans healthcare.

There are two silences in the Guide's problematisation of an illness-based model that occur alongside its list of demands. The first is the summary of the Guide's proposed new protocol, and the second is the stance that requests for body modifications are not medical issues but part of physical processes of the body that entail medical "care". These silences are significant in revealing the complexity of creating the conditions for "care" from a rights-based approach. Chapter four shows how the "absence of identity delusions" appears to be unproblematically included as a component of informed decision-making alongside a more general assertion that "a prior psychiatric diagnosis" should not impede access to "trans-related health care" (STP, 2010, p. 28-29, see Appendix). There is certainly a possibility for positive transformation when dialogue about "identity delusions" is situated within a democratised process of professional accompaniment in self-determination. However, the extent of this transformation is limited by the uncritical use of the concept and the accompanying tacit normalisation (legitimisation) of other psychiatric diagnoses, even if they are not to become a barrier to "care". The silence is in the discrepancy between the Guide's proposed protocol and its previously stated objection to the "imposition of a diagnosis of a mental disorder" in responding to requests for access to "care" (STP, 2010, p. 16). There is a concern that the objection to the imposition of psychiatric diagnoses related to gender self-designation does not extend to problematising the consequences of imposing other sorts of diagnostic categorisations – specifically, what it means when delusions are represented to be the "psychotic features" of multiple mental disorder diagnoses (APA, 2013). As discussed at length in the following chapter, the complexities of explicitly engaging such a thorny consideration of different forms of pathologisation in "care" creates uncertainty about the extent of the transformation brought about by a rights paradigm.

The second silence is the Guide's attempt to normalise access to gender-affirming medical technologies as physical bodily processes that entail medical "care". Chapter five draws attention to the Guide's conceptualisation of gender self-designation not "as a mental disorder, or as an organic or physical condition, but like other physical processes of the body, such as pregnancy, that require medical care" (Arjonilla, 2014, p. 38). During a discussion of the Guide in the group WPR analysis, Arjonilla's (2014) naming of pregnancy as an example of such an embodied process drew an incisive

critique:

> Researcher: So, if someone is pregnant, they assemble around them a whole range of healthcare professionals and policies and [a] whole range of other things. But they're not pathologised.
>
> P4: But they are!
>
> Researcher: They are, but [the Guide is] inviting this sense that maybe someone who is pregnant doesn't first have to meet the criteria for a diagnosis of a mental disorder to enact the health care around them.
>
> P4: But the diagnosis is they're pregnant. And with that comes all this set of… again, they're treated like a child… it's still a medical problem that you're pregnant, and because you're in this medical problem, we're going to watch you very closely, and if anything goes wrong in your body, we're going to take over.
>
> P1: Like ageing. As soon as it became located in institutions, in hospitals, you know, then it took it away from being a naturalistic part of our experience.
>
> P4: I was actually thinking about this in terms of pregnancy. It's not the same because it's less stigmatised … but this is seen as this person is unwell and they need to be taken care of, and these are the ways to do it.

This exchange shows the forms of biopolitical control left unproblematic in this attempt to normalise access without focusing on psychological distress. Chapter five reflects on how the Guide's approach to depathologisation necessarily includes de-medicalisation, even though the logic of rights is continually interacting with and shaped by the underpinning logic of medicalisation. The critique in the group WPR analysis shows how the contradictory ethics and imaginaries of tampering with "healthy" reproductive bodily systems align with a dominant ethics of care for people classified as "perinatal", "physically declining", and "mentally ill". The additional complexity in these interactions between logics underpinning the alternative model for "care" generates further questions about the transformative potential of a rights-based paradigm for the total depathologisation of trans healthcare.

The final demand under discussion is the Guide's assertion that "support for the concept that body modification for trans people, when they request it, is a public health matter and should be covered by the public health system" (STP, 2010, p. 12). In the years since the Guide's publication, there are some examples of a health system undertaking a straightforward replacement of an illness paradigm with a rights paradigm (e.g. Rucovsky, 2015; Hollar, 2018; Kara, 2020). The Guide explicitly links gender-affirming medical technologies to the rights of bodily autonomy and self-determination through a demand for the public funding of health care, thus demonstrating how Spain can meet its obligations for a right to health (STP, 2010). Scrutinising what follows from this re-attribution of responsibility for "care" at an institutional level is crucial because of the ways that rights have ascended to become a sacrosanct (dominant and comfortable) emancipatory discourse (e.g. Irving, 2013; Dietz & Pearce, 2020).

While it is not a replacement, Israel offers a prominent example of incorporating a discourse of a livable life for people with self-designated genders into a localised political, cultural, and social context of an established state-funded illness-based healthcare system. As transgender studies scholars Aaron Devor and Ardel Haefele-Thomas (2019) describe, one component of this process is that Israel now permits name and gender changes on identification documents without any psychiatric diagnoses or medical intervention. Despite the numerous gender-affirming medical technologies that have, for several decades, received public funding in Israel, approval for access occurs "under a relatively conservative interpretation" of the SOC-7 (Devor & Haefele-Thomas, 2019, p. 100). For example, the process for gaining access to genital surgeries requires approval from the Gender Reassignment Board, which verifies professional assessments of a person's physical and mental suitability (Israel Ministry of Health, 2020). People seeking this approval are required to provide the Board with a "notice of financial commitment" from one of Israel's four Kupat Holim or "complementary insurances" providers; referrals from either clinical psychologists or social workers that include a psychiatric assessment; and documentation of the use of hormone technologies (Israel Ministry of Health, 2020). Allowing a change of name provides another example of broadening some avenues of access to rights while maintaining a model for "care" that orients around mental illness diagnosis and

"treatment", with an added bureaucratic component of providing security for the cost of technologies.

Against this backdrop, journalist Tzvi Joffre (2021) reports that voice feminisation surgery is a recent addition to the approved list of state-funded services, with Israel's Health Minister Nitzan Horowitz promoting the decision as the response of a state that has, for too long, "pushed many members of the [trans] community to the margins of the society, to a life in difficult conditions and to the street" (para. 1). In response to high rates of suicide attempts, reports of discrimination and refusals from practitioners to provide "care", Minister Horowitz is quoted as arguing that it "isn't just another ordinary struggle, it is a struggle to be who you are, a struggle for freedom, a struggle for life," and "as elected officials and as a state our moral duty is to allow every person to live their lives as they choose" (Joffre, 2021, p. para. 11). Yet, as journalist Amy Spiro (2022) reports, this discourse of Israeli state-funded healthcare allowing a liveable life — particularly for trans women — circulates amid estimations that only 20 people access gender-affirming surgeries in Israel each year, with an even smaller number seeking out what is constituted as surgical "treatments for gender adjustment of the voice" (Spiro, 2022, p. para. 2). Moreover, these surgeries effectively amount to less than half a per cent of the 550 million Israeli Shekel (nearly 250 million Australian dollars) allocated for all newly approved procedures and medications in the recent health budget (Spiro, 2022). The Israeli Ministry of Health certainly appears to address the demand for state funding of gender-affirming medical procedures by rationalising it as a life-saving response to the ill-health effects of violence, mental distress, family and social exclusion, employment, and housing discrimination (Joffre, 2021; Spiro, 2022). However, this justification operates at a distance from the provision of "care" as part of a responsibility to uphold the rights of bodily autonomy, self-determination, and the highest attainable standard of healthcare.

The disparity between the Guide's demand and the activities of the Israeli Health system highlights the value of the analysis within question six of the WPR approach by inviting scrutiny of "the *means* through which particular problem representations reach their target audience and achieve legitimacy" (Bacchi, 2009, p. 19, emphasis added). Partially responding to one, rather than meeting a set of

interrelated demands indicates that the Guide's representation of an illness-based model as a "problem" has not achieved legitimacy in Israeli healthcare structures. Instead, Israel's mobilisation of a neoliberal-inflected discourse of an individualised response reinforces an illness paradigm, as it attempts to recuperate the state from marginalising (denying) to allowing (saving) the lives of people with self-designated genders. Moreover, it demonstrates how the demand for access to gender-affirming medical technologies in a state-funded health system is disrupted as part of a larger, well-documented, localised pinkwashing project whereby Israel presents itself as a progressive, welcoming, LGBT rights-upholding state in an effort to obscure its ongoing illegal settler colonial invasion and genocidal occupation of Palestine (e.g. Puar, 2017). Scrutinising how Israel subordinates the public funding of gender-affirming medical technologies to the illness-based model of "care" reveals how easily the discursive and literal investments in trans health are folded into the state-securing biopolitics of settler colonialism.

In this section, I have integrated three questions in the WPR approach to scrutinise the implications of the Guide representing the "problem" to be an illness-based model of "care". The analysis demonstrates how this problem representation directs the Guide to focus on reconceptualising "care" in its entirety: its purpose, mechanism, function, roles, and practices. I began by illuminating how the Guide is attending to de-medicalisation alongside depathologisation, making it possible for it to defend "treatment" as a means of establishing a liveable life rather than medically managing specific modes of living. The piecemeal application of a rights-based approach in "care" has led to a range of responses to the Guide's demands, including those from within the SOC-7 and from research participant analysis, reform advocates, depathologisation activists, medical research and other academic publications, legislators and politicians, and from within government health policy. I have shown that the co-option of informed consent in the SOC-7 disrupts an attempt to establish autonomy in decision-making throughout the entire process of body modification. I suggested that disseminating a model for accompaniment coincides with legitimating embodied experience as knowledge; and that attempts to democratise both the structures and practices of "care" carries the potential for responding

to its political dynamics even as community support is left as unproblematic. There is an active ongoing dispute and outcry at pushback against the liberatory effects of redefining psy-practices that exists alongside a constant clash with and gradual upending of accepted knowledges; and contrarily, a subordination that disrupts the re-attribution of responsibility for "care" with an attempt at recuperating and securing a colonial state formation. Each response reveals that the Guide is structured by and proposes a multi-pronged and multi-layered approach to replacing an illness paradigm. Scrutinising these responses shows that creating conditions for a liveable life can occur through depathologising and de-medicalising the provision of gender-affirming medical technologies; that these conditions are constituted through processes of redefining, divesting, and de-subjugation, alongside state funding for the entirety of "care". Creating conditions for "care" indicates another feature of the conversation between problematisations – namely, how speaking back, over and around demands for total depathologisation reveals the shape of the power-knowledge it seeks to avoid.

Conclusion

This chapter has scrutinised proposals concerned with setting limits at the point of entry of "care" and creating the conditions for "care". I have offered a comparison of the SOC-7 and the Guide that integrates questions in the WPR approach. I have directed attention to the silences found in each problem representation, the sorts of effects they produce, along with the various ways they have been disseminated, defended, disrupted, and replaced. I also considered what such scrutiny reveals about the conversations between the problem representations within the SOC-7 and the Guide. I argue that in maintaining the link between "treatment" and diagnosis, the SOC-7 provides a continuation of "care" as medically managing appropriate modes of living, whereas demanding a transformation of practices, relations, and structures suggests that the Guide affords the possibility that depathologisation can perhaps assist in disestablishing this function and unsettling colonialism as a primary condition of governing gender.

The claim of continuation rests on scrutinising how "treatment" and diagnosis operate in the SOC-7 to circumvent multiple silences, effects, defences, and replacements. This scrutiny reveals that even with sustained attempts to rework and disrupt gatekeeping relations, the representation of the problem to be the distress of "Gender Dysphoria" preserves the biopolitical function of the SOC-7 to administratively maintain populations in ways that are shaped by a broader project of colonial futurity. The claim of the possibility of disestablishing this function rests on scrutinising co-option, disputes, pushback, clashes, and subordination in response to those demands in the Guide that are designed to transform "care" in multiple and overlapping ways. This scrutiny reveals that the representation of the problem to be an illness-based model is a strategy for creating conditions for a liveable life for people with self-designated genders through the expression of autonomy and self-determination. Such conditions are created by depathologising and de-medicalising the provision of gender-affirming medical technologies, as well as through processes of redefining, divesting, and de-subjugation, supported by state funding for the entirety of "care". The significance of revealing the SOC-7 as a continuation of the biopolitics of settler colonialism in contrast with the Guide which affords the possibility of disestablishing or at least unsettling this function in "care" is that it supports further critical examination of the (un)intentional legitimation of established governing relations. In the following chapter, I discuss the findings of this WPR analysis of the problematisations in the SOC-7 and the Guide by comparing how preservation and the potential for abolition operate as different modes of transforming the governing of access.

Chapter 8
Discussing preservation and potential abolition

Discussing the opposing concepts of preservation and abolition is a way of evaluating what different approaches to depathologisation can mean for trans health policy. In this thesis, I have asked two questions about the mechanisms of healthcare that allows for gender self-designation. The first asks how the governing of gender through the governing of access to gender-affirming medical technologies operates in these two discrete but related policies, while the second is concerned with how this governing connects to the biopolitics of settler colonialism. The analysis undertaken to answer these questions is framed by a critical reading of the literature that traced intricate processes of coloniality, scientific racism, and the management of non-normative bodies that permeate trans health. Within the analysis, the genealogy of "care" also considered several moments that show the inextricable link between the governing of gender and the imposition of settler colonial rule. These include moments of dispossession through policies of "civilisation" and "protection"; the moment of synthetic hormones manufacturing illuminating the making of bodies as "treatable" and un-"treatable"; and the moment of medical surveillance created as another form of population management. The mechanisms of politics that allow for trans life are thus entangled within colonial projects, regardless of whether they involve establishing and maintaining a settler state or another colonial formation.

This chapter uses conceptions of preservation and abolition to discuss the identifying, reflecting, considering, and scrutinising of problem representations in the SOC-7 and in the Guide. Preservation and abolition are used to determine what each policy problematisation means for the governing of gender through the governing of access to gender-affirming medical technologies, and what connections they have with settler colonialism. Section one introduces the phrase preservation through transformation, coined by legal scholar Reva B. Siegel (1996), to discuss the assertion that the SOC-7 maintains an entrenched illness model for "care" even as it transforms the terms of diagnosis and

access in trans health. Discussing the dynamics of this preservation highlights a co-option of activist demands for depathologisation and de-medicalisation in the SOC-7 as a move to help maintain and legitimise a status regime in trans healthcare. Moreover, it pinpoints how the transformations within the SOC-7 help to preserve and stabilise colonialism as an underlying condition of modern governing. I suggest that the SOC-7 is an exemplar of preservation through transformation. I also highlight the importance of analysing its representation of the "problem" to be the distress of "Gender Dysphoria" as a function of the biopolitics of settler colonialism.

Section two introduces the notion of an abolitionist political vision to discuss the analysis of how the Guide seeks to disestablish an illness model and redesign "care" according to a paradigm of rights. Discussing uncertainty about the sorts of transformations this paradigm indicates overlaps and points of disconnection between the Guide's demands and a broader political vision of abolition. This discussion echoes a concern about how the depathologisation of "care" aligns with colonial projects. Although the Guide identifies how the pathologisation of gender self-designation is part of a colonial mechanism, I suggest that it is necessary to extend that critical attention to its own proposal and address the enduring colonial modes of population management inherent in a liberal logic of rights. Discussing the uncertainties of abolition shows how analysing the Guide's representation of the "problem" to be an illness-based model in view of the biopolitics of settler colonialism provides valuable lines of inquiry that could frame alternative formulations and futures of "care". This section closes with a discussion of an ethical stance that offers important lessons for such investigation. Granting that an illness-based model of governing access in the SOC-7 represents a form of preservation through transformation inherent to a biopolitics of settler colonialism, uncritical use of an alternative rights-based model in the Guide potentially maintains the function of these power relations and naturalises their conditions. I suggest that understanding the governing that a trans health policy relies upon and is producing is crucial for contesting its revisions and evaluating proposed alternatives.

An exemplar of preservation through transformation

This section introduces *preservation through transformation* as a term to summarise the findings from analysing a representation of the distress of "Gender Dysphoria" as a diagnosable mental health "problem". It conceptualises how the governing in the SOC-7 operates as a preservation of an illness diagnosis and "treatment" model through a limited transformation of its clinical guidelines on responding to requests for access to gender-affirming medical technologies. More trenchantly, it helps to establish the importance of understanding that this governing of gender through governing access is part of a continuing process of maintaining and naturalising colonial projects. There are important implications from analysing the preservation of the prevailing paradigm for "care" as a function of the biopolitics of settler colonialism. I contend that this broader understanding is crucial for contesting an approach to depathologisation that upholds an oppressive model of illness and sustains the ongoing violences of colonial governing.

Preservation through transformation is a useful concept to discuss the significance of analysing the representation of "Gender Dysphoria" as the "problem" in the SOC-7. Siegel (1996, 1997) coined the term in her critical examination of equal opportunity laws that were created in response to activist demands for legal reforms to address race-based discrimination, rape, and intimate partner violence. Siegel's (1996, 1997) analysis demonstrates that over the course of two centuries, "facially neutral" laws were created in the US by removing race- and gender-specific terms from their rules and simultaneously changing their justifications. Analysing this process revealed that "when the legitimacy of a status regime is successfully contested", the regime "will both cede and defend status privileges" (Siegel, 1996, p. 2119). It is important to situate this dynamic within racialised heteropatriarchy, and colonial mechanisms of slavery, segregation, and marriage in the US. Eschewing references to hierarchies of race (master/slaves/servants) and gender (husband/wife) for a facially neutral language of contracts, privacy, and the home, and further distinguishing between "civil" and "social" rights made it possible to defend certain violent and discriminatory actions as beyond the power of the law (Siegel, 1997). Despite inherent discursive tensions and contradictions,

such transformations effect just enough change to give the appearance of ending harmful practices while preserving the prevailing status regime (Spade, 2013). What remains "unarticulated in such accounts … is any theory about what kinds of state action are discriminatory, or status enforcing … [thus] it is tacitly assumed that race- or gender-specific state action is status-enforcing, while so-called 'facially neutral' state action is not" (Siegel, 1997, p. 2188). Approached biopolitically, preservation is an apparatus that maintains political relations (patterns of power and authority) through strategic changes in the practices of regulating populations.

Preservation through transformation usefully conceptualises how a regime slowly jettisons what is contested and replaces it with seemingly new rules and reasoning to secure the privileges it wants to uphold. This analytic is crucial because it shows how "status-enforcing state action evolves in form as it is contested" (Siegel, 1997, p. 1113). It provides a way to conceptualise what happens when the SOC-7 is heralded as an important success in moving towards depathologisation despite the ongoing presence of many harmful pathologising practices. Analysing the problem representation in the SOC-7 shows that while its transformations are often depicted on this trajectory, they keep an illness model intact, thus securing the privileges and social inequities it legitimates. As identified by the incisive participant comment in chapter four, the SOC-7 protects "an authority structure and an authoritarian system". The analysis in this thesis hinges on understanding "Western" medicine as another status regime, one that interlocks with "Western" law for the enduring regulation of life and populations.

The dynamic of preservation through transformation occurs in the SOC-7 through changes to clinical guidelines and the justification for clinical standards. Consequently, the most straightforward answer to the first research question is that governing operates in the SOC-7 through the preservation of an illness model. The underpinning medical logic, contingent critical moments, and limits set on "care" that were revealed through this analysis correspond with existing studies that identify the preservation of an overarching normative structure constitutive of professional gatekeeping, psychiatric diagnoses, language, and verification practices (e.g. Arjonilla, 2014; Davy et al., 2018; Dewey & Gesbeck, 2017; Johnson, 2015; Riggs et al., 2019; Schwend, 2020). This analysis in this thesis also illuminates the

intricacies and implications of preserving an illness model in trans health policy, confirming that the SOC-7 preserves an overarching normative structure by ostensibly making changes to its formerly rigid and overtly pathologising professional consensus on disorder management in the SOC-5 and SOC-6. The clarification in chapter four details how it transforms itself into a policy for the promotion of optimal "care" by offering guidance on the verification and "treatment" of an experience of gender dysphoria that is severe enough to warrant "a formal diagnosis" of distress "that might be classified as a mental disorder" (Coleman et al., 2012, p. 5). Even with an assertion that this policy is a departure from formerly problematic versions, chapter five identified an important change in the SOC-7's use of the concept "flexible". Despite indicating that it is permissible to adjust "care" according to a person's needs and the setting, the SOC-7 implies that any change must retain the administrative practices of diagnosis.

Bacchi and Goodwin (2016) argue that a need for the repetition of terms reinforces the contingency of the relations it addresses, opening up "the possibility of challenge and change" (p. 30). Yet the qualifiers "might be", "departure", and "flexible" signal the kind of transformation the SOC-7 made to its justification for clinical standards in response to the extensive challenges it received. Changing a rationale that a person requesting body modifications must be diagnosed with (and receive "treatment" as a result of) a "Gender Identity Disorder" into a rationale of treating the distress of a diagnosable medical "problem" of "Gender Dysphoria" is not only the preservation of psychiatric diagnoses within a logic of medicalisation. Maintaining a representation of the "problem" in medical terms is also an adherence to the liberal co-constitution of subjects of rights and economic actors for appropriate management. In this instance, it is also an adherence to the neoliberal responsibilisation for self-management that calls people with self-designated genders into relation with psy-practice as a necessary condition of "care" and state recognition. The use of qualifying language in constructing its problem representation indicates the parameters of change in the SOC-7. It demonstrates an assumption that its clinical guidance will bring about depathologisation even as it maintains a specific hierarchical ordering within the status regime of "Western" medicine to grant access to requested technologies.

This analysis presents further intricacies and implications of preservation. In chapter four, a participant in the group WPR analyses identified the representation of the "problem" in the SOC-7 as the preservation of professional gatekeeping. This identification is emphasised by the critical moment in chapter six that considers the installation of eligibility criteria as the standard for "care". For this participant, gatekeeping continues to safeguard "the authority of practitioners to make decisions about other people's lives … as the people who get to dictate who's in, who's out, who gets a yes, who gets the no". This observation is echoed in Velocci's (2021) analysis of written correspondence between Harry Benjamin and other early practitioners that shows how psychiatric evaluation was not only a way to safeguard its authority to reinforce gender normativity. These medical practitioners (endocrinologists, urologists, and surgeons) brought in psychiatrists to give their opinion about people's lives in order to protect their status and reputation as the professionals providing a controversial kind of "care"; this is how a set of time- and site-specific informal practices "congealed into" an enduring and set path for the purposes of limiting access to gender-affirming medical technologies (Velocci, 2021, p. 466). A suggestion that maintaining a gatekeeper also involves preserving psychiatric verification practices within a hierarchy of status relations, is important because it illuminates how the SOC-7's transformation also widens the status regime provided by "Western" medicine.

The SOC-7 arranges its guidance around the competency requirements, roles, and everyday tasks required of practitioners—mental health professionals, physicians, specialists, and surgeons (Coleman et al., 2012, pp. 22, 41, 52). As chapter four clarifies and chapter five reflects upon, these technologies of expertise and responsibilisation authorise more professionals — social workers, mental health counsellors, marriage and family therapists, nurses, and family medicine (general) practitioners — as political subjects to carry out the assessment and diagnostic components of "care". Scrutiny in chapter seven of how diagnosis and "treatment" continue to structure the discourse and practices of this "care" indicates that one repercussion from preservation through transformation is the continued calling of people with self-designated genders into existing status relations that are cemented into place by psy-

authority. Verifying distress (including capacity and risk) amplifies existing power differentials. The status of a person seeking to modify their body remains subordinate. While my analysis is not the first to show that structures of social control are built into "care" via such administrative practices, it details how preserving practices of assessing psychiatrically distressed "gender dysphoric" subjects limits problematisation of the governing of "other" and "unmanaged" diagnoses, and even less recourse to respond when judged unmanageable. A further repercussion is the uneven widening of those authorised to approve access requests and those skilled and experienced in providing direct care. As the critical moment in chapter six of the surgery skills development workshop indicates, expanding these practices generates increased economic interest in offering care that results in a lag between approved and realised access to requested medical technologies. I suggest the SOC-7 is an exemplar of preservation through transformation because it simultaneously preserves and reinforces a medical status regime by maintaining a diagnosable psychiatric "problem" as the focal point of the mechanism of "care" as "treatment".

It is widely accepted in critical scholarship that governing gender, especially through an illness paradigm, is integral to multiple projects regulating human life at the level of populations (e.g. Burstow et al., 2014; Ussher, 2010). However, it is less common to interrogate these as part of colonial projects in which gender is biopolitically mobilised for the elimination and absorption of Indigenous peoples and polities for the settlement of others and to ensure its futurity. Analysing the SOC-7 in view of the biopolitics of settler colonialism benefits from longstanding theorisation which recognises that while race and racialisation are both foundational components, settler colonialism is also a normatively gendered and gendering process (e.g. Anzaldúa & Moraga, 1981; Arvin et al., 2013; Foley, 2020; Kauanui, 2017; Lugones, 2010; Moreton-Robinson, 2015; Morgensen, 2012; Smith, 2021). This critical scholarship implicates the heteropatriarchal governing of gender and sexuality as it draws attention to situated mechanisms that regulate multiple modes of non-normative identity, expression, kinship, and social position. The multiplicity and overlap between biopolitics means there is not a straightforward answer to the second research question that asks about the connection this governing of gender *through* governing of access to gender-affirming medical

technologies has to settler colonialism.

In this thesis, the theoretical framing of gender and its embodiment facilitates an understanding of how profoundly the preservation of an illness-based model for "care" through a calculated transformation in the SOC-7 connects to seemingly unrelated (invisible) projects of settler colonialism. As Morgensen (2011b) argues, "settler colonialism is present precisely when it appears not to be" because "its normative function is to appear inevitable and final" (p. 42). This framing made it possible for chapter six to show how historically contingent moments have modulated conceptions of gender self-designation and requested body modifications in ways that implicate their purpose as part of different colonial projects in multiple places. These moments include the installation, revision, and attempted reorganisation of medical coding systems; illness re-categorisation; nascent colonial legislations and enactments; hormone manufacturing; securing professional authority; articulating the obligations of a state; and collective resistance. The framing also made it possible for chapter seven to reveal how reconfigurable techniques of verifying distress and risk are tactics for regulating access as "care". Examining the governing in the SOC-7 reveals that it is not just an authoritative text that sets the standard for "care", it is also a means of bringing people with self-designated genders into seemingly unyielding hierarchical status relations within the interlocking mechanisms of "Western" medicine and healthcare, "Western" law, and citizenship.

Analysing the SOC-7's problem representation marks the colonial conditions through which this governing occurs. The analysis suggests that governing access is not only a continuation of "care" as medically managing appropriate modes of living, but also a part of an uninterrupted continuation of the conditions of colonial nation-building and settler state-securing projects. There is a meaningful connection between a *continuation* that extends or carries on and *progress* in a set course to a more developed or advanced state. In her comprehensive critique of Western research, Smith (2021) illustrates how "ideas about progress are grounded within ideas and orientations towards time and

space … Deeply embedded in these constructs are systems of classification and representation which lend themselves easily to binary oppositions, dualisms, and hierarchical orderings of the world" (p. 63). The "sense of innate superiority" imbued in Western research continues to be very dangerous for Indigenous sovereignties and Indigenous self-determination (Smith, 2021, p. 63). Coloniality has distinct life-threatening effects on converging Indigenous resurgences that must not be conflated with, or minimised by making comparisons to struggles for gender self-determination. Yet, the ideas and systems of Western research do manifest as conditions in the unmapping of the field of trans health. Unmapping reveals yet another space in which essentialist bodily classifications and a rigid binary gender system work with medico-scientific knowledges to reinforce racialised, class-based, religiously driven, contested forms of social control and colonial relations of domination. Not only for the sanction but also for the provision of "care". It is a demonstration of how the analytic strategy offered in a WPR analysis helps connect the theoretical to the practical across difference.

Unmapping the field of trans health together with analysing two of its policies adds to the extensive theoretical and historical study of these systems of classification and representation. That is, a critique that situates practices of measuring, pathologising, containing, and treating populations within multiple, contingent, and contested political projects in specific places that manage deviations from and secure the basis of dominant norms (e.g., Gill-Peterson, 2018; Puar, 2017; Rose, 1999; Spade, 2013). This analysis contributes to a complication of the dominant narrative of trans health as a bitter struggle that, in challenging the founding pathologising classifications, has progressed into a field that provides evidence about the benefits and necessity of "care" to improve health and wellbeing. Chapter seven shows the biopolitical function of care standards is to direct a staged, linear process of a person overcoming a gender "problem", then an identity "problem", and now a distress "problem". It is a way of representing progress from overt pathologisation and rigid control to a more advanced state of "care" that is being de-pathologised. To use Siegel's (1997) words, it outlines the SOC-7 as another form of status-enforcing action that evolves as it is contested. Crucially, chapter five identifies that the SOC-7 calls people with self-designated genders into relation with psy-practices just as it calls "the

West" into relation with "other" parts of the world. While the purpose of the guidance outlined in the SOC-7 is to facilitate an individual's "lasting personal comfort", chapter seven identifies the unspoken endgame as the recognition (and reincorporation) of people who modify their bodies into distinct structures of citizenship that are nonetheless integral to mechanisms of coloniality. Thus, it is a design feature, rather than an unfortunate by-product of policy, that access to gender-affirming medical technologies and the recognition it provides is only available to those already verified as suitable state subjects.

It is crucial to assert the purpose of this analysis is not to discount or undermine the struggle for trans depathologisation. If the SOC-7 evolves strategically in response to critique, then these findings show how techniques of progress and "progressive" and recognition are woven into already identified neoliberal racial capitalist mechanisms of marketisation, debilitation, value extraction, and mobility in trans health (e.g., Aizura, 2018; O'Brien, 2013; Puar, 2017). The purpose of this analysis is, therefore, to sustain attention on its conditions and their consequences. In other words, to highlight how oppression manifests in the SOC-7's attempt to naturalise the authorisation of external, subjective interpretations of a person's distress, capacity, and medico-legal risk as the means of granting access to medical technologies that are classified as gender-affirming.

A final implication of preservation is how the status regime of "Western" medicine in trans healthcare is normalised and promoted through an expectation that the SOC-7 is for "worldwide use". It appears in light of the implicit racialisation and the apparent colonising effects identified in the remarks from participants in the group WPR analyses quoted in chapter five. Locating these practices in the SOC-7 shows how they are an extension of colonialism as a primary condition of governing. The consideration of critical moments in chapter six marks the white supremacist rationale guiding the development of hormone technologies and the colonial state interests driving the development of medical categories that generate population-based health data. Invoking DSM and ICD categories as

the means of access to gender-affirming medical technologies suggests that the depathologisation of trans health in the SOC-7 is a form of settler common sense, a way that "processes of settlement" are treated "as a given in developing … ethical visions" for the future (Rifkin, 2014, p. 3).

The mechanism of "care" in the SOC-7 directs people with self-designated genders into a biopolitical apparatus in which the vision for depathologisation is a liberal one of progress and recognition that functions as conditional futurity. As one participant comments in chapter seven, it is a disturbing vision in which care standards are used to "weed out things"; ensuring that "the 'right' people" are approved for body modification and the accompanying benefits of updated identity documentation. Depathologisation in the SOC-7 renders an uneven and unjust futurity that aligns with Philosophy and Political Science scholar Rita Dhamoon's (2015) formulation of settler colonialism as "an activity for assigning political meanings and organizing material structures" that "function to make and consolidate hierarchies of Otherness" (pp. 32). This activity appears in the ways "care" is anchored to practices of diagnosing distress, capacity, and complexity associated and arranged under broader mechanisms of medical management (surveillance). This organising appears in the ways that granting access involves a variety of health professionals – including social workers – and institutions in governing specific modes of living through a medical logic that constitutes only some bodies as "treatable" and through an enduring colonial logic that produces "other" bodies through notions of defectiveness.

In this section, I have discussed the political and practice implications of changing diagnosis terminology, widening the sphere of authorised health professionals, and changing the rationale that standards are for discerning a "problem" of distress as a way of continuing to regulate access to medical technologies as "treatment". A proposal for determining distress as a method of depathologising "care" thus legitimates and expands the existing system, leaving little room for further problematisation of its harms and generating responses to the limits it places on "care".

Despite an unacknowledged presence of colonialism, I have also discussed how progress and recognition function in the SOC-7 as techniques of conditional futurity for people with self-designated genders in ways that tenuously but resolutely help to secure both settlement and the state. Understanding that governing in the SOC-7 operates through the preservation of an illness-based model for "care" and occurs as a continuation of the conditions of settler colonial state-making projects is crucial for contesting its revisions. Because the illness model maintained in the SOC-7 does little to disturb the coloniality that it legitimates, different problematisations are required for discontinuation through transformation. The following section evaluates the contrasting finding that when an illness paradigm is represented as an inherently problematic component of healthcare, its replacement concentrates on the complete reconceptualisation of governing access to gender-affirming medical technologies.

A strategy within a broader abolitionist political vision

This section presents an abolitionist political vision to summarise the findings from analysing the representation of the "problem" to be an illness-based model for "care". The analysis shows that the Guide governs access according to a rights paradigm that attempts to recreate the conditions of "care" in the Spanish healthcare system. This part of the analysis requires an evaluative discussion due to its provisional phrasing. I characterise the Guide as attempting to dispense with an illness model and its underpinning logic of medicalisation. However, I also suggest that the interactions between the Guide's underpinning logics complicate its open-ended proposal for an alternative model. Although this approach to depathologisation has enormous potential, it is just as likely to sustain as to dismantle colonial modes of governing gender. An abolitionist political vision helps to locate important points of overlap and disconnection in the Guide. Identifying the possibilities and limitations of a rights-based approach amidst uncertainty helps to sustain the focus on its liberal underpinnings and on the consequences of its colonial connections. Analysing the Guide's problematisation of an illness paradigm in the context of a broader abolitionist political vision makes it possible to think critically about its approach to depathologisation. I suggest that ongoing critical attention is imperative when an

approach to depathologisation expressly decouples access from a medicalised vision for "care" but raises doubts about dismantling its foundational colonial state-securing mechanisms.

Abolition refers to a broad set of actions occurring over generations within multiple social movements to eliminate systems of subjugation (slavery), practices of punishment (death penalty and solitary confinement), and carceral institutions (including prisons, locked hospital wards, and immigrant detention). Political activist, philosopher, scholar, and author Angela Davis (2016) explains that prison abolition is the disarticulation of "crime" and punishment through dismantling the Prison Industrial Complex (PIC). Abolition is undertaken more broadly within a framework that considers the intricate network of interests within and the connections across multiple industrial complexes that are perpetuated by racial capitalism and founded in colonisation. A relevant example of this critical work is the detailed diagram of the medical-industrial complex (MIC) created by disability and transformative justice activist Mia Mingus (2015). It utilises the framework of abolition to show how this industrial complex is constituted by profit, power, control, exploitation, ableism, oppression, violence, and trauma in a grid "connecting the outer broad categories to inner underlying motives: 'Science and Medicine' is connected to 'Eugenics;' 'Access' to 'Charity and Ableism;' 'Health' to 'Desirability;' and 'Safety' to 'Population Control'" (Mingus, 2015, see Appendix: MIC Visual). Recognising the importance of these connections, Davis (2016) remains adamant that within the abolitionist movement, "advocacy can and should occur in relation to [other] demands … and within other progressive movements" (p. 6) so that "the struggle for an abolitionist democracy is aspiring to create the institutions that will truly allow for a democratic society" (p. 26). For example, the goal of prison abolition is eliminating and creating lasting alternatives to the material structures of prisons which will require "undoing the society we live in" (Critical Resistance, 2019, para. 4). This undoing includes efforts at queering prison abolition and supporting an understanding that "enforcing gender conformity and heteronormativity" are vital features of an ongoing carceral state alongside "white supremacy, ableism, and xenophobia" (Stanley & Spade, 2012, p. 116). The goal of anti-psychiatry work is "nothing less than the abolition or end of the psychiatric system" that, like prison abolition, requires countering its public approval and state sanction, and devising its alternatives (Burstow,

2014, p. 37-38, introduced below). Keeping this larger vision in view, I cautiously discuss the Guide's approach to depathologisation as an abolitionist strategy.

A tentative position on the abolitionist potential of the rights-based model for "care" is distinct from the varied arguments against an abolitionist political vision. Geographer and prison scholar Ruth Wilson Gilmore recognises that abolitionist work invokes a "gut deep anxiety" for some people, especially with regard to ideas "that abolition means knock it all down, scorch the earth and start something new" (Gilmore & Lambert, 2019, p. 14). A participant in the group WPR analyses offered a comment that locates this intensity of feeling in the context of a health professional contesting illness-based policy problematisations in practice:

> It's that thing about scaffolding, isn't it? How can we be scaffolded in language that helps us? It's a funny thing. It's big … like psychiatry, for example, I'm continually drawn to it because I like the scaffolding, but I want to tear it apart at the same time. It's a strange process…

Another participant asked a different yet connected question in terms of policies as strategies for change:

> …because I think about it in terms of realms of control. What or where you're able to see change happen? And so, I got the feel that with the WPATH, it's like so change happens within the healthcare system ... and then it creates the problem because what is the issue … something that needs fixing not within the healthcare system but within the individual. Whereas within the Guide, it's positioning the issue as needs fixing is society, and when I think about realms of control and how do you make changes within society, it feels a bit more of a reach.

The concerns raised by activists in chapter two and those I elaborate on in chapter five reveal another

focus, not on the mechanisms of change but on their consequences. Namely, that de-medicalising gender self-designation and the removal of medical codes will likely delegitimise some people's need for, and further, jeopardise access to body modifications (e.g. Burke, 2011; Eisfeld, 2014). Reservations about depathologisation and de-medicalisation in abolitionist terms range from a kind of ambivalence to a belief that it is counterproductive.

Many activists clarify that the kind of change abolition seeks is not only about putting an end to but also creating alternatives to the conditions that create and permit harm. In response to concerns about the removal of the whole system of psychiatric labelling, anti-psychiatry scholar Bonnie Burstow (2014) argues that beneath "the reformist stance, whether it is expressed or not, is the contention that psychiatry has something to offer, is worth retaining, moreover, that to do otherwise is reckless" (para. 5). Naming the MIC as an oppressive system, Mingus (2015) conveys the nuance of such arguments from an abolitionist stance. Mingus (2015) stresses that "we are not anti healthcare or science, but are rather exposing the reality that many of us are dependent on the MIC while we are simultaneously trying to change it and ultimately build alternatives to it" (para. 6). This statement echoes the complexities of reliance introduced in chapter one, where Puar (2017) points out that many people with self-designated genders require costly technologies, protections of the law, and general accommodations, "from the very same institutions and apparatuses that functionalize gender normativities and create systemic exclusions" (p. 35). Gilmore is famous for her counterpoints to sentiments of anxiety and recklessness. Upholding a continuing commitment to the work that "requires that we change one thing, which is everything" is possible because "abolition is not *absence*, it is *presence*" (Gilmore & Lambert, 2019, pp. 14, emphasis in original). In other words, an abolitionist political vision seeks to eliminate economic and political systems, practices, and institutions that cause harm. Abolition occurs by recognising that "what the world will become already exists in fragments and pieces, experiments and possibilities" (Gilmore & Lambert, 2019, p. 14). Abolition thus requires a series of overlapping strategies for "building the future from the present" (Gilmore & Lambert, 2019, p. 14). I use an abolitionist political vision to discuss this

analysis of the Guide because its problem representation appears as a potential strategy for building another model for "care" out of repurposed parts of the old.

The analysis in this thesis shows how the Guide rejects the prevailing illness paradigm and its pathologisation of people with self-designated genders. Consequently, the answer to the first research question is that governing operates in the Guide through redesigning its purpose, function, structures, practices, and relations. It is a strategy that has significant overlap with a broader abolitionist political vision. The overlap appears in the Guide's demands that are clarified in chapter four, considered in chapter six, and the implications of which are scrutinised in chapter seven. As clarified at the outset of this thesis, these discourses and demands do not conceive of depathologisation as a single trans-specific issue but as one "part of the structural violence inherent to the social gender order" (Suess et al., 2014, p. 7576). Consequently, the "link between the demand of trans depathologization and a broader questioning of Western psychiatric classification systems and practices" generates "potential alliances with other critical theoretical reflections and social movements, among them intersex, body diversity, and antipsychiatry discourses and activisms" (Suess et al., 2014, p. 7576). Chapter five outlines the Guide's focus on providing "analytical tools" and "reference points" for replacing an illness paradigm and redesigning the purpose and function of "care". Its alternative protocol, practices, and relations are thus premised on a notion that "care" should improve the quality of a person's life, contextualised within a history of the harm caused by the pathologisation of gender self-designation and its function within an imperialist colonising mechanism.

Further analysis emphasises the Guide's concern about addressing the conditions of "care". Chapter five shows how the Guide seeks the removal of diagnoses related to gender self-designation from the DSM and ICD while challenging the legitimacy of psychiatry as a practice and a knowledge-system for governing access to gender-affirming medical technologies. Significantly, the Guide does not locate itself inside lesbian and gay activist histories but rather in a distinct political movement of recent origin that "takes many of its cues from the anti-psychiatry movement" (STP, 2010, p. 9). Thus, informed by anti-psychiatry, the Guide argues:

> Advocating for the depathologization of trans identities involves more than simply removing the disorder from the psychiatric manuals; it also involves, above all, the insistence that in the course of the medical treatments they require, trans people be viewed as active participants with the ability to make decisions for themselves, with autonomy over and responsibility for their own bodies, and capable of speaking with authority about their own lives—things that until now have been the exclusive province of the physicians. (STP, 2010, p. 9)

The scrutiny in chapter seven identifies this insistence on autonomy in decision-making and access without illness diagnosis as an attempt to democratise the structures and practices of "care". This democratisation corresponds with the demands for state-funded healthcare and for improving knowledge of medical technologies to guarantee access to the best quality healthcare. It seeks to eliminate, at least, the current fee-paying economic systems of "care" and the political system of "Western" essentialist binary gender and sex categories underpinning the construction of illness classifications for people with self-designated genders and people with innate variations of sex characteristics. It also seeks to change the pathologising practices within overarching institutions of trans health, including medical and associated professions, all of which cause harm. The overlap with an abolitionist political vision appears in an understanding that creating an alternative model for "care" is also about redesigning the ways that society is organised around gender. The importance of this proposal for a rights-based trans health policy in Spain is that it is relevant for developing multiple protocols that are responsive to local contexts. The Guide's attempt to create conditions for a liveable life for people who request access to gender-affirming medical technologies appears as an abolitionist mobilisation of many localised concurrent strategies.

Although the governing through a remaking of "care" in the Guide overlaps with abolitionist strategies, the findings from this analysis also reveal important points of disconnection. The previously quoted argument in the Guide incorporates a long-held radical perspective on securing

epistemic justice through knowledge de-subjugation into a liberal discourse that connects bodily integrity to individuality via the privileged position of proprietary rights. It is another echo of the complexities introduced in chapter one, where Puar (2017) asks: "How do people who rely on accessing significant resources within a political economic context, where the possessive individual is the basis for rights claims—including the right to medical care—disrupt the very models on which they depend?" (p. 35). As a result of this complexity, the answer to the first research question also motivates my caution in this discussion of the Guide's approach to depathologisation as being entirely abolitionist. The reflection in chapter five identifies this liberal governmentality as a web of complexity within a logic of rights that leaves uncertainty about what sort of transformation such a paradigm will provide. One point of disconnection from an abolitionist strategy is an objection to the imposition of diagnoses related to gender self-designation that does not extend to critical engagement with all mental disorder diagnoses. Chapter four shows how informed decision-making includes an idea about the "absence of identity delusions" alongside a more general assertion that "a prior psychiatric diagnosis" should not disqualify someone from "care" (STP, 2010, p. 28-29). This assertion implies that autonomy and responsibility in decision-making are (still) only available to those who are safe- and risk-free enough to become "active" decision-makers in their "care".

This troubling implication relates to preserving psy-mechanisms' biopolitical control. Chapter seven shows how preservation is realised in the SOC-7's containment of the Guide's assertion that prior diagnosis should not impede access with a statement that "significant medical or mental health concerns … must be reasonably well controlled" (Coleman et al., 2012, p. 34). The Guide generates a possibility for positive transformation by situating a dialogue about "identity delusions" within an overall process of accompaniment in self-determination. However, the extent for transformation is limited by the uncritical use of this psychiatric label that indirectly legitimates and normalises the imposition of other psychiatric diagnoses, even if they are not to become a barrier to accessing gender-affirming medical technologies. Attending to de-medicalisation alongside depathologisation, the Guide defends "treatment" as a means of establishing a livable life, rather than medically managing specific modes of living. Yet the disconnection with an abolitionist political vision remains

because of a latent tension in the Guide between outright rejection and tacit normalisation of different forms of pathologisation.

Another point of disconnection with an abolitionist political vision is found in the Guide's attempts to normalise access to gender-affirming medical technologies as the same as any other physical bodily process that requires medical "care", which links to the reflection in chapter five that considers how the underpinning logic of medicalisation interacts with this liberal logic of rights. The disconnection appeared in the group WPR analysis when participants used examples of "care" during pregnancy and in older age to critique the possibilities for change in relations by incorporating body modification into existing medical systems and practices. The propensity towards liberalism in this interaction between logics is emphasised when chapter seven scrutinises how an illness paradigm is pervasive in setting limits on rights-bearing subject positions. It is important to note that while I am discussing points of disconnection, I am not attempting to undermine the alternatives for trans depathologisation. Normalising the use of gender-affirming medical technologies as a physical process of the body is an important strategy. The concern is that even rejecting and re-placing a representation of the "problem" in these medical terms will adhere to a liberal constitution of rights-bearing economic subjects for appropriate management within current systems of governing. This uncertainty is not a reason not to proceed; rather, it is a reason to sustain attention on the conditions and consequences of proposed alternatives to deepen and facilitate the critical engagement with these difficult questions.

The complexity and uncertainty that emerge in the spaces between a radical vision and a liberal underpinning provide the keys to answering the second research question about the connections a rights-based approach to the governing of gender and access has to settler colonialism. As with the SOC-7, there is no straightforward answer to this question. I suggest that the redesign of governing in the Guide connects to settler colonialism through the liberal governmentality that lurks within a conceptual logic of rights. In this thesis, recognising colonialism as the foundation of modern government made it possible for the reflections in chapter five to highlight how the liberal assumptions *about* rights and the interrelationship *between* rights connect to State-securing colonial

logics of claiming proprietary ownership and granting citizenship. These reflections also point out how the Guide appears to detour around the liberal medico-scientific rationality underpinning the SOC-7 by producing active, autonomous, self-determining, rights-bearing subjects alongside health professionals as accompanying subjects and rendering both governable through rights.

I have suggested that setting out an alternative route of rights is how the Guide grapples with the dominant medicalising, self- and citizenship-making modes of recognising people with self-designated genders. Yet, as the critical moments in chapter six show, this strategy may not be enough to counteract an underlying liberal logic of (re)placing economic subjects within civil society for appropriate management. One of these moments is the Spanish legislative response to activist demands regarding changes to official identity documentation, which included numerous rights, not only legal recognition of trans status. Considering that Spain passed a law maintaining the "medical treatment" requirement shows how an imperial colonising State functions to biopolitically incorporate people with self-designated genders into the interlocking mechanisms of "Western" medicine and healthcare required to access the purported benefits of Spanish laws and citizenship. This pattern of selective uptake of demands is one that repeats across multiple settler colonial states. Platero (2020) outlines arguments by activists in this conversation about status relations. An argument emerges that because "transgender laws make it easier for people to change their name and sex on national and social security IDs and to access hormonal treatments in a self-chosen path, they mitigate the impact of transphobic violence" (Platero, 2020, p. 262). This argument calls to mind the dynamic of preservation through transformation described in the previous section, where change that gives the appearance of ending harmful practices elides the discriminatory, status-enforcing state action it preserves. Such an argument is countered by an assertion that "these actions rely on the individual being able to navigate the often transphobic social reality and do not directly tackle their economic marginalization" (Platero, 2020, p. 262). This conversation draws attention to parallels between the dominant governing of gender, which entails determining and managing the integration of bodies as biopolitical resources, and the governing of access to gender-affirming medical technologies and the benefits of citizenship through the recognition of (some) rights.

The publication of the ten additional Yogyakarta Principles (2017) provided another critical moment highlighting the limits of a rights paradigm which does not address its underpinning liberal governmentality. Built into the YPs is the necessity of being responsive to changes in human rights law and to understand the mutually constitutive and overlapping operations of human rights violations. Responsiveness allows an international non-governmental human rights organisation to generate a set of demands that escalates from *inclusion* in current legal norms to *recognition* that addressing compounding oppression is part of a State's human rights obligations. In referencing the YPs, the Guide adds an important layer of complexity to its proposal for producing multiple responsive protocols. Puar (2017) argues that there is a "steep cost of the intelligibility of transgender identity within national discourses and legal frames of recognition" that is the generation of "new figures of citizenship through which the successes of rights discourses will produce new biopolitical failures—trans of color, for one instance" (Puar, 2017, p. 34). Aizura (2006) makes a further connection, arguing that it is not only a matter of "being at home within one's body, but at home in the nation" (p. 295). There is a high cost in the liberal-democratic capitalist structuring of rights claims and the ways that citizenship:

> Means fading back into the population (and exercising the rights of populist democracy) but also the imperative to be 'proper' in the eyes of the state: to reproduce; to find proper employment; to reorient one's 'different' body into the flow of nationalised aspiration for possessions, property, wealth; to consider the responsibilities as well as the rights of being a recognised citizen. The most important of these responsibilities is to keep one's material difference from others private; that is, to sustain the public fiction that recognition of queerness or gender variance is gained under the aegis of universal entitlement, rather than because 'difference' has remade itself as non transgressive or non-threatening. (Aizura, 2006, p. 295)

Puar (2017) and Aizura (2006) render explicit the heteropatriarchal normativity and white supremacy inherent in these imperatives and responsibilities. When citizenship is so central to the possibility of

exerting rights, these inducements can be read as another iteration of settler common sense. Chapter four clarified the Guide's position that a healthcare system must do more than adopt a non-pathologising viewpoint and reconceptualise its involvement with people seeking access to gender-affirming medical technologies as laying the groundwork for their empowerment and self-worth (STP, 2010). Yet the presence of settler common sense appears in the Guide's emphasis on recognising people who modify their bodies within existing structures of citizenship. The alternative model for "care" in the Guide seeks to abolish one apparatus but clears the path for another in the same biopolitical mechanism.

The implications of a liberal governmentality are a crucial component of this analysis of the Guide in light of the biopolitics of settler colonialism. Narayan's (1995) argument, introduced in chapter five, is that a conceptual logic of rights emerges from a liberal ontology and epistemology as an agent of the colonial project. Narayan (1995) pinpoints the construction of a liberal rights discourse at a crucial time of increasing interdependent relations between "Western" colonising countries and their multiple colonies. The implication for the Guide's approach to depathologisation is the simultaneous identification and elision of colonialism in its rights-based model for "care". It is an unsurprising but significant finding, considering that the normative function of settler colonialism is to obscure itself while appearing both inevitable and final (Morgensen, 2011b). This is a foreclosure that generates uncertainty about how the elimination of the harmful economic and political systems, practices, and institutions associated with trans health can be achieved through a liberal paradigm of rights.

Uncertainty emerges in two places indicating another overlap and suggesting another point of departure from an abolitionist political vision. The first place is the identification in the Guide of how trans health is colonially conditioned by the "Western", medico-scientific model of sexuality, the body, and gender; and further, by the invention of "transsexuality" as a term to categorise, label and pathologise "the life trajectories" of people with self-designated genders (STP, 2010, p. 10). The second place is the identification in the Guide of how this pathologisation functions as part of a progress-oriented imperial-colonial mechanism. Chapter four clarified how this set of conditions is

offered as a contextual analysis that historicises the origins of pathologisation, the medical situation in Spain, and the current status of international trans depathologisation activism (STP, 2010, pp. 8-10). These conditions are the reference points that are used in the Guide for developing its alternative proposal. Chapter five suggests that the Guide's use of rights provides a way to grapple with dominant modes of state recognition as a result of access, and to produce "localised places" of responsive protocol development to address the colonial underpinnings of the governing of gender according to an illness paradigm. A hallmark of abolitionist activism is the use of site- and community-specific strategies. There is an overlap in the possibility of "localised places" unmaking North America and Western Europe as the places from which knowledges for protocol development emanate. The point of departure lies in the limitations on this transformation created by the elision of Spain's position as a European colonising nation. The literature reviewed in chapter two demonstrates that Spanish colonisation of islands now known as the Philippines was instrumental in creating a place for unintelligible, gender non-conforming Indigenous bodies as objects outside of what was considered human. This is but one example in the process of also invading, claiming, settling, and attempting to incorporate Mexico, large portions of Central and South America, multiple islands in the Caribbean, and parts of North America into the Spanish Empire. The governing in the Guide thus operates through selective attention to colonial mechanisms, identifying the colonial function of pathologisation while eliding the implications of Spain's complicity in the process. The Guide calls attention to the coloniality of an illness-based model, but the disparity with the abolitionist political vision is that neither its analytical tools nor its reference points appear to address the colonial mechanisms of its alternative model.

A further implication of the analysis in chapter five of the Guide producing "subjects", "objects", *and* "places" otherwise is a lack of attention to its entanglement with the underpinning colonialism implicated in these actions. Closely related to offering rights an alternative route for "care" is Arjonilla (2014) theorising how the Guide's "deep commitment to move over a pathologizing scheme based in a mental health disorder" enables consideration of the various ways this paradigm change creates space for different models of "care" (p. 42). Chapter seven shows how the Guide moves over

the need to legitimise requests for access by invoking the right to healthcare, and moves over the concern that de-medicalising jeopardises access by demanding that this "care" be publicly funded. This strategy to travel over a pathologising scheme adds to the uncertainty about detouring around because the connection to liberal governmentality and, thus, the biopolitics of settler colonialism are not challenged by arriving at the right to healthcare. Again, I am not attempting to diminish the alternatives for trans depathologisation. A change in paradigm is a valuable strategy because it creates space for considering what is underpinning and contained withing different models of "care". The uncertainty is not a reason not to proceed with a paradigm of rights, rather, it helps to sustain attention on the colonial conditions of its governing. These conditions are outlined in chapter seven, where Israel is discursively utilising its discretionary and limited state-funded healthcare as part of its "moral duty" to allow its people "to live their lives as they choose" (Joffre, 2021, para. 11). It is also how Ita Segev (2018), a transfeminine anti-Zionist Israeli performance artist, writer, and advocate residing in the US, was confronted by the realisation that the Israeli-owned Teva Pharmaceuticals has near-exclusive control of the supply of hormone technologies. These are two practical examples of how easily the investments in trans health are folded into the state-securing biopolitics of settler colonialism. However, joining the Palestinian-led Boycott, Divestment and Sanctions (BDS) movement, Segev (2018) and another trans activist have created an online resource that lists companies linked to Teva in a search for alternative hormone manufacturers. It shows how a refusal to accept Zionist attempts "to tie trans liberation to Palestinian oppression" generated an alliance with a human rights movement demanding an end to Israeli occupation and colonisation of Palestine (Segev, 2018, para. 13). The danger of proposing a liberal rights-based approach to "care" without ongoing critical attention is that the futurity imagined in the Guide is also a continuation of colonial nation-building projects.

The Guide's problem representation overlaps with an abolitionist political vision in ways that generate possibilities for replacing an illness paradigm, while its points of disconnection cause uncertainty about the extent of its transformative potential and ability to disrupt colonial structures. The example of how a refusal generated an alliance for action is crucial because it illustrates important sites of

contestation that support ongoing scrutiny of a rights-based approach. As mentioned in the introduction to this chapter, the genealogy of "care" shows how a colonial logic saturates many critical moments and spans at least two centuries. However, another moment illuminates generative distinctions between the liberal struggles for autonomy and a radical abolitionist position on gender self-determination. In the perpetual moment of external gender designation at birth, critical scholarship identifies how autonomy is coopted into the neoliberal responsibilisation of subjects, the privatisation of healthcare, and the perpetuation of colonial progress narratives. Within this literature, Irving's (2013) account of rights operating as an ideal form of biopolitical governance connects to Mol's (2008) argument that introducing logics into those already in existence alters daily practices in ways that, despite the improvements it hoped for, may not "fit well with the intricacies" of the people subject to those practices (p. 2). In other words, rights may facilitate conditions for a liveable life for people with self-designated genders at an international and localised level; but introducing a rights logic into the medical and gatekeeping logics of "care" may alter practices in ways that further obfuscates the necropolitics that marks certain groups of people with self-designated gender for social and literal death (Gossett, 2014; Puar, 2017). Stanley (2014) thus condemns the fiction of a human rights discourse that maintains state power by substituting a collective for an individual "self", and identifies the consequences of an attempted negation of "an ontological position always in relation to others and dialectically forged in otherness" (p. 90). These sites of contention are the grounding for an ethical stance that also offers important lessons for the ongoing critical investigation called for in this thesis.

In contrast with the demand for autonomy in the Guide, gender self-determination is presented as a radical political position and a collective praxis that offers a critical re-reading of legal recognition, the articulation of human rights standards, and changes to passport documents (Stanley, 2014). A political position of gender self-determination is unwilling to read "biopolitical shifts as victories" (Stanley, 2014, p. 90). What makes this refusal crucial in the context of trans health policy is that it resists the ways that "the state and its interlocutors, including at times trans studies, work to translate and in turn confine the excesses of gendered life into managed categories at the very moment of

radical possibility" (Stanley, 2014, p. 90). Abolitionist-oriented scholarship that is critical of a human rights discourse thus contributes to addressing the limitations of governing access through a paradigm of rights. The contestation of different orientations to depathologisation in a genealogy of "care" builds upon the material in chapter five, revealing a connection between the Guide constituting "care" as a continuing process of decision-making and situating itself in a continuing process of developing responsive, localised, non-pathologising protocols; it also serves as an important backdrop for chapter seven to show the difficulties in mobilising human rights as a basis for transforming relations and knowledge production. As one participant in the group WPR analysis points out, the Guide seeks change through being part of that change in a way that suggests a kind of collective praxis. The development of alternative models with their accompanying protocols for care is an ongoing process in which the Guide is participating. The uncertainty of such an open-ended process helps to focus attention on what it means to approach depathologisation by detouring around or travelling over rather than actively dismantling all the components of an illness paradigm.

In this section, I have connected this analysis to the critical abolitionist literature to demonstrate the importance of an analysis of rights that reveals how liberal governmentalities are interwoven with logics of settler colonialism. I have discussed overlap and disconnection as the possibilities and limitations of a rights-based approach. These include the possibilities of divesting from an illness-based model, and the limitations of upholding the function of psy-knowledges and professions in the practices of biopolitical incorporation. Also, the potential in producing an autonomous, self-determining, rights-bearing subject in relationship with an accompanying professional subject and the limits of appearing to step around and over how this (re)subjectification retains a connection to the apparatus of citizenship that is integral to mechanisms of coloniality. Also discussed are the possibilities of identifying a "Western" scientific model as an imperialistic colonising mechanism and the limitations of not extending critical attention either to the coloniality embedded in liberal human rights discourse or the colonial position from which the alternative protocol is developed. Discussing uncertainty about how governing through rights might maintain practices of biopolitical incorporation

supports analysis of how rights are also likely to operate as part of naturalising, maintaining, and furthering settler projects. This discussion also highlights the danger of an uncontested liberal rights-based approach to "care" normalising the underpinning assumptions of proprietary ownership, bodily integration, and citizenship central to multiple colonial projects. I have briefly discussed how a radical politics of gender self-determination offers a collective ethics of resistance and critical re-reading for interrogating and contesting developments in trans health policy. Contesting rights, their liberal underpinnings, and their relationship with coloniality shows that developing an alternative model for "care" in trans health is an ongoing process. Just as settler colonial state formation and maintenance is a process that includes the governing of gender, so too is the dismantling of the pathologising illness-based model of governing access to gender-affirming medical technologies. As the uncertainties in this process suggest, ongoing critical attention to the conditions and consequences of proposals for alternative models of "care" in trans health is imperative for depathologising gender self-designation and access to medical technologies classified as gender-affirming.

Conclusion

This chapter has used conceptions of preservation and abolition to discuss the findings of this comparative analysis of problem representations in the SOC-7 and the Guide. It has discussed what this analysis means for the governing of gender through the governing of access to gender-affirming medical technologies and, further, their connections to settler colonialism. In this thesis, the focus on denaturalising governing and its conditions formed an imperative to interrogate its colonial workings. The implications of findings from analysing the SOC-7 and the Guide in view of the biopolitics of settler colonialism is that depathologisation can preserve, legitimate, and expand the existing system and offer productive uncertainty about how the potential for its abolition can be achieved. I argue that ongoing critical attention to the liberal and colonial governing operating in models for "care" is imperative in trans health. Making sense of how governing in the SOC-7 operates through the preservation of an illness-based model for "care" and how this governing occurs as a continuation of the conditions of settler colonial state-making projects is crucial for contesting not only its revisions

but its existence. Discussing the findings from analysing the Guide in light of an abolitionist political vision helps to illuminate its liberal underpinnings as well as the uncertainty surrounding transformations that will disestablish an illness-based model but could still uphold the practices of biopolitical incorporation. Understanding that a psychiatric label of transsexuality has an imperial and a colonial function is crucial for developing an alternative model that seeks to eliminate economic and political systems, practices, and institutions of "care" that cause harm. Equally important, however, is a sustained and expansive examination of how a liberal paradigm of rights is part of the same mechanism. The significance of an abolitionist political vision is that it offers valuable lines of inquiry into what is creating and sustaining the conditions for "care" and provides an important framework for developing alternative protocol for responding to requests for access to gender-affirming medical technologies. Without this interrogation and a stance from which to proceed limits the realisation of depathologisation of gender self-designation and a total transformation of trans health policy. In the thesis conclusion that follows, I draw together the insights from this comparative analysis, comment on the effectiveness of a group WPR approach, and offer a self-problematisation that interrogates the position from which I argue for sustained critical attention on the development of trans health policy.

Chapter 9
Conclusion

This thesis has compared approaches to depathologisation in two trans health policies to investigate the governing of gender through governing access to gender-affirming medical technologies and its connections to settler colonialism. I compared problem representations in the prevailing professional standards to those in an alternative best practices guide because I had noticed that depathologisation was being used to push for improvements that seemed to have little effect on long-standing pathologising practices. While there is persistent concern about a continuing illness-based approach in established policies, there is considerably less concentration on how an alternative rights paradigm that attempts to replace harmful practices and relations may still help to secure colonial domination and state power. Utilising a poststructural sensibility that understands gender as a biopolitical apparatus, this thesis shows how governing access can preserve or potentially overturn structures of pathologisation as colonial practices of settling. It argues that sustained critical scrutiny of proposed alternatives is necessary to realise a non-pathologising transformation of trans health policy. This concluding chapter offers a summary of the key findings of this research and an additional discussion according to the ethic of self-problematisation, which is an integral part of the WPR approach to policy analysis. This chapter also includes a short discussion of the significance and implications of this research for continuing scholarship, activism, and practice. It then offers some closing remarks on the importance of these ongoing struggles for a liveable life.

Summary of findings

The analysis in this thesis investigates the mechanisms that surround and allow for body modifications classified as gender-affirming to interrogate how an approach can preserve or potentially abolish pathologisation. This is not simply because pathologisation structures harmful practices and relations in trans health but also because it is part of a mechanism that helps to secure

colonial state power and to maintain populations on stolen Indigenous lands. To address this concern, I asked how the governing of gender through the governing of access to gender-affirming medical technologies operates in the SOC-7 and the Guide and how it is connected to settler colonialism.

The thesis began with a literature review that critically engaged the field of trans health. Chapter two unmapped formations, enforcement, and negotiations within a white supremacist heteropatriarchal colonial system of governing gender as a critical starting point from which to investigate the governing of access to gender-affirming medical technologies. It also sketched a series of critical overlays and outlined the central depathologisation debates. Research on trans health policy that centres the lives lived by people with self-designated genders distinguishes distinct but overlapping practices and effects of medicalisation and pathologisation, and shows how these prompt different proposals and strategies for change. The chapter also introduced the concepts and critical analysis of biopolitics and settler colonialism, central to the poststructural theoretical framework that guides this thesis. This section describes how the research is scaffolded by pivotal trans-specific interrogations using a biopolitical analytic and the limitations illuminated by critical Black and ethnic studies scholars and critical Indigenous and settler colonial studies scholars.

Chapter three introduced the WPR approach as the analytical strategy used in this thesis. It detailed how it served as the methodology and method for analysing and comparing the SOC-7 and the Guide and how it was used to facilitate two group analysis sessions that contributed supplementary findings. This was a novel implementation of the WPR approach, supporting analysis from multiple subject positions and practice experiences that produced a rigorous comparison of the policies. This chapter also described the methods of recruitment and consent in data collection, participant demographics, and group session facilitation. Finally, this chapter introduced a form of reciprocal research used with the community of practice that participated in the group WPR analyses. Reciprocity began as a way of inviting research participation in return for something that could be directly useful to participants. However, recognising reciprocity as central to research by, with, and for First Nations peoples ultimately meant recognising the presence of Indigenous sovereignty in a way that provided an

opportunity to take up its invitations to responsibility. This chapter thus described building a relational, reflexive, and accountable research practice through reciprocation that directly supported collective organising by mental health practitioners. This process indicates that using the WPR approach with reciprocal research function as a generative methodological strategy for analysing approaches to depathologisation. The utility of this combination has the potential to extend beyond this research in that it encourages crucial scrutiny of the politics and relationships inherent in and needed for knowledge production.

The following chapters presented findings from a sequential application of the questions in the WPR approach. Chapter four provided a detailed reading of each policy, allowing the clarification of their problem representations. An application of question one revealed that "Gender Dysphoria" is represented to be a diagnosable health problem for which the SOC-7 provides clinical practice guidelines for its "treatment". Also, that a traditional, illness-based model is represented to be a paradigmatic problem for which the Guide offers a non-pathologising, human rights-based alternative that redesigns the Spanish healthcare system and its practices of "care". Despite its statement opposing the pathologisation of identities and expressions, the SOC-7 offers standards that govern access through the external, professional judgement of a person's gender-related distress to qualify for "treatment". In contrast, the Guide demands that "care" must be an autonomous, informed decision-making process directed by the person requesting access. It aims to abolish an illness paradigm in trans health and replace it with one of rights. Its approach to depathologisation indicates a complete removal of one model to make way for the installation of an alternative. Rights provide the framework for the Guide's further demands for quality, publicly funded healthcare, body modification without an illness diagnosis, and a focus on improving medical technologies. For this reason, the SOC-7 was argued as utilising an illness diagnosis and treatment model, and the Guide as proposing a form of access that divests itself of a logic of medicalisation.

The purpose of chapter five was to reflect on the conceptual logics of medicalisation and rights that circulate beneath and are put to use in representing the "problems" to be the distress of "Gender

Dysphoria" and an illness-based model for "care". This response to WPR question two highlighted a medical presumption that a request to affirm self-designated gender by modifying one's body indicates a form of illness that requires treatment. It also highlighted how ideas of "human" and universal often assume a neutral and non-hierarchical position in rights discourse. Suggesting an interplay between these logics in the Guide called attention to the liberal rationality that lurks in constructions of, justifications for, and strategies that contest pathologisation.

Paying attention to the patterns in liberal rationalities reveals how the SOC-7 advances medicalisation as a universally applicable mode of governing access and achieving depathologisation. In contrast, the Guide offers a rights paradigm to decouple diagnosis *from* "care", democratise the model of and relations *in* "care", and formulate locally responsive non-pathologising protocols *for* "care". However, even with this layered approach to depathologisation, the Guide invoking responsibility for the process does not appear to deviate far from the liberal governing that produces political subjects for appropriate (self) management within established social relations. In other words, producing active, autonomous, self-determining, rights-bearing and accompanying subjects does little to challenge the neoliberal responsibilisation within contemporary "Western" healthcare, nor does it attend to the ways proprietary ownership, bodily integration, and citizenship aligns with colonial political projects that create and maintain the terms of recognition by the state. While there is scope for significant modification of these presuppositions, this chapter introduces the uncertainty that emerges from the complex interaction between conceptual logics and governmental rationalities in the Guide. The findings in this chapter underscore the importance of directing attention to the dynamic ways that conceptual logics, governmentalities, and colonial power appear in the processes of un/making "care" in trans health policy.

The task of chapter six was to consider what made it possible to represent the "problems" to be the distress of "Gender Dysphoria" on the one hand and an illness model on the other. Question three of the WPR approach prompted a genealogical study of how people who request body modifications classified as gender-affirming become subjects of "care". The consideration of twelve critical

moments uncovered multiple ways that "care" has functioned as foundational in enforcing a colonial white supremacist binary gender system and as a way to secure, authorise and protect hegemonic medical authority and state power. These critical moments also reveal how these opposing problem representations came about through an array of historically contingent techniques and tactics for constructing and governing access. Such activities are interwoven with multiple conceptualisations and practices of gender self-designation in a tenacious struggle to maintain their focus, shift their attention, and ultimately refuse to accept their legitimacy in light of their often-devastating consequences.

Chapter seven looked closely at what follows from each approach to governing access. It combined three WPR questions to scrutinise what each policy is silent on (question four), the effects produced by each problem representation (question five), and how these problematisations are authorised and contested (question six). Analysis of how the SOC-7 sets the assessment of distress as the threshold for "treatment" reveals an approach to depathologisation that does little to change the purposes, practices, and power relations of mental illness diagnosis. This governing through eligibility and verification, approval and denial/delay is also the regulation of a renewed or continuing existence for people with self-designated genders. It is a conditional futurity that illuminates how the biopolitical projects of settler colonialism operate within the SOC-7.

Analysis of the Guide creating the conditions for a liveable life illuminates an approach that attempts to rearrange the response to a request for access to gender-affirming medical technologies in multiple and overlapping ways. This is an approach to governing that alters the function of "care" through demands for a change in paradigm, knowledge production, positions, and practices. The analysis examined examples of depoliticisation, containment, and backlash that reveal ways in which power in "care" is produced and contested along multiple modalities (listening, dialogue) and points (research, legislation). An incisive critique from research participants of the supposed neutrality of medical care revealed the difficulties of a proposal that requests for access to medical technologies should be seen the same way as "other physical processes of the body … that require medical care" (Arjonilla, 2014,

p. 38). The findings in this chapter underline that non-pathologising and non-medicalising conditions for "care" can be brought about by redefining roles and relations, divesting from psy authority, respecting self-designation and valuing experiential knowledges, alongside total unconditional funding for the entirety of "care".

Chapter eight discussed the findings from analysing the SOC-7 and the Guide using the WPR approach. It discussed how preservation through transformation, as an analytic, helps to establish the importance of findings from analysing the representation of the "problem" to be the distress of "Gender Dysphoria" in the SOC-7. Preservation occurs by the SOC-7 authorising psychiatric knowledges and the judgement of expert health professionals, maintaining established hierarchies in healthcare, and expecting all of this to be taken up through worldwide use. The transformation is in shifting the problematisation of identity to distress. Attention remains at an individual level, with limited problematisation of social and economic components or the process itself. Representing the "problem" in diagnosis and "treatment" terms continues even though it has been demonstrated to be harmful and is recognised as part of a colonising mechanism. Components of this mechanism that have been identified include setting the terms of state recognition, enforcing systems of classification and surveillance as forms of elimination, and using consent for containment. When an illness paradigm is represented as an irreducible component of healthcare, depathologisation that advances a logic of medicalisation appears as an inevitable and reasonable means of governing access to gender-affirming medical technologies.

This chapter also discussed how an abolitionist political vision helps to establish the importance of findings of uncertainty about what sorts of transformation the Guide's alternative proposal for governing access from a rights-based approach will provoke. In problematising "care" at a paradigmatic level, the Guide focuses on a person's right to access quality, publicly funded, gender-affirming medical technologies free from psychiatric requirements. It links a medico-scientific model to a colonising mechanism. It substitutes diagnosis and treatment for a position that practitioners are to accompany trans people who are experts on and responsible for their own processes. The Guide's

critique signals the potential for disrupting colonial structures. However, this chapter also discussed the implications of uncritically mobilising a human rights paradigm as a basis for the multiple points at which the Guide seeks to disestablish a medical model for "care". The purpose of this discussion of uncertainties was not to say that depathologisation should not proceed from a rights model but that there needs to be critical attention. In light of these uncertainties, a radical politics of gender self-determination is presented as one approach that offers a collective ethics of resistance and a critical re-reading of developments in trans health policy.

This thesis argues for sustained critical interrogation of the liberal and colonial governing that trans health policy relies on and is producing. This argument is formed from the generative uncertainty about the transformation achieved through the liberal rights model in the Guide. However, the rigorous historical research in trans health offers a reminder about how uncertainty is also pivotal to preserving psy-authority and an illness model (Velocci, 2021). Conceptualising problematisations in a dynamic political space of conversations has deepened this analysis and helped to convey the complexities in approaches to depathologisation. Hale (1997) and colleagues' advice to non-trans writers that understanding comes from paying attention to ongoing, overlapping discourses that involve multiple positions and complex power dynamics remains relevant a quarter century after it was first delivered.

Self-problematisation

While the WPR approach facilitates analysis of what is within, surrounding, and created by the SOC-7 and the Guide, maintaining an ethic of self-problematisation is essential to the critical thinking it offers. Investigating my thinking means applying the WPR questions to my own proposals and problem representations (Bacchi & Goodwin, 2016). At different points throughout this thesis, I discuss how I am a white settler researching from within a genocidal land-grabbing project. I am also researching as a qualified social worker and a youth worker with a history of practice in LGBTIQA+

homelessness spaces. I am also a queer, cis, university-educated, contract-working, chronic illness-suffering, adopted person. I have undertaken an analysis of trans health policy in relationship with a group of practitioners who provide therapeutic support for non-binary, trans, and gender diverse people. I bring a lot to this process that shapes my thinking. However, the self-problematisation in Step 7 of the WPR approach is a directive to go further than "easy-to-make declarations" and take up "a precise and demanding *activity*" (Bacchi & Goodwin, 2016, p. 24, emphasis in original). In this thesis, I argue that positive transformation in trans health policy is politically limited without ongoing critical scrutiny of colonial power. Following Step 7, I discuss two aspects of who I am and how it shapes my thinking in ways that are important for how I represent the problem to be the inherent coloniality of governing access to medical technologies.

My focus on depathologisation in this research is shaped by who I am as a person with a chronic illness that relies on injectable hormones. Step 7 directs me to identify my preferences in proposals and "check out" how my thinking and ideas are lodged in particular aspects of my position and upbringing (Bacchi, 2014). The point is to examine not *if* but to *what* extent I am implicated in standard, commonly accepted, and authoritative knowledges and how it modulates this analysis (Bacchi, 2014). As a young child, I was diagnosed with insulin-dependent diabetes mellitus (IDDM), or Type 1 diabetes. A chronic illness diagnosis is one aspect of who I am that has bound my thinking up in discourses and practices of management for autoimmune disease and associated depression. Undertaking a genealogy of conditions of "care" in trans health, I learned that before synthetic manufacturing, pharmaceutical companies chemically isolated hormone preparations from urine. Specifically, the hormone-rich urine of pregnant horses sold by farmers and slaughterhouses, the urine of pregnant women obtained from gynaecological clinics, and the urine of men collected from factories, military barracks, and prisons (Oudshoorn, 2003). I also learned that the Dutch pharmaceutical company Organon established its dominant position in the industrial hormone market with insulin because it "was considered a "respectable" drug for a well-defined disease (diabetes)" (Oudshoorn, 2003, p. 82).

The analysis drew my attention to the histories of diagnosis, which have complex relationships with justifying and developing "treatments". For example, I recalled learning about the widespread punitive use of catastrophic "insulin-shock" or "insulin-coma therapy" on people held in psychiatric institutions who received "schizophrenia" or "psychotic personality" diagnoses. This type of "treatment" was, unsurprisingly, more likely if the person was labelled "difficult" or "irredeemable" because they were poor, Black, or gender non-conforming (e.g. Ryan, 2022, in a US context). My thinking shifted as I realised that I had underestimated how much white supremacy shapes the function and use of mental illness categories in colonial capitalist biopolitics and necropolitics. It focused my attention on the knowledges, professions, and practices that are granted authority to preside over decision-making. Delineating the different political understandings and purposes of informed consent, autonomy, and self-determination has been crucial for this analysis. I am implicated to the extent that I have ready access to the hormones I inject daily and am a qualified social worker. However, I am still problematising approaches to depathologisation in "care" that I have no direct experience seeking. My proposal for ongoing critical analysis is based on findings of generative uncertainty about a liberal rights model in the Guide. However, rigorous historical research warns me that uncertainty is also used in the trans health space to preserve psy-authority and an illness model (Velocci, 2021).

My focus on the shoring-up settler of colonial governmentalities is shaped by who I am as a settler. Considering that complex, colonial geopolitical relations are woven into the SOC-7 and the Guide has helped me develop a perspective on my own social position, one that is sharpened by the fact that I was adopted as a baby at the end of the 1970s. I discovered my Italian and Scottish heritage after reading a hospital social worker's notes in my adoption file. Put another way, I am a white European adoptee whose access to culture is normalised by its pervasiveness but limited by my birth mother placing her name on a Contact Veto Register designed to counter the damaging legacy of secrecy and coercion in Australian adoptions before 1990 (Community Affairs References Committee, 2012). I can situate myself at a particular point in the Australian settler colonial project because of policies designed to secure white middle-class heteropatriarchal "Australian" family norms. However, the role

of “free and informed consent” in my being “given up” for adoption remains a mystery.

State-making adoption policies have irrevocably changed my life, yet I gained a lot because of my parents’ (birth and adoptive) social position. I am implicated in the recommendation for ongoing critical scrutiny to the extent that I am a social worker and a critical scholar, and I am problematising colonial power as a settler who benefits from colonisation. As I moved through the analysis, slowly, I began to recognise the prompts offered by First Nations scholars for settlers to develop ethical and meaningful relations. These were brought into focus by the assertions (demands) of Indigenous sovereignty made clear within anti-colonial scholarship and radical decolonial movements in multiple places (Estes, 2019; Land, 2015). This research is thus shaped by my understanding that First Nations peoples do not waver on the centrality of respect and relationality to culture. Nor do they lose sight of the political purpose of articulating First Nations as self-determining polities and naming the ongoing projects of extractivism and dispossession along heteropatriarchal binary gender lines as colonial genocide. So, when I argue for sustained attention to colonial power but not Indigenous sovereignty, I am aware that I am foreclosing further generative questions: What changes when policies are recognised as colonial artefacts? How can recognition of the enduring presence of Indigenous polities and laws in place shape access to gender-affirming medical technologies? What relations are required for this work?

My location within the political landscapes of responding to requests for access to gender-affirming medical technologies has shaped this analysis of trans health policy. This self-problematisation shows how I approach “problems” as complex and contingent and how this analysis generated a more nuanced anti-colonial abolitionist stance. It highlights the importance of questioning the political work of governing through concepts of informed consent and decision-making, autonomy, and self-determination in approaches to depathologisation and beyond. I cannot and should not do problematising, re-problematising, and self-problematising work alone. Moving beyond easy-to-make declarations to take up these precise and demanding activities requires accountability and repair through relations.

Significance of findings

Trans health policy plays a significant role in the lives of people with self-designated genders and the practitioners who respond to their requests for access to "care". However, its role in maintaining colonial nation-states and the constantly re-asserted claims to sovereignty over occupied lands is no less significant. I have approached this critical comparative analysis with a poststructural sensibility. I have considered the ways in which gender operates within a complex mechanism concerned with managing all bodies – or rather, populations of bodies – through a complex array of administrative practices (Stryker, 2004). Existing critical analyses have examined how settler colonialism functions as a biopolitical mechanism that disavows the humanity and experience of some groups to justify dispossession and facilitate the settlement of others (see for example, Moreton-Robinson, 2006; Morgensen, 2011a). I draw upon these considerations of gender as an apparatus within the biopolitical mechanism of settler colonialism and apply them to the proposals for governing gender in the SOC-7 and the Guide. This application of a poststructural theoretical framework opens additional space for political thinking. It adds to critical accounts of the oppression inherent in settler colonialism by examining how trans health policies preserve and potentially interrupt ongoing efforts to naturalise the colonial conditions in which self-designated gender is governed.

This research offers several methodological contributions to the field of trans health and also to conventional and critical policy studies. Using the WPR approach, I have engaged several of Foucault's analytical concepts. Foregrounding a critical application of a biopolitical analytic alongside problematisation, genealogy, and analysis of discursive practices, governmentalities, and subjectification, I have expanded the scope of the WPR approach while maintaining its poststructural premise. By making Morgensen's (2011b) theorisation of the biopolitics of settler colonialism a central part of the theoretical framework, I have been able to think about the deeper implications of each policy's representation of the "problem". I have also described a novel application of the WPR

approach. First through the facilitation of group policy analysis sessions to generate data from a broader range of perspectives, and second through a reciprocal research strategy that contributed directly to participants' ongoing collective organising. The significance of using the WPR approach with reciprocity in research is its capacity to generate critical scrutiny of and accountability to the political work of forming relationships for and through knowledge production. This approach to the research contributes to the innovative and responsive ways that the WPR approach can be applied. It contributes additional ways to make visible the colonial conditions of governing through policy. It also shows that the histories and present forms of collective organising outside the academy offer multiple ways to engage in the political work of knowledge production.

Through my account of problem representations in two trans health policies, I have analysed different approaches to depathologisation and identified ways that they preserve and could potentially disestablish an illness model and interrupt the colonial conditions of "care". In this way, I have built on the work of trans health researchers such as Arjonilla (2014), Davy, Sørlie, and Schwend (2018), Dewey and Gesbeck (2017), Lane (2018), and Pearce (2018) to better understand the governing of gender that takes place through the SOC-7 and the Guide. In addition to contributing an updated policy analysis in such a rapidly changing field, my account of trans depathologisation expands the field by exploring how it is constrained by its function within colonial projects. These explorations offer lessons that are relevant to many fields of study. However, the potential to transform social work practice through commitments to reciprocity and widen the frame of critical analysis is at the forefront of my mind since social work is the discipline from which this research is undertaken. The findings of this comparative research in trans health support a claim that *all* policy analysis should be concerned with the colonial conditions of governing, no matter how tenuous the link may seem.

Implications for further research

This research occurred during the revision of the SOC-7 and was completed before the official release

of the SOC-8 (Coleman et al., 2022). There appears to be a remarkable, positive transformation in the development and content of the SOC-8 that, when coupled with the new WPATH standing ethics committees, represents the first time in the history of the field "where trans folks were officially and actively consulted regarding the treatment they received" (Malatino, 2020, p. 64). The SOC-8 is now explicitly rooted in fundamental human rights. It also shifts the focus from the roles of practitioners to "what should and should not be offered with gender-affirming care, and the settings in which these guidelines should be applied to promote equity and human rights" (Coleman et al., 2022, p. 58). This engagement with people who receive "care", grounding in fundamental rights, and the shift of focus onto care and widening its scope are strategic moves in achieving trans depathologisation. The findings of this research on the preservation of an illness model, combined with the uncertainties about the transformation premised on a liberal model of rights, support the ongoing investigations of how much movement there is away from illness diagnosis and its hierarchy of subject positions.

Bacchi (2021) explains that WPR is not put forward as a method "for devising policy "solutions" but for critically commenting on the "solutions" (policies) that have been put in place" (para. 2). The call for ongoing critical attention can open space for thinking and strategy beyond a dilemma of either illness or rights. In practical terms, sustained critical attention through further research could mean developing alternative models that reject liberalism and recreate conditions for "care" that emphasise rights and justice to promote respect. Stryker argues that such efforts "encourage us to begin thinking of rights from a 'post-humanist' perspective, and to envision justice in ways that exceed the framework of rights and representation altogether" (Balzer & Hutta, 2012, p. 12). The scope of such an approach highlights how critical scholarship, research, and activism are closely intertwined through practice.

The politics and practices of Indigenous sovereignty and self-determination, such as those emphasised in this thesis, can help maintain research attention on the broader political and material contexts of "care" in specific places. For example, Puar (2017) discusses the impact of war on healthcare in Afghanistan and Iraq with a summary of research on the effects of US military invasion and

occupation simultaneously overwhelming and incapacitating systems and provision of care. It raises important questions for the Guide's proposal for formulating multiple responsive, place-based, non-pathologising protocols for governing access: How does an accounting of ongoing wars factor into drawing up these protocols? What would colonising nations need to relinquish and provide to meet local demands? Going further, what does it mean to be attempting to secure rights from an occupying colonial state? Answers to these questions will likely include thorny issues of ceasing occupations and extractive capitalism, returning land, paying reparations, and resourcing infrastructure for (re)building alongside cultural and ecological restoration and repair. The increasing presence of far-right political parties actively working to dismantle rights and the combined health and economic effects of the Covid-19 pandemic generate an urgency and involves further complications of these issues (see Platero, 2020, for discussion of the Spanish context). These are additional components for work that is, in many ways, undertaken in contexts that are hostile to radical change. Any answers will require sustained interrogation of the logics, conditions, and consequences of the vision for radical transformative change.

Closing remarks

This research has examined approaches to depathologisation in trans health policy because it impacts the lives of people with self-designated genders who seek access to "care". Approaching gender as part of a complex mechanism through which power takes control of life (and sanctions death) through the body at the level of the population has made it necessary to consider its function in efforts to dispossess some people so that others can settle on stolen territory. Because different protocols produce contrasting political subjects and relations, the histories, locations, and approaches to depathologisation require ongoing critical attention.

Asking how different approaches to depathologisation form into governing in trans health policy has, at times, felt misdirected in the context of escalating anti-trans abuse used in service of right-wing populism. I completed much of this research under Covid-19 stay-at-home restrictions. One gloomy

winter's day, I checked the mail after returning home from my daily walk. I found a high-quality glossy leaflet from the right-wing conservative Australian Christian Lobby (ACL) in my letterbox. It featured a photo of two hands restrained by handcuffs with the slogan, "Parents like you could be jailed for ten years under new law", emblazoned underneath. The leaflet was delivered in anticipation of debate on the Victorian parliament's Change or Suppression (Conversion) Practices Prohibition Bill. The Bill was designed to eliminate coercive practices restricting the expression of non-normative sexuality and gender identities. The leaflet tried to incite reactionary fears about being reported, investigated, and prosecuted for "having the "wrong" conversation with your kids" about their gender (see, Yuen, 2021). Around the same time, my elderly neighbour struck up multiple conversations with me because she was astonished and frustrated that she was apparently no longer allowed to refer to her grandkids using gender pronouns. A year later, another leaflet was delivered in anticipation of the state election tying the introduced Bill to the party currently in power. This leaflet claimed that "The right to parent your own children is being threatened" and was followed by a spurious suggestion that there is a "plan to let the Government decide if your child can transition their gender". In this context, there have been times when I have questioned what this research means for people holding the line and stopping it from going backwards. Yet, considering my work with the community of practice who participated in this research, there is meaning to be found in its connections to experience and the rich radical traditions of working collectively using theory in practice.

In this critical comparative policy analysis, I have questioned what it would look like to redesign non-pathologising healthcare systems. Also, ways to disrupt prevailing constructions of agency, rights, and the role of a healthcare system and its practitioners in the lives of people with self-designated genders. My thinking about the depathologisation of trans health at the level of governing and how to take it further is made possible by the accomplishments of the critical thinkers and activists who have gone before me and who remain in the struggle. As this analysis has increased my capacity and deepened my commitment, I am enlivened and encouraged by the collective work currently for depathologisation to address the conditions and structures of violence and harm.

Appendix

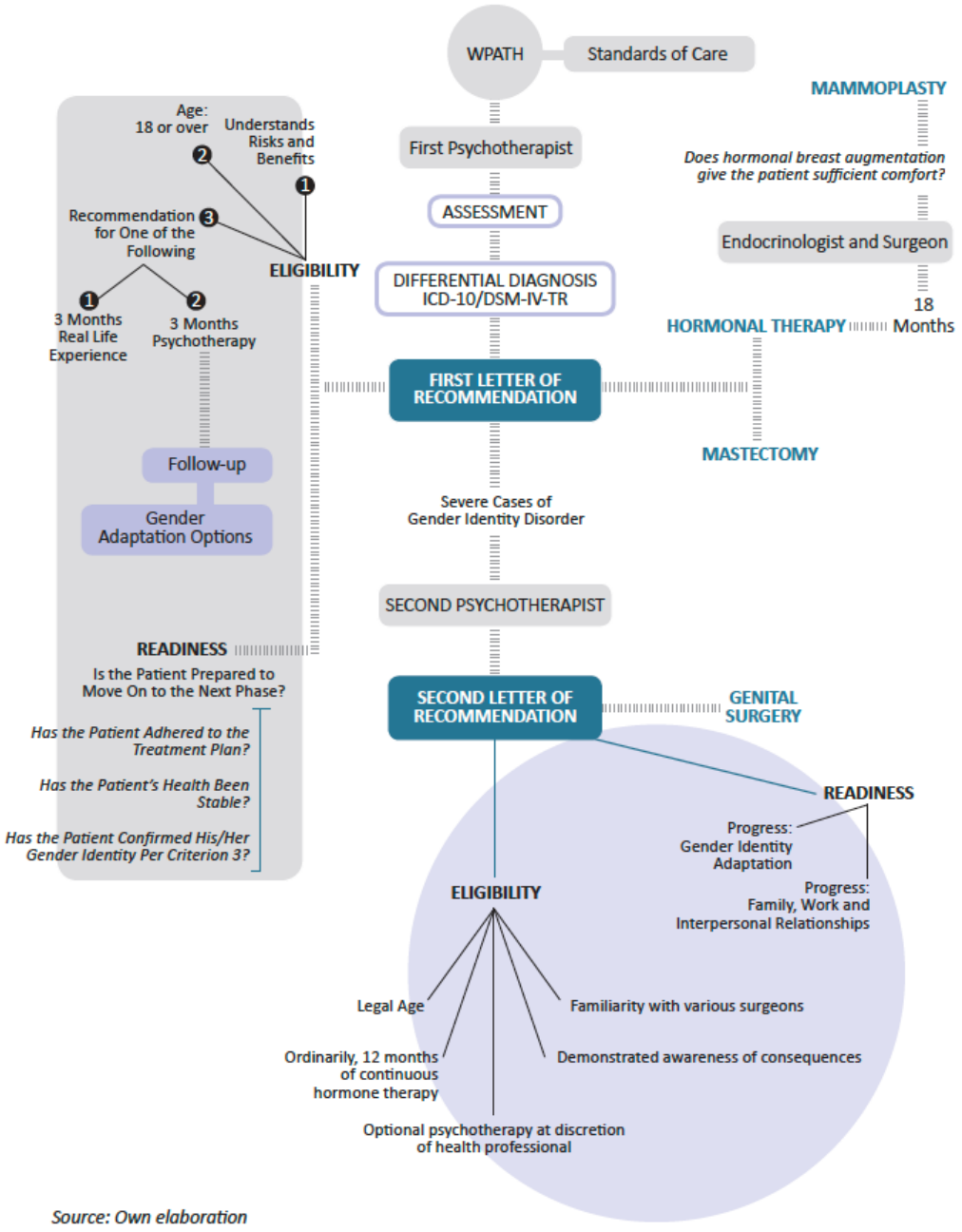
Policy overview

1992	2000	2002	2010	2012	2015	2019	2020
ICD-10	DSM-IV-TR	SOC-6	The Guide	SOC-7	DSM-5	ICD-11	SOC-8
Categories include: Transsexualism Gender identity disorder, Gender identity disorder of childhood, Sexual maturation disorder, and Ego-dystonic sexual orientation as part of Disorders of sex development.	Categories include: Transsexualism, Gender Identity Disorder, Gender Identity Disorder of children, Gender Identity Disorder Not Otherwise Specified, Transvestic Fetishism, Autogynephilia.	Relies on ICD-10 and DSM-IV diagnostic categories. It also used a set triadic therapeutic sequence of care: psychotherapy and DSM diagnosis (1); hormonal treatment (2); sex reassignment surgery (3).	Rejects a pathologising illness paradigm. Demands a system of care that permits body modification without an illness diagnosis.	Emphasises the shift of focus from identity to experiences of distress at such a level that meets criteria for a Gender Dysphoria diagnosis.	Replaced diagnosis of Gender Identity Disorder with Gender Dysphoria, maintains a Disorders of Sex Development specifier. Also maintains	Replaced ICD-10 mental illness categories with Gender Incongruence of childhood, adolescence, and adulthood categories in a new chapter, Conditions related to sexual health.	The first time trans people have been officially and actively consulted in the process. Focusing on assessing gender incongruence, it is explicitly grounded in fundamental rights, shifts focus onto care and widens its scope.

Diagrams of Care Protocol in the Guide

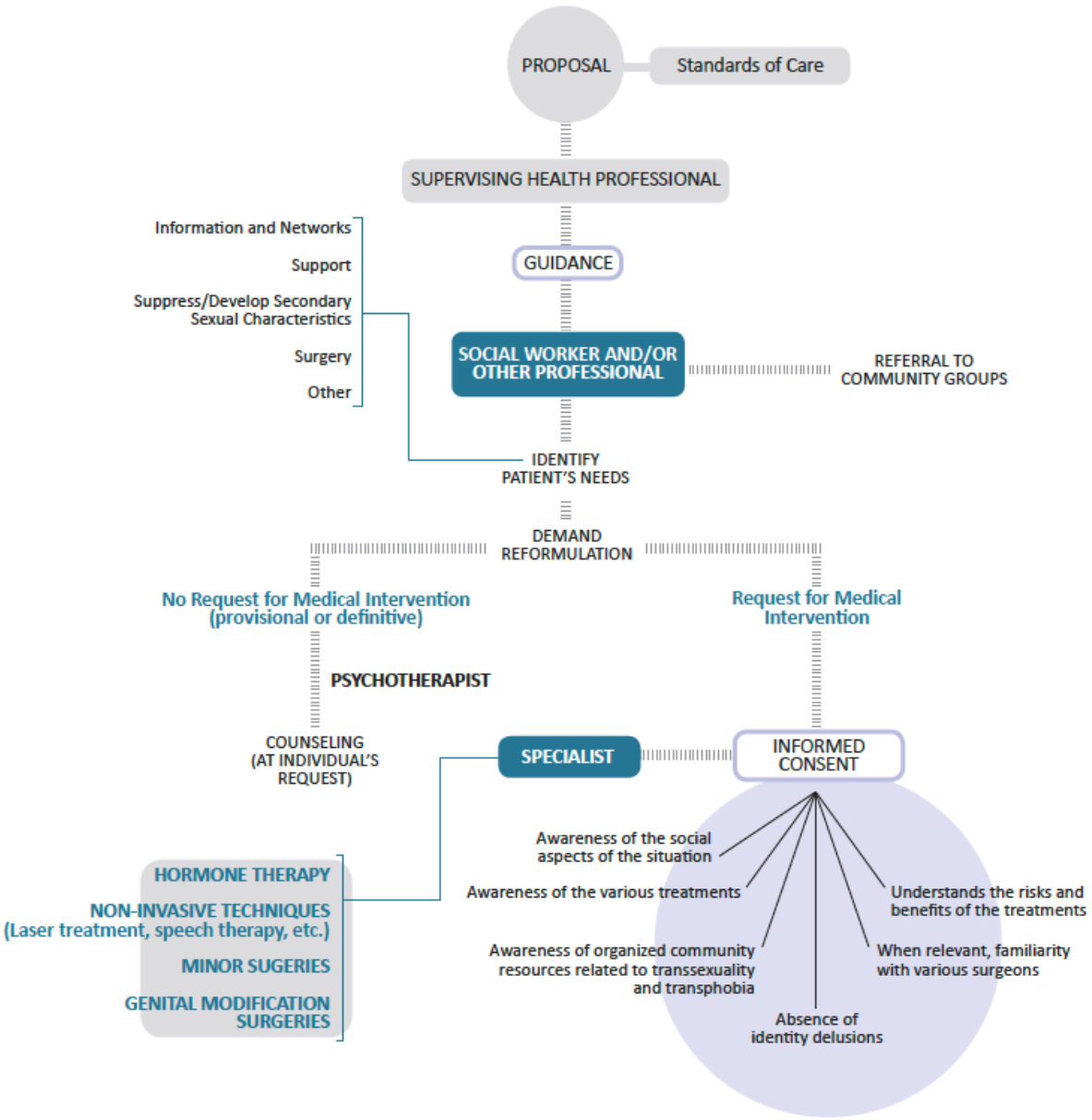
The following two figures appear in the Guide as a visual description of the SOC-6 protocol (p. 25) and its proposed Best Practices protocol (STP, 2010, p, 28). These diagrams are included in the appendix as a useful reference.

Figure 1: The Treatment Process under the Standards of Care



Source: Own elaboration

Figure 2: Proposed New Protocol for Best Practices for Trans Health Care



Ethics approval

THE UNIVERSITY OF SYDNEY

Research Integrity & Ethics Administration
HUMAN RESEARCH ETHICS COMMITTEE

Monday, 14 January 2019

Ms Emma Jane Tseris
Social Work; Faculty of Arts and Social Sciences
Email: emma.tseris@sydney.edu.au

Dear Emma Jane,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

I am pleased to inform you that after consideration of your response, your project has been approved.

Details of the approval are as follows:

Project No.:	**2018/948**
Project Title:	**Challenging a sacrosanct tradition: Depathologising people whose gender is self-designated who seek access to medical affirmation technologies.**
Authorised Personnel:	**Tseris Emma Jane; Howe Rebecca; Rawsthorne Margot;**
Approval Period:	**14 January 2019** to **14 January 2023**
First Annual Report Due:	**14 January 2020**

Documents Approved:

Date Uploaded	Version Number	Document Name
20/12/2018	Version 1	Safety Protocol
20/12/2018	Version 2	Participant Consent Form
20/12/2018	Version 2	Participant info statement (individual)
20/12/2018	Version 2	Participant info statement (group)
20/12/2018	Version 2	Email introduction letter
05/11/2018	Version 1	Poststructural Policy Analysis
24/10/2018	Version 1	Focus group topics and sample questions (rhow3518)
24/10/2018	Version 1	Conditional participant approval (rhow3518)

Special Condition/s of Approval

- It is a condition of approval that all font (including footers and page numbers) is changed to black for consistency prior to distribution. You do not need to submit copies to the Ethics Office.

Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - Serious or unexpected adverse events (which should be reported within 72 hours).
  - Unforeseen events that might affect continued ethical acceptability of the project.
- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).

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CRICOS 00026A

Invitation to participate in research

Invitation to participate in PhD Research Project:
Depathologising trans and gender diverse people seeking access to medical gender affirmation.

Hello,

My name is Rebecca Howe. I am a PhD candidate in the School of Education and Social Work at the University of Sydney. I am writing to invite members of the [Group] to take part in a second focus group for my research which is looking at the complexities of work to depathologise trans and gender diverse people who seek access to medical gender affirmations.

Why us?

My research study seeks to bring together a pre-existing group of practitioners to critically examine two policies for granting access to medical gender affirmations. The [Group] is invited to participate in this study because the group's members have direct experience supporting trans and gender diverse people who are seeking such medical services.

This is a 'reciprocal' research project.

This study operates on the premise of reciprocation, as a way to recognise the time and labour involved in supporting and participating in the research. Members involved in the organising of the [Group] are in negotiation with the researcher about a reciprocation/trade/exchange of time and labour between me as a researcher and the group as a whole. If you'd like to know more about this process, feel free to contact me (details below).

What would the research involve for me?

Participating in the research involves participating in an online facilitated [Group] meeting via the Zoom meeting platform Thursday 27 June 8:00am-10:00am (2hrs) to make a critical comparison between two policies of "care" for people who are trans and gender diverse.

The meeting includes a short introduction to the 'What's the problem represented to be?' (WPR) approach to policy analysis; then a workshop to use that approach to analyse excerpts from two policies. These are the WPATH Standards of Care version 7, and the Best Practices Guide to Trans Health Care in the National Health Care System (the Guide), developed by the Spanish Network for

Depathologization of Trans Identities.

What benefits come from my participation in this special [Group] meeting?

As well as contributing to research seeking social justice for people who are trans and gender diverse, there is an opportunity for professional development by participating in a facilitated peer exchange.

We will be looking at how two policies produce an understanding of “problems” of “care” for trans and gender diverse people, and what is operating through these two policies. There is much to be gained from applying skills and experience from your work, alongside fellow practitioners and a facilitator with a depth of experience, to consider formal documents written to guide your practice.

I'd be interested, what do I do?

Have a look at the attached Participant Information Sheet as it includes more information about the research. If you're still interested, simply RSVP by replying to this email and I'll send you the link for the meeting, extra info for the day and a consent form to sign.

Participant information statement

THE UNIVERSITY OF SYDNEY

Discipline of Social Work
School of Education and Social Work
Faculty of Arts and Social Sciences

ABN 15 211 513 464

CHIEF INVESTIGATOR
Dr Emma Tseris

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NSW 2006 AUSTRALIA
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Email: emma.tseris@sydney.edu.au
Web: http://www.sydney.edu.au/

PARTICIPANT INFORMATION STATEMENT

(1) What is this study about?

This research study will investigate the depathologisation of trans and gender diverse people who seek access to medical gender affirmations. This research study seeks to bring together a pre-existing group of practitioners, to examine two policies for granting access to medical gender affirmations.

This participant information statement is to inform you about the research study. Knowing what is involved will help you decide if you'd like to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

You will be given a copy of this Participant Information Statement to keep.

(2) Who is running the study?

Rebecca Howe is conducting this study as the basis for a Doctor of Philosophy (Social Work) at the University of Sydney. This research will take place under the supervision of Dr Emma Tseris and Dr Margot Rawsthorne.

Rebecca has previously worked facilitating social support services for LGBTIQA+ young people at Twenty10 Inc. GLCS NSW; and, was a member of the Policy and Research team at the National LGBTI Health Alliance.

(3) **What will the study involve?**

You will be asked to participate in a facilitated meeting involving individual activities, small- and whole-group discussions. Topics will include:

- What are the positions created by each policy, for those seeking access/ those granting access to affirming medical care?
- How does each policy demonstrate a commitment to depathologising a person seeking access to affirming medical care?

This meeting will take place at place and time nominated by ____. There will be an audio recording made of the discussion.

(4) **How much of my time will the study take?** The study will take up two hours of your time

(5) **Who can take part in the study?** To take part in this study you must be a member of ____.

(6) **Do I have to be in the study? Can I withdraw from the study once I've started?**

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researcher, anyone else at the University of Sydney or with ____.

If you take part, you are free to stop participating at any stage or to refuse to answer any of the questions. However, it will not be possible to withdraw your individual comments from our records once the group has started, as it is a group discussion.

(7) **Are there any risks or costs associated with being in the study?**

There is a potential risk that you may be identified as a result of participating in this project. This risk will be minimised by creating pseudonym for you, and ____ that will be used in the transcripts made of the audio recording. Great care will be taken to ensure that any details that could inadvertently identify you (such as the names of colleagues or other organisations), will be taken out of the transcripts.

In addition, it is possible that your participation in the research may prompt the recollection of experiences that may result in negative feelings or trigger some distress. In that event, you are encouraged to seek out your existing mechanisms for support (such as debriefing with your external supervisor, accessing support services provided by your workplace/professional body).

(8) **Are there any benefits associated with being in the study?**

We cannot guarantee that you will receive any direct benefits from being in the study.

(9) **What will happen to information about me that is collected during the study?**

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. Study findings may be published. Although every effort will be made to protect your identity, there is a risk that you might be identifiable in

publications due to the nature of the study and/or the results.

Please note that minimum retention period for data collection is five years. The data and information you have provided will be securely disposed of.

(10) Can I tell other people about the study?

Yes, you are welcome to tell other people about the study. However, to minimise the risk of you, or other participants becoming identifiable in any published findings, please do not discuss your fellow participants personal information with others.

(11) What if I would like further information about the study?

When you have read this information, Rebecca Howe will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact Dr Emma Tseris using the details listed in the header.

(12) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive individual feedback by ticking the relevant box on the consent form. This feedback will be in the form of a written summary. You will receive this feedback before the study is finished so that you can provide comment if you wish.

There is also an option to receive feedback as part of the entire group. You can tell us that you wish to attend a presentation of feedback by ticking the relevant box on the consent form. This feedback will be in the form of a short presentation and discussion at a group meeting. This is also an opportunity to provide comment.

(13) What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney [Project Number: 2018/948]. As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007).* This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** human.ethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

This information sheet is for you to keep

Participant consent form

THE UNIVERSITY OF SYDNEY

Discipline of Social Work
School of Education and Social Work
Faculty of Arts and Social Sciences

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CHIEF INVESTIGATOR
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Challenging a sacrosanct tradition:
Depathologising people whose gender is self-designated who seek access to medical affirmation.

PARTICIPANT CONSENT FORM

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers, anyone else at the University of Sydney or the group of which I am a member of now or in the future.
- I understand that I can withdraw from the study at any time.
- I understand that I may leave the research study at any time if I do not wish to continue. I also understand that it will not be possible to withdraw my comments once the group has started as it is a group discussion.
- I understand that all participants have been asked not to share personal information about other participants.

- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that the researchers will only share information about me with my permission, except as required by law.

- I understand that the results of this study may be published. Although every effort will be made to protect my identity, I may be identifiable in these publications due to the nature of the study or results.

I consent to:

- **Audio-recording** YES ☐ NO ☐

I would like to attend a group presentation of feedback on the overall results of the study ☐ ☐
YES NO

I would like to receive feedback about the overall results of this study ☐ ☐
YES NO

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: _____

_____

☐ Email: _____

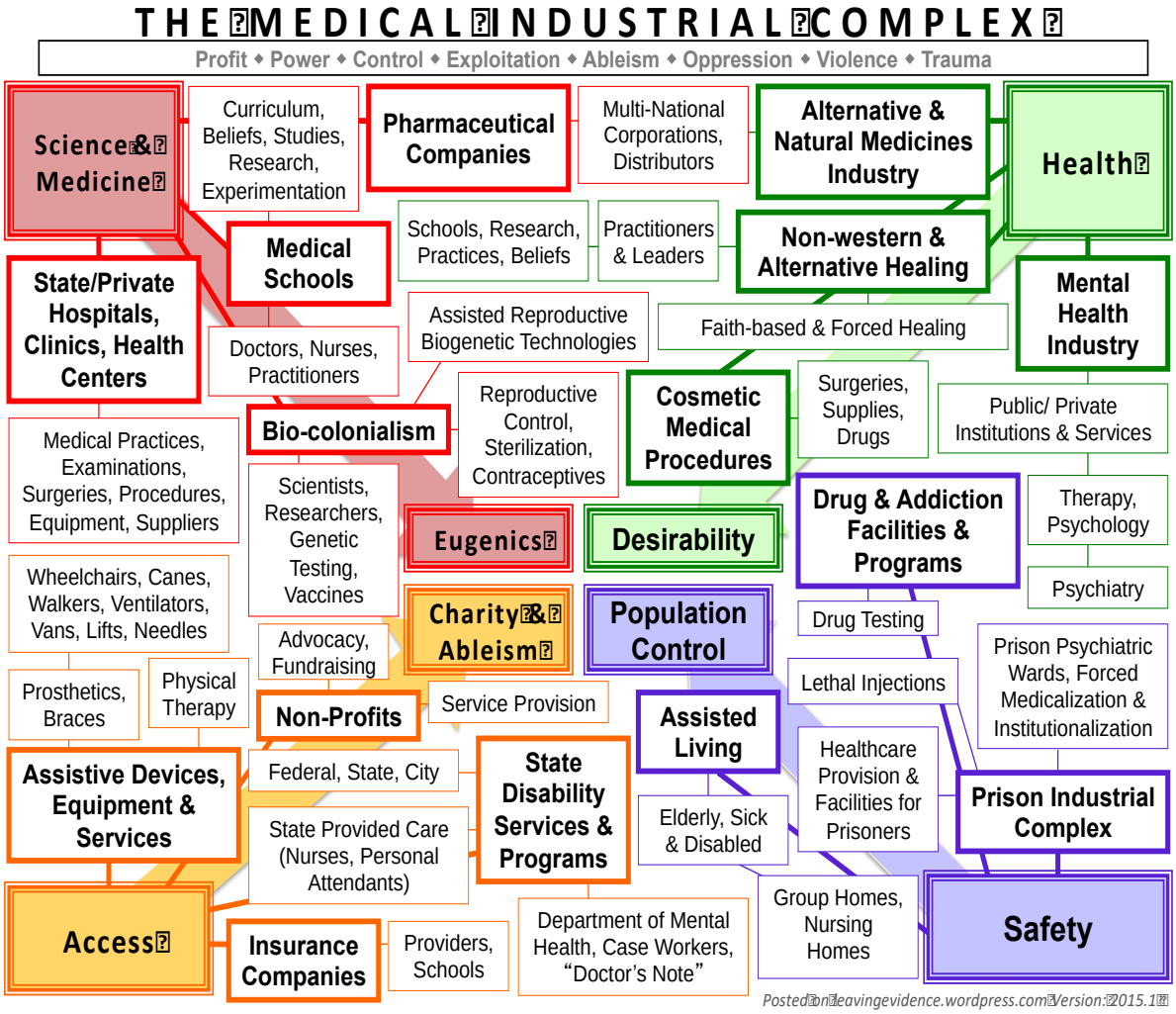
.....
Signature

.....
PRINT name

.....
Date

Medical Industrial Complex Visual

This visual was created by disability and transformative justice activist Mia Mingus (2015)



[The image shows a visual layout of the Medical Industrial Complex, which is written at the top in large letters. Just under it, there is a thin, long box that contains the words: Profit, Power, Control, Exploitation, Ableism, Oppression, Violence, Trauma. There are four main quadrants, each in a different color with large matching colored arrows connecting the outer broad categories to inner underlying motives: "Science and Medicine" is connected to "Eugenics;" "Access" to "Charity and Ableism;" "Health" to "Desirability;" and "Safety" to "Population Control." Subcategories and main categories within each quadrant, are listed in large and small boxes that are all connected to each other with lines, forming a web-like effect, filling the entire page. (There is a complete listing of all the boxes by quadrants below.) In the bottom right corner there is small grey lettering that reads, "Posted on leavingevidence.wordpress.com Version: 2015.1]

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