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Queering Care: Community Advocacy Among Trans Health Professionals

A Dissertation submitted in partial satisfaction
of the requirements for the degree of

Doctor of Philosophy

in

Anthropology

by

Joshua P. Liashenko

March 2022

Dissertation Committee:

Dr. Juliet McMullin, Chairperson

Dr. Jennifer Syvertsen

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2022

The Dissertation of Joshua P. Liashenko is approved:

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ABSTRACT OF THE DISSERTATION

Queering Care: Community Advocacy Among Trans Healthcare Professionals

by

Joshua P. Liashenko

Doctor of Philosophy, Graduate Program in Anthropology
University of California, Riverside, March 2022
Dr. Juliet McMullin, Chairperson

This dissertation examines how gender-affirming care (GAC) is shaped by the inclusion of trans healthcare professionals within clinical interactions and institutions. Tension among trans therapists, physicians, and healthcare system navigators persists between their experiences as a patient, engagement with activism, acquired clinical authority, and varied strategies in providing GAC during the COVID-19 pandemic. Trans care, defined as both activist and clinical practice, is complicated by uneven care standards and unequal access across Los Angeles and Riverside Counties. This work presents *queering care*, an analytical framework for assessing how contradictory practices, intracommunity conflict, liberation politics, and the reproduction of medicalization is interwoven within the provision of trans medicine for and by trans people. In Southern California, the availability of GAC and representation of trans people within care professions is expanding, yet barriers to care and health disparities are still present. Anthropological and interdisciplinary research on trans health has increased in recent years. However, further intervention is needed to document changes in

community-driven approaches to care. Study findings are based on one year of ethnographic fieldwork from 2020 to 2021 among networks of trans healthcare professionals in Los Angeles and Riverside Counties. The level in which activist aims and discourse are infused with clinical care practice was traced through participant stories collected through semi-structured interviews and observant participation within local community events and national trans health conferences. Qualitative data analysis reveals divergent approaches in incorporating experience-informed care within the clinic. While some trans healthcare professionals embrace a care model informed by liberation-centered activism, others resist deviating from established institutional and clinical norms. This project provides insight into how trans lived experience resists monolithic classification and demonstrates the need for an immersive ethnographic intervention to understand meaning-making in debates regarding what constitutes “good” trans care. This work contributes to theorizing about trans medicine by centering trans people’s perspectives as both patient and provider. Furthermore, methodological contributions are realized by trans healthcare professionals serving as co-producers of knowledge through lending their expertise and reflective analysis as data collected for this project.

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Abbreviation List

APA: American Psychiatric Association

DSM-V: Diagnostic and Statistical Manual for Mental Disorders, fifth edition

GAC: Gender-affirming care

GAS: Gender-affirming surgery

ICD-11: International Classification of Diseases, eleventh edition

LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer, and “Plus”

PTWC: Philadelphia Trans Wellness Conference

SOC-7: Standards of Care, seventh edition (from WPATH)

WPATH: World Professional Association for Transgender Health

WHO: World Health Organization

Chapter 1: Introduction

“This work—like all care work—is about fostering survival; it is maintenance work that must be done so that trans folks can get about the word of living. But the mere necessity of this work also points to the fact that the most fundamental networks of care that enable us to persist in our existence are often threadbare or, sometimes, nearly nonexistent” (Malatino 2020:41-42).

“I always wondered why somebody doesn’t do something about that. Then I realized I was somebody.”

-Lily Tomlin

In the early afternoon on Thursday, June 18th, 2020, I turned on my desktop and logged on to Zoom from my home office. As my fingers tapped the keyboard and guided the cursor to click “start meeting,” I realized I was about to enter my field site. I scoffed at the idea of entering *the field* involving a solid internet connection and an ergonomic chair surrounded by my possessions and cat sleeping beneath my feet. The notion of “being in the field” while comfortably seated in my inland Southern California monstrosity of a rental home was, at that moment, laughable. Yet I was, doing “fieldwork” sheltered from the summer heat in the air conditioning while sheltering-in-place during a pandemic.

The imagery of lauded anthropologist Bronislaw Malinowski watching the dinghy sail away after arriving on the beach in Omarakana flooded my mind. He was left with nothing else to do but ethnography in a village while I was physically still in my home. I considered Malinowski’s calls for cultural immersion and going “off the verandah” (Malinowski 1984). Was I still on the verandah? Is my office chair my very own “armchair” from which to perch myself and peer down upon “culture?” Indeed not, I was

engaged and immersed, just in a different way and perhaps in a way that would afford my work new types of questions and themes to explore. However, as the insecurities of my “authenticity” as an anthropologist plagued me, I was determined to snap out of it and “step into” the field.

When the Zoom meeting began, I was met with a friendly and familiar face. Hank is a 30-year-old white trans man whose life straddles the world of trans community activism and his professional work as a licensed marriage and family therapist (LMFT) living in Los Angeles. He kindly agreed to serve as my first interviewee for my dissertation research. Hank and I met years before as my journey in crafting a dissertation project centering trans activists in Southern California was taking shape. Hank’s brother was a student of mine at a local college where I taught part-time. He graciously connected us upon hearing of my research interests and desire to understand better the people represented by the often forgotten “T” in “LGBT.”

I was initially drawn to how activist labor was related to trans-self-actualization and community formation. Since Hank has been a long-standing activist in his community, he was a perfect point of contact. When Hank decided to pursue a career as an LMFT, I was intrigued by his pivot from on-the-ground activism into professional healthcare practice. This observed shift in life experience inspired questions that eventually became a part of this project’s aims. How do the institutional mechanisms within contemporary trans medicine and therapeutics respond to the inclusion of trans activists among their ranks of healthcare professionals?

As a part of my opening questions, I asked Hank, “would you say your gender experience was a direct influential force in your decision to become a therapist?” This question guided much of my research, and I was eager to tease out the relationship between trans subjectivity, activist labor, and clinical practice among trans healthcare professionals like Hank. He confidently replied, “I knew that once I started coming out and was not met with many barriers to care, I realized, oh shit! Why isn't this being done?” At that moment, Hank reflected on his privilege growing up in the San Fernando Valley region of Los Angeles with supportive and affirming parents. The “this” he was referring to was increased access to affirming care and support for his community. As a teenager, Hank had access to comprehensive gender-affirming care. Gender-affirming care (GAC) is defined by medical sociologist stef shuster as, “...all interventions that fall under trans medicine including therapy, hormone therapy (e.g., estrogen or testosterone), and surgery (e.g., vaginoplasty or chest masculinization surgery)” (shuster 2021). Hank was part of cutting-edge applications of trans medicine among trans youth at Los Angeles Children’s Hospital. His caseworker in the hospital’s trans youth program was a well-known trans-Latina activist and was an inspiring role model for Hank as he navigated transition.

Hank’s life history speaks to broader questions about trans healthcare professionals. Growing up in Los Angeles impacted his life course as a patient of trans medicine, and I was curious about patterns in trans healthcare among the various subregions in Southern California. In what ways does geography act as a social determinant of health, and how does regional positionality influence the practice of

GAC? How have processes of trans-self-actualization led to engagement with activism, healthcare practice, or both? How has receiving GAC and being a patient of trans medicine influenced approaches to care? What meanings have been made by trans people who receive GAC, and how do those experiences impact ideas about community advocacy and care?

Hank's ability to self-actualize at an early age and early integration within trans community spaces led to an intimate education on the precarity facing trans people from diverse racial, ethnic, and class backgrounds. These adolescent life experiences and his love of the off-Broadway musical "Hedwig and the Angry Inch" (which features an East German trans character reeling from botched gender-affirming surgery) connected Hank to the intersection of trans culture, the trans medical community, as well as activist circles. He was and is not ignorant to the plight of many in his community and knew his experiences were unfortunately far from typical.

In our conversation, Hank continued,

"I think Lily Tomlin said it best, 'why aren't more people doing something?' Oh wait, maybe I'm the person that needs to be doing it. Or like, why can't I find this? [referencing accessible trans-affirming services] Oh, it's because I'm the person that needs to create it. And so, I kind of just took that mindset and went from there, if it's not being done, someone has to do it, and I guess that person's me."

Hank's words reveal the trans community's growing capacity to mobilize knowledge, training, and resources to expand the reach of activism and revolutionize trans medicine and care. This passage uttered early during fieldwork, represents what makes this community, trans professional healthcare providers, distinct within the discourse of trans politics, activism, and medicine. Hank's understanding of himself as a change agent led

him to desire to bridge the chasm between activism and clinical care. Recognizing the potential for transforming the lives of trans people led me to wonder, how does this style of clinical practice produce novel forms of community engagement, advocacy, and care? Also, how do intersections of privilege and oppression affect experiences in receiving and providing care?

While trans people working to meet the needs of other trans people is not new, the addition of clinical authority within community care networks and among activists is not widely present in the existing literature. Limited quantitative research exists on trans and non-binary medical students (Dimant et al. 2019) and LGBT physicians' experience at work (Eliason, Dibble, and Robertson 2011). While these studies provide important information about the existence of trans people as healthcare professionals, in-depth, narrative-driven ethnographic research is non-existent. My research fills the gap in both the ethnographic record and public discourse concerning trans care.

This research presents trans lived experience in ways not included in existing ethnographic work conducted among the trans community in the United States. In response to the stories collected through fieldwork, I argue the blurred boundaries between trans activism and trans medicine articulated by Hank and the other LMFTs, Licensed Clinical Social Workers (LCSWs), physicians, and healthcare system navigators I had the pleasure of being in conversation with, constitutes a *queering* of care.

As a performative act, care transcends institutional and community affiliations while also establishing practice norms. As a concept and cultural practice, care resists simplistic value judgments solely regarded as "good" in binary opposition to "bad" or

neglectful. Care is relational and embedded with systems of power, oppression, and has a history from which it is constituted (Mol 2008; 2002; Garcia 2010; 2015; McKearney 2020). I apply the queer analytic here about the arguable “queerness” of trans people (something I address later) and how trans care is continuously being contested not only by institutions both hostile and benevolent but also by trans people themselves.

I use *trans care* as a signifier of the interwoven practices, institutional (dis)investments, and direct actions by trans people in numerous capacities caring for other trans people. Building on Hil Malatino’s work, I position trans care as a web of relations with no center, emerging from acts of survival and joy where normative paths of existence are unavailable or desired (Malatino 2020). Trans care involves both trans activism and trans medicine, both of which are fraught with competing and often counterproductive objectives (Plemons 2017; shuster 2021). Clinical oversight, gatekeeping of GAC, upholding ever-changing “care standards,” being responsive to needs within disparate and diverse communities, and the wide acceptance of promoting “change from within” interacting with the politics of liberation and abolition all work in tandem to complicate the relationship between activist and clinical labor. Through illuminating the lives and work of trans health professionals, this research fills gaps in anthropological knowledge about trans people and trans medicine while highlighting the role trans people have in reshaping trans care through blending activism with clinical labor across diverse populations and interrelated regions.

As my conversation with Hank continued, I was curious how the placement of a trans person within a position of medical authority “over” other trans people would play

out in the clinic. My a priori expectation was that trans people would use their power to usurp existing inequalities that disproportionately affect trans patients and clients in healthcare systems. However, this assumption was quickly proven to be a reductive and narrow expectation of clinical relationships between a trans provider and a trans patient. Hank provided clarification in explaining his interactions with his clients¹ in saying, “Your client comes in, and they want a letter [to be sent to a physician for recommending GAC], and you know that’s why they’re coming in. So instead of being like, ‘okay, we have to meet for ten sessions, and I’ll write a letter,’ you write a letter collaboratively and maybe in the second or third session.” Here, Hank references gatekeeping, one of the most pervasive sources of marginalization experienced by trans people seeking GAC. The clinical interaction he describes is his attempt to circumvent care standards that he believes are inconsistent with quality care. He continued, “We write together and talk about it. I tell the client what I’m going to say; I ask them, ‘what do you think about this?’ and they will say, ‘well, actually, that’s not how I feel.’ Then I ask, well, how do you feel?” You’re actually doing therapy as you’re writing a letter. That’s what I do; I write my letters *with* my clients.”

After learning about Hank’s technique, I asked him, “that’s not in any guidelines or care standards? Are you the only trans provider who does that?” He replied, “oh, no. I know a lot; it’s a thing that we all kind of talk about, do, and teach.” Based on this

¹ The use of “patient” and “client” varies within the literature on care and among participants in this study. “Client” is preferred among mental health professionals, yet “patient” is often used interchangeably. I used both terms throughout fieldwork and will use either depending upon the words used by study participants during interviews. Angela Garcia warns against the use of “client” due to its association with purchasing power and healthcare as integrated within capitalism see (Garcia 2010).

assertion, I wondered, to what extent does is this divergence from care standards and clinical improvisation informed by providers' experiences as a patient of trans medicine? Widely accepted care standards and guidelines for trans healthcare have been set and continually updated by the World Professional Association for Transgender Health's (WPATH) Standards of Care (SOC)², American Psychiatric Association's (APA) Diagnostic and Statistical Manual for Mental Disorders (DSM), World Health Organization's (WHO) International Classification of Diseases (ICD), and the Endocrine Society's Clinical Practice Guidelines. Practitioner divergence from any of these standards demonstrates how practicing GAC is entangled with activist ethics and thus, contributes to the *queering* of care.

Patterns in trans clinicians challenging or disregarding care guidelines reveal how their commitment to community advocacy is often at odds with their commitment to institutional norms and clinical practice. In a conversation I had with Hank's colleague, George, a white trans man who works as an LCSW and psychotherapist with trans youth in Los Angeles, it was confirmed that challenges to care "standards" are becoming standard practice among trans clinicians. This is especially true when writing letters of recommendation for biomedical GAC. George showed me how these conflicts play out within the clinic in saying,

"In terms of the letters, the way our agency does it is we just bullet point it. Whatever the insurance company needs, we give very concise bullet points. We don't go into narrative formation because that's just giving them too much that's giving them too much information that they don't need. It doesn't matter that little

² When I use the phrase "standards of care" or the acronym "SOC," I explicitly reference WPATH's seventh edition of SOC. In the general discussion of broadly normative care protocols, I use the phrasing "care standards" or "guidelines."

Johnny played baseball; that literally doesn't matter, that's just playing into gender stereotypes.”

George and Hank’s stories from the clinic challenge normative standards of care that guide GAC, primarily when provided by non-trans clinicians (shuster 2021). These grounded examples of clinical activism, which seek to deteriorate hierarchal and paternalistic standards in managing gender, illuminates what I argue is a *queering* of care.

Hank genuinely loved walking me through his interactions with clients in our conversations. He would show me how he disrupts institutional standards and integrates the ethics of activism into therapy sessions through acting out clinical interactions over Zoom. Hank understands his professional role in assessing trans patients and providing a recommendation for biomedical GAC (hormone replacement therapy or gender-affirming surgery) as a means of navigating discriminatory red tape and persistent gatekeeping. Hank tells his clients, “I’m like, ‘this is what you should do’ [when talking about insurance]. ‘This is why I’m gonna to bill, and this is what it means. And I feel like you know the title of gender dysphoria, how do you feel about that diagnosis?’ and the client would be like, ‘Oh, I get it, and it sucks.’” Hank engages clients and ensures they know why certain words are used clinically or in terms of insurance. For insurance to cover GAC, Hank must use the language of pathology, something he and many trans clinicians despise but continue to connect their patients with care. Hank reassures his clients from a perspective of embodied understanding. He says,

“‘Yeah, I know. [he asks his client] Why does it suck?’ and then I turn it [the conversation with the client] into an activist moment. ‘So, you’re fucking the system; you’re getting insurance to pay for your shit if you use this diagnosis. By using gender dysphoria, let’s take power in this diagnosis.’ And the client’s like, ‘yeah, cool.’ It’s evolving what therapy looks like.”

The blending of clinical care with activism and professional expertise with experience-informed knowledge charts new possibilities in studying trans medicine and therapeutics. Care is not solely located within the clinic or activist labor but exists in an entirely new set of social relations. Traditional boundaries between healthcare providers, institutions, and communities are being challenged, reconfigured, and even eliminated. However, activist labor is sometimes rejected by trans healthcare professionals, leading to the reproduction of clinical hierarchies. As will be made evident throughout this work, many trans healthcare professionals' approach to care resists dichotomous categorization and trans care becomes a composite of intersecting and contradictory practices provisioned by trans people themselves.

Queering care is not merely a signifier for disrupting trans oppression in healthcare practice for the sake of trans liberation. This work does not situate trans actors in medicine as operating in concert towards shared liberatory agenda. My use of the *queering care* analytic does not purport a positive or negative value judgment attached to the ways care is queered by trans people with clinical authority.

Trans people have the capacity to imagine and work towards transformative and lasting change, which is liberatory, and they also can internalize and reproduce clinical harm. For example, Mitch, a Hispanic trans man from Los Angeles trained as an LCSW and works as an independent consultant uncritically defends clinical gatekeeping. Mitch said, "The argument goes that if we remove anything gender-related from either the ICD or the DSM, there are certain people who will never get medically necessary care because there's no CPT code for it." I quickly ask, embarrassed I didn't know what a CPT code

was, “CPT is?” and Mitch responded, “It’s the billing code.” Mitch is referencing the Current Procedural Terminology or CPT coding system used by insurance companies to bill for covered procedures. The ability to bill patients for procedures covered by insurance is based on each medical procedure being assigned a diagnostic code. In California, insurance companies are mandated by law to cover biomedical GAC thus a code for diagnosis is often required for insurance to cover the costs of hormone replacement therapy (HRT) or gender-affirming surgery (GAS). Mitch continued,

“If you're using your insurance, you got like 12 to 15 sessions, and you better have a diagnosis by at least the second session or else the insurance company is going to cut you off. I know that what the arguments are, and I personally think that the people who argue for it [maintaining gender dysphoria diagnosis to access GAC] to be in have a strong argument because it's probably true that people in institutions would not get access to medically necessary gender care if it wasn't a diagnosis.”

Mitch’s perspective is intended to be interpreted as pragmatic. However, unlike Hank or George, Mitch sits on the WPATH board of ethics and is partially responsible for reproducing clinical norms as outlined in the SOC. Instead of using his relative privilege to push for a care model beyond the limits imposed by capitalism, Mitch willingly acknowledges the apparent need for continued pathologization of trans people.

These stories from my fieldwork further demonstrate how trans people working in trans medicine produce vastly different effects, even though Hank, George, and Mitch, all desire trans people to receive GAC. As an analytical tool, I argue that the lens of “queering care” embraces the queer critique by resisting reductive expectations of trans people’s commitment to liberatory political coalitions and/or regulatory powers associated with clinical authority. In this work, to *queer* care means following trans

professionals' narratives to uncover the diverse possibilities for transforming trans care in light of underexamined and interconnected domains of activism, authority, and lived experience.

The Political Landscape of Trans Care

Trans care exists within the broader political context of the United States, where conflict is present in multiple layers. Rapid changes in federal policy, state-level anti-trans legislation, virtue signaling from high-profile politicians, and disagreements within the trans activist community contribute to the contemporary context in which I conducted research. I will show how trans healthcare professionals integrate themselves within this political landscape and how their perspectives and actions constitute a queering of care.

Chris is a white trans man LMFT who works in private practice and as a university professor in Los Angeles. During our first interview, I found it curious that he took the conversation from explaining his embrace of being a feminine man and his apathy to "passing" to a commentary on trans politics without directed elicitation. Chris said,

"My identity is kind of more in the kind of androgynous feminine, man. Like, I don't have a desire to pass as male, but I've had phalloplasty so I'm a weird trans guy [laughter]. It's more about the presence of manhood and not the absence of female-hood and for me, there's something about non-binary politics that...I'm not that radical, I'm not that liberal, like in the queer world, I'm moderate. In like the scheme of things, I'm pretty left but in the queer world I'm pretty...not [laughter]. So, this is where I don't feel like gender queer, gender non-binary really fits in with my politics because I don't like to see things in such black and white. I don't like to hold on to so much anger. I like to find the common ground and a lot of queer politics are not about that; they're more about burn it to the ground. And I'm like, let's try and change it from within."

Chris's story was a not-so-subtle reminder that the trans community resists monolithic classification, and perspectives regarding the aims of trans politics and activism vary widely. This was one of the many moments in which my political commitment to abolition stood in contrast with community members who I believe need liberation the most. This was not the last conversation I had during fieldwork, where I closed the Zoom call feeling unsettled. Why did I feel detached from the politics of trans healthcare professionals? Why is there is a common, yet not universal, resistance to liberation among this population? Again, the analytic framework of *queering care* attends to these discrepancies and apparent paradoxes in trans care as ethical practice.

Through connecting his gender journey and feelings of resistance to trans normativity, Chris felt it necessary to distinguish himself from what he perceives as the fringes of trans-political discourse. Chris' words reflect ongoing debates within the trans community regarding the aims of trans care and activism and its relationship with institutions and power. In this section, I set the macro-level scene that grounds my work's context. I provide an overview of trans politics in the current historical moment and interweave stories from fieldwork to illustrate how these macro-level conditions play out within trans medical discourse.

Threats to trans personhood and survival permeate urban, suburban, and rural communities in the United States. As the homicide rate of trans women of color continues to skyrocket year after year in what is viewed as an unfortunate consequence of increased public visibility, institutional and government powers have set course on an unyielding mission to enshrine anti-trans discrimination into law. The intersection of the

ongoing COVID-19 pandemic and the associated economic crises, nationwide Black Lives Matter protests in the wake of a series of murders of unarmed Black people by police, and the tumultuous 2020 Presidential election serve as background for this research. Beyond 2020, the years leading up to my fieldwork saw increased attention, visibility, and public scrutiny of trans people leading to compounded vulnerability.

The 2016 ascension of Donald Trump to the presidency of the United States led to increased governmental hostility towards trans people. As of January 1, 2018, transgender Americans were again banned from serving openly in the United States military, a decision defended by Trump by citing trans people as a “distraction” to military readiness. In June 2020, at the height of the initial wave of COVID-19 infections, the Trump Administration again set its sights on further curtailing hard-fought protections in accessing healthcare services. Under the direction of the administration, the United States Department of Health and Human Services (HHS) issued a final rule to Section 1557 of the Affordable Care Act (ACA), which effectively removed protection from discrimination based on “gender identity.” For many within the trans community, this was perceived as a means for the Trump Administration to “define transgender out of existence.” However, later in the same month, the Supreme Court ruled in *Bostock v. Clayton* that Title VII of the Civil Rights Act of 1964 did protect employees from discrimination based on sexual orientation or gender identity. This decision was a surprise for many LGBTQ advocates, albeit a welcome one after years of anti-LGBTQ rhetoric spewing from the White House, Congress members, and state legislatures across the country.

The November 2020 election of Joe Biden to the presidency signaled a potential shift in American political policy towards the trans community. Most notably was Biden's mention of transgender Americans in his victory speech, the first time the word "transgender" was uttered by a President-Elect in his first address to the nation. This historic occasion followed Biden's 2015 endorsement of marriage equality which is often cited as the reason for the Obama/Biden 2012 reelection campaign's ideological "evolution" to embrace marriage rights for lesbian and gay couples. This trajectory of political maneuvering reflects the mainstream (cisgender lesbian and gay-led) LGBTQ rights movement's shift toward trans issues in the wake of the nationwide marriage equality (Stryker 2017). While Biden is touted by liberal LGBTQ+ activist organizations as a pioneering political ally, his expansion of the military-industrial complex (MIC), prison industrial complex (PIC), and continued deportations of undocumented immigrants (issues that have a disproportionately negative impact on trans people) have caused abolition and liberation-minded trans activists to hold short in calling him an accomplice to the cause. Furthermore, many activists and academics alike view him as an obstacle and adverse agent to dismantle transphobic systems by working towards prison, police, and military abolition (Spade 2011; Stanley 2015).

Mainstream LGBTQ+ organizations have recently pivoted towards addressing transgender community issues after the Obergefell vs. Hodges United States Supreme Court decision that legalized same-sex marriage. In mirroring these shifts in liberal identity politics, Biden famously referred to transgender equality as the "civil rights issues of our time" in the forward of the 2017 memoir written by then HRC National

Press Secretary current Delaware State Senator, Sarah McBride. As the first trans woman to address the 2016 Democratic National Convention, McBride joins a growing cohort of trans American politicians gaining seats in state legislatures across the nation. The 2017 election of trans journalist Danica Roem to the Virginia House of Delegates was punctuated by a congratulatory call from Biden the night she won her race.

Turning to health matters, the Biden Administration announced that pediatrician and Secretary of the Pennsylvania Department of Health, Rachel Levine to serve as the United States Assistant Secretary for Health. Levine is the first trans federal official to be confirmed by the Senate, making her highest serving trans official in the United States government. Furthermore, her position as a trans physician serving as second in leadership within the HHS signals the administration's supposed commitment to trans health. However, at the time of this writing, the only major news to be reported about her tenure at HHS was her commission as a four-star admiral. Levine's story was intended to bookend a supposedly bleak and temporary chapter in the movement for trans rights during the Trump administration. It seems the liberal narrative in which Dr. Levine is set center stage perceives enough has been done for the time being, and little mention of trans health currently circulates in policy proposals from the White House.

Biden's position against police defunding and abolition and support for the propagation of the status quo prison-industrial and military-industrial complexes demonstrates his commitment to status quo liberal governance and, thus, working against the aims of trans and queer liberation. Biden's selection of California Senator Kamala Harris as his 2020 running mate has given the abolition and liberation trans activist

community a reason to remain skeptical of the Biden Administration's capacity for lasting positive change. Harris has gained a reputation for her unabashed support for social and marriage rights for LGBTQ people; however, during her time as California's Attorney General, she and her office famously denied GAS for incarcerated trans people (Gilchrist 2019).

The push for "progressive" acceptance of and promising rights to trans people is situated within liberal U.S. political agendas and a mainstay for liberal campaigns of visibility, especially within media. A common assumption is that increased visibility and positive representation within government, social institutions, and media is the key to positive social change. At the heart of this trust in organic social change is the idea of incrementalism and creating space for "evolution" among the populace to become more trans-affirming. This is consistent within the liberal political zeitgeist, given this is how widespread acceptance of same-sex marriage gained traction. Many Americans view "trans rights" as what Joe Biden refers to as the "civil rights issue of our time." The incremental momentum fuels support for codifying legal rights and protections within the authority of the state.

"Progressive" policies also work with increased visibility and positive representation as a neoliberal tool of establishing transnormativity through assimilationist practices. Trans theorist Eric Stanley argues that positive representation renders the trans body a respectable facet of modern society. The promotion of a national idealized trans subject (as figures like Biden seek to accomplish) does nothing more than reify state regulatory power and continually oppress trans and gender-expansive people the state

deems outside its purview (Stanley 2021). According to Toby Beauchamp, increased trans visibility and recognition within governing bodies are intertwined within the growing surveillance U.S. apparatus. The production of the trans subject under the gaze of governing bodies simultaneously produces categorizable bodies to regulate, surveil, and manage (Beauchamp 2019). Regulatory measures that are explicitly hostile to trans people (bathroom bills or exclusionary policies targeting trans student-athletes) as well as supposedly favorable inclusionary policies (non-binary gender markers on IDs or reform in how trans people are incarcerated according to their gender) both operate to increase the state's capacity for violence. I argue increased popular/state representation of "official" or transnormative subjectivities and embodiments further marginalizes the trans community and falls short of liberation. Furthermore, the governable and surveilled trans subject produced by the state parallels the trans subject produced by the clinic. Care itself becomes a locus of regulation not as an aberration or dysfunction of care but as an implicit quality of care (Garcia 2010; Livingston 2012).

This brings me back to my conversation with Chris. His desire to flesh out where he stood concerning trans, and queer political discourse is directly tied to how he approaches his care work. His position as a healthcare provider and trainer of LMFTs who plans to work specifically with LGBTQ+ populations inform his politics and reveal divergences in political perspectives. In stark contrast to the writings of trans scholars like Spade and Stanley, Chris said,

"Um...so, I think that the system has some fucked up shit in it. Don't get me wrong, but I don't think we have a good solution in burning it down, other than there's something cathartic about breaking down something that doesn't work. But

if you're going to burn something down, you have to have something else that's going to replace it. And I don't think we do.”

This “moderate” brand of “in-system” and reform-based trans politics exists in contestation with figures in trans studies, the activist community, and my politics. As previously mentioned, I often found myself at odds with the politics of my participants, which was perplexing given the immediacy of need in removing barriers experienced by trans people.

Mitch offered commentary which eviscerates the objectives of critical trans politics and abolitionism in reflecting on his disdain for “leftist” politics in trans political discourse. He said,

“I think they're pushing too hard. I'm a moderate; I'm not a lefty; the lefties are pushing too hard, that means the people on the far right are going to push back even harder, and the majority of us in that middle place are going to be left just wondering what the hell is going on. You can't burn down buildings and then expect that people aren't going to come after you.”

Mitch's resistance to abolitionism and his allusions to the trans-political left seeking to “burn down buildings” reflects the moderate queer politics of Chris. However, unlike Chris, Mitch engages in what some might interpret as victim-blaming, where he essentially places fault with trans activists for the increase in systemic hostility towards the community. Chris continued his pontificating on the subject in stating,

“There's something about the ‘burning down’ that feels very like kind a little kid that's frustrated with their LEGO set. And so, they just tear it apart. And I'm like, ‘but what are you going to build?’ And if I had clarity about, what are we building, fine, but I don't think that we do. I'm more about let's change the system from within because there are some good foundations here. There are some that are rotted and needs to be pulled out abso-fucking-lutely! But let's not tear down the pieces that do work. It's more like a house renovation.”

There are two observations presented here that I believe are significant. The metaphorical comparison of trans medicine to a “building” that needs saving reveals patterns of loyalty to institutions rather than radical change centering trans lives. Two, I would argue that the perspectives articulated by Mitch and Chris are at odds with Hank and his Lily Tomlin-inspired call for self-action and George’s caution in reproducing harm through his care work. Here, we see evidence of trans medicine and the politics that foreground its reproduction, existing upon contested terrain.

While the political objectives among trans healthcare professionals are not and will likely never be in sync or wholly solidified around the cause for liberation, all participants in this study believe their labor promotes alleviation of disparities for their community. There is a collective desire to seek positive change through care work beyond solely applying oneself within direct action activism or clinical labor. I argue that the lens of care that is queered offers a starting place to assess the intersecting and sometimes contradictory ways trans people desire trans abundance and vitality. The fear and anger towards American society’s indifference and often hostility toward trans well-being have led trans people to do what they have done for decades and look after one another. However, trans care exists not only in the streets but also in the clinic. Beyond just calls for engagement with activism, there is a call for trans people to integrate themselves within social institutions to apply knowledge and professional skills within community advocacy. This is *queering care*.

Why “Queering” Care

The theoretical underpinnings of this dissertation intersect in providing a productive interdisciplinary foundation from which to undertake an examination of trans medicine and care in Southern California. This project primarily calls forward the theoretical traditions of critical medical anthropology (CMA). CMA assists in accounting for inherent inequities within medicine, especially those coursing throughout trans medicine. Medicine is understood to act as a source of established and hegemonic knowledge from which to interpret the patient. This conflation of neoliberal values with modernist science promotes what Thomas Csordas refers to as “biomedical hegemony” (Csordas 1988). When applied to the relationship between trans people seeking affirming care and the institutions responsible for administering said care, disparities result from a lack of cultural competency regarding trans needs and concerns involving health.

As a cultural process, care operates on multiple levels, including interpersonal clinical care, informal care, and large-scale institutional care (Milligan and Power 2009). Through adopting a critical medical anthropology framework, professional care work is understood in the United States as being implicated within macro-level systems and unequal social relationships (Singer and Baer 1995). Biomedical knowledge and care practice that proceeds is a mode of disciplining, controlling, and regulating populations (Foucault 1973) Care is produced by an interwoven network of knowledge, science, capital, and systemic and historicized inequalities infused within the structural and interpersonal relations. Care is situated within patriarchal gendered hierarchies and white supremacy in how the historical foundations of medicine and current operation of clinical

care reproduce the white cisgender heterosexual male gaze. How care is imagined and practiced are mediated by these intersecting factors leading to a divorce between care as policy and institutionalized standard and care as the socio-cultural relationship between care provider and patient.

Margaret Lock and Vinh-Kim Nguyen's analysis of the "practitioner-self" applies to this work's engagement with trans providers serving trans patients. The educational and professionalization process of trans health professionals leads to a "transformative experience" of empowerment that can reshape healthcare practice. Furthermore, evaluating "therapeutic communities" serving as a challenge to traditional hierarchal and paternalistic provider-patient dyadic relationships will contextualize what I refer to as a *queering* of care within a critical medical anthropology framework (Lock and Nguyen 2010).

This work deploys *queer* as both composites of non-heteronormative sexual and gender subjectivities and theoretical device and analytical framework from which to challenge accepted and assumed orderings of the world (Chen 2012). In writing about a *queering* of care, "queer" is deployed as a productive process of deconstruction. The analytical framework of *queering care* is centered on challenging assumptions of care when trans people serve as care providers (both within and outside the clinic). Trans lived experience is medicalized and they are often represented in research as the objects of trans medicine (Plemons 2017; shuster 2021). This work deploys *queering care* to examine a disruption in the role trans people play in medical discourse through studying trans people as figures of medical authority.

Queer theorist Eve Sedgwick famously defined “queer” as “the open mesh of possibilities, gaps, overlaps, dissonances, and resonances, lapses, and excesses of meaning when the constituent elements of anyone’s gender, of anyone’s sexuality, aren’t made (or can’t be made) to signify monolithically” (Sedgwick 1994). Based on my preliminary observations, I traced a path between activism to professional healthcare practice. As I conducted more interviews, I realized my error in assuming a linear relationship between trans activism and trans medicine. As will be made apparent throughout this work, trans lived experience and trans care, by and for trans people do not exist as monoliths. The breadth of possibility articulated in Sedgwick’s construction of queer’s “open mesh” signifies the functionality of *queer* in development of the *queering care* framework. While trans care by and for trans people is not new, care webs within institutionally regulated medicine charts new possibilities for making trans lives livable.

Judith Butler defines *queer* as a “site of collective contestation, the point of departure for a set of historical reflections and futural imaginings” (Butler 1993). In following the experience-informed practices of trans healthcare professionals, I will show how their subjectivity, embodiment, and positionality within trans medicine introduces new points of departure and imagined futures in care practice. In short, *queering care* is defined as an analytical framework for assessing how contradictory practices, intracommunity conflict, liberation politics, and the reproduction of medicalization of trans existence is interwoven within the provision of trans medicine for and by trans people.

The pathologizing gaze of healthcare is being reshaped by actors who have experienced and continue to experience its capacity for “othering” and stigma. In this context, the practice of what anthropologist Eric Plemons refers to as trans-medicine and trans-therapeutics enacts a subjective perspective within models of institutional recognition. Furthermore, the way in which the medical-psychiatric gaze produces trans bodies is contested through the participation of trans professionals within healthcare practice (Plemons 2017).

The words of Hank, Chris, and Mitch earlier in this chapter and many other voices of trans healthcare professionals who participated in this study point to a layered perception of self. This layering adapts W.E.B. Du Bois’ double-consciousness as these trans people have unique access to how the medical gaze interprets and defines them and the entire trans community (Du Bois 2014). The conflicting approaches to care and perspectives held by trans clinicians shows how affiliation with oppressive mechanisms within trans medical discourse and practice complicates understandings of self as trans person and agent of trans medicine. The paradoxical relationship between recognition of self as oppressed by medicine while also engaged in its reproduction is understood as integral in how trans people provide trans care. *Queering care* interprets trans double consciousness within the clinic as a feature of the ways in which trans people reshape trans medicine.

The ability for trans bodies to do what ethnographer Annemarie Mol refers to as “animate” healthcare practices are now contested given the inclusion of trans perspectives in the clinical production of the trans subject (Mol 2002). Unmooring

healthcare from hierarchal and paternalistic models of top-down interpretation for the sake of narrowly defined transition outcomes and instead, allowing for collaborative approaches is a novel push for revolutionizing trans-medicine (Lane 2018; Plemons 2017). Unmooring trans care from institutional power through the infusion of activist affects with clinical care practice allows for new ways in which trans people *animate* trans medicine. The shift from patient to provider, while still being a patient, complicates perceptions of self, community, and relationship to field of care practice. *Queering care* provides a lens for which to assess and interpret how these overlapping subjectivities are a part of how trans care is continuously being renegotiated.

Trans health professionals are now representative agents of the very institutions that have been responsible for the medicalizing of their bodies and experiences. This process has effectively displaced personhood in the name of pathology. As the history of care within the trans community is uneven at best, abusive, and arguably genocidal at worst, this complicates the subject-position of this growing demographic of trans people. How can one articulate their activism with their caregiver status and privileges of diagnosis? How does activism take on new life within the framework of the clinic? How does Foucault's "clinical gaze" alter its perception when clinical authority is held by its objects (Foucault 1973)? Is loyalty to profession and institutional relations in conflict with community membership and advocacy? If so, to what extent? The predicament I describe here is not solely based on the potential conflict between community and profession. I argue the onus rests upon how healthcare institutions, as well as individual clinicians, continually buttress or dismantle gatekeeping and how social perceptions of

trans existence frequently emerge from the discourse of diagnosis and pathology and towards embracing self-actualization (Spade 2006).

This project activates queer as analytic by operationalizing “queer” as a concept, theory, method, and subject-position. However, the use of “queer” as a category is complicated within the trans community. According to Gavriel Ansara, some men and women who are trans and heterosexual reject the inclusive label of “queer” due to their understanding of self as rooted in gender and not sexual orientation. Ansara refers to this patterned objection to queernormative nomenclature as “coercive queering.” As “queer” is deployed as inclusive of gender and sexual subjectivities or desires distinct from heteronormative expectations, the colloquial use of queer in a historical sense was often used in place of homosexuality (Ansara 2015). This form of contestation reflects both inter-generational shifts in lexicon and dynamic socio-cultural conditions, which have altered queer and trans people’s relationship to subject-position categories (Valentine 2007).

Trans Care as Medicine

I argue that trans care is comprised of both medical and activist in orientation has been contested and conflict-ridden since the emergence of trans medicine and mutually constituted community activist labor. The epistemological origin story of trans medicine is implicated within the epistemological legacies of the white supremacist, settler-colonial state as well as pathologizing rhetoric that sought to medically “cure” or manage gender “incongruence.” Furthermore, these legacies propagated a science-based

deconstruction of gender, sex, and sexuality in the mid 20th century which did the work of both sidelining trans-centered social movements in favor of homonormative assimilationism and reproducing the myth that sex and gender are separately constituted phenomena. Outlining the history of trans medicine is vital for the grounding of the queering care framework as the contemporary socio-cultural landscape of trans care and perspectives in trans medicine (including among trans healthcare providers) is built from these contentious legacies. The complex web of intersecting and often contradictory views among trans healthcare professionals both mirrors and continually reproduces the sites of contestation responsible for the emergence of trans care over the past century and a half.

The medicalization of sexed and gendered bodies has a fraught history embedded within colonization, chattel slavery, and neoliberalism. C. Riley Snorton's *Black on Both Sides: A Racial History of Trans Identity* provides a vivid historical summation as well as poignant analysis of how "plantation medicine" was used to advance the aims of gynecological medical procedures and surgery. It is understood that surgical intervention upon genital anatomy paved a path forward for expanded surgical techniques for altering genitalia among transgender subjects. Snorton provides an overview of experimental surgeries for the treatment of vesicovaginal fistula (VVF) upon enslaved women in the 19th century. This marked a turning point in the medicalization of bodies and the confirmation of the racialized and enslaved body as an object of the biomedical gaze to be used to advance the science of the body (Snorton 2017).

The link to the emergence of trans medicine and gender confirmation surgery in the early to mid-20th century rests at this medical labor's material and affectual products. Snorton cites and critiques Foucault's chronological characterizing of clinical approaches to bodies and flesh. According to Snorton, Foucault does not apply race and colonial "civilizing" processes to western biomedical understandings of the distinction between bodies and objectified flesh. For Foucault, the "body" category is synchronistic while "flesh" is the deconstruction and elimination of subjective ordering of one's corporeal form. For Snorton, this assessment negates the role racialization has played (especially within the context of chattel slavery) in producing bodies as flesh and thus rendered subject to biomedical manipulation and appropriation as an extension of racialized slavery (Foucault 2003; Snorton 2017).

Beginning in the mid-19th century, the conceptual relationship between "homosexuality" and what we would now consider "trans" has been intertwined by shared disdain within western public and institutional relations as well as contentious intracommunity schism. Central European journalists and medical doctors applied scientific analysis and social advocacy relevant to homosexual desire and "inverse" gender identification. Starting in 1864, Austrian journalist Karl Heinrich Ulrichs published a series of texts based on his study of biological theories, which endeavored to account for same-sex attraction and romance. The term *homosexuality* was coined in 1869 by German-Hungarian journalist and pioneering gay rights activist Karl Maria Kertbeny. In turn, thanks to the naming of "the homosexual," the category of "heterosexual" was also coined by Kertbeny as its inverse (Meyerowitz 2004, Stryker

2017). The 19th-century categorization of western subjectivities regarded as unnatural aberrations was a step forward in legitimizing non-heteronormative communities. The legitimizing of homosexuality was not a marker of social acceptance, but the alignment of subjectivities once regarded solely through the lens of behavior (e.g., the sodomite) into what Foucault refers to as a species (Foucault 1978). This erotic speciation (Rubin 2011) produced a classifiable and analyzable figure of “the homosexual” from which to manage and regulate biopolitically. The homosexual also served as a point of divergence from which the newly established “heterosexual” could coalesce based on the abjection of the former. The pathologization of homosexuality was no longer limited to behavior regarded as separate from the person; it was not ascribed as quality of personhood.

It must be noted that the work of legitimizing non-heteronormative subjectivity and embodiment in the west was consistent with colonial settler ideals of discrete categorization and taxonomic intelligibility. BIPOC gender and sexuality embodiments were violently targeted by European colonizers, thus producing the modern framework for contemporary transphobia, homophobia, and transmisogyny. The late 19th century brought forth concurrent aggressive classificatory systems of race and sexuality, which were interconnected processes of white supremacist and cis-heteropatriarchal violence. The regulatory separation of the white body from the Black body and the heterosexual subject from the homosexual subject worked together to maintain the hegemonic ordering (Somerville 2000). Whiteness was privileged in manufacturing the intelligible queer subject of the mid-20th century. Community advocates and leaders and the eventual establishment of trans medicine crafted “approved” and “official” trans subjectivities

from which gender expansive people could coalesce. These subjectivities were produced through pathologization and uncritically reproduced whiteness as standard.

Dr. Magnus Hirschfeld founded the world's first gay rights organization in Berlin, Germany, in 1897 (Stryker 2006). Hirschfeld's Scientific Humanitarian Committee was a site of advocacy and expanded sexology research leading to the 1919 opening of the Institute of Sexual Science (Stryker 2006). Hirschfeld was responsible for developing the concept of "sexual intermediaries," which postulated that individual humans were defined by biological sex, sexual preferences, inclinations, and culturally acquired behaviors (Hirschfeld 1910, Stryker 2008). This early theorization of humanity as a composite of anatomical, physiological, psychological, and cultural elements has guided research in sexology and gender for decades. In partnership with fellow sexologist Havelock Ellis, Hirschfeld coined "transvestism" in the early 20th century. Transvestism was inclusive of cross-dressers and people we would now regard as transgender. This early distinction between homosexuality and gender expression was vital in guiding theorizing, community formation, and health research throughout the early 20th century (Meyerowitz 2004).

Dr. Harry Benjamin founded the International Gender Dysphoria Association (GBIGDA), formed in 1979 and renamed the World Association for Transgender Health (WPATH) in 2007 (Plemons and Strayer 2018). Benjamin popularized the term "transsexual" and advocated for comprehensive transgender treatment that sought to understand the phenomenon as psychologically and hormonally produced and not psychopathology. This critical distinction separated gender experience from sexuality as

it was based on “wrong body” interpretations of trans subjectivity (Plemons 2017) and reified notions of homosexuality being something discursively different than being transgender (Valentine 2012). He clearly establishes a conceptual differentiation between the mid-century blurred boundary between transvestite and transsexual. Benjamin claims that a male transvestite merely enacts a female role while a transsexual seeks to be and function as a member of the opposite assigned sex. His lasting contribution to the field of both queer and transgender studies is his advocacy for the treatment of trans persons, including endocrinological and surgical approaches to allow people to embody the sexed and gendered bodies they understood themselves to be. Benjamin demystified the psychiatric mythos surrounding the trans phenomenon by attributing the desire to transition sexes to cultural and non-selective hormonal characteristics (Stryker 2006, Benjamin 1954).

Dr. Harry Benjamin’s contributions to trans medicine, as well as the positive impact his work had in improving the lives of trans people, is still deserving of critique. Benjamin discursively created the modern concept of “transsexual” to secure medical legitimization within hegemonic norms of the time. Benjamin’s care work contributed to the formation of transnormativity, whereby the subjectification of trans people crafted an idealized way to embody transness. The standards of care he established signified his commitment to the pathology of gender incongruence as a solvable problem. For Benjamin, the disagreement between the body of the mind among trans people was the issue, not their inherent existence. While this was “progress” for the mid-20th century, and his recommendations for HRT and genital surgery improved the lives of trans

patients under his care, his protocols privileged modernist scientific expectations of supposedly reproducible results. Thus, Benjamin's standards of care promoted an image of trans normativity that was white and palatable to heteronormative social and cultural expectations for "fully transitioned" trans people. It is fair to assume contemporary ideas of the culturally legible transnormative (Bradford and Johnson 2021) subject where trans subjectivity and embodiment are embedded within heteronormative ideals stemming from Benjamin's intertwining gender with compulsory heterosexuality.

While European physicians were pioneering genital gender affirming surgeries in the early 20th century, many American physicians to offer these care services were operating in secret until the 1960s. Beyond the overtly pathologizing gaze trans people became susceptible to from the medical and psychiatric community, networks of activists and community leaders started to lay the groundwork for networking between community members and sources of affirming care. It is interesting that transgender activism and community-led advocacy work are largely responsible for crafting affirming trans medicine and therapeutics. Relations between communities, activists, medical professionals, and capital became a driving force for transgender social movements. Wealthy financiers again demonstrate the power of capitalism's ability to produce and maintain collectives based upon shared sexual and gendered subjectivity (Stryker 2017).

In 2013 the American Psychiatric Association published the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), which included an amendment to clinical approaches regarding transgender (trans) persons. The latest edition modified the language used to "diagnose" one as transgender by replacing

“gender identity disorder” (GID) with “gender dysphoria.” The DSM-V defines gender dysphoria as “the distress that may accompany the incongruence between one’s experienced or expressed gender, and one’s assigned gender” (APA 2013). It continues through clarifying that this experienced “dysphoria” is not indicative of all those who are said to have a sex/gender incongruence yet also makes a direct link between dysphoria and the alleviation of “distress” through physical interventions, including biomedical transition (Wiggins 2020).

This recent linguistic shift is understood to be necessary on behalf of the psychiatric community as a means of “removing stigma” that also “removes the connotation of a patient being disordered” while still ensuring the classification “protects access to care” for transgender “patients.” By referring to the distress caused by incongruence as *dysphoria* instead of a *disorder*, the psychiatric community attests that the clinical problem is the distress, not the incongruence itself. However, it must be noted that language recommending the “diagnosis” of “patients” is still present within the psychiatric community’s approach to evaluating transgender subjects. Psychiatry and endocrinology overemphasize the need for clinical intervention to mediate between assumed biological “needs” and cultural comports (Lane 2018, Rubin 2003).

“Gender dysphoria” is recognized as a conceptual domain ingrained within power dynamics, physical and mental health discourse, as well as subjective understandings of the transgender self. I will highlight the various components that speak to its construction and the resulting social effects to operationalize this term. Gender dysphoria provides an explanatory model for the psychosocial processes involved in transgender.

According to the DSM-V, the crux of gender dysphoria does not reside in the experience of being trans in and of itself, but rather, dysphoria is caused by the socio-cultural stress, anxiety, and discomfort of living as an incongruent gendered self-body in a cis-normative world (APA 2013). Diagnosis of gender dysphoria also provides institutional recognition of one as transgender, a point of contention within trans care communities that dismantle paternalistic gatekeeping within trans medicine. Advocacy by trans activists has led the way in pushing for care models emphasizing self-actualization rather than adherence to traditional paternalistic approaches. However, many activists, trans scholars, and trans clinicians featured in this study have divergent perspectives regarding the application of WPATH guidelines and question the level at which contemporary standards of care remove paternalism and gatekeeping from GAC.

Contemporary biomedicalization, pathologization, reliance on “diagnosis” has a history embedded within white supremacy, settler colonialism, and cultural othering of trans people. Through giving attention to the historical conditions which produce contemporary facets of trans care, the divergent stories of trans people included in this research can be contextualized. In deploying these stories to *queer* care, recognition of trans medicine’s history concerning its mutual construction with trans activism must be considered.

Activism, Revisited

Advocacy and activism are central to this work as it is a catalyst for the type of *queering*, I illuminate. First and foremost, activism is labor both in the physical sense of

bodily work and through affectual labor. Affects produced from labor's recognized, experienced, or felt impacts that are considered in keeping with the aims or objectives in question are realized through relations of ethics. If we accept that activist labor is constituted of actions that provoke both paradigm shifts and changes in social relations, the present disruptive function could be said to be reminiscent of an inherently queer quality. While activist labor is not a specifically queer endeavor, actions intent on agitation and disruption of established norms undoubtedly demonstrates fundamental tenets of queer as analytic. While modern medicine is predicated upon the West's affinity for hierarchal organization, trans people as authorities within care continuums challenge the immutable scientific authority that constructs healthcare as a socio-cultural object of analysis. In thinking through this transformative domain within medicine, I'm left wondering, does the presence of trans authority within medicine always include interaction with activist discourse? If so, to what extent and what are its limits? If not, when trans people desire to care for their community, one that experiences extreme marginalization and vulnerability, why not embrace the aims of activism or even liberation?

This work explores the relationship between community-driven activism and community-driven healthcare practice. Research in medical anthropology has a history of emphasizing the role activism has in ethnographic research that intersects gender and sexuality (Parker 2012). This project has been concerned with how trans medicine has been impacted by trans activism from its inception. Specifically, I was interested in how lived experiences of trans people themselves articulated with activist discourse and the

capacity for providing gender-affirming care. As this project was being evaluated by academic mentors and trans community collaborators for its scholarly merits and research feasibility, it was clear that ethnographically centering the voices of trans-activists-turned gender-affirming clinicians was crucial. Knowing a trans activist who became a therapist caused me to consider points of articulation between activist labor and healthcare practice. However, through fieldwork, I learned that the relationship between being a trans patient seeking and receiving GAC and then providing GAC as a healthcare professional does not always involve prior activist practices.

Mainstream liberal LGBTQ+ activism relies upon identity politics to garner support and achieve “change” through legislative and legal processes. Hate crimes legislation increases the relevance of the prison industrial complex in developing “solutions” to mitigate anti-trans violence (Bassichis, Lee, and Spade 2015). The state then constructs “trans” as a protected class under regulatory surveillance, which compels trans people to fit within sanctioned ideals of *transnormativity*. The production of the respectable, white, and gender normative trans subject under capitalism then becomes the way trans lives are deemed livable (Beauchamp 2019; Johnson 2016). Sociologist Laurel Westbrook argues identity-based anti-violence activism fails to apply intersectionality in interpreting how trans people experience vulnerability and violence based on intersecting subject-positions such as race, class, immigration status, ability, and occupation (Westbrook 2021).

Anthropologist Naisargi Dave posits that activism constitutes a practice of ethics where relations are situated beyond their intelligibility to the state, law, or identity

politics. Dave's ethnographic research among lesbian activist collectives in India highlighted how activism moves beyond legitimizing oppression by representing its inverse. The ethics of activism produce a fashioning of the self where its practice and labor establish new subjectivities. Intersubjective relations among lesbian activists in Dave's work and trans activist/clinicians in my work allow for an expansion of potential possibilities in reimagining social conditions through activist labor. I adopt Dave's conception of activism as constituting Foucauldian problematization, novel invention, and creative, relational practice in this work. (Dave 2012). For Dave, activism is based on a yet-to-be-determined imaginary of potential. From this perspective, activism is understood as resisting institutionalization as it resides in the experience that moves individuals and collectives to imagine new worlds and structural conditions.

I want to emphasize the importance of "imaginative labor" when writing about how trans healthcare professionals reflect upon their work concerning their careers, fields, and communities. This work posits activism as a set of affects that engages with the yet to be imagined possibilities (Muñoz 2009). In her 2008 ethnography, *Moving Politics: Emotion and ACT UP's Fight Against AIDS*, sociologist Deborah Gould details the rise and fall of ACTUP's political mobilization throughout the early years of the global HIV/AIDS crisis. Gould positions activism within what she calls "political horizons," where potential is imagined, and desires emerge out of reach for necessities. To foreground activism's political horizon, Gould centers her approach on analyzing activist labor through the framework of affect. Through considering how emotions are

interwoven within an activist practice, relations embedded within moments of uprising can be more holistically traced (Gould 2009).

According to Gould, “the movement in ‘social movements’ gestures toward the realm of affect; bodily intensities; emotions, feelings, and passions; and toward uprising” (3). Like in the case of HIV/AIDS activism of the 1980s and 90s, participants in my study are invested in the aims of desires of activist agendas. And while the stakes associated with the drive to participate in activist labor are different, many do argue the life-or-death nature of organizing around trans existence and medical access. It should be noted that contemporary trans arguments in favor of framing access to affirming medical services as “life or death” is consistent with data emerging from research on health outcomes and impacts to quality of life among trans patients (Green et al. 2021).

One challenge facing this work as it attends to trans activism is mitigating the articulation between queer and trans of color activists in the years surrounding the Stonewall Inn uprisings and that of white liberal assimilationist political activism of the late 20th and early 21st centuries. In addition to these movements, this work also contends with contemporary liberatory and abolitionist political formulations that are not new but are gaining recognition and taking up space thanks in part to social media mobilization and waning confidence in mainstream LGBTQ rights discourse. When I use the phrase “trans activism,” it can be challenging to clarify which form of activism I am addressing or indexing in this writing. This signifies the truth of trans lives, labor, and organizing existing as ontologically multiple. Liberating understandings of trans activism from white modernist classificatory domains is key to expanding the academy’s recognition of

critical trans politics and reframing the political landscape in which trans people engage in activist labor (Spade 2011; Stanley 2015).

For this work, the historical through-line of labor that constitutes “activism” emerges from pre-Stonewall trans-led uprisings to Sylvia Rivera and Marsha P. Johnson’s Street Transvestite Action Revolutionaries (STAR) and on to HIV/AIDS activism by AIDS Coalition to Unleash Power (ACTUP). Since the 1990s, numerous organizations and initiatives representing mutual aid networks, abolitionists, and self-described “politically pragmatic” have comprised a robust, though often fractious, force for improving trans lives (Stryker 2017; Spade 2020). While it would be inappropriate to unilaterally assign the designation of “activist” to all trans healthcare professionals, their work extends community-centered care networks spanning decades. Furthermore, the presence of trans people within positions of clinical authority has been described as nothing short of “miraculous” by a trans scholar consulted in the planning of this project.

Participants in this study fell into one of three general categories based on their relationship to trans medicine, activism, and professional labor. Some of my participants expressed participation in activism before becoming healthcare professionals. They brought on-the-ground perspectives both from their own experience as a patient of trans medicine and an advocate for their community. It should be stated that continual identification as an “activist” varied among healthcare providers in this group. Others began to assert an activist identity through their experience as providers and recognition of their liminal position as clinical authority within systems that afford them life and self-actualization. In conversations with these individuals, it was clear that they viewed the

rarity of their experience-informed expertise as a disruptive anomaly within their respective fields of practice and thus constituting something resembling activism. Lastly, a few participants claimed to have activist aspirations through their care work. Still, they acknowledged that the eventual goal of a life based on community-centered advocacy had yet to be realized. The similarities and divergencies between the lives of trans health professionals in Southern California will be fleshed out in the proceeding chapters.

Southern California: Transcending Urban, Suburban, and Rural Divides

California has long been a leader for trans activism, research, affirming policy change, and advancements in trans medicine and clinical care. In the 1950s and 1960s, the state was home to trans activist organizing, culminating in the 1959 Cooper Do-Nut uprising against police in Los Angeles and the 1966 Compton's Cafeteria riots in the Tenderloin District of San Francisco. The Cooper Do-Nut and Compton's Cafeteria riots marked the start of trans-led militant uprisings that preceded the Stonewall Inn riots in New York City (Stryker 2017). Contemporary research on the intersections of queer theory, queer community, and geography foregrounds my research. Queer theorist Jack Halberstam argues queer life and visibility is guided by *metronormativity*, which creates normative queer narratives based on affiliation with metropolitan urban centers and a rejection of rural living as culturally "queer" (Halberstam 2005). Inland Empire-raised queer theorist Karen Tongson complicates urban/rural dichotomies in Southern California through centering suburbia and critiquing its role in reproducing white, neoliberal, and imperialist American cultural values (Tongson 2011). Access to queer and trans sociality,

including networks of care, is bifurcated by urban/suburban/rural divides, which translates into regional trans health disparities.

The prominence of urban-centered trans medicine is evident in the history of medical researchers and physicians at UC San Francisco, Stanford University, and UCLA pioneering advances in transgender health and gender-affirming surgery (GAS) throughout the 20th and continuing into the 21st century (Stryker 2017). As of 2013, the California Department of Managed Health Care (DMHC) has required all health insurance plans offered to consumers in the state to cover transgender health services, including GAS. This mandate also extends to the state-run Medi-Cal program for low-income Californians. Directives and guidance at the state level do not further specify which medical procedures should and should not be covered, nor does the state mandate a specific range of medical procedures be included in insurance plans or treatment protocols.

However, for as trans-affirming as California seems to be on paper, the protections and inclusionary policies do not translate into widespread accessibility for healthcare or general safety on the streets and in institutions. National political discourse and systemic inequalities that shape the contemporary trans experience are also reflected across California. The Southern California counties of Los Angeles, Riverside, and San Bernardino represent a microcosm of wildly uneven living conditions for the trans community. Within a one hour's drive, the distribution of community resources and healthcare providers competent in trans health ranges from safe and inclusive to almost non-existent. While Los Angeles is perceived as a bastion of progressive politics, the

growing unhoused community, expanding the reach of gentrification, systemic violence, and mounting wealth of the privileged illustrates inequality as a byproduct of the city's commitment to neoliberalism racialized policing. Suburban and rural regions of Southern California struggle to accommodate communities Los Angeles pushes out, leading to demographic and political-economic shifts.

According to research conducted by the Williams Institute at the UCLA School of Law, there are 1.4 million transgender adults and 150,000 transgender youth in the United States, constituting approximately 0.6% of the U.S. population (Herman et al). This figure will be cited for demographic purposes throughout this research and used to estimate trans population distribution within specific geographic regions per 2010 United States Census data. This project is interested in transgender health within the Southern California counties of Los Angeles, Riverside, and San Bernardino. These counties represent urban, suburban, and rural population centers with an estimated total transgender and gender nonconforming (GNC) population of 88,000 people. Southern California perfectly, but unfortunately, illustrates the *patchwork* (Plemons 2017) of institutional systems and practices that comprise transgender medicine and care due to its clusters of abundant resources in some areas contrasted with regions with very few trans-affirming providers.

The Inland Empire encompasses Riverside and San Bernardino counties with an estimated population of 4.5 million, including approximately 27,000 transgender and gender-nonconforming people. The greater Los Angeles area's eastern suburbs bleed into the western cities of the Inland Empire, effectively establishing overlap in social and

medical service outreach for the region's trans population. However, as one moves east, population density decreases, as well as the distribution of trans-affirming healthcare providers. In recent years, trans serving biomedical and mental healthcare institutions have been established in the Inland Empire and Coachella Valley regions; however, their reach and service offerings are limited compared to the established providers in Los Angeles County.

This research seeks to understand how trans health disparities are mapped upon the geographic distribution of trans-serving institutions of care across Southern California. In connecting positive social change with community organizing and activism, this work desires an intimate knowledge of the interworking of trans medicine in Southern California among community members actively engaged in professional healthcare work. Given the moment in history I conducted fieldwork, the social conditions made possible by the COVID-19 pandemic provided an opportunity to examine how trans healthcare systems and providers mitigated challenges in providing care. By ethnographically centering the voices of trans healthcare professionals, this work highlights the role trans people have in providing care and evaluating the quality of care provisioned to trans patients.

Outline of Chapters

In this first introductory chapter, I introduced new configurations of trans medicine that include trans people as authorities within GAC. The reconfiguration of trans medicine rests on a queering of care based on an expansion of trans activism's reach beyond the streets and into the clinic. In the chapters to follow, I frame trans medicine

within Southern California during the COVID-19 pandemic by privileging the narratives of trans health professionals across diverse regions and modes of practice.

Chapter two will provide an overview of this project's positionality within anthropology and its use of ethnographic methods. As this work was imagined and realized during a time of social and political upheaval, I will show how I approached ethnographic work considering the COVID-19 pandemic and social and political turmoil in the United States. How GAC is shaped by ongoing social instability demonstrates how trans lives and experiences challenge or *queer* status-quo understandings of care, and thus my use of methods reflects this queering.

Chapter three engages trans medicine and personal narratives of experience within Los Angeles and Riverside Counties in Southern California. I present how care is imagined, carried out, and queered by trans people across proximal urban, suburban, and rural subregions. This chapter also assesses how class, race, ethnicity, and California healthcare policies intersect with approaches to trans care across a socially disparate yet infrastructurally interconnected region.

Chapter four follows the voices of trans healthcare professionals in detailing their relationship with community advocacy, institutional affiliation, and clinical authority. Through centering trans narratives of navigating the world as patient and provider of GAC, I show how a queering of care involves disruption to oppressive mechanisms within medicine and constitutes its reproduction.

Chapter five focuses on newly emerging patterns in trans medicine and specifically within mental health due to the COVID-19 pandemic. The expansion of

telemedicine within GAC paradoxically promotes access while solidifying persistent barriers. I engage my observations from attending a trans health conference panel featuring national leaders in direct-to-consumer GAC products and trace perceptions of teletherapy among trans LMFTs across Los Angeles County.

In conclusion, chapter six provides a final assessment of the *queering care* analytical framework based on its utility as a lens to interpret the role trans people have in shaping its practice. I also review how the theoretical and methodological interventions of this work contribute to knowledge about trans people and medicine in anthropology and transgender studies. Lastly, I present opportunities for future engagement with trans care considering contemporary structural challenges to its provision.

Through situating this study within the lived experience of trans physicians, therapists, and healthcare system navigators, I challenge medical and queer anthropology's ethnographic scope. Regarding trans people as an authority in medical practice, I hope this work challenges reductive disciplinary interpretations of trans people and contributes to a growing body of knowledge where trans stories, lives, and experiences are centered.

Chapter Two: Methods and Trans Health Research in Anthropology

Framing Queering Care

This work denies a single meaning of truth. As an ethnographic project in both, the knowledge presented here is partial and contextual (Clifford 1986). The embrace of reflexivity to distance ethnography from western ontologies of modernist science and deploying the queer critique resists fixed and immutable expectations to interpret the stories featured in this work. This work cannot provide a universally accurate account of healthcare systems, protocols, procedures, or standards of care, nor is such an endeavor a goal in completing this research. The presentation of narratives and the integration of storytelling highlight living experience and meaning-making patterns among trans health professionals. Reconciling one's authority as a provider of institutionally legible *care* with one's experience as an object of the same institutional dynamics that informs said care is at the core of this work. Also, expanding how I use the term "care" as a part of "trans care" includes activist labor and practice. By adopting a broad contextual use of "care," I can better apply the queering care framework in arguing for a radical departure in assessing *how* trans people imagine and interact with care as both patient and provider. Furthermore, the queering care framework allows trans care to be examined as medical practice and activist ethics.

This chapter opens with my desire to illuminate the words of trans healthcare professionals when considering questions of representation and my use of narratives collected throughout fieldwork. As a reflexive exercise, I engage directly with the voices

of the people who made my ability to produce knowledge possible. I show how trans healthcare professionals serve as co-creators of knowledge through integrating moments of reflexivity throughout the data collection process.

In the following section, I offer a critique of anthropology's methodological and theoretical legacies that foreground this work. I also provide an overview of how the concept of the field site has been challenged due to the necessity of remotely engaging with community members who are already dispersed across multiple subregions in Southern California.

In the third section, I summarize this project's research design and application of methods. I focus on how this project relates to the community through the language used in its design and outlining participant recruitment. This section also provides an overview of data collection, management, and analysis from the design phase and continuing through the writing of this dissertation.

In the final section, I provide an analysis of my foray into "Zoom Ethnography." As the COVID-19 pandemic was an ever-present entity during fieldwork, this section offers an honest rendering of my shift from trepidation to acceptance to embrace a modified methodological toolkit.

A Moment of Reflexivity: Engaging Participants in Evaluating Research

At the end of my interview with Skyler, a white, Los Angeles based trans man who works as an LMFT and educator, he said something that surprised me: "Um, you know actually found it pretty surprising that you are doing this research as a cis white gay

guy [laughter], you know? or queer guy...I mean that it's rare for me to find individuals that care about the trans community, other than other trans people.”

There were several takeaways from this interaction that I wish to unpack. First, I had an emotional reaction to Skyler’s statement. While I am naturally a dramatic person, I never planned to have an ethnographic encounter that caused my eyes to water. There is a general expectation within the trans community that the outside world does not care about them. Their lives and well-being are considered abject, and if they are brought into consideration, they are fetishized, tokenized, or violently victimized. This is the reality of being trans in the United States, and this passage from Skyler’s story is a window into the uphill battle trans healthcare professionals are facing in caring for their community. Skyler’s words immediately reminded me of my conversation with trans healthcare system navigators in the preliminary stage of fieldwork. During an enlightening and often jovial lunch meeting, someone said, “No one cares about us. We have to do the work because no one is going to do it for us.” The introduction to this dissertation reflects on these themes through the voice of Hank and his desire to be the one who is doing something to benefit his community.

Second, I appreciated Skyler problematizing my gender in stopping himself after referring to me as “gay” and instead of settling on “queer.” Of course, I am white; I do self-identify as gay, inhabit “maleness,” and do not take on the adjective of trans to describe my subjectivity or gender experience. However, through my engagement with the trans community and fieldwork, I recognize the necessity to problematize my own normative-*ish* gender presentation. A critical error anthropology has made in its attempt

to apply ethnography to the study of gender expansion is the lack of attention given to “cis” subjectivities rendered normative and immutable. Furthermore, this conflict speaks to the need to problematize the cis/trans dichotomy.

My gender subjectivity is not as fixed as I assumed a mere five years ago. According to Butler, no one’s connection with “gender” is particularly fixed, so of course, this is not a surprise. Yet, given my gendered socialization within “cisgenderism,” I neglected to turn the critical lens inward even in the early days of my intellectual curiosity within trans community issues.

Methodologically, I had always struggled with studying the trans community and asking trans people to be “subjects” within another investigatory project into their lives. Anthropology provides a space for this distance to be perfectly acceptable, even expected. However, the idea of me embodying the image of the benevolent and reflexive anthropologist studying “the other” seemed absurd. I was (still am) extraordinarily insecure about my positionality as an ethnographer of trans care, should we not create a space for trans anthropologists to be doing this work?

In these moments of insecurity grounded in my reflexive training in anthropology, I find Anima Adjepong’s practice of *invading ethnography* to be helpful in problematizing my relationship with the field. They write, “...the construction of the ethnographer as ‘another white boy tourist’ is instructive” (Adjepong 2019:28). This critical engagement with the performative elements of ethnographic work addresses the anxieties I have felt as I perceive myself as an *invader* in trans spaces. Furthermore,

invading ethnography creates a productive space for my fears and discomforts to exist and become part of analyzable insights.

At the end of every interview, I would fear that “Zoom fatigue” would be setting-in for whomever I happened to be “zooming” with that day. However, I always asked participants about their thoughts regarding trans representation in social science research. These questions were ways to turn my discomforts in research into something productive that also challenged the inherent power dynamics that often frame research. These parts of interviews were extraordinarily “meta” in that as a part of the interview from which I was eliciting ethnographic data, I was also expecting the interviewee to offer insight into the research process. While this work did not deploy Community Based Participatory Research (CBPR) methodology, my approach to ethnographic work is greatly influenced by the ethics of community engaged research. I viewed participants in this study as cultural experts, collaborators, and co-producers of knowledge (Rycroft-Malone et al. 2016). Discourse in health research regarding the dissemination or “returning” of knowledge to communities asked to participate in research that led to its creation (Chen et al. 2010) informed my desire to pose reflexive questions during interviews. Also, in knowing the legacy of how anthropologists have misrepresented marginalized communities, especially those which could be classified as “gender expansive” (something that will be explored later in this chapter), I desired a component of this project to address disciplinary missteps, provide a space for participant feedback, and to offer a critique of the research process in which I had asked trans healthcare professionals to participate.

When I asked Chris to share his thoughts about the role of a non-trans researcher doing trans community research, he said, “I don't think that your cisness makes it that it's bad research. Inherently good research is meant to be objective, right?” While I strongly disagree with the assertion that ethnographic research is anything close to objective, I appreciated Chris' affirming words. And yes, given he is trained in Psychology, I could forgive him for his misreading of ethnography. Chris then flipped the script when he said,

“I think sometimes people outside the community are not going to have the same blind spots that people inside the community are going to have. So, it's just a different perspective and just being mindful of biases that might be a play, which you should be doing in any research anyway, particularly in the social sciences; it's good research. Because I've seen trans researchers do shitty research. Good research is good research. It's going to look at the nuances of the data. It's going to try and encapsulate the data as best as possible, and research needs to be done. And if we're only saying trans people can do the research, we're not going to get enough published.”

Here, we see Chris adopting another pragmatic approach, but this time, not about institutional standards and gatekeeping. Chris views the need for an ever-expanding array of trans knowledge to supersede calls for prioritizing trans voices in carrying out research and reporting results. While alleviating some of my insecurities about being in this research arena, this view would be met with consternation among some trans scholars and activists (Radi 2019; Galupo 2017).

Stacy, a white trans woman who is a psychiatrist living in Palm Springs, did not mirror Chris's affirming attitude in terms of evaluating trans community research done by trans or non-trans researchers. She said,

“You know, most transgender research is not generated by transgender individuals. I'm promoting transgender research because I am a medical doctor. I'm a physician. So, my questions that I want answered obviously are going to be different than the questions that an anthropologist would want answered. The

questions that I want to know is how progesterone causes your titties to get bigger. That's a big thing for us. And as a doctor, I can do that trial, I can answer that question.”

While Stacy was kind, gracious, and supportive of my work, she did not hold back in expressing her frustration that trans people do not create a great deal of knowledge about trans people. Beyond her frustration with the overabundance of cis representation among researchers of trans people, Stacy highlighted the role that trans people play in crafting research questions based on issues and concerns that directly impact their everyday lives and bodies. Her research in breast tissue growth and HRT reflects potential shifts in research questions and production of different kinds of knowledges due to trans people doing, not just participating in research.

Jaylen, who is Black, non-binary, and works as an LCSW in a QTPOC-centered organization in Riverside, is intent that inter-community diversity is respected in research. They said,

“There’ll have to be a fight to include more than one identity. Though the identities are vast, they are important to people. To capture the actual full story of whom you’re researching, your biggest thing is understanding nuances within the trans community. And of course, you’re not going to capture them all, but to get to a space to capture them all means there needs to be a discussion and changes within the research community as a whole.”

Jaylen’s lived experience as a trans person who is assumed to be a woman but who layers the language they use about their gender reinforces the point they are making. When I asked Jaylen which words, they use to describe their gender, they replied, “Queer, non-binary, non-conforming, genderqueer. Um, those are the terms I use interchangeably.” This personal attachment to multiple terms that speak to their experience reflects their concern that all subjectivities and embodiments within the trans community find

representation in research. I will build off Jaylen's words later in the chapter as I discuss my use of language in this work and the broader discourse concerning categories of subjectivity and embodiment.

I briefly alluded to the fact that many of my Los Angeles-based participants were white trans men. In the design phase of this project, I intended to recruit as diverse of a sample population as possible. Being trans transcends racial, ethnic, and class-based divides, yet there were limitations in how representative this study would be. Systemic inequalities in education and clinical training have led to disparities in representation among trans people of color within the healthcare practice. Also, since this project exclusively focused on trans healthcare professionals in Los Angeles and Riverside Counties, the recruitment scope was intentionally limited.

I asked Kim, a west Los Angeles based white trans woman who works as an LMFT her perspectives of research within the trans community. She said, "Well, I hope we can get it right and that we represent the diversity of the trans experience, there's not just one narrative, and it'd be easy to see all the research done through the lens of white trans experience." Kim's words reflect Jaylen's desire to open up perspectives that do not privilege the most privileged in the community.

In terms of trans representation, Pablo, a non-binary Latinx person who works as an LCSW in Riverside, foresees continued improvements to trans community research as being linked to expanding community-based participatory research (CBPR). They said,

"An uplifting, or maybe collaborating with up-and-coming trans researchers. I know that's hard and that they are difficult to come by. But I think it's one of those things that is needed as you gain credibility and visibility on the community on an academic level. It's like bring someone with you, whose research you've built on

because ultimately, all research is built upon prior existing research that trans people have already done.”

Pablo’s words deeply resonated with me because of my previously mentioned insecurities regarding my place in trans community research. The idea of maintaining recognition of how knowledge is built off community experience and local ways of knowing and using one’s privilege within the academy to empower and uplift future generations of trans scholars. Mitch took this energy one step further in saying,

“I love to participate in research, but I would say to any researcher is please share your results with the community, because what happens, many times is people [researchers] get the information from the community, and then they can even get notoriety from it, they can publish a book they can get tenure, they can they get awarded, but in what way is the community better? In what way is the community benefited? So, anything that can be gathered from our community can then be shared back as an educational resource for our community.”

Questions of ownership and stewardship of trans knowledge guided Pablo and Mitch’s responses to my questions about trans representation. In grant writing, we are taught to consider the “broader impacts” of our research and “real-world” applications of the work we do and the knowledge we produce. Perspectives most certainly vary regarding the level of co-collaboration that should take place in research. The points raised by Pablo and Mitch and those raised by all participants mentioned above provide a basis from which the ethics of research can and should be (re)considered.

Queering Anthropology and (Re)Imagining the Field

When a person applies to graduate school in anthropology and submits a research plan, department faculty rarely expect the eventual project to be identical to the original plan. This was communicated to me by numerous faculty members and other graduate

students. This knowledge was always a source of comfort for me. I interpreted it as permitting me to grow, adjust my expectations, and follow my shifts in perspective and interest. However, one of the pitfalls of this institutional allowance is the potential for untethered and under-guided exploration. The ensuing professional and academic flailing permit unsustainable freedom which, at least for me, translated into taking steps forward in what the institution understands as a “timely manner.” The internalized pressure, self-doubt, anxiety, and real stigma of this graduate school journey works as a negative feedback loop. Absent presumed “progress” translates into a lack of drive and initiative to put oneself out there to see research projects through to their end and submit work for publication.

Perhaps an evaluation of how anthropology departments admit and support graduate students in their careers regarding the intersections with their personal lives is needed to promote a healthy environment based on guided growth and enrichment and which fosters intellectual maturity centering the person, not the person expected results. Throughout my meandering interests, one consistent through-line through the many years it has taken me to reach the dissertation writing phase is *transition*. Of course, I use this term in myriad ways in the writing of this dissertation but here, I wish to examine the word beyond its relevance to the trans community and consider its broader implications in my ethnographic interests. First, the twists and turns involving dissertation committee changes, project topic shifts, and many starts and stops with research demonstrate the transitive nature of my career.

In past decades, my relationship with “the field” would have sparked curiosity, if not controversy within anthropology. The legacy of ethnographic fieldwork rests on the understanding of imagined ideation or even fantasizing of an intrepid anthropologist equipped with a toolkit, both literally in terms of materials needed for living and survival in parts unknown as well as figurative in terms of methodology. Today, the scope of ethnographic fieldwork has been deconstructed in the aftermath of the literary turn of the 1970s and 1980s. The search for objective reasoning and scientific rigor gave way to postmodern critique and reflexive analysis. In the 21st century, the shifts of 40 years ago have sprung forth new intellectual offspring regarding an ethnographer’s connection to the field. Field sites are currently imagined without a passport and airplane.

The “site” in which trans health is realized is embedded within the colonial logic of white cisgender heterosexual patriarchal capitalism. The biomedicalization of trans bodies and the knowledge produced reflects a paternal relationship between medical authority and patients they serve, treat, and ultimately make into objects of the clinic. The task in this work is to center the embedded and sometimes divergent actors operating within and situated as a part of the field. The disparate arrangement of trans bodies within networks of professional (i.e., settler state-sanctioned)

The subfield of queer anthropology exists in a site of contestation. A continual battle within itself to define its scope is punctuated by a collapsing of past ethnographic work in feminist and gay and lesbian anthropology within the same domain as contemporary broadly interdisciplinary work centering on dynamic conceptualizations of sex and gender. Furthermore, the integration of the queer critique within ethnographic

work more broadly challenges the assumption that queer anthropology is solely the domain of research that centers on LGBTQIA2S+ populations.

Current movements in queer anthropology have worked to center non-western and non-white populations in terms of fieldwork practice and selection of a field site. The challenge to white modernist epistemes extends to the creation and application of theory in queer anthropological work. Contestation of the traditional theoretical canon in anthropology and the move to embrace methodologies of decolonization and indigenous theorizing work to liberate scholars housed in anthropology who yet want to move beyond the limited confines as defined by decades of methodological and theoretical precedence.

Queer anthropology can trace its foundations to Margaret Mead's deployment of the feminist perspective in her analysis of cross-cultural gender roles in Samoa, Melanesia, and North America. By using non-western cultural contexts as a thought experiment intended for Western academia and in Mead's case, a general public audience, allowed for some level of deconstruction of western sex/gender essentialism. A necessary counterpoint to this narrative of gender liberation facilitated by Mead is her lack of critical analysis of gender beyond binary formulations reflective of western heteropatriarchy. Mead's contributions were vital in anthropology's pivot from biological determinism. Yet, her work falls short of engagement with what anthropology would be obsessed with for decades after her death: non-western sexuality and gender variance. However unfortunate, anthropology in the two to three decades following Mead's death would continually reproduce western and (neo)colonial logics when encountering and

writing about gender and sexuality. What's even more damning is anthropology's apparent need and desire to fit cross-cultural categories of being and desire within a legible taxonomy intelligible to western distinctions between sex, gender, and sexuality.

Gender variance is cross-culturally salient across non-western and indigenous communities a demonstrates sex and gender exist on a continuum rather than within western genitalia-based binary categories. These continuums of gender are not universal, nor should they be considered analogous to one another within global mores of indigeneity or Western embodiment patterns. To the consternation of contemporary queer anthropologists, past ethnographers conducting fieldwork in North America, Southeast Asia, Melanesia, and Polynesia have often misrepresented non-western "homosexualities" and gender variation as being analogous to western queer sexual practice and gender performance (Bleys 1995; Towle and Morgan 2002). Anthropologist Kath Weston referred to this tendency as "ethnocartography," where anthropologists sought sameness and similitude between sexuality and gender systems in the West and non-western communities (Weston 1993).

Trans, non-binary, gender non-conforming, and gender-expansive people are often at odds with the Euro-American binary sex/gender system, which centers settler-colonial, white supremacist, cisgender, heteronormative, and patriarchal cultural values and embodiments. Trans people are often perceived as embodying a challenge to Euro-American cultural conventions of gender. This assumption is frequently amplified in the social sciences, especially anthropology, as contemporary western trans subjects are propped up as "Figure A" in overgeneralizing declarations of universal cross-cultural

variance. While gender variance beyond western binary categorization is historically and cross-culturally salient, the tendency to assign the label of “transgender” reveals a reproduction of the western hegemonic ordering (Valentine 2007; Stryker 2017; Towle and Morgan 2002). While anthropology recognizes trans and gender-expansive communities as worthy of ethnographic study, the ex post facto taxonomy privileges western cultural legibility. This ethnocartographic tendency clearly shows the capacity for trans and gender-expansive communities to determine “primitive” origination of sex/gender variance. Such a schema reduces the lived experience of trans and gender-expansive while also objectifying them as evidence for biologically determinist frameworks.

Scott Lauria Morgensen pushes the needle further in assessing the deployment of “queer” as a settler-colonial endeavor linking the expropriation of indigenous land to this misrepresentation (Morgensen 2011). The western academic tendency to expand “queer” to encompass all configurations of gender and sexuality rendered intelligible by the binary paradigm for the sake of “inclusion” promotes a faulty set of assumptions. This shows how settler ideology is grounded in western theorizations of the cultural “other,” where attempts to promote inclusive discourse do nothing more than reproduce colonial and orientalist representation. Furthermore, the legacies of settler colonialism and white supremacy have impacted how anthropology and ethnographic work on gender variance represent communities outside of western heteronormativity.

Margot Weiss suggests the utility of “queer” rests within its call for us to think “differently,” a call she links to the general aims of anthropology (Weiss 2016). She

continues to flesh out “queer” as not only a community identifier but as a way to “signify transgression of, resistance to, or exclusion of normativity, especially, not exclusively heteronormativity” (628). This research makes use of queer in the same dualistic manner, as trans people are regarded as queer subjects and through this project’s attention to resistant acts of transgression within biomedical and psychiatric care practices. By thinking differently or against accepted convention, Weiss argues that anthropology is unbounded and adapt methods to shifting cultural terrains, which situates the discipline as *inherently* queer (628) in its methodological scope.

While this assertion is potentially productive for the aims of this work, I exercise caution in propagating the notion of anthropology’s inherent “queerness.” Due to the discipline’s history of privileging the settler-colonial gaze (Morgensen 2011), I adopt an adapted understanding that posits anthropology’s queerness as conditional to its deconstruction and critique. In the era of the post-postmodern turn and reflexivity in ethnographic writing, I argue anthropology *can* be queer if the discipline desires queerness. By embracing resistance to the proper objects of anthropology, forging an alliance with antinormative analysis, and engaging desire over identity, ethnography can adopt the queer analytic.

I sought what Clifford Geertz referred to as experience-near or the natural and effortless ways trans health professionals define themselves and their relation to care (Geertz 1983). This work examines the ways participants understand their subjectivities, worldview, and experience through exploring how the professional is blended with the personal. In keeping with a familiar trope found within queer anthropological fieldwork,

conducting ethnographic research among queer communities involves navigating what Boellstorff refers to as fragmented field sites. The (dis)locatedness of my intended field site is rendered “fragmented” not due to a lack of cohesion among members of the trans community but due to the set of imaginaries detached from spatial physicality yet attached through intersubjective affective experiences (Boellstorff 2005). These detachments from expected physical locatedness are amplified beyond the narratives presented by traditional narratives of queer community coalescence.

Project Origins

I am not an activist, healthcare professional, or a person of trans experience, yet this project required engagement with people whose lived experience intersects all three of these domains. My connection to the trans activist community began in 2014 when I became acquainted with trans activists living and working in Los Angeles and Orange County, California. My relationship with trans activists grew from contacts established through adjunct teaching at Chapman University in Orange and eventually expanded networking (Merry 2005).

In 2018, I learned about trans activists expanding their advocacy work into healthcare practice, especially within mental health fields. In conversation with community contacts established in 2014 and maintained through the present day, I learned of a growing pattern of trans people who could enter graduate programs in clinical psychology and the communities that flourished due to their increasing presence in the field. During this time, I explored the possibility of expanding my research interests

beyond Los Angeles also to include trans healthcare professionals working across inland Southern California.

My initial ideas for a project centering on trans activism alone, without the healthcare angle, positioned power in dialectical relationship with my would-be activist study participants. Shifting my project design to trace the interwoven relations of trans care, both activist and clinical, reconfigured the role of power in participants' lived experiences. I was aware during the design phase that most study participants would have advanced degrees and/or clinical authority of some kind. Out of the fourteen trans healthcare professionals I interviewed, twelve hold at least one graduate degree, while the other two are both in positions of power in their respective institutions of employment. I realized my project would effectively be “studying up” as I would be examining power relations between individual healthcare professionals, institutions, the aims of activism, and trans patients (Nader 1972; van Eijk 2017).

Upon reentering the Ph.D. program in anthropology at the University of California, Riverside, in the Fall of 2019, after withdrawing in early 2016, I began developing professional relationships with trans-serving health institutions across Riverside County. I developed connections among staff and healthcare professionals working with Borrego Health, TruEvolution, The Transgender Health, and Wellness Center, Eisenhower Medical Center, and recent Coachella Valley startup Queer Works. On several occasions, I have participated as a part of Borrego Health’s LGBTQ+ Task Force with their Office of Community Research, and trans staff members were instrumental in assisting in this project’s design and confirming research feasibility. Since

2019, I have worked with employees at TruEvolution, and Queer Works on several projects, including assisting with grant writing, developing an LGBTQ+ educational workshop, participating in a trans health symposium, volunteering at in-person outreach events such as Palm Springs Pride, and currently serving as a member of Queer Works' Board of Directors. The contacts established through these institutional relationships were crucial in establishing me as a presence within the community (both virtually and physically). Furthermore, these relationships were primarily responsible for assisting in study participant recruitment.

Language

I include this overview of language in the methods chapter because of the meanings invested in language use within this community and its role in representational politics. As previously mentioned, language is contested and, as I have shown, is dynamic in its use within the community. Categories and terms relevant to trans subjectivity and embodiment are shaped by deeply personal and public modes of socio-cultural comportment. Language reveals ways in which people understand themselves and their positionality in the world. Furthermore, as language within the trans community exists in constant flux, foregrounding my use of language in this intervention reveals the temporal context in which this work took place.

As a discursive object, the term “transgender” reflects a history of multilayered and nuanced modes of subjectivity. To reject the assumption that “trans” persists as a stagnant and black-boxed category of identity, this work will operationalize the concept, effectively linking its contemporary use with its history. “Transgender” has a story, and

the term (as was its conceptual predecessors) is continually contested within academic, activist, community, and medical discourse. This work situates transgender and its widely accepted abbreviation, “trans,” representing a spectrum of interrelated experiences united by people who do not continually identify with the sex assigned and the gender assumed at birth (Valentine 2007; Stryker 2017; Halberstam 2018).

Like *queer*, trans is used as an umbrella term inclusive of diverse and perpetually expanding compartments, quite perfectly representing Sedgwick’s “open mesh of possibilities.” Trans historian and leading transgender studies scholar Susan Stryker defines the concept of transgender as being “the movement across a socially imposed boundary away from an unchosen starting place—rather than any particular mode of transition” (Stryker 2017:1) and for it to apply to “the widest imaginable range of gender-variant practices and identities” (19). In the broadest sense, a transgender or trans person is someone whose gendered subjectivity and embodiment contrasts with socio-cultural expectations of their sex and gender-based on genitalia and sex/gender assignment at birth.

At the beginning of my first forays into trans anthropology, the category of non-binary was understood as within the umbrella of transgender, and thus, abbreviations such as “trans” typically fit for people using the non-binary label. When we accept the definition of transgender or trans as being “identifying with a gender other than the one assigned at birth,” the use of trans to include non-binary is clear. However, as discourse plays out and meanings rearrange themselves, the distinctions and overlapping terrain between these categorical terms are shifting at the time of this writing. The promise of

“transgender” as an all-encompassing term for gender expansion is being cast into doubt as understandings of being non-binary are currently in flux, while trans people who regard their gender subject position as binary are renewing their claim to the once outcast category of “transsexual.” Some in various pockets of the trans community deploy transsexual in essentialist terms that may or may not embrace separatism from mainstream movements in queer activism or as a mode to distance themselves from the perceived “fluidity” encapsulated by non-binary subjectivity today. For others, the embrace of terms that are narrow in scope provides a space for claiming and reclaiming within an ever-expanding field of gender expansion.

Methodological Training

My training and experience in community-engaged research with the Community Engagement and Dissemination Core (CEDC) with the University of California, Riverside School of Medicine Center for Health Disparities Research (HDR@UCR), brought consideration for polyvocal ethnography to the forefront of this project’s design. My work with HDR@UCR provided needed methodological training, which prepared me for dissertation research. As a Graduate Student Researcher, I served as project coordinator for the Center’s “Narrating the Pandemic: Coronavirus Health Disparities” project, where I assisted with IRB paperwork, research design, data organization, and data analysis. In working with fellow graduate students and supervising faculty, I honed my research skills and data management, especially in terms of conducting interviews using Zoom. Through my HDR@UCR training, I also learned how to use MAXQDA

data analysis software for the COVID narratives project and then, by extension, to analyze dissertation research data.

Interview recruitment took place through existing and newly formed relationships with community partners and organizations in Los Angeles, Riverside, and the Coachella Valley. Freshly formed relationships were facilitated by connections made apparent through my work as a Graduate Student Researcher at the UC Riverside School of Medicine Center for Health Disparities Research. I used a snowball sampling process to follow connections within trans community health networks and other community health organizations. Primary contacts were established with these partners in the community, and their selection was reliant upon their integration within the field of trans health.

Trans people were involved in framing this project and participated in conversations concerning research with trans communities. As part of my commitment to navigate trans spaces ethically and responsibly, used the Transgender Research Informed Consent (TRICON) Policy from The International Transgender Health (ITH) Forum (Winters, D'orsay, and Sirenu 2019). The purpose of the TRICON policy is to standardize the way researchers communicate details about their projects and research objectives when recruiting trans people as participants. This information was sent to participants and available for organizations I consulted while recruiting participants.

In ideal circumstances, I would have had the opportunity to meet prospective study participants in-person before conducting interviews. My anthropological training emphasized the role of relationship and trust-building with communities and interviewees. The conditions presented by the pandemic thwarted any plan of establishing

rapport before scheduling an interview. As I was placed in contact with trans healthcare professionals who would potentially be agreeable to an interview, I felt anxiety about the legitimization of my use of ethnographic methods. How would I be able to call my research “community-centered” and “ethnographic” if I was solely relying upon word of mouth (or, in this case, email) for the recruitment of one-off interviews through Zoom? How could I be holistic in analyzing the entire contents of the social relationship cultivated during an interview with participants? As I navigated these potential conundrums in the application of applying methods, I relied upon the existing literature on digital ethnography and virtual fieldwork.

The impact of the pandemic severely limited my ability to carry out research as according to my training in graduate school and ways I had long imagined. While the pandemic shifted my relationship to the field in ways, I had preferred it did not, I do not apologize for my use of methods or the quality of data I collected. Serendipitously, the pandemic allowed me to trace and examine the capacity of health institutions and providers alike to respond to an unprecedented set of challenges in providing care.

I was fortunate some in-person experience in the field before March 2020 and during the Summer and Fall of 2021. In the fall of 2019, I met with trans health administrators and health system navigators who work for an FQHC based in the Inland Empire. During this preliminary meeting, we discussed the feasibility of my project, networking opportunities, and future collaboration. A few weeks later, I was invited to the home of the chair of the City of West Hollywood’s Trans Advisory Board (TAB), where we discussed the aims of my project, its merits as a productive line of inquiry in

trans health, and his labor as an activist and impending licensure as a therapist. In February 2020, I was invited to attend the City of West Hollywood's kickoff of Transgender Awareness Week. The event was held in a well-known queer bar on Santa Monica Boulevard, and I was able to network with more members of West Hollywood's TAB and individuals in the trans care and activist community. These instances of what became fleeting moments of using the classical methodological approaches I had been trained to undertake were brief yet valuable in providing a foundation to carry out research.

Amid lulls in COVID-19 case surges, I attended in-person events in the Coachella Valley in association with Queer Works. These moments of in-person immersion included organization fundraisers, trans community awareness events, volunteering at Palm Springs Pride, and representing Queer Works at a Trans Day of Remembrance (TDOR) gathering in Palm Springs. In addition to in-person gatherings, I also had conversations with community partners, trans scholars, and other figures within regional queer and trans care networks. All these interactions provided an opportunity for me to engage with the community and trans health discourse beyond interviews.

Participant Recruitment & Rapport

According to data from the United States Census Bureau and the UCLA School of Law Williams Institute, the LGBTQ people make up 5.3% of California's population of nearly 40 million. Current estimates state that "transgender" people are 0.6% of the total national population; thus, all demographic information and population estimates are

based on that figure. As of 2019 estimates, the transgender adult population in Los Angeles County is 60,234 and 14,823 in Riverside County. It should be noted that these population estimates distinctly deploy the word “transgender” in broad terms and may or may not be inclusive of adults who are non-binary.

I conducted interviews among 14 trans and non-binary people I refer to as “trans healthcare professionals” throughout this work. I desired to have a population sample representing diverse expertise in GAC; however, from the onset of research, I was unaware of how many trans people work in healthcare across Southern California.

It was my intention for project data to reflect the diversity of Southern California and my regional subsets of interest. Structural inequalities and concerns surrounding access to education, licensing, and clinical practice was evident both in my sample population and in the data gleaned through ethnographic engagement. The barriers that historically limited or prevented trans and non-binary people from entering professional healthcare roles are still experienced today. Structural racism, white supremacy, and how settler colonialism and neoliberal capitalism are all inundated within higher education, medicine, and logics of care further marginalize trans and non-binary clinicians (or would-be clinicians) of color. The over-representation of whiteness in this work causes me to consider both my methods and participant recruitment acumen and structural conditions that foreground this study’s scope. This work rejects the idea that intersectionality and concern for trans people of color must be *overlayed* on the analysis of trans medicine and clinical advocacy as adjunctive to a project grounded in trans studies. This research adopts the trans of color critique where trans life is integrated

within discourses of race, racism, white supremacy, Blackness, anti-Blackness, transnationalism, refugees, ability, ableism, xenophobia, and indigeneity. The assumption that trans stands apart from any preceding domains is intellectually and historically irresponsible and in-line with the further institutionalization of trans studies within the settler-colonial university (Gill-Peterson 2018).

Out of the 14 participants I interviewed, nine were white, while only five were people of color. During the planning phase, including the wording in my IRB protocol, I had intended to recruit as diverse a sample size as possible. As will be explored in the next chapter, I did collect data from participants regarding racial and ethnic diversity within trans medicine. Access to wealth, education, licensure, and employment inform demographic representation in healthcare. Furthermore, trans people experience extreme inequalities due to societal transphobia and anti-trans bias within employment, housing, and education which are exacerbated by the intersection of disparities based on race, class, and ethnicity (Herman et al. 2016).

Los Angeles-based clinicians were recruited through a snowballed network of therapists (both LMFTs and LCSWs) whom I met through the years proceeding this research. Connections with the trans community in Los Angeles initially revolved around networks of activists. Given that this project's scope attends to healthcare and trans medicine, therapists, recruited from Los Angeles were connected to me through existing community relationships. All Los Angeles participants were white except for one self-identifying Hispanic LCSW.

Participants interviewed throughout Riverside County were ethnically diverse and represented differing educational and training trajectories compared to their Los Angeles-based counterparts. Riverside County participants were also recruited using a snowball method where community connections with healthcare and research organizations assisted with introductions. My affiliation with Riverside County-based organizations such as TruEvolution, Health Assessment and Research for Communities (HARC), the Transgender Health and Wellness Center, and Eisenhower Medical Center facilitated participant recruitment.

Rapport was established in several ways, depending upon participant and how they were recruited to participate in this research. Among participants whom I had developed prior relationships through pre-fieldwork interactions, rapport was previously established. During interviews where I was placed in contact with a participant through community networks, our common point of contact often vouched for me to set minds at ease and establish a basis for trust. While I appreciated the kind words and assurances of confidence in my “allyship,” I did not solely rely upon word of mouth, email, or text to maintain rapport. I always allowed participants to ask me questions at the beginning and end of each interview, and there were several occasions where a participant briefly interviewed me to confirm my positive intentions. For example, Kai, an Asian, non-binary, and an internal medicine resident physician in the Coachella Valley, started their interview by interviewing me. Later in our conversation, I asked them questions about the research process, and they addressed their “interview” of me by saying,

“So, in the beginning, I was asking a couple of questions about you, like what your goals are, what your purpose was and why you're doing this, and where

you're coming from. I think a great thing to do is step forward and just say, 'this is me; this is how I identify; I want to work with the trans community because there's this need here, there's a gap that I want to answer with these questions that I think are important to answer. And if they are important to you, then great, that's something we can work on together.'"

I sincerely appreciated Kai's willingness to honestly help me reflect on how I, as a non-trans person, could better approach conversations with trans people in research. Overall, I welcomed opportunities for participants to question my knowledge and I wanted to ensure everyone who agreed to an interview understood the reasons behind my work.

Data Collection, Management, and Analysis

Data collection took place between June 2020 and June 2021. This project received approval from the University of California, Riverside's Internal Review Board (IRB) on June 12, 2020. The research design produced minimal risk for human participants and was processed with expedited approval after two rounds of revisions. Data collection began during the SARS-CoV-2 COVID-19 pandemic and while much of the state of California, including the University of California system, was working remotely. While the colleges and universities adapted to what would become a "new normal" of academic work-life, there were specific considerations for the fate of ethnographic projects and fieldwork for anthropologists. Since this project's field site is situated in Southern California, the region in which I live, and where the University of California, Riverside is located, I pivoted the methodological scope of this research considering health and safety concerns and in compliance with the state of California

health regulations and guidance. I expand on my participation in what I refer to as “Zoom Ethnography” in the next section.

I conducted semi-structured interviews with 14 trans healthcare professionals representing healthcare practice in urban areas of Los Angeles County, the city of Riverside, and the Coachella Valley. I produced an interview guide for use in each interview. The guide included questions that thematically matched the project aims I outlined in the introduction of this dissertation. Study aims and the interview guide, were produced in consultation with my dissertation committee, trans community members with research experience, and trans studies scholars from across the country. Study aims and project goals were communicated to participants during the verbal consent process.

With IRB approval, I performed verbal consent with each participant. Before each interview, I sent participants my IRB-approved verbal informed consent document and reviewed the document before proceeding with the consent process. Participants provided consent to participate in research and lend their voices to project data, as well as their support for the Zoom call to be audio and video recorded. Consent responses were recorded in research notes, and participants were notified of their right to withdraw consent before June 2021. It was communicated to participants in the informed consent form that the June 2021 withdrawal cutoff was due to data being used in written work after that date. Participants were also provided with contact information for UC Riverside’s IRB office if they had questions or complaints about the research process.

As previously mentioned, I carefully considered the language I used in crafting my research design and when interacting with community members. I ensured the

terminology I used throughout the research was consistent with community use and in keeping with trans academic, activist, and medical discourse. I began each interview by confirming participant pronouns and allowing them to self-represent in terms of which gender categories best represent their subjectivity and embodiment. Ultimately, I used words participants used to describe themselves and their experiences during interviews. I assigned pseudonyms to all participants to ensure that record of their participation and words included in written work was confidential. References to potentially identifying information such as names of employers or affiliated organizations were also omitted from this dissertation to maintain confidentiality and protection of all participants.

This project did not receive funding before its execution, and thus, participants did not receive compensation for their participation in interviews. Participants were made aware of the lack of monetary compensation during the consent process and were notified of their right not to participate. Instead of monetary compensation, I communicated the potential benefits of participating in this research. I discussed the value of broadening knowledge about trans people, especially surrounding trans health and care practices. I do not believe expanding awareness and knowledge production is an adequate solution to the many structural problems facing the trans community and trans medicine. However, many participants told me of their enthusiasm to participate in this study. They were happy to lend their voices, stories, and experiences to produce knowledge about trans care in Southern California.

I took handwritten jottings during interviews and produced typed field notes after the interviews concluded. Handwritten data was stored in a locked cabinet in my home

office, and digital interview data was saved on a password-protected computer also in my home office. I conducted interviews using my UC Riverside Zoom Pro account. The Pro version allowed me to record uninterrupted interviews between 60 and 120 minutes in length. Zoom is Health Insurance Portability and Accountability Act (HIPAA) compliant in its operation and storage of data files. Audio and visual recordings, as well as automatically produced transcriptions, were downloaded from the Zoom cloud storage website and saved to my password-protected home desktop computer (Lobe, Morgan, and Hoffman 2020).

Zoom-produced transcripts were frequently filled with errors and required intensive review and editing. I proceeded with a hybrid approach to transcription management which included relying on the Zoom auto-transcription feature and manual transcribing with audio playback of recorded interviews. I used Express Scribe Transcription software and an Infinity foot pedal to streamline the transcript editing process. Areas of the Zoom produced transcript that were accurately recorded involved little clean-up of the text, which was limited to punctuation, and the addition of bracketed vocalizations to provide needed conceptual depth to the text. Ancillary sounds such as breathing were recorded and included as data when the sounds provided a depth of revealed meanings attached to said words during interviews.

I used MAXQDA data analysis software to code research data and proceeded with analysis for relevant themes. Interview transcripts and audio recordings were imported into MAXQDA along with field notes. I organized interview transcripts and fieldnote documents based on region (“LA Interviews” for Los Angeles County, “IE Interviews”

for Riverside city, and “CV Interviews” for the Coachella Valley). I produced thematic codes using a two-stage process. First, I identified potential codes based on my questions during interviews. As interview questions were based on project aims as outlined in the introduction of this dissertation. I was interested in how understandings of trans medicine are impacted by the presence of patients of trans medicine now serving as its agents. I wanted to highlight moments of meaning-making among trans healthcare professionals where concern for community health and wellbeing is placed in tension with their healthcare practice. For example, I asked questions about activism, workplace interactions, and disclosure, so those concepts were all early codes.

Second, as participants were free to self-represent their experiences, I followed their direction during interviews. Other themes presented themselves through discussions based on what participants wanted to talk about. Through the data collection process, I would track patterns in participant conversations that informed later interviews. As I transcribed interviews, I would create preliminary codes and then adjust as I progressed with reviewing data. Every code used in the final code system eventually had a memo that described how and when the code should be used in data. This assisted with consistency in applying codes and thus in the use of data throughout this dissertation.

During the writing stage of this project, I began with framing my research questions, project aims, relevant literature, and socio-cultural/historical context in which I conducted fieldwork. I organized chapters based on research aims and patterns in coded data. Using MAXQDA, I selected interviews and codes for retrieving segments of interviews relevant to a particular theme or set of research questions. In following a

grounded theory approach, I loaded interview data into my dissertation writing document and proceeded to craft narrative stories which coincided with the objectives in each section of this work. Theoretical analysis and grounding emerged from and followed the stories captured from interview data (Emerson, Fretz, and Shaw 2011).

Zoom Ethnography and the COVID-19 Pandemic

I initially resisted thinking about my work in terms of the pandemic. Studying the social effects of a global pandemic and one responsible for upending my life in genuine ways was not something I wanted to engage with as an ethnographer. My perspective changed when I realized I could trace novel social relations within a particular framework. I was keenly aware that focusing my research on trans and health professionals was something that had never been done in anthropology; however, to be able to showcase lived experience during such an unprecedented period of global upheaval was humbling.

It seemed fitting that a dissertation project titled, “queering care” would also include an unconventional use of research methods. The disruptive force that is the COVID-19 pandemic may have led to me *queering* methods through quickly pivoting to Zoom ethnography and relying upon the limited (but growing) methodological literature as a guide. However, it is also possible that the pandemic itself *queered* methods through what Amin Ghaziani and Matt Brim phrase as “...making strange the otherwise commonplace or familiar; interrogating alternate possibilities for worldmaking and livability...” (Ghaziani and Brim 2019). The pandemic reorganized my relationship to

my field site, community of study, and application of methods in ways that were arguably *queer*.

The opportunity to be a part of ethnography's expansion into curating community narratives during this specific moment in history would make my work timely and representative of unrealized horizons in anthropology. Little did I or any of us know, the conditions of the COVID-19 pandemic would be much more long-lasting than previously anticipated. While I stand by the strength of my work and its ability to chart new directions in my discipline, I fear what I was observing was the beginning of the end of what was and the beginning of a new normal fraught with uncertainty and increasing precarity for the trans community. Fortunately, there was an existing (and currently growing) methodological literature based on using video conferencing technology (such as Zoom or Skype within qualitative interviews (Lo Iacono, Symonds, and Brown 2016; Gray et al. 2020; Deakin and Wakefield 2014; Ayling and Mewse 2009))

My expectations of being physically out of my house were dashed by warranted fears of increased COVID transmission in being around people outside my household. I realized my fieldwork represented the potential for ethnographic engagement through a time of extraordinary social change and upheaval. I bore witness to and lived throughout the reorganization of society. I had a front-row seat to the structural and personal impacts the pandemic had to trans medicine, something which I had a responsibility to represent through my writing. Furthermore, I eventually came to think of the pandemic as breathing life into this project.

At first, the pandemic with its lockdowns and restrictions for in-person events was nothing but an inconvenience in life, both professionally and personally. However, as time progressed and months turned to years, COVID-19 became a social actor to analyze during fieldwork. In conducting interviews and doing what observational work I could do online, patterns in trans medical discourse began to emerge. Conversations shifted towards adjusting care protocols and “making do” in light of closed clinics and redirected medical resources due to regional COVID-19 outbreaks and circulating viral variants. Words and concepts I never imagined using or including in my writing quickly took up much of my interview transcripts. In my initial research design, I never had any desire to write extensively about “telemedicine” or “telehealth,” let alone “teletherapy.” Yet, there I was, jotting field notes during and after interviews where the pandemic was front, and center and remote care became routine.

Even though the pandemic led to online ethnographic engagement, I had planned on always considering the ways virtual life is integrated within contemporary trans community building. Trans people are spread across all demographics and locations; however, they make up less than one percent of the total population. This has led to limited opportunities for in-person community contact and thus, necessitating online social engagement. The online presence of trans people intersects with care networks and sources of social support (Horak 2014). Furthermore, “actual life” or physical/in-person community building, and activism are frequently organized through virtual organizing.

During fieldwork, my attention to virtual sociality and the application of digital ethnographic methods became embedded in my research. Anthropologist Tom

Boellstorff's groundbreaking ethnography, *Coming of Age in Second Life*, was the first text I encountered that troubled traditional anthropological imagining of what constitutes the "field site" and anthropologists' relations to fieldwork. Boellstorff argues that studying an online community through avatars (as was the case in Second Life) is no different than what anthropologists had been doing for decades prior. He cites Malinowski's call for ethnographers to "imagine themselves" in unfamiliar surroundings as indicative of ethnography's long-standing tradition of calling on researchers to abstractly imagine themselves somewhere else and in somebody else's shoe (Boellstorff 2005). Unlike ethnography within Second Life, my work is not encapsulated within an online community on a singular internet platform. However, the boundary-pushing facilitated by Boellstorff provided practical methodological scaffolding, which informed my pivot to internet-based research with a community that has also transitioned much of their care work online.

My entry into the world of digital ethnography was out of concern for access and safety instead of a desire to conduct online fieldwork. However, since ethnographic research can often be obtrusive, especially among a population that faces continual public scrutiny, I had concerns about feelings of surveillance among interview participants. In my research design, I outlined how I desired to understand both professional and personal experiences with GAC, including participants' negative experiences as patients. The premise of this work is based on the data-informed premise that trans people experience health disparities that are often exacerbated by negative clinical encounters. Thus,

probing questions concerning negative and possibly even traumatic experiences could be unwelcome and traumatizing.

The COVID-19 pandemic was a constant “presence” throughout this research. Any attempt to separate the pandemic conditions from this project’s design, execution, findings, and reporting would be futile. COVID-19 was an apparent hindrance in conducting ethnographic research; however, in some ways, the alterations in social interaction necessitated by the pandemic breathed life into this work. The continual uncertainty, fear, and struggle imposed by stay-at-home orders, lockdowns, limited social interactions, and a dramatically rising infection and death rate comingled with a, dare I say, a refreshing change of pace.

Contemporary discussions within anthropology concerning being “home” versus being in the “field” deviated from their traditional place within debates surrounding the nature of ethnographic fieldwork. Questions regarding an anthropologist’s place in the field and the appropriateness of conducting fieldwork at home or abroad became irrelevant. Many of us set forth to do ethnography in 2020 were left with two options, wait out the pandemic for in-person fieldwork in the undiscernible future “post-pandemic” or amend our research design to include virtual ethnographic methods. For ethnographers *going* to a field site across vast distances where the location of the work is as essential as the interpersonal interactions with interlocutors, an embrace of “remote fieldwork” was not an option.

Given that my home is within my “field site” of the broader “Southern California” region, my intended work transitioned from driving to various physical locations for

participant observation and interviews to digital ethnography. Throughout the literature, the type of ethnography I engaged in has many names; did I complete “digital ethnography,” “virtual ethnography,” “remote ethnography,” or “pandemic fieldwork?” I came to understand my engagement with the field as “Zoom ethnography,” since my primary mode of collecting narrative data was through Zoom (Archibald et al. 2019).

Given the somewhat disparate arrangement of physical “sites” from which I would meet and interview participants, including “video conferencing” interviews were originally included in my research design. However, video conferencing through the now ubiquitous Zoom telework platform became the primary mode in which data was to be collected throughout my time in the field. I was cognizant of the limitations Zoom ethnography would incur upon my desire for an immersive interview experience, so I recognized the need to capture all extra-communicative content possible to maintain a commitment to immersion and to promote a sense of “presence” within the “field.” Including sighs, exhalations, lip-smacking, nonverbal acknowledgments, head movements, and visible upper body movements was a crucial part of my data collection process during interviews, and record of notable unspoken communication and observations was kept in electronic handwritten interview notes documents.

Several logistical challenges needed to be considered due to the online format of my interviews. The interview process necessitated quick jottings and extended fieldnotes, however during interviews, I found myself feeling challenged with consistent notetaking. My participants and I could only see one another’s upper bodies. To feel as if I was displaying an attentive disposition, I realized I needed to consistently keep my head up to

look the person in the eyes through my camera. This limited my ability to write extensive notes during my interviews out of fear the top of my head would be far too visible as I leaned over to write. I was also cognizant of possible anxieties my participant may have whenever I would feverishly write something about what they were saying. The somewhat panoptic nature of elicitation in this manner led me to be aware of my bodily movements and embodied reactions to what was being said in interviews (Lobe, Morgan, and Hoffman 2020).

Conclusion

I started this methods chapter in an unorthodox manner by centering study participant voices as co-producers of knowledge. The first section is intended to frame the overview and critiques of anthropological research and literature on gender diversity in the second section. It was my desire to account for anthropology's missteps in representing trans and gender-expansive communities while also problematizing my own positionality in this research. *Trans* should not be operationalized without the same critical lens also being applied to *cis* or any other category rendered normative by Western epistemologies. Furthermore, by incorporating trans perspectives on the research process and trans representation in social science writing, I provided depth to this project's reflexivity and allowed trans healthcare professionals to lend their voice to how research *with* their community should be conducted.

I presented an overview of my use of methods with attention given to what makes this project distinct within anthropology and trans studies: the co-production of knowledge and pandemic ethnography. The next three chapters comprise this project's

main ethnographic interventions. Methodological approaches summarized in this chapter were applied to the collection of data featured in the chapters to come. Chapter three argues how Southern California and its various subregions throughout Los Angeles and Riverside Counties shape trans care for and by trans people. The *queering care* analytical framework is especially useful in considering how geographic realities are interwoven within webs of care, structural inequalities, and the lived experiences of trans healthcare professionals.

Chapter Three: The Geography of Trans Care: Region, Intersectionality, and the Patient-Provider

I first approached the study of trans care and, specifically, trans activism while exclusively focused on Los Angeles. My earliest contacts in the field were with Los Angeles-based activists like Hank or other activists I met elsewhere in Southern California who later settled in the city. When I pivoted my work to consider questions of healthcare practice among trans providers, my starting point was to revisit previously established relationships in Los Angeles. When my research interests evolved, so did the possibilities of engaging with trans communities with a modified scope. Being based in between Los Angeles and the main population centers in the Coachella Valley, I began to think about crafting a project that not only examined trans care by and for trans people but also one that actively challenges the notion of “divide” in considering rural, suburban, and urban populations.

First, I want to amplify the voices of trans healthcare professionals who live and work in Riverside County, effectively serving trans people from suburban and rural areas. Near the end of a conversation with Jaylen, I asked them, “How do you see people like yourself creating positive change in the Inland Empire?” Jaylen replied, “Honestly, existing is important, but it’s not enough. Trans people doing the work out in the Inland Empire for years, we’ve made change on people’s micro levels, but it’s the macro level that really needs to change.” The value of existing as a visible trans healthcare provider in the community is not downplayed and is regarded in historical context. The “micro-level” changes Jaylen is referring to consist of “triaging” the community since only a few

decades earlier, GAC was largely unavailable outside of Los Angeles. Trans affirming community support interventions such as housing, job placement assistance, and mental health support exists at this “micro level.” However, Jaylen’s words reveal a need for a broader regional commitment to care where Riverside County can witness capacity building and stand on its own without being limited by and beholden to Los Angeles’ trans care infrastructure. To show what I mean, I offer more words from Jaylen taken from our conversation:

“The Inland Empire is about five years behind everyone else, and that's why people keep getting sent to LA because their care is more accessible and it's easier because they get more money, whereas LA is seen as one city, whereas the Inland Empire, seen as one region. So, all the cities in San Bernardino and Riverside County are seen together, both those counties are seen together, and LA is seen as one. So, when the money comes down from the state, they go, ‘LA has a lot more cases than San Bernardino, Riverside County has combined,’ For example, our cases are the same, but since we're not LA or Palm Springs, we don't get as much money to make our resources accessible.”

As a patient of trans medicine and as an agent of trans-affirming social services and healthcare, Jaylen understands care accessibility personally and professionally. Jaylen’s assessment of ongoing disparities in the Inland Empire is directly tied to geography relations among the arbitrarily segmented subregions of Southern California. In the case of funding for trans healthcare, it’s not merely county boundaries and infrastructure which maintain barriers to care; state funding agencies continually reproduce inequalities as a manner of systemic function. The geographic distribution of trans-affirming social and healthcare resources and state funding to keep them running are mapped onto county boundaries and along racial, ethnic, and class-based lines. Queering care works to disentangle how geography, inequality, and patient experience

constitute contemporary trans care in Southern California. Through understanding how location, intersectional oppression, and lived experiences work in tandem, a holistic examination of care can be maintained.

In this chapter, I argue that geography, population distribution, and health institutions serve as social actors in how trans medicine is imagined, carried out, and propagated in Southern California. As a core tenet of *queering care*, disruption, divergence, and conflict coincide with labor working towards improving access to GAC. Trans community members, activists, and healthcare professionals (and persons who inhabit all three domains) contend with structural realities present within this multifaceted region that shifts narratives of access to care, the providing of care, and survival. This chapter provides rich detail concerning the figurative and literal lay of the land of trans medicine in Southern California and how race, class, ethnicity, economic inequality, and structural violence intersect with the lived experience of trans people advocating for themselves and their communities.

In the first section titled, “Relations of Geography,” I argue trans medicine is mediated by relations between humans, institutions, and non-human actors. I position geography, built environments, and infrastructure as social actors concerning human care work and clinical labor. In further arguing the imperative for the queering care analytic, I complicate common assumptions about trans existence and access to care in urban centers compared with suburban and rural communities. Ultimately, this section will provide a lay of the land of what is considered “trans care” across different regions of

Southern California and how the inclusion of trans people as authority figures within trans care reshapes the region's relationship with the trans community.

Second, I focus on understanding trans care's relationship with Southern California's subregions. Here, I adopt the analytic of intersectionality to assess multidimensional disparities based on race, class, ethnicity, and gender among healthcare professionals featured in this work (Crenshaw 1989). I illuminate this analysis with context provided by the words study participants from over one year of fieldwork. Discussions of vulnerability, precarity, and privilege are included in this section to connect reflexive understandings of participants' care work as trans people in various positions with differential authority in their respective areas of work.

The third part of this chapter dives further into the personal narratives of study participants. As this project is intended to reflect community voices and experiences, it was by design that participants have an opportunity to add their voice contested language and terminology often used to represent and even interpolate the trans community. I give attention to language considering previously discussed demographic and regional characteristics. In acknowledging this project's limitations due to the pandemic as well as the structural realities which reproduce inequity in access to professional care work, this section centers the words of participants as they reflect on their personal lives, respective communities of origin, perspectives of their trans subjectivity, education, and their decision to enter a career as a healthcare professional.

The final section of this chapter outlines challenges and obstacles facing trans healthcare professionals today. Analysis of these briefly outlined challenges (which will

be further developed in the next chapter) connects explicitly their stories to relations of geography and how trans medicine is working to overcome regional imbalances in accessibility for this widely distributed population. The chapter concludes with reflections on how interviews revealed a complicated relationship between trans people working as healthcare professionals and the broader political context of trans activism. I revisit the initial questions presented in this introduction concerning study participants' political orientation and divergencies from mainstream liberal LGBTQ+ activism and critical trans politics centering on liberation and abolition.

Relations of Geography

In considering the multiplicity of actors involved in making trans medicine in Southern California, geography and land play a role in articulating between access and barriers. Through engaging land as a social actor, I borrow from the contributions of actor-network-theory and assemblage theory in positing all actors, human and non-human, natural and otherwise, as interconnected in producing what we know as trans medicine in Southern California (Latour 2005; Deleuze and Guattari 1987; A. Mol 2010). As both natural and ordered by human action, the land and its geographic composition exerts power over how trans medicine and care practice is produced, reproduced, and altered over time.

This project's scope includes a broadly understood notion of "Southern California," however one that does not privilege Los Angeles over suburban or rural locations. This work examines relations in care practice in Los Angeles and Riverside

Counties and regions known as “Los Angeles,” “Riverside” city, and the Coachella Valley. I often will refer to sites as “Los Angeles” and the “Inland Empire” or “IE” throughout this work, and it should be noted that while the Inland Empire includes San Bernardino County, Inland Empire participants were recruited solely from Riverside County. I make these distinctions in site for one, based on the reach of my community connections and feasibility in completing data collection. In addition to a question of access, the segmented situatedness of this work demonstrates a particular kind of ethnographic intervention that intends to trace clinical and care narratives in correlation with health disparities based on geographical distribution.

As is true across the United States, GAC is bifurcated and fragmentary due to patterned structural domains that are geographically organized. Factors by which trans medicine is constituted include uneven access to care, disjointed knowledges which informs care practice, multilevel systems of governance, and practitioners of care with their patients who receive it in the clinic. As an object of study, trans medicine is comprised of this assemblage of interlocking and contested relations. Forces working in favor of trans-self-actualization and those that promote hindrances to trans existence through paternalism and gatekeeping and those that desire violence and genocide produce the landscape in which trans medicine operates (Plemons 2017; Müller 2015; Deleuze and Guattari 1987).

Trans serving healthcare is widely available in California; however, services are unequally distributed. For example, Los Angeles offers the full suite of trans medicine and therapeutics in clinics and medical centers across the county. Relatively widely

available services include affirming mental health services and an extensive array of physicians and surgeons who offer gender-affirming surgery and prescribe HRT with little gatekeeping. Patient-centered care that is increasingly provided with an informed consent model is becoming commonplace and even expected by the trans community in large American cities, especially in states that have codified trans health availability into civil rights legislation. While California is relatively progressive regarding policies ensuring accessibility of GAC, suburban and rural areas do not have the vast influx (and ever-expanding) of services found in places like Los Angeles. Palm Springs a city with a large, growing, and aging gay while cis male population, lacks the same robust trans healthcare offerings found three hours away in Los Angeles. In interactions with community health organizers throughout the Coachella Valley (where Palm Springs is located), I soon learned there is a severe communication breakdown between heavily cis and gay-centered HIV/AIDS support and care networks. Health disparities among the trans community include disproportionate rates of people living with HIV. However, the few trans-specific organizations and providers in the desert have an expansive set of aims for improving quality of life and health outcomes distinct from the long-standing institutional mechanisms addressing a growing and aging HIV-positive population.

Compared to other queer subgroups, this clear distinction in institutional prioritizing is indicative of how cis lives (including the queer ones) matter more than trans lives. The post-Stonewall queer schism of the 1970s paved a path of progress for gender-conforming cis queers to the targeted detriment of trans and gender-non-conforming people. This unfortunate reality is amplified when considering the long-

established political capital enjoyed by cisnormative queer people through their appeal to respectability politics and homonormative assimilation (Duggan 2003).

Until the turn of the 21st century, trans people were not centered in large-scale public discourse. “Gay” became the standard-bearer for “queer issues” present in the public consciousness, most notably HIV/AIDS and marriage equality movements. Since the 2010s, trans people have been frequently centered in public discourse but either as an afterthought for the mainstream “Gay, Inc” activist industrial complex or as the object of genocidal actions by the state. Geography serves as a social determinant of health for trans people as access to care is unequally distributed across Los Angeles and Riverside Counties (Dummer 2008). Existing research on trans healthcare in rural communities suggests increased provider education and trans health competency is needed to serve trans patients better. Studies also recommend more research on trans communities in rural areas will lead to a comprehensive understanding of needs and barriers facing the community (Movement Advancement Project 2019; Rowan et al. 2019). While California is considered to have more robust trans-affirming social and health infrastructure than other parts of the United States, availability does not always translate into accessibility.

Challenging Urban, Suburban, and Rural Separation

Southern California challenges long-standing ideas of demographic distribution such as the “queers in cities, straights in the country” archetype. In recent years, increased public awareness, visibility, and violent targeting of trans people have coincided with challenges to dichotomous interpretations of the relationship between

LGBTQ+ population distribution and urban and rural divides. I do not suggest dismissal of queer urban narrative be struck from the ethnographic canon. Yet, I caution against broad claims to universalizing queer life within reductionist (and often imaginary) understandings of space and place.

While the Inland Empire is relatively more politically conservative than Los Angeles, it is home to a growing class and ethnic diversity. The shifting demographic and political landscape of the Inland Empire is primarily thanks to encroaching suburban sprawl and a lower cost of living. Disappearing farmland is paving the way for high-density tract housing, shopping centers, and the ever-ubiquitous corporate warehouses. Furthermore, the lower cost of living and intricate freeway interconnectivity provides workers and families who would otherwise be priced out of coastal communities a comparatively affordable option at homeownership (Patterson 2014).

At first glance, the monotony of the Inland Empire leaves many from outside the region doubting diversity in any regard, which exists within its many cities and neighborhoods. Of course, this is not true as queer, and BIPOC communities have thrived in the region. However, the anthropology of North America, especially ethnographies of queer populations in North America, center on urban centers comprised of “transplants” seeking traditionally tolerant and “forward-thinking” social environments. As Tongson points out in her groundbreaking work, *Relocations*, marginal and suburban communities also possess queer populations whose experience often diverges from that of queer people living in large cities (Tongson 2008). The marginality of queer and trans people of color (QTPOC) in the Inland Empire is based on distance from Los Angeles and the exteriority

from the urban queer community, systemic racism taking the form of environmental racism and population displacement, as well as segregation between white cis gay male-dominated spaces and QTPOC.

In California, proximity to the ocean and coastal cities are regarded as ideal, while distance from oceanic riparian regions is not idealized to the same degree. This negative association with distance from the Pacific Ocean and beach cities parallels differences in wealth flows, perceived opportunity, and a general sense of cosmopolitan accessibility. Furthermore, the class, race, and ethnicity-based associations many Southern Californians have when comparing the Inland Empire with Los Angeles or Orange County cannot be understated. It is no *coincidence* that health disparities demarcated by geography are also disproportionately distributed based along the lines of economic inequality and systemic racism. Furthermore, contemporary research on trans health disparities links access to affirming trans healthcare with proximity to coastal cities (Edmiston et al. 2016).

Narratives of trans and LGBTQ activism and/or community care do not necessarily imply trans communities exist as monoliths. Yet, distinctions in approach tend to be bifurcated by the reproduction of liberal/abolitionist dichotomies (Spade 2011). The lived experience of trans healthcare professionals highlighted in this work distorts such dichotomous interpretations of trans activism and care. Approaches to sewing together the patches of trans healthcare and social services are varied and often inconsistent with interpretations of labor as purely liberal or liberatory. The patchwork model may be insufficient in assessing care work (both clinical and otherwise) led by

trans people due to the reproduction of rights-based neoliberal approaches while simultaneously embracing goals and using the language of abolitionism.

These complex and nuanced relations between activist objectives and achieving greater accessibility to GAC do not exist in isolation to the geographic realities in which they are distributed. The patchwork of trans healthcare in Southern California resists the encapsulation of care continuums by arbitrary boundaries between subregions. Trans care in suburban rural areas in Riverside County depends on trans care networks in Los Angeles. Also, the saturation of care initiatives in Los Angeles and has led to an eastward shift in focus for trans clinicians. Working in tandem with this shift among clinicians, the rising cost of living and financial unsustainability of Los Angeles has caused populations to move east, including their healthcare needs. The interrelatedness of urban, suburban, and rural trans healthcare “patches” complicates how care is conceived, realized, and received among trans people across Southern California.

Southern California’s versions of “urban, suburban, and rural” localities resist classical reference points in distinguishing one type of populated landscape from another. For example, Los Angeles arguably contains suburban sprawl within its city limits while centers of manufacturing and industry shift east to more traditional “suburban” communities. As one travels further east through Riverside County to areas traditionally designated as “rural,” the number of significant corporate warehouses increases. The ubiquity of Amazon fulfillment center warehouses throughout the Inland Empire has also had a substantial impact on labor and a detrimental impact on the surrounding environment. However, Eastern Southern California has long been a depository for

coastal Los Angeles' pollution without the same concentration of health infrastructure to contend with growing and intersecting disparities.

Queer Geography

Past work on the draw of large cities for queer people and the promise of community building in tandem with increased safety offered by relative anonymity promotes a flawed image of queer life throughout much of the country, not to mention Southern California. Urban spaces exist as overrepresented sites within the queer anthropological imaginary representing safe social landscapes that provide geographic attachment in proximity to similarly identifying persons. Kath Weston's well-cited article "Get Thee to a Big City: Sexual Imaginary and the Great Gay Migration" significantly reinforces tropes of "cities are for queers" and "rural regions are inherently dangerous to queer people" (Weston 1995). Collective belonging, social support systems, and an imagined sense of community have maintained queer collectives (Anderson 1983). Building from Jack Halberstam's work related to geographies of resistance, urban areas of Southern California provide the context for which non-heteronormative sexualities and genders interact with the politics of representation and activism.

As mentioned in the introduction, Halberstam's *metronormativity* establishes a hegemonic ideal for queer and trans-socio-cultural existence to be components of the city. Within metronormativity, suburban and rural queer and trans populations are abject and cast off to the margins of queer cultural intelligibility. I argue his abjection of the perceived peripheral regions of the city is not limited to symbolic cultural exclusion but

also translates to health outcomes due to lack of services, competent care, and affirming providers (Halberstam 2013; Kristeva 1982).

Karen Tongson's work bridges traditional assumptions of queer community placemaking in cities with the overlooked and understudied existence of queer people in suburban Southern California (Tongson 2011). According to Tongson, "The queer cosmopolitanism that disavows the suburbs for its homogeneity still relies on the traditional urban rubrics of density, diversity, and verticality offered by New York and San Francisco" (11). Tongson's focus on Southern California beyond Los Angeles includes the observation of the city's decentered sprawl. Building from her work, I argue that the lack of discrete boundaries between urban, suburban, and rural Southern California has produced a geographic area that resists classification. The framework of queering care allows for the apparent complexities and contradictions present in both trans care and Southern California to be better understood. Trans care in Southern California is distinct in quality, availability, and accessibility across Los Angeles and Riverside Counties. While health outcomes, patient experiences, and provider experiences are divergent, networks of care and trans medical infrastructure are spread across both counties in ways that resist regional boundaries.

Across Southern California, the relationship between trans providers and trans care, both in practice and the broader imaginary, sits as both a literal and proverbial crossroads. Los Angeles is home to a strong foundation of queer and trans activist, service, and medical organizations supported by wealthy LGBT donors and sometimes support from the city governments of both Los Angeles and West Hollywood. Trans

medicine is entrenched in longstanding social institutions where access is present but not without disparities. There is a continually rotating selection of start-up activist-oriented social service organizations working to improve the lives of trans people and connect people in need to support, work, housing, and healthcare. While many organizations have great intentions, the sustaining work of a select few carries forward through the decades.

Just as the main freeway arteries of Interstate 10 and Highway 60 spread their paved tentacles eastward from Los Angeles, their bisecting of perpendicular freeways marks geographic transition and a transition in trans community relationships to care networks. As one crosses Interstate 710, then Interstate 605, and finally Interstate 15, trans community visibility and care resources become increasingly scarce. The farther east one travels away from Los Angeles, the more fragmented trans medicine is available and being practiced. This observation is buttressed by the diminishing results one receives when Googling “transgender healthcare [insert non-Los Angeles County city]” and the on-the-ground experience-informed knowledge of trans providers across Southern California, especially those in Riverside County.

Regional Divergences in Perspective

Providers in Los Angeles never discussed the Inland Empire nor provided evidence of knowledge concerning disparities based on geography. Reflective comments about their personal lives and careers tended to not problematize institutional frameworks to the same degree as that of their Riverside County counterparts.

Donna Haraway's concept of "situated knowledges" provides a theoretical grounding to assess and interpret these observed differences during fieldwork. According to Haraway, "Many currents in feminism attempt to theorize grounds for trusting especially vantage points of the subjugated; there is good reason to believe vision is better from below the brilliant space platforms of the powerful (Haraway 1988). While research that centers the voice of trans people can always be considered work that trusts the "vantage point of the subjugated," this work challenges and amends this assumption. Given that this research centers trans voices with clinical authority and relative forms of power, the subjugated voices I reference here are those clinical authorities that lack equitable access to resources because of geographic location. Haraway's model is beneficial here because it considers *limited location*, evoking a particular site and positionality to offer critical understandings of oppression.

Commentary on the state of trans activism and medicine was much more common among clinicians living in Riverside County. This is not to say Los Angeles-based providers were uncritical of institutions or lacked a robust analytical perspective of their positionality within care work; however, moments of divergence among Los Angeles-based clinicians were uncovered through elicitation while participants based in Riverside County were eager to lay out their perspectives. Furthermore, recognition of inequalities was apparent regardless of the region in which clinicians lived and worked; however, very little about regional dynamics beyond Los Angeles was discussed among Los Angeles-based providers, while those in Riverside County were quick to offer

comparative critique between their region of work and services or opportunities available in metropolitan Los Angeles.

Jaylen continued their critique of how state funding for social services is distributed across the different regions in Southern California. Since they are a patient-provider based in the Inland Empire, they have their finger on the pulse of local GAC offerings. Riverside County is left behind as funding expands almost exponentially for Los Angeles service providers. As mentioned in the framing of this chapter, many trans people in the Inland Empire go to Los Angeles for services. Thus, the state tabulates those cases as originating there, not Riverside or San Bernardino County. State funding is based on providing service, not where patients live. Service providers who attempt to meet people where they live are not as funded and, thus, not as resourced.

“And so, LA has to send back money all the time because it's going unused. As capitalism grows, people cannot afford to keep going back to LA, and many people are moving to the IE. And so, the IE is stuck with rapid changes, faster than what they can to accommodate with all these people but they're doing the best they can. I like to say that Riverside city is a large town with small town feel and people are doing great metamorphosis to change who they are to accommodate people that are different from them, which is no huge feat. I'm not saying a lot of people is doing it, a lot of people are still homophobic and racist as hell and transphobic as hell. What they're doing is transforming their work life but their personal lives, not so much.”

The cyclical nature of how geography reproduces regional health disparities is apparent to providers in Riverside County while primarily going unnoticed by those in Los Angeles. Distinctions between subregions become less clear given that care infrastructure is shared on the patient level. Still, there is a lack of equity in the dispersal of funds and resources for providers.

Providers in Riverside County consistently discussed the plight of trans patients in difficulties accessing GAC and would reference regional disparities as a causality of barriers. Riverside County providers also always referenced infrastructure in Los Angeles and demonstrated their knowledge of how trans healthcare operates there and how Inland Empire-based trans people are beholden to Los Angeles' services and resources. Below is an excerpt from a conversation I had with Pablo about perceived "chasms" in care produced by geographic ordering:

Joshua: "I heard people who work in LA have clients that live out here [the Inland Empire], and I'm like, 'there are services out here as well!' How do you perceive chasms between information and access based on the geographic distribution of patients or clients in Southern California?"

Pablo: "The IE, as big as it is really, I do think still misses the mark. I think there are reasons for that. And unfortunately, if were to be completely honest, I think it has to do with people who want the spotlight and the attention, their activism is more for notoriety and fame. There aren't any issues with that, ultimately, in my opinion, that's what you want to do, that's what you want to do. The problem with that is it deepens these chasms that you're referring to, because we do this kind of gatekeeping thing with some of these folks and it's like I know people who know people, but the issue is often feel like I can't reach out to them because then I get left out of the loop and therefore left out of someone's care who I referred to them. And this isn't how it should work. And these are other queer and trans people who are doing the this, this isn't necessarily like cishet people, but it I already think the IE doesn't have enough and we don't have enough resources."

As the framework of queering care seeks to attend to discrepancies in how trans care is imagined and realized, attention must be given to the ways land and geography shapes access and availability of care. For the trans community, where one resides in Southern California, serves as a social determinant of health. Furthermore, the geographic distribution of trans people versus the distribution of GAC resources will also determine the quality of GAC a trans patient receives.

I cannot emphasize enough how valuable Pablo's story is in presenting an incredibly multifaceted narrative in how trans medicine operates in Riverside County. Pablo's perspectives and direct critiques of the hegemony the local FQHC clinic network has established for GAC are informed by their lived experience as a patient and healthcare professional who refers patients to said clinic. Pablo was conscientious not to use the name of the FQHC in which they interact as both patient and professional partner. Still, knowing what I know about trans care in inland Southern California, I knew precisely which organization was being evoked during our conversation. I do not intend to present this information or offer this discussion that is even passive-aggressive towards the FQHC clinic network, or the professionals employed there. In queering care, assessments and perceptions of care are never singular but always multiple. The need for critiques of institutions and healthcare practice exists alongside recognition of positive, trans-affirming care work. Care that is queered embodies all the way interventions in trans medicine, by and for trans people, continually shape access to GAC.

Pablo offers broader critiques of health institutions and perceptions of trans-serving institutions regarding accessibility and affirmative approaches to care. They said,

“It's very hard to say like these spaces or these places or people or organizations are inclusive if they don't necessarily include community in them. You have your gatekeepers who have access to all this information who don't want to share because they want to be the person everyone goes to, which is bullshit and I think it's a detriment to us all. I think that's why a lot of folks in the IE go to LA for services and that's already difficult and people say, “well, you have Palm Springs! And I'm like, well, no, they don't have Palm Springs. Palm Springs is for like older cis white gays and those services won't necessarily be catered towards us.”

Pablo provided commentary not only on the barriers imposed by paternalism in GAC but also barriers produced due to a lack of grounded understanding of how geography serves

as an actor in trans care. Local FQHC clinics in the Inland Empire desire to centralize GAC under the banner of their “specialty care” programs. For Pablo, they see this FQHC-led medical hegemony as why many trans people do not remain in the Inland Empire for services and instead travel to Los Angeles for a broader array of options.

Jaylen has observed similar issues with trans medical hegemony on the part of FQHC clinics and local Medi-Cal providers. They said,

“There are still some big people out here doing the work, which I feel is phenomenal. However, paying for surgeries doesn’t mean that the doctors and the nurses and the people who are part of their care plans are actually trans-affirming and actually can do the work really well.”

For Pablo, clinical declarations of “inclusivity” are met with suspicion and consternation. The lack of comprehensive GAC providers distributed across the many cities in the Inland Empire combined with the leading FQHC clinic network desiring consolidation under their banner of care offerings leads to bottlenecks in care. Pablo echoed my use of the term “chasms” in reference to disparities between Los Angeles and the Inland Empire. For them, the chasms are not due to conflict between Los Angeles and the rest of Southern California; chasms are reproduced due to competition between agents of trans medicine and institutions with infrastructure (or the potential for infrastructure) working together to alleviate trans health disparities. Pablo summarized some of their principal frustrations by saying,

“So ultimately, like it's places that spout inclusivity (or say that they're inclusive and diverse) and gatekeepers that really maintain the chasm, we're not doing anything to build bridges. We're not doing anything to combat that biggest hurdle, which is how do we get more people into care and how to get the right services. There are certain doctors, one doctor, I know that I can think of that three other trans people would recommend on the spot. But It's one doctor and they're in Riverside and San Bernardino. But it's like, that's it, that's the two places. So, if

you can't get to either Riverside or San Bernardino, you're screwed (if you want like transitioning services). It's kind of shitty, one of the things we learned in my social work program was to go with their need is, but if the need is here, it's kind of why I don't want to leave the IE, which could also become a huge detriment to my professional life in any kind of long-term career goals I may have made.”

Pablo doesn't want to leave the Inland Empire however, the in-fighting and institutional monopolization of trans healthcare in the region limits opportunities for expanding services. Furthermore, the consolidation of services in San Bernardino and Riverside works to exclude rural communities from accessible GAC. As demonstrated by Pablo's words, distinctions between urban, suburban, and rural Southern California often leave Los Angeles standing on its own, ready to accept trans patients external to its primary patient catchment area. Los Angeles trans health infrastructure benefits from suburban and rural trans populations but is not reliant upon their presence to maintain current service offerings. However, trans people from the Inland Empire are still largely dependent upon Los Angeles for GAC, which is the reality Pablo views as possible by clinical power dynamics.

The tidy categories of “urban, suburban, and rural” fail to critically examine racial dynamics and changing socio-economic conditions in different regions across the country, let alone the world. The assumption that coastal cities unquestionably have something in common due to geopolitical similarities perpetuates a racist collapsing of BIPOC experiences and living conditions, which leaves whiteness uncritically accepted as culturally salient. Past work and contemporary assumptions about the relationship between queerness and cities foregrounds BIPOC erasure in our collective understanding of queer demography, population distribution, and lived experience.

The regional differences represented in this work highlight distinctions and disparities within trans medicine, care networks, and trans subjectivity. The dynamics of class, race, ethnicity, and gender play out within trans life as they do in any other demographics in American society. However, “trans experience” is perceived as being primary in the eye of society, even within affirming LGBTQ+ discourse. This phenomenon overlooks other life intersections, including other forms of inequality beyond, but not fully disentangled from transness. As previously mentioned, transnormativity standardizes hegemonic transness within the cisnormative public’s imaginary as white (Stryker and Aizura 2013; Puar 2015).

Kai in the Coachella Valley did not view the region as the primary determining factor in barriers to care. When I asked them about access to GAC and its accessibility across regions in Southern California, they were quick to acknowledge that many procedures that trans people need are not exclusive to the trans community. For Kai, what makes specific medical procedures considered a part of “trans care” or GAC is that care involves routine health screenings among men who require pap smears or women who require prostate exams. Transphobia is the primary factor determining poor health outcomes, not specifically region. Kai clarified their perspective in saying,

“These screenings are things that we can provide at all levels; I think it just depends on the provider, whether or not they recognize the needs of the patient. That could be said for someone in a rural community, suburbia, or a city. It really just comes down to provider and health insurance. Honestly, the main barrier to anyone’s health care is health insurance, or it depends on what their gender marker is on forms. For myself, I am on estrogen blockers, but my insurance doesn’t cover it because of my gender marker. I don’t remember if I have an ‘F’ next to my name, so they won’t cover estrogen blockers and I have to pay out of pocket.

Kai's perspective reveals how their personal experience with barriers to GAC informs their knowledge and interpretation of persistent disparities. Like Jaylen and Pablo, Kai brings the conversation to a critique of bureaucracy due to their issues with health insurance coverage acting as a gatekeeper through requiring sex/gender category congruence on paperwork with then allowances for care coverage (van Eijk 2017).

In conversation with Kim, who lives in West Los Angeles, she cites the accepting and progressive image of the city as often taken-for-granted as she navigates life with relative ease. This observation should not indicate ignorance of trans people's precarity. However, the overall scope of their worldview was based on living in a region generally assumed safe for gender-expansive people. Kim seemed pleased with the level of trans inclusivity in Los Angeles in stating,

“I think that all that opportunity in LA and Hollywood and West Hollywood probably lends itself to people being like we should be fully actualize as human beings, like what's there shouldn't be letters there shouldn't be (for hormones) there shouldn't be any transphobia there shouldn't be any because, you're right it's like it's been so normalized and there's so much support in the community here that it's like they should be getting everything right people should not be getting my pronouns wrong yeah. I shouldn't face any discrimination where other people are like, “well hold on people from. I don't know from another part of California probably like don't have that same level of support”

This passage was stated with confidence and empowerment. Kim views her experience as a trans woman as being normalized where she lives. The abundant GAC options and community resources she utilizes and refers patients to use as well helps Kim maintain an image of Los Angeles that is positive and ripe for life for the trans community.

Of course, Kim's life experience is partial and dependent upon her life circumstances and should not be considered typical for trans people across the United

States, let alone California. Kim acknowledged that California does not have equal access for all trans people in the same breath that she praised Los Angeles' progressive stance towards her community. Throughout our conversation, Kim did not bring up how she experiences privilege and how those intersections of life circumstances influence her view of Los Angeles. As a white, upwardly mobile, and economically stable woman living in an affluent area of coastal Los Angeles, her life diverges from her trans counterparts with differential access to support and resources. Furthermore, Kim's affinity for her city's ability to serve as a shield from everyday transphobia and targeted institutional violence demonstrate how whiteness and class privilege shape unquestioned understandings of region and transness.

Vulnerability is considered elsewhere and not in the purview of what people like Kim would call the "here and now." Kim was not against our conversation, including concern for the broader community; on the contrary, she acknowledged a need for people like her to have a significant role in addressing disparities based on race, ethnicity, and class. However, our discussion of intersectional oppression and the plight of trans people of color and community members experiencing economic disparities or who are unhoused did occur but only after I elicited her perspective through my interview questions.

This was a typical pattern among the many white and Los Angeles-based providers I interviewed in this study. Whiteness tends to homogenize transness where it encapsulates and then flattens concurrent subjectivities that reshape oppression experiences. White cisnormative hegemony perceives transness through a two-

dimensional image whereby the intelligible trans subject is gender normative and overwhelmingly white. The transnormative subject promotes a collapsed image from which gender performativity and general social comportment must emanate to maintain containment within a transphobic society's model for acceptable existence. The fact that this process is further reproduced in trans care communities speaks to the tension between being trans (or what white cisnormative society interprets as such) and holding clinical authority within trans medicine. Respectability is equated with the viability of the trans person who secures social legibility within a transnormative matrix (Puar 2015; Johnson 2016; Ward 2008).

Racial Inequalities in Trans Medicine Across Southern California

I asked Jaylen about their experiences receiving GAC in the Inland Empire. Their response to my questions connects with how geographic realities regarding access to GAC intersect with forces of oppression to exacerbate trans health disparities. Jaylen graciously shared highly personal insights into vulnerability they experience through their subjectivity and embodiment. They said,

“My names are never correct on my documents even though they [clinics] have the system for where my chosen name is supposed to show up, but when I call using that name, it's never registered, and so I have to use my dead name a lot. Most of the time, I keep it to myself that I'm trans-identified because I already have a hard enough time getting care because I'm Black, and I'm very large, and so I have to deal with that first before dealing with you using my pronouns right and my name right. And so, for me, when it comes to my trans health care, I give up forcing the issue in respect of my transness in favor of just receiving care because I'm more worried about how my Blackness and fatness affects my care which have been my largest experiences throughout my life when it comes to my health care. “I'll go in [to the clinic], and they're like, 'well, you say you're not that much in pain, so you can take over-the-counter Tylenol.' Or they'll say, 'Well, I'm

more concerned about your weight, that's probably what's causing the pain in the first place.' You know, those are the things that I encountered.”

Jaylen’s story shows how intersectional oppression within an under-resourced region promotes poor trans-patient experiences. This passage discusses how anti-Blackness and fatphobia operate as barriers to care. Furthermore, Jaylen’s experience as a non-binary, trans person is underwritten by their experience as a fat Black person seeking healthcare in the Inland Empire, where options for competent and affirming care in all areas of Jaylen’s life has proven difficult to obtain. I asked a reductive question about how they navigate accessing GAC. Their trans experience is not the defining facet of their lives that determines their patient experiences. The trans of color critique attends to long-standing anti-Blackness and the production of transnormative whiteness within medicine (Gill-Peterson 2018). The genealogies of trans medicine are settler-colonial and white supremacist which foreground Jaylen’s experiences in navigating healthcare systems. Furthermore, the framework of intersectionality assists in assessing how other sources of oppression coexist with transphobia to shape the provision of trans medicine as well as how it is received within therapeutic practice.

This work applies the analytical framework of intersectionality in examining, assessing, and critiquing the practice of trans medicine across Los Angeles and Riverside Counties in Southern California. I will explain how both analytical frameworks are productive in examining the role geography has in Southern California’s trans medical landscape as inequality and oppression are mapped along with regional ordering. Like the lines freeways mark on a map and upon the entirety of Southern California, trans medicine finds itself simultaneously restricted and dispersed due to geography functions.

Furthermore, I will show how queering care framework benefits from intersectionality and the trans of color critique in its interrogation of trans care as a decentralized web of contradictory, liberatory, contested, and regulatory practices.

Emanating from theorizing of Black women's experience and feminist theory, lawyer and theorist Kimberlé Crenshaw first posited the framework of intersectionality in 1989. Crenshaw developed the framework in critique of Black women's oppression being solely interpreted through racism or sexism (Crenshaw 1989). According to Crenshaw,

“Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars traveling from any number of directions and, sometimes, from all of them. Similarly, if a Black woman is harmed because she is in the intersection, her injury could result from sex discrimination or race discrimination” (139).

As this chapter is centered on geography and landscapes of health and community activism across a region subdivided by intersecting thoroughfares and vehicular traffic, I find the imagery in Crenshaw's example compelling and valuable. Trans care exists in various domains where reductive notions of identity obfuscate sources of oppression. *Care, medicine, activism, and trans* do not exist as monoliths, and oppression circulates through all these concepts. In the decades proceeding the first application of intersectionality, the term was repeatedly misappropriated in ways that actively decentered Black women from its application, and instead, its use was transformed into an adjunctive concept revolving around layers of identity (Kupupika 2021). Intersectionality is a lens to interpret the effects of intersecting oppression and what

Crenshaw describes as the way “power comes and collides, where it interlocks and intersects.”³

In California, trans-serving healthcare is guaranteed on paper and embedded within “official” institutional policy yet disconnected from communities and the webs of actors and resources necessary for its propagation. Jaylen and Pablo’s stories from the previous chapter speak to how trans healthcare is “officially” available in the Inland Empire yet institutionally lacking competency. The focus on regional divergences and geography within the queering care analytic rejects the notion that trans care (both activist and medical) should or can be interpreted using what Crenshaw refers to as a “single-axis” framework (Crenshaw 1989:140). Trans care is interwoven within intersecting interests in service of both capital and the desire for free access, gatekeeping, and the aims of trans liberation, as well as bodily autonomy and normative regulation. Furthermore, as evidenced by Jaylen’s story, anti-Blackness and fatphobia also impact trans care in tandem with existing regional disparities.

This work applies intersectionality as a lens to better understand how the queering of care challenges identity-centered discourse concerning trans people, trans activism, and trans medicine. The ways race, ethnicity, class, immigration status, body size, and age intersect the contested domain of trans medicine. This highlights intersectionality’s utility as a lens to engage with sources of oppression experienced by trans people based on intersecting factors beyond their trans subjectivities and embodiments. Queering care

³ See “Kimberlé Crenshaw on Intersectionality, More than Two Decades Later” from Columbia Law School and posted on June 8th, 2017: <https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later>

seeks to attend to all these domains, which foreground trans experience and underwrite practices of trans care.

The systemic racial disparities in healthcare exemplified through Jaylen's story as patient reflect Hank's clinical experiences as a white therapist. Hank told me, "Yeah, I've had I've had trans women of color clients and they tell me that they're scared to be in the room with me because I'm a white man. And then once they know I'm trans, it helps a little bit, but they still don't think I get it, and I'm like, 'I know you're absolutely right.'" Hank's whiteness is a barrier to trans people of color accessing GAC. It counteracts the power of disclosing his trans subject position in easing client-therapist tension or establishing rapport.

"It wasn't until five years ago that I got a good PCP [primary care provider] I love him to death, where yes, my weight is his concern, but my concerns are his concerns first. We have talked about my trans health care, but she's been on pause because of the racism and anti-Blackness in the healthcare community, which is much more prominent for me, seeing as I read and pass as a woman when it comes to trans healthcare, I don't have much of a story for you. I had a three-year plan to start T [testosterone] and transition the way I want to, but I have another health issue that is stopping that, so I have to get that fixed [Jaylen laughs]. But since it's been in the last five years that my trans health care has also been incorporated within my Black and body health care, my stories are limited."

White clinicians interviewed for this study did not generally bring our conversations to race or racism until I elicited that information directly. At first glance, the psychology-trained mind of many of my white participants seems to overlook intersectional oppression within their collective assessment of trans healthcare needs. Inequality is understood as being constructed solely through the lens of being trans and from the perspective that "trans" is a universalizing experience that transects and trumps

all other subjectivities. Providers of color I interviewed were much more likely to have a nuanced approach in discussing their own trans experiences or the experience of patients who were also people of color. In some cases, Blackness was centered in our conversation as a primary lens of inquiry rather than gender. Overall, when it came to race and class, I was interested in how these domains were layered within clinical relationships with patients, occupational dynamics in terms of representation among providers, and how participants in this study perceived inequality based on skin color, systemic racism, and socio-economic class.

The history and contemporary practice of trans medicine reproduce “white as standard” discourse in myriad ways. First, the apparent placement of trans medical discourse within the white supremacist state power apparatus (Plemons 2017) and “standard” objective female faces, exclusion of POC from medical training and knowledge, trans medicine as a byproduct of white supremacy, chattel slavery, and plantation medicine (Snorton 2017). Today’s white-dominated field of trans medicine, most notably among clinicians trained in psychiatry and clinical psychology, disavows the field’s reliance upon racialization and white supremacist violence.

In conversations with study participants, there was a recognition of holding privilege, including through the lens of passing privilege. Perceptions of quality-of-care work and efficacy in their career were related to self-reflection on how they pass. Morgan, a trans healthcare system navigator and leader within a Coachella Valley-based trans health and social services center, reflected on her passing privilege while giving credit for her ability to pass as well as her whiteness as to why she has been able to

navigate the world and be effective in her work. Furthermore, transphobia reinforced Morgan's understanding of how racism, anti-Blackness, and double standards for white people and people of color can shape life experiences and authority in care work. During the interview, Morgan stated,

“As a white person I'm not accepted by my own community. I'm seen first as trans before I'm seen as white. And where, if you see a Black person, you see them as being Black than trans. I don't get white privilege; I get white privilege because I'm more passing which allows me to be seen as an older white woman. But if I was an older white non-passable trans woman, life would be totally different for me.”

Here, Morgan recognizes the racial and gendered hierarchies at work within the intersecting communities she inhabits. One may interpret Morgan's words as emphasizing the virtue or value in passing; however, during our conversation, she was reflecting on how white supremacy and transphobia intersect. This passage demonstrates how access to power, opportunity, and professional authority often depends upon other hierarchies such as white supremacy and cisnormative expectations of bodily presentation.

Morgan's comment about passing politics and privilege is not escapable from a broader conversation about race and racism. As previously mentioned, trans embodiment has been crafted through the lens of white supremacy by media representation in tandem with medicalization. Debates around “authenticity” have pervaded trans medicine for generations. White trans people throughout history, such as Christine Jorgensen, have been lauded as what C. Riley Snorton refers to as “...a vehicle for expressing ‘freedom’ as a mode of technological manifest destiny—rife with racial meaning—articulated as a prerogative for persons and nation-states” (Snorton 2017:142). The white trans body is a

transnormative symbol of hegemonic racial, settler-colonial, and nationalist ideologies. Ideas of passing reproduced along with ideas of *curative* transition stemming from medicalized “wrong body” narratives are not separate from the white supremacist creation of the “proper” trans body. Morgan’s authority in the clinic and the community rests upon these broader racial assumptions from which trans people of color do not benefit (Morgensen 2011; Bradford and Johnson 2021; Plemons 2017).

I discussed issues regarding the representation of trans people of color in the previous chapter about methods. I recognize limitations in this study concerning the abundant presence of whiteness in my sample population. In interviews, I decided to interrogate the overt over-representation of whiteness among providers of GAC. I asked Skyler, “Institutionally speaking, what's being done to make it [trans medicine] more inclusive for people of color to go into caregiving professions?” Skyler let out a long, thoughtful breath and said, “I think the issue lies within education and accessibility to education, the affordability. Because what we're seeing is mostly people of color as the frontline workers. At least, that's where I'm seeing, frontline workers are mostly people of color, which means it's the lowest paying wages and they're the hardest jobs.” Throughout the pandemic, the term “frontline worker” has been used a lot, especially about anyone working in a position that is considered “high risk” for COVID-19 transmission and infection. I was not entirely sure what Skyler was referring to, so I asked him to clarify, “you say frontline. What do you mean exactly?” He responded, “When I talk about frontline in the substance use treatment world, it's like tech people who are spending the most time with the clients, assistants, that kind of frontline worker.”

When considering ways to create more representation within trans healthcare and to attend to racial disparities among agents of clinical authority, Skyler said, “It’s having conversations, bringing people of color, trans people, queer people to the conversation of what needs to be changed in the institution, what do we need to do differently, what are you seeing, how can we offer more support, try not to be performative.”

Skyler’s discussion about the racial division of labor in trans medicine draws upon the intersections of oppressive systems discussed in much of this chapter. Class, wealth, and access to education promote disparities among trans healthcare professionals. I asked the same question to George, he replied,

“POC are in less quote, unquote “education required roles” and we don’t do a good enough job of mentorship and helping people gain the skills to have professional development and move up. The reality is in our clinic, we see a lot more white kids coming in, and that’s a problem; that means we need to be doing a better job with outreach into communities with parents and families who don’t necessarily understand what’s happening with their young person. We have a lot of Spanish-speaking families that come in, and so we do a pretty good job here of always making sure like we’ve got Spanish-speaking providers. But that’s something that a lot of places don’t do, so I think it’s really understanding, the geographic location where you’re at and what you’re doing to help serve the people that aren’t getting in the door. The white family is with a mom and a dad, and they’ve got PPO insurance, and they’re totally fine with their kid’s gender identity and all of that stuff; that’s well and good, but that’s not everyone who’s coming to the door.

George expands on Skyler’s concern for a divided labor force; however, he shifts critical observations to matters of clinical care among trans youth. Through George’s remarks, we see a concern for the geographic location in which trans care is operating. Here, the queering care is productive in attending to how trans medicine, a field that seeks to serve a marginalized community, is doing so in a marginalized manner. What I mean by this is that inequalities and oppression are still present within queered care or the practice of

clinical trans care by trans people. Representation of trans people in positions of clinical authority does not translate into liberatory practice. *Queering care* allows us to recognize how intersectional oppression from white supremacy, anti-Blackness, fatphobia, and classism is integrated within trans care in Southern California.

From Patient to Provider: Life Trajectories and Experience-Informed Care

A fascinating angle this research allows me to take regarding trans medicine is my privilege in collecting narratives about healthcare experiences from patients who have the clinical knowledge and an understanding of medical and/or psychiatric language used in reference to their lives. As will be demonstrated in the coming pages, even trans people who possess clinical knowledge and serve as care agents continue to encounter obstacles as patients. Difficulties or unforeseen complications in accessing GAC go far beyond gatekeeping, prohibitive roadblocks, and explicit transphobia in healthcare.

During one of our two interviews, Jenny reflected on her experience attempting to secure GAC through service offerings advertised through the Los Angeles LGBT Center. Jenny was a teenager when she came out and was fortunate enough to be enrolled in Los Angeles Children's Hospital's Trans Youth Program by her affirming parents. The services at Children's Hospital are robust, comprehensive, and cutting edge. However, since it is a "youth" centered program, patients age out at 25, leaving many with the unwelcome task of navigating the patchwork of trans medicine for themselves. Upon reflecting on her experiences in seeking GAC services at the Los Angeles LGBT Center, Jenny stated,

“So, for instance, when I got to be 25 and was too old to continue going to Children's I was trying to figure out where can I go, there's only so many places and that I'm very privileged to be as financially have access to financial resources that I do. That even for me, it was like, or can I go where it's going to be a place where I cannot just feel safe as a trans person accessing healthcare. But like, literally, where can I go where doctors know what to do and how to how to treat me and treat my body as a trans person. There's not that many places.”

The stress and anxiety in Jenny's voice spoke to the uncertainty of finding care even though she recognized she had the class privilege to ease the transition in care modality. Due to her socio-economic status, she knew accessing general healthcare wouldn't necessarily be a problem, but she desired a physician who had trans health competency.

Jenny's story highlights another dimension of accessibility and distinguishing between *receiving* and *desiring* care. Privilege distributes community members into different care continuums where access affords some the ability to desire a type or quality of care which best fits their needs. Quality, affirming, and comprehensive care is available for those with access. Access is determined by geography, race, language, economic resources, knowledge, and mobility, which actively work against the most vulnerable within the trans community. For Jenny, she desired care that was more than just trans-serving but was also trans-affirming and trans-competent. While her whiteness excluded her from racism in medicine, her trans experience and region of residence impacted her ability to find care. She expands on this point in her own words:

“For a minute, I was going to the LA LGBT Center. I think it's mostly community mental health, and it's just swamped with patients. I had such a long wait time trying to even get my first appointment scheduled there like; it must have been a month, maybe a month and a half before I was able to get an appointment there. I've heard people tried you had having to wait even a lot longer than that to get access to care. that was really challenging. And so, the doctors I had (at least in my experience) were knowledgeable *enough*, and I felt safe *enough* there. But you know some of the people, at least everybody who works at the front desk, is an

LGBTQ person. Which is nice but it can be challenging because there are some areas of the LGBTQ community that are not always as affirming and supportive of trans people.”

The appropriation of trans representation works to signal inclusivity while failing to shift institutional attention away from cis centered services. Jenny’s experience with desiring trans-affirming care and then being thrust into the bureaucracy of an institution which reproduces inequalities it is supposedly attempting to alleviate perfectly shows one of the main hindrances in improving the quality of life for trans people today. Los Angeles has a large, well-funded, and well-resourced LGBT Center that includes a full healthcare clinic that is *trans-serving*. She felt that the care she received at the LGBT Center was adequate, based on her repeatedly emphasis on the word “enough” to describe physicians’ knowledge and her feelings of relative safety. However, care at the LGBT center was not *trans-centered* and thus proved to be frustrating. The clinic advertised as “LGBT” versus specifically “trans” did not fully alleviate Jenny’s anxieties in seeing providers as trans patient.

In considering her experiences desiring and obtaining GAC, I wanted to take the conversation to reveal how (if at all) her patient experience informed her decision to become a therapist. I asked her, “How do you think your gender identity has influenced your career choice?” She responded in saying, “I really knew that I wanted to (based on my own experience as a trans person and as a queer person) to work with folks from my community.” Jenny explained how her university training program specifically geared towards LGBTQ+ affirming mental healthcare also led to her decision. She continued explaining,

“For me, going to graduate school to be a therapist was kind of, you know, it was going to was me going to study how to use my experience in a way that would be beneficial for LGBTQ+ clients. If I weren't going to be studying in a program that was specific to working in affirmative psychotherapy for gender and sexual expensive folks, I wasn't going back to school.”

The desire to blend official disciplinary training with her own lived experiences as a priority for Jenny is deciding to become a therapist. Furthermore, the availability of an LGBTQ+ centered clinical psychology program in Los Angeles created a known safe space for her to bridge her experience-informed knowledge with newly acquired clinical knowledge. This effectively legitimized her trans subjectivity within broader healthcare systems and institutions consistent with her life goals. Jenny’s experience in the trans youth program, having received a decade of affirming therapy, as well as uncertainty with navigating non-trans specific “LGBT” healthcare, all contributed to her perceptions of trans care within Los Angeles. The known unevenness of trans medicine and the promise of trans-centered directly guided her career path.

Riley is a white, trans man who works as a transgender patient advocate at a large hospital in the Coachella Valley. He was unequivocal in not wanting the name of his employer to be included in written work produced from his interview. I asked Riley, “What led to your decision to pursue a career in healthcare?” He told me, “Once I came out in 2012, I found it difficult to find services. Knowing where to go with the least amount of discrimination was tumultuous at best in trying to find providers that would treat me and not straight out say, ‘I don’t treat your condition’ and not have to teach them how to treat me.”

His struggle in locating GAC informed Riley's path towards his career in trans healthcare. The fear of clinical rejection and discrimination shaped his journey in finding a physician and defining what he was willing to tolerate in terms of receiving healthcare. His statement about not wanting to teach providers how to treat him speaks to standard practices in how many physicians "land" in trans medicine. Until recently, specialized clinical training programs in trans medicine and GAC did not exist. Expertise develops when physicians treat trans people by happenstance and learning to navigate HRT and referrals for GAS along with their trans patients (shuster 2021; Plemons 2017). Riley's life experience speaks to these uneven medical conditions, and he clarified in saying,

"When I first came out, that was the just as I found a doctor who was willing but had no clue what to do. So, not knowing the UCSF guidelines, I gave the doctor the WPATH guidelines. It probably wasn't the best choice. I never recommend somebody starting out the gate at the highest dose of their hormones. So, health-wise, that was certainly a challenge in the first year to acclimate to such high doses of testosterone right off the bat. I've gone through the mistakes that I guide others not to do in my job, which was one of the reasons that I approached my current employer into starting this position."

To frame Riley's unfortunate experiences as a patient of trans medicine, I turn to stef shuster's 2021 book, *Trans Medicine: The Emergence and Practice of Treating Gender*. Their work centers knowledge production and the practice of trans medicine by cis healthcare professionals. Many of shuster's observations stemmed from discourse analysis at a trans health conference and their attendance of various workshops and seminars. Relevant information for seeing trans patients circulates among providers themselves, conferences like the one shuster attended, the scant formal training medical schools and fellowship programs offer, and improvised strategies developed on the job that translates into patient-responsive modalities of care (shuster 2021).

According to Shuster, there is a distinction between “self-assured” and “uncertain” physicians working in trans medicine. Self-assured providers possess scant formal training about trans health and rely on standardized care protocols established by WPATH, the WHO, the Endocrine Society, and the APA. Care standards published by these organizations are non-binding and are regarded as informational guides for “best practice” in providing GAC. Riley views recently published guidelines from UCSF as being more comprehensive than those published by WPATH yet given his limited knowledge so early after coming out; he was eager to supply his physician with something “official” to facilitate biomedical transition services. Existing research on primary care physician willingness to provide care for trans patients speaks to patient anxieties of transphobia in the clinic and physician exposure to the trans community (Shires et al. 2018; J. L. Lee et al. 2022). Riley revealed his priority for GAC was not based on a metric of quality but just finding a primary care physician who was *willing* to work with him and display outward hostility towards him as a trans person.

Given the uneven terrain of trans medicine, self-assured providers heavily rely on published guidance and privilege biomedical intervention as a marker for trans “authenticity.” Expectations in patient patterns create a trans patient archetype for providers to base their clinical decisions and assess “the need” for GAC. This provides two benefits in the mind of a self-assured physician, one being a sense of “scientific” clarity regarding the “treatment” of gender dysphoria in trans men and women. The other being confidence from adhering to best practices as proposed by the beforementioned healthcare oversight organizations. Shuster notes that the inadequacy of self-assured

physicians in serving non-binary patients is based on outdated curative models of GAC which privileges acquiescence to binary gender performance, a desire for “passing,” and a linear interpretation of transition among trans patients. This oversight is consistent with the medical community’s relative comfort with patients who are trans men and women due to their perceived “affliction” reductively explained and managed through “wrong body” narratives (Plemons 2017; Sullivan 2008; shuster 2021).

Riley’s physician was willing to follow Riley’s desire and need for GAC while also relying upon Riley to do the groundwork in education. The non-standard practice of blindly following standardized guidelines presented by a patient further engages with the framework of queering care. According to shuster, cis physicians with trans patients remain uncertain of their expertise and will do what Riley’s physician did and allow their patients to teach them how to provide GAC (shuster 2021).

Finding his way through uncertain and potentially harmful clinical environments led Riley to advocate for establishing the transgender patient advocate position at the hospital where he is currently employed. He said,

“I’ve kind of gone through the mistakes that I guide others not to do in my job, which was one of the reasons that I approached my hospital into starting this position. I was the first one that put this kind of position together here in the desert, and then a couple of the other organizations followed with their own versions. And since then, in talking with the other organizations, we’ve kind of all agreed, and I’ve talked to other people around the country that each organization seems to have their own needs. “

Riley applies experience-informed trans care and ensures trans people in the Coachella Valley have access to GAC. He liaisons between patients and physicians to ensure

competent care is consistently offered and available for the trans community living in the Coachella Valley

Riley's work is queering care through his position within the web of knowledge, labor, advocacy, and institutional affiliation that comprises trans care. His work is also in association with other similar initiatives across the country. He expanded on this point during our conversation by saying, "It's not a cookie-cutter kind of position despite HRC [Human Rights Campaign] wanting the transgender patient advocate title across the nation, it means something different for each organization. So, unfortunately, at this point, there still isn't a standard format in how to put it together for each place." Using guidance from the Human Rights Campaign and best practices published by the UCSF Center of Excellence for Transgender Health, Riley blends directed advocacy with the increasingly normative standards of practice circulating within trans health discourse.

The establishment of programs and resources coincides with the reproduction of medical hegemony, not to mention HRC's record of supporting rights-based non-discrimination bills for cis lesbian and gay people at the direct detriment of trans-well-being and survival (Spade 2011; Stryker 2017). The contradictions, pragmatism, and action informed by lived experience demonstrate the utility of the queering care framework in navigating the expansion of trans medicine by trans people. Riley's experiences as a patient and understanding of the region in which he lives, and works have allowed new types of care relations to be realized where none was present before.

An a priori assumption I made about the lives and career trajectory of trans health professionals was that their intrinsic transness served as a primary motivating factor for

their career decision. Jenny and Riley's stories show a clear through-line from their trans-subject-positions to their experiences navigating GAC and then to their decision to work in healthcare. However, I quickly learned this was not universally true among the providers I interviewed for this project. In retrospect, my thoughts before fieldwork were based on a prevalent set of assumptions many trans people face from those outside their community. As mentioned before, the trans of color critique problematizes the notion that being trans is *the* defining feature of trans people's lives. It was true that participants' trans experience was mapped out on their life career trajectory (to varying degrees). Still, other motivating factors also contributed to working in healthcare.

Among some participants, family connections to healthcare contributed to their career decision much more than their experience as a patient of trans medicine. Anupam is a non-binary and Indian-Sri Lankan resident physician at the same Coachella Valley hospital where Riley works as a transgender patient advocate. I asked them, "What led to your decision to go to medical school?" Anupam replied,

"It kind of evolved. My father's a physician, and it seemed like something I could pursue. It seemed very familiar to me because of what I've seen him do as I grew up. But as I grew older, I think there were particular things that I wanted to do differently that I think health care providers don't do, which is what I think further motivated me to continue that aspiration. LGBTQ+ health is just almost nonexistent among general physicians, and it's something I'd like to do differently, regardless of what I do."

Anupam's story about his father's career as a physician serving as an influential factor for their own career goals further disrupted my assumptions going into fieldwork. As a medical resident with plans to go into family medicine, Anupam desires to engage in care work that increases LGBTQ+ community competency at the primary care level of health

intervention. Current research finds that trans patients overwhelmingly report negative experiences within primary clinics (Herman et al. 2016) and disparities in access to affirming primary care related to provider age, connection to the trans community, and transphobia (Shires et al. 2018). Due to persistent disparities in GAC across continuums of care, Anupam's desire to be a primary care provider (PCP) will dismantle barriers and improve LGBTQ+ health outcomes.

Anupam's story reveals how my assumptions about connections between care work and gender experience proved to be a reductive assessment of trans healthcare professionals' career motivations. The queering care framework disrupts assumed knowledge about trans people and trans medicine. While Riley's story demonstrated how his personal patient experiences were directly linked to his care work, Anupam showed how family and upbringing could produce similar outcomes. Hank's story expands consideration being given to the role that family has in influencing one's decision to choose a healthcare career. He explained a pivotal moment from his childhood by saying,

“I knew I wanted to be a therapist before I knew I was trans. When I was younger, my mom went back to school to get her therapy license and therapy degree. I would help her study, and I would watch her go over her study materials, and by the time she started taking her test, I was about 12-13 years old, so I really fell in love with psychology. I always knew like I wanted to do something with psychology; I just wasn't really sure what. As I got older and I started traveling and doing training on trans issues, I realized one of the ways that I could really help people was to talk about psychology.”

Cultural capital inherited through exposure to a parent's career and educational aspirations in mental healthcare was a driving force for Hank's own academic and career trajectory. The knowledge and care practice he was exposed to as a child predates his self-actualization as a trans man. Furthermore, how his family was able to navigate GAC

for Hank when he came out as a teenager speaks to their educational capital (Bourdieu 2000). Geography also contributes to the availability and accessibility of the cultural capital and trans medical infrastructure necessary to facilitate Hank's transition. Having a mother trained in clinical psychology and familiar with mental health services in Los Angeles allows Hank's family to navigate trans medical infrastructure more easily. Hank's story of becoming a provider of GAC is informed by networks of care, knowledge, and cultural capital that is not separate from his experience as a patient but also includes more than just his trans subjectivity and embodiment.

Some trans clinicians possess intersecting positionalities or life experiences that play a significant role in providing care. For example, Skyler and Kim were very open about their experiences with drug and alcohol addiction and 12 step recovery programs. During an interview with Skyler, addiction and recovery were brought up in response to questions about personal life experiences and the lead to choosing to become a therapist. I noted that experience as recognition of an integral part of the clinician's life story. Still, I did not immediately ask pointed questions or seek elaboration. I will admit that I was initially more interested in learning how experiences receiving gender affirming or trans-specific healthcare influenced the decision-making process to become a therapist. While Skyler provided basic answers to those questions, it was apparent addiction and recovery weighed more heavily on his mind. In reference to questions about his origin story as a therapist, Skyler said,

"I am a person in recovery. And I think that, and I started working at a treatment center. Early in my recovery, I decided to go back to school and become a counselor, and that ultimately led to the work that I do now. My undergrad is in

sociology, with the emphasis on gender and sexuality, and so all of these intersected at the time.”

I noticed when addiction and recovery came up again in the same interview. I followed Skyler’s strong desire to make it known that their approach to care is informed by more than just their trans subject-position. This led me to be curious about how his experiences as a trans man intersected with his journey of recovery from addiction to substance use as well as his sobriety. I rephrased my initial question and integrated concern for his story about recovery along with gender-specific experiences.

As I acknowledged the intersecting nature of these elements of Skyler’s life, he relaxed and went into further detail. He said, “I was not out [as trans] when I started in this field. I was out as gay and working in the LGBT community was super important to me based on just the amount of LGBTQ folks that were that were affected by substance use.” Like Hank, Skyler realized his desire to work in mental health before becoming trans. However, while Hank was influenced by cultural capital, Skyler was influenced by observations privy to him due to his recovery as a queer person. He said, “What I saw was little or no resources or people really focusing in on gender and sexuality as it relates to addiction. So, I found that kind of peace, but it’s still pretty small. With the abundance of people who are affected and the number of resources for my community is small.” I responded by asking him, “Why would you say that is? Why is there that disparity in resources? Skyler responded,

“I think it's most treatment centers or mental health facilities, they say that they work with the [queer] community and the population and they actually don't, they just *allowed*. They allow us in but they're not really doing work behind it. And I think there's no real intentionality around the work that is happening. And so, I've

kind of tried to carve out my identity as a provider and network with other providers that do same stuff and do it right.”

For Skyler, “doing it right” is about centering LGBTQ+ people within addiction care and recovery programs. A motivating factor for his entry into mental healthcare is compounded by his advocacy work for people who share his experience. Qualitative research from Canada found that addiction treatment programs need trans-centered, anti-stigma policies. This research also found a desire for trans-specific programs among trans people seeking pathways towards recovery (Lyons et al. 2015).

Skyler’s story highlights the utility of the queering care framework. The queer critique is productive in resisting monolithic interpretations of trans experience due to its destabilizing effect on identity. Trans lived experiences are multifaceted and trans labor devoted to improving the lives of other trans people is just as varied and complex. The desire to provide care can be foregrounded by clinical experiences as a patient and through different lived experiences that often precede trans self-actualization. As discussed in the introduction, *Queering care* accounts for divergences from assumed linear trajectories regarding trans healthcare providers’ life experiences leading to their career choice. The inclusion of other sources of inspiration and lived experiences influencing trans people to enter healthcare professions, further demonstrates how webs of trans care resist monolithic categorization.

During the second interview where addiction and recovery were mentioned, I was more prepared to follow their story in the directions they saw as vital to their wellbeing and work as an LMFT. For Kim, a trans woman who came out in her 40s and at the same time she started her journey to becoming a therapist, credits her education and experience

in a 12-step recovery program for her success and self-actualization more than her ability to navigate transition or trans community support. Kim's life and perceptions diverge from what I assumed would be the central unifying theme. In the formative stages of this project, I had assumed transition narratives and interactions with trans medicine as a patient would be the primary motivating factor for the decision to enter healthcare yet, Kim's life diverges from that expectation.

I asked Kim, "You said that you were in therapy for 20 years; what about that time period eventually led to you coming out and then going into this field?" Kim carefully pondered my question for a few seconds and replied, "Boy, good question. I'm really thinking back to finding out about the marriage and family therapy clinical psychology degree; I think that was part of the self-actualization." Kim was a student in the same Los Angeles-based clinical psychology program with the LGBTQ+ emphasis as Jenny. Kim credits learning about the program and eventually being accepted as a student as a defining moment in her gender journey. She continued, "The idea of being able to be in a safe environment, where I was going to be affirmed as an LGBT trans person, was really important to me. I very, very quickly discovered that I wanted to work in with the trans community and that there weren't enough trans therapists available for trans people if they wanted to have a trans therapist."

Kim also discussed the positive experiences associated with her transition, which occurred during the first semester of her LMFT graduate program. The safety and respect she found in school, receiving therapy and GAC, as well as positive experiences related to coming out and going through transition, led me to view her story as quite distinct in

terms of the overwhelming levels of marginalization, gatekeeping, and vulnerability many trans people experience in the United States. I asked her, “Why do you think your experiences were so positive when so many people have so many negative experiences?”

She replied in saying,

“I think a lot of it has to do with me getting sober. I've been in 12 step for like 28 years. I've been actively involved in a lot of therapy, a lot of prayer, and meditation. I've been going to meetings for 28 years with sponsorship. I've sponsored people; I've worked the steps multiple times, so I'm very conscious. You know, when I first got into therapy in 1996, I had been referred by my sponsor at that time. So that was a really positive experience.”

Kim's experiences in 12 step recovery and managing her sobriety for almost three decades has been a constant source of strength. For her, Los Angeles has been a bastion of support and safety while her age and life history prepared for embracing a later-in-life transition and career change. Furthermore, her whiteness has also proven to be a source of privilege in navigating social institutions and accessing trans-specific services and healthcare.

The diversity of perspectives presented in this section and throughout this chapter showcases a snapshot of life experiences that guided trans healthcare professionals to enter their current careers. The stories I presented further demonstrate the utility of the *queering care* analytic that accounts for divergence and patterns in how trans care is navigated as both patient and provider. Furthermore, the layered yet distinct geographic realities that make-up Southern California also constitute the landscape trans care is imagined and realized within this project's scope.

Chapter Four: Queering Care in Practice: The Clinic, Activism, and Medical Regulation

I want to start this chapter by revisiting my first day of fieldwork during my interview with Hank. I believe opening with this conversation brings my argument for the queering care framework into particular focus. Hank's words set the scene for a comprehensive examination of how the entry of trans people into professional healthcare practice can positively reshape trans medicine but not without complications.

On that hot June afternoon, I was grateful for the air conditioning and the relative darkness my east-facing home office window afforded. It felt surreal to be doing fieldwork, and I was lucky to have an interviewee with ample time to get my bearings in establishing a conversation flow for interviews. Considerable time had passed, and I had yet to go through my complete interview guide and found myself following Hank through tangents and rabbit holes while tracing his story. I was eager to get through questions while being equally keen to allow him to self-represent his life on his terms. I nervously attempted to ask questions that followed the natural progression of our conversation, and after 90 minutes, I was finally able I approach a crucial question which later led to the framing of queering care. I asked Hank, "What role do you see trans people, trans activists, and trans advocates having in continuing to shape and reshape trans health care in Southern California?" I was careful with the words I chose in asking this question. I did not want to reveal my assumptions of activist labor always coinciding with trans healthcare practice. Still, I desperately wanted to get a sense of how he perceived trans people in a field he has intimate knowledge about as both patient and practitioner. He replied,

“By being the providers that do the care. And I think in a way, it’s like going in the back way. I think we need to make systemic change on accessibility to education. So that trans people can go to school and become doctors and mental health providers because mental health providers and doctors and only listen to people like them in the field. They’re gonna be like, ‘I’m not gonna listen to you because you don’t have the degrees’ and unfortunately, that’s how it works. So, we need to get more people who are qualified to have those discussions. So, the change really needs to be getting people to go to school and getting people to be able to access training and access licenses for care professionals”.

I didn’t expect Hank to discuss expanding educational opportunities in response to my question. I expected him to directly address clinical interactions between patients and providers and how trans providers improve patient experience. Hank values the professionalization of trans people to establish credible and legible expertise within institutional frameworks of care. This value system is consistent with ideologies forged within twentieth century trans medicine. Developing recognizable expertise regulated by modernist medical practice and then holding those standards of practice as desirable works to maintain hegemonic structures for the treatment of gender (shuster 2021). Nevertheless, I followed his direction in the conversation and asked, “Is there an influx of trans people who are seeking out these types of professions?” He replied, “There were 2400 Point Scholar applications [an academic scholarship program for LGBTQ people that Hank assists with award selection] this year. I read at least 100 applications from applicants, and the majority of them were in a care profession.” I was intrigued. Then, Hank pivoted from his almost celebratory revelry at the prospect of growing numbers of trans healthcare providers to offer sobering details behind the numbers. Hank continued,

“Yeah, so there are trans people going into healthcare professions, but they’re also mostly white and mostly people who were assigned male at birth, which means that their education as youth was a little bit better. So, there’s that, but I have a lot of friends who are trans feminine doctors, but they’re in different states.

So, it's happening, I mean look at Marci Bowers look at Maddie Deutsch, but once again, they were assigned male at birth, and they are white people.”

Hank’s words reveal several intersecting factors which shape trans medicine as well as perceptions of privilege that are often read as inflammatory and not in keeping with contemporary trans theory regarding gender socialization among trans people. First, I do resonate with Hank’s pointed critique of whiteness within the trans community. Whiteness is maintained within hierarchies of power and knowledge within the trans community in ways that are often unquestioned (Vidal-Ortiz 2014). Second, signaling his agreement with the assumption that trans women possess privilege based on being assigned male at birth. Thus, “socialized as male” has been fervently debunked in trans studies research on trans childhood (Meadow 2018; Gill-Peterson 2018). As of 2022, “assigned male/female at birth” vocabulary is being challenged, and some community voices are advocating for the adoption of TMA (Trans Misogyny Affected) and TME (Trans Misogyny Exempt) categories to be outside of medical discourse. This development which builds on *transmisogyny* first developed by biologist and trans activist Julia Serano (Serano 2016), further demonstrates how the broader trans community, within and outside of academia, is dispelling with gender essentialist assumptions that still permeate discussions of “pre-transition” and gender socialization.

I do not take issue with Hank’s words for the sake of questioning his clinical expertise, commitment to trans activism, or deep care for his community. On the contrary, these moments in our conversation establish a premise for the utility of the queering care analytical framework. In the same breath, Hank shows the capacity for a searing critique of trans racial politics while also reproducing problematic assumptions

about gender socialization and privilege. Within these moments of conflicting and contradictory perspectives, queering care is advantageous. Assessing trans care for and by trans people in a way that accepts “good” comingling with “bad” and transformational clinical labor being constituted with the reproduction of institutional harm produces a more accurate snapshot of how both activism and medicine mediate trans care.

In this chapter, I address a critical intervention in trans medicine that was a guiding theme for this project: the analytical framework of queering care. I summarized the premise of what I mean by queering care in chapter one, where I showcased the words of Hank, Skyler, Mitch, Jenny, and George. While their stories and modalities of practicing GAC were divergent, their labor stemmed from a shared sense of service to their community. Chapter two summarized my use of methods and showed how queering care was a guiding force in my approach to research. Chapter three reinforced the utility of queering care in situating webs of trans care across the various Southern California subregions represented by the healthcare providers I interacted with throughout fieldwork.

In the pages that follow, I continue to show how the personal and the professional are interwoven within systems of power and conflicting clinical and activist-centered dynamics. First, I expand on how I use the concept of *care* in this work by grounding my research in medical anthropology and ethnographies of care that have proceeded my work. I show how the theoretical and methodological legacies devoted to the study of care and care work inform my examination of trans care as simultaneously embracing narratives of disruption and normativity. Second, I center the workplace and how trans

healthcare professionals navigate their subject-position as patient-provider. I focus this discussion on stories navigating disclosure, trans care by and for trans people, and how experiences of gatekeeping extend beyond receiving GAC and apply to providing it. Third, I consider the ways trans healthcare professionals interact with power, through serving as a challenge to it as well its agent. I highlight the stories of trans health professionals in examining how activism becomes deprioritized in light of the professionalization of care within trans medicine. Building on this tension between activism and medicine, I explore how participants in this study reproduce institutional norms which further regulate trans lives and bodies through normative framings of power.

Framing Care

It is important not to reduce assumptions about trans care to a clinical dyad in applying the *queering care* analytical framework. Imagining care as a dyad reduces its practice to institutionalized and clinical work, excluding activism. It also fails to engage social touchpoints with agents of care beyond what occurs in the exam room and the interconnected systems of power that inform all forms of care work. Healthcare systems including hospitals, clinics, educational training programs, insurance companies, and actors present within every level of all those structures, comprise apparatuses of care that are larger than the sum of their parts (Plemons 2017; shuster 2021).

This research is informed by the anthropology of care. I view this work as contributing to the existing literature and discourse concerning the ethnographic study of

care, with a few pivotal amendments. Since I am arguing for a shift in how anthropologists come to understand the specifically trans ways of providing and receiving care, I believe it necessary to outline how I orient myself and this work within the broader field. This is vital in fleshing out my argument favoring the queering care framework to demonstrate both applications and points of departure from canonical works. Thus, it shows how the stories of trans healthcare professionals challenge current perspectives on what constitutes care.

Care is broad, inexact, subjective, and messy. A statement as simple as “providing care” must be contextualized within intersecting elements of power, extant and pervasive inequities, and rampant intentional harm (both past and present). Minoritized communities feel the brunt of uneven standards, structural barriers to health and vitality, and psychiatric and medical experimentation histories. The assumption that care translates to health and vitality is shortsighted. Even when there are positive *intentions*, care causes harm and promotes violence.

Care is embedded within systems of meaning and systems of power. According to the authors of the 2021 article, “Critical Exchange: The Politics of Care,” care is defined as “...a collection of principles, practices, and laws that facilitate communal gathering and the governance of politics” (Woodly et al. 2021). As this definition implies, care is not singular but multiple. Care is an assemblage of ontologies, actions, and power. Care is also dichotomous and, at times, contradictory as it is interwoven within non-hierarchal community relations and the often-violent operation of state power.

Approaching questions of “good” versus “bad” trans medicine and trans care was complicated by the pandemic, and I can safely assume responses to interview questions before 2020 would have been vastly different compared to those I recorded during fieldwork. Adjudication between good and bad trans care was a central question during interviews thus my data provides personal, self-reported insight into how trans providers define practiced and/or idealized care. Institutional and systemic logics of care are imbued with what Annemarie Mol refers to as “clichés of the west” (Annemarie Mol 2008). The idealization of patient choice is a hallmark of western Enlightenment ideology that emphasizes individual responsibility and personal autonomy. The illusion of autonomy in western health systems coincides with valuing consumer choice in patient care. For Mol, a marker of the modern world of care is the separation of non-clinical care (comprised of amicable behaviors associated with “tender love”) and institutionalized, evidence-based care within the clinic.

I propose that distinctions be recognized between the availability of care regarded as “gender-affirming.” Based on insight from Jaylen and Pablo in the previous chapter, evaluations of the quality of GAC reveals geographic patterning. Their critiques of uneven patient experiences within FQHC trans “specialty care” clinics and among Inland Empire Medi-Cal providers demonstrates the need for distinctions in how trans medical care is assessed. Trans-serving care is GAC “on paper” but due to inconsistencies in patient experience or lack of trans competency among staff or clinicians. Trans-affirming care is where GAC is practiced in a welcoming and affirming clinical environment. Clinical expertise may not be specifically tailored to trans patients, but knowledge has

been expanded and space created for GAC. Trans-centered care is where GAC is practiced with trans patients in mind, and trans people have a direct role in providing services either as office staff or as part of the care team.

Just as trans *serving* healthcare is not the same as trans-affirming healthcare, trans-affirming care is not the same as trans-centered care. However, Stef Shuster warns us that calls to promote specific centering of care for trans people may lead to siloization of trans medicine. For Shuster, expansion of trans health resources, services, and technologies within trans-specific healthcare initiatives (in what are often referred to as “specialty programs”) will do very little for widespread access (Shuster 2021). If comprehensive trans care is localized to only a few clinics or housed entirely within insular trans knowledgeable spaces, much of the care continuum will be mired in continual unevenness. The specialty care model facilitates quality GAC in terms of offering trans-specific services, such as GAS or HRT; however, a trans person’s health extends beyond biomedical transition to also include the need for primary care clinicians to be competent and welcoming trans patients (J. L. Lee et al. 2022). The siloed care forewarned by Shuster does not guarantee gender affirmation in clinical spaces beyond those covered as “specialty.” Furthermore, if trans competency training is contained to segregated specialty programs, that’s where lifesaving and affirming care will remain (Shuster 2021).

The continuum of trans health includes healthcare at all levels, within multiple clinical environments, and across fields of knowledge. However, trans care consists of both psycho-medical and activist care for this work (Malatino 2020). Likened to issues

presented by trans medicine's siloization within gender clinics, limiting trans care exclusively within medicine or activism eliminates opportunities to evaluate both domains as culturally interwoven practices. The queering care framework recognizes trans care as diverse, divergent, contradictory, messy, and multiple and centers trans voices as its primary lens of inquiry. Next, I follow the voices of trans healthcare professionals in exploring how care is queered at work.

Out at Work

Experiences of trans clinicians serving and providing care for trans people were represented mainly by LMFTs and LCSWs interviewed during fieldwork. Physicians who participated in this study were both in their residency programs and spoke at great lengths about a desire to serve their communities with their personal and professional expertise. However, their current capacity to effect change within a non-trans-specific institution was limited to educated colleagues, pushing boundaries for inclusion and cultural sensitivity training and their existence and visibility in overwhelmingly cis-centered spaces.

Trans and non-binary people seeking mental healthcare often elect to see clinicians whose personal lives reflected their gender journeys. This pattern was not surprising as it was my a priori assumption that many trans people seek biomedical and/or mental healthcare from members of their own community for various reasons. According to interview data with LMFTs and LCSWs, the lack of trans competency in healthcare, desire to be understood by someone who has similar lived experience, seeking

a streamlined clinical experience to ensure fewer barriers to care were often sources of guidance for therapist selection. It should be noted that patient/client choice in selecting gender affirming therapist, let alone one who is also trans, serves as a source of privilege and should not be considered a universal experience for trans people desiring care. As discussed in the previous chapter, access to provider choice and modalities of GAC is stratified based on geography, capital, insurance, and to be discussed in the following chapter, digital literacy, and technology.

In this section, I will be focusing on GAC by and for trans people. I show how trans healthcare professionals manage their own trans subject-position in relation to their trans patients and clients while also engaging with what it means to be “out” at work and among patients. I also show how themes common in trans discourse such as disclosure, gatekeeping, and tokenization are reconfigured through the lens of care that has been queered by trans people participating in its reproduction. I argue that barriers trans people experience as a patient of trans medicine are also present in how they navigate providing care for trans patients. Furthermore, I argue that paternalism and general institutional distrust of trans people does not cease due to their inclusion in trans medicine.

In a conversation with Jenny, I asked her, “what happens if your client sees you (as their therapist) at a protest? How does that work if that happens?” Jenny and I were talking about activism in the context of their professional care work, and the conversation came around to questions of geography and trans population distribution intersecting with activist spaces and clinical spaces. As a trans-LMFT who weighs the pros and cons of disclosure with trans patients, Jenny is mindful of potential conflict due to space, place,

and community visibility issues. In responding to my question about the distorted boundaries between the community and the clinic, Jenny said, “In most places, Los Angeles included, The LGBT community is pretty small. it's very possible that you would see your client out in the community. You know, at private events, whatever it might be.” As large as Los Angeles is and as visible as its LGBTQ residents may be, the trans community is still relatively small and insular. This was proven to me throughout fieldwork when participants would talk about their community networks, and I would realize how many people knew each other, especially if one is active in both activism and trans healthcare. My conversation with Jenny continued as she explained the unanswered questions, she would have to contend with in the clinic due to disclosure and visible activism. She said,

“And so, how do you handle that both disclosure wise and kind of activism wise in the moment when you see them [patients] out in public? And then also, when you get back to the therapy room for the next appointment, how do you address that? What questions do you ask? That’s one form of the intersection of activism in the therapy space.”

Jenny describes a multi-layered set of considerations about her work, life, activism, and visibility as a trans person navigating complications in clinical relationships.

Many in the clinical community would perceive what Jenny was talking about as an inappropriate interaction between provider and patient, which would hinder quality of care. The fear or concern of “being seen” outside the clinic proved to be a common experience for clinicians I interviewed. Being visible in public, especially in spaces specific to the trans community, such as activist events, fundraisers, social gatherings, or community support groups, gave Kim pause in how she relates to her community. When

Kim was coming out, she frequented a Friday night trans support group hosted by the Los Angeles LGBT Center. The group was a crucial component in Kim's comportment as a recently-out trans woman in her 40s, and she valued the space and relationships she developed while in attendance. Friday nights spent with other trans people became an integral part of establishing her womanhood and served as a critical weekly event that punctuated her life.

Kim came out around the same time she started her LMFT program within the same LGBTQ educational track many other Los Angeles-based LMFTs I interviewed during fieldwork. The supportive environments she found during the Friday night gatherings at the LGBT center were complimented by a supportive educational environment as she worked towards becoming a therapist. However, Kim's desire to serve her community as a mental health professional disrupted her ability to maintain valued support in trans public spaces. Kim said, "I started to show up at like the Friday night transgender perceptions group at the LA LGBT Center and still presenting as male and meeting other people in the trans community. I don't know if I shared with a lot of people at that time that I was studying to be a therapist, but there was a time where I had to stop attending that group because I became a therapist." I was taken aback by Kim's perceived need for explicit separation between enjoying community with other trans people and her work as a therapist. When I responded with surprise that she sought to deny herself a lifeline of support, she quickly continued by saying, "Because I wanted to start referring my clients to that place [Friday night trans perceptions group] because it had been so helpful to me."

The fulfillment Kim found among other trans people on Friday nights led her to suggest that community space for other trans-Angelinos. However, in directing patients to a trusted space, Kim ended up displacing herself in the process. Recognizing the potential conflict in being seen as a person instead of as a healthcare professional led Kim to prioritize the wellbeing of patients in her care at a direct detriment to her access to the community. The impulse to self-regulate her behavior in public as a visible trans woman is wrapped up within notions of adhering to cultural and perhaps generational perspectives of professional decorum. Beyond simply “being seen” in public by patients or potential patients in trans spaces is a strategy to counteract perceptions of trans people as unfit for respectable labor and clinical authority.

It was clear that Kim’s hesitancy to being seen in public was exclusive to her community. Whenever Kim would speak about fears of being in the same place as patients, it was always about trans patients and trans spaces. Interestingly, she does not have the same level of anxiety of being seen in public among non-trans patients, which was evident when she said, “I have run into clients who are cisgender on the street. Like I’m at Third Street [Promenade], and I’m out shopping or something, and I see them, and they’re like, ‘oh my God Kim, hi!’ and we hug, and they recognize me, and they know me, and that’s really great.” Kim demonstrated her split perspective here about inter-community recognition and visibility, which provokes a specific response about professionalism. She expresses no conflict in being seen by cis clients and even engages in friendly tactile contact, which would signal discomfort in her field. Based on Kim’s (and to a certain extent, Jenny’s) stories, feelings of self-consciousness seem to emanate

from expectations of surveillance due to their trans-subject-positions, engagement with the community outside the clinic, and a desire to maintain professionalism.

Kim expanded on the internal dialogue she has regarding the feelings of surveillance she experiences in saying,

“I have to be very careful as a therapist that I present a certain way; I mean, that's just smart business. Now that I'm a therapist and I've got a reputation I have to uphold, so that's part of it. So, I don't have the same amount of freedom I would have in the trans community if I wasn't a therapist; I could probably act a little crazier, act a little, you know, sluttier or whatever, probably get away with a lot more. So, I guess the way I hold myself in public is, I try to mature and pretty much, you know stay in some way. So, like I said, I wouldn't go to that Friday night group as a therapist because I have clients who go there, so that restricts my movement there a little bit.

This was an illuminating part of my conversation with Kim because no one is telling her she can't be seen in public by trans patients in her care or even how to behave or present herself in public. However, the restrictions she feels in public are self-imposed for the sake of professional reputation. By sacrificing her own joy and ability to celebrate her transness with the community, Kim demonstrates her acquiescence with *transnormative* expectations that constitutes the respectable trans citizen while also respecting norms of American organizational culture. She also shows her loyalty to her discipline and consideration for her professional standing as a healthcare authority.

Kim is proud to be a therapist, and she has every right to relish the material benefits of education and applied knowledge in a career. Furthermore, her commitment to serving as a source of care and support for her community demonstrates a deep understanding of the vulnerability trans people face, even though her personal life experience was filled with support and affirming social environments. However, in

expanding on the point about surveillance as a trans person in trans spaces, another dimension of Kim's anxiety relates to imagined perceptions of her inappropriately using her visible trans subjectivity in the service of capital. Kim said,

“You know, and I also felt like there was a part of me that worried, I could turn into some kind of like guru or something or that I would be there, or potentially trolling for new clients. And it's just not me. You know I mean what you know, but also like involved I can't run into my own clients at that group I just can't like that's not a not an option, so if any of my clients did start going and some of them did so yeah, I think it just made it easier.”

Anxieties about how she would be perceived in trans spaces as a therapist extends beyond just her attachment to professionalism and includes wanting to not appear predatory for clients. I would argue that the expectation that she would present with nefarious intentions in public spaces is a derivative of the trans trope Stef Shuster refers to as the “trans trickster” (Shuster 2021). Over the past century, the medical community has cast trans people as unreliable and particularly adept at lying to physicians. Questions regarding moral character and trans people's “authentic” need for GAC perpetuated the negative stereotype of the “trickster.” I adapt Shuster's concept and apply it to Kim's insecurities about being visible in public. Her fear she could be perceived as predatory in trans social spaces for the sake of expanding her client base and, thus, billing opportunities reveals the level at which capitalism is integrated within trans care, a topic I expand on at the end of this chapter.

Kim's hesitation in being in public social situations with clients centered around care for her place as a professional in the community. While I have critiqued trans health professionals' loyalty to institutional training and affiliation as a mode of reproducing clinical inequalities, Kim's story challenges that assertion. In reference to what she

affectionately calls her “Friday night crew,” Kim said, “we would go off to dinner after every meeting, and after every group, we built a community. We would have trans pride every year, and it was an amazing community.” Kim’s heartfelt nostalgia for the early days of her gender journey coincided with gaining affirming knowledge and training in her LMFT program. She continued, “It just felt like it was such a game-changer for me, and it made it easier, knowing that I was going to send my clients there [trans perceptions group].” Kim’s personal experience contributed to her embodied knowledge which shifted the quality-of-care relations between therapist and patient. This kind of social formation is only possible and plausible because trans people like Kim provide care to members of their community.

As Kim felt her career trajectory necessitated pulling back from the community, in what at first glance seemed to be a clear separation in how she compartmentalizes varying aspects of her life, she was evident in how she understands the relationship between these two domains. I asked her, “Do you ever find yourself of split mind in terms of how you approach the trans community as a person as opposed to as a therapist? Are those worlds blended for you, and is your profession completely intertwined with your identity, or are they ever in conflict with one another?” This question was central to the overall aims of this project in terms of getting at the complexity of asserting clinical authority when also interacting with community relations and activism. Kim responded by saying, I really think it's very, very blended, me being a therapist, I think I feel like if somebody asked me, ‘what are you?’ it's like, I am a therapist, I'm a trans woman, so I think they're [her personal and work life] fairly blended.” This perception of her life as

“being blended” between her work as a therapist and as a trans woman existing in the world further reveals a complicated relationship between clinical authority and everyday life.

Furthermore, when I asked Kim if she felt she is an activist in her community, she responded by saying, “I am definitely an activist; I feel like me just living my life is activism.” Here we see an acceptance of the label “activist” without any attention being given to the history of trans activism, current organizations or movement leaders in Los Angeles, or a feeling of needing to prove herself in claiming participation in activism. This is what I find fascinating about trans activism; there are traditional modalities in which trans activism resembles other social movements in terms of direct action and organizing. However, many trans people, especially members of the community who are publicly visible or possess authority in trans-serving institutions, take on an activist identity due to recognition of their power in the public spaces they inhabit.

This conflict within trans-for-trans clinical care relationships illustrates how geography, community, and professional life intersect in specifically *queer* ways. What I mean is that this conflict (which arises from an integration of community care within regulatory institutions of healthcare) promotes a blurring of boundaries between a trans person as a clinician and a trans person as an advocate. The intimacies of the clinic and the intimacies of activism are co-constituted in ways that disrupt clinical distance and community solidarity. The *queering care* analytical framework is useful in interpreting how the confluence of the personal and the professional is complicated by the presence of trans people within healthcare institutions. Workplace politics promote anxieties

concerning clinical distance while the relatively small size of the trans community increases the likelihood of patient-provider interactions outside the clinic. This leads to a discussion of disclosure and the place this concept has within trans culture, the vulnerabilities it reinforces, and its presence as a tool for improving care.

Disclosure in the Clinic

Existing as a visible member of the trans community within a clinical setting alters relationships between providers and their patients and providers and any institutional authority overseeing their care work. These moments of articulation between the three domains of care relationships speak to the interwoven power dynamics at work within trans medicine and therapeutics. Power ultimately shapes how and when trans providers elect (or are compelled) to disclose the trans identity and perhaps share elements of their journey with their patients. What is messy in these moments of openness is to what extent sharing personal experiences concerning transition or any other aspect of being trans is inherently a clinical practice or the provider offering insight as a community member.

Throughout fieldwork, the balancing act between presenting as an authority of care and as an authority of common experience was extremely blurry. To what extent is personal experience that is relevant to the task of providing GAC warranted within a clinical relationship? Suppose we assume trans healthcare is uneven based, in part, on the historical exclusion of trans people from clinical decision-making. Would it not be appropriate and deemed vitally necessary for personal knowledge to be entrenched within

GAC at every level? These questions were not a part of my prepared interview guide; however, through analysis of patterns in conversations about trans people providing care for trans people, I will illuminate how trans clinicians understand their unique role in care continuums, internalize institutional and discipline-based training and standards of practice, and how their place within trans medicine demonstrates the production of novel social relations and constitutes a paradigm shift in GAC.

As trans clinicians disclose their own trans experiences to their trans patients, another layer of influence (and this time influence legitimized by medical authority) is presented to the patient navigating transition and selfhood development. Questions remain regarding how provider disclosure fully impacts the quality of GAC and how trans identity manifests among patients. This critique of self-actualization models of GAC and the implications for the establishment of unexamined processes of production of self will be further interrogated in the section focusing on the analysis of interview data about trans people providing trans healthcare and the potential of transference and countertransference in clinical relationships.

Navigating disclosure permeates multiple areas of trans everyday life and has been a hallmark in trans media representation for decades. The term itself has become a pop-cultural lightning rod after the 2020 documentary, *Disclosure* which curated an intensive overview of trans representation in television and film over the past century. The film's gravitas rests on its powerful imagery, and its commentary offered exclusively by trans people. Some commentators are featured in short video clips integrated within the film's narrative. *Disclosure* provides a new perspective of media analysis that reflects

the intersubjectivity of trans people critiquing and celebrating the missteps and strides forward in representation and how the changing nature of their place on screen impacts society.

Disclosure proved to be a new fixture within trans culture in the United States during my fieldwork. It brought the personal life histories of trans clinicians into perspective alongside broader conversations about representation. Trans representation in all areas of society provokes a ripple effect with reverberations manifesting as affectual energy. Affect produced through the waves caused by mere trans existence, let alone moments in which trans activists effectively push the needle of consensual and positive representation and improved quality of life, engages a tumultuous dialogue between trans people and power that is intended to impact them but simultaneously be out of their reach.

As I approached this work, the decision whether for trans providers to disclose being trans to their patients and clients was of great interest to me. While I did not initially phrase my research questions around the specific concept of “disclosure,” instead of choosing to center questions around trans people providing care for other trans people, study participants consistently brought our conversations to this topic and explicitly used the term. As an outsider within professional care communities, I made many assumptions based on preliminary discussions with trans providers who broadly embraced disclosure throughout their work within institutions and in the service of trans patients. Disclosure was also reserved as a tool that providers could use when clinical circumstances necessitated openness to increase the quality of care or improve health outcomes.

I asked George, “Do you incorporate or deploy your transness into a clinical space, and how does that affect your rapport with patients?” He replied very confidently, “Yeah, I do, especially with young people. If I know that there have an unsupportive household, I’ll definitely do some more self-disclosure. It’s important for them to know that there’s hope.” George’s willingness to adjust his care protocols demonstrates clinical malleability that is informed by his own lived experiences as a trans person. He continued, “I talk about my own personal experience, not as if, like their experience is my experience, or vice versa, but that, but I at least I have a sense of what they’re going through.”

George uses disclosure to communicate to patients, especially those most at risk or experiencing vulnerability due to life circumstances or family situations. Since he works primarily with trans children, he often interacts with families who have been referred to his clinic due to their child’s patterned gender non-conformity and expressions of dysphoria. He continued to elaborate in saying,

“Sometimes I’ll do it [self-disclose], even with parents, especially if someone says something that’s a little bit, not right or not backed by science. I’ll definitely self-disclose a little bit because it usually snaps parents out of it and it’s like, ‘oh wow *you’re trans*? I would have never known that! As a trans person it’s such toxic crap that people do, but like professionally, it’s a really helpful intervention tool.”

To connect trans kids to GAC, something only secured through parental approval, George consents to allow himself to be visible in ways that expose himself to toxic attitudes about trans people. He makes himself visible as a trans person by engaging with problematic passing politics. His masculine embodiment coincides with his passing privilege to alleviate anxieties held by the parents of trans kids. In addition, his position

as a mental health professional further demonstrates to weary parents that trans people exist within their understanding of “normal.” He provided more clarity regarding his approach to speaking with parents in saying, “When you put yourself out there, being a really competent and experienced mental health provider, that adds some clout to you and then they're [families] like, ‘Oh, it turns out my kid is not destined to be an alien.’”

George’s words demonstrate the utility of disclosure while also acknowledging how such action can expose trans clinicians to transphobia—working with the public while trans allows one to be susceptible to increased vulnerability and different forms of transphobia, like the “benevolent” version presented above. Reaching positive outcomes and providing the best clinical care for often difficult-to-reach trans youth means navigating parents' difficult questions and comments. George later went on to discuss how many families that had been referred to him and the program he represents often do not fully understand what their child is going through or what exactly they are doing at a gender clinic. The realization that their child may be trans and will be receiving services to assist their child fully understanding what they are experiencing in terms of gender expansion or questioning is often difficult to process and accept. Disclosure is a tool that can be deployed by a healthcare provider to help assuage anxieties and misunderstandings parents can have about their children. By disclosing their trans status in these tumultuous conversations, the provider can present themselves as “figure A” in terms of what a well-adjusted, happy, and successful trans person looks like. While this does leave the door open for over-simplifying trans experiences and glossing over diverse

transition experiences, the ability for families to connect with a trans adult provides hope for their child's future.

As is true in other elements of trans life, whether it be access to healthcare or public visibility, disclosing one's trans experience is a double-edged sword. Access to GAC often includes acceptance of the medical gaze and pathologization, while public visibility offers the potential for acceptance but usually translates into increased vulnerability through discrimination and violence (Stanley 2021). For trans clinicians, external and internal pressures guide the decision-making process regarding disclosure. Externally, these providers navigate institutional pressures to either limit the deconstruction of perceived professional barriers with patients, staving off the appearance of activism in care work, and/or fear of transphobia among colleagues.

Anupam expressed trepidation in disclosing their non-binary subject-position when applying to residency programs. Anupam indicated they struggle with declaring identity labels in general and was even hesitant to participate in this study for not feeling trans or non-binary "enough." During our conversation, I asked them, "When you were applying and before you matched with your hospital, did you disclose your use of they/them pronouns?" They replied, "Yeah, I didn't bring it up when I interviewed; I just didn't want any awkward situations. it's frustrating that you have to think about things like that, but you do so; I only brought it up after I matched." Anupam's thoughts concerning disclosure resonated with me as I have experienced nervousness in disclosing my queer subjectivity in professional settings. Even though California has strict non-

discrimination laws, the internalization of queerphobia, transphobia, or homophobia leads to moments of pause when considering being “out” at work.

Trans therapists who work in general mental health clinics instead of working in private practice find themselves among only a few other LGBTQ people and often are the sole trans clinician at the site. In my conversations with Jenny, being one of two trans people working at her site was not an issue. Collegiate relations with supervisors and other therapists are described as professional and being trans is not an obstacle in the workplace. In some cases, the disclosure of a therapist or physician as being trans within their place of work led to opportunities to expand their influence and apply their expertise. However, deciding to disclose is often a multi-layered process involving a series of actors with a mutually vested interest in byproducts of a disclosure interaction.

In one of our interviews, Jenny reflected on the process of consultation with program instructors and her clinical supervisors when navigating disclosure. She said,

“I want folks to feel too comfortable with me as a trans person, particularly if they are trans themselves if they are trans themselves and looking for someone who's a clinician who will be able to work with them and be affirming towards their trans identity. But at the same time, it might not necessarily be a good thing to be 100% open about your trans identity because you might bring up things in your client that might not have otherwise, and it might be a hindrance to them being as active in their participation in therapy but could also potentially be activating for them in a negative way. So, it's hard. It's a judgment call. Even as a trans clinician myself, I'm still feeling it out. I almost never see that this reflected in any kind of professional literature, but I think these things are really important.”

Jenny's indeterminate perspective concerning whether to disclose or not disclose her trans subject-position with clients is illuminating. Her thought process shows the improvisational nature of mitigating the personal with the professional. The lack of guidelines in professional literature regarding best practices for disclosure, let alone in

the context of GAC, shows how drawing upon experience is integrated within care practice. These moments of clinical liminality may prove frustrating for providers; however, they are an integrated part of care practice. Queering care is productive in examining the tenuous relationship between personal preferences, clinical comfort, and potential benefits and hindrances presented by disclosure. Jenny continued summarizing her thoughts on disclosure by saying,

“You know it's really a case-by-case thing. There are, for instance, some clinicians, even some of my instructors in my program who, kind of as just a blanket rule, are very open about it; they decided, you know, clients might find out eventually. Like, let's just rip the band-aid off, let's do it. But then other folks, I think for myself, is it for my comfort that they know? Why am I disclosing? I think it's the important question that I am trying to make sure that I am getting as deep into as I can.”

Jenny's recollections of the politics of disclosure illustrate how even through interactions with clinical educators and workplace supervisors, there is not a specific course of action from which to approach revealing one's identity as trans. Expertise coexists with the uncertainty of setting the tone of a clinical relationship. Here we see a trans therapist who was explicitly educated in LGBTQ+ mental health by trans instructors still struggle with navigating how to proceed with disclosure.

Professional Typecasting, Tokenization, and Transactional Care

Trans providers often find themselves tokenized within their field of practice due to the automatic assumption that because they are trans and work in healthcare, they will want to primarily see trans patients and provide GAC. According to Hank, he saw benefits to colleagues in his field associating his transness with expertise. He told me, “It

actually is really good because then that means I'm the go-to person, and I get referrals. Just this week, I've gotten seven new referrals for trans stuff from other therapists, so it's really beneficial." Hank appreciates his place in care networks not only because these referrals coincide with his long-standing commitment to trans activism but also because it is financially lucrative in his private practice. He also spoke of frustrating moments from the professional typecasting he often experiences. He said, "However, sometimes, that's the only thing that people think that you do, and it can become kind of frustrating because that's not the only thing I'm interested in." Hank is interpreted as being especially fit for seeing trans patients due to his trans subjectivity and embodiment.

I foresee that professional typecasting will be a stumbling block for both trans providers on the job market and the clinics that employ them. Debates regarding the efficacy of diversity and inclusion training and awareness campaigns within organizations manifest in an essentialization of marginalized members of the workforce community. Rapidly, "diversity and inclusion" is becoming code for a form of tokenization that is arguably more insidious than the empty placement of a person within a position based solely on what box they tick in their employer's staff roster. Diversity and inclusion deploy virtue signaling in organizations where concern for marginalized staff is acknowledged in words and ways beneficial to the organization's image. However, actions that work to rectify past failures and harm and fully incorporate QTPOC staff within processes to improve workplace culture and representation are severely lacking. Professional typecasting satisfies the needs of healthcare and social service institutions, including those specifically "LGBTQ+" focused and even queer-led,

to project a climate of desired inclusion only as imagined by privileged figures in those organizations.

Hank told me about a pattern he has noticed among his clients seeking him out as a trans therapist. He said, “Client retention is hard because most of the time clients just come for their letters, and they don't want to stay on longer, so like my client turnover is really high. And that's frustrating because I like in-depth long relational therapeutic relationship experiences. After all, then I get to see people change.” Hank is describing a balancing act between his desire to connect people with lifesaving biomedical GAC, need for clients to bill to keep his practice operating, and a desire to provide comprehensive care for members of his community.

Trans clinicians, especially therapists, must contend with is what I refer to as the expectation of providing *transactional care*. When trans people seek GAC, they often understand and expect the red tape and bureaucratic inconsistencies that go into accessing GAC. The mental health providers I interviewed often spoke about patients expecting a particular type of care because their provider is also trans. There are often unspoken interactions between trans patients and trans therapists where the patient expects their clinician to do everything in their power to streamline access to HRT or GAS, including sidestepping care standards or guidelines otherwise adopted by their field. Many trans people who seek mental health care services do so to meet a requirement within their healthcare continuum to begin biomedical transition. Many physicians require trans patients to meet with and obtain recommendation letters from mental health professionals before prescribing HRT or moving forward with GAS. As trans medicine is a patchwork,

it should be noted that requirements for letters before securing HRT or GAS are currently in a state of flux as some physicians no longer require mental health evaluations before prescribing HRT.

Letters of recommendation written by therapists on behalf of trans patients seeking HRT or GAS is referenced as one of the most common sources of medical gatekeeping trans people experience (shuster 2021; Lane 2018). Trans therapists included in this study offer distinctive insight into this arena of trans care with a perspective unique to their positionality as both patient and provider. Throughout my research, trans people have effectively been given the keys of the gates that keep GAC out of reach from their community. What trans clinicians do with those keys speaks this project's examination of the relationship between activism and trans medicine. *Queering care* offers a pathway to reveal and analyze how trans healthcare professionals, especially therapists, navigate gatekeeping and letter writing while also considering their history of obtaining GAC. I argue that tensions between trans healthcare professionals, activist discourse, their experiences as a patient, and their clinical authority is evident through the various patterned, yet divergent perspectives they have regarding the place letter writing has in trans care.

The politics of letter writing is fraught with conflict within trans medical and activist communities, including among trans healthcare professionals themselves. Among participants in this research, perspectives regarding letter requirements are extraordinarily mixed. Conversations during fieldwork would range from some clinicians expressing a

desire to abolish all requirements for letters, others fervently believing in their purpose as regulatory and necessary, and some adopting a perspective somewhere in the middle.

After hearing Hank discuss the high turnover of clients and his lamenting that trans people were not opting for holistic mental health care beyond the letter, I wanted to learn if transactional care was patterned. Furthermore, I sought to understand how trans providers precisely navigated this phenomenon since it demonstrates the tension between community and healthcare systems.

I asked Pablo about their perspectives on trans people seeking mental health care for the sake of a recommendation letter for biomedical GAC. They responded by saying,

“Yeah, I think. I think the way I would respond to something like that is a client. And the client knows what they want to go in for, and I think ultimately, they know what's best. So, we can assess and say, hey, there may be some other some other things you want to talk about, but that's, that's always up to a client like to, to say like, I'm ready to deal with those things. We shouldn't like to say, hey, ‘I noticed you mentioned X y & z. Did you want to come back and focus on those things?’ I think it's worth mentioning, but I think the system made (if we're talking about the letter) made that kind of transactional relationship happen. If we didn't have the need to pathologize trans identities, they wouldn't need to have these transactional relationships with therapists or trans therapists specifically. The idea would be like, ‘I don't need a letter to say I'm trans, I'm here because I know you're a trans therapist, and these are the things I'm going through.’”

Pablo focused their response to transactional care on informed consent and the value of following trans clients. They view providers of GAC as partnering with trans patients and clients on their journey towards self-fulfillment and self-actualization, regardless of what that entails. Like Hank and Chris, Pablo recognizes the value of holistic mental healthcare beyond the office visit to procure a letter for recommending biomedical transition services, but unlike Hank and Chris, he does not assert that the value of holistic

care is prioritized over the immediate needs of GAC. Ultimately, they view responsibility for navigating GAC to be within the hands of the individual patient or client and should not be hindered for any reason. Pablo continued,

“If we look at it if I use Maslow's hierarchy of needs as a point of reference. It's like transitioning and getting transition services will always come first before wanting to deal with anything after that. If that's my goal, that's how you have to view what I want to do. So, I think, rather than saying like, ‘they're not getting holistic care because they only want to come in for a letter,’ I don't think that's fair. When you know, that's kind of how we've forced trans people to look at transition services and surviving.”

Pablo's insistence on bringing in the word “surviving” speaks to how GAC is framed in contemporary trans care discourse that bridges activism and medicine. Pablo's story exemplifies and gets at a core element of queering care in thinking about how the necessity of access is not only a question for clinical bureaucracy but a question of community survival. Changes in protocols and standards that dismantle mechanisms of gatekeeping start as activist endeavors fueled by experience-informed knowledge. That knowledge is then applied to clinical interactions, and positive change can be realized. This is queering care.

Pablo's story coincides with Hank's experiences in collaboratively working with clients to ensure a streamlined connection between them and the care they need.

However, I do find it interesting that while the tone and perspective of Pablo is divergent from Chris (who wholeheartedly embraces using the DSM and diagnostic criteria as care practice), both they and he still desire some level of clinical dialogue due to requiring a session or two before providing a letter. Pablo said,

“If we're going to have someone come in and say, they just want a letter, okay, cool, that's fine. We'll have a session; maybe two, I'll; I'll write the letter and let them

know whenever you're ready to come back, please feel free. There may be things you want to talk about once you're ready. I think a client should have the agency to choose how they want their treatment. I think therapists and clients do you have to collaborate on what the treatment will look like. But I think like ultimately if a client says, 'I just want my letter, I'm not here for anything else,' I think that should be something all therapists, whether they're trans or not, should say 'okay, let's do this session or two and then you'll get your letter.' That's it; I don't think it needs to be anything more than that, because until we get rid of gender dysphoria in the DSM and requiring it for transition services, this is exactly what it's going to look like."

Pablo speaks the language of liberation and abolition in how they approach trans care, yet there are still moments of institutional connection which ground their care practice. In many ways, the words and views of Pablo diverge from others within the trans care community. However, differences between care practices seem to stem primarily from affiliation with queer and trans rhetoric and understandings of "pragmatic" use of medical authority versus adopting a largely critical standpoint (like Pablo). Riverside-based LCSWs Jaylen and Pablo were consistently more likely to discuss trans medicine, gatekeeping, and disparities in the context of flawed and unequal systems compared to their mental health counterparts in Los Angeles.

Skyler expressed divergent perspectives regarding his personal and clinical relationship with standards of care. During our conversations, we spoke extensively about letters and their role in trans medicine, and he said the following,

"I think, like requiring mental health letters for surgery is nonsense because trans people are very smart and know what to say in order to get what they need. So, I think that we need to be operating more on a system of like you know, let's talk about what's going on with you right so as in like a therapeutic space not like, we need to check all these boxes in terms of giving you something. Because that's one of the things oftentimes when I work with people it's like. Especially the right mental health letters for surgery you even know you can sense from them; they already know what to say before you even talk to them so it's not actually a productive conversation."

Skyler's understanding of how trans people access care is informed by his own experience securing GAC and his observations in working as an LMFT for the better part of a decade. He is experiencing professional typecasting, and Skyler touches on another dynamic here that deserves exploration in terms of how trans medicine diverges from long-established standards in the hands of trans clinicians.

I asked Stacy about the tendency of trans patients to desire transactional care and her response was like Skyler's perspective. She told me,

I'm fine with that because I'm gonna know within 10 minutes of talking to you if you're going to be a good candidate for gender reassignment surgery and that This is something that you thought out. And when I tell you to tell me your story, and then your story goes on. You tell me this and this and this. And then I'm going to ask questions like, well, you know, this can be kind of permanent, have you have you, you know, started to disclose this to other people with trusted people and what are their reactions and what is your family and what are your parents. What are your kids. And what does your spouse think about this. Have you begun to live as in this role, you know, and all these kinds of things before we decided to make this change to as well? And I want you to convince me a little bit, but this is something that you've really thought about and you really want Because it's not just a matter of me taking you off. Estrogen and your little kiddies go away. It just doesn't work that way. So, I have to be convinced. But fortunately, you know, if you're coming in and you're telling me, trans, I'm, you know, I'm going to ask your story, and I'll know at the end of the story. If you're if you're going to get a letter or not. And hey, I don't need to sit there and do the DSM criteria and all this kind of stuff. I usually have developed, you know, a pretty good feel about situations like this.

Stacy seemed happy to operate in a clinical setting where her patient was expecting service from her and viewed her capacity for care as a technical formality. She is all right with this type of patient interaction because of her own lived experience as a trans woman. She relies upon the stories of patients and how their words resonate with her own “feel” when interacting with patients who are seeking GAS.

Clinical experiences between trans providers and trans patients do not always look like Skyler or Stacy's experience with the expected transactional nature of care. Chris spoke to his perspective on this topic when I asked him about what Skyler described to me. I asked Chris, "Do you ever feel as if the relationship between you and trans patients is transactional and your capacity to provide holistic care is limited?" Chris replied in a questioning tone, "No?" as if he understood why I would pose the question and could imagine himself navigating such a clinical conundrum. However, his tone suggested that he does not need to navigate questions limiting his ability to provide care based on expected transactional relationships. Chris continued to explain,

"I think that I'm really clear in my first session with people. I hate the term 'gender therapist' because then it makes it sound like we can only talk about gender. I'm a therapist who happens to work with trans patients. And so, everything and anything is 'on-limits.' We can talk about your dreams, fantasies, things unrelated to gender, work, gender, your relationship to your body. We can talk about everything and anything."

Asserting his role as a therapist and not a gender therapist is an essential distinction as he desires his expertise and skill to be centered, not his positionality as a trans man. At this moment, I began to critically consider my motivations in conducting this research and how I potentially cast all trans clinicians as agents of trans medicine. While trans clinicians can and do have a vested interest in seeing quality GAC available for the community, their professional expertise is not necessarily enveloped within trans medical discourse. I found Chris' words curious since he is a professor within an LMFT training program specializing in LGBTQ+ mental health. Additionally, Chris has trans clients; however, his care for trans people is more informed by his professional expertise and experience than his experience receiving GAC.

In terms of navigating letter writing, Chris' experiences reflect the changing landscape of trans medicine in Los Angeles. Some barriers are coming down, and "gates" are becoming more penetrable without the need for letters acting as keys. Chris said,

"I don't get a lot of requests for letter writing much anymore; there's a lot of local providers that are no longer needing them for HRT. I haven't had a letter for hormones in years. I had my first one in a while, and it was someone that wasn't local, and they were needing a free letter because of where they were. It was bizarre having to do that process."

As will be explored in the following chapter, the recent expansion in teletherapy due to the COVID-19 pandemic has removed barriers to care imposed by distance to affirming clinicians. Chris is based in Los Angeles, which has a robust network of trans-affirming healthcare providers, and his experience of not writing many letters reflects the regional privilege I discussed in the previous chapter—furthermore, labeling the letter writing process as "bizarre" speaks to how Chris has adjusted his approach to care in response to recent changes in trans medicine.

Kim's experiences echoed some of what Chris told me during our conversation. Kim said, "Well, this is a very, very charged question. There are so many opinions in our community about this, so I can share with you what my experience has been. I have had people that have said, 'I just need the letter,' and there are enough organizations in the city of Los Angeles that will do that service for free. I will give them a list of places." Kim is not voicing support of lengthy gatekeeping for her trans patients, however, nor is she acquiescing in providing what I call "transactional care." Her desire to serve trans patients resists dichotomous categorization. She is not operating as a gatekeeper nor as a figure embracing liberation from established care hierarchies. *Queering Care* challenges

assumptions of motive when trans people serve as agents of trans medicine. The desire for clinical authority and a means for making money coexist with the infusion of experience-informed care practice and diverging from institutional guidelines for best practices.

In responding to trans patients seeking letters, Kim tells them, “I’ll do it for you; I would I want to see you, maybe once, twice tops I would never require more than that.” In our interview, I wanted to immediately dismiss Kim’s words as gatekeeping by another name. However, she expanded by saying, “I mainly just want to make sure they’re safe and stable. It’s tricky because the gatekeeper thing is really tricky. If I’m doing a letter, I just want to make sure that person is stable. If they’re actively psychotic, I’m not going to write them a letter.” Kim understands the propensity of clinicians to desire power associated with gatekeeping and the financial reason to bill patients for multiple therapy sessions. Monetary compensation was never brought up in our conversations, and it was clear her motivation in serving trans clients was care and concern for her community.

Like Chris, Kim’s experiences supporting trans clients in accessing GAC with letters do not include participation in transactional care. About prospective patients going to a trans therapist with the explicit desire for a letter, Kim directs them to the beforementioned agencies in Los Angeles that provide immediate and free letters to any trans person in need. Kim does not disparage trans people who prefer not to receive mental health care in addition to receiving a letter and told me, “They usually just say, ‘okay, thanks for the referral,’ and they’ll go to those organizations that do it for free.

Most of my clients have worked with me for a while and then eventually say, ‘okay, I want that letter,’ and I’m like, ‘I’m doing that now.’” Kim is currently working with a trans client who is a minor, and their affirming mother desired comprehensive GAC before proceeding with HRT. Kim explains, I’ve been working with the same client for like four months, and the mom finally said, ‘all right, we’re ready for the letter’ I’m like, ‘great, and I’m on it now.’ I’m writing it up, and I’ll have it ready for her next week.”

The complicated relationship between lived experience, desire for expanding trans care, and embrace of clinical authority reveal patterns in trans care for and by trans people. The queered care of Skyler, Kim, and Chris challenged my a priori expectations for trans people in positions of clinical authority. They are interested in providing person-centered care and not having their expertise and clinical labor reduced to a function of bureaucracy. Their care work is neither a freely available key to open gates nor reflective of paternalistic trans medicine. The desire to work within existing systems may be met with consternation among activists, yet “whole person” care is embraced among trans people with clinical authority. Expectations of how GAC is performed were not necessarily disproven but complicated by the stories presented through fieldwork. There was recognition of the dangers of gatekeeping articulated by providers; however, there are divergences in how the concept of gatekeeping is interpreted and related to what providers consider “good care.” *Queering care* assists us in recognizing how this tension among trans healthcare professionals in straddling the patient and provider roles is foundational in how their clinical authority in trans medicine is reshaping trans care. What is clear is that none of the providers I interviewed would possibly imagine

withholding letters in favor of their patients or clients accessing GAC. However, the desire to exercise clinical authority in moments of *transactional care* is out of concern for patient wellbeing beyond medicalizing “being trans” or managing dysphoria.

Professional Gatekeeping

Gatekeeping is a hallmark of trans medicine through the imposed barriers many trans people experience in their interactions with healthcare systems, insurance companies, institutions, and care providers at every level. Experiences of gatekeeping among trans patients are well-documented in personal testimonials and the medical and academic literature (shuster 2021, Plemons 2017, Lane 2019, van Eijk 2019). However, accusations of gatekeeping have seldom been applied to the experiences of healthcare workers who provide GAC on behalf of their trans patients and clients. Many of the trans healthcare providers I interviewed talked about how they felt limited in providing trans-affirming care by institutions and clinical supervisors. These providers experience what I call *professional gatekeeping*, where their ability to provide experience-informed care is curtailed or even drawn into question because they are trans and have clinical authority. Due to these experiences, trans providers are susceptible to double gatekeeping in their own personal care and how they attend to other trans people in their practice.

Hank reflected on the ways his trans subject-position was used against him by a supervisor through accusations of countertransference with trans clients. In clinical psychology, transference and countertransference are concepts therapists find themselves navigating while providing experience-informed care to clients within their communities.

Hank, a trans man, and LMFT was careful to point out the potential conflicts that could arise with trans patients in saying,

“Transference is when out there when a client is putting on something that they feel on to a therapist. So, if the therapist reminds you of your mother, you're going to start acting with that therapist how you would act around your mom, so like if your mom makes you scared, you start becoming kind of like mousy around your therapist. And then countertransference is like the opposite where like you let a client's experience or something about the client guide your work and for some therapists, that's actually good cuz you're like this client makes me feel irritated, so maybe other people make them feel irritated, or maybe other people feel irritated by them, and you can bring that up in the session.”

Hank's supervisor at a mental health residential facility assumed his disagreement with treatment protocol concerning a trans client was due to Hank's personal proximity to the client due to them both being trans. Hank described his experience with professional gatekeeping by saying,

“At my old job, there was a client that came out as trans, and people were like, oh, well, we can't treat their transness because they're psychotic. So, we have to treat their behavioral issues, but I can see a lot of their behavioral issues or because they were trans. They didn't want to shower. And they're like, no, ‘she's just not showering because she's defiant,’ and I'm like, no, she's not showering because she hates her body. My boss said that because I'm trans and she's trans, my countertransference is getting in the way. I wasn't ever allowed to be a part of the conversation about that client in case management and anytime that client was mentioned, I think my boss said I couldn't speak up on it.”

The care relationships described by many of the clinicians who participated in this study involve both proximities to their own experiences and acknowledged divergences in experience. In the example presented above, Hank was prohibited by institutional power from applying experience-informed care. The judgment call made by his supervisor targeted Hank and brought his expertise as a mental health professional into question.

Paternalism, infantilization, and gatekeeping have all been experienced by trans people receiving healthcare from cis providers. Experiences with these medicalizing and dehumanizing practices are often discussed only in the context of patient experience. However, queering care challenges how trans people experience inequalities when interacting with trans medicine, either as patient or provider.

Riley is responsible for connecting trans patients with the limited GAC options available in the region and offered at his place of work. He told me that regional politics and demographics largely determine how he does his job and limit his capacity for advocacy, even though advocacy is in his job title. Riley said,

“My hospital is a nonprofit organization, so lot of their donors are, without becoming political, conservative Republicans. So, they don't want the headlights on what I'm doing. So as long as I am low-key and stealth as much as possible, I can get a lot of things done. If I'm vocal, yelling, screaming, beating the drums, I'm going to get shut out.”

I found Riley's desire to not explicitly bring the conversation to partisan politics quite interesting. It was as if he was concerned, he was speaking with a conservative Republican, and lucky for him, he most certainly was not. According to many within the activist community, the stakes facing trans people are so high that direct action and “fighting back,” instead embracing anti-violence approaches to trans activism, would be more effective at securing sustaining change (Westbrook 2021). Activist intervention in yelling and “beating the drums” is often seen as necessary for making trans lives livable. However, Riley is experiencing professional gatekeeping, not based on doubt regarding his expertise or knowledge, but for economic reasons. The hospital fears losing high-dollar donors from the conservative donor class it relies upon in the Coachella Valley.

Here, we witness how wealth, capital, and geography all work to shape the practice of trans medicine.

As previously mentioned, Riley's expertise has not been drawn into question by his employer, even though there is institutional hesitancy in embracing trans visibility. Interestingly, Riley's position is that he does not have a degree or clinical training. His expertise is based upon his personal experience as a patient of trans medicine and history of advocacy work. The patchwork and uneven nature of trans medicine, especially within the Coachella Valley, has continually reproduced trans health disparities. However, the lack of trans health infrastructure has led to the lack of hierarchical oversight, allowing experience-informed knowledge to be prioritized in connecting community members to the few GAC resources available in the region.

Professional gatekeeping occurs for several reasons, but they all include censoring or silencing trans voices in care practice. One reason is to protect institutions from increased scrutiny given how trans health is politicized—increased negative scrutiny within institutions can lead to retaliation among conservative donors and long-standing clinicians with power who are potentially hostile to trans people. Trans providers have also found themselves experiencing paternalism as they are viewed as subordinate clinicians in larger workplace environments.

Trans Care: Activism & Medicine

Trans care exists in a myriad of relations, both community-based and institutional. The discursive contestation between activism and advocacy, mutual aid, and community

support networks constitute one side of trans care. These interventions often exist outside of clinical spaces and are set apart from bureaucratic entanglements of institutional regulations, gatekeeping, and relations of capital. Trans care is also realized through these complex webs of unequal relations. Multiple actors designate to care for community members through mechanisms, procedures, and protocols beholden to western epistemologies of care practice and its settler-colonial, white supremacist, and neoliberal structural underpinnings.

Trans clinicians in this study did not articulate a form of what Eric Plemons termed *restitutive intimacy* through their clinical interactions with trans and non-binary patients or clients (Plemons 2017). According to Plemons, cisgender surgeons who practice gender-affirming facial feminization surgery understood their practice as a mode of “righting wrongs” committed against trans patients. This form of relational care illuminates widespread acknowledgment of trans vulnerability in healthcare among providers. In speaking with participants in this study, recognizing health system-imposed inequality is present; however, care in practice and the reason they care for other trans people does not reflect a drive for restitution. The motivating factor for these clinicians’ desire to serve their community did not emerge from a deeply rooted sense of being wronged and thus perceiving their care work to rectify those wrongs. Inequality and marginalization experienced by trans people throughout multiple healthcare systems are understood to be the status quo, the standard, the expected norm for trans clinicians. However, trans clinicians have a nuanced relationship with care institutions and psycho-medical authority compared to their cisgender provider counterparts and trans patients.

One view of the origin story for care work would be straightforward and, in some ways, *activist* in the sense we see direct action to usurp what is interpreted to be transphobic institutions, medical gatekeeping, and paternalistic structures within medicine. However, the connection between experience-informed care and clinical practice proved to be more complex and nuanced than a superficial relationship comprised of trans clinicians playing victim-turned-retaliator and thus merely using education, training, and clinical authority to a destructive end.

Jaylen spoke to the reality of existing between worlds due to their training and visibility as an LCSW. They said,

“One of the things I have to contend with, with following this path is that the historical context of social workers is racist; social workers are racist as hell. And they are not people that people like to see in communities, especially since they're heavily tied to CPS workers because when people think of social workers and when I think of CPS workers, neighbors have children being stolen, which is the history of social workers, which you also learn in social work school. So, I always have to constantly remind myself that even though I'm from the community, I have worked hard for community to view me in a different light but because I'm a social worker. I always have to remember that when I step in someone's face, I'm seen as police. I can seem as someone that can damage your family structure, depending on if I'm working with children or not. And that's something I always try to carry with me, though I feel very empowered to be a Black, queer, and trans person to work in this because then I can think about how I can usurp structures and as a social worker to help my community get what they need is kind of like a double-edged sword.”

Clinicians tended not to go out of their way to discuss the assumed or perceived balancing act of managing their life as a professional and life as a member of a community marginalized by medicine. It should also be noted that clinicians were not intentionally avoiding this subject, nor were they made uncomfortable being asked questions concerning potential conflicts between personal life, community, and

profession. However, I did find it surprising that my conversations with participants would only delve into community-profession relations when I would specifically bring up the subject during interviews.

It was clear that providers were aware of systemic inequalities; however, their attention was centered on their relational, person-to-person interactions with trans people in their care. Macro-level dynamics, which are of great interest to activists and academics alike as a site of critique and even potential dismantling, those conversations were positioned as secondary among providers I interviewed. Furthermore, I felt that a complicated personal narrative reflecting the potential conflict between clinical practice and loyalty to community service was not central in how trans healthcare professionals understood their lives. The contradictory observations I make in this section speak to the utility of *queering care*. Participants in this study are acutely aware of trans health disparities through personal lived experience and their care work. However, explicit recognition of internal conflict was not volunteered during interviews. Jaylen's critique of social work was not a source of an internal struggle between being loyal to community or profession, they used those critiques as a source of empowerment to reshape how care is provisioned.

Care as Activism/Activism as Care

The abject and marginal status inhabited by queer, trans, and gender-expansive people in the United States is the basis for long-standing community-driven activist labor. The history of trans care has included activism, and the history of trans activism has

always included care. The long-standing tradition of trans people sharing resources, knowledge, and capital reveals instances that place the narratives captured in this work within a broader legacy of community involvement. Trans people themselves, most notably trans men, played a role in the early 20th century 20th-century development of trans medicine. Julian Gill-Peterson provides a comprehensive history of the development of trans medical knowledge by and for trans people in introducing their 2017 text, *Histories of the Transgender Child*. American physician Alan L. Hart underwent medical transition from 1917 to 1918. Hart's transition included surgery, making him one of the earliest trans men to undergo GAS in the world. British endocrinologist Dr. Michael Dillon is assumed to be the first trans man to receive testosterone therapy in the 1940s. Dillon also published *Self: A Study in Endocrinology and Ethics* in 1946, which included information learned from his self-administered experiences with HRT (Gill-Peterson 2017).

Since the mid-20th century, American trans people have shared knowledge within community networks to assist others in accessing social services and care. Many trans patients of endocrinologist Dr. Harry Benjamin would often refer one another to his clinic at Stanford University to access HRT or transition surgery. Trans and queer publications of the time also led to the sharing of personal life stories, experiences navigating healthcare, and support services. Some trans people used their respective points of privilege to assist other community members in accessing GAC. Privilege among these early intra-community advocates was often based on skin color, the ability to pass, and/or access to wealth. One of the most notable early trans benefactors of the 1960s was Reed

Erickson. Erickson amassed significant financial resources from an inheritance after his father's death and soon after became a patient of Dr. Harry Benjamin to facilitate his transition. He used his wealth and privilege to financially support Dr. Harry Benjamin's work and writing while funding other trans-serving gender clinics throughout the United States (Stryker 2017).

Many who hear of my work consider trans people serving as clinicians as something new. The aims of this project are either understood to be curious given its relative obscurity within the minds of most non-trans people or as necessary and profound by trans people and non-trans academics and clinicians. What I argue is perhaps most problematic, if not outright insidious, is the interpretation of trans clinicians' existence as a demonstration of social progress, something natural and inevitable within western liberalism. Trans people who produce and/or possess trans medical knowledge and clinical authority are co-opted by modernist ideological frameworks. Trans expertise in medicine or the capacity of trans people to provide care is used to signify the success of liberal incremental reform within the sciences and healthcare institutions.

The marginal status of trans people is not questioned by broader society. The notion that genders expansion is non-normative indicates the stranglehold cisgenderism has among the public. Of course, this goes without saying; however, the pervasiveness of cisnormativity is more extensive than many would assume. Cis-hetero-patriarchy promotes the generalizable and unquestionable reality of trans oppression, even among those who know very little of the specific forms of oppression trans people experience any given day. The a priori nature of trans vulnerability underwrites the expectation of

gender-expansive people *belonging* on the fringes of society. Thus, the baseline for how trans existence is to be understood and assessed is solely through the lens of exclusion, regulation, and violence (Gill-Peterson 2017).

Is there a space for liberatory and abolitionist activism within professional care work practice, or does the nature of clinical authority beholden an inherent acquiescence to established systemic norms? I often brought conversations to a discussion about activism's role in trans healthcare and vice versa. My initial ethnographic interest in trans social networks was regarding how activism courses through the lives of trans people. In the early days of conceptualizing this research project, I started with posing questions about how the mere presence of activism within community spaces influences trans subjectivity, collectivity, and a sense of belonging. This led me to consider how performative activism, or a life devoted to social change for trans people impacted pathways of self-actualization and one's internalized acceptance of their *transness*. Thus, as the direction of my research aims evolved to include questions related to trans medicine and approaches to care, I wanted to disentangle the relationship (if one exists) between activist potential and the capacity for trans people to become healthcare professionals.

Trans care in the Inland Empire is not only susceptible to lack of funding or FQHCs and Medi-Cal providers monopolizing uneven GAC services. For Pablo, activists who seek fame or influencer status through social media notoriety tend to disrupt continual on-the-ground and local initiatives to expand GAC service offerings. Pablo commented on this subject by saying,

“Agencies and people within agencies or activists in the IE, who want to be stars. They want to be recognized as the ‘It’ person from the Inland Empire who made this happen, and I’ve seen it several times where, ultimately, it burns bridges with connections that they’ve made so that no one else can make those connections because they automatically assume they’re trying to do the same thing. Ultimately, that hurts the community in the long run, and a service just either stops being provided or becomes very ‘discreet, not discreet’ practice unless you know someone who’s done it before, where you can trust them.”

Pablo has had a great deal of experience in LGBTQ+ community advocacy throughout the Inland Empire, well before their current position and work as an LCSW. Before being based in Riverside, Pablo worked with the LGBT Resource Center at California State University, San Bernardino, and was part of the LGBT Subcommittee set up by San Bernardino County. Their knowledge about queer and trans services in the region is extensive, and they had a lot to say about the current state of trans care in inland Southern California. Pablo is not blaming activists or activist-oriented providers of GAC for why health disparities persist in the Inland Empire. However, they are articulating a critical point that connects back to their and Jaylen’s critiques in the previous chapter regarding the monopolizing of trans care and the under-resourced region.

Western epistemologies of medicine desire the appearance of personalized attention and concern for wellbeing; however, this has proven to be a ploy in the service of capital. Care standards and diagnostic protocols maintained by WPATH and the DSM work to gatekeep GAC in ways consistent with the neoliberal healthcare model currently operating in the United States. Pablo and Jaylen show how Western epistemologies of care and capitalism are ingrained within normative practices of trans care. Pablo shared a familiar and repeated story, “We’ve had like a lot of trans folks come to us [the clinic where they work] asking for letters to be able to begin HRT or other transitioning

services. They say they've gotten a couple therapists [at other clinics] who tell them, 'No, you need to be here for a year, you need to do X, Y, and Z...'” Here, Pablo starts laughing at what they understand to be an obvious ploy for clinics and therapists to bill for services. They continued, “It's kind of like at that point, like okay, you want money, fine.” The drive for financial compensation “I think this whole idea of needing a therapist letter to transition is already a gatekeeping bullshit practice, and the fact that gender dysphoria is still a pathology like transness is still pathologized is still an issue.”

Jaylen offered their own commentary about the use of diagnostic language from the DSM and hegemonic care standards from WPATH in trans affirming care work.

Their perspective was complimentary to that articulated by Pablo,

“For me, it’s about transparency with our clients and saying, ‘this is what we call it, but this is how we have to word it. And this is why we word it because they needed to be worded like this because the system is racist.’ [laughter] At the end of the day, the DSM is something I should know, but I also know it's also very racist as well. And it wasn't until I want to say about ten years ago or less than trans identity and transness was not seen as an illness. Which had debates because like I said, the community worked towards moving towards normalization, and part of that normalization was going along with the DSM-V, and that’s who approves how surgeries got made for insurance is based off of this diagnosis. So, if it's no longer considered an illness, how do people pay for their surgeries to live the life as who they are? The bigger question in the discourse is, ‘why do they exist in the first place, and why do people have to prove why they should exist and get these surgeries and get them paid for! [emphasis, shouting] in the first place? But we live in a capitalistic society, and we're all capitalists by extension, and so a lot of our thinking about solutions are based off capitalistic ideologies, whether we want to admit it or not, because there’s no ethical consumption under capitalism at the end of the day.”

Jaylen’s perspective reflects actions taken by Hank and George mentioned in the introduction. Explaining why certain words are used or why specific procedures are followed in securing access to HRT or GAS, then making it clear to patients that the

process itself is problematic is an example of trans healthcare providers going off-script. These divergences from care standards and institutional guidelines are informed by lived experiences of providers like Jaylen, Pablo, Hank, and George. Furthermore, Jaylen and Pablo's critiques of capitalism and its inundation within healthcare, including GAC, provides a different register of interpreting their relationship to care work. Queering care embraces the multitude of possibilities which constitutes trans care discourse. The implicit contradictions in working within capitalism while also understanding its abolition as necessary for trans liberation are integral in trans care.

Knowing George works with trans youth at a hospital, I was curious how he perceives barriers to care imposed by standards and gatekeeping. The question of trans child under age 18 receiving GAC is currently a volatile political issue across many parts of the United States, and so I believed bringing this up during our interview was going to reveal a fascinating perspective. George did not disappoint and spoke directly to the absolute necessity of providing GAC to youth and using his authority to usurp systemic barriers. I asked George, "How do you provide care from a clinical context while mitigating the potential for the perhaps dehumanizing elements of pathology?"

"I always do this work with honesty and intentionality, so what that means for me is that, like when it comes to, if there needs to be a diagnosis of gender dysphoria let's say I see I work at a hospital so like there needs to be some you know coding. I talk about, hey we're going to use this for you to get stuff covered that you need. This isn't about labeling you; this isn't about saying that you have gender dysphoria, or you need to have gender dysphoria or any of these things. Whatever you say that you need, if we can use this to our advantage for you to get hormones or any kind of gender-affirming surgeries covered, we're going to do that. But really recognizing this is all crap and if it wasn't for how our society works, we wouldn't need to be going through this process of using the DSM coding, but we do, and so we're going to use it to our advantage. "I really always set things up, same thing when I write letters for surgeries, like minimal barriers to care. That

includes if folks can't afford certain things, making sure to connect them to services that are free. I write letters for people for free. We really heavily focus on being an informed consent model of care clinic; we're probably the most lenient when it comes to being non-gatekeeping in the way we do our practice, especially for youth care, and that's definitely a hot button topic right now. I think a lot of people have feelings how we do this work and how we work with young people, but the reality is that young people get the care that they need. And we were based on science and research. That's always in our back pocket, making sure we've got really sound research to back up our practices.”

As of 2022, GAC for trans minors is viewed as evidence-based care by the American Academy of Pediatrics, the Endocrine Society, the American Academy of Child and Adolescent Psychiatry (AACAP), and the American Psychiatric Association (APA) and thus, the work of George and his colleagues is in keeping with recommendations provided by medical oversight (Conron, O'Neill, and Vasquez 2021; AACAP 2019; APA 2021; Rafferty 2018; Hembree et al. 2017). While I am situating George's clinical labor as an example of care as activism, his work is actually considered best practices in the eyes of hegemonic clinical authority. His work is only considered “activism” in that he disregards the institutional necessity for gatekeeping through bureaucratic measures such as letters. This type of evidence-based activist care work is how George is queering care. His life as a trans provider is a testament to the benefits of GAC, and through infusing his concern for his community with providing care that is both the hegemonic norm (as far as the organizations mentioned above are concerned) and activist in orientation, he is queering care.

In exploring the contested and sometimes common ground between activism and institutionalized care, I was eager to approach the subject with study participants during interviews. My population sample was a mixed bag regarding engagement with labor one

would traditionally define as “activism.” Chris discussed being of two minds regarding trans politics and trans care. In our conversation about the relationship between activism, GAC, and gatekeeping, he said, “...just yelling and screaming and demonizing other people isn't going to bring about progress, it's actually going to create more riffs less understanding because then they'll be like, oh, you're just angry, and you know insulting me, and then we lose our potential allies.” This sentiment was felt by other participants I interviewed where I noticed the propensity for what I refer to as “professional moderation” of politics.

Existing research on professional activism is limited; however, there have been a handful of quantitative, qualitative, and mixed methods studies over the past two decades. Early literature on the subject generally focuses on how professional activism is growing in clinical psychology due to calls for a more “social justice-oriented” approach. This work evaluates shifts in mental health and clinical training that embraces feminist and multicultural principles as tools for social change (Goodman et al. 2004). Research since 2016 focuses on how clinical psychologists and other professionals working in community-oriented care and service blend their professional work, concern for inequality, and desire for justice into a praxis grounded in integrity and ethics (Costa, Vaz, and Menezes 2021; Nadal 2017; Wolff 2013). Professional activism in this literature is distinct from “activist professionals” or people whose primary mode of work or career involves activist labor. The concept of “professional activism” is based on individuals working as authority figures in professional fields and institutions centering needed political and social justice applications of their work and even pushing boundaries to

achieve positive social change. Based on the limited but existing literature on this subject, the construct of professional activism closely aligns with the type of social formations observed through the data collected for this project.

Professional moderation has proven to be complex to disentangle and analyze as my politics and perspective greatly influenced my participants' ideologies, clinical interactions, and relationship to activism. As a queer medical anthropologist who embraces abolitionism and queer and trans liberation, I struggled throughout interviews where study participants expressed perspectives divergent from the abolitionist political project. There were moments throughout multiple interviews where I could almost sense the care providers felt it necessary to defend some of their clinical and political perspectives due to an unspoken assumption that their views could be viewed as controversial among more radically minded contingents within trans activist circles. The questions included in my interview guide and follow-up probing questions most certainly alluded to my political orientation. I observed two emerging reasons for this moderating phenomenon: one, health professionals were embracing what they view as pragmatism within broader institutional structures, and two, professionals' views about care and procedures ultimately coincided with institutional standards, and their political moderation reflected their opinions and worldview.

The professional status of trans clinicians transformed their approach to activism and advocacy. Anupam expressed sincere insecurity with the idea of identifying as an activist on both a personal and professional level. As they come from a family of physicians, managing familial expectations of their education and future career have been

an obstacle for self-actualization and being visibly queer and non-binary. This dynamic has translated into Anupam feeling conflicted about their role as a physician whom one day sees themselves providing GAC as a primary care physician and being an LGBTQ health advocate but not currently in a position to be active in that type of role. During our conversation, Anupam said,

“Coming out and that was because my parents are kind of putting some shackles on me, you know they're like Oh, once you finish Medical School, you can come out entirely it was a very weird thing, and you know coming to terms with you know, the entire situation you know I just kept everything more low key I'm more of a low key person and I always you know thought it'd be a little bit more patient as far as you know, just finish medicine, you know, then you can do your part. So I would say I'm not yet an activist I use that term because I think as a physician provides gender-affirming care, LGBT people's health, you are an activist you're doing something that you know many other people can't that are doing a lot more than you in the community I'm sure, but that's something that's solely for you, and it's something that you know, I look forward to doing.”

The aspirational desires articulated by Anupam reflect the potential inaccessibility of activism due to adverse work or personal life conditions, which would jeopardize providers' ability to provide care in the first place.

These interpersonal pressures stem from transphobia and extend to institutions desiring to reproduce status quo norms. Trans health professionals navigate anti-trans bias, institutional hostility, and clinical authority that stems from said institutions. The presence or promise of activism produces tension within institutions that provide GAC that is also beholden to transphobic benefactors. Knowing that the Coachella Valley hospital in which Anupam, Kai, and Riley all work finds itself within this tenuous place led me to ask Riley, “do you ever feel a push and pull or tug of war between institutional

loyalty or being an authority within the institution and being a community member?”

Riley saw right through my question and directly addressed activism. He said,

“One of the biggest things when I started, they [the hospital administration] told me straight off the first day no activism here. So, I have to be very careful about how I present things that it doesn't come off sounding like activism, and I have to be extremely diligent on backing up what I put out there with published articles, published content like from UCSF, or what WPATH's journal puts out for trans care and all of those that contribute to W path, I follow the majority of those authors because they have been in it for decades cementing what I turn around and regurgitate to the staff here. Because I can say all day long what needs to be said. But if it's not backed up by all of that credential data, it's going to go nowhere. That was one thing that I had to be very mindful of when I started doing my research and pulling it together was to make sure that I could document it all the references. So that's that has been the most time-consuming piece of what I do is to make sure that I have the backup documentation about what I'm saying that, and that I'm not just saying it as a transgender community member”

I was shocked when Riley uttered the words, “no activism here,” and he certainly noticed. For him, he is being diligent and pragmatic. He knows that given the conservative political climate of the hospital in which he works, an institution that does provide trans medical care, he must always conduct himself on behalf of medically legible care standards without giving the appearance of activism. Moments of divergence from care guidelines that have been recorded among other participants in this study are not a part of Riley's approach to providing care for his community.

Riley doubled down on his apparent rejection of blending healthcare work with activism in expressing frustration with what he views as trans activists' inability to think and behave pragmatically as he does within the conservative hospital. He said, “There are, in my experience, a lot of activists that come off....” At this moment, Riley's voice started to trail off while he struggled to find the correct word to use in describing his feelings. Again, he was hesitant to cause offense or appear overly political. He then

continued, "...overly forceful and so that has a tendency to turn off providers and staff that really want to listen. And I think for activists to understand that those [providers] that really do want to learn about trans care, they need to have the empathy and the compassion to do that." Riley's frustration was palpable, and he was not making a snide or off-handed remark. As discussed in the previous chapter, Riley's lived experience on the receiving end of inadequate care by a physician who was willing but not equipped has led him to embrace care standards rather than engaging in activist labor.

According to Riley, his professional conduct continuously opens the gates in the Coachella Valley for trans people to access GAC, however, not participate in activism. His professional work is not informed by years of institutional training but his experience as a patient and sole healthcare navigator advocating for his community in a hostile environment. While his directed critique could be read as opposition to the aims of trans activism, his place within the webs of trans care presents questions of scale. *Queering care* interprets the complications presented by Riley's story through situating regional needs for trans patient-centered advocacy as the primary motivating factor for his pragmatic, in-system, and explicitly non-activist approach to care. His labor is not seeking to abolish the system that provides his livelihood and personal access to GAC, nor does he seek to reproduce barriers or gatekeep. Riley's life and work challenge dichotomous interpretations of trans care, activism, and medicine in service of medical hierarchies or in solidarity with the community. In the next section, I will address how clinical authority works to produce a set of regulatory measures for and by trans people.

Transnormative Governmentality

In continuing my conversation with Pablo about their frustrations with gatekeeping and the current state in which GAC is available in the Inland Empire in trans medicine following up about activism and its relationship to clinical care practice, I asked Pablo, “Wouldn't it make more sense for trans healthcare institutions to accept liberatory practices that be more oriented towards mutual aid or how we upend the system to end these types of roadblocks [gatekeeping and institutional monopolization of care] from occurring in the first place? They replied,

“No, like literally every time I find something out like that, like there's another agency or another org or another nonprofit that that *could* be started by queer or trans people and isn't but says these are the services they provide, but then they uphold the same oppressive strategies, practices that ultimately...it's money, and I get it like we can't escape like capitalism, I'm not stupid, but I also don't think it's fair that if all a person needs is on a visit, is one letter to start their transition if we are looking at folks in trans healthcare and trans social services, I don't understand why you would prolong that for somebody. And how are you okay with that? Some of these folks are paying out of pocket for therapist services. And so, it just doesn't sit right, and I just always think, like, ‘I hope the universe takes care of you. The way you're taking care of me.’”

Pablo's frustration spoke to years of observing harm continually being reproduced by healthcare professionals and healthcare institutions that were supposedly invested in improving care for the trans community. These layered and contradictory social transformations in trans care exemplify the utility of the queering care analytic. The capacity to reproduce regulatory medicine among trans-serving organizations, especially among trans healthcare providers themselves, constitutes care that has official institutional *intentions* of promoting positive health outcomes while being in service of capital and medical regulation. This tendency of contemporary trans medicine to

reproduce disciplinary mechanisms within medicine is what I refer to as *transnormative governmentality*.

Before conducting fieldwork, I assumed trans people working in healthcare who have experienced the unevenness of trans medicine would support transformative change and perhaps use clinical authority to usurp reproduced barriers to care. However, as I quickly learned, the professionalizing of trans care and its position within the clinic promotes affiliation with institutions rather than communities. To be clear, many of the participants in this study do recognize themselves to be activists and have an intense desire to make healthcare better for their community. Yet, I noticed patterns in their narratives that suggested more commitment to the status quo than I previously assumed. Professional moderation does more than temper the activist potential among recently “included” trans clinicians. The moderating effect that professionalizing care has upon trans people produces new arrangements of governmentality.

I understand the reproduction of clinical power to be what I call *transnormative governmentality*. The theoretical framing for this trans-regulatory power is borrowed from what Brandon Andrew Robinson defines as “homonormative governmentality” in their ethnography, *Coming Out to the Streets: LGBTQ Youth Experiencing Homelessness*. Homonormative governmentality is defined as “the structures and processes within LGBTQ institutions and spaces that discipline LGBTQ people who do not or cannot uphold the white, middle-class, capitalistic relations within society” (Robinson 2020). Robinson’s crafting of *homonormative governmentality* deploys Foucault’s concept of

governmentality whereby populations experience all-encompassing control and management consistent with the dominant social relations (Foucault 1991).

Transnormativity, posited by Austin H. Johnson, is defined as “...the specific ideological accountability structure to which transgender people’s representations and experiences of gender are held accountable” (Johnson 2016) is a concept I adapt and expand upon about governance and discipline enforced by trans healthcare professionals. In the article in which Johnson introduces this concept, “Transnormativity: A New Concept and its Validation through Documentary Film About Transgender Men*,” he deploys it in reference to “a hegemonic ideology that structures transgender experience, identification, and narratives into a hierarchy of legitimacy that is dependent upon a binary medical model and its accompanying standards, regardless of individual transgender people’s interest in or intention to undertake medical pathways to transition” (466). My use of *transnormative governmentality* is not exclusive to examining binary idealizations structurally reinforcing what it means to be trans.

For *transnormative governmentality*, “transnormative” is regulatory, but beyond maintaining binary ideologies concerning perceptions of trans “authenticity.” In my work, I am focused on how trans people’s interactions with the psycho-medical industrial complex are shaped through normative schemas of securing access to biomedical technologies of transition. Agents of trans medicine, including trans healthcare professionals, reproduce the normative logics of diagnosis, pathology, paternalism, and clinical gatekeeping, which represent hindrances to trans self-actualization. In response to what I have learned from trans healthcare professionals throughout fieldwork, their

loyalty to institutional norms, traditional approaches to clinical authority, and reproduction of gatekeeping practices demonstrate their willingness to participate in *transnormative governmentality*. In the paragraphs that follow, I will draw from interviews to show how *transnormative governmentality* operates within trans medicine. Furthermore, I will also show how the analytical framework of *queering care* is particularly productive in making sense of trans care by and for trans people to reproduce structural inequalities and further marginalize trans patients.

The professionalization of trans care involves including trans people within cis-hetero-patriarchal, white supremacist, and settler institutions. Moreover, institutions responsible for educating and training physicians and therapists featured in this work are the same institutions responsible for the systematic pathologization of trans people. The politics of diversity and inclusion repackage expectations of heteronormative assimilation into palatable and friendly-sounding organizational initiatives. The embrace of a definition of “diversity” co-opted by neoliberalism produces a queer subject born out of respectability and heteronormative governability (Ward 2008). Diversity and inclusion initiatives are not so much about celebrating existence as it is about appropriating the language of queer identity politics to produce queer subjects in service of capital. As has been observed within the corporatization of queer identity, neoliberal and settler economic conditions are reproduced within the halls of higher education. How providers are educated and trained is informed by models of care that were never designed to center existence beyond what was hegemonically understood as normative. While “reformed”

institutions embrace diversity politics, neoliberalism's persistent and pervasive hidden curriculum is still active.

Social reproduction of institutional norms and practice was a phenomenon I was inclined to study through this work. Knowledge grounded in the reproduction of clinical norms through education guides the tendency for trans healthcare professionals to rely upon regulatory models of care (Bourdieu 2000). The assumption that trans-subject-position would manifest in a revolutionizing alteration of care relations and institutional organization was in some ways short-sighted. In some ways, one could argue I was reproducing the trope of monolithic trans subjectivity and perhaps even using reductive reasoning to prematurely conclude that being trans always should indicate activist labor. The privilege of my subject-position as well as my political persuasion saw a through-line between systemic mechanisms within medicine with a destructive and marginalizing impact on trans lives. However, the grounded, real-world experience of trans people working in healthcare maintains messy, unordered, and complicated social relations. As I have argued, trans life is not a monolith. I have written about the problematic assumption of community acquiescence in all things; I also reproduced this logic in the initial framing of my ethnographic work. At the core of my proposed queering care analytic is the capacity for trans care to be realized in ways contradictory to the aims of trans liberation. Caring for trans people also involves reproducing mechanisms of power that promote harm. Harm can be in the form of clinical gatekeeping, prioritizing the accumulation of wealth, asserting regulatory authority as a means of wielding power, and

relying upon cultural logics of care that coincide with white supremacist and settler-colonial ideals of assimilation.

During my second Zoom conversation with Jenny, I wanted to steer the conversation toward difficult conversations about power, politics, and care. I asked Jenny, “Do you see yourself working within the system, bucking the system, messing with it, not messing with it? What does that look like for you?” I was attempting to get at how she understood or even participated in practices that would be divergent from her training as an LMFT. Jenny responded in saying,

“I think it would be naïve, at least from my perspective, to say that mental health doesn’t have a political component to it. It’s important to work with clients in a way that is based on research and best practices, etc. But then, of course, where did those best practices come from usually cis het wealthy white men to have access to be able to do those studies.”

Throughout fieldwork, I found myself at odds with the politics of most of the trans health professionals I interviewed. Going into this project, I knew trans medicine was fragmentary and comprised an assemblage of voices and interests. Interests in service of political and activist objectives and those in favor of capital, exist in tandem with trans health professionals black boxing clinical hierarchies. In this writing, I hope that I have portrayed an accurate and detailed overview of trans medicine by and for trans people.

Chris believes in the utility of diagnostic protocols built within clinical psychology. In defiance of liberatory-minded activists and defense of status quo care paradigms, Chris said,

“I think of the DSM like a hammer. I could use a hammer to build a house, or I could use it as a hammer to bash someone's head, and so getting rid of the

hammer doesn't actually help me. It's not bashing people's heads in because if we look at the DSM, it's not just trans identities that are pathologized. And I don't think that it's actually pathologization. I think it's been *utilized* as pathologization, but all the diagnoses in there have been stigmatized. So really what we need to be doing is destigmatizing mental illness, not throwing out the DSM.”

Chris’ perspective is based on the notion that the current conditions in which care is to be provided are unchanging and will remain intact. Throughout our conversations, Chris was very clear in his understanding of the harm that can occur along with reproducing the biomedicalization of trans lived experience. I do not see immediate fault in recognizing how systems operate and using one’s authority to navigate systemic hindrances. However, Chris considers the DSM as a value neutral tool that can be used in clinical support service, especially in navigating insurance coverage for GAC.

Chris reflected upon his own experiences receiving affirming therapy and how the language of diagnosis opened gates that would have otherwise been closed. He said,

“I got therapy covered at full fee with my therapist for several years because I'm trans. I could use that hammer, and I could be like, ‘hey insurance company, you need to pay up because if you don't, you're actually breaking the law because you have an inadequate network of people that are trans affirmative, and I actually could get Anthem fined a shit ton of money because they didn't have adequate coverage for me as a trans person.”

In the previous passage, Chris blends the personal with the professional and essentially presents an example of how his own experiences in receiving GAC inspire his own approach to care work and education. He explained the necessity of diagnosis and then clarified his position regarding destigmatizing mental illness. He continued by saying,

“We also work in a system that has insurance companies, and we have a requirement for medical necessity, and if we do not have a diagnosis, a couple of things happen. People cannot get coverage for transition-related care; they can't get coverage for hormones because there's no diagnosis. If there's no diagnosis of diabetes, we don't give you shots of insulin; that’s a good thing. We should not be

giving people who are not diabetic insulin in the same way we should not be giving phalloplasty to people who don't want penises. And so, this is where I think we have to be destigmatizing mental illness, and maybe that means that trans identity needs to be removed from the DSM and moved into ICD. But if it has moved into ICD, then trans affirmative mental health professionals cannot get single case agreements, then we can't fight an insurance company.”

His choice in using the word “fight” continues to fascinate me. Providers featured in this study, like Pablo and Jaylen, would vehemently disagree with almost everything Chris was saying about using the DSM and using the language of diagnosis in care practice. However, his point about fighting insurance is curious because he didn't dare attempt to imagine a world where health insurance companies would be unnecessary. He never articulated a sense of desire for a world where abolishing regulatory institutions would be a worthwhile goal. His imagining of trans care is completely encapsulated within the current neoliberal system, which is black-boxed and regarded as eternal. Marieke van Eijk's research on insurance, trans medicine, and clinical labor demonstrates the inherent flaws in a market-driven insurance system. Her work is consistent with critiques from liberation-minded voices in trans care discourse (van Eijk 2017). However, for therapists like Chris and many clinics operating as trans-serving providers of GAC across Southern California, critiques of capitalism and its hold on trans health and wellness are not embraced.

Near the end of our conversation, he firmly and passionately reiterates his clinical authority as a mental health professional. I would argue that his words here are not intended to be performative or even offer support of regulatory gatekeeping. He earnestly believes in the value of his work and regards his institutionalized power as being necessary for *good* trans care. He said,

“We are mental health treatment professionals; if we're treating something, we have to be able to recognize that there's a problem. We're not friends. We're not just chat buddies. If we were, we wouldn't have had grad school. I think that it actually minimizes what we do as a job and actually makes us look not like treatment professionals, and I don't like that.”

The argument laid out by Chris is compelling and easy to follow for an anthropologist not trained in clinical psychology. However, he favors reproducing status quo clinical power hierarchies and does participate in *transnormative governmentality*. However, Chris' embrace of the regulatory powers at his disposal is not for the sake of capital or power for power's sake. His perspective is not only personal and professional but also political. He provided a window into his politics in saying,

“This is where I don't fit in with a little bit of queer politics because most people are like, ‘remove that shit,’ and I'm like, I worked with fighting insurance companies. If you know the tool, you know how to use it, use it to your advantage. Use it so that you can advocate for patients. Why would you get rid of the tool? And you need to reframe it as a tool.”

Again, he frames the DSM, diagnostic language, and clinical authority as a tool against power he does not see as diminishing or being abolished. This sentiment of using regulatory systems in ways that usurp their hegemonic authority is expected throughout this work. I also frame this type of “in-system” labor as comprising activist forms of care, and I stand by that previous characterization. What I am claiming constitutes *transnormative governmentality* is the stance that these oppressive systems are not to be questioned but merely navigated through invention by agents of trans medicine.

This web of care based on knowledge, authority, lived experience, concern for community, and loyalty to medicine is at the heart of the queering care analytical framework. How care is imagined and considered “good,” is not a monolith, but it is

multiple and contradictory. There is not a doubt in my mind that Chris wants to serve his community, and I believe wealth or power is not at the center of his professional work. However, the desire to analogize regulatory authority as a “tool” sparks a critique inspired by Audre Lorde. After hearing so much about the capacity to regulate, I cannot help but consider Audre Lorde’s warning: “For the master’s tools will never dismantle the master’s house. They may allow us temporarily to beat him at his own game, but hey will never enable us to bring about genuine change” (Lorde 2007).

Care as Politics: Imagining Queered Possibilities

A significant amount of time is spent critiquing care; however, in a dissertation entitled “Queering Care,” there is more to be done than simply calling for its deconstruction. The everyday violence that is reproduced within western epistemologies of care as practice stand in contrast to a radical reimagining of what care can be when it has been queered. In following queer theorist José Esteban Muñoz’s conceptualization of “queer,” I offer a counternarrative to posit care beyond liberal applications beholden to market-based initiatives.

Muñoz recognized the indeterminacy of “queer” as a concept without physicality, stasis, and permanence (Muñoz 2009). His understanding of queer as not something we can contain or hold in place but as a yet-to-be perceived utopic potentiality broadens its use beyond synonym of deconstruction or limiting queer to an imperfect and slippery identity category. This work does not intend to propose a one-size-fits-all solution to the

faults of care (in any register); however, what this exercise in exploring a critique of care can offer us is the opportunity to consider possibilities offered by queer theory.

Detaching care from the 20th and 21st-century modernist and capitalist paradigms, which underwrite its place within market-based medicine, requires an embrace of the politics of abolition and liberation. The affects produced from such a political reorientation allow for care to enter the imaginary not as a far-fetched or fictitious possibility but as a perceivable yet not fully realized imperative. Accepting the queer analytic as perpetually in a state of impending arrival yet never embodying a static destination promotes an idea of possible new worlds represented by what Muñoz referred to as a “warm horizon.” It is always just out of reach but nevertheless beckoning the world we inhabit to desire its promise of renewal and liberation. Christopher Paul Harris states, “the only horizon of an ethics of care is a world undone” (Woodly et al. 2021). In this model of critique, care is positioned as a productive ethic that possesses the capacity to carry forward a reordering or “undoing” of a world where neoliberal mechanisms bind care.

In the United States, trans medicine operates within a neoliberal market-based healthcare system. Access to GAC is beholden to the forces of capitalism, while mainstream trans activism is maintained by a movement in service of state surveillance, policing, and the prison industrial complex. The capacity of trans healthcare professionals to practice care is strengthened by their affiliation with neoliberal institutions, as is evident through the words of Chris and Riley. This systemic reality curtails an embrace of abolitionist and liberatory ideals. Unfortunately, rights-based activism and identity

politics often shapes how trans healthcare professionals can infuse activism with their care practice.

Many participants in this study imagine a world where trans liberation is within reach, yet their participation within healthcare systems perpetuates the mechanisms actively working against that goal. Some trans healthcare professionals, like Jaylen and Pablo, desire trans care through liberation, their participation within healthcare systems prohibits their desires from being fulfilled. Lauren Berlant referred to this disconnect between desire and fulfillment as *cruel optimism*. The object of desire (free and available access to GAC) is obtained through healthcare practice; however, how trans healthcare professionals come to be authorities in trans medicine involves their integration within the very institutions they seek to disrupt or abolish (Berlant 2011). *Queering care* provides a lens to interpret this discrepancy between personal politics and care practice and intracommunity disagreements regarding activism as an integral component of new configurations of trans care when provided by trans people.

In the next chapter, I expand my critique of trans medicine embedded within neoliberal systems. I show how the COVID-19 pandemic has led to an entrenchment of neoliberal values and service to capital cloaked as “consumer choice.” This has been facilitated by the establishment of online and app-based GAC. My discussion then turns to how this transformation in trans medicine is accompanied by institutional changes opening the door for telemedicine to go from fringe offering to standard practice.

Chapter 5: Care from a Distance: Trans Care, Teletherapy, and the COVID-19 Pandemic

Jenny and I spent quite a bit of time talking about how her life had changed over the course of the COVID-19 pandemic. In response to the pandemic, I adjusted some of my interview questions to include a space for trans healthcare professionals to reflect upon their lives and careers to assess patterns in experience. Initially, I believed the temporary adjustments to care modalities would further exemplify the queering of care since trans clinicians would potentially have increased autonomy to adjust their practice. Little did any of us know, the pandemic would be longer lasting than any of us had hoped or anticipated.

Jenny provided personal insight on how the pandemic affected her due to not going to a physical space to work. She told me, “It’s hard for me sometimes to feel like I’m at my best when I’m not able to spend very much time with other people. For instance, when I have 10 minutes between sessions, just seeing my colleagues in the hallway, there’s a lot of interactions there that don’t happen anymore.” The sense of longing in Jenny’s voice for something as seemingly mundane as passing a co-worker in the hallway revealed the deep understanding of connection resonating among clinicians while physically present in a site of care. The site brings all the clinicians together and breaks down walls between their respective forms of training, specializations, and client populations. These non-clinical yet integral elements of the clinic as a site of social bonding primarily existed in the background, unexamined, until the pandemic changed everything. Jenny continued,

“Not having that sense of place at the clinic, it’s something that I really miss. There’s been a lot of instances where the clinic has tried to come up with events, like a little zoom holiday party or other opportunities for people to connect, even if we’re not in person. There’s lots of colleagues who I literally don’t see any more or haven’t seen since the pandemic started. I wouldn’t have seen them except in the break room or in the hallway between sessions, and so It’s a loss of place or a sense of what is ‘the clinic,’ in both terms of working with clients but also as a group of mental health professionals.”

Jenny invests meaning into the sense of place she feels while present in the clinic.

Her perception of the clinic is limited to the physical location, and for her, virtual gatherings will never replace the sense of place and connection she values with her colleagues and clients. This shows how her perception of work and personal life interwoven and how in-person interactions and place-making guide those perceptions. Furthermore, Jenny turned to her own queer identity and the now lost opportunities to existing in community with other LGBTQ clinicians. These reflections led Jenny to wonder and feeling somewhat lost without the LGBTQ clinician community at her disposal. She said, “We are now spread so thin. What are the ways that you connect, not just with your fellow clinicians but then also as an LGBT clinician? To what extent does that look like, particularly if there aren’t pride events going on?” I again picked up on an intertwined worldview where the boundaries between trans clinician and trans person are thrown into question. While Jenny bemoans the notion of online social gatherings, the move to online sociality has led LGBTQ+ community organizations to offer online accessible events over Zoom and social media. Trans people who were previously unable to participate in social activities are no longer locked out of resources or support. Skyler offered support of this position by stating, “from what I see is that there’s more. I mean,

there's more accessibility to different groups; even an LGBT Center is putting on a Zoom meeting like anyone can go to that.”

As I will soon show, other boundaries, such as those between virtual and actual (physical) place, understandings of “good” versus “bad” community connection, and the political divide between activism and fidelity to capitalism are distorted through how trans clinicians (as well as how trans medicine in general), has responded to the COVID-19 pandemic.

This chapter provides an overview of telemedicine, teletherapy, and how the act of offering and receiving trans-affirming mental healthcare services has been adapted to a remote format. The first section is based on my observations while attending a virtual trans health conference and is presented as a story from the field beyond data collected through interviews. I desire to show this moment during fieldwork as a vignette that details the broader scope and structural mechanisms which inform the everyday experiences of my participants. The pandemic and telemedicine have more general implications to GAC in light of emerging online direct-to-consumer GAC products and services. As the pandemic engenders an expansion of neoliberal strategies for addressing increased demand for GAC, I critique calls for greater accessibility as well as the under-examined potential pitfalls of relying on market-based “solutions.”

Next, I center the voices of trans LMFTs in crafting a narrative of how they use teletherapy in their respective clinical practices. These narratives also include therapists’ perspectives on its efficacy based on patient interactions. I chose to focus on therapists in this chapter because out of all the different trans providers included in this study, LMFTs

and LCSWs had the most experience providing care from a distance. The pandemic and telemedicine have broader implications to GAC in light of emerging online direct-to-consumer GAC products and services as outlined in the introduction to this chapter. As the pandemic engenders an expansion of neoliberal strategies for addressing increased demand for GAC, I will show how trans therapists (both LMFTs and LCSWs) navigate calls for greater accessibility as well as the under-examined potential pitfalls of relying on market-based “solutions.” This section will also highlight how trans therapists perceive the benefits, limitations, and continual challenges of providing GAC through teletherapy. Stories told by trans therapists include assessments of the quality of care, as well as reflections on teletherapy’s potential, continued clinical presence.

Lastly, I demonstrate how trans stories from the remote clinic illuminate contemporary relational patterns consistent with how the trans community coalesced through community contact across vast distances. Trans care and community advocacy emerged from mid-20th century networks sustained through virtual rather than physical, social relations. I turn to the history of written correspondence and the dissemination of trans-centered print media as the cultural forebears of today’s embrace of online-based care and resource sharing. I argue that geographically distributed contemporary care networks facilitated by internet communication follow this historical legacy. I will show how the labor of trans LMFTs is a point of departure from status quo care modalities while also a “homecoming” that demonstrates a queering of care. This chapter concludes with a reckoning of potential futures in light of the continued pandemic and broad acceptance of teletherapy. Trans health professionals are faced with an uncertain future

while turning to clinical improvisation and amending care strategies. These alterations in care practice reflect broadening concerns of access and care equity and how trans mental health professionals are at the front lines in simultaneously reproducing and ameliorating inequalities in GAC. Lastly, questions regarding the possibility of a “new normal” and novel way of imagining “good versus bad” trans-affirming healthcare are considered and challenged.

Observations from a Virtual Trans Health Conference

In the Summer of 2021, as I was wrapping up data collection and moving towards full-time dissertation writing, I attended the annual Philadelphia Trans Wellness Conference (PTWC). This conference is one of the largest trans-centered health and wellness gatherings in the world and includes participation among both healthcare providers and trans community members. PTWC is renowned for its long-standing place within trans medicine and is symbolic of trans medicine’s long road to professionalization continual struggle for scientific legitimization. Concurrently, the conference serves as a community space where trans people seeking information about GAC congregate and share information.

Given that my work focuses on the intersection of providers and patients, I was enthusiastic about attending an event where the production of trans medical discourse could be observed in real-time. Ideally, I would have participated in the conference in person, but alas, the COVID-19 pandemic forced the meeting to be hosted remotely. This was a common theme throughout fieldwork; I often felt dissatisfied with my level of community engagement and was eager to find moments of “entering the field” beyond

interviews. Whenever there was a virtual topic with themes that intersected with my research or a conference such as PTWC and WPATH's annual meeting, I ensured I was in attendance and treated those moments sitting in front of my computer as participant-observation. I also reflected on how my study participants' modifications in their professional work paralleled my amendments to research methods through Zoom ethnography. As was previously mentioned in chapter two, these reflections and realizations guided me to different types of questions in response to the particularities of my field site. Being online is interacting in "real life," and I tried not to feel guilty for appreciating the opportunity to conduct research without leaving my home. With all of this in mind, I conceded to attending the PTWC while comfortably seated in front of my home computer.

While attending the PTWC online, I was struck by the virtual layers I was engaging in this site. I wrote extensively on the inclusion of telemedicine services in trans healthcare, specifically the increase in teletherapy among mental health clinicians. I found it fascinating that my engagement with the clinical community reflected how the clinicians were engaged with their patients. I was doing fieldwork online, learning about how online communication impacts trans medicine by practitioners of trans medicine, and now attending a trans health conference online to learn more about GAC being offered online. I soon realized that I had become an ethnographer not only of trans healthcare but of trans cultural production within virtual spaces during a global pandemic.

PTWC organizes panels is by two concurrent tracks, one called “community” and the other “medical.” When selecting panels, I was drawn to one led by the leaders of organizations that positioned themselves as ready to revolutionize the accessibility of GAC. The panel, “A New Landscape of Access: Emerging Lessons from Telehealth,” featured representatives from telehealth start-ups FOLX and Plume. FOLX and Plume are two direct-to-consumer telehealth companies that connect trans people with hormones, HIV pre-exposure prophylaxis medication (PrEP), and offer referrals for GAS. Both companies began operation in 2020. I had become aware of their services through existing in trans medicine-centered internet/social media ecosystems and in conversation with interview participants.

I was pleasantly surprised to learn FOLX and Plume both had trans people in leadership roles during the panel. I felt relief and was immediately drawn into the discussion given this project’s emphasis on trans-affirming care provided by and for trans people. It was as if many pieces I had been grappling with in interviews and through my writing were falling into place. By attending this panel, I was excited by the prospect of being privy to discourse that could potentially change the way trans medicine operates forever. Two panelists were trans women, another non-binary/queer, and the fourth was cisgender. Most of the panelists were white, with one Black trans woman representing one of the organizations. They all reflected on their leadership roles in their respective organizations and directly addressed how extant health disparities have shaped the design of care programs. I could sense the enthusiasm exuding from each panel member as they represented cutting-edge innovation in GAC. The timeliness of Plume and FOLX

emerging as an alternative to in-person clinical care was evident and their leadership was fully aware of the impact and financially lucrative nature of their services. I had the impression that these individuals recognized the untapped potential for expanding their services and coverage area. Given the disparate and widely distributed nature of the trans community, being able to offer services through their websites and smartphone apps bridges literal physical gaps in accessing trans-affirming clinicians and provides potential protection from in-person scrutiny, gender policing, and transphobia in clinics.

Interestingly, these two very similar companies with overlapping services and clientele agreed to host a joint panel. After all, FOLX and Plume are technically competitors in trans telemedicine, but their respective leaders seemed perfectly cordial, if not friendly. During the panel, competition was articulated as a positive pathway toward health equity and necessary to address health disparities. Telemedicine for trans patients and clients is imagined as a single option among many other options in accessing care. The “direct-to-consumer” model of app-based care was portrayed as a luxury item when one provider enthusiastically declared, “trans people deserve good things!” While I shared the sentiment behind the exclamation (I do not prescribe to the notion that marginalized communities should be relegated to care out of step of societal expectations), there was a sense that the flashy marketing campaigns, tech-savvy presentation, and user interface reflective of other app-based, on-demand services needed to be excused as something trans people *deserved* to use.

This gentrification of trans health promotes an image of modernity and increased consumer access while glossing over other questions of accessibility. The prioritizing of

progress within a for-profit healthcare model is at odds with contemporary strains of trans activism that emphasize the need for abolition of oppressive systems, not increased entrenchment within them. The panel only briefly addressed the “elephant in the room” or what I consider the most necessary, piercing, and often overlooked critique of direct-to-consumer trans healthcare organizations. I observed leaders from FOLX and Plume brimming with optimism for a future with greater access to GAC, I; I watched and listened for them to address potential pitfalls in their business models. Knowing these leaders recognize the faults in trans healthcare, I was eager to learn how they plan to attend to inequalities based on access to technology. As almost an afterthought, they mentioned the limitations imposed on access due to reliance on smartphone technology, personal computers, and internet connectivity. They recognized the potential for increased inequalities, and one of the panelists even provided an empty promise of “we are working on expanding our reach.” The perceived inevitability of market-based solutions existing alongside known gaps in community accessibility (especially for the most vulnerable population members) demonstrates capitalism's false promise within trans health.

Beyond access to technology, I could not help interpreting implicit ageism present within FOLX and Plume’s plans for changing the face of trans medicine. Quite literally, the faces present in marketing campaigns depict a diverse arrangement of representation in terms of gender presentation, race, and ethnicity, but not age. The assumption that gender-affirming telemedicine is primarily marketable to younger trans and non-binary people with smartphones misses the mark in assessing needs for older patients who

require accessible GAC. The panelists' lack of concern for uneven digital literacy within the communities they hope to serve yet again demonstrates layered failures inherent in for-profit care models (Blandford et al. 2020).

Capitalism's response to health disparities always falls short in alleviating the root cause of systemic inequities "necessitating" its intervention. Market-based solutions to shoring up the gaps in access to gender-affirming don't come without cost. Direct-to-consumer companies like FOLX and Plume are for-profit entities fueled by social media and influencer culture and market themselves as a new and needed alternative to traditional clinical care. However, the services provided by these two companies are not covered by private insurance or eligible for Medicaid coverage. The intersection of poverty, poor mental health, job insecurity, and institutionalized transphobia means many trans people are at the mercy of programs like Medi-Cal to ensure access to trans-servicing providers, let alone actual trans-affirming care teams. All costs are pushed on to the patient-turned-consumer except for charity-based donations intended to assist in patients covering the price of medications and services.

FOLX and Plume are not marketing HRT pharmaceuticals; they have turned the experience of receiving affirming and non-invasive care into a product to be purchased and consumed. The rhetoric of accessibility and convenience from trans health start-ups speaks to "revolutionizing" trans health and addressing disparities in access. However, the language and aesthetics of liberation fall short as their business model and mode of providing care merely repackage existing neoliberal logic embedded within existing inequities. The illusion of choice as a beneficial facet of healthcare relies on an

unquestioning acceptance of for-profit health and is counterintuitive in working towards trans liberation.

However, as with FOLX and Plume, there is an opportunity for increased financial gain among upstart gender-affirming health service organizations. While the COVID-19 pandemic can undoubtedly be attributed to increased interest in telehealth, the desire and the arguable necessity for virtual healthcare goes beyond ease of access during a pandemic. FOLX and Plume offer gender-affirming telehealth services accessible from websites and smartphone apps. In the same way, many Californians can access meals, groceries, and even marijuana from a smartphone, now estrogen and testosterone regimens can be accessed by a quick tap. Both organizations started serving clients in select states beginning in the middle of a global pandemic. Their vast social media campaigns have brought the promise of accessible and probably most sought after, non-invasive gender-affirming care. However, access to such services requires technology and internet connectivity. Again, these innovations that offer increased access simultaneously exacerbate barriers to the already most vulnerable trans and non-binary community (Das and Gonzalez 2020).

COVID-19 and Trans Medicine

When I started fieldwork in 2020, the United States healthcare system was pushed to the brink as case numbers soared and hospitals began filling. At the time of this writing, 34.5 million cases and 611,000 deaths have been reported in the United States, with over 64,000 of those cases from California alone. The strain on health institutions

was felt in emergency rooms, primary care clinics, surgery centers, and mental health professionals' offices. Non-emergent procedures and surgeries were postponed or rescheduled across the nation to ensure supplies to treat the most at risk were reserved amid reports of personal protective equipment (PPE) shortages. This pattern had a disproportionate impact on the trans community as GAS was classified as elective, and thus, many scheduled gender-affirming operations were slated for indefinite postponement.

Beyond the potential for harm due to structural forces impacted by the redirection of resources, COVID-19 itself also disproportionately affected trans people. According to data from the UCLA School of Law Williams Institute, transgender adults are at higher risk for complications related to COVID-19 thanks to disproportionate medical preconditions & socio-economic vulnerability. Underlying health conditions such as asthma, diabetes, heart disease, and living with HIV all substantially increased the risk of complications or even death from COVID-19 illness. Stigma & minority stress promotes avoidance in seeking healthcare while the beforementioned health disparities & the lack of access to GAC worsen existing inequalities leading to increased adverse health outcomes. In addition to the physiological dimensions of illness experience, social determinants of health contribute to poor health outcomes. Rampant systemic and interpersonal transphobia, racism, anti-Blackness, and xenophobia intersect within and outside healthcare systems to increase vulnerability within the trans community (Drabble and Eliason 2021, Herman and O'Neill 2020).

Categorizing GAS as non-emergent seemingly represents contradictory rhetoric from states (such as California) where trans medicine is often covered by private insurance and the state's Medicaid system, Medi-Cal. The medicalization of trans experience, while fraught with problematic pathologizing assumptions, does maintain a pathway of accessing care through the diagnosis of gender dysphoria, where surgery is deemed corrective, lifesaving, and essential for "treatment." Due to hospital policy nomenclature concerning the decision-making process on scheduling surgeries during a public health crisis, misunderstandings are common in how gender affirming surgeries exist in the hospital imaginary. Temporarily denying GAC, something the American Medical Association does designate as lifesaving, harkens to past and present voices within healthcare, which posit trans medicine and even GAS as "cosmetic." Furthermore, the similarities between procedures classified as "cosmetic" plastic surgery and those procedures used in GAS complicates interpretations of "cosmetic" versus "elective" surgeries. The body of knowledge specific to trans medicine is not fully contained within care for trans patients. Trans and cis people are imagined into dichotomous and binary oppositional categories, which distorts the reality that medical care and procedures classified as GAC or GAS also have applications for non-trans patients.

According to the American Medical Association (AMA), surgical categorization differences are based on *acuity*, not an inherent judgment of a set of procedures unilaterally being recognized as medically unnecessary (Ehrenfeld, Green, and Schechter 2021). However, as has been reported across the country, many trans people waiting for gender affirming surgery were left with uncertainty as to when their vital care would be

provided. To claim transition surgery is optional, cosmetic, and non-emergent is widely refuted by both the trans activist and trans medical communities. Due to high rates of interpersonal violence, self-harm, and suicidal ideation or attempts, access to gender-affirming care is a matter of life and death and anything but cosmetic. Regardless of how the AMA frames procedural coding or publishes guidelines on managing surgery scheduling during a pandemic with scarce resources, the symbolic weight embedded within medical jargon promotes uncertainty and reproduces experiences within traumatic non-affirming clinical relationships. In the same vein, “gender dysphoria” is excused by health institutions and the editors of the DSM-V as a necessary clinical means to provide “treatment” for gender incongruence and its associated negative mental health impacts, the presence of diagnostic language, categorization, and gatekeeping works to maintain trans health inequities (Flaherty et al. 2020; shuster 2021)

Amid perpetual uncertainty during the pandemic, especially in accessing GAS and hormonal replacement therapy (HRT), there has been an increased demand for trans-affirming mental health services. Telemedicine brings increased accessibility for those with access to technology; however, there is the potential to exacerbate inaccessibility for those most vulnerable before the pandemic. Trans people with consistent internet access and smartphones are poised to benefit the most from telemedicine services. At the same time, unhoused and economically disenfranchised community members now have less access to GAC than they did before 2020 (Felt et al. 2021). The prolonged precarity of the pandemic ushered in an era of improvised innovation and rapid changes in care protocols across global health systems. Telemedicine quickly made its way from the

periphery of clinical care to having a central role in access to gender-affirming health services. While telemedicine was not born out of the pandemic, the conditions presented by COVID-19 and associated stay-at-home or shelter-in-place orders necessitated an expansion of its adoption by providers and patients alike (J. Y. Lee et al. 2021; Lock, Anderson, and Hill 2021; Hamnvik et al. 2020). The pandemic's impact on LGBTQ+ populations often center around concerns for mental health and well-being. Lockdowns and physical distancing guidelines translated into many queer people lacking contact with community members and social support networks. Disparities in accessing mental health resources combined with the existing increase in the likelihood of queer and trans people experiencing poor mental health further marginalized and already at-risk populations (Drabble and Eliason 2021).

Throughout my interviews, teletherapy was becoming common practice, especially among licensed marriage and family therapists (LMFTs) across the Los Angeles basin. I will present their perspectives on providing gender-affirming teletherapy, including perceived benefits and challenges. It should also be noted that the aftermath of adjusting to teletherapy in a long-term capacity has also led to transformative and dynamic perspectives about access to mental health after the pandemic. Additionally, this work assesses the now ubiquitous nature of telemedicine in gender-affirming care and its implication within broader socio-cultural and economic transformations where ideas of access, health equity, and quality care are often at odds with the realities of everyday life for the most vulnerable members of the trans community.

Innovation has risen to the occasion during the tumult of the COVID-19 pandemic. Trans providers recognized their role in continuing their commitment to deploying experience-informed care to their trans patients and clients during unprecedented upheaval. Reliance on in-person care intervention was quickly replaced with dependence on technological solutions. Telemedicine and teletherapy have been embraced, and services expanded in ways that would not have been possible before COVID-19. Structural and clinical adaptations continue to alter trans people's relations with systems, capital, and one another.

Through interviews with trans providers, perceptions of organizations like FOLX and Plume vary. Some interactions reveal inconsistencies between the organizations' stated mission and how care is imagined and realized in practice. On the other hand, FOLX and Plume's work was accepted as a solution to gaps in care. A significant concern raised by Hank was the cost of access and difficulty in collaboration with external care providers. FOLX and Plume rely upon contracting labor out to independent providers. Upon further investigation of their respective websites, I learned they share many of the same clinicians reported to be on-staff.

Hank has approached described challenges in working with both organizations. He found the organizations fraught with bureaucratic complexity and that the staff lacked a personable approach when seeking to partner with providers. For Hank, one of the most frustrating parts of being in contact with FOLX and Plume was their generic emails that were autogenerated and did not address him by name and professional title. Hank was

viewed as a potential cog in the wheel of the spinning machinations of GAC made possible by trans capitalism.

Earlier in the year, Plume contracted Hank to run a “Trans 101” training seminar. Representatives at Plume told Hank they were dissatisfied with the information taught during the workshop and that they no longer wished to partner in contracting educational services with him. Dissatisfaction was linked to disagreements with the presentation of material, incredibly nuanced and even contested definitions in terminology. As an experienced consultant and educator, Hank always strives to be responsive to the needs of organizational clients, and he attempted to connect and address concerns directly with Plume. He even went so far as to suggest a collaborative training session with Plume to meet their needs better, however, due to lack of response from the organization, the second training opportunity was never realized.

Mitch’s politics and interpretation of issues regarding trans people accessing care leads him to accept FOLX and Plume without any critical reflection. During our first conversation, Mitch made it clear he took a “no-nonsense” “pull yourself by your own bootstraps” approach to trans people finding care. In response to trans patients being unable to secure trans competent GAC, he said, “it’s not that difficult if you live in a place where it is difficult [to find care] and go online and do those online things like FOLX and Plume.” While I find this statement and the entirety of Mitch’s politics abhorrent and short-sighted, this is not the main issue I take with what he said. Mitch’s comment reveals a complete lack of consideration for the cascade of inequalities that would be exacerbated if the direct-to-consumer model of GAC is propagated. The

assumption of universal cell phone and internet access combined with assumptions of digital literacy demonstrates how even within the trans community, healthcare providers reproduce inequalities linked to classism, ageism, and ableism.

By offering a critique of FOLX and Plume, my desire is not to discourage trans people from accessing services in ways within their reach nor invalidate the labor of providers who work within FOLX and Plume's organizational apparatus. In following Donna Haraway, capitalism renders identities fragmentary which shapes the contradictory nature of the cyborg. The cyborg figure represents subjectivities that are not defined and delimited by oppressive mechanisms such as capitalism and technoscience, yet the cyborg operates within said mechanisms. The cyborg resists declarations of purity and achieves modes of resist politics otherwise not afforded to fully realized subjects. Trans healthcare providers and trans patients are not free from the capitalist systems, which serve to empower them in the service of capital; however, the simultaneous capacity for oppression disrupts their assumed complicit status within capitalism's reproduction (Haraway 1991; O'Brien 2013). Trans people working within and benefiting from FOLX, and Plume also can resist and should not be understood as in simple relation to oppressive systems. However, the tendency for trans clinicians to adopt Mitch's perspective presents a potential for an insidious denial of intersectional oppression. Like many initiatives under capitalism that attempt to circumvent barriers imposed by capitalism, there are material benefits associated with product offerings and consumer choice. My critique here challenges how these benefits are short-term and fail to address underlying structural factors that shape health disparities. Furthermore, I

highlight how the inclusion of trans people within neoliberal health systems can result in continual inequality and medical violence through inaccessibility.

Trans-Centered Teletherapy

I use *telemedicine* to describe a set of relations between health institutions, providers, and clients where clinical care is offered remotely. The term *telehealth* is broader in its application and includes telemedicine; however, telehealth also includes other forms of care that would not be explicitly considered “clinical” or “medical.” Telehealth is most like Jeannette Pols’ use of “telecare” in which she defines as “direct patient care, in which the recipient is at home and spatially remote from the clinician, nurse, or informal caregiver, and in which communication media are used” (Pols 2006). Given that the following sections focus on the narratives of LMFTs providing therapeutic mental health services, I use *teletherapy* when explicitly referencing therapy sessions where a therapist and patient are not physically in the same room. Remote care can take place through various mediums, including telephone calls, text messaging, email, and, most common today, video conferencing platforms. My interviews with trans teletherapy providers include reflections on their use of video conference calls with their trans patients.

I aim to disentangle relations between actants who mutually participate in teletherapy sessions and challenge the presumed nature of these relations. The new ubiquity of teletherapy in the public sphere has provided an opportunity to reflexively examine how therapeutic relationships are constructed maintained, and what type of

meanings are produced in these encounters. I adopt what Hannah Zeavin refers to as “distanced intimacies” to describe types of relationships cultivated within teletherapy sessions (Zeavin 2021). Care from a distance disrupts the traditional dyadic interpretation of therapy to acknowledge a third actant within what I understand to be a network of care relations. While the therapist and client constitute the conversational elements of therapy, the technological intervention also plays a role in curating care intimacies. *How* care is sought and provided is mediated by technological interfaces that construct a particular care environment distinct from what one would expect with in-person therapy.

The closure of clinics and the on-going fear of being exposed to COVID-19 worked to expand online accessible therapy offerings. I examine how teletherapy transitioned from a present but fragmentary resource to a fully integrated part of mental healthcare services in the United States. Teletherapy, or therapeutic mental health services offered remotely through technological intervention, is not new but for decades has been considered obscure and has remained a largely unavailable service. However, given the stay-at-home orders, government-imposed lockdowns, the shuttering of clinics, and general concern for public health, teletherapy has mainly been embraced as a practical and increasingly essential way of offering GAC. I center my writing here on the experiences of trans Licensed Marriage and Family Therapists (LMFTs) serving clients throughout Southern California. Telemedicine was initially not a focus of this research from the design phase, this reporting emerged from following the stories of cultural experts participating in this study.

The transition in care models from in-person to telemedicine was abrupt and fast-paced, which added to the precarity, and uncertainty expanded daily in the early days of the pandemic. The medical community was constantly learning new information about the COVID-19 virus, and guidelines from the Centers for Disease Control (CDC) was in a consistent state of flux. At first, it was not recognized that this coronavirus was transmissible through aerosol contact; thus, wearing masks was not required or enforced. This quickly changed as it was found that the virus was airborne and being in a public space put all of us at risk. Shifting statements and public expectations represented the increasing instability within healthcare systems and the inability of governing institutions to control the spread, either by happenstance or design.

Telehealth and teletherapy are now considered to be standard in trans healthcare. It has yet to be seen if the relaxing of prohibitive institutional regulations that severely limited telehealth offerings pre-pandemic will be widely reinstated or if this is the new reality (Hamnvik et al. 2020). My interactions with clinicians reflected research on health insurance policy changes and clinics changing their service offerings. The prohibition against teletherapy reveals more about the imaginary of the clinic than it does regarding concern for maintaining quality care standards. Also, given the apprehension of insurance companies to expand coverage of telehealth services, I suspect relations of capital are also complicit in the prohibition. Regardless of the structural reasons behind debates for or against implementing teletherapy, its quick acceptance highlights the malleability of systems often considered unyielding.

George offered the following insight regarding allowances being made for teletherapy:

“Hilariously it was always something that our medical director was like, ‘let’s do telehealth like I want our providers to be licensed in other states, so we can like see people from other states,’ but it just like wasn’t happening and then COVID happens, and I think that our medical director, especially is like, ‘wow this is awesome like this is needed, we need to do this.’”

During interviews, therapists had a lot to say about the transition to teletherapy. Some discussed negative perceptions of telehealth before the pandemic, others mentioned overwhelming personal and professional benefits, but all acknowledged the challenges and limitations imposed by the lack of in-person therapy sessions. One therapist admitted a negative association when asked about their perceptions of teletherapy in sessions with clients. They clarified that they likened teletherapy to text therapy through services like “Talk Space,” which they did not consider “good” therapy. There was an assumption that virtual correspondence between therapist and client constituted an automatic boundaryless relationship where care would not be contained within the confines of professional and institutionalized protocols.

Anxieties about professional boundaries spoke to the general concern for one’s personal space and a needed divorce between career work and personal life. I found more fascinating about this perceived arrangement because, like many people who started working from home during the pandemic, the distance between “work” and “home” became almost non-existent. Clinicians expressed concern for how much their clients could see in their homes during sessions and discussed rearranging furniture and décor to curate what was visible on screen. This concern was legitimate, and clinicians navigated;

however, they also approached their problem with levity. In all their years of clinical training, not once did they consider their private residence a role in therapy sessions, a reality I shared in not expecting a similar set of considerations for conducting ethnographic fieldwork.

Here, I will follow the words of LMFTs and show how trans therapists navigated their care work from a distance. These words capture perspectives that are divergent yet threaded together by the distinctive quality of subjectivities and embodiments represented by these clinicians' lived experiences. While each therapist approaches care from a different perspective (some work in a general mental health clinic, others are in private practice, while others work in a gender clinic), there is commonality in the energy they devote to caring for the most at-risk among their respective patients. Interwoven within the professional lives of trans therapists is a window into how their personal stories and experiences inform their care work amid the pandemic. I intend to show how the presence of trans clinicians in telemedicine continues to challenge queer trans healthcare practice.

Queering care is vital in interpreting the social transformations present during the COVID-19 pandemic. Not only are trans healthcare professionals providing care during a time of upheaval, but they are also doing so in ways that promote further upheaval. In the following paragraphs, narratives from the clinic show how trans therapists have specific concerns regarding their ability to provide care that is tied to their experiences as a patient of trans medicine.

Teletherapy's Benefits

When asked about the benefits of teletherapy, Hank mentioned the ability to use purchased technology as a tax write-off and being able to lower fees due to lack of overhead. Hank said, “Yeah, I love it. I think it's the best thing that's happened, at least in my career because now I don't have to pay for overhead. I don't have to pay for an office, and my home office becomes a tax write-off.” The financial benefits of providing care from a distance are compounded for clinicians working in private practice. Hank continued discussing the benefits for his clients where they no longer had to travel over long distances to access not only a gender-affirming therapist but one who is trans himself. He continued by saying,

“So instead of being limited by people having to come to an office in West Hollywood, I have clients in Oakland, San Diego, San Francisco, Bakersfield. Like people that would normally have to travel a long distance are seeking me out. Um, so, personally, I love it. I think it's also really beneficial for my population. Because they now have an opportunity to see a therapist that reflects them without having to travel far take buses for a long period of time (which I had some clients do). They save money on transportation, which means that they can afford more frequent therapy.”

Geography and distance were cited as dimensions in which working remotely was viewed positively. Population distribution across Southern California and car commuting culture intersect with work/life balance and convenience. Saving money and time without commuting across Los Angeles translates into increasing therapists' ability to spend more time with clients. Also, as an LMFT in California, he can take on clients from across the state, including cities and regions where access to GAC, let alone access to a trans clinician, is nearly impossible. Above all, Hank is a pragmatist. He cares deeply for his community and has devoted his life to promoting a better quality of life for trans people.

He is highly attuned to the value of being present as a trans therapist and actively celebrates the ability to expand his clientele. This blunt and overwhelmingly positive response to the abrupt transition to teletherapy is born out of a desire to promote better access to GAC.

Jenny lives a considerable distance from the clinic in which she is employed and discussed the pandemic's positive impact on her quality of life. Jenny said, "I don't have to commute. You know, I live in Pasadena. And my training site is in Culver City, which is quite a drive. It's, it's been much easier to be able to not have to wake up so early just to get ready and make my drive all the way down there. And so, I like to think at least that's extra energy that I can put into working with my clients." Jenny's ability to redirect energy away from an early morning commute across the Los Angeles basin to be more present with her clients offers pointed commentary of the status of healthcare labor in the United States.

There has also been a positive impact on patient access and the use of time in accessing care. Time itself is a factor that shapes health outcomes and general experiences in accessing care. Barriers to accessing trans serving clinicians and providers who possess community competency significantly limit where trans people can receive GAC. Beyond providing care, trans clients and patients value being *seen* and respected on their terms by their care team. As mental health services are one component of trans medicine among many others, trans people seeking care often stitch together a patchwork of providers that are not always comprehensively linked or geographically near one another. Clinics and provider offices can be dispersed across the urban sprawl of Los

Angeles, meaning “staying healthy” involve hours of travel time between appointments. Telemedicine has compressed time and space for patients and providers. The hindrances imposed by geographic dispersal, scheduling, transportation costs, and career and family obligations have been drastically reduced by adopting telemedical care strategies.

Teletherapy's Challenges and Limitations

Ultimately, the therapists I interviewed had many concerns about the use of teletherapy while they still saw the value and benefits. Challenges that were most often discussed in interviews were concerns about maintaining space between work and home, the inability to read body language & view the “whole person,” concerns about privacy, especially for clients who are minors and/or who fear disclosing being trans to people at home, technical difficulties using teletherapy platforms like Doxy.me or internet connectivity issues, and some therapists mentioned how since telehealth services require devices capable of face-to-face video conferencing, teletherapy is often inaccessible to trans people experiencing homelessness or who lack access to a smartphone or computer.

Concerns over privacy, especially for clients who are minors, weighed heavy on the minds of therapists. While this can be a concern for anyone during a teletherapy session, this becomes a matter of safety for trans clients, specifically trans and gender-expansive youth under California's Mental Health Services for At-Risk Youth Act (SB 543) signed into law in 2010, minors as young as 12 years old to consent to mental health services (therapy) without a parent's permission. SB 543 was drafted in the state legislature to increase suicide and suicide attempts among LGBTQ+ youth and earned

sponsorship from state and national LGBTQ+ advocacy organizations such as Equality California.

The meanings invested in providing care for trans youth were particularly interesting to me since several participants came out as adolescents and received GAC as minors. These providers did attest to having supportive families during their coming out process, and their GAC included comprehensive care at Los Angeles Children's Hospital's Trans Youth Program. Jenny reflected on the risks posed to trans youth, "so, if you're trans and you want to have a therapy session, and you're a teenager, you know, you want to talk to me about stuff, you know, your parents can be listening at the door, and it can be potentially dangerous." Even though Jenny and several other LMFTs benefited from affirming personal and medical environments as teenagers, they do not consider the experiences universal or typical. The acknowledgment of privilege coincides with providers' recognition of the precarious realities facing their community.

Jenny provided insight into how she organized her home and managed what is visible or not to her clients. She said,

"It can be challenging for somebody to do therapy literally in the same room where, for instance, they might feel like they're kind of stuck having to kind of work and live in the same space versus if they were in person, they could at least, you know, go to a separate, you know, building to the clinic in this case. And so that has a different sort of clinical dynamic, or at least there's its own kind of both physical and kind of mental space that's separate from their home. I mean, that's another thing too is that, for instance. You know, I try to keep my space here. But literally, what you're seeing is what my clients see right now. I try to, you know, keep my background relatively kind of sparse and not, you know, not make it too much like me to clients are looking into my living room, but also vice versa. It's like I'm literally seeing them at home versus and you know at the clinic."

Also, not being able to see a client, especially when discussing something as serious as an upcoming surgery, left Jenny especially unnerved as they reflected on their own experiences with therapy and transition surgery. Her subjective experience as a someone who has had transition surgery and is still a receiver of gender-affirming care provided insight into the reflexive process at work due to experience in both positions in networks of care. She told me,

“...certainly, as a trans person myself, I think that it would feel weird for me. Like if I'm going through so much of, like, what's a very viscerally kind of physical experience in terms of trying to feel more comfortable in my physical body and have my therapist who's, of course, somebody that knows me very closely, not even be able to see my body before or after these procedures, that's interesting.”

This excerpt from Jenny demonstrates her understanding of care as relational and her role in a care relationship involves drawing from her own experience with gender GAS. The fusion of her personal experience with her training as a therapist within the surgical process is valued. The embodied process integral within GAS also involves the politics of recognition. Being recognized as a whole person in-light of variable modes of embodied gender expansion is a vital part of the decision to undergo affirming surgery (Plemons 2017).

The observation of body language is critical in the clinic, which is impossible over telephone therapy sessions. Therapists who have offered therapy sessions over the phone view the format as, of course, being less than ideal and use it as a last resort, “better than nothing” strategy to provide care. Teletherapy through video conferencing technology was always preferred. However, there were still severe limitations and challenges in providing care for the “whole person.” Teletherapy through video call

allows for observation of facial expressions and vital face-to-face contact and communication however most of a client's body is invisible to the therapist's point of view. The inability to pay attention to changes in body language through therapeutic encounters limits the therapist's ability to fully assess their client and provide the most comprehensive care possible.

The clinical gaze operating within therapy sessions is subtle and relational, yet still present and consequential in how therapists respond to their clients, offer guidance, or recommend behavioral modification or treatment. This is not discernable from only the conversational elements of the therapy session but also observable through the unspoken and embodied behaviors indicative of mental or emotional processes. Hank spoke to challenges associated with not seeing his client's body that proved to be a hindrance in recognizing potential mental health conditions. He said,

“If a client is telling me, ‘Yeah everything's going great,’ but they're tapping their foot, and I don't see them doing that, that's an important part of what they're telling me because they might say some things are fine, but really, the evidence of how they're responding to the question in their body language tells me a very different story, but I missed that. And so, I'm not able to help them as well as I would be able to in person. So, It's hard.”

Technological difficulties are a source of frustration for therapists and offer another layer of challenge of doing their jobs. Not only are they concerned with providing quality care in the adverse conditions of working beyond their in-person clinical training, but they now must also be their own IT technician, troubleshoot malfunctions and connectivity issues, and exercise patience with either their internet connection's quality or be at the mercy of their clients' unstable internet or less-than-reliable technological devices. Additionally, maintaining HIPAA compliance and

ensuring the protection of clients' privacy presents another added challenge for therapists.

Jenny describes the difficulty in sending medical documents to her clients using

Doxy.me, a HIPAA compliant telemedicine platform. Jenny said,

“At my site, we, unfortunately, don't have our own HIPAA compliant email addresses. So, for instance, sending documentation back and forth, we have to try to do it through Doxy, which of course doesn't work very well or very consistently clients who might be older, or for other reasons, less comfortable with technology that doesn't work very well. So, it's a problem.”

George lamented on how difficult teletherapy has been for the most vulnerable trans youth is sees in his practice. Regarding trans children at risk for self-harm or attempting suicide, George fears trying mental health intervention remotely could do more harm than good. He articulated his concern in saying,

“I think that the hardest thing is doing mental health services to doing therapy over telephone was hard because the reality is like a lot of our trans youth have high suicidality. They have a lot of self-harm, whether it's past history of attempts or whatnot. There's a lot of negative mental health stuff, and as a therapist, I'm not going to do telehealth with someone who has active suicidality right like. Two hours away from me that's just not an ethical or smart thing to do, so that's hard.”

Trans Care Has Always Been Virtual

Before the development of online trans communities and the narrow accessibility of GAC through internet telemedicine, “care from a distance” has been a part of the trans culture for decades. The small percentage of people who are trans is spread across all population demographics. This characteristic of trans population distribution has shaped the coalescing of relations for decades. The relationship between time and space has always been a contentious factor for the development of queer and trans social units. Thus, the act of categorizing “queer” subjectivities and embodiments was exclusive to the

medico-psychiatric gaze. The power of pathology to gatekeep, medicalize, police, and eliminate trans people also promoted an acknowledgment of patterned experiences from which meanings could be made. Giving language to trans experience provided trans people a way to self-actualize and adopt common language to coalesce and build support networks, virtually and physically.

The disparate availability of GAC and the sporadic institutional recognition of gender and sexuality variance as something to be scientifically studied or managed was the norm in the early 20th century. However, by the mid-20th century, socio-cultural and economic changes paved a path forward for community development. World War II and its immediate aftermath changed U.S. population distribution forever. People from around the country who would have otherwise had very little reason to move far from their communities of origin suddenly found themselves geographically circulating like never. One cause of this change in relations of geography was the centralized training of people at military bases across the country in preparation for deployment in Europe or the Pacific.

During the war and immediately after, people from across population divides, including race, class, and gender, were now in regular community with one another. Many people with subjectivities and embodiments we would now regard as queer could meet others who shared their desires and worldview. In the post-World War II era, mass industrialization was facilitated by continual technological expansion. The Cold War renewed nationalist economic commitments to expanding biopolitical industrial

complexes, which shaped the further development of trans medicine (Preciado 2013; Gill-Peterson 2018).

Populations grew in the 1950s and 60s while the spatial arrangement of those populations in urban, rural, and newly created suburbs was in a constant state of flux. Improvements in access to mobility for some and growing inequalities for others led to reshaping the U.S., which reproduced inequalities based on race and socioeconomic status. White flight to the financially well-endowed suburbs left communities of color to under-funded infrastructure in large cities. The advent of widely accessible television programming broadcasted new hegemonic norms for which the entire population was set to emulate. Rural white communities now had access to cultural production stemming from white-dominated corporate media. The global economy was being compressed through the rapid machinations of neoliberalism while simultaneously, the world for many rural and traditionally disenfranchised communities was expanding. Amid unprecedented and rapid social change, biopolitical technological innovation emerging reached new heights and broader applications.

In the 1940s, developments in “treatments” for intersex people were circulated in U.S.-based medical journal publications. Many of the procedures were starting to be considered applicable for the treatment of trans people, especially among Doctors David O. Cauldwell and Harry Benjamin (Meyerowitz 2004). Building from the pre-WWII work of Magnus Hirschfeld, Benjamin sought to legitimize the medicalization of gender and promote biomedical strategies for “curing” gender incongruence. Benjamin’s early

GAC in California and others across the country were based on community referrals and mail correspondence between gender clinics and potential patients.

The mid-20th century gender clinic correspondence coincided with the circulation of community-based print material. The spread of ideas, medical information, and the promise of community support demonstrated the utility of connecting trans people through virtual mediums and were a precursor to today's online accessible information forums and telemedicine. Publications from the late 1960s and continuing into the 1970s worked to shape trans community building and disseminate lifesaving information about the growing availability of GAC. Magazines and newsletters like *Vanguard* from the Tenderloin in San Francisco, the *Conversion Our Goal* newsletter, the Queer Liberation Front's *Drag Queen*, and the Transsexual Activist Organization's (TAO) *Moonshadow* and *Mirage* represented virtual community-driven care initiatives that were significant in trans cultural production. (Stryker 2017).

The latter half of the 20th century was marked by social shifts leaving queer and trans people with often contradictory living conditions. As mentioned in previous chapters, Increased recognition and inclusion by the state and mass media coexist with increased vulnerability and policing within interpersonal relationships and social institutions. Movements to depathologize the language used about GAC occurs in tandem with an increased murder rate and malicious public policy proposals. In recent years, access to trans-affirming social services and healthcare has expanded; however, the COVID-19 pandemic added another layer of precarity for trans people. Like many moments of hope or expansion of opportunities for the trans community, those positive

moments are concurrent with structural setbacks, further demonstrating the failures of fragmentary neoliberal approaches to amending systems that work to defile, maim, and eliminate trans people from existence.

Conclusion: Encountering a New Normal in Trans Medicine

This chapter attended to how COVID-19 shaped the context of how this project approached trans medicine. During data collection for this work, trans medicine, therapeutics, and healthcare, in general, were not what they were the year before my research. The microcosm this project represents a snapshot in time whereby the forces of societal rupture, how trans clinicians and trans patients related to one another was in a messy patchwork of improvised care modalities. What is still left undetermined is whether the pandemic's effects on trans medicine, especially trans-affirming mental health care, are permanent. What may have been a temporary adjustment in response to adverse public health conditions may have given birth to a wholly new industry filled with multiple layers of actants, interests, and capital flows.

Therapists offered insight into both the benefits and challenges of teletherapy; some took the time to posit possible new realities in the time after the pandemic. The reflective action constituted a moment of questioning accepted norms ingrained through training and their own experiences on the receiving end of a care relationship. The historical break prompted by the pandemic forcibly removed the clinical environment from clinical care. The situatedness of in-person clinical therapy is one of the modern care paradigms where norms have been established and maintained through training and institutional mechanisms. Teletherapy and telemedicine, in general, usurps norms of in-

person placemaking and clinical presence. The deconstruction of normative clinical practice and then production of a system of care needed to circumvent clinical norms further delineates the utility of the queering care analytic.

I want to use this concluding section as a space to highlight trans visions of the future of trans-affirming care. This dissertation centers trans voices in an ethnographic exploration of how care is queered in Southern California, a region that challenges the boundedness of rural, suburban, and urban divides. By extension, giving attention to the virtual as an alternative “place” which transcends physical boundaries, the stories in this chapter illuminate timely applications of how care is to be queered in light of social reconfiguration.

George weighed the benefits and drawbacks of telehealth services in stating, “There is something about in-person that’s really important there’s something about like building that rapport in that dynamic and having young people have a private space where they can actually talk. You know about their feelings, so I hope we can have some kind of a hybrid.” Here, George takes a pragmatic approach in assessing the inclusion of telehealth within GAC. However, if trans care is to be bifurcated in such a way, would there be a potential for reproduced inequalities due to some patients and clients opting for one modality over the other? The nuanced perspectives presented by the stories featured in this work suggest that could be the case. None of the therapists who practice teletherapy are particularly intransigent one way or another regarding in-person versus remote care practice. The relative level of vacillation towards “pure” approaches to care reveals a consistent pattern of malleability in care work among this population. The

plasticity evidenced through these stories reflects the blended subjectivities that all healthcare professionals featured in this study have attested.

In terms of the temporality of the pandemic and teletherapy's place in questions of time, queer futurity takes on new life and possibilities. Imagined visions of a return to pre-pandemic conditions offer an imaginary recreation of the past filled with hindsight and nostalgia perceived through rose-colored glasses. Hoping for a return to "normal" is a return to rampant transphobia, health disparities, and death. None of the trans people I spoke with during fieldwork addressed the reality of facing such common hopes in light of the pandemic. However, wariness of what the future may bring was common. Jenny expressed optimism that teletherapy would be offered in the post-pandemic "back-to-normal" era to address accessibility issues within the community.

"I hope it [teletherapy] will continue; I hope that my site [clinic where she is employed] will continue to offer telehealth as an option, even after things start to go back to normal if that's even something that happens at this point. But that you know folks who might not have access to resources being able to see providers that they might not otherwise be able to see. I think that is something positive about telehealth."

I found Jenny's uneasiness of accepting the reality of a future "return-to-normal" intriguing and quite telling. Getting back to a pre-pandemic has been the carrot place in front of the masses when governing bodies and institutions highlight the importance of stay-at-home orders, mask requirements, and vaccines. However, Jenny's perspective demonstrates doubt in returning to what was before and offers a space from which new paths may be charted.

Jenny's story does not exist in isolation, and experiences like hers impact healthcare practice beyond trans medicine. As stated earlier, the pandemic conditions

produce unanswerable questions that promote a general sense of upheaval. Jenny reflected on her journey to become a therapist, and as she is documenting her hours for full licensure, she is also mindful of the quality of experience she and other early-career LMFTs are receiving. Jenny told me,

“Fortunately, I had a good couple months before the pandemic started where I was actually working in person, but there are a lot of the, I mean, quite frankly, probably more than half now of the clinicians at my training site started working there after the pandemic started. So, they’ve actually never worked with clients in person. There’s, of course, lots and lots of clinicians who are more started working many, many years ago who don’t have that [teletherapy] experience. But that’s sort of an interesting dynamic that happens with colleagues; you literally are now working with people who have never had the opportunity to work with clients in person.”

Hearing this from her was shocking. Of course, I realized that life continues, and people need to be trained and should be allowed to progress with their careers even in times of upheaval and social instability. Hell, I continued with my plans to conduct fieldwork and finish my dissertation while staring straight down the barrel of a pandemic that limited in-person fieldwork. However, the prospect of mental health professionals with long careers ahead of them never seeing a client in-person during the formative years of their training and practice was admittedly unnerving.

What Jenny said next put the reality of telehealth and the pandemic into even sharper focus. She said, “Before we started our call, I was tracking my hours, and I think at this point, looking at the hours that I have done through telehealth versus in-person, I’ve now worked twice as many hours working remotely through telehealth than in-person. So that’s kind of interesting.” Jenny gained more experience providing therapy through telehealth rather than in-person sessions. At that moment, I realized another

dimension in which my professional life paralleled the lives of my study participants: our disciplinary “expertise” is based on engagement with our respective fields mainly in part through virtual means. While I have already attended to my insecurities due to how I completed fieldwork, I think a more productive and thought-provoking exercise would be to consider how these realizations work to disrupt, reimagine, or even *queer* disciplinary norms.

Jenny presented more questions towards the end of our conversation that continued to incite my revelations in my connection to the broader discipline of anthropology. She said, “When we do go back in-person, what’s that going to be like when have another kind of learning curve like we did at the start of the pandemic? What is it going to be like when we go back to work in person?” These questions speak to the uncertainty for the future and uncertainty in navigating a future that does not reflect the past, nor does it continue to reproduce how we currently live and work. The pandemic offered me the opportunity to study novel social relations emerging out of unprecedented upheaval and precarity, and it has provided therapists featured here much of the same in terms of providing care. What does that reveal about her expertise and the experience of others in her position and related fields? What does this mean for the future of therapy, not to mention the future of GAC? Will these transformations in cohorts of healthcare practitioners serve as another factor that reproduces inequalities, or will these conditions promote creativity and novel approaches to improving health outcomes? I have found that, like the therapists I have interacted with through research, I am left with nothing but questions.

The COVID-19 pandemic has radically altered social relations, and many would advocate for the everyday operations of society to never return to a pre-pandemic status quo. This sentiment rings especially true within trans and queer care networks as a “return to normal” would be a return to inadequate care protocols, rampant inequalities, and unchecked systemic violence and marginalization. The pandemic offers an opportunity to reimagine how GAC is practiced, and trans providers are at the forefront of this reconfiguration of norms. While therapists offered insight into both the benefits and challenges of teletherapy, some took the time to posit possible new realities in the time after the pandemic. These mixed sentiments illustrated a reflection on how things were not working before, how they are (in some ways) working better now, and how they may be able to work even better in the future. This optimism is contrasted with a deeply rooted knowledge of how the conditions of the pandemic have indeed been a hindrance to so many, including trans people. What remains to be seen is if this form of queered care is temporary and fleeting or a precursor to a newly imagined “normal” of trans medicine.

As socio-cultural discourse surrounding humanity’s relationship with COVID-19 has shifted from “overcoming” to “managing,” the once ubiquitous use of promising a tomorrow that looks like the time before COVID-19 has fallen by the wayside. No longer do we imagine a return to normal but the establishment of a new normal shaped by improvised care practices. These moments of “new world-making” place trans healthcare professionals at the front lines of innovation in ways that can be liberatory, hierarchal, or resistant to dichotomous categorization.

Queering care attends to the ways in which trans people in care professions can improvise and be amendable to changing conditions while also accounting for the ways trans people (providers, patients, and patient-providers) are embedded within relations of capital. In the case of direct-to-consumer telemedicine, the neoliberal “solutions” are embraced to “solve” inequalities caused by neoliberalism. In the case of embracing telemedicine, trans therapists demonstrate their willingness to adopt new protocols and imagine more equitable care moving forward. Whether or not trans medicine directs improvisational and amendable affects toward liberation-minded care practice has yet to be seen. However, the COVID-19 pandemic has shown that a different world is possible and trans healthcare professionals are well-positioned to make it a reality.

Chapter 6: Conclusion: Looking Forward

Care that has been Queered

Returning to my first day of fieldwork, Hank set the tone for my exploration of trans care. As he played out example conversations, he has with his trans clients, he meticulously showed me what trans care by and for trans people looks like. Towards the end of a litany of examples he provided of his clinical interactions, he said, “Let's move forward, instead of examining the past. If my client is having surgery coming up (and this is something a lot of my trans colleagues do), I make a request. I say, 'Hey, so I think we should have a couple of sessions before your surgery.'”

In this passage, Hank is not relinquishing clinical authority or using his position as an LMFT to usurp trans medical bureaucracy. However, he is also not promoting barriers or seeking to gatekeep his trans client. He speaks to patterns in clinical care practice undertaken by other trans providers in his professional networks. He maintains that this type of interaction is only made possible by trans people doing the care work. Hank continued to play out of the conversation by saying,

“Not because I'm second guessing, not because I think you don't know, but I think it's just good to talk about all the feelings that are being brought up, good or bad.’ And then I continue to see the client. I say, 'Let's make a plan like who's gonna take care of you when you recover? What are some things that you're going to need?' We make goals; it's kind of like case managing. I ask my clients, 'Who can you call in an emergency? Do you know your doctors' phone numbers? Let's make a list in case you're bleeding and where the closest hospital is,' that kind of stuff. So, it's turning therapy into a resilient exercise”

Hank's forward-looking perspective to GAC includes care for the whole person. In this example, every contingency is accounted for, and clients are looked after in a way

that is infused with experience-informed care. His own experience with GAC, including HRT and GAS, along with his experience as an activist, community organizer, and now licensed mental health clinician, all inform this sample conversation with clients. His approach to care is not seeking to “tear down buildings,” nor is it to insist that medicalizing trans lived experience is necessary for providing *good* trans care.

Hank’s approach to care exemplifies the utility of my proposed queering care analytical framework. He blends activism with clinical authority in ways that wouldn’t necessarily be accepted as fully liberatory nor entirely in service to maintain clinical hierarchies and medical hegemony. Through *requesting* clients continue to see him and offering a comprehensive explanation of why that request is given is a shift in care practice. As Hank says at the end of his statement, “turning therapy into a resilient exercise” shows his commitment to looking forward with clients and empowering them with knowledge and affirmation informed by his personal and professional expertise.

Queering care works to understand how trans care, both as a set of activist actions and ethics and clinical knowledge and practices is reproduced in light of intersectional factors stemming from geographic location, racism, classism, patient experience, gatekeeping, and structural barriers to care. How trans health professionals balance the personal with the professional, blend the two, and/or allow one or another to guide their clinical interactions constitutes queering care. The inherent contradictions, moments of contestation, divergence, and social reproduction of harmful practices all work in concert with one another to define what trans care is in Southern California.

Contributions to Anthropology

As I conclude this dissertation, I revisit my initial insecurities regarding the quality of this work throughout the COVID-19 pandemic. My mind plays with the imagery of Malinowski along on the beach, faced with the objective of immersion and remaining off the verandah. Through Zoom ethnography and following care networks, I immersed myself in trans care discourse and was in community with the trans health professionals who graciously shared their stories throughout this project. In following João Costa Vargas' application of *observant participation*, rather than *participant observation* (Costa Vargas 2008), I faced challenges in immersion presented by the pandemic and reflected on how trans healthcare providers' labor and strategies in propagating GAC promotes liberation, regulation, or both.

This research contributes to anthropological knowledge about trans and gender-expansive people's lived experiences in Southern California. It is now a part of the mere handful of ethnographies about trans people in the United States and the only one that centers trans lives in the discourse of medicine and care. For far too long, trans people have been cast in the ethnographic imaginary as solely marginalized and abject within broader society. This intervention in anthropology shows how trans lived experience is multiple, plural, and anything but monolithic. It was my intention to show how common understandings of trans activism and trans medicine shift when trans people manifest authority in professional healthcare practice.

Contributions to Transgender Studies

My interventions within the interdisciplinary field of transgender studies stem from my critiques of trans care and how trans people operate within communities. The queering care analytic provides a needed tool for assessing the contradictory and contested terrain in which not only trans medicine resides but also trans social life in general. This work presented trans people's capacity to provide comprehensive care and desire for liberation on the same continuum as their capacity to reproduce harmful structures and reify white supremacist, settler-colonial, and transphobic cultural logics. The lived experiences showcased in this study present a holistic snapshot of trans care without reproducing binary and dichotomous understandings of "good" versus "bad" care. Furthermore, this work debunks the assumption that trans representation in systems of power will always translate into liberatory practice.

Due to the COVID-19 pandemic, trans care has changed, probably forever. The dissemination of online care modalities and service offerings facilitated by the embrace of telemedicine and teletherapy has shifted norms within GAC. However, as technological integration and the expansion of neoliberal healthcare increasingly becomes a part of trans medicine, existing disparities will be exacerbated, and new domains of inequality will be produced. This work is at the cutting edge studying trans medicine in this new reality and doing so as an ethnographic intervention contributes to the breadth of knowledge transgender studies seek to promote about trans people.

Attending to Project Aims

This project began with a desire to trace trans life trajectories from activism in the streets to activism in the clinic. I did this to center providers' positionality as patients of trans medicine while also being an active part of providing GAC to others in their community. The central question I ask in the introduction, "How do the institutional mechanisms within contemporary trans medicine and therapeutics respond to the inclusion of trans activists among their ranks of healthcare professionals?" is answered through the ways trans medicine is in a constant state of flux. As more trans people lend their embodied knowledge to healthcare practice, the relationship between health institutions, patients, and clients is becoming more destabilized. In applying the queering care framework, I argue that this destabilization can further integrate activist aims of liberation within how GAC is imagined, provided, and received. The questioning of clinical norms and standards by trans healthcare professionals has led to novel approaches in dismantling barriers to care and reducing clinical reliance upon diagnosis and pathologization. While trans representation does not promote liberation and sustaining change, the consistent introduction of care that is experience-informed promotes new, improvised care practices that, if shown to improve trans health outcomes, will reshape how GAC is provided.

This work's focus on Southern California allowed me to show how geography serves as a social determinant of health for the trans community. Geographic location in Southern California translates to funding, resources, and care networks being stratified between distinct yet interwoven urban, suburban, and rural landscapes. Divergencies in

perspective between trans healthcare professionals in Los Angeles versus those in Riverside County account for how trans care practices are uneven and simultaneously promote access and barriers.

Patterns persist among trans healthcare professionals regarding their relationship with institutionally developed and accepted care standards. Providers' diverse experiences as patients of trans medicine have led some trans clinicians like George, who unabashedly criticizes institutional guidelines he views as gatekeeping to adopt an activist approach to care. George communicates his discontent with requirements for letters of recommendation before accessing HRT or GAS with his patients. He also demonstrates activist care through creatively interacting with bureaucratic red tape just to ensure his patients can receive lifesaving GAC. However, other providers like Chris and Mitch rely upon medically legible care guidelines. They believe in their ability as trans people with clinical training and medical authority to offer the best care possible through adhering to established clinical norms. There are also trans health professionals whose stories and care practice present a complicated narrative whereby institutional limitations and insurance billing must be navigated to propagate GAC in hostile environments. Riley's experiences as the sole Transgender Patient Advocate in a conservative hospital near rural Coachella Valley communities means he must resist the *appearance* of activism to ensure would-be transphobic powers do not eliminate his capacity for serving geographically vulnerable trans patients altogether. As shown through my presentation of data, adherence to clinical hegemony can be due to pragmatism in connecting patients

with care, ensuring insurance coverage of HRT or GAS, navigating hostile institutions, as well as through *transnormative governmentality*.

So, what happens when trans people become healthcare professionals in trans medicine? The answer is not universal throughout this work, given the varying degrees in which trans healthcare professionals assimilate within normative care practice or seek to usurp established systems. Regardless of if trans providers promote activist-inspired care, reproduce normative medical hierarchies, or chart a path somewhere in between, their intentions and desire to improve the lives of members of their community are universal. While questions remain regarding if trans medicine will embrace pathways towards liberation, the growing presence of trans people in professional healthcare practice will continue to reshape trans care discourse for decades in the future.

I hope this dissertation allows readers of this work to expand their knowledge about the trans community and trans health disparities in a way that amplifies and centers trans voices. I desire readers to understand how the application of queer theory through the *queering care* analytical framework provides a lens to interpret how trans medicine is provisioned by trans people in consideration of geographic inequalities, intersectional oppression, contradictory care objectives, activist practices, and clinical authority. Lastly, I hope by completing this project, I show how trans people can and should serve as co-producers of knowledge in ethnographic research about their lives and experiences. Through expanding the participation of trans people within research and embracing a polyvocal research agenda, trans people are empowered to tell their own stories and create knowledge on their own terms.

Looking Forward

As I conclude this project and reflect on the relationships I cultivated and the knowledge I gained, I consider the future of research in trans medicine and healthcare. Los Angeles has long been a center of queer and trans community organizing and healthcare services. What was clear through fieldwork was that trans activists and healthcare professionals are increasingly challenging the hegemony of urban trans care networks. Since the beginning of this project, I have known of queer and trans health professionals who have relocated and redirected their care practice towards the east. New horizons in expanding trans health are being realized in Riverside County, especially in the Coachella Valley. As of late 2021, a trans woman is serving as mayor of Palm Springs, a city with 100% LGBTQ+ representation on its city council. Capacity is growing, entrenched figures within smaller communities face a plurality of trans-affirming organizations, and increased state and county investments are changing the conversation in eastern Riverside County.

While progress seems to be taking shape in Southern California, trans health, especially for trans youth, is experiencing an all-out assault from the political right in the United States. Right-wing extremists have taken hold of state legislatures and governorships, and they now are promoting exclusionary policies targeting evidence-based GAC for trans youth. In 2022 the governor of Texas has issued an executive order banning GAC for adolescents and has directed state officials to investigate affirming parents who heed expert medical advice in ensuring their trans child has access to necessary and lifesaving care. Declaring GAC as constituting child abuse has led to

threats of removing children from their homes. This reflects a long history of agents of the settler-colonial state destroying families to promote assimilation within hegemonic ideals. Once again, the legacies and current iterations of white supremacy coursing through social institutions work to target the most vulnerable members of our society.

The future of trans medicine is uncertain as moments of supposed “progress” occur in tandem with genocidal forces emanating from state power. In thinking through the current moment and the work that must be done for trans liberation to be realized, my interests in engaging with trans community health are evolving. Throughout this work, I felt a constant pull towards the east and a desire to examine further trans cultural transformations occurring in eastern Riverside County and the Coachella Valley. I hope to continue this research by studying trans patient experiences and health outcomes in contrast to their healthcare provider’s level of trans competency training and knowledge. My interests in education and passion for developing pedagogical tools to communicate better the value of trans existence with the broader public as a driving force for this potential research pivot.

In conclusion, I hope this dissertation has done justice to the voices of the trans healthcare professionals who kindly agreed to assist me in the production of knowledge. These trans people, who against all odds in our intensely transphobic society, have found fulfillment and purpose through their care work. While they do not operate with one voice or practice care in the same ways, their presence shows the potential for trans futures waiting to be realized.

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