

Uncaring systems and the production of trans* subjectivities: exploring
digital spaces of trans* care

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Abstract

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As documented by trans and queer scholars, trans* people face a fundamental paradox in accessing care (Stone 1992, Butler 2004, Spade 2006). In order to access gender affirming care, trans* people are implicated in a care system that is uncaring in its approaches to trans and gender non-conforming people. However, changes in the ways trans bodies and identities are conceptualized in care spaces has resulted in a refiguring of trans care resulting in a shift in the geographies and spaces of trans. The resulting shift in trans care geographies is an uneven one; both geographically but also in the ways different trans bodies experience these care spaces based on age, gender, race and sexuality.

In this thesis, I will explore the ways in which trans* people use digital spaces to reform and work through available networks of care. Drawing from digital research on institutional care websites and YouTube videos as well as auto-ethnographic reflection, I

critically address the strategies, techniques and methods implicated in trans* care. Following the work of Gray (2009), by examining these digital spaces of bodily and subjective production my goal is to explore the conditions under which trans* people are cared for and about. By interpreting these digital spaces through the lens of past work on care politics and care geographies, my work examines how care is networked and relational—and asks for a more complicated approach to a care ethics or care practice of the self. Finally, my research points to and demands for a more multi-scalar and relational approach to trans* geographies. In my concluding remarks, I lay out how such an approach would necessarily connect the multiple sites and processes imbricated in the production of and governance of trans* lives.

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CHAPTER ONE: INTRODUCTION

Reflecting on my experience as a trans* person, each time I draw testosterone my body is knit others—cis and trans*—across space and place. There is something intensely intimate in self-injecting testosterone, where my body is produced and changed by the biochemical synthesis of testosterone. While self-injecting may be self-administered and private, it extends me out from an initial moment into a set of relations that are very much public as my body changes. Every time I take a shot of testosterone, I am implicated in the political-economic structures of global pharmaceutical exchange—in trans-national corporations synthesizing hormones in laboratories. I am implicated in a tiered system of unequal and inaccessible health care that hinges upon diagnosis and pathologization. And as I move through the world, my body is read through normative conceptualizations of masculinity and embodiment—as in or out of place. It forces me to acknowledge how I am made and unmade through social, political, economic and biological processes—processes that extend far beyond my body that make me trans*.

The multiple scales, processes and technologies that I and other trans* people bring together in accessing gender affirming care can be traced to a variety of different gender policing technologies that have sought to deny the bodies and experiences of trans* and gender non-conforming people (Spade 2006, Doan 2010, Hines 2010, Rotondi *et al* 2013). Paradoxically then, it is through these historically othering and uncaring systems that I access the essential health care that I need. For trans* and gender non-conforming people then, medical and social care systems are fundamentally uncaring as

they continually deny the existence and humanity of trans* people (Butler 2004, Spade 2011).

It is from this position, as a geographer and a trans* person, that I am framing my research, which will explore the paradoxical and intimate relationship trans* and gender non-conforming people have with care. Despite the relational and geographic interconnections I experience as a trans* person, both in daily life and as I access care, few geographers have studied trans* geographies or trans* lives. While there are notable exceptions here (see Browne and Lim 2010, Doan 2010, Hines 2010, Nash 2010) there is scant geographic analysis on the way trans* people experience care (Transgender Law Center 2014).

Past work from authors based in law and legal studies (Spade 2008, 2011), communications (Gray 2009, Kuper *et al* 2012) and gender studies (Butler 1999, 2004, 2007, Namaste 2009) have begun to engage with trans* lives and have identified a handful of the spaces of contradiction where trans* people are defined and made legible. By coupling critical research (Spade 2011, Bauer *et al* 2009) with rich academic (Spade 2008, Doan 2010, Stryker 2010) and non-academic (Stone 1992, Feinberg 1996, 1999) accounts from trans* people there is a clear and contentious relationship between trans* individuals and spaces of care. Meanwhile, research on care has interrogated the politics of what it means to give and receive care in an increasingly globalized and neoliberal world (Tronto 1993, Brown 2003, Lawson 2007, Atkinson *et al* 2011, Green and Lawson 2011), and how care is implicated in political projects of defining subjectivity (Brown 2003; Foucault 2003, 2009). Thus, this research stems from a personal and academic (Stone 1992, Spade 2007, 2011, Doan 2010) knowledge that trans* and gender non-

conforming people have and continue to experience discrimination and exclusion from care.

This project aims to bring these two literatures together in order to address how trans* lives are governed and produced by care. In bringing these two literatures into conversation with one another, this project fills a gap in the care literature on trans* and gender non-conforming experience and further explores care as a theoretical lens for interrogating and uncovering the ways life is counted and provisioned (Brown 2003, 2006, Foucault 2003, 2009, Lawson 2007). Furthermore, it builds on past care literature (Tronto 1993, Brown 2003, Brown 2004, Green and Lawson 2011) that has pointed to the way that care produces particular sets of relations and subject positions. What my research shows is that trans* care necessitates a particular cared-for subjectivity that echoes past conceptualizations of who trans* people are as well as current understandings of who gets cared for and how. These subjective definitions are intimately tethered to trans* care provision and have very real implications for the life chances, embodiments and lives of trans* and gender non-conforming people.

My research also directly fills a gap in geographic research on care and care politics by demanding that we consider the ways trans* lives are produced and contested in institutional spaces of care. Building on this, and past work on the relationship between care and the self (Foucault 1998, 2007, Gray 2009, Atkinson 2011; Ball and Olmedo 2013) as well as its political potential (Brown 1995, Butler 2004) my research asks how trans* people access care and care for one another despite living in an uncaring world. In answering this question, my research follows past scholarship from Gray (2009), asking

what are the conditions under which trans* care work is made necessary and what might be the implications for trans* politics and activism.

In exploring the way care produces trans* people, my research draws from institutional spaces of trans* care and non-institutional relations of care enacted by trans* people in digital space. I have collected data on two different digital spaces where care relations are enacted; 1.) websites directly linked to trans* care providers and professional organizations and, 2.) YouTube videos created by trans* and gender non-conforming people. My methodologies, which are informed by past research on digital space (Gray 2009, Thein and Brooks 2014) and the work of trans* scholars (Stone 1992, Doan 2010, Spade 2011) include critical discourse analysis as well as moments of auto-ethnographic reflection.

My findings re-affirm academic and popular knowledge that has characterized the trans* care landscape as uneven (Stone 1992, Bauer *et al* 2013). By including YouTube videos and conceptualizing care of the self as a mode of care, my research speaks back to previous work on trans* care, which has focused on uneven access in terms of institutional, Cartesian and place-based conceptualizations of care. Building on thinking of care in a place-based sense, my research makes an important link between conceptualizations of trans* people as legible subjects and care access. My research points to how the de-legitimation of trans* people as subjects, who can consent to and frame the terms of their care needs, has worked alongside a neoliberal logic of care to further exceptionalize trans* care and trans* people that makes care access uneven across different embodiments and positionalities. Concurrently, my research also points to the

importance of non-institutional spaces of subjective production as a form of care and, when networked, potential space of visibility.

Taken together, my research sets out the groundwork for incorporating a geographic perspective into critiques of the trans* care system. By laying out the different scales involved in trans* care a more careful critical analysis of the current trans* care paradigm can be formulated. Furthermore, my research points to the importance of subject formation in care provision—that the conceptualizations of who is being cared for plays an important role in not only setting out care relations and practices but what sorts of life are cared for and about. Alongside of this critical project, my research highlights the importance of caring for the self as a form of subjective production. This caring for the self, when enacted across multiple spaces that are networked and visible, comes to form new subjective possibilities where trans* people have a more active role in defining who they are, what their bodies mean and what a full life entails. Finally, and perhaps most importantly, this project sets out new directions in trans* research. In my concluding remarks, I begin to ask how a radical trans* politics can be formulated that addresses immediate care needs without tethering trans* people to the medical and institutional spaces that have consistently limited who we (as trans* people) are and our possibilities in the world.

CHAPTER TWO: LITERATURE REVIEW

As noted in the introduction, while care geographers have addressed intersectionality and difference in care and its political ramifications, there is scant literature directly addressing trans* care geographies. This is despite the existing literature from trans* people (Stone 1992; Spade 2007; Doan 2010; Feinberg 2010; Stryker 2010) documenting the paradoxical and contentious relationship trans* people have with care. In an effort to bring these literatures together, I will first outline past work from geographers on care and care politics pointing to the ways subjectivity is defined through care provision. Building on this I will bring in critical trans* scholarship in order to address the lack of trans* perspectives and voices on the work from geographers of care and care politics. Here, my aim is to point to the ways that incorporating a geographic perspective that critically engages with care politics and biopolitical processes that define life can re-invigorate trans* scholarship with through a multi-scalar and relational approach.

In doing so I will also pull out two processes of the production of and governance of the self, narrative and disclosure, that have not been widely discussed in work on care geographies. Finally, following past work on digital geographies, I will address how care relations are enacted in digital space by putting together past writing on the politics of digital space as well as critical scholarship on the way bodies and subjects are produced through digital relations. Taken together, my research asks care geographers to take up the questions and paradoxes of trans* lives and pushes trans* scholarship to think critically about the ways life is defined through institutional and non-institutional relations of care.

Conceptualizing Care

Feminist engagements with social welfare have critiqued the reliance upon and assumption of a unified and normalized subjectivity that can be cared for (Young 1990, Tronto 1993, Kobayashi and Proctor 2003). Specifically that those in need of care are othered against the norm of a rational, capable citizen-individual. In this logic of care, needing social services, needing care indicates an internal flaw, which is often mapped onto the individual bodies or group identities of those who have been systematically disenfranchised and often violently dispossessed. In critiquing the notion of an autonomous, liberal subject feminist theorists have pointed to the ways that all individuals are implicated in relations of care (Tronto 1993) Far from being an autonomous, closed system people are dependent upon the existence, labour and care of others (Tronto 1993 and Taylor and Vintges 2004). This work has problematized taken for granted notions of who is cared for and who does care work. In response, authors have reframed care as practice, relation and action (Milligan and Wiles 2010) rather than a principle or causal result of a particular place or relation. By delinking care from particular locations, embodiments and interactions, care theorists have opened care up to include a broader set of relations and practices.

Thus, for the purposes of this research I am conceptualizing care as practice that relates the self to others. As Tronto (1993) states, care is:

“... a species of activity that includes everything that we do to maintain, continue, and repair our ‘world’ so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.” (Tronto 1993 p103)

Implicit in Tronto’s work is that care necessarily links together different spaces and places across spatio-temporal scales. Key for the context of this research project is that

care is always a relation, or practice; far from occurring in isolation or in a dyadic relationship, care connects places and spaces in visible and invisible ways (Milligan 2000, Milligan and Wiles 2010). Care constitutes the practices and relations that give lives meaning—caring relations are ones that produce the system of possibility for our bodies and selves to exist, to count and to flourish. Far from being a simple ‘counting’—care, in Tronto’s conceptualization, necessitates that we act and build relations that allow us to exist now and into the future. Where we imagine care to be occurring, and who we imagine to be caring for and doing care work has important political implications, which I will return to in this chapter.

Extending Tronto (1993) further, taking care as a relational brings different assemblages of bodies, subjectivities and identities into contact. Indeed, an essential part of care and building a caring world is connection and multiscale interaction and visibility. In conceptualizing care as relational, care then includes the production of bodies, subjectivities and identities. While Tronto continues in *Moral Boundaries* to develop an ethic of care situated in caring for and about actors, it is important to note that care in and of itself does not casually link to a moral or prescriptive end. By exploring the ways we care for and about ourselves and others, Tronto asks us to care across spatiotemporal scales in ways that push against care as a discrete or acute moment.

Given the pervasiveness of care, and its variable visibility, geographers have used care as an approach in examining relations and contradictions across place and space. Geographers have contributed to this complication of care by providing theoretical interventions (Milligan 2000, Lawson 2007, Lawson 2009) and contextual, empirical work that highlights the multiple places and spaces of care with sensitivity to context and

connection (Brown 2003, 2004, Atkinson 2011). While these approaches have shifted across sub-disciplines, many critical human geographers have been particularly sensitive to 1.) care work and its associated meanings and theorizations and/or 2.) uneven geographies of care and care provision.

One particularly important intervention made by authors researching uneven care geographies has been work that examines shifts in conceptualizations, spaces and relations of care alongside political and economic transitions (Green and Lawson 2011). Of particular interest is the ways in which care has been discursively and materially changed with the roll out of neoliberal governmentality (Brown 2004). As care has entered the market, geographers have been particularly interested in the effect on how care relations are formed, conceptualized and enacted (Green and Lawson 2011). Geographers have contributed to this body of work with important insights into the individualization of care (Atkinson 2011), removal of care standards (Brown 2003, 2004), gendered and raced care labour dynamics and the effects of uneven care access (Brown 2004, Green and Lawson 2011, Wiles 2011). In researching uneven care access, research has focused on divisions in care labour where definition of care needs, or entitlements, and the actual practice of care are separated both spatially and temporally (Milligan 2010).

Further interrogations into this division of care labour situates this labour division within a wider pattern of neoliberal welfare rollback and circuits of capitalist labour restructuring and globalization (Brown 2004, Sothorn 2007). The re-drawing of where and when care takes place implicates new bodies and subject positions into care work as both carers and the cared for (Atkinson *et al* 2011). By asking where care takes place, and

examining the places where care is thought to or supposed to take place, geographers have problematized care in a way that challenges taken for granted ontological framings of care. While care is implicated in normative moral and ethical meanings, geographers have interrogated the power of care provision and decisions regarding who is to be cared for and how. For example, Green and Lawson (2011) convincingly argue that care implies a vertical social ontology in which entitlements and needs are determined by others. These ‘determining others’ are rarely those who directly perform care work—instead, care work is stratified and reproduced not only by the bodies being cared for but by those who do care work (England 1993, 2010). By presenting care as neutral and natural, the gendered, raced and colonial aspects of care’s genealogy are erased and oft repeated (Taylor and Vintges 2004, Green and Lawson 2011). Thus, not only is care invisibilized, it is also differentially experienced and perceived across spatio-temporal scales (Milligan 2010).

Despite the ways the cared for can refigure needs (Stone 1992, Thein and Casino 2012), care often connotes a relationship in which one is dependent on another. In this relation of one-way dependency, the person who is cared for is set outside the bounds of being an autonomous, liberal subject. As explained by Green and Lawson (2011): “...concepts of care are implicitly founded on a specific theory of relationality in which the normatively autonomous individual is central.” (Green and Lawson 2011, p.232). When care is based on an autonomous, active care-giver it sets a limited field of practices and actions; care becomes tied to a binary of need and capability where the existence of one implies a lack of the other. Thus, what geographers have asked care scholars to do is consider the ways the space of the body and the subject are produced through care

relations (Atkinson 2011) and what implications those productive moments have for controlling and managing individuals and populations (Brown 2006).

By troubling care as a normative concept, new research questions and problems emerge in contextualizing and localizing care in particular relations and locations. One is the way care practices implicate subjects and bodies into relations that are complicated by different dimensions of identity and subjectivity (Stoler 1994, Brown 2006, Sothorn 2007, Foucault 2009, Spade 2011). Furthermore, as Lawson (2007) indicates these relations of care are often far from being ‘caring’ in any sense of what Tronto (1993) describes in *Moral Boundaries*. Increasingly, care is used in such a way that other-ed or abnormal bodies and subjects become tied in relations of state surveillance and investigation. In this vein, care has become an increasingly important aspect for governing at a distance while maintaining a seemingly close relationship to the scale of the body and individual (Foucault 2003b).

Governing Through Care

While past work has looked into the ways care and care work has produced colonial and post-colonial subjects (Stoler 1994, Morgensen 2011), work on the way care produces other sorts of subjects and how those mechanisms of production are refuted and reworked remains limited. This is despite recognizing the normative power of care and care ethics in producing understandings of particular populations (Rose 1989, Foucault 2003b). As both a concept and practice care is full of moral and ethical meanings that lend it a particular sort of normative, biopolitical power. Tronto’s work suggests a more critical albeit normative stance regarding care, however Tronto stops short of considering the multiple subjects that care and care work produced. Here, literature from medical

sociologists and philosophers like Nicolas Rose is instructive in further teasing apart the power of normativity in care claims alongside the rise of personal responsabilization and self-governance (Adam 2005).

Drawing several different genealogies of medical science, including the ‘pys’-sciences, Rose (1989) argues that biopolitical power has seeped into a multiplying set of strategies and technologies of the self. These strategies and technologies, which Rose maps onto new and existing governing machinery, solicit self-governance as a key conduit for biopower. In tracing different technologies of self-governance Rose argues that biopolitics includes a diverse assemblage of strategies that have responsabilized individuals into governing themselves along a moral and ethical horizon (Rose 1989, 1999). Key for Rose’s later work is the multiplication of medical and pys-science based knowledges that produce a particular relationship between the self and biology that allows for a unique moment where traits are mapped onto the body for management and control through the scale of the individual, community and nation. (Rose 2007, 2013).

These strategies and technologies, which Rose maps onto new and existing government machinery, make the governing of the self a key conduit for the control of the population through normalization and discipline. For Rose, governmentality works through universal notions of what it means to be human, what it means to be a liberal subject by individualizing processes that solicit governing the self against an increasingly rational and coherent norm of humanity.

Following Foucault’s lectures on governmentality (Foucault 2003, 2009), Rose traces how a seemingly united field of body and self, or the uniting of the material and mental spaces of self works to govern behavior and bodies (Rose 1989). Arguing against

the idea that ‘belief systems’ of the self are indicators of particular cultural moments or evidence of a place based world view, Rose situates these conceptions of the self as produced through institutionalized and technological practices. These practices and technologies stretch across and through traditional knowledge structures including medical, political, economic and spiritual ones. The production of individuality, or a type of self, is produced and reproduced through these knowledge structures. In this sense, the link between the self and body (or lack thereof) is one tool that produces a sense of self that is discrete and governable.

Stretching this further, it may be the case that chasing after examples or theory that seeks to united the self and the body may be doomed to repeat this separation instead of destabilizing it. As previously discussed in this chapter, the normative power of a ‘unified’ self has also been critiqued by feminist scholars working through Foucault’s later works (Taylor and Vintge 2004). Notably for this project, Valverde’s explanation of the relationship between self and truth is complicated by re-imagining the political potential of multiple truths, multiple selves and thus multiple possibilities of an ethical self: “...promote a less ‘deep’ and serious sense of self, a more pragmatist, flexible, de-centered, less territorialized ethical self.” (p71). While it is worth considering the in-place implications and privileges of being ‘ethical’, reading Valverde alongside Rose prompts taking up the political and ethical possibilities of self-narration and the production of the self.

Rose traces notions of self-knowledge and legibility in the context of Christianity’s spiritual discourses of the self. Touching on technologies of meditation and diary writing, Rose traces how the pious individual was universalized and individualized.

As elaborated on by Rose, this process was at once normalizing and disciplining: “Discipline not only consists in a way of organizing social life according to rational thought, exactitude, and supervision, it also embraces a mode of personal existence within such practices.” (Rose 1989 p226). The body is normed along a horizon of the self, or how it should relate both to the self and other bodies, while it is also disciplined into the very material practices associated with norms of rationality and civility. Set against this horizon of rational choice and civility, the individual is made to be a whole self through exercising free choice by stringing together various decisions that constitute a legible, full human life. However, Rose is careful to set this active, choosing self against a multiplying and diverse biological field where difference and non-normativity is increasingly mapped onto the body.

The geography of these moments of normalization and disciplinary action seem particularly important and politically relevant considering past work from care geographers. The normalization, even naturalization, of this concept of the ‘choosing’ and maximizing individual self hides the way past relations and existing structures work to make the experience of self uneven. Where these processes of normalization and naturalization occur, as well as where they slip up, is an important empirical intervention to be made using Rose’s work—one that this project seeks to do with trans* subjectivity and care relations in digital space. While not specifically addressed by Rose, this unevenness in experiencing self-governance can be mapped across different shifting spatial scales from the body through the nation or region.

In the final chapter of *Governing the Soul*, Rose traces how technologies that seek to unite the field of body and self work to govern behavior and bodies. While Rose offers

little by way of direct theorization or inclusion of the body in his discussion of governing the self, he seems to see the body as a material or site where self-governance technologies are imbricated and embedded:

“The body has simultaneously become the diagnostic object and clinical intermediary of a range of new holistic therapies, the means of access to and transformation of the alienation, repression and fragmentation of the self in modern times.” (Rose 1989, p217)

For Rose the body is space where the self is constituted, where the self is worked on and fragmented into parts. In this sense, Rose builds on Foucault’s work, which highlights the norming and naturalizing power of linking conceptions of the self, or behavior to a biological or embodied ‘reality’ (Foucault 2003a 2003b). However, Rose extends this further—noting, but not providing detail, on how we understand our selves through technologies and languages connected to embodiment.

Arguing against the idea that ‘belief systems’ of the self are indicators of particular cultural moments or evidence of a place based world view, Rose situates these conceptions of the self as produced through institutionalized and technological practices. These practices and technologies stretch across and through traditional knowledge structures including medical, political, economic and spiritual ones. The production of individuality, or a type of self, is produced and reproduced through these knowledge structures. In this sense, the link between the self and body (or lack thereof) is one tool that produces a sense of self that is discrete and governable.

Here, the lack of detail regarding how these technologies of the self-work across different spaces is troubling. Surely, the ability to self-narrate, disclose and communicate oneself to others differs across different spaces and places. While Rose seems to acknowledge that this was the case in opposing the figure of the monk or pious individual

as compared to the general population, he does not elaborate on how these technologies are universal but also refigured and extended through their uneven application to different bodies and spaces.

Taking Rose's work alongside that of critical geographers writing on care, the provision and practice of care emerges as an important place where human subjectivity is produced and power is reproduced through a logic of self-governance. Exploring when, where and how care makes, or unmakes, intelligible subjects is a powerful pathway of animating care politics in both a critical and productive sense. Critical in the sense that we can better understand the way material practices and places produce particular subject positions and productive by exploring alternative processes and spaces of subjective production where bodies and positionalities are given meaning and possibility. While this interpretation of care politics is not far from a matter of resource provision, it asks us to question how decisions are made regarding who's care needs are worthy and under what systems of logic and meaning these needs are recognized.

Thus, bringing more empirical and geographic specificity to the notion of self-governance and governmentality is an essential project in understanding the ways that self-governance is unevenly experienced and mobilized across spatio-temporal scales. In doing so, the political potential of Rose's work can be re-assessed—far from being a smooth plane of governing power, the instability of taken for granted systems can be exposed and reworked. It is in these moments of slippage, where technologies of the self are used in normative and contradictory ways, that we can begin to reform and re-invigorate processes with processes of complexity and specificity.

Care Politics

Past research has focused heavily on the gendered aspects of care—how care is feminized through a variety of different processes, including where it is placed (England 1993, Tronto 1993, Milligan 2010). As England has argued (1993, 2010), despite societal shifts in norms of gender care work is still routinely feminized thus entrenching notions of what bodies perform care work and where. While care geographers have made important interventions into care, few have explored the ways in which queer people navigate existing care systems. Notably, Michael Brown’s work on HIV/AIDS in Vancouver British Columbia explores the ways in which gay men were produced as diseased bodies, prompting figurations of gay men that mapped the epidemic onto gay bodies. In *RePlacing Citizenship: AIDS Activism and Radical Democracy*, Brown explores the relations, discourses and complications associated with this moment, showing the ways in which gay men internalized and reconfigured these discourses and practices (Brown 1997).

For the context of my research, it is important to note here that while there is existing literature regarding the relations produced under social welfare relations in capitalist societies (Gilligan 1982 Young 1990, Tronto 1993), there is less regarding the ways that care practices and social administration hinges upon a notion of a binary gendered human subject. While Gilligan’s work contains its own problems due to the way it reproduces and naturalizes binary gendered difference, what her book *In a Different Voice* points to is the way gender is expressed and performed through care work and being cared for. Thus, in many ways gender is produced by and policed through care spaces wherein norms of identification, legal name and gendered care provision exclude gender non-conforming and trans bodies (Spade 2004, 2006, 2011).

Spade's work on the administration of gender through state institutions points to how binary gender norms in care spaces results in a denial of critical services and care for gender non-conforming people including transsexuals and transgender people (Spade 2004). This lack of care is further exacerbated by intersectional race, class and sexuality oppressions resulting in a patchwork landscape of care and welfare for trans people. Considering that transgender and transsexual people face a much higher chance of abuse, criminalization, homelessness and violence (Transgender Law Center 2014) this lack of care is critical.

The exclusion of trans people and trans realities in these care spaces is nothing short of a crisis where trans* lives are valued less or else invisible in formal care spaces. Spade's work focuses on spaces that provide traditional direct care provision such as the clinic, homeless shelter and spaces of legal administration. However, drawing again from past conceptualizations of care as relational there seems to be an important and missing analysis regarding the non-Cartesian spaces of care and care relations. Specifically, how do trans* people care for themselves and each other outside of the institutional care spaces that have failed them?

Spade's work has been essential in opening up new spaces for political action and organization in trans* politics, however his work has not found traction in geographic research. This is despite the acknowledgement that, as Brown (2003) notes;

“...care is political precisely because it embodies issues typical of politics in a democracy; questions over the allocation of public resources as well as agonistic relations wherein equity, justice, obligation, and rights are lived.” (Brown 2003, p 835).

As is made clear through the above quote, care is a key pathway through which the liberal citizen subject is produced—care sets out the boundaries of the liberal subject by

deeming who is worthy of care. Determining which lives and which bodies are counted and given resources to flourish is a key biopolitical power in managing life—in making live and letting die (Foucault 2003a). This delineation of who is not worthy of care, or not legible as a citizen-subject and part of the governable population, has very real implications for those outside of these boundaries. In a recent US survey of trans* and gender non-conforming people 19% were refused routine medical care due to being transgender, 50% reported having to educate their care provider and 48% postponed care because they were unable to afford it (Transgender Equality 2011). This clearly points to an inequality in care that has a direct effect on the lives of trans* and gender non-conforming people. In being beyond care, or having care needs that are imagined to be excessive and thus not real, trans* and gender non-conforming people are told that their bodies and subjectivities do not fully count.

Trans Subjectivities*

The relationship between trans* people and trans* scholarship is a contentious one, with past work critiquing the objectifying effects of over theorization (Namaste 2009) and a lack of sensitivity to the everyday lives and oppressions trans* people encounter (Stone 1992, Doan 2010). This is in no small part due to the relationship between the academy and other institutional spaces (eg. medical, judicial, carercal) and can also be traced to the lack of trans* people in academic spaces (Doan 2010). Past ethnographic work from Valentine (2009) has laid the groundwork for intersectional and sensitive understandings of trans* people and their identity positions, however little work has investigated what it means to be trans* beyond an identity category. The lack of research into what it means to be trans* has left being trans* or transgender as a static

identity position rather than a dynamic and moving subjectivity. As a result, trans* people are often understood solely as institutional objects and frequently cast as victims and limited to studies regarding transphobia and its effects (Brown 1995).

For the purposes of this project I will focus on conceptualizing trans* as a subjectivity or subject position rather than as an identity. I am roughly adopting this from Foucault's later work on 'care of the self', for Foucault the subject is a networked space or form that consists of multiples as opposed to one, singular coherent 'self' or substance. As he clarifies:

“Undoubtedly there are relationships and interferences between these different forms of the subject; but we are not dealing with the same type of subject. In each case, one plays, one establishes a different type of relationship to oneself.”
(Foucault 1998 p290)

The subject then, whether trans* or otherwise, is the result of a continuous process of identity construction that stretches across multiple spatiotemporal scales. Additionally, Foucault is pointing to the way that subjectivity shifts depending on where and under what conditions the subject is being produced under. In this way, there are multiple spaces of subjective production as well as multiple relationships to the self, multiple subject positions an individual can occupy. While not explicitly stated here, based on Foucault's past work (2006), occupying and establishing different relationships to oneself occurs within pre-existing systems of meaning and power—thus, these relationships to the self are not entirely new. However, what Foucault seems to be suggesting in the above quote is that identifying and establishing multiple relations to the self is one strategy of complicating or slipping away from a single subjective meaning that is essential in neoliberal governmentality (Miller and Rose 1998, Foucault 2009).

Institutional spaces have been particularly important places where trans* people have been routinely defined as a particular sort of subject. Authors and scholars from a range of different disciplinary backgrounds have described and discussed the fundamental paradox that trans people encounter in institutional care spaces (Stone 1992, Butler 2004, Spade 2011). Gender affirming care, specific medical care that includes technologies like hormone replacement therapy and surgery, often requires diagnosis (Butler 2004). This is particularly the case in the United States where diagnoses like gender dysphoria (formerly gender identity disorder or GID) are often required in order to access care that is increasingly expensive and prohibitive both in terms of cost and geographic distribution.

Thus, in order to access care, trans people are required to work within a medical system that requires a process of diagnosis, pathologization and intense bodily surveillance. As discussed by Butler (2004), even in the best of care circumstances, trans* people are often implicated in a care system that is based on and embedded in normative, binary notions of gender and gender expression that deny or overwrite trans* people:

“It subscribes to forms of psychological assessment which assume that the diagnosed person is affected by forces he or she does not understand. It assumes that there is delusion or dysphoria in such people. It assumes that certain gender norms have not been properly embodied, and that an error and a failure have taken place. It makes assumptions about fathers and mothers, and what normal family life is, and should have been. It assumes the language of correction, adaptation, and normalization. It seeks to uphold the gender norms of the world as it is currently constituted and tends to pathologize any effort to produce gender in ways that fail to conform to existing norms (or, fails to conform to a certain dominant fantasy of what existing norms actually are).” (Butler 2004 p76)

When seeking care, trans* and gender non-conforming people are slotted into teleological care relations that seek to produce a unified, coherently gendered citizen-subject. This process of production, as suggested by Butler (2004), requires that trans* people are problematized and made to be in need of a specific type of care. These relations work on the scale of the individual trans* person in ways that fragment bodies and identities but also on the families, relationships and worlds that trans and gender non-conforming people live in.

This process of diagnosis carries an especially problematic history for trans* people—the ways trans people have been medicalized and pathologized has worked to discipline gender non-conforming people into preconceived notions of gender and sexuality (Stone 1993, Doan 2010, Spade 2011). These processes of medicalization essentialize and compartmentalize trans people into particular subject positions has profound impacts on the way trans* people, particularly youth, view their own identities and subject positions (Gray 2009).

Conversely, as Doan (2010) explains care practices that acknowledge the multiplicity of gender expression and messiness of being in the world allow for different relations to self: “...facilitated by a therapist who eschewed gatekeeping and encouraged me to explore the multi-dimensional and non-dichotomous identity I was experiencing.” (Doan 2010, p232). In this sense, Doan’s (2010) account of her transition adds to the group of trans* people who complicate taken for granted notions of trans* care narratives (Spade 2004, Feinberg 2007). It is becoming clear that trans* people strategically navigate care landscapes, seeking care spaces that eschew models of gatekeeping and require normative trans* narratives or explicit pathologization (Stone 1992, Spade 2004,

Doan 2010). Instead of pathologizing or problematizing trans* identities, these practitioners avoid terms and practices embedded in historic models of trans* care that sought to reform gender non-conforming identities into binary categories of maleness or femaleness. This process, as Stone (1992) argues, has denied the subjective existence of trans* people—of the existence of transgender and transsexual as not a medical category but a living, breathing subjective place that is not in need of curing.

Comparing Doan's (2010) account to reports from the Transgender Law Center (2011) the trans* care landscape is clearly uneven. While there are care practitioners who actively engage and grapple with the gender norming tendency of trans care, these spaces the exception, not the norm. Often times, in a similar vein to former 'gatekeeper' models (Spade 2004), these spaces of non-norming trans* care are focused around an individual or small group of care practitioners that are located in urban centres. Furthermore, due to constraints on diagnosing and issues around insurance coverage, most of these care spaces are inaccessible to most trans* people whether due to cost or location. This uneven access to care has very really biopolitical implications for the lives of trans people who are further marginalized by intersectional race, class, gender and sexual identities. Again, Dean Spade's (2010) work is particularly instructive here; marginalized trans people tend to have minimal access to gender confirming care while also being subject to further interaction and relation with institutional spaces, that through administration and management of social welfare, effectively police normative conceptions of gender by disciplining trans* and gender non-conforming people.

In Spade's book *Normal Life*, he uses systems of gender identification that rely on medical intervention as one example (Spade 2010). By requiring surgery to change

gender markers on identification documents, gender non-conforming and trans* people are placed in potentially violent situations each time they are required to show identification. This violence spans from actual physical harm to further surveillance and body knowledge through excessive questioning and explanation. On a number of different scales, trans* people are asked to conceptualize, explain and rationalize their bodies and identities—from intimate person relationships to interacting with state social institutions, trans* people are often expected to provide more information and subject to more scrutiny and surveillance than gender conforming people.

Furthermore, most governmental and non-governmental service agencies require identification to order to access welfare and care which is often provided in gendered spaces. One such example includes shelter systems which are typically gendered by biological sex not gender identity. The result of such policies is that, for example, a transgendered woman has not had or do not wish to have medical care (which is often a normative gender surgery such as vaginoplasty or ‘bottom surgery’) may be denied services or access to shelter.

Connection to Care Politics

Following work from critical trans* scholars and queer activists, there is a need for work exploring the lived experiences of trans* people. For authors like Namaste (2006), focusing on descriptive explorations of the way trans* bodies and identities present remarkable limits to the human or pathways for describing gender norms further places trans* existence and experience as exceptional and objectifies trans* people. Study of trans* bodies and identities with little regard to trans* voices, experiences and

responsibility to the trans community continues historically problematic relations that trans people have with academic spaces and knowledge.

However, following the work of Young (1990), understanding different identities and subject positions is an essential political project:

“The dissolution of cultural imperialism thus requires a cultural revolution which also entails a revolution in subjectivity. Rather than seeking a wholeness of the self, we who are the subjects of this plural and complex society should affirm the otherness within ourselves, acknowledging that as subjects we are heterogeneous and multiple in our affiliations and desires.” (Young 1990, p124)

In Young’s explanation of a ‘politics of difference’ she pushes against a political project that requires a unified self or subject. Instead, Young emphasizes that our being in the world is one of difference from the scale of the self through the community and city. Consequently, her politics of difference asks that we look anew at how the self and subjectivity are produced and governed. Instead of requiring a single subjectivity, Young demands that we acknowledge our differences rather than attempting to find common ground under the assumption that such a common ground is possible or desirable. Key here, is that Young does not demand that we fully understand or examine difference for the sake of intellectual curiosity or ‘celebration’ of multiculturalism; rather it is a long process of understanding the self and how we are made through relations with each other. Furthermore, and more implicitly here, Young asks us to consider producing the conditions of possibility for our difference—how do we build a society in which difference and multiplicity is not just recognized but affirmed and valued?

As previously mentioned, there is a clear past tension with trans* subjective production and academic knowledge. One only needs to reflect on the excessive protections and restrictions placed on trans* people as a study-able population on ethics

board research proposals to skim the surface of the complicated relationship between trans* people and academic knowledge assemblages. For many institutional research ethics boards, trans* people represent such an overstudied population, that empirical research on trans* lives and trans* people necessitates further documentation and consent (Knopp *et al* 2011). While these ‘protections’ may well be in place to prevent potentially damaging and objectifying research, these policies create further barriers in conducting rich, situated and empirical knowledge on trans* lives that incorporate trans* voices. Taken as such, current institutional academic framings and understandings of trans* people preclude important work exploring trans* experience and subjectivity that refutes the notion of the vulnerable, risky or needy trans* body. This project attempts to critically address one space of trans* subjective production (institutional care spaces) while exploring another digital space of subjective production by trans* people themselves.

These misinterpretations and damaging conceptualizations of who and what trans* people are have long been pushed against by trans* people themselves. Stone’s (1992) *The Empire Strikes Back* is one particular example that also speaks to wider trends in trans* scholarship that focus on narrative. Writing against transphobic radical feminisms, Stone addresses the ways in which transsexuals are disciplined and normed into certain types of narrative that requires in-depth examination of the body and knowledge of the self. This knowledge is conceptualized as being embedded within the transsexual person and in need of extraction and verification by medical and expert understandings of transsexuality. Stone shows that the non-normative bodies and selves of transsexuals are subject to different standards and potentially violent processes of self-narration. Stone argues that medical discourses on transsexuals have placed transsexuals

against a horizon of normative gender and denied the existence of transsexuality as a subjectivity in and of itself. By only allowing access to care through discourses and technologies that emphasize gender conformity and binary gender normativity, Stone argues that transsexuals are disciplined into gender conformity—with damaging effect to a transsexual politics of difference.

Furthermore, Stone shows the way that the transsexual subject position has been produced through both medical and self-authored narratives of transsexuality. Despite being seemingly discrete worlds of knowledge production, Stone shows that these two spaces of transsexual narrative are very much in conversation with one another. Narratives of transsexuality are repeated in medical discourse of what it means to be transsexual while at the same time, transsexuals are disciplined into repeating these narratives in their interactions in spaces of medicalized transsexual care. As a result, narratives and conceptions of who transsexuals are and who they ought to become circular and self-fulfilling.

Stone suggests that this circular process has erased the possibility of transsexual subjectivity, of a transsexual self and body in favor of a securitized and bounded transsexuality set against the back-drop of normative gender and sexuality. Not only does this limit and discipline gender non-conforming bodies and selves, compartmentalizing gender non-conformity to transsexual bodies denies the ways that all bodies and subjectivities do not conform to normative gender expressions or embodiments. Pushing this to an extreme, we could think of transsexuality as a boundary space where gender is securitized and policed so as to constitute rational, legible gender throughout the population. This boundary space is meant to be a place of movement, of transcending one

gender and moving into another. In this process of migrating from one gendered embodiment to another, the relation of a past self to a present and/or future self becomes uneven. Thus, Stone points how the transsexual self is made not only through fitting to particular narratives of what a transsexual is, but also a process of erasing and refiguring how one relates to a past self. Here, reading Stone alongside Rose complicates our understandings of technologies of the self as Stone shows how narratives are disciplining in the way they erase dimensions of the self in favor of a united or legible subjective field. Again, the uneven nature of technologies of the self is particularly important as transsexual bodies and subjectivities are governed through processes of erasure, silence and rewriting.

Stone charts medical narrative as well as literary narratives written by transsexuals showing the ways these different texts work with and against each other. Both of these types of text seek to narrate and interpret transsexuality—connecting transsexual subjectivity to embodiment and biology in an effort to produce a governable subject. Where these narratives are produced and imagined to occur is one method by which they produce transsexual subjectivity. Both medical and self-authored narratives of transsexuality cite the space of the clinic or doctors office as a key place where transsexual body knowledge and subjectivity is produced. For Stone, the ‘intake interview’ at the clinic was a particularly important space where individual transsexuals experienced the full force of a disciplining and norming apparatuses of transsexuality where experts were positioned as the sole decision makers regarding access to gender reassignment surgery. Here, slippages in expert knowledge and ‘patient’ knowledge become particularly striking as exchanges in narrative work with and against one another.

Another dimension of spatiality emerges in the way that the transsexual narratives in *The Empire Strikes Back* refer to interior and exterior selves. Specifically, there is a recurring theme of separate selves and dissonance between self and body: “Partly what emerges from the book is how Hoyer deploys the strategy of building barriers within a single subject, strategies that are still in gainful employment today.” (Stone, p157) As indicated here, the traffic between medical and transsexual narratives results in an exchange of technologies of discipline and normalization. These exchanges further reproduce and entrench spatialities of the self that discipline transsexuals against a normative gender binary. These moments of translation and repetition are important ones in which certain technologies, selves and embodiments are naturalized and reinforced.

Online Narrative

As Stone (1992) has shown, there is important traffic between literary trans-narrative and medical knowledge. However, given that Stone’s piece was written over ten years ago it seems important to explore how has the production of trans* subjectivity shifted. Since my research is writing against medical and institutional subjective understandings of trans* people, I will briefly explore recent scholarship on digital narrative—a topic that will be elaborated on in my methods chapter. Here, more recent work from researchers exploring the ways social relations are produced and reproduced by digital and online space is an instructive way forward. Work from Gray (2009) has pushed us to consider how identity work occurs through online spaces and with digital tools. For Gray (2009), identity work constitutes the systems of meaning queer youth use in order to understand themselves as individuals and members of a wider group of LGBT and/or queer communities. In her conceptualization of identity work, Gray situates this

process within the context of queer youth care by citing statistics regarding the vulnerabilities and violence queer youth face. For Gray then, the queer identity work that the youth in her ethnographic work undertake is a matter of determining the value and possibility of life—in other words, it is tied up in the biopolitical future of young queer lives.

Similar to authors like Del Casino and Brooks (2014), Gray conceptualizes online communities and technologies as constitutive of a place or space of self-formation. One of Gray's key critiques, which maps onto critical debates in care literatures, is that queer politics needs to untether queer or gay identity from a particular place or space. Gray asks us to consider how narratives of what it means to be queer are tied to place, movement and mobility. While Gray focuses on the networks of information and knowledge that queer youth access in understanding and working on themselves, similar to Stone (1992) there is a process of erasure for some of the youth as they are governed by normative understandings of who and where queer people are.

In her findings, Gray argues that many queer rural youth form their individual and collective sense of what 'queerness' is and where they are situated through online 'identity work' as well as through more traditional sites such as the home, school or support group. Thus, in Gray's work the interactions of systems of meaning produced on and offline become a key site for understanding queer identity work. The way the youth in Gray's ethnographic work perform 'queer identity work' makes space for their identities and bodies to exist—in a way this work makes them possible both as individuals and as members of a larger group.

In a similar vein, I am interested in asking what sorts of care work is being undertaken online by transmasculine identified individuals. In doing so, my aim is to critically explore the conditions under which this care work is taking place both on and offline. This project also draws from recent research examining the relationship between care, embodiment and subjectivity. Here, the work of Parr (2003), Del Casino (2014) and Del Casino and Brooks (2014) is particularly instructive as they draw from digital evidence in understanding how care relations produce subjects and bodies.

In *(Un) Healthy Men, Masculinities, and the Geographies of Health*, Del Casino and Thein (2012) explore the relationship between masculinity, subjectivity and care. Specifically, they examine how discourses of masculinity in online spaces of HIV/AIDS care map onto particular meanings and care practices. One of their key findings was the way particular websites used confession-style narratives to construct HIV positive men as visible and responsible for their HIV status. Del Casino and Thein point to the way normative understandings of masculinity, through discourses of ‘taking ownership’ and ‘reporting your status’, map onto a neoliberal logic of care that responsibilizes individuals based on their status. Thus, HIV status becomes a key identity marker that men have a duty to ‘take care of’ as individuals because of their community ties to the LGBT or queer community. The men on the website are expected to be visible and make their care for themselves legible to others as responsible men who are members of a wider community. This points to the ways in which self-governance occurs through practices that govern individuals across and between several different ideas of what the ‘population’ might be.

Taken together, my research fills several gaps in the care literature. First, it aims to re-situate the way care produces certain subjects and visibilizes and invisibilizes those subjects across different places and spaces. As outlined in this chapter, while past work has addressed the way that care produces what it means to be human, through biopolitical processes of subject definition and life management (Rose 1989, Brown 2003, Foucault 2003b), care research has yet to critically include trans* and gender non-conforming people in their analysis. This is despite the work of past scholars (Stone 1992, Spade 2006, 2011) who have pointed to the relationship between the production of trans* subjectivities and care spaces. In particular, the work of Spade (2006, 2011) has pulled out the way trans* people experience care as policing, uneven and disenfranchising having very real biopolitical effects on trans* lives. Most of this work has been from auto-ethnographic or biographic academic (Spade 2006, Doan 2010) and non-academic (Stone 1992, Feinberg 2007) sources. As such, my research builds on past work to further current understandings of the role of self-narration in producing trans* subjectivities and trans* lives.

Furthermore, as I have pointed to here, care thus far has been heavily conceptualized in institutional spaces, or formal care spaces, with limited (but growing) attention to understanding how care exists and is enacted outside of these locations (Parr 2003, Del Casino and Brooks 2014). By drawing on past work on digital space (Gray 2009) and the work of narrative (Rose 1989, Foucault 2006) my research directly addresses this gap in current understandings of what makes for caring relations and where care occurs by asking how trans* people care for and about one another through digital spaces. In sum, my research addresses these gaps in the literature by asking what care

work trans* people are undertaking in digital space, and, under what conditions are these care relations taking place?

CHAPTER THREE: METHODS

In answering my research question, of what care work trans* people undertake in digital space and under what conditions, I adopted two different methodological approaches. These two approaches, which I will outline in detail in this chapter, were 1) critical discourse analysis of websites and YouTube videos and 2) auto-ethnographic reflection and analysis of my own experience as a trans* person accessing gender affirming care. After laying out these two different modes of observation, I will detail my method of data collection and analysis with attention to past scholarship and conceptualizations of digital spaces.

Mode of Observation

Two modes of observation were used for this research project; discourse analysis and auto-ethnographic reflection. Since my research is situated in digital space, I am following past work that has used discourse analysis to analyze websites and YouTube videos (Sumiala and Tikka 2011, Rose 2011, Meek 2012, Del Casino and Brooks 2014). Since my research question is exploring how care work is enacted through digital space and under what conditions, using discourse analysis allowed me tease apart the multiple variables and dimensions that produce trans* care (Babie 2006). Rather than counting instances, this mode of observation aims to trace out the system of possibility or what meanings and practices produce care and caring relations for trans* and gender non-conforming people. This mode of observation is also suited to address my question about under what conditions this care work is taking place. Far from being isolated to a discussion of only ‘digital’ care, using discourse analysis as my mode of observation will

uncover what sorts of work these videos and websites do in the lives of trans* people and what sorts of possibilities they signal and generate (Babie 2006).

Research using YouTube as a field site is limited, however researchers from communication studies, computer science and geography have all explored YouTube as a unique space of interaction, connection and data accumulation (Longhurst 2009, Garrett 2011, Sumiala and Tikka 2011, Meek 2012, Del Casino and Brooks 2014). Work from Sumiala and Tikka (2011) includes in-depth analysis of representations of violence on YouTube and its networked nature—the repetition of violence on YouTube occurs, in part, through comments and discussion between users. Far from being a single visual moment, the way the images are repeated and networked produces their ontological power and crystallizes their permanence.

Critical geographers have begun to analyze the relations and practices occurring on and through YouTube with specific reference to its spatiality and place making potential (Longhurst 2009, Garret 2011, Meek 2012, Del Casino and Brooks 2014). Work from Longhurst (2009) examining pregnancy on YouTube revealed the norming tendencies of user uploaded videos of birth and pregnancy. Specifically, Longhurst's (2009) research found that YouTube videos provide a sense of connection and dialogue for pregnant people and their families, while representations of the body and normative narratives of pregnancy further heterosexual norms of reproduction. In her exploratory work on pregnancy and YouTube, Longhurst used discourse analysis to conceptualize and understand how bodies and subjectivities are produced, normalized and reproduced—a question that this research project also aims to answer.

Building on this work, Garrett (2011) argues that YouTube videos can be conceptualized as artifacts and evidence of discourse. Created by users living in real time, in different contexts they provide a window into particular lived moments while also being implicated in wider circuits of group identity and community on and offline. More recently, Del Casino and Brooks (2014) conceptualize YouTube as:

“...not a free-standing autonomous and virtual space; it is a dynamic site through which various discourses flow, are temporarily sedimented, and reimagined. As such, YouTube is just one node in a much more complex and contradictory network of socio-spatial relations that allows us a glimpse into our ever-increasingly techno-social world.” (Del Casino and Brooks 2014 p16)

Similar to previous conceptualization and theorizations of space (Lefebvre 1991), YouTube is a space that is produced and reproduced by material practices, meanings and imaginations. The relationships, connections and networks present in YouTube videos are produced and reproduced by discourses operating both on and off YouTube. Individual videos then are units of analysis or discursive traces in conversation with an uploader and potential audience. Thus, for digital researchers a video or individual website is not meant to be ‘representative’—rather they point to different operative and explanatory meanings. Furthermore, samples from YouTube are always non-representative because of the impossibility of obtaining a random sample from YouTube due to their algorithmic search system. Rather, videos from YouTube give a non-representative sample similar to a more traditional snowball sampling methodology.

While not in the scope of this research project, there is little research into why users choose to use YouTube or produce videos. Clearly, there is a textual and format difference between YouTube and other digital media formats. Aside from the video format, YouTube has built in tools for networking, communication and curating. Users

can link to other videos, form ‘channels’ with other users, comment on videos and ‘like’ or vote up videos. However, because there is limited research exploring why users choose YouTube as opposed to other online or offline formats this project cannot directly speak to why, more broadly, users created videos on YouTube. While some clearly used YouTube to show particular body parts or bodily changes, such as voice changes or surgery results, it is not in the scope of this project to fully tease apart why trans* people use YouTube. Despite this some conclusions regarding why trans* people use YouTube can be deduced based on how they use YouTube and the normative formats of the videos coded as related to trans* topics and trans* care.

For this project, using auto-ethnography directly links my research to past work using autobiography and auto-ethnography in trans* scholarship (Stone 1992, Spade 2006, Doan 2010). The use of personal narrative for this project is also motivated by the way the YouTube videos, as units of analysis, are somewhat diary like in textual format. Using auto-ethnography as a mode of observation alongside discourse analysis places my project in past research while also addressing gaps in digital and trans* care scholarship that has focused on institutional care spaces (Bauer *et al* 2009) or individuals without working between these scales to tease apart their interactions.

For the purposes of this project I am taking auto-ethnography to be a mixture of autobiography and ethnography:

“When researchers do *auto-ethnography*, they retrospectively and selectively write about epiphanies that stem from, or are made possible by, being part of a culture and/or by possessing a particular cultural identity. However, in addition to telling about experiences, auto-ethnographers often are required by social science publishing conventions to analyze these experiences.” (Ellis *et al* 2010, p4)

This style of research includes moments of reflection and self-analysis that invigorate my research project with narrative and experience. By including my own experience and reflections in this project I situate myself as both a researcher and a participant—while our experiences may be individualized, I both interact with trans* care systems and the narratives of the trans* YouTube users that make up my research.

Extending this further, the choice to include auto-ethnography in my methodology is also prompted by the work of Gray (2009) and Longhurst (2009) who have asked digital scholars to insert themselves or otherwise critically engage with the way digital space produces material space. For Longhurst (2009), who explored YouTube videos on pregnancy and birth, the way the body is represented and situated on YouTube was a particularly striking finding. In her article “YouTube: A New Space for Birth & Quest”, she urged geographers and digital scholars to look for the way digital spaces produce bodies—the visual component of YouTube and its potential for creating networks of conversation and debate around a particular topic. Rather than conceptualizing digital space as without embodiment, or body-less, Longhurst’s work asks us to consider how digital spaces norm and produce systems of meaning for bodies to count. Inserting my own narrative and body into this field is one response to Longhurst’s critique of digital geographic scholarship.

Units of Observation and Data Collection

This research project draws from three different units of observation and, thus, three different units of observation. First is a set of publicly available websites of trans* care clinics, organizations and community health spaces. Following the first mode of observation outlined in the previous section, websites were collected over the course of

three months using a non-probability snow-ball sample using Google to search the following terms: “transgender care”, “trans clinic”, “ftm care”, “ftm health”. While these terms are not exhaustive, they provided a pathway into snowballing the total sample size to thirty unique entries (n=34).

Using a non-probability sampling technique was appropriate here as I am not seeking to produce a representative sample—rather, as my research question is exploratory in nature, I am tracing out the overall network of trans* care through these institutional websites. Additionally, since I am interested in exploring how these websites are networked using a snowball sample with multiple starting points or search terms is a useful sampling method for my analysis (Babie 2006). Searching for “transgender care” returned 58,200,000 results, “trans clinic” returned 21,500,000 results and “ftm care” returned 3,910,000 results. I will refer to this set of websites as ‘institutional websites’ for simplicity in the rest of this section. The search terms were developed alongside my literature review of relevant trans* scholarship, as well as my own personal experience as a trans* person accessing gender affirming care.

YouTube videos were my second unit of observation, where individual YouTube videos were collected for observation and analysis. According to YouTube’s website, “YouTube allows billions of people to discover, watch and share originally-created videos. YouTube provides a forum for people to connect, inform, and inspire others across the globe and acts as a distribution platform for original content creators and advertisers large and small.” (YouTube 2013). Thus, the YouTube videos used in this project represent volunteered videos that are known by the users to be publicly available. YouTube includes video content uploaded by users, comments and forum discussions

between users and preferred or ‘liked’ videos chosen by users. For the purposes of this project, I have chosen to focus only on the videos themselves and not the dialogue and connections between different users. While I did record information regarding the date uploaded, view count and number of comments I did not record or analyze exchange between users.

Founded in 2005 YouTube is relatively old in technological years, however there remains limited research into YouTube as a technology or as a data site. In a similar fashion to the institutional websites, I used a non-probability snowball sample for the YouTube data set using searches in YouTube’s interface. Using the terms ‘ftm care’, ‘transmasculine care’, and ‘trans care’ I sampled and snowballed to forty videos (n=40). Because of the exploratory nature of my research question, this sampling technique is best suited for tracing out the systems of meaning, norms and subjectivities produced and enacted through the YouTube videos (Babie 2006).

Again, my sample for YouTube videos was not meant to be representative or statistically significant as my research question is not seeking to produce generalizable ‘results’ or use statistical tools for analysis (Babie 2006). Rather, I am interested in exploring what care relations are being enacted and what sorts of bodies, subjectivities and meanings those relations produce (or not). In this sense, my mode of observation and analysis directly address the exploratory nature of my research and my effort not to produce a singular meaning of what trans* care is, but rather how care comes to produce trans* people in diverse ways.

These videos were chosen based on the order they appeared in the YouTube search engine with additional videos added by selecting videos on the ‘Suggestions’ bar

that links to related videos. The term 'ftm care' returned 9,930 videos while 'transmasculine care' returned only 75 and 'trans* care' had 462,000 results. Notably, the 'ftm care' and 'transmasculine care' searches returned mostly user created videos from individual uploaders while the 'trans* care' search returned videos from individuals as well as organizations, popular media and researchers. The videos and institutional website data entries were entered into Zotero, a cloud based reference system, for coding tags and field notes. This file was then exported into a password protected Microsoft Excel file for analysis.

The third and final unit of observation was my own experience has a trans* person accessing care. Following past research from trans* scholars (Stone 1992, Spade 2006 Doan 2010), personal narrative and auto-ethnography figure strongly in situating politicizing the personal and embodied experiences of trans* and gender non-conforming people. Furthermore, the videos themselves present a sort of ethical dilemma wherein I am (as a researcher) consuming and analyzing a particular type of digital narrative that is authored and uploaded by trans* people. While including my own reflection and narrative in this research is not meant to be an ethical escape, it does situate me in this project as a sort of participant-observer with key inside knowledge and insight into one trans* care narrative.

Units of Analysis

As previously outlined there are three different units of observation, which map onto three different units of analysis. These units of analysis are individual institutional websites, individual YouTube videos and my experience as a trans* person accessing care. For the purposes of this project, I am examining these units of analysis for evidence

(or not) of care relationships and caring relations. From the previous chapter, YouTube itself is not a landscape of care—nor is it a care space. Instead, it is the way transgender people use YouTube as a platform to discuss care practices and by caring for and about each other in their videos and interactions that constitute my coding of an instance of care. Thus, in coding these videos I first adopted a grounded theory approach in developing emic codes drawn from the videos themselves (Gee 2005); an approach used by other geographers doing research with YouTube videos (Del Casino and Brooks 2014).

Alongside a grounded approach to my analysis, I also drew analytical codes from two literatures—the first being the methodology laid out by Rose (1989) and the second from Tronto (1993)’s conceptualization of care quoted in the beginning of the literature review chapter (Table 1).

Code/Theme	Literature Drawn From
Problematizations	Rose (1989)
Explanations	Rose (1989)
Technologies	Rose (1989)
Authorities	Rose (1989)
Subjectivities	Rose (1989)
Strategies	Rose (1989)
Care For/About (Body)	Tronto (1994)
Care For/About (Self)	Tronto (1994)
Care For/About (World)	Tronto (1994)

Table 1: Table of preliminary codes drawn from literature

By using these two different literatures I was able to compare codes drawn from the two different data sites and develop a framework for moments of similarity and difference. These moments of similarity and difference, which will be further explored in the results

and analysis chapters, occurred between the different units of analysis as well as across emic and etic codes suggesting new findings and ways forward.

From the data collected from Google and YouTube, I created a database of websites for reference in a Microsoft Excel document to analyze the individual websites and videos. Following sampling, I went through each website and video roughly following Rose's (1989) method of analyzing the emergence and proliferation of techniques of self-governance. Rose's (1989) work was particularly useful for this project since it denaturalizes medical discourses and explores the movement of these discourses across different places and spaces. Following Rose (1989) I focused my initial coding on problematizations, explanations, technologies, authorities, subjectivities and strategies.

These codes were meant to be flexible and allow me to point to moments of coherence and incoherence in the logic of trans* care. This method of analysis follows that described by Gee (2005), which does not seek to claim objectivity or find a singular, discursive truth. Instead this method of critical discourse analysis seeks to:

“...not just to describe how language works or even to offer deep explanations, though they do want to do this. They also want to speak to and, perhaps, intervene in, social or political issues, problems, and controversies in the world. They want to apply their work to the world in some fashion... discourse analysis can illuminate problems and controversies in the world. It can illuminate issues about the distribution of social goods, who gets helped, and who gets harmed.” (Gee 2005 p9-10)

While my project does layout a somewhat descriptive, but critical, discursive analysis of the current trans* care landscape, it does so with the aim of problematizing this landscape and asking what are the effects of this landscape on of trans* people. This links back to my research question, which is interested exploring not only in instances or evidence of

care but how care, as a relation, comes to produce particular systems of meaning and possibility.

Since my project is also interested in exploring dimensions of care, Tronto (1993) was useful in operationalizing relations or practices that could be coded as care. Key here, and as evident in my literature review, is that these relations and practices of care are not mapped onto a moral or ethical schema. Instead, using Tronto (1993) here is meant to add further scalar sensitivity to my analytical framework that may or may not be picked up by using only Rose (1989), a weakness is Rose's work that was previously outlined in the literature review. Given the power of care politics in both theory and practice and lack of literature regarding trans* care, using the language of care is a potentially powerful way to frame my findings and leverage them in a way that can be used for tangible change in the lives of trans* people.

The websites were sampled and coded first—my units of observation were the individual webpages. In sampling and organizing these units I followed Rose's (2007) visual methodologies approach, a method used by previous scholars researching web-based documents and artifacts (Longhurst 2009, Meek 2012). The units of observation for this sampling group was the individual webpages, with each sub-page on a website making up a nested entry in my database. These pages were first scanned using a basic content analysis approach with an eye for the intended audience, location, type and services offered. Through this process, it became increasingly clear that notes regarding the genealogy of the different trans* care websites was a recurring piece of information presented and highlighted.

Since the purpose of the trans* care websites sampled through Google was to contrast the relations and practices of care occurring through the YouTube videos, these websites were collected and coded first. Following this, I sampled the YouTube videos using the search terms previously outlined to create a database of entries in Zotero, a cloud based reference system. Each entry included notes taken during the data collection and initial emic codes. Again, these codes included broad content analysis based codes such as intended audience, video format, number of views, date uploaded and number of comments. I did not read or analyze the comments on the videos—my units of analysis were only the videos themselves.

After creating this database in Zotero, I exported the file into Excel where I went through my etic codes drawn from the literature (Table 1). Keeping the codes separate per unit of analysis proved to be useful in tracing the differences and similarities in how institutional care spaces and trans* people conceptualized care. This analytical separation aided in teasing apart the different places involved in the current trans* care landscape, allowing me to map relationships, practices and shifting meanings. In operationalizing the etic codes from Rose (1989) and Tronto (1993) I sample coded five preliminary videos to develop a vocabulary of keywords (two of which can be seen in Appendix B). Following this, I used those keywords with the codes developed throughout my analysis process.

In structuring the results and analysis, my first step was to narrate the findings from the two different modes of observation which included a critical lay out of the existent trans* care system. Following this initial critical work that is grounded in data from my two research sites, I then approach recurring tensions in both the data and my interpretation of them as a trans* person and critical geographer.

CHAPTER FOUR: WEBSITE RESULTS

Institutional Spaces of Trans Care*

By sampling websites related to trans* care (n=34) I was able to trace out existing spaces and networks of trans* care. As previously discussed, this sample is not a complete picture of trans* care—nor is it intended to be. Instead it is a snapshot of the different places and spaces that make up trans* care. This sample also provides a rough sketch of the spatiality of trans* care in that it allowed me to map the ways these different spaces and places are related and connected through direct links and knowledge networks.

As described in the previous chapter, examining the ways these spaces conceptualize themselves and their relation to networks of knowledge operationalizes care as relational. Taking care as a relation, and not an inherent outcome of a particular place or space, moves away from a Cartesian mapping of the brick and mortar locations of care. By untethering care from a particular location this conceptualization demands for more comprehensive and careful understanding of care; one that does not assume a casual link between a place or set of relations and care. Conceptualizing care in this way demands that we consider the places and spaces that build the world we live in, ourselves and relationships to each other—or, how care produces subjects and subjectivities (Foucault 1998).

Following the sampling process outlined in the methods chapter, the websites were categorized into four different groups: 1. direct care providers; 2. professional protocols and associations; 3. mental health and peer support; and 4. advocacy and legal specialists. These categories are not meant to be exhaustive, rather they provide a useful

starting point for considering the spatiality of trans* care and the different assemblages associated with them¹. Furthermore, they represent the ways in which the websites placed themselves within the larger system of trans* care both as a practice and ‘emerging’ body of knowledge. In this and the next chapter, I will tease out the ways that these self-described care practices and relations relate to one another and map onto a broader horizon of trans* care and subjectivity.

Direct Care Providers

The first category, direct care providers, consisted of websites of gender clinics, specialists and community care centers. In this section, I will highlight how direct care providers imagined trans* people, connecting these subjective imaginations to the way they describe their care practices. These websites were associated with a particular place of trans* care that was often specific to an address. For example, out of all the websites, 76% were direct care providers that had physical address listed on their website. Additionally, these care providers varied considerably in the types of care they provided and how they conceptualized themselves within the broader context of national and international trans* care.

Some provided direct care for trans* people that focused on one particular type of medical care, such as hormone-replacement therapy. Others, typically the larger clinics

¹ It’s worth noting that the trans* care spatiality/network in this chapter (and the thesis more broadly) is predominantly situated in the United States and Canada. Trans* care has developed through important care practices and systems in other places in the world (notably Thailand), however the digital spaces of trans* care are predominantly tied to either clinical spaces or organizations operating in United States or Canada. While not entirely in the scope of this project, it’s worthwhile to link this to wider debates regarding the digital divide (Sui *et al* 2012) and the use of digital tools in different places and spaces—access to and cultural/social conceptualizations of what digital tools are and what their uses may be clearly play a strong role in the extent to which and information exchanged regarding trans* care.

and community health centers, provided a broader set of care technologies including therapy, needle exchanges, surgery consultations and referrals. Surgery was associated with individual surgeons and care practitioners who were often included through links or references. These links and references connected to private practices and large gender clinics associated with university research centers like the University of Minnesota Family Medicine and Community Health Center, which has a special Center for Sexual Health. Historically, these university centers were sites for early research on trans* and gender non-conforming people as well as surgical operations and treatment programs. In outlining their center's history, none of these university affiliated research centers connected their current practice to previous models and moments in trans* care in North America.

For private surgeons, who made up 17% of the website sample, services were described in text along with expected results, after care instructions and requirements such as letters of reference and pre-payment. Notably, none of the community clinics or gender clinics provided direct contact to surgeons. Instead, for surgery, they provided a referral service, which entailed directly contacting or providing letters of reference for those seeking surgical care. These references were based on quality of surgical care, availability of insurance coverage and geographic proximity.

Many of the care providers that offered an array of different care technologies and practices implied the multidisciplinary nature of trans* care. For example, one clinic described its care mission as: “increasing access to comprehensive, effective, and affirming healthcare services for trans and gender-variant communities” (Website #18). Providers, like Website #18, often noted the diversity of trans* and gender non-

conforming people alongside their commitment to multidisciplinary and comprehensive care. The language used by care providers worked to signal conceptualizations of who trans* people are and who may seek the care services offered. Thus diversity and difference, in this particular application, mapped the difference within the population or community of trans* people who visited that particular clinic onto the need for individualized care practices.

Diversity was a frequently used term amongst community clinics who linked diversity in the presentation and lived realities of trans* patients² to their multidisciplinary care practice. This link was often presented as one strategy in addressing the care needs of their clients and patients. The casual explanation was that because the identities and embodiments of their clients were diverse, then, ‘good’ providers offered an array of technologies and practices to solve those variable and individualized problems. This was reproduced in the standards of care, discussed in the next section, where multiple types of knowledge and expert authority were required to address the care needs of trans* and gender non-conforming people.

In descriptions of their multidisciplinary care provision, tensions and contradictions emerged regarding the scale of intervention for a particular care technology. Most of the providers suggested needing to use a flexible suite of care practices that intervene on individual bodies and/or minds of their trans* patients. Technologies such as Hormone Replacement Therapy (HRT), ‘top’ surgery and/or mental

² Patient was the most widely used term from the direct care provider websites with 86% using the term to describe the trans* people they cared for. Client was the other term used by direct care providers, with 12% using this term.

health counseling were regularly mentioned care practices that were aimed at caring for trans* patients.

While the emphasis was on caring for the individual, many care providers suggested targeting particular places as sites for curing or managing patient needs. These sites of intervention included the patient's sense of self or identity through mental counseling and peer support family, as well as the patient's body through particular gender affirming care technologies. Community clinics in particular were sensitive to the interaction between the individual and their surrounding community either linking to support groups and advocacy that the clinic was undertaking or regional services. Thus, many of the providers conceptualized trans* care as occurring across the various spaces and places that make up an individual person's life as well as across temporal scale from pre to post transition.

Taken together, the community clinic direct providers seemed sensitive to, or at least aware of, how intersectional identities and place work to produce care needs and concerns. For these providers meeting the particular care needs of their individual patients extended beyond the scale of the body and into the community to address the particular needs of their clients. This work of caring across and between scale comes through language around 'comprehensive care' and care technologies that work not only on the body of trans* patient but also on their internal self, personal relationships and surrounding community.

Despite recognizing interrelation between scales, individual care practices were fragmented in the process of caring for their clients and patients. This was reflected in the way care providers separated treatments into two main categories that addressed either

the mind or the body. This was outlined in mission statements and goals that sought to “make patients’ external presentation congruent with their internal self” (Website #11) or otherwise implied through organizing care technologies under headings such as ‘surgeries and hormones’ and ‘mental health’. While these technologies did often interact, in effect they set out and define the problem space of their clients and trans* people more broadly.

Many of the care providers used gender dysphoria, a term from *The Diagnostic and Statistical Manual of Mental Disorders V*, to describe and give language to their patients or clients experience and care needs. As that described by the DSM:

“For a person to be diagnosed with gender dysphoria, there must be a marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months.”
(DSM V 2013)

While it is not in the scope of this project to analyze the use of gender dysphoria as a diagnostic tool, or its shifting terminology and meaning over previous iterations of the DSM, it is important to note its use and application by care providers. Many providers used ‘gender dysphoria’ as a diagnostic tool for mapping patient experience onto bodies that connects to a particular suite of treatments, technologies and practices. Here, providers often seemed to be treating ‘the dysphoria’ or else managing dysphoria as an umbrella of experiences and affects expressed by their trans* clients.

Others, recognizing the term’s problematic and pathologizing genealogy, saw ‘gender dysphoria’ as a useful tool only for accessing certain types of care that are typically prohibitively expensive and inaccessible. Examples here include care providers who, alongside explicit reference to gender dysphoria, also provide consultation services for clients navigating the insurance and benefits side of trans* health. In this sense, gender dysphoria becomes a strategic tool used by progressive care providers in

consultation with their patients to access care. For many care providers the way they discussed and employed gender dysphoria in their care practice and descriptions was a signaling tool to potential patients and clients regarding how they conceptualized trans* people.

This represents a radical departure from the use of gender dysphoria as diagnosis for particular sorts of anxiety and stress attached to gender non-conforming bodies. In its use as a diagnosis, gender dysphoria works to name experiences as knowable symptoms and map them onto gender non-conforming bodies. This produces trans* bodies as individual, treatable spaces that can be manipulated, managed and intervened upon. In this application, gender dysphoria is used to individualize experience and place trans* individuals within a larger population of trans* people who are institutionally defined, clinically known, and medically treatable.

For care providers, gender dysphoria was either situated as a normative diagnosis or a politically important point of elaboration for providers to signal particular practices and conceptualizations of who trans* people are. Through their explanations and interpretations of gender dysphoria and diagnosis, care providers signaled to patients and clients how they understood their trans* clients. Thus, the use of gender dysphoria points to the way providers conceptualized trans* subjectivity through their interpretation of trans* care needs as well as past and present tensions between care systems and gender non-conforming people.

Another point of difference amongst the direct care provider websites was the way each provider positioned themselves in the historical context of trans* health and trans* politics. Many of the clinics situated their practice in the context of trans* justice

and health care reform by critiquing the lack of accessible, quality health care for trans* people. Others politicized their care practice by acknowledging past trauma caused by care places to trans* people, recognizing the complicated relationship between institutional care spaces and trans* people. This was often coupled with statements on trans* specific and intersectional oppression clients may face. Care providers associated with LGB health and community care were particularly sensitive to and aware of issues related to economic discrimination, sexual health and social justice. This was manifested not only in official mission and vision statements but also in the resources and links made to other websites and organizations.

Through these links and references, many of the care providers formed knowledge networks of trans* care that extended beyond individualized care for one trans* person. While the context of care provision was centered on the scale of the individual client or patient, the way care providers communicated their practices and networked with other providers situated particular clinics as authoritative. These links and references were to clinics in other cities as well as care and service providers in the same region or area. For example the Fenway Health website, a clinic in Boston Massachusetts, had a lengthy list of resources and localized services for potential clients or patients. This list includes services specific to youth, AIDS/HIV prevention, sex-workers, domestic abuse and shelter services and guides to navigating identity document changes and regional insurance providers.

Aside from addressing trans* clients and patients, links and referrals included education and awareness for providers and connection to advocacy and political groups working on national and international transgender rights. Taking this into account, the

care provider websites were variable in how explicitly political they were, with some positioning themselves within a broader movement for trans* justice based on their services or programming. The extent to which the care provider websites were politically active, in the sense that they situated their care work within the realm of trans* politics and activism, was communicated through advocacy work aimed at changing the trans* care landscape. For care providers, changes in the trans* care landscape meant increasing access and training practitioners.

Thus, to a certain degree, clinics that situated themselves as working with and for trans* people were often the most authoritative in the field of trans* care as they often developed their own standards of care and services that were tailored to the trans* community in a certain place. One particularly poignant example of this was the Tom Wadell Urban Clinic in San Francisco, which was initially a clinic for meeting the care needs of people experiencing houselessness or working in the sex industry. However, because of a need for trans* health related care, the clinic began to offer gender affirming care services. Without a clear model of community trans* health provision, the providers at the Wadell Clinic created their own standards of care and set of documents, all of which are publicly available on their website.

Standards of Care/ Protocols

Among the direct care providers standards of care or professional protocols were directly cited—echoing past and present imaginations of trans* care as a still emerging field of knowledge (Stone 1992). Here, I will outline the most cited standards: the World Professional Association of Trans Health (WPATH) and a newer standard of care that situates itself in direct opposition to WPATH, Informed Consent Access for Trans Health

(ICATH). WPATH's 98 page standards of care was cited by 88% of the care provider websites. Direct care providers cited WPATH to situate themselves as knowledgeable about norms of trans* care practice and their involvement in the "growing and advancing" field of trans* care. Alongside publishing standards of care, WPATH is a broader organization of "trans health professionals"—including medical doctors, mental health practitioners and researchers. WPATH was formerly known as the Harry Benjamin International Gender Dysphoria Association, switching to their current organizational name in 2001. Originally stemming from the work of Harry Benjamin, who researched gender non-conforming people in the early 1950s, the association has come to be an international group that seeks:

“...to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transgender, transsexual, and gender-variant people in all cultural settings.” (WPATH, 2014)

WPATH situates itself as an authority in trans* care through research, clinical practice and professional accreditation. The WPATH website serves to advertise conferences and meetings as well as enroll new members into the association for access to their publications, including their standards of care from 2011.

WPATH also serves as a one-stop location for an international listing of institutional authorities on trans* people. This list is only accessible to members indicating that this list is largely for other trans* medical-professional authorities. By going through the sign up form on the WPATH website, I was able to deduce that the list

included graduate students, health practitioners, academics and care providers³. All of the listed professions or occupations on the form required a graduate or professional degree of some kind and endorsement or recommendation from a colleague in the field as well as a history of publications and/or health practice. WPATH positions itself as both a historical and present authority on trans* care. Historical in the sense that WPATH emphasizes the role of its founder Harry Benjamin in the field of trans* care/studies and present in its enlisting of a new cadre of trans* researchers and professionals.

The coupling of standardization and professionalization produces an implication that trans* people are in need of specialized care that is outside of the capability of the present, 'normal' care system. This specialized care includes medical care as well as a paternalistic variety of advocacy that is specially supplied by trans* care experts endorsed by WPATH. Within their standards of care, WPATH emphasizes the need for care providers to be advocates for their patients by offering letters of reference and referrals to other medical authorities accredited by WPATH. As outlined in the literature review, trans* care needs are clearly not being met. However, WPATH does little to engage with a longstanding trans* political movement that has been critical of the very care standards and authoritative stance WPATH endorses and reproduces. Further, by viewing itself as a-political WPATH reproduces status quo conceptualizations of trans* care and trans* people.

While it is encouraging to see standards of care that begin to recognize the lived realities of transphobia and intersectional oppressions, the WPATH standards of care

³ Not only did one have to declare your medical-professional credentials through a drop down menu, references were a required part of applying for WPATH membership. Naturally, membership fees were due at time of sign up with \$180 annual cost.

conceptualize trans* people as individualized receivers of care that do not act in ways that re-build and re-shape the world around them. Conceptualizing trans* care as a one-way relationship between trans* people and care providers silences decades of work, writing and activism by trans* people (Stone 1992, Feinberg 2007 Doan 2010). This activism has sought not only to make trans* people legible as subjects to care institutions, thus making trans* people worthy of care, but also to re-write understandings of gender and the extent to which it is medicalized, pathologized and compartmentalized to only gender non-conforming bodies. Furthermore, as will be made more clear when I outline the results from the YouTube videos, it silences the essential care work that takes place outside of institutional care spaces for trans* and gender non-conforming people.

Broadly then, the way that WPATH seeks to build a more caring world is through further institutionalization of trans* health via academic and clinical knowledge. Here, as indicated by WPATH's membership restrictions, professional practice and academic knowledge are privileged pathways to being an authority on trans* care. In order to access WPATH's standards of care, membership is required with a requisite fee and screening process. Within the standards of care the tension between WPATH as a medical-professional organization, with its roots in objectifying institutional understandings of trans* people, and as an organization that seeks to provide care is evident. WPATH paradoxically recognizes past transgressions committed by the medical community against trans* people while simultaneously positioning itself as a leader in a more progressive and caring variety of trans* care.

This tension is most evident in the contradictory conceptualization of trans* subjectivity in WPATH's published standards of care. In WPATH's standards of care,

letters of reference from a mental health professional are recommended for accessing hormone replacement therapy. This recommendation occurs paragraphs after a broad introductory statement that being trans* is not a pathological medical condition. Despite claiming that being trans* is not a pathological condition, WPATH recommends that care providers use letters of reference from mental health care providers as a means of assessing a patient's ability to consent and commitment to accessing trans* health care technologies like hormones and surgery. In recommending the use of letters of reference, WPATH advances a trans* care paradigm that ties gender affirming care and trans* people to pathological conceptualizations of who trans* people are as well as understandings that trans* people are unable to consent to their own care and require specific sorts of expert knowledge.

Expert knowledge is not only imbricated in medical and academic expertise, which is removed from the lived experience of trans* people, but also in a conceptualization of trans* subjectivity that is pathologizing. It is pathologizing because it requires gender non-conforming people to submit to a mental health screening, implying that gender affirming care technologies like hormones and surgery connote an unstable or disordered person. This practice can be traced to past trans* care paradigms and, while now in a language of letters of reference, ostensibly serves the same purpose. Now, that purpose is described as covering liability and consent, a point WPATH's standards of care emphasize. Treating trans* care as exceptional and in need of heavily documented consent and liability further exceptionalizes and individualizes trans* people—which has very real implications on limiting care access for trans* and gender non-conforming people.

Furthermore, the process of screening and consent reproduces gender affirming care as exceptional, as an unknown field that is full of risk and in need to legal recourse in order to protect responsible care providers. This is partially, as stated before, due to the exceptionalization of gender affirming care and trans* people. In this sense, it is also linked to discourses and processes that constitute gender affirming care as experimental and new. Insurance companies who deny gender affirming care coverage cite the experimental nature of gender affirming care, effectively reproducing the experimental or ‘fringe’ discourses of gender affirming care.

While not directly cited, it is also conceivable that the individualization and excessive cost of gender affirming care makes research outside of institutions like WPATH less viable both socially and economically for medical practitioners and researchers. Finally, the idea of gender affirming care as risky and in need of thorough liability and consent documentation links to discourses that understand gender affirming care as an abnormal desire for bodily change as opposed to a care need. Here, legal consent stands in for covering a care provider who would (theoretically) be liable for forever changing someone’s body who may change their mind later on. In this case, those needing gender affirming care are required to demonstrate they fit the mold of a ‘true’ and ‘responsible’ trans* individual. Here, normative trans* subjectivity stands in as a sort of liability or risk coverage—trans* persons who can be understood as moving from one gender to another fit squarely in a world reliant upon enforcement of a patriarchal gender binary. To not fall into this teleology then, is to be a ‘risky’ trans* person—one who may not receive the stamp of approval from trans* care authorities and/or professionals to access gender affirming care.

While former models requiring ongoing mental health care alongside gender affirming care is no longer recommended standard practice, the antecedent model of assessment and monitoring remains intact. WPATH emphasizes that the initial appointment where a patient seeks care is essential for establishing informed consent, a process that evaluates the potential patient's knowledge of the risks and benefits of a particular care technology and ability to make an informed decision. Due to variable availability and quality of information on trans* care technologies, this step of informed consent is undoubtedly important no matter the care paradigm. However, the delivery remains embedded in historically pathologizing spaces and authority positions rather than at the point of care with the prescribing doctor or care provider.

As previously mentioned, WPATH's standards of care were cited broadly by care providers. Another standard of care that was returned in searches of trans* care was Informed Consent Access to Trans Health (ICATH). The ICATH website outlines its mission statement, point members to contact for information and activities to date. There is no information describing its historical genealogy or enlisting new members. Instead, the ICATH website is intended for trans* people who need access to gender affirming care and want to work with a care provider in their area⁴. The website describes ICATH in direct contrast to WPATH's standards of care with the homepage describing ICATH's model in one column as opposed to WPATH's. In their organizational description, ICATH uses language that situates their care practice in the context of past and present political work by trans* activists:

⁴ Notably, the only places where ICATH representatives are located are Seattle and New York City.

“ICATH promotes the use of informed consent as a recognized standard of care to support the ultimate well-being and autonomy for people who are transgender, intersex, and gender non-conforming. The ICATH model reflects the basic human right to self-actualization.” (ICATH 2014)

Here, unlike WPATH, ICATH openly acknowledges the way past paradigms of trans* care disconnected trans* people from making choices about their health and well-being. For ICATH, the pathway to ‘self-actualization’ for trans* people includes accessing gender affirming care technologies, which should not come at the expense of a sense of self and an undermining of an individual’s ability to make decisions about their body.

ICATH continues, describing itself “not an institution, an agency or an organization” but as a standard of care based on informed consent. Here, informed consent stands in for an agreement between the care provider and care seeker regarding the effects, risks and benefits of a particular care technology. Documents and resources on the ICATH website are provided as tools for trans* and gender non-conforming people to use in discussing individual care needs. In situating itself as a standard of care, ICATH is speaking directly to care providers in a way that addresses issues of risk and liability.

These documents are supplemented by training and educational resources for care providers, that push care providers to educate themselves about trans* care needs and to acknowledge that their patient are informed and aware. In using the language of a ‘standard of care’, ICATH situates itself as an alternative to WPATH—one that recognizes past and present tensions in the trans* care landscape: “ICATH promotes a departure from a system that uses gender dysphoria as a diagnosis, formally known at Gender Identity Disorder, as a means for accessing gender-confirming health care.” (ICATH 2014) In this description, ICATH recognizes that for many trans* and gender

non-conforming people taking on a diagnosis is the only way to access prohibitively expensive care procedures like surgery and/or hormones.

Thus, ICATH presents an alternative to diagnosis that seeks to situate the process of accessing care between the patient and care provider—in doing so ICATH de-exceptionalizes gender affirming care. The need for expert knowledge, multiple care providers or specialized care is not mentioned—rather gender affirming care is folded into ‘normal’ care provided by a direct care provider. The underlying argument here is that while diagnosis does offer access to care, the long term effects and production of trans* subjectivities as exceptional and/or abnormal have created an uncaring and uneven trans health care system. While not explicitly discussed on the ICATH website, links to resources and articles regarding health care lobbying and insurance reform seem to suggest that a potential pathway forward that de-individualizes trans* health responsibilities and care is advocating for comprehensive trans* health care coverage. And, as I will further elaborate, a recognition of the limits of medical care and institutional meanings of what trans* care is and who trans* people are.

Mental Health and Peer Support

As previously noted, many of the direct care clinical websites included mental health services such as therapy, support groups and peer advising. In addition to these clinics, another set of websites represented places that only offered mental health and peer support related to trans* people. These places were included within larger clinical practices, as well as being separately located in mental health specific care spaces, community centers, trans* advocacy groups and gender centers.

Many of these websites offered services that sought to connect trans* people either through discussion or peer led support groups. In emphasizing this aspect of working on the self within a group of peers, many of the websites cited the impacts of isolation felt by trans* people in transitioning as well as navigating the world as an out or stealth⁵ trans* person. Here, services and discussion topics ranged from talking about gender identity to advice on how to navigate insurance and administrative systems to switching gender markers and identification on official documents. From the service descriptions, these spaces of mental health and peer support often served as information nodes where authorities consisted of mental health professionals with past experience and trans* peers who were ‘further along’ in transitioning.

In discussing gender identity, many of the peer support groups and mental health providers emphasized developing tools and strategies for becoming “comfortable” in one’s gender. This discussion of comfort or working toward a feeling of belonging in one’s body was a common theme amongst this group of websites. For many, comfort was achieved by reducing anxiety and depression through work on the self alongside work on the body. While the technologies or practices were separated into self and body—the solution to issues of ‘discomfort’ was often disclosure or self-narration to get at some internal truth. Disclosure and self-narration in this particular context was wrapped up in language that pushed clients and patients to be their ‘true’ selves and to live full, authentic lives.

In contrast to the direct care provider websites, there was little discussion of diagnosis or use of the term gender dysphoria to describe participants. Additionally, the

⁵ Here, stealth refers to ‘passing’ as a cis-gendered and not disclosing or being visibly trans*.

use of terms like ‘patient’ or ‘client’ were dropped in favour of ‘group participant’ or ‘member’ indicating a more familiar or intimate relationship. This is counter to the detailed explanation of different mental health authorities in the WPATH standards of care and the websites of some care providers.

Legal and Advocacy

The final categorization of sampled websites included trans* law clinics and advocacy groups. I included these websites in my sample because they were often linked under the resource sections of the direct care provider websites. As previously discussed, my research on trans* care websites suggests that there is broad network of trans* care knowledge that traffics through digital and non-digital space. However, the way care providers situate themselves in the broader trans* political movement was variable across the different institutional lineages and clinic locations. While it is not in the scope of this research project, an interesting future project would be to explore the historical trajectories of these clinics with specific attention to the methods and types of knowledge exchanged between them.

Since many of the care providers linked to legal and advocacy sites it also suggests that many of the providers recognize the different administrative systems gender non-conforming people move through. In particular, that for many trans* people concerns like changing identity documents require documentation of care—often in the form of a letter of reference indicating that an individual has had a particular surgery. Furthermore, since many of the law clinics and advocacy organizations take an explicitly political stance on the obstacles and policing nature of these administrative systems, it places trans* health provision as part of a wider project of trans* justice and critical politics.

Direct care providers and mental health/support websites linked to these organizations as resources for clients as well as other care providers and medical professionals who may be visiting their webpage. When linked to or targeted at other care providers, these organizations were described as resources that could be passed along to clients as well as important tools for learning and continued education for care providers who may not be familiar with gender non-conforming people. Linking to these organizations as resources for clients suggests that a care need for many trans* people is understanding the particular set of oppressions and acting in ways to make those oppressions known. Being trans*, accessing care and making oneself visible was a key care practice that actively built a world where trans* lives were possible. Alongside a push for continued education and re-training that focuses on understanding what it means to be trans* and what care providers can do maps onto the shifting conceptualizations of who trans* people are and who they ought to become.

In this chapter, I have laid out a preliminary sketch of the landscape of institutional trans* care. In doing so, I have pointed to four main spaces where trans* care is produced, enacted and imagined—direct care providers, standards of care, mental health providers and legal and advocacy groups. In tracing out the trans* care landscape, I have pointed to some initial themes and processes that produce trans* subjectivities. While this initial mapping of trans* care is not exhaustive, it provides a broad contextualization for framing the YouTube videos that make up the upcoming second section.

CHAPTER FIVE: YOUTUBE RESULTS

Taken together, the YouTube sample includes 46 user created videos uploaded to and shared through YouTube (n=46). My first pass in categorizing these videos focused on the topics and themes discussed in the videos, and the way they are situated on YouTube. By this, I am referring to the ways that the videos are linked to other YouTube users through group ‘channels’, views, reference to other users and discussion of the YouTube community in the videos. To start I will touch on the care technologies discussed in the videos with reference to the previous chapter outlining the spaces and networks of trans* care from institutional websites.

Building on this I will then reflect on ways the YouTube videos, through their format and content, worked as video diaries where users disclosed information and narrated themselves. In my final sub-section I will pull out the subjectivities that were produced by trans* YouTube users, emphasizing the processes and strategies employed. Together, these sub-sections show how YouTube users experienced and conceptualized their transition and themselves as trans* people. These experiences and conceptualizations were diverse and non-linear, thereby pushing against a universal trans* subjectivity. More importantly however, the videos worked to make trans* care needs visible and networked—an important point that I will reconsider in my analysis of trans* care politics.

Care Technologies

A major focus of the videos was the different gender affirming care technologies users were seeking or accessing. The care practices and technologies described by the YouTube users shared many similarities to those outlined in the institutional websites.

Care technologies that changed the body, like hormone replacement therapy (HRT) and surgical care, featured strongly with 89% of the users referencing HRT or surgery directly. In these videos, users either discussed these care technologies from recent or present experience or outlined their plans and aspirations for accessing these care technologies.

For videos on HRT, testosterone was the main topic of discussion for the users. This included discussions of different hormone regimens and testosterone delivery methods including evaluations of injectable, oral and dermal testosterone. These evaluations often focused on the speed and types of changes users were experiencing in comparison to their personal transition goals and what they had seen for other trans* people. Videos on injectable testosterone, which was the most common both because of cost and effectiveness, injection sites, dosage amounts and timing were discussed. Several videos also described personal experiences with care providers and specific institutional care spaces. Videos on specific care places were targeted toward other trans* people who were beginning to access testosterone or enter institutionalized care as users evaluated and described their experience with care providers. Videos on testosterone ranged from before access, with videos outlining the process of accessing HRT and going through their decision-making process, to users who had been on testosterone for over five years. Videos also discussed the material aspects of HRT such as dosage amount, self-injection techniques and bodily changes with 19% of the videos providing direct advice on these topics.

In discussions of the bodily changes, most of the users understood testosterone as variable based on the individual taking it:

“I am a huge advocate of explaining that testosterone does not do the same things to everyone...It’s super hard to explain. But I can say that I am the same person. It’s been under a microscope, me paying attention to how I’m changing how other people change in reaction to me.” (Video 36)

Similar to the user in Video 36, users often prefaced their discussion of bodily change knowing that the audience consisted of people seeking to use or otherwise already taking testosterone. In the above quote, the user from Video 36 is speaking directly to a perceived misconception about HRT—that in taking testosterone you ‘become a different person’. Many users described changes to their emotions, gender, sexuality and relationships, all of which are important places and processes that form the self.

However, amongst the YouTube users there was not a universal agreement that in taking testosterone and transitioning one became a different self or subject. Rather, it seemed that many of the users understood that different aspects of themselves were changing—and with shifts to how they related to different aspects of their lives and world, shifts in self-perception and subjectivity seemed to follow. In accessing gender affirming care, almost all of the users experienced a heightened attentiveness to how their sense of self was changing, perhaps because of a bodily changes as the user in Video 36 indicated. However, there was a marked difference in the way that some users interpreted this process of change—a topic I will return to in my analysis chapter as it connects with notions of legibility and masculinity.

Amongst the videos, there was less discussion regarding mental health care. When mental health care was mentioned, it was often in the context of receiving a letter of reference or referral for access to either hormones or surgical care. However, one user noted how the process of making and uploading YouTube videos served as a sort of mental health care through building community:

“I’ve been following YouTube vlogs because they’ve been really supportive and helped me figure out some things. And I feel like I have a sense of community. And they’re all different—it’s sort of therapy online.” (Video 31)

For this user, the diversity in the YouTube videos they accessed played an important role in developing a sense of inclusion, or community in this case. The user in Video 31 also cites how this sense of community, one that is at once similar and different to their experience, provided space for them to further understand themselves during their transition. Instead of one singular conceptualization of who trans* people are, and how that conceptualization rationalized access to gender affirming care, multiple, situated examples that chart trans* people across different spatio-temporal scales emerges as an important factor for caring about trans* and gender non-conforming people. Thus, in the face of an uncertain institutional care system, seeing other trans* people and how they relate to institutional care technologies was an important strategy for producing a sense of self and subjectivity.

A handful of users compared the videos to therapy or providing similar care services. It’s unclear whether the users are comparing their involvement with YouTube to their own therapy experience or a broader notion of what therapy should do. In this instance this user was discussing coming off of testosterone as they felt like they had “lost” themselves after undergoing HRT: “Putting up videos helps me. It’s like talking to a therapist. It really really helps.” (Video 39). Similar to the user in Video 31, this user felt compelled to share this process because of their past involvement and investment in the YouTube community. Additionally, the user from Video 39 is suggesting that creating videos allowed them to chart their own experience in a way that was legible and intelligible to them. Considering the uneven and uncaring nature of institutional trans*

care system, producing and charting a sense of self in relation to gender affirming care does important work in forming oneself as trans* but not pathological.

As previously discussed, most of the users understood the effects of these care technologies as individualized and variable. Many users understood trans* care technologies as part of a wider set of strategies, technologies and methods for living a full life. Instead of a single moment of accessing gender affirming care, trans* YouTube users who understood themselves as trans* needed the space of YouTube to understand themselves as individuals and as trans*. While gender affirming care technologies like HRT were essential in addressing discomfort and anxiety, uploading and accessing videos on YouTube was a method for producing a trans* self that was not tethered to medical and institutional subjective definitions of who trans* people are. This understanding on HRT as one component in a larger story of being trans* is in tension with conceptualizations of HRT and surgery as magic bullets or ‘cures’ to ailing or pathological subjects.

This recognition of non-linearity was mirrored in how users understood the process of transitioning:

“Post-transition doesn't really exist. [It's a] journey you make for the rest of your life. Yes I'm on T. I made a physical transition and a social transition. But my life is constantly shaped by my trans experience. I can't divorce that from my day-to-day life. New problems arise once you start to transition.” (Video 26)

For this user, becoming or being trans* was not reliant upon bodily change or movement through a particular institutional care landscape. Instead, accessing gender affirming care was one strategy for living a fuller life. And, as the user from Video 26 indicates, transition is not a boundary space where an old self is erased and a new, legible one is produced at the end. Rather, being trans* is a place in and of itself—one that has a

particular set of problems and challenges.

As previously mentioned, this processual conceptualization of what it means to transition and be trans* was not universally shared. Other users understood gender affirming care as a technological strategy that moved away from an untrue or inauthentic past self. For the user in Video 27, unification of mind and body through trans* care technologies was the strategy for being comfortable and present in the world:

“The thing with being transgender or transsexual or whatever you want to call it, is that there is a big disconnect in my body and my mind. My mind is very masculine identified. I feel like I should have a male body but my body isn’t male in that sense. The one thing that seems to be holding back from comfort in my physical masculinity is my chest.” (Video 27)

For the user in Video 27, accessing surgery was one pathway toward reforming themselves by connecting their mind and body. For the user in Video 27, surgery works to align the gender of their body and mind surgery works to reform the individual trans* person, making them a full person again.

Alongside information about particular care technologies, 17% of the videos also provided information about the care system, as in the different places where trans* care is available. This information was passed in videos that detailed individual stories in accessing gender affirming care like HRT and surgery in particular regions or locations. For example, one user outlined their experience accessing HRT through the Centre for Addiction and Mental Health (CAMH) in Toronto Ontario. In describing their experience with CAMH, the user cites the different medical providers and places of care they passed through in order to access care that met their needs. This included the main CAMH clinic as well as seeing a counselor and endocrinologist. By describing their experience, this user provided specific information about CAMH and trans* care in Toronto, as well as a

general idea of how and where to access gender affirming care in an urban setting. For many users, there was uncertainty regarding where to begin—many felt uncomfortable or unsure about going to their general practitioners or else unsure about where to get competent and quality care. In this sense the information exchanged through the videos is not only knowledge specific to one particular place, but serves as a more broad and contextual mapping of what the spaces of trans* care may be like—a key response to the uneven landscape of trans* care.

This was also mirrored in videos that showed results and care for the body after surgery. The 26% of the videos on surgery focused on ‘top’ or ‘chest’ surgery, rarely using the medical terms of double incision or peri-areolar ‘key-hole’ surgery. Only three videos discussed hysterectomies—of those three, two framed the surgery in the context of a medical necessity because they planned on using testosterone long term and were worried about the ovarian cancer. The other user discussed how initially they considered surgery non-essential for their transition and that his focus was on top surgery and HRT access as those two care technologies were much more visible both in his community and at the clinic he went to.

However, once he received insurance coverage for surgical care getting a hysterectomy became a more immediate possibility. This indicates that medical treatment, in the form of hormones or surgery, is a more distinct and real possibility with insurance coverage—and may allow trans* people to make more situated and individualized decisions regarding what their care needs are. Gender affirming care becomes a possibility through insurance as coverage provides essential financial support and formal recognition of a care need. In one of his YouTube videos, he describes how he

realized the idea of his body having ovaries made him feel “dysphoric”:

“A lot more on my mind in the last few months. After you get top surgery, other dysphoria pops up. It’s not as pervasive or constant. But I still find myself daily thinking about the perks of it—I just never thought I’d feel dysphoria about it. I thought I’d get a hysto because it’s the safe and health way to go... Processing my dysphoria—more and more I think about the fact that without my shot, my estrogen is just going to kick back in again. I don’t know why I think about that, but I do. And I don’t feel good about that. I still worry about getting pregnant. I still get cramps. All of that is a huge bummer.” (Video 20)

Thus, with financial and institutional support for surgery, the user in Video 20 was able to address a care need that they had previously never considered because of the uneven and dis-enfranchising care system they were operating in.

Similar to the user in Video 20, YouTube videos cited the way that their initial understanding of a problem, or of themselves and who they wanted to be, shifted after accessing different care technologies. This was evident in care technologies that worked directly on the body, surgery and HRT for instance, as well as processes of coming out. In this sense, many of the videos served as places where users could narrate their experiences of being trans* and the ways their relationship to themselves and the world was (or was not) changing.

Video Diaries: Personal Disclosure and Self-Narration

As discussed in the methods chapter, videos were sampled using search terms in YouTube. While there was some diversity in gender identity (users self-identified as transsexual, transgender, FTM, trans*, trans*masculine, transman and genderqueer) 85% of the videos were produced by young (under 30 years of age) white transmasculine YouTube users from North America. Despite my focus on ‘care’ in my search terms, the majority of the videos had titles or topics that focused on personal experiences with

particular care spaces or technologies.

Videos were typically shot with the user taking up the majority of the frame, sitting or standing, talking to the camera. Some videos also used photographs blending together past pictures of the user in a slideshow showing bodily changes over time. Similar to past academic (Stone 1992, Spade 2006, Doan 2010) and non-academic (Feinberg 1993, 2007) work, these videos were autobiographical—presenting moments where the users were imbricated in institutional care spaces as well as the multiple other spaces and places that made up their lives. However, they differed from past textual examples of trans* narratives in the way many of the videos included in depth disclosure including moments of admission (to themselves or to a wider audience via YouTube) and discomfort. This, alongside the temporal element of the videos lends them a somewhat diary-like format where users used them to understand themselves and link together different moments through the production of YouTube videos.

Unlike a traditional diary, that is presumably only for oneself, the diary-like format of the videos was produced both for the self and the wider YouTube community, which was reflected in the way users produced introductory style videos. In these videos, users would describe themselves, their identity and gender affirming care regimen (whether already accessed or desired). Alongside introductory description, which contextualized and humanized the users as both trans* and as individuals, users would often state their purpose for uploading and creating videos. One common purpose was to track and chart changes to their bodies and selves—to create a space where they could link shifting relations together and understand themselves as a trans* person.

Introductory videos then, were key moments where users cited problems in their

lives alongside strategies and aspirations for who they wanted to be. For some users who they wanted to be was directly tied to accessing gender affirming care. As one user explained: “I feel like my life is on hold...I’m happy I’ve made my first appointment, but I can’t help but feel impatient about starting T [testosterone] and finally getting changes.” (Video #9). For this user, gender affirming care was an essential pathway toward not just living a full life, but to experience their life as ‘progressing’ or moving toward something. Here, life is interpreted as a space of movement, of forward progress into a body and self that is not yet here.

As previously stated, users often explicitly or implicitly rationalized making videos as a strategy of self-documentation and work that would allow them to chart changes and talk through their experience. For many of these users, accessing specific gender affirming care technologies like hormones or surgery were aspirations that became problems that needed to be carefully considered. Gender affirming care became a problem for users in the sense that some users felt pushed to consider or use technologies like hormones and surgery because they were trans*.

Here, users questioned the extent to which they were truly ‘trans*’ because of their previous understandings and imaginations of trans* people and how they related to particular care technologies. One user in particular doubted their need for gender affirming care because they felt they had not “earned their suffer stripes” (Video 13) or experienced enough doubt, strife and angst in order to warrant accessing gender affirming care. Because this user did not experience extreme discrimination, anxiety or discomfort, they questioned whether or not gender affirming care was right for them. In these moments, the YouTube videos are similar to the institutional care spaces as being trans*

is not necessarily beget or set in motion particular care technologies. However, previous models of care that tethered gender affirming care to trans* identified people in an effort to move from one gender to another still follows the subjective imagination of who trans* people are—both inside and outside institutional care spaces.

Whether explicitly titled or because of the content, the purpose of many videos was often to ‘document changes’ or chart transition progress. ‘Transition progress’ style videos included a description of bodily changes a particular user was experiencing at a certain point in accessing a specific care technology. This description took the form of the users updating YouTube by talking to the camera or through a montage of images and video showing physical changes over time. Physical changes, particularly those from users who were using hormone replacement therapy, were described both on the scale of individual change as well as how they changed how users interacted with other people and places in their lives. For these videos, testosterone was consistently mentioned as a care technology. While the bodily changes caused by testosterone have an expected range or result, the videos overwhelming emphasized changes in voice, hair, facial structure and muscle tone.

While bodily changes were explained in the context of trying to understand and interpret a self that was both familiar and unfamiliar, users also brought up bodily changes because of past YouTube videos on the same topics. This was mirrored in the way that users made their video titles about particular changes, or else, temporal update videos related to particular gender affirming care technologies. There also was a need to interpret bodily changes in light of what it means to occupy a masculine or masculinizing body as many users were taking testosterone to change their body. This relating of the

self to meanings of what it means to be trans* and masculine both on YouTube and in the wider world connects with past work that has written about the relational-self (Tronto 1993, Milligan 2010). Furthermore, it links with past digital scholarship that understands the use of and production of digital space not as a discrete moment, but as networked with processes on and offline (Gray 2009). However, what is not evident in past literature that emerges from the YouTube videos is that the users were not only attempting to understand themselves in relational to broader community and societal scales, but also in the context and in relation to a past self, current embodiment and emerging trans* subjectivity.

As discussed in the literature review, the gendered aspects of care and the production of self are important operative discourses that govern the possibilities for care as well as particular subject positions. Comparing the videos, the sorts of embodied and practiced masculinities on YouTube were varied. Some users expressed and described accessing testosterone as a key moment where they ‘overcame’ a more turbulent past and became whole, visibly male person. Others, through their series of YouTube videos, discussed the way their transition was a longer process that brought up unexpected physical and emotional changes. Rather than problematizing being trans* as a boundary space to move through, these users tended to see their transition process more as an unfolding. Thus, the way trans* YouTube users cared for and about themselves and each other used varying ‘gendered’ care strategies.

Many users understood their videos as ‘updates’—pointing to the way users often had multiple videos charting changes over time. Again, users that posted videos in this format seemed to interpret their lives as in progress, moving from less life to more life.

For many of the users, particularly those undertaking ‘introductory’ videos, these changes presented an exciting time when their transition process was finally ‘starting’. While some of the users had been making videos before accessing direct care like HRT or surgery, framing the start of their videos and documentation with the start of their transition emphasizes the importance of gender affirming care like HRT and surgery for trans* individuals. This importance is mirrored in the institutional websites, however the language around the goals of these care technologies differs. The direct care institutional websites understood gender affirming care as part of a suite of medical interventions used on an individual to manage or treat gender dysphoria. Conversely, for trans* YouTube users, gender affirming care technologies were something that marked a start to life and a new (and in some cases beginning) relationship to their selves.

Many users adopted the term gender dysphoria or dysphoria to describe their experience and explain their need for gender affirming care. Using gender dysphoria or dysphoria connected individual videos with other trans* people and worked to condense explanations regarding their relationship to their body. Interestingly, there was little debate or complication amongst the users regarding the use of dysphoria—none of the users found the term to be problematic or inaccurate. While some users did not use dysphoria as a citational term, when it was used dysphoria seemed to work as a past or present problem to be fixed by gender affirming care.

Whether directly mentioned or implied by discussing a particular gender affirming care technology, these videos documented changes to the self. By changes to the self, I am referring to how users documented changes to their bodies as well as how they related to themselves and to other people in their life. This included changes in

gender identity, sexuality, relationships with family, strangers and the spaces users moved through and produced. Again, this notion of changes to the self maps onto previous care literature that understands the self as networked rather than as an individual, autonomous liberal subject (Tronto 1993, Milligan 2010).

Users also frequently discussed how their transition shifted their perceptions of their gender identity, gender, sexuality and emotions. Videos on particular care technologies were never only descriptions of physical changes—rather they were a particular users description of changes and reflection regarding those particular bodily shifts. As one user remarked, since beginning HRT (specifically testosterone):

“I’m perceived as a young gay guy. I think I’m also perceived as that in trans* community. I’m not afraid of my femininity. I was when I first came out, but since I’ve started passing I feel a lot more comfortable with my femininity. That was one thing I wanted to achieve through hormones...” (Video 22)

Many of the users cited experiencing further comfort, less anxiety or fear around certain aspects of themselves or their environment after accessing certain care technologies.

Thus, while the act of accessing a gender affirming care such as testosterone or surgery marked a change to the body, it was often through the process of documenting and narrating these changes that users produced a sense of self.

As previously mentioned, this sense of self was counter to normative or expected notions of being trans*, being a man and/or being masculine. Users detailed challenges, emotions and struggles in an effort to connect with other trans* people but also for themselves. Thus, the videos produced a counter-narrative to the notion that transition is a singular moment or space to pass through. Similar to the work of Del Casino and Theirn (2013) masculinity, when cared for and being care about, often becomes coherent and incoherent with normative discourses of who men are and who they ought to be. In the

case of the YouTube videos, disclosing via diary like YouTube videos exposed the material and social relations users were dependent on in order to be in the world. While there was variability in how users conceptualized being trans*, which I will elaborate on later in this chapter, the users who understood being trans* and transitioning as a process rather than a barrier to overcome suggested a sort of ‘caring’ masculinity that is counter to the self-assured, autonomous man evident in Del Casino and Thein’s work.

Through process of describing their experiences and explaining them in the context of who trans* people are many users were able to situate themselves within the group of the trans* community as well as set out the space for linking together way they were experiencing different places and spaces. Additionally, 28% of the users also discussed how changes in body and self shifted or brought up anxieties around friends, family and partners. Often users would make videos pertaining to specific topics that other users were discussing or ones that they felt were not being talked about or expressed on YouTube. Topics that were raised under this pretense included videos that touched on changes in how users had sex over the course of their transition, which accounted for 13% of the total sample. Perceived norms in the trans* community were also discussed with 4% touching on perceived norms of race, 17% on norms of masculinity and 6% reflecting on sexual orientation.

While these video topics were the exception to videos describing progress or shifts, they point to the way that YouTube videos are positioned in producing and contesting trans* subjectivities. Specifically, these videos point to the edges of what it means to be trans*. Rather than being a boundary space of movement from one gender to another, trans* YouTube users express a variety of different genders, sexualities and

positionalities. What is particular to the trans* experience, and is reflected through the YouTube videos, is the extent to which non-normative constellations of gender and sexuality must be analyzed (whether by the self or an institution), networked and interpolated into broader communities and populations.

Many of the users described changes in their relationships as important components in understanding themselves. Specifically, as user in Video 17 explained, changes in their relationship to their family worked to produce themselves as a trans* person. Taken together, changes to the body, self and familial relationships do not map in a linear or hierarchical fashion for users. At different points in their lives and transitions, these scales and technologies were alternately problems in need of solving or key sites of caring. Despite variation in where problems were to be solved, similar to the institutional websites, YouTube users understood being trans* as an internal struggle. Internal in the sense that the problem of being trans* was conceptualized at the scale of the individual patient or client, to be overcome through bodily change.

Users that charted changes over time were aware of the potential bodily changes associated with different care technologies. This knowledge of gender affirming care technologies and bodily change was reflected in the clinical websites as well as past trans* authors who have discussed the important role trans* people have played in developing trans* care (Stone 1992, Feinberg 2007). In videos discussing bodily changes, many users also recognized that these changes are contingent on the individual—repeating some of the conceptualizations of trans* care technologies found in the institutional websites. Understanding their transition as an individual, and embodied experience triggered a sense of anticipation for many users, as well as uncertainty:

“It’s hard to facing transition, because there are so many unknowns. We don’t know what’s going to happen to our bodies, what we’re going to feel like, what other people perceive us like, what we’re going to look like and how our relationships are going to be effected.” (Video 30)

For many users, anxiety around what happens after accessing certain care technologies was addressed through viewing and uploading YouTube videos. By seeing and hearing emotional, physical and social changes, YouTube videos work to contextualize and provide examples of the effects of gender affirming care in representations that are situated and real then those from institutional care places.

Additionally, the videos documented changes in a way that provided examples of trans* experience that were not always linked to a diagnosis or medical term like gender dysphoria. For the users, the act of creating videos seemed to help manage changes in their lived experience and narrate their experience of being trans*. Thus, the videos represent moments where different meanings of who trans* people are and how they produce and are produced by space. Together the YouTube videos show the non-linear way that institutional care discourses work with situated experiences to formulate meanings of who trans* people are.

Similar to the institutional websites, the YouTube users and videos used citational practices in networking and connecting videos. Making individualized experience into a documented, transferrable sort of knowledge was a goal for many users. This was also evident in the ways that users acknowledged past videos as particular sorts of knowledge about trans* care and their own desire to contribute to that knowledge network.

Acknowledgment also came in the form of thanking past users and explaining their video as a way of ‘giving back’. While these videos can be thought of as a form of work on the self, a topic I will return to in the coming chapter, they are also evidence of a sort of

group or collective work. In networking individual videos and using similar vocabularies, the videos work to trace out the landscape of who trans* people are—what their problems, concerns, possibilities and means to live full lives are.

Producing a Self on YouTube

In all of the videos, there was a clear sense of the users speaking to a larger audience of both familiar and unfamiliar individuals. Often they would address the “trans* community”, “trans* YouTube community” or else specific YouTube users and videos. In this way, the YouTube videos were networked both in digital space as well as non-digital space by interactions between different users. This movement between digital and non-digital space maps onto past work that conceptualizes digital space as unique or static but as imbricated in the everyday and co-constituent of non-digital relations (Gray 2009, Sui *et al* 2010, Del Casino and Brooks 2014).

While it seems that many users did not meet up in physical space, the shared experience of visiting certain care places or familial situations worked to create relationships that carried through digital space and were technically ‘offline’. Further examples here include the ways that users asked for advice, gave advice or otherwise narrated their experiences. Exchanges of in-place experience and knowledge worked to form relations of proximity and care between the trans* YouTube users. Mutual exchange and reciprocity was often explicitly mentioned, as users cited the importance of ‘giving back’ implying that they had been viewing videos and found them useful:

“Since I’ve started to feel like I’ve wanted to help other trans people, been out for about 4 months, been living full time, passing pretty much most of the time and tried everything—all the different types of binding, STPs, haircuts, stuff to reduce spots. Just general things that people ask for advice about.” (Video 19).

Similar to the user from Video 31, the user from Video 19 cites wanting to join the trans*

YouTube community as they come into and claim themselves as trans*. In doing so this user positions their videos less as doing work on themselves and more as an act of care for other trans* people uploading or viewing videos. For this user, part of being trans* and understanding themselves as being part of the trans* community includes sharing care information and being a part of the ‘trans* YouTube community’ where other trans* people are.

One way that users placed in the trans* YouTube community was by positioning themselves as an authority on being trans*. From the above quote, the user in Video 19 does this by citing the amount of time they have been transitioning or out, as well as the different gender affirming care technologies they have used. For the user in Video 19, their experience, being ‘out’ and ‘passing’ mapped onto being able to give advice to other trans* people, who are presumably seeking to ‘pass’ as a cis-gendered person as well. This was a pattern seen across many of the YouTube videos—users who had more ‘experience’ or were out for longer, often spoke authoritatively on issues and problems tied to trans* people. While important, as it directly addresses issues of uncertainty and a lack of visibility, the information and advice from those videos tended to reproduce normative problems and concerns for potential trans* viewers. However, the way these problems are reproduced was not a direct copy of the institutional websites—rather they become contextualized and located in the individual lives of the YouTube users.

As previously noted, users often stated that their videos were meant to ‘give back’ or contribute to other trans* people and help with uncertainties, anxieties and discomfort. This speaking from a group, or speaking to a group that the users identified with, was evident by the way most users situated themselves across scale. Users would often move

from explaining their identity and embodiment in relation to conceptualizations of who trans* people are as a group, and then situate themselves within the trans* YouTube community:

“I am sitting in my bedroom right now. And I’m going to try to look at you and not at myself...I’ve been following YouTube vlogs because they’ve been really supportive and helped me figure out some things...But I wanted to make a vlog to become a part of this. Part of this FTM vlog revolution. And I’m beginning to make some changes around my life with transition and I thought it’d be cool to document these things and communicate with y’all out there and share this huge thing that’s happening.” (Video 31)

Again, users understood their videos as documentation for themselves as well as providing information for other trans* people. Thus, while the videos are a sort of ‘self-work’ or production of the self, they necessarily occur in conversation to the production of the group or larger community of who trans* people are.

Feeling a sense of connection and closeness with other YouTube users and potential trans* audience members was referenced by 58% of the users. These relationships were evident in the way users felt responsible to one another; responsible for the information they provided as well as being responsible for uploading with enough frequency and depth that those connections were maintained. The users in both Video 31 and Video 39 directly cited feeling a sense of responsibility to the trans* YouTube community. This responsibility hinged upon how their past experience with YouTube had unfolded, which for many was a positive one that allowed them to see other trans* people and obtain information about what it means to be trans*.

Interestingly, this responsibility to the YouTube trans* community often compelled users to share information about their transition as it was unfolding. One user (Video 26) in discussing their decision to stop taking testosterone because of depression

remarked that they “...don’t want to hide anything from you guys. You’ve all been so wonderful on this journey...” (Video 26). Despite not falling into normative conceptualizations of transition or trans*-ness, this user wanted to keep the YouTube community informed of their decisions and the reasoning behind them. For this user the care work required to transition included accessing gender affirming care technologies however, it also included understanding themselves as trans* outside of testosterone. For them, YouTube was one place where they formed a sense of self—both in narrating and placing themselves within the trans* category as well as connecting with and forming relationships through YouTube.

This responsibility to share information was also evident in videos from users who lamented the turnover and shifts in the YouTube community. While many users recognized that creating and uploading videos was a personal decision, others felt that longtime users had a responsibility to either continue making videos or otherwise let the community know when they were leaving:

“[I am] Stepping away from vlogging; I was definitely bummed, it’s hard to see people come in and out of the vlogging community. We become attached to their lives. Its hard but I think it’s a reality of vlogging. Its important to recognize that people feel a sense of loss...” (Video 32)

Through viewing and interacting with other users through comments, likes and subscribing, users on YouTube form relationships. As is made clear by the user from Video 32, the way that users detail their lives and include viewers in on their daily experiences bring users in closer proximity to one another. Some of these relationships matter deeply—they are relationships of empathy and care that otherwise are, perhaps, not available. The way the user in Video 32 laments the impermanent nature of YouTube videos points to the close relationships developed from the videos. Even if users are not

directly interacting with one another the level of detail and information exchanged in the videos produces caring relations where users care for and about one another. Producing a self that is cared for and about in the trans* YouTube community is contingent on both the quantity and depth of videos.

As previously mentioned there was diversity in the gender identities of the users (ranging from transmen, FTM, transmasculine, trans*, transgender and transsexual), there was very little variability in sexuality and race. While socio-economic class is difficult to tease out from a video, many of the users discussed the high financial cost of transition and surgery (n=31). Despite discussing the high cost, most of the users were able to access even the most expensive care technologies—even if some had to wait a number of months or crowdsource funds for surgery. In videos that discussed sexuality a handful of users identified as gay (n=3) or straight (n=2) with the majority self-identifying as queer (n=16). Visibly white users produced the overwhelming majority of the videos with only four of the total sample representing visible racialized minorities. The extent to which this reproduces whiteness and masculinity as normative in queer and trans* communities is an important tension; one that I will return to in my analysis of the findings. However, at this point, it bears noting that the self produced through the YouTube videos is very much the product of a particular set of intersectional privileges—privileges that map onto who has access to digital tools (Sui *et al* 2010) as well as privileges that map onto who trans* people are and what trans* bodies are visible and valued (Namaste 2009).

Taken together, the YouTube videos represent individual trans* people describing and narrating their experiences as trans* people. As I have shown here, the users in the videos directly discuss experiences with gender affirming care technologies and the

trans* care system. This exchange of information reflects an uneven care system that disenfranchises, discounts and pathologizes trans* people—in preparation for interacting with such a system (some) trans* people use YouTube to gather information and address uncertainty and anxiety around accessing care.

This is reflected by past research that has described and uncovered the close relationship between trans* people and gender affirming care technologies—far from being ignorant consumers of care, trans* people must perform research and self-work prior to accessing medical care (1992 Stone, Bauer *et al* 2009, Doan 2010, Spade 2011). In this sense, I have also shown here how trans* people use YouTube to formulate a sense of self. This sense of self, as outlined in the second sub-section, is individuated and deeply contextual. The trans* subjects produced on YouTube are not singular, rational subjects with expected relationships to their selves and bodies. Rather, the videos complicate institutional definitions of who trans* people are, who they ought to be and what strategies produce trans* lives that count.

In using YouTube trans* people are clearly producing a self that is oriented toward the wider trans* community. This positioning within the trans* YouTube community included relations of caring for and about other trans* people. Users, some of which were particularly authoritative because of previous experience with trans* care, provided detailed information about particular care technologies and places in order to address knowledge gaps and help other trans* people. While varied in the topics and problems they address, on the whole the videos work to trace out what being trans* means for the individual users. Thus, the videos point to the way that being trans* does not begin and end with accessing gender affirming care. For trans* YouTube users care

work, enacted here through individual videos that are networked together, involves understanding themselves as trans* and as more than their institutional, medicalized subjectivities.

CHAPTER SIX: *Imagining and Caring for Trans* Lives*

“I write because our lives are largely unwritten, and if written largely not self-written, and we need to textually, conceptually, and artistically (re)inhabit these previous places of absence and longing.”

- Ahimsa Timoteo Bodhrán (from Tolbert and Peterson 2013)

“It is the telling of these stories that makes our changes real and possible”

-Ariel Goldberg (from Tolbert and Peterson 2013)

In this chapter, I will first address the ways in which trans* care is imagined drawing from the institutional websites and videos. Building on past work from care geographers, my goal here is to point to a handful of operative processes that set out the field of trans* care in a way that limits the possibilities of trans* people and trans* lives. Specifically, I will draw from past care literature that has linked practices to a neoliberal care logic that has profound effects on the possibility and valuing of life (Brown 2004, Spade 2008, Foucault 2009, Green and Lawson 2011).

Using this literature will directly address gaps raised in the literature review chapter—namely, that while trans* scholarship has done important situated and narrative work, larger scale critical analyses of the trans* care system, how its imagined and how it imagines trans* people, remain limited (Bauer *et al* 2009). Drawing from the websites and YouTube video results, I will pull out the way imaginations of trans* care as experimental and requiring consent individualizes trans* care. This process of individualization, which employs different medical and legal language relates to past work exploring neoliberal care logic. What my work expands on is that this particular logic also necessitates and reproduces a particular trans* subjectivity. As outlined in the literature review, the way care provision and the conceptualizations of who is cared for

and for what ends has very real implications for living full, legible lives. In order to connect my analysis with the lives of trans* people, a missing component in current research *on* trans* people, I will connect the production of trans* subjectivity with the governance of trans* lives. Here, I will also include critical reflection of my own experience as a trans* person accessing gender affirming care in Seattle Washington.

From there, I will then trace out the importance of networked work on the self as form of care (Ball and Olmedo 2013). Drawing from Young (1990) and Rose (1989) I am conceptualizing the YouTube videos as critical sites of subjective production—while they are not cleanly non-normative or normative, the way they open up the possibility for different understandings and relationships to the self is evidence of a sort of care work. Pushing this further, I will reflect on what the implications are for considering the production of a self as care work for care political scholars as well as the broader trans* political movement.

Neoliberal Imaginations of Trans Care*

In this section I will draw out two explanatory mechanisms that connect trans* care to broader neoliberal restructuring of care. These two explanatory mechanisms are that trans* care is an emerging or experimental field of knowledge and, related, that trans* care requires particular kinds of diagnosis and assessment in order to care for trans* people. The purpose here is that while trans* care, and trans* people, have been exceptionalized in the past (Namaste 2009), trans* care falls into previous understandings of care in the current political economic moment. While the operative or explanatory mechanisms may be different, trans* care is not an isolated care space—and should be considered by care geographers and critical social scientists researching health and care.

Additionally, this section is meant to point to how neoliberal imaginations of trans* care are reliant upon a particular understanding and production of trans* people as legible, but damaged, subjects.

Evidence from the institutional websites and the YouTube videos point to how trans* care is imagined to be an emerging field of expertise. As outlined in the websites results chapter, trans* care is made to be experimental through past and present processes of knowledge building and care provision. The way these processes work together to reproduce trans* care as experimental normalizes trans* care as outside the norm of care for the general population. In effect, this process continues to exceptionalize trans* care needs (such as gender affirming care) and trans* people—whether or not their care needs are tethered to gender affirming care.

As a medical field, trans* care knowledge has been built through individual doctors and health professionals (Stone 1992, Doan 2010, Feinberg 2010, Spade 2011). Organizations like WPATH are attempting to synthesize and aggregate professional and medical trans* authority and produce a coherent body of trans* care knowledge, which is a clear response to a fragmented and individualized body of knowledge. In synthesizing professional trans* care knowledge, WPATH attempts to reform the experimental connotations with trans* care by reproducing traditional sites of medical authority and incorporating trans* care into normalized systems and processes of care.

However, WPATH does this by focusing on the individual trans* person and their relationship to a particular provider. As I described in the institutional websites chapter, the focus of both WPATH's Standards of Care as well as the information from community clinics for other providers focused fostering a productive patient-provider

relationship. While this is clearly an important factor in providing competent care, it does little to address issues of uneven care access for trans* people. Specifically, it does not address barriers to care access, such as socio-economic position, race, sexuality or ability—nor does it make any effort to put forward alternative community clinic models in new places.

The normalized system that emphasizes patient-provider relationships uses particular bodies, positionalities and sites, such as the research institution and clinic, to produce trans* care as exclusively medical. As a result, this reproduces trans* care as a clinical affair pertaining only to gender affirming care technologies that act on the body rather than a wider field of experiences and intersectional care needs that have been and can be met outside the clinic. Furthermore, by positioning trans* care as belonging solely to the medical-professional field, it rewrites and overwrites the rich and complicated histories trans* people have had with providing their own care to themselves and each other (Stone 1992, Stryker and Whittle 2006, Feinberg 2010).

Alongside securing trans* care to patient-provider relationships, the imagination of trans* care as an emerging field of medical knowledge is used by insurance companies to deny trans* care needs. This denial of trans* care needs was an issue that was present in both the websites and YouTube videos—in the case of the videos denial of coverage (or a perception of lack of insurance coverage) had very real implications for the way users imagined their futures and accessed gender affirming care. In this sense, the experimental nature of trans* care is used to further placed trans* care needs on individual bodies that require social workers, knowledgeable doctors or else in depth research by individual trans* people in order to access care. The cost of accessing gender affirming care then, is

not just the financial burden brought on by a neoliberal care system that situates access and responsibility at the scale of the individual. Rather, the high financial and social cost of accessing gender affirming care dictates what sorts of embodiments and possibilities trans* and gender non-conforming people have available to them. Far from simple production of medical knowledge, the professionalization of trans* care is tied to efforts that reproduce trans* care as experimental by situating care between the patient-provider relationship. The effect, as I have described here, is a discounting of the important past and present care work that occurs for trans* people outside of medical-professional spaces.

Trans* care is further perpetuated as experimental, by its placement both in and outside of normal medical care. It is inside the norm of care in the sense that insurance providers and medical-professional associations acknowledge the existence of gender affirming care technologies, a point re-iterated by the institutional websites. However, for insurance providers, gender affirming care is deemed elective and medically unnecessary. By conceptualizing gender affirming as both experimental and unnecessary, trans* care needs are denied and gender affirming care, when tethered to gender non-conforming bodies, is further exceptionalized.

Because of a narrow conceptualization of who trans* people are, and perhaps a general panic surrounding bodily manipulation and securing a binary gendered world that is fundamental for the biopolitical state (Stryker and Whittle 2006, Spade 2011), diagnosis is a required tool of categorization. In governing trans* bodies, categorical diagnosis serves as important disciplinary tool that sets in motion a particular set of gender affirming care technologies that are dependent upon a pathological trans*

subjectivity. Maintaining trans* care and gender affirming care technologies as experimental perpetuates an individualized model of trans* care that targets individual bodies without addressing broad trans* population care needs on any sort of systemic or structural level. As described in the website results chapter, some community care clinics are attempting to provide long term, sustained and affordable care. Because of the current patient-consumer model of health care in North America and the high cost of care that is deemed ‘non-necessary’ like gender affirming care technologies, individual trans* people are forced to be their own advocates.

Aside from insurance categorization and discrimination, the process of assessment, diagnosis and monitoring that is materially and immaterially still present in trans* health care provision exceptionalizes trans* care and trans* people. This process of exceptionalization reproduces gender affirming care technologies as not only unnecessary, but linked to pathological desires. The notion that a person needs to alter their body and gender presentation outside of a linear mapping of sex and gender is still tethered to excessive medical-professional intervention and monitoring. This system repeats the paradoxical reasoning that trans* people are incapable of consenting to care, because their care needs are pathological and experimental, and thus require tools like informed consent to individualize care as it is tethered to gender non-conforming bodies.

The logic follows that because I am trans*, my body and care needs do not map onto notions of someone who is capable of making decisions about their care and body. Rather than being a (neo)liberal subject that can make decisions about my body, my care needs are interpreted as unnecessary desires that require diagnosis and render me as a non-authority. This is reproduced by requiring written documents from health care

professionals in order to make decisions about my body because my care needs are exceptional. In working with the medical system, which is often the only way I can afford quality and competent care, my care needs may be met but at the cost of consenting to diagnosis which challenges my autonomy (Butler 2004).

While gender affirming care practices may be inside the norm of care, through their institutionalization and medicalization, the ways that trans* care is imagined and enacted is far from how the rest of population experiences care. As was clearly evident from the YouTube videos the memory of the pathologizing and criminalizing work of the care system has resulted in anxiety and distrust on the part of trans* people, a pattern found by previous trans* authors (Stone 1992, Spade 2004, Davidson 2007, Bauer *et al* 2009, Case *et al* 2009, Browne and Lim 2010) Anxiety and distrust is not only directed at accessing gender affirming care, but also receiving general or long term care (Bauer *et al* 2009). As shown by the community clinics, through intersectional identities and embodiments, the lack of care provision for house-less, genderqueer, differently abled and racialized trans* people is further exacerbated.

In particular, the process of assessment reproduces institutional medical authority—and depends on producing trans* people as unable to consent to their own care. Gender affirming care is deemed outside of the norm of care and excluded from comprehensive, general care. Under WPATH, gender affirming care requires expert knowledge, and specialized medical authority—due in part to the ‘emerging’ nature of gender affirming care technologies as well as past imaginations of who trans* people are. Specifically, the idea that trans* people are split between mind and body, and, as a result, are not fully

formed. This produces trans* people as in a state of stasis and ‘waiting to be made whole again’ through medicalized gender affirming care.

Again, this imaginations of trans* care has a direct impact on the uneven material reality of the trans* care landscape. Results from the direct provider websites and the YouTube videos show that access to care is pervasive issue with coverage routinely being denied or else dependent on problematic diagnoses and its prohibitively expensive cost. This is in line with past research from academics and activists documenting barriers to care for trans* and gender non-conforming people (Spade 2011, Bauer et al 2009, Doan 2010, Butler 2003). As such, the neoliberalization of trans* care occurs not only through the processes of individualization and an imagined experimental care knowledge. It also occurs through the production of trans* people as diseased, pathological and illiberal subjects that are not capable of consenting to their care and in need of a particular kind of specialized care that replaces a collective responsibility to an individual relationship confined to trans* bodies.

Reflecting on past work from care geographers (Par 2003, Kobayashi and Proctor 2003, Brown 2004, Lawson 2007, Green and Lawson 2011), one result of trans* care’s inclusion in this imagined institutional care landscapes is also the folding of gender affirming care into a neoliberal logic of care. By neoliberal logic of care, I am referring to the de-centered, individualized model of care that seeks to optimize bodies and subjects through a multiplicity of potential solutions (Rose 1989). This particular logic of care⁶, is neoliberal in the sense that it emphasizes individual cures and advances a model of

⁶ I use logic here to refer to the way that as a system care tends to naturalize itself through professional-medical knowledges that casually link problems and cures together

unending choice despite the very clear intersectional limitations placed on trans* care access.

The current system of trans* care is not set up to provide care that allows trans* people to build worlds where diverse constellations of bodies and identities are possible (Tronto 1993). Rather, the logic of trans* care problematizes experiences and affects and map them onto individual bodies in a way that renders them legible and manipulable (Foucault 2003). As previously discussed, insurance providers have had a strong, but always visible, impact on imaginations and conceptualizations of trans* care. Beyond the financial aspects of trans* care, the emphasis on treating individual bodies and the unique problems associated with individual trans* people places the burden of responsibility on the trans* patient or client to navigate and self-advocate. In doing so, it collapses the diverse set of experiences and problems that trans* and gender non-conforming people face in a cissexist, transphobic world. In medicalizing these experiences and giving them an institutional name, bodies are made to be manipulable at the cost of a deeper and multiple set of subject positions and selves (Foucault 2003). In effect, the process of diagnosis embedded in trans* care produces trans* people as static subjects in waiting for medical intervention. The logic here is that the diverse nature of trans* people requires individualized and specialized care that produces trans* bodies and identities in a particularly narrow and problematic way.

Even before accessing care, trans* people are expected to self-identify as trans* or gender non-conforming—a process that requires an immense amount of self-work, which was seen in the YouTube videos. This work, acknowledged by some providers in statements regarding the ‘bravery’ of their clients and patients, is by and large assumed to

occur in private or else in the space of peer support groups. This work, alongside accessing gender affirming care, is often imagined as a single point in time or a momentary struggle that trans* clients and patients are able to overcome through physical and social transition. Thus, the responsible trans* person is one who internally struggles, accesses care, changes externally and is then able to be a legible, whole person. By giving themselves over to the medical system, the responsible trans* person submits to diagnosis and is made visible to state and non-state institutions—their internal self is controlled and managed as well as their external body.

As outlined in the results section, the places and spaces that make up the trans* care landscape work together to reproduce this logic of care. For many of the institutional care websites, becoming trans* began as a moment of individual identification, which was evident in the way that care providers understood their clients and patients as already being identified trans*. While identifying as trans* was not tightly linked to gender affirming care, it was implicit that an individual's trans* identity was solidified by accessing gender affirming care in particular institutional care spaces. This was also evident in the YouTube videos where being an 'expert' or 'authority' was tied to accessing particular gender affirming care technologies and progressing through transition.

Thus, the logic of trans* care employs moments of individualization commonly associated with neoliberal governmentality as well as the use of centralized institutional places. Following previous work from geographers working on neoliberalism and its manifestations on the landscape (Brenner and Theodore 2002, Peck and Tickell 2002), as a system, trans* care works across and between individual and national scales to produce

and govern trans* life. While not a clean mapping onto more political-economic analyses (Brenner and Theodore 2002, Peck and Tickell 2002), as a system and grid of power that defines bodies and subjects, trans* care has moments of ‘roll back’ and ‘roll out’ that work often at the same time. The interaction between processes of individual responsibilization and the places of trans* care work together to produce trans* people as legible and imbricated in normative health care systems.

Governing Trans Lives*

In the previous section, I outlined the way the results from the institutional care websites and YouTube videos show how trans* care is part of a larger neoliberal imagination of what caring for and about people means. Building on this, in this section I will pull out two operational and explanative discourses that govern trans* people and the care they do (or do not) receive. These two discourses operate through the process of consent, present and discussed in the institutional websites, and the notion of a split-subject—a recurring understanding of what it means to be trans*. These two meanings, made particularly logical when tethered to trans* bodies, work to govern the subjective possibilities and futures of trans* people and further invisibilize the important care work that occurs outside of institutional care spaces.

While a trans* person may, after screening be able to consent to care (see WPATH 2013), consenting to care is one point in care trajectory that includes care work that happens before and after ‘beginning’ a particular gender affirming care technology. Consent, as a technology, moves legal⁷ and medical responsibility onto individual trans*

⁷ This is another potentially important pathway for future research—how are trans* people made to be legal or illegal subjects? Tying this question to emerging popular and academic work regarding the prison-industrial complex and its relationship to governing

people based on a shared set of meanings between patient and provider. On many of the institutional websites, the documents for obtaining informed consent were readily available for potential patients to download and review. This process of consent can be an important and useful one—particularly when considering the uneven landscape of trans* care in terms of quality and information (Bauer *et al* 2009, Heinz 2012). However, as was evident in the YouTube videos, prior to walking into the clinic or doctors office door (where the formal consent process occurs), trans* and gender non-conforming people have already researched gender affirming care technologies. This is supported by past work from trans* authors and activists who have detailed their own processes of accessing care (Stone 1992, Stryer and Whittle 2006, Heinz 2012).

While consent may serve as a useful starting point for patient-provider relationships, in practice consent reproduces trans* care needs as experimental and unnecessary. In accessing primary care, cis people do not need to routinely sign forms or otherwise provide documentation that they understand the care they are receiving. Returning to the YouTube videos, the effect of having care needs deemed experimental and unnecessary is evident in the uncertainty many trans* users felt in approaching institutional care providers. It is further reflected in the doubt expressed in several videos around their care needs—for many users they felt they had not ‘suffered enough’ or were not ‘needy’ enough.

Extending this further, and reflecting on my own experience accessing gender affirming care, the experimental and unnecessary imagination of trans* care tends to

and ‘letting die’ particular sorts of trans* lives is a politically important project that has the potential connect together different spaces of trans* subjective production that acknowledges difference while also seeking a politics of connection and recognition (Young 1990, Zerilli 2005).

govern trans* and gender non-conforming people into particular narratives regarding their care needs (Stryker and Whittle 2006). This was evident in the YouTube videos from users who used medicalized terms, such as gender dysphoria, to describe experiences and situations in a way that would map onto institutional conceptualizations of trans* people. In attempting to ‘prove’, to oneself or a provider, that gender affirming care is necessary trans* and gender non-conforming people are often normed into being ‘split subjects’ with particular relationships to their mind and body. In order to be legibly trans*, these sets of problems were adopted to link to gender affirming care as a solution or cure (Foucault 2003).

The legible, ‘good’ trans* subject is someone who seeks gender affirming care to reform themselves—to stitch together their mind and body in a way that is unified and intelligible to the current medical landscape and the wider binary gendered world. Furthermore, the ‘good’ trans* subject is one who is educated and knows what gender affirming care technologies are available as well as the potential problems and explanations associated with them so as to gain access to the types of care that they need. This ‘good’ trans* subject is similar to past work that has explored the responsibilization of patients as consumers and the way the availability of medical knowledge has changed patient-provider relationships (Parr 2003). While this may be a factor in the responsibilization of the ‘good’ trans* subject, there is also a push to be ‘good’ to seek reformation that moves one from one gender to another in order to disprove one’s unnecessary and pathological care needs.

As discussed in the results chapter, trans* YouTube users did use medical language and medical subjective imaginaries of who trans* people are in their videos. However,

the citation and use of medical language did not always map cleanly onto users' experiences in the world. In this way, the YouTube videos are evidence of "being thrown into a discourse not of one's choosing" (Butler 2003), of using available language and systems of meaning in ways that are not entirely comfortable. While these moments of discursive displacement can often be violent, and in the case of trans* people being thrown into a system of meaning and materiality that necessitates conformity to a gender binary is often extremely violent (Spade 2011), it can also bring about a particular sort of confusion or anxiety as one seemingly does not fit into the world. Far from being completely abject, or illegible, the experience of not fitting into the model of a 'good' trans* subject requires using existing discourses of what it means to be trans* in different ways. What the videos show then, is that when networked and exchanged, spaces of subjective production come about not as entirely new but as a sort of slippage and recycling of the old that requires staking out a position and being vulnerable.

Being legibly trans* was reflected in the way that users meticulously documented changes to their body, self, family, friends partners. Changes to the self, body or relationships with other people were often described or refracted through the lens of the user being trans*. What the videos suggest is that trans* care encompasses scales and relationships that exceed the individual body. Rather than being a problem neatly situated at the scale of the individual trans* person, the YouTube videos show that being trans* is an existent space, that is networked and co-constitutively produced by relationships and processes occurring at a number of different scales. While some care providers made efforts to provide comprehensive care, or else acknowledge the full lives of their patients

outside of providing gender affirming care, the majority of direct care providers were focused on care technologies targeted at scale of the individual patients body.

One reading of this individualizing process is that it is a necessary part of medical knowledge—in producing a treatable, diagnosable space medical technologies are often mapped onto the body. As conceptualized by Foucault (2003) this mapping onto the body fragments and problematizes bodily spaces in a way that renders them curable. In situating trans* care as an individual problem, as an issue of connection between mind and body, trans* lives are made to be governable against the horizon of liberal subject that is a rational, complete and autonomous individual. Furthermore, conceptualizing trans* people as spatially dissonant in that our minds and bodies are disconnected, reproduces a normative, Cartesian understanding of the individual where minds and bodies work together logically (Foucault 2006). Thus, in order to cure and govern the ‘sick’ trans* people there is a dual need for understanding and problematizing their bodies as well as linking that to a particular, static identity and subject position which is legible and contained.

Expanding on Rose (1989), the self is not a unique or non-networked space of governmentality—rather the relationship between the self and the body emerges as an essential place where trans* subjectivity is produced and governed. The way in which medical knowledge conceptualizes the body as a static space that is controllable and manageable compartmentalizes and reduces trans* people to their bodies and to relationships of institutionalized care. Prior to gender affirming care, prior to transitioning, trans* people are defined by a split between mind and body, between their visible and invisible self that can be reformed changing the visible or biological self. The

way trans* bodies are imagined and conceptualized, both in the context of the individual as well as the society, is one way trans* people are governed.

This conceptualization of trans* people as split, reproduces the notion that the legible, liberal subject is a binary gendered individual that experiences their mind and body discretely but in line or in harmony with one another. This understanding is rooted in the notion that the individual is an autonomous, rational, liberal subject—one that is visible to the general population, who can be counted, who's body is legible and 'passes' as one gender or the other. Following past work from both Foucault (2003, 2007) and Rose (1989), one solution for reforming the self, for producing a liberal subject is process of disclosure and narrating the self—a technology that both Foucault and Rose trace to confession.

Reforming the Self: Disclosure and Self-Narration

Disclosure and self-narration were both evident in the institutional care websites and, more explicitly, amongst the YouTube videos. In the case of the YouTube videos, self-narration was used to understand individualized experiences. In this way, the process of self-narration worked to link together individual trans* people—this linking process was often done by users making videos on similar topics or else using language that signaled common ground or differences between other users. Often, signaling languages and words were borrowed from institutional trans* care providers. The most poignant example of this was how YouTube users used the term dysphoria or gender dysphoria to describe the relationship between their mind and body. This relationship between mind and body, split and interacting but fundamentally different, was a recurring problem for YouTube users who identified as trans*.

As I pointed to in the results chapters, institutional care spaces use gender dysphoria to collapse the experiences and affects of trans* and gender non-conforming people. In this context, gender dysphoria works to compartmentalize these experiences to trans* and gender non-conforming people. Through this interpretation, experiencing a disconnect between mind and body, feeling anxiety or discomfort related to one's gender becomes tethered to trans* people, further exceptionalizing trans* experience.

Understanding trans* people as split subjects, as defined by disconnection between mind and body, further confines trans* people to their individual experiences and bodies and problematizes these in a way that maps them onto individuals. From past multi-disciplinary research on trans* health and trans* lives, this individualizing process has very real impacts on the lives of trans* people. In the sense that trans* people experience higher rates of suicide, mental health problems and substance abuse as well as how trans* people experience their lives as not being full, as not being enough (Namaste 2009, Bauer *et al* 2009, Heinz 2012, Nooshin 2012). This was evident in the YouTube videos where users explored feelings of inadequacy and expressed feeling isolated and confused.

Furthermore, it reproduces normative trans* health technologies that consequently intervene either on the body or the mind in a way that seeks to 're-connect' them and reform legible, governable subjects. This process of reconnection maps onto a trans* care system that seeks to enforce binary notions of gender as these disconnections between mind and body are often conceptualized as one space or the other being of opposite, opposing genders. The implication is that a 'connected' or gender-legible person is one whose mind and body are of the same gender. Having a 'coherent' or legibly gendered mind and body is implicitly tied to producing governable subjects. Here, the ability to

govern is very much linked state in the sense of census counting and identity documents—under the current biopolitical state, to not fall in the gender binary means to not be counted. Identity documents, national census data and social services all rely upon a body counting system that reproduces a gender binary of male and female. As outlined by both Foucault (2007) and Rose (2001), the counting of bodies is one essential tool in governing from a distance and producing a norm—for trans* and gender non-conforming people, our bodies and subjectivities are invisibilized by these forms of counting. By not counting in the population, we are further confined to our individual bodies and to our individual stories.

While not entirely in the scope of this project it is worth carefully considering the politics of including trans* people in the census and counting trans* bodies. At the moment, most trans* activism regarding identity documents surrounds removing or loosening standards regarding surgery and medical care documentation in order to change one's gender marker from one (male/female) to another (female/male) (Transgender Law Center 2011, National Center for Transgender Equality 2014). While important, and often a matter of life and death for trans* people when we are accessing essential social services (Spade 2011), trans* people are forced again to yield to a discourse of binary gender that undermines the ability to be trans*. As Stone (1992) warned over a decade ago, yielding to tools that reproduce and rely upon a gender binary further invisibilizes trans* lives and the existence of trans* people. By conceptualizing trans* people as subjects only in transition, as a boundary space or space of movement from one to another rather than a space in and of itself—we are forced to adopt a narrative that limits our ability to live as trans* people. Furthermore it denies the extent to which all life is in

process, is in movement and relation, an important critique of the liberal subject brought from several perspectives, but notably here care theory (Tronto 1993).

The continued use of individual disclosure and narrative in understanding trans* people can be linked to past trans* care regimes (Stone 1992). In most cases these narratives were used for and by trans* people in accessing gender affirming care—a practice that continues, partially because of limited imaginations of who trans* people are and what their care needs are (Spade 2008). However, from examining format of the YouTube videos, self-narration was a technology that was adopted by many of the trans* YouTube users.

For trans* YouTube users, self-narration was used to connect their individual experiences to a broader, normative understandings of who trans* people are. In contrast to the use of self-narration in institutional care space, YouTube users employed self-narration to stake out and understand themselves as trans* people in the context of other trans* YouTube users. Rather than self-narrating to slot themselves into a category for clinical, teleological reformation, trans* YouTube users self-narrated in a more variable way. As outlined in the results chapter, self-narration sometimes served to rationalize use of particular gender affirming care technologies or make sense of experiences and feelings that made users feel out of place or else confined to a medical, institutional subjective definition.

In my own experience of accessing gender affirming care, I readied myself before going to institutional care spaces by talking to other trans* friends and researching on the internet. Less directly, I spent time reflecting on my gender identity and relationship to my body—did the problems and anxieties I was experiencing map onto my imagination

of who trans* people are? Was the anxiety or discomfort that I was experiencing enough? Upon visiting my first care provider, a counselor specializing in trans* health, I was ready with the ‘correct’ responses to potential prompts about my childhood, about my sexuality, about how I relate to my body. I was surprised to sit through a somewhat awkward, silence filled session at the end of which I was given the contact information for a doctor and told that unless I felt particularly compelled, that (in their opinion) I did not need to return for another appointment.

I had clearly internalized the steps or process of accessing gender-affirming care. Both in the sense that I did not know exactly where to start in the process of accessing care, and assumed I would need a letter or the approval of a mental health practitioner, as well as anxiety and uncertainty regarding my desire for gender affirming care technologies. If I was interested in and in need of hormone replacement therapy, then surely I must have issues regarding my identity and body that were in need of professional resolution. However, this was not the case. Reflecting on my experience against those of the YouTube users, who did experience narrative policing and discrimination, while the landscape of trans* health is changing it remains uneven and experienced individually. My experience accessing care was very much coloured by living in Seattle—past activisms and a more liberal urban culture both played a role in my ability to access gender affirming care with minimal invasion and doubt.

In the case of the trans* YouTube videos, there seems to be a particular value placed on disclosing details about oneself as a solution to this split mind-body problem. Following past work from Thein and Del Casino (2013), the work of disclosing oneself, of taking responsibility for ones problems and working towards those solutions,

reproduces a sort of normative masculinity (Hopkins and Noble 2009). It reproduces normative masculinity in that it places responsibility on the individual to take control over their problems, emotions and experiences and then solve them by using proper and (what are thought to be) universally available resources (Berg and Longhurst 2009, Hopkins and Noble 2009). Similar to Thein and Del Casino however, this sort of cared-for masculinity does not map neatly onto normative masculine figures or geographies (Berg and Longhurst 2009). The way trans* YouTube users took on responsibility for their own care, as well as the social, mental and financial cost of that care, was individualized at moments but also recognized the multiple people and relations that made their lives possible. Furthermore, the way that users conceptualized being trans* or transitioning as a larger process instead of an end goal or boundary space to pass through, signals that many of the YouTube users were not seeking to reform or 'fix' themselves. Rather they were seeking to understand and place themselves, to use the available systems of meaning in way that made their identities and bodies possible.

The level of detail and repetition of the processual nature of transition indicates that many of the YouTube users did not see a linear or single solution that they could handle or else overcome. In this sense, revealing more dimensions and positions of themselves and the varied places and spaces that produced their sense of self emerged as a method of care. As detailed in the results of this research, trans* YouTube users did not follow linear pathways of disclosure, care access and reformation. Rather, through their specificity and situated descriptions the videos presented a wide array of different pathways with variable problems and solutions depending on the embodiment, identity and location of each user.

Self-narration and disclosure were governing processes in the sense that users made videos to make sense of their individual experiences as compared to broader conceptualizations of who trans* people are and ought to be. In identifying oneself as trans* on YouTube, describing ones experience and documenting changes users were actively inserting themselves into the broader population of trans* people. While the terms used to do this were often borrowed from medical-institutional spaces, such as dysphoria, by placing themselves within the trans* YouTube community users were able to produce a sense of self that was individuated and belonging to the group. The way users detailed vulnerable moments of their everyday life as well as their broader understandings of transition as a process and shifts in their gender identity suggests that there is not a singular way to be trans*. Rather than a clean pathway of identification and care access that follows from being responsible to oneself as trans*, the YouTube videos make visible moments of slippage between who trans* people are in the present, who they aspire to be and who they ought to be. Following Rose's (1989) conceptualization of (neo)liberal subjectivity, the YouTube videos present a moment where the self is not cleanly governed against the norm of institutional trans* subjectivities.

While quality gender affirming care has become more accessible over time⁸, the prohibitive financial and social cost of accessing gender affirming care raises some issues when considering the race, gender identities, sexualities and socio-economic backgrounds of the YouTube users. Only two of the videos had visible minorities and while there was a range in the way users self-identified (from genderqueer to trans*, transsexual and transgender) most users self-identified as straight and had employment or lifestyles that

⁸ Here, by more accessible I mean more socially accepted, available in more geographic locations and (somewhat) less expensive.

indicated a relatively secure financial background⁹. Thus, in many ways, the YouTube videos reflect the way the current trans* care landscape reproduces those who occupy positions of privilege and have the financial and social resources to access gender affirming care technologies. This becomes increasingly problematic when considering that the ‘goals’ or ‘solutions’ offered by some of YouTube videos and the majority of the care websites were hormone replacement therapy or surgical intervention—two particularly expensive and potentially gender norming care technologies.

Considering my own experiencing accessing gender affirming care, while my insurance did not cover hormone replacement therapy, I was able to cover the cost because I was employed. My care provider, who describes themselves as an ally specializing in trans* health, was savvy in scheduling appointments and lab work to best use my insurance benefits and limit my number of visits with doctors as opposed to nurses. While I do experience moments of financial stress, my health care is relatively affordable and meeting my care needs. It is not so expensive that accessing gender affirming care is an impossibility for me. This is directly linked to my positionality as an employed, white, middle-class, able bodied, masculine presenting person—the privilege I accrue by having a body that moves through a multitude of places and spaces without excessive or obvious discrimination contributes to my ability to access (and continue using) gender affirming care.

Networked Care of Self

⁹ Finances and money was not a formal topic of discussion amongst the videos, however they were often mentioned alongside other topics or as a longstanding problem. It was either mentioned directly, usually in relation to raising money to obtain a surgery, or else indirectly in discussion of life stress. Here, it is important to note that trans* and gender non-conforming people face increased risk of job and housing discrimination, which can compound the financial stress of paying for health care.

As outlined in the literature review, the notion of caring for the self, or self-care, maps onto conceptualizations of self-governance (Foucault 2003b, 2009, Rose 1989, 2007). However, the care for self occurring in the YouTube videos is not as complete a form of internal responsibilization as Rose (1989) seems to suggest. This is supported by past work from scholars who have explored and problematized the notion of care and its relationship to a multi-scalar neoliberal care logic (Brown 2004). In the instance of the self and self-care, authors like Ball and Olmedo (2013) have asked us to reconsider how care of the self and self-work is written off as a neoliberal politics of individualization and self-responsibilization. Instead of linking technologies or practices associated with ‘care for the self’ to neoliberal notions of personal responsabilization, my research asks us to consider how and under what conditions this care for the self is occurring under. For trans* YouTube users, an uncaring and uneven system of care alongside a narrow understanding of who trans* people are necessitates care work that produces a self—that traces out the possibility for trans* people to live visibly and having meaning in the world.

Adding in geographic specificity and considering the ways that caring for the self occurs across and between spatio-temporal scales opens up the potential to tap into a potentially radical politics of self-care (Lorde 2007). Thus, making care needs and care work visible by actively connecting with others is one pathway toward re-invigorating a politics of the self that moves away from a territorialization of identity categories or need for subjective unity (Young 1990). Focusing not on the place of an identity as its definition but rather the processes and methods by which we are produced and produce ourselves becomes an important project—here, naming ourselves and our actions and

being responsible to them is one way of networking and visibilizing our multiple, complex and impossible to govern selves. A new political way forward then, is not focusing on a single trans* identity or place of subjective production. Similar to Zerilli's (2005) feminist politics of freedom, that recognizes the pitfalls of basing a feminist political project on a single subjective category or definition of womanhood, a radical trans* politics might be one that embraces multiplicity and the unknown nature of ourselves and futures. This embrace of the unknown does not come at the cost of trans* or transgender as a category—rather is de-links and de-centralizes particular places of trans* subjective production. Crucial here, is that there is neither a wholesale denial of the institutional and medical spaces that have produced trans* subjective meanings—rather it is an acknowledgement of those past and present spaces of production alongside an active recognition of and orientation toward other places of subjective production.

While the use of medical terms like gender dysphoria and the internalization of normative trans* and transition narratives is present amongst the videos, they are also evidence of situated, visible descriptions of being trans*. The ways the videos agree and disagree with another widen the field of who trans* people are and how they relate to gender affirming care. Reflecting on the lack of trans* narratives and non-institutional places where trans* subjectivities are produced, networked and made visible, the videos do important work in showing and documenting trans* lives. In connecting different individuals together, the YouTube videos make care needs and the messy, incomplete work of forming a self in a world that denies your care needs and possibility of life visible. Imperfect, occasionally rambling and moving between norms of trans*-ness, masculinity and personhood, the videos show dependence, mutuality and the particular

stresses and challenges of being trans*. While the videos do make certain material aspects of gender affirming care visible, such as self-injecting hormones or caring for scars, on a broader level they visiblize and connect individual experience of being trans* and accessing gender affirming care.

Operating in an uneven and uncertain care landscape, trans* people on YouTube used their videos to communicate information with other users and to understand their how they were changing as individuals. The YouTube videos do care work in the ways that they produce knowledge regarding trans* health. For many users, viewing or making videos addressed uncertainty and anxiety in accessing care—by further understanding a particular care need or technology or else narrating oneself and understanding oneself as trans* and included in the wider trans* YouTube community. For many users, doing so required adopting certain norms of who trans* people are which was a point of tension for some users who expressed not feeling ‘trans’ enough.

This tension is further reflected in past work from scholars writing on trans* care and subjectivity: “Are we stopped in time, made more regular and coherent than we necessarily want to be, when we submit to the norms in order to achieve the entitlements one needs, and the status one desires?” (Butler 2004, p279). While Butler is discussing norms of trans-ness in the context of accessing institutional care, in accessing the non-institutional care of trans* YouTube videos this was evident as users commented on or else used language that was legible to the wider YouTube community in an effort to be read as trans*.

As noted by Doan (2010), transitioning is an inherently public process. While it involves ‘private’ scales and often occurs in privates spaces, (Hausman 1995 Diamond *et*

al 2011) transitioning and being trans* encompasses not only changes to the body but a broader set of shifts that change the relationship to the self and the world. While there was some disagreement amongst trans* YouTube users regarding how particular gender affirming care technologies altered their internal self, there was broad agreement that transitioning resulted in changes in how they perceived their life chances and possibilities. Examples here include the way YouTube users charted changes in their gender identity and sexuality as well as how they experienced their life trajectory and emotions.

Politics of Trans Care*

Expanding on past work in geographies of care and care politics, the provision of care has very real implications for what sorts of life are deemed worth caring for and about (Tronto 1993, Brown 2003). For trans* YouTube users, the ability to imagine and live full lives was linked to gender affirming care, both in the initial point of access as well as the longer trajectory of how that care changed their body and self. Following previous literature on trans* health, access is a major and longstanding issue (Butler 2004, Hines 2007, Case *et al* 2009, Bauer *et al* 2009, Doan 2010). Focusing on access has revealed that the relationship between the technological landscape of trans* care and insurance coverage is intimately linked to the ability to access gender affirming care. However, imaginations of who trans* people are, what gender affirming care is and what care needs it can address are stitched together in the explanations of coverage and denials on the part of insurance companies, having real implications on the care available for trans* people.

While care politics is very much an issue of access—in the sense that certain forms of life are or are not allowed to live through the availability of care in both quality and

location—it also involves the underlying implications and long-term conceptualizations of what a life becomes after accessing care (Brown 2004). In this sense, the institutional landscape of trans* care is falling hopelessly short by reproducing an extremely narrow field into which trans* people can exist and flourish. For trans* people, the work of understanding oneself as trans* and understanding one's care needs as legitimate indicates that the current trans* care system cares very little about trans* people. While the technological means may be available, and more medically institutionalized in North America, the possibility of trans* bodies and subjectivities remains a limited and potentially damaging field to enter into.

While not an even or homogenous landscape, the YouTube videos point to the important care work that takes place outside of care access—where lives and bodies that are cared for are interpreted outside of institutional care and animated with the possibility of life that is not tethered to medical and institutional definitions. In the context of trans* care the production of trans* narratives and subjectivities outside of institutional spaces of care is an essential process for caring about trans* people. Producing and networking these narratives widens the possible forms trans* life can take place. The importance of documenting and networking these narratives is highlighted by Ariel Goldberg, a trans* poet, who remarks in the opening quote to this chapter “It is the telling of these stories that makes our changes real and possible.” (Tolbert and Peterson 2013 p47). In the telling of these stories, trans* people are made to be more than their institutional subjectivities. Instead of being confined to medicalized bodies that reproduce Cartesian notions of the self, places where narratives of trans* people are produced complicate trans* subjectivity and re-animate static norms of who trans* people are. Furthermore, as the YouTube

videos suggest, these narratives make trans* lives possible as they let us use available languages and systems of meaning in new and unexpected ways.

Linking back to writing on care and care politics, the way trans* people are imagined and conceptualized has very real implications regarding the ability to access quality care. Far from a single moment of determination, accessing gender affirming care is tied up in processes that stretch across a variety of spatio-temporal scales. What my research suggests, and is supported by Tronto's (1993) ethic of care, is that trans* care access does not necessarily map onto an ethical care relationship. A broader question then that this project introduces is the limits to medical and institutionalized care. Can these institutional spaces, which have brought such harm to trans* people, ever really care in an ethical way? As I have argued here, there are particular subjective conceptualizations tied to institutionalized spaces of care that limit the ability of providers in caring for and about trans* people.

Extending this, while there is important work and organizing to be done in accessing basic health and human rights for trans* people by changing institutional landscapes, focusing trans* politics solely on these institutional and centralized spaces reproduces their authority. In focusing solely on access to care, there is a risk of focusing on a trans* politics that is tied up in defining who trans* people are in an effort to situate trans* people as another normative, but different subjectivity. As can be seen in the current, mainstream LGB political movement the cost of organizing around a static political subject or subjective definition is the reproduction of privileged bodies and political goals (eg. marriage equality) and at the expense of others (eg. queer youth).

The way these institutional conceptualizations govern trans* lives and possibilities have important implications for the way trans* people experience institutional and non-institutional forms of care.¹⁰ The issue of accessing gender affirming care for trans* people does not begin and end with institutional spaces of care. While trans* activists have organized for essential medical care access, this has often come at the expense of recognizing the important non-institutional care work that trans* people have and continue to undertake for each other. As I have traced out in this research project, different methods of digital communication and networking are one pathway to producing and making visible different trans* narratives and experiences with gender affirming care. In this sense, my research speaks back to scholarship on the politics of digital space (Castells 2010, Sui *et al* 2010). Rather than instantiating or implying a particular type of political action, the way that digital spaces are used to network different actors and make certain issues and bodies visible produces particular spaces of political action.

This runs counter to previous scholarship on digital space that tends to understand digital space as a way of organizing political action offline (Castells 2010) or else the politics of the materials implicated in digital tools (Elwood and Leszczynski 2013). While some of the YouTube users did meet offline, the way they made their care needs and their selves visible in an effort to care for themselves and other trans* people made the videos a sort of political act. As such, this research project asks digital scholars to think differently about what being political online or the politics of digital space might mean.

¹⁰ While not in the scope of this particular project, the extent to which the past places of trans* care come to reproduce un-caring relationships and narrow conceptualizations of who trans* people is an important tension that could be explored in future research.

This is particularly important when considering critiques of digital space that point to the way different people and groups interact with and use digital space and tools due to technological knowledge or past experience. Rather than a narrow conception of digital politics as organizing for ‘offline’ activity where ‘real’ political action occurs, the interactions occurring in and through digital space are political in the sense that subjects are formed, made visible and contested through interaction in digital spaces like YouTube.

As previously suggested, imaginations of trans* care and trans* people have a direct (although not always visible) effect on discourses surrounding standards of care, diagnosis and insurance coverage¹¹. As outlined in the literature review, these discourses are not only present in institutional care spaces but also trafficked and reproduced in other spaces and places such as the carceral and judicial systems as well as the academy (Murphy *et al* 2010). For most Human Subjects Review divisions, trans* people fall under a ‘high-risk’ population—a category that reproduces the notion that trans* people are not fully formed and are not capable of consent. The issue of trans* categorization in the academy is a particularly concerning one as it further exceptionalizes trans* people and limits the ability for researchers outside of the health sciences to understand the lived realities and experiences of trans* and gender non-conforming people.

¹¹ Reflecting on the process of researching and writing up this particular project, I have been struck by the way trans* health is very much a global project—one that is tied up in global medical knowledge networks as well as pharmaceutical commodities and capital. This runs in tension to the way that trans* care is conceptualized as an individual relationship, one either between patient-provider or else to be handled by individual trans* people. While not in the scope of this project, this is an interesting point for further research—how can recognizing the global processes of knowledge production and capital politicize trans* care in new ways? As suggested in my introductory paragraph, an interesting way forward here would be an object-oriented, commodity chain analysis of testosterone.

Recognizing the way that conceptualizations of trans* subjectivity interact with trans* care makes some important demands on current trans* activisms. Following the work of trans* activist and scholar Dean Spade, acknowledging these interconnections can push trans* politics towards “forg[ing] new alliances, demand[ing] accountability from movements that purport to represent us, and create and pursue a broad, daring vision of the change we are seeking.” (Spade 2004 p233). Staking out the geographies and processes that effect and produce trans* people emerges as important and critical project—one that necessarily looks for connections across spatio-temporal scales in an effort to actualize a ‘trickle up’ politics of human connection as opposed to a ‘trickle down’ politics that remains blind to the way these interconnections are produced and experienced.

Again, access to competent, quality care is an essential and matter of life and death for trans* and gender non-conforming people. However, what bringing the production of trans* subjectivity in conversation with care asks us to do is critically engage with other institutions and spaces of trans* subject production. Acknowledging the way that places and spaces like the clinic, the courtroom and the prison produce notions of who trans* people are pushes trans* politics to connect with the varied spaces of the production of trans* subjectivities (and those who are not full subjects that are trans*).

Furthermore, as evident from the YouTube videos, these discourses are actively contested by trans* individuals and activists who have had longstanding relationships to institutional care provision. Thus, what this research project asks trans* scholars and activists to do is imagine trans* lives and possibilities outside of the institutions that have come to define them while at once acknowledging the past and present geographies of

trans* subjective production. As such, what is needed now more than ever, is both careful critical analysis of the production of trans* people in place alongside projects that are sensitive to and make visible past and present work by trans* people to live and be beyond these institutional conceptualizations. This dual project, both critical and productive, sets out a trans* political movement that is concerned with trans* lives and care but is also intimately linked with other critical projects and imaginations of what an equitable and just world would or could be.

CHAPTER SEVEN: CONCLUSION

“We need an earth wide network of connections, including the ability to partially translate knowledges among very different—and power differentiated—communities. We need the power of modern critical theories of how meanings and bodies get made, not in order to deny meanings and bodies, but in order to live in meanings and bodies that have a chance for the future.” (Harraway 1990)

In examining institutional meanings and conceptualizations of trans* care I have pointed to the ways that care is intimately linked to conceptualizations of trans* subjectivities. Who trans* people are thought to be, who they ought to become and how they relate to care spans a variety of different places and spaces. Processes embedded in the trans* care system, like diagnosis and consent, construct trans* people in contradictory ways—however, the overall impact of individualizing care and responsiblizing patients further confines trans* and gender non-conforming people to their medical, institutional subjectivities. Trans* people are confined to their bodies, or else conceptualized as split subjects, further tethering trans* and gender non-conforming people to identities and embodiments that are dependent on medical and institutional meanings.

By individualizing trans* care, trans* and gender non-conforming people are pushed into a neoliberal care logic that reproduces larger scale issues and problems surrounding individual access. As my research has shown, trans* care produces and hinges upon a particular trans* subject that is unable to consent to care and pathological. This particular subjectivity is reflected by the focus of trans* activism on diagnosis, consent and insurance coverage. However, the cost of accessing gender affirming care is not limited to financial barriers—rather it includes a more complex and multi-layered set of processes that often require networks of social and emotional support. Thus, my research

lays out the groundwork for further inquiries into the way that care necessitates and produces particular subject positions.

Following the above quote from Harraway (1990), the YouTube videos present an interesting case in which institutional, medical knowledges and understandings of who trans* people are are repeated but reformed by trans* people themselves. In networking and making their care work and needs visible in digital space, trans* YouTube users are politicizing their individual experiences by placing them in the wider field of trans* care. Future work exploring the politics of digital space would include more qualitative research on how trans* YouTube users perceive their use of YouTube. Furthermore, as demonstrated by the YouTube videos, social and financial barriers in accessing gender affirming care tend to reproduce normative trans* bodies and subjectivities. What my research points to is the importance not only of emergence of problems, technologies, subjectivities and explanations with regard to care, but the way methods of networking and different processes of connecting space and place produce care and caring relations. Thus, future work in care should address the ways that care produces particular subject positions as well as how different places of subjective production do or do not work together.

Undoubtedly there is a clear need for competent, quality care access for trans* and gender non-conforming people. What this project suggests is that institutional trans* care tethers trans* people to medical institutions and a neoliberal care logic that limits trans* people to a particular set of problems and a narrow subjective space. In limiting trans* people to their individual bodies, the current trans* care landscape formulates trans* people as split between self and body—as needing institutional intervention to re-

align and overcome their present conditions. Implicit here, is that as split subjects, trans* people are not fully legible, a point made clear in the way that trans* people are not counted in the wider, governable population by state institutions or social service provision outside of medical care. Trans* people are also made to be illegible by medical narratives that rely upon an incomplete trans* subject who's mind and body are disconnected or split and in need of realignment.

Thus, my research points to the need for a trans* politics that tacks between fighting for material rights and make demands upon traditional sites of power while maintaining a critical, aspirational stance that allows new bodies and identities to exist, take place and flourish. As such, future academic research on trans* care needs to undertake a dual position of critique and recognition of the places of trans* subjective production where lives and bodies are animated with meaning. As I have shown here, there is immense potential in applying spatial theory and thinking to the way trans* people are governed and produced. Considering that geographers have not engaged with trans* geographies since 2010, it's about time that geography, with its radical theoretical potential and attention to empirics, re-engage with the places and spaces that produce trans* lives. Doing so, provides a potentially powerful pathway toward re-opening care to consider the biopolitical implications of defining and conceptualizing life. As my work has pointed to here, the cared-for subject is governed against the horizon of a liberal subject—one who is autonomous, has particular relationship between mind and body and, as is oriented toward a life in progress. In this case, as I have shown in analyzing institutional care spaces, trans* people are governed toward a life that progresses from one gender or another.

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Appendix A: Preliminary Etic Codes from Rose (1989)

Problematizations: emergence of problems (in relation to concerns), who defines, what norms are certain things/people problems?, dividing practices?

Explanations: operative concepts, what counts as evidence?, forms of visibility, remarkability

Technologies: assembly of means of judgment, reformation/cure?, apparatuses within which intervention is to take place

Authorities: constitution of authority figures/spaces, emergence of expertise, procedures used to acquire authority, alliances/conflicts between claims to authority, types of local authority, relation with subjects/objects

Subjectivities: ontological (spirit, consciousness, habits, emotions, will, desire, individual/collective), epistemological (knowable?—test, confess?), ethical (who should they be?), technical (what must they do to themselves? Pathways to being autonomous)

Strategies: aspirations, goals, connections and associations with particular political or other programmatics and logics of reform, role sought by or ascribed to practitioners within governmental complex

Appendix B: Preliminary Emic Codes

Video 27:

Relation to Self	Relation to Body	Relation to Others	Sense of Self?	Format
Mind/body disconnect	Wrong body “not feeling whole”	Money problems	Non-normative masculinity	Talk to Youtube
Transgender	Binding	Perception in public	Timeline of transition	One person in front of camera
	Chest Surgery			Describe results/care technology

Video 38:

Relation to Self	Relation to Body	Relation to Others	Sense of Self?	Format
Mind/body disconnect (being on HRT)	Off of hormones (needing to make video)	Health professionals	Non-normative masculinity	Talk to Youtube
New problems arise	Binding	Family/Mom	Non-normative trans*	One person in front of camera
Interior Self	Passing	Access to care	‘take care of myself’	Reason off Testosterone
		Read as Male		