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Galvanising criticality: Analysing trans health policy in a hostile political context

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ABSTRACT

INTRODUCTION: Pathologisation has long provided the architecture for governing access to gender-affirming medical care. An explicit orientation towards human rights in the latest revision of the World Professional Association for Transgender Health's (WPATH) Standards of Care appears as an important success in achieving trans depathologisation. This development is largely the result of sustained efforts by trans activists who have been dismantling pathologising structures and practices in the face of intensifying opposition and vitriolic attacks.

METHODS: This article presents findings from the comparison of approaches to depathologisation in the WPATH Standards for Care, version 7 (SOC-7), and an alternative best practices guide created by the Spanish Network for Depathologization of Trans Identities (the Guide) using the What's the Problem Represented to be? (WPR) approach to policy analysis. This WPR analysis is informed by the work of trans and First Nations policy workers, scholars, and activists. This methodological–conceptual approach is used to explore uncertainties about the limits of a liberal rights model in the Guide.

FINDINGS: Situating rights in the broader field of governing logics indicates that, although this approach seeks to replace harmful practices, it does little to address underlying colonial mechanisms. Noticing uncertainty supported consideration of the dynamic ways that medicalisation and rights, liberalism and neoliberalism, and colonial power are sustained in trans health policy.

CONCLUSION: In an increasingly hostile context, when uncertainty about the transformative capacity of human rights necessarily shifts focus, returning to trans analytics provides solid ground for deepening interrogation of the colonial conditions of care to enable full depathologisation to unfold.

Keywords: Transgender, human rights, trans health, depathologisation, anti-colonialism

For over fifty years, polyvocal trans-led activist movements have been dismantling the pathologising structures and practices of care in trans health. All while being met with a steady barrage of opposition. In this article, I report on comparing different approaches to trans depathologisation and the usefulness of uncertainty in research within an increasingly hostile political context. It might seem distracting (or even irrelevant) to raise concerns about the transformative capacity of human rights at this time. I believe that asking these questions is crucial because it can (re)orient the work towards disrupting the colonial conditions of care to support full depathologisation.

Pathologisation has long provided the architecture for an entire process of governing gender and access to care. Ansara

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and Hegarty (2014) clarified its foundation, arguing that because "authorities in English language contexts typically assign 'permanent' gender at or before birth … people's own descriptions of their genders and bodies are treated as invalid unless they are typically associated with their assigned sex designations" (p. 259). This invalidation forms the basis for a pathologising structure that incorporates medical concepts classifying these non-medical states of being into the leading diagnostic manual for mental disorders and an international disease classification system. Medical, psychiatric and sexological expertise is authorised in the construction of diagnostic categories used to identify and thus "treat" gender self-designation as a medical problem. Struggles for trans depathologisation carry on political legacies of highlighting collective experiences of institutional oppression and providing a framework for protest (Stone, 1991; Worley, 2011), strengthening community networks (Malatino, 2020; Meronek & Griffin-Gracy, 2023), building multi-issue education for health care practitioners (Sharman, 2016; Zoe Belle Gender Collective, 2021), and collaborative engagement at the level of international human rights law and policy reform (GATE, 2012; Yogyakarta Principles, 2017).

Yet, in the face of this work, trans people are facing increasing harm in the current political context. On this basis, trans-led advocacy organisations have been tracking the growing power and geographical reach of right-wing populist anti-gender movements, documenting its dangerous flow-on effects as resources that support community organising to challenge the intensification of this opposition at all levels of society (GATE, 2024; TGEU, 2024). The impacts of an increasingly hostile environment, fostered by well-resourced and networked anti-trans groups have been documented in the UK (Horton & Pearce, 2024), both historically and more recently the US (Billard, 2024; shuster, 2021; Stryker, 2017), Aotearoa New Zealand (Hattotuwa et al., 2023), and Australia (Stoff, 2023). The effects of invalidation and attempts at obliteration have cumulative and often devastating impacts on trans people's daily living, highlighting what is at stake in the determination and continuity of trans resistance.

Proposals for a rights-based model in trans health have been circulating for over a decade but have still received, at best, only a partial application. In what has been touted by many as an important success, the SOC-8 now clearly states that its guidelines are "rooted in the fundamental rights of TGD people", with each section containing recommendations reiterating that these can and should be applied "to promote equity and human rights" (Coleman et al., 2022, p. 58). This incorporation of rights, informed consent models, and widening the scope of advocacy responds to many of the longstanding demands of trans depathologisation activists and movements. However, close readings of the SOC-8 find that any achievements are undermined by contradictory language, compromises on its principles (Winters, 2022), and concerns that it can still be used to enforce transnormativity (Jacobsen, 2024). As a rights framework forms much of the foundation for a depathologisation position (Schwend, 2020), it can be difficult to find in-depth engagement with expressed concerns about its consequences in healthcare settings. However, in a legal context, there have long been arguments that rights produce "individualized states of existence" that, intentionally or not, also legitimise established relations of neoliberal governing of "social subjects according to the hegemonic colonial, capitalist, nationalist, racialized and heteronormative logics" that are "obscured through such liberal democratic exercises" (Irving, 2013, p. 320). These arguments coincide with what Spade (2015) has called a critical trans politics, an invitation to expansive and resistive thinking beyond a rights-based politics. Because an alternative and emancipatory framework of rights has not been subject to as much critical or influential scrutiny as the prevailing illness model, there remain unaddressed concerns about the potential rendering inevitable these underlying governing mechanisms known to cause harm. These concerns suggest that examining the different strategies for depathologisation through rights is crucial.

This research project took form within this context of ongoing struggle for depathologisation. For nearly a decade, I coordinated therapeutic social support programmes at a specialist LGBTIQA+ homelessness service where trans young people often shared their experience negotiating (resisting) the privileging of so-called expert knowledge over their own (Howe et al., 2019). The 2010s was a period of intensive activism and change. As I became aware of different depathologisation struggles, evidence was mounting—from my practice experience and research (Strauss et al., 2017)—that diagnostic criteria were still being used to delay, deny, and otherwise regulate young people's access to care. Working as I was with young people experiencing the maddening and motivating effects of empty assertions of depathologisation, I kept returning to ask: What would it take to relinquish both psy-authority and a system focused on restriction and risk mitigation? Although I have many professional and personal connections and solidarities in this area, following this line of inquiry did not change the fact that I was problematising approaches to depathologising care that I had no direct experience seeking. These realities translate into obligations that include continually asking, "What am I contributing?" and proactively taking accountability for what I do. In the context of this research, it meant working reciprocally with a group of counsellors who provide support for non-binary, trans, and gender-diverse people. Together, we produced a group policy analysis, and I joined a working group writing a shared ethos for their community of practice.

Using this context, I summarise the findings of a comparative analysis of the WPATH *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, version 7 (the SOC-7) (Coleman et al., 2012) and the *Best Practices Guide to Trans Health Care in the National Health Care System* (the Guide), created by the Spanish Network for Depathologization of Trans Identities (STP, 2010). I then outline a set of uncertainties to explain why I think expressing concern about a human rights approach is important and how asking questions about the relevance of a critique can be galvanising. The change in focus signifies a return to the analytical tools offered by trans-led scholarship, policy work, and activism. The Guide is a model for how critical interrogation led *by* trans people is achieved in and through practice *for* trans people. Extending an analysis that starts with a focus on the colonial mechanisms governing gender broadens the scope for action. It is also a way to locate the potential for political mobilisation, for an intertwining of anti-pathologisation and anti-colonial political projects and social movements.

A critical comparative analysis of two trans health policies

I used the What's the Problem Represented to be? (WPR) approach to critically compare each policy's conceptual premise and underpinnings, to trace how these have developed over time, examine practices that sustain their logics of medicalisation and rights, and consider their effects (Bacchi & Goodwin, 2016). I used a reciprocal approach to facilitate group policy analysis that sought to analyse each policy's proposals for governing access in ways that also consider the politics and relationships inherent in knowledge production. Meaning that, while the research received approval from the University of Sydney Human Research Ethics Committee, working reciprocally supported proactive accountability to people working 'on the ground' for trans depathologisation and provoked a deeper consideration of the requirements of centring

Indigenous sovereignty, especially in an Australian settler colonial research context (Barker, 2017; Carlson et al., 2023; O'Sullivan, 2021; Pehl, 2024). Using WPR's directive to self-scrutiny (Bacchi & Goodwin, 2016) as part of this combined approach offered a way to practise what is required to build relations in non-pathologising and anti-colonial work.

Published a decade and a half ago, these policies appear obsolete at first glance. Given their age, it is important to locate the chosen policies in time and relate them to other authoritative texts in the field. Published in 2012, the SOC-7 was selected as the prevailing international trans health policy when the research began and because it actively sought to rework its gatekeeping reputation. Although published in 2010, the Guide was selected for its uniqueness in the field. The STP (2010) created the Guide to provide "analytical tools and reference points for developing alternative non-pathologizing trans health care protocols that have local and international applicability" (p. 5) amid revisions to the DSM-IV (American Psychiatric Association, 2000), SOC-6 (Meyer et al., 2002), and ICD-10 (World Health Organization, 2016). In doing so, STP (2010) simultaneously offered a framework and developed an entirely new protocol for care in the Spanish health system, which was submitted as a proposal for fundamental change to the SOC-7 (Coleman et al., 2012). The analysis done as part of this article was bookended by the release of the ICD-11 (World Health Organization, 2019) and the SOC-8 (Coleman et al., 2022), leaving pressing questions of research relevance now that psychiatric diagnosis is no longer a prerequisite for care and rights have come into ascendancy. As a result, it appears that many of the issues raised in the Guide either no longer apply or have been superseded by concerns about the rise in anti-gender populism. However, the Guide issuing four interconnected demands—autonomy in decision-making, access without illness diagnosis, improving knowledge about medical technologies, and state-funded healthcare—remains an instructive and crucial means of establishing a rights-based approach (STP, 2010, p. 12). Although the SOC-8 declares that its guidelines are rooted in fundamental rights, its objective appears instead to *promote* equity and rights (Coleman et al., 2022). I see a significant difference between using a multi-pronged approach for establishing rights as a basis *for* care and suggesting ways of promoting rights *in* care. The Guide and its demands have been circulating for nearly 15 years yet have received surface-level application. Irrespective of my uncertainty about the transformative capacity of a human rights approach, the current research shows that scrutinising co-option and containment of its demands can be helpful in confronting the pushback that has occurred in its wake.

Analysis of the SOC-7

As a policy on responding to requests for access to gender-affirming medical technologies, the SOC-7 offered flexible "standards for promoting optimal health care" and guidance on "the treatment of people experiencing gender dysphoria" (Coleman et al., 2012, p. 2). Conceding that "most of the research and experience" originates from North American and Western European standpoints, the SOC-7 suggested that its standards could be adapted to any setting by "thinking about cultural relativity and cultural competence" (Coleman et al. 2012, p. 1). The SOC-7 repeated an earlier public statement that self-designated gender identities and expressions "should not be judged as inherently pathological", instead using the term "gender dysphoric" in reference to people who "experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that *might* [emphasis added] be classified as a mental disorder" (Coleman et al. 2012, pp. 4–5). Even with the transformation from diagnosing a person's identity as *disordered* to assessing the level of distress, attention remains at an individual level, with limited problematisation of social and economic components or the process itself.

As mentioned, this analysis proceeds from an established critique of an illness-based approach and the pathologising practices embedded in the *Standards of Care*. I hoped to contribute by delving into how verifying the distress of gender dysphoria, used as a method of depathologising care, effectively legitimated and expanded the existing illness paradigm. Clarifying how the SOC-7 relied upon and reproduced a logic of medicalisation encouraged reflection on how redirecting attention onto individual distress maintained the authority of psychiatric knowledges and continued to prioritise professional judgement.

Considering the preservation of mechanisms and hierarchies of clinical and geopolitical relations opened space to analyse further how this occurs as a continuation of the conditions of colonial state-making projects. Expanding the scope to consider the colonial basis of contemporary governing is made possible through a sovereign Indigenous critical analysis. This includes what Pehl (2024), who belongs to the Cherokee Nation of Oklahoma, named as a trans* Indigenous framework and critique that starts from the potentiality of an anti-colonial otherwise to uncover the workings of settler colonial logics in the here and now. This is what Wiradjuri critical Indigenous scholar O'Sullivan (2021) skilfully identifies as the colonial project of gender—and everything else—that requires persistent erasure of multiplicity and complexity to render specific formations of Indigenous bodies, genders, and relationships visible for governing. Trans health is still reckoning with the effects of representing an illness paradigm as an irreducible component of care. It should be cause for alarm when an approach to depathologisation that advances a logic of medicalisation appears as an inevitable and reasonable means of governing access. I see Indigenous trans scholarship that visibilises and rejects colonial conditions of care as setting a crucial direction for creating alternatives to making gender self-designation identifiable and thus treatable as a health "problem".

Analysis of the Guide

Compared to the SOC-7, the Guide explicitly states that the problem of pathologisation in trans health can be addressed by replacing the prevailing illness model with a rights paradigm. This alternative protocol for the Spanish healthcare system is premised on a person's right to access quality, gender-affirming medical care that is publicly funded and free from psychiatric requirements (STP, 2010). Equally as important, the Guide was created using analytical tools and reference points made available to develop multiple, locally responsive trans depathologisation projects (STP, 2010). These include the identification of "the scientific model developed in the West" regarding "sexuality, the body and gender … as an imperialistic colonizing mechanism" that invokes notions of progress to elide alternative understandings of gender and negate experiences of violence (STP, 2010, p. 10). Arjonilla (2014) showed how the Guide substitutes a diagnosis and treatment model "for a new one in which every single trans person is responsible for the process, because they are considered experts on their own processes" (p. 41). Reflecting on how the Guide strategically positions those requesting and providing care on an equal footing raises questions about rendering both governable through rights. Yet, for Arjonilla (2014), democratising the structures and practices of care remains key. The Guide's problematisation of care at this paradigmatic level promotes accountability to human rights, which provides an important challenge to the hierarchy of relations between those who seek access and those with the power to allow access. The Guide's critical analysis and alternative protocol attempts to reconfigure the potential response to requests for access to gender-affirming medical technologies. The Guide is a policy that both declares and enacts "the objective of health care for trans people … to create conditions that improve their quality of life" (STP, 2010, p. 1). Thus, it set an entirely different policy trajectory that remains an essential resource in the current political moment.

This section describes the methods and summarises the research findings. It also situates the SOC-7 and the Guide in time to underscore what is dynamic yet entrenched in this policy space. Given the focus of this article is uncertainty and its utility in research, the following section outlines four issues that raise questions about the consequences for care under the Guide's proposed human rights paradigm.

A set of uncertainties

The research findings indicate that the SOC-7 undermined its own attempts to rework a gatekeeping position. This occurred through the use of qualifying language that pressed people into status relations established and maintained by psy-professions, Western medicine, and that are replicated within Western law and correspond to citizenship requirements. In contrast, the Guide problematises the entire illness-based paradigm, arguing that the Western, medico-scientific model of sexuality, the body, and gender has colonially conditioned trans health. As an alternative, the Guide makes demands for publicly funded gender-affirming medical technologies (based on a right to healthcare) that are accessible via a process of informed decision-making (based on a right to bodily integrity, autonomy, and self-determination) without a requirement for a diagnosis of illness (based on the interrelationship between health and citizenship rights). Although many of these demands appear to have been met in more recent policies, the Guide remains unique in presenting an alternative care protocol in Spain that is also a model for developing other localised, non-pathologising protocols. This layered approach to depathologisation seems quite radical compared to the SOC-7 and -8. Yet, without critical examination, an alternative rights framework may also legitimise underlying oppressive governing mechanisms. Noticing when uncertainty about a transformation through rights began to appear revealed the dynamic ways medicalisation and rights, liberalism and neoliberalism, and colonial power appear in trans health policy. This section examines four uncertainties that reveal the operation and limits of these governing rationales. It is important to note that the following discussion is not an attempt to undermine the movement for trans depathologisation. As I started to notice uncertainty about the Guide's analytical tools and reference points, careful reading helped me appreciate what their limitations offer for engaging critically in the difficult task of establishing rights.

Normalising neoliberal responsibilisation

The first uncertainty about the Guide concerns a tacit normalisation of neoliberal responsibilisation. Considering the time of its publication, the Guide was radical in its representation of trans people as active, autonomous, self-determining, rights-bearing subjects and positioning health professionals as providing professional accompaniment for trans people in their decision-making process, free from psychiatric requirements (Arjonilla, 2014). Over time, the selective uptake of different demands in revisions of the DSM, ICD, and SOC suggests an enduring pattern containing activist strategies for change to maintain established status relations. The Guide attempted to intercept co-option, emphasising the right of people with self-designated genders to make autonomous decisions throughout the entire process of body modification, not only providing consent to receive "treatment". Ongoing conversations about informed consent models (Ashley et al., 2021; Jacobsen, 2024) allowed me to notice that normative forms of governing—that produce self-managing political subjects within Western healthcare—are not disrupted or addressed when the concept of autonomy is anchored to informed consent within a rights paradigm. A concerning alignment with an imperative towards "health" to become/remain productive is tempered by the Guide's aim to decouple gender self-designation "from a medicalized vision" (STP, 2010, p.

20). However, facilitating the autonomy of people with self-designated genders and honouring their requests to modify their bodies is constrained by neoliberal racial capitalism, which presumes personal power and entitlement that marks certain groups of people for social and literal death (Gossett, 2014; Puar, 2017). Gould's (2024) rigorous analysis echoes similar concerns about broadly liberal responses to coordinated attacks on trans health that align with the same late-capitalist structuring of US anti-trans laws. The Guide interrupts health professionals' unidirectional and regulatory role, but its compatibility with a neoliberal rationality, even if unintended, raises concerns about uncritically mobilising rights as a paradigm in care.

Normalising psychiatric diagnoses

Further investigation of the Guide's informed decision-making process reveals another implication of tacit normalisation. The Guide is clear in its objection to the "imposition of a diagnosis of a mental disorder" when responding to requests for access to care (STP, 2010, p. 16). It asserts that "a prior psychiatric diagnosis" should not disqualify someone from care, yet includes an "absence of identity delusions" as a component of its decision-making protocol (STP, 2010, pp. 28–29). The concern is that the objection to the imposition of psychiatric diagnoses related to gender self-designation does not extend to problematising the consequences of imposing other sorts of diagnostic categorisations—specifically, what it means when delusions are represented as the "psychotic features" of multiple mental disorder diagnoses (APA, 2013). The Guide defends "treatment" as a means of establishing a liveable life rather than medically managing specific modes of living (STP, 2010). Yet there remains a latent tension in the Guide between outright rejection and tacit normalisation (legitimisation) of some psychiatric diagnoses. This tension is equally made apparent through critical analyses of the SOC-8 (Winters, 2022). Jacobsen (2024) also revealed the implications of recommending extended assessments for young people labelled as risky, as well as a further multidisciplinary assessment for people who request seemingly unconventional *individually customised* combinations of surgical technologies. The discourses surrounding the Guide's demands do not conceive of depathologisation as a single trans-specific issue but as one "part of the structural violence inherent to the social gender order" (Schwend et al., 2014, p. 7576). Consequently, the "link between the demand of trans depathologization and a broader questioning of Western psychiatric classification systems and practices" is seen as generating "potential alliances with other critical theoretical reflections and social movements, among them intersex, body diversity, and antipsychiatry discourses and activisms" (Schwend et al., 2014, p. 7576). The inadvertent normalisation of some psychiatric diagnoses is a worrying limit of the Guide, not only on these potential alliances but also on how far depathologisation extends.

Identifying but not accounting for colonialism

Another important uncertainty lies in how the Guide presents its analysis as a reference point for developing other localised and responsive protocols in trans health. The Guide sees trans health as colonially conditioned by the *Western* medico-scientific model of sexuality, the body, and gender and, further, by the invention of *transsexuality* as a term to categorise, label and pathologise "the life trajectories" of people with self-designated genders (STP, 2010, p. 10). Crucial for developing the Guide was how this pathologisation functions as part of a progress-oriented, imperial-colonial mechanism. These are the colonial conditions historicised as the origins of pathologisation, the medical situation in Spain, and the status of international trans depathologisation activism (STP, 2010, pp. 8–10). Marking these reference points is a significant offering that could remarkably transform policy development, particularly extending beyond

North America and Western Europe as the places from which knowledge for protocol development emanates. However, the elision of Spain's position as a colonising nation limits these possibilities. For example, the writings of Spanish colonial missionaries, explorers, and administrators during the colonisation of the Philippines in the late 16th and early 17th centuries show that Indigenous Peoples' pre-existing ancestral gender systems were rendered "incomprehensible within the [Catholic] binarist and patriarchal gender system" (binaohan, 2014, p. 105). This is only one instance of Spain exerting colonial power in invading, claiming, settling, and attempting to incorporate multiple islands in the Caribbean, large portions of Central and South America, Mexico and parts of North America, and Western Sahara into the Spanish Empire. The Guide calls attention to the coloniality of an illness-based model, which is a crucial contribution. The concern is how selective attention to colonial mechanisms limits the analytical strategy's ability to address the colonial mechanisms in developing other emancipatory models.

Perpetuating liberalism while rejecting universalism

The final uncertainty arises through the failure to identify the human rights paradigm as part of a colonial mechanism. Despite clarifying that it does not aim to "establish a new universal model" for care, the Guide appears to perpetuate liberal notions of universal human rights (STP, 2010, p. 16). There is a pervasive silence on how constructions of the *human* justify colonial invasion, genocide, and occupation, which has effects when ideas of human are universalised into a neutral and non-hierarchical position in rights discourse. Hunt (2007) argued that human rights are made legible, not only through the formulation of doctrine, but also by "a set of convictions about what people are like and how they know right and wrong in the secular world" (p. 27). In her comprehensive critique of Western research from a critical Māori positionality, Smith (2021) explained how the tenet of "humanity" functions within established, gendered, and hierarchical "systems of rule and forms of social relations which governed interaction with the Indigenous peoples being colonized", making it possible "to consider Indigenous peoples as not fully human, or not human at all", in ways that "enabled distance to be maintained and justified various policies of either extermination or domestication" (p. 99).

The current political moment demonstrates that these continue as real-time practices. Colonialism has distinct life-threatening effects on converging Indigenous resurgences that must not be conflated with, or minimised by, making comparisons to struggles for gender self-determination. Yet, these ideas and systems do manifest as conditions of trans health. Hence, another implication is how dominant rights discourse closes off interrogation of assumptions of proprietary ownership underpinning an individualised notion of bodily autonomy. Access to care is implicitly connected to bodily integration and citizenship entitlements within nation-state formations that play a central role in colonial projects. Bodily integrity is widely used when invoking a person's decision-making rights over what happens to their body. However, this invocation also discursively connects the body to liberal assumptions of individuality, including property rights (Stryker & Sullivan, 2009). A rights paradigm does not appear to register how these broadly liberal ideas of proprietary ownership, bodily integration, and citizenship align with colonial political projects that create and maintain the terms of recognition by the state.

In terms of practical application, Platero (2020) outlined arguments by activists in a Spanish context that because "transgender laws make it easier for people to change their name and sex on national and social security IDs and to access hormonal treatments in a self-chosen path, they mitigate the impact of transphobic violence" (Platero, 2020, p. 262). Such an argument is countered by an assertion that "these actions rely on the individual being able to navigate the often transphobic social reality and do not directly tackle their economic marginalization" (Platero, 2020, p. 262). These two arguments in an ongoing conversation draw attention to parallels between the governing of access to gender-affirming medical technologies and the benefits of citizenship through recognition of (some) rights. Such a connection raises questions about whether a rights-based paradigm creates positive transformation or maintains processes integral to the state-securing colonial logics of claiming proprietary ownership and granting citizenship.

These four uncertainties about a human-rights-based approach come from a concern that it becomes another layer over, rather than a replacement for, this oppressive governing mechanism. The Guide uses its analysis to support an argument that "the objective of health care for trans people should be to create conditions that improve their quality of life" (STP, 2010, p. 16). However, questioning what care ought to be directs attention to the conditions needed for a liveable life. The Guide, therefore, develops its best practices by locating pathologisation within a colonising mechanism and marking both as key conditions shaping what is possible for people requesting access to gender-affirming medical technologies. Asking what uncertainty can do has meant returning to the Guide for a close (re) reading of how its analytics are applied and what they continue to offer. Asking this question has also meant (re)turning to critical interrogations led by trans people, which broaden thinking about alternatives that can disrupt a liberal logic of rights and dismantle the underlying colonial structures. Identifying this pathway makes possible the reflections in the final part of this article on how analytical tools galvanise this work in an increasingly hostile political context.

Analytical tools galvanising criticality

I began thinking about the importance of the word galvanise as I heard Puar (2017) discussing *The Right to Maim*, what she wanted for an anti-imperial politics and why she thought it was so important to be thinking "not just in terms of political mobilisation, and … solidarity organising, [but also] how we can kind of galvanize in relation to each other" (Adler-Bolton & Gill-Peterson, 2022). The uncertainty in this research came from situating rights in a wider field of governing logics, which has meant asking some difficult questions about who and what a liberal human rights paradigm serves. Although I still struggle to shake the uncertainty, I look to the work of trans policy workers, activists, and scholars—of whom only a tiny fraction are cited here—for the lines of inquiry they offer. Introducing rights into the medical and gatekeeping logics of care may positively change practices while further obfuscating oppressive governing. These analytical tools, especially those offered by First Nations scholars, set a direction for interrogating the colonial conditions of care. This thinking occurs amid an ongoing fight against coordinated anti-gender mobilisations and working for its alternatives that Gilmore and Lambert (2019) so cogently asserts "already exists in fragments and pieces, experiments and possibilities" (p. 14). I see the Guide's proposal for a complete paradigm change as a valuable strategy for depathologisation because it pushes for considering what underpins and is contained within different models of care. The emerging issues help to sustain attention on dismantling the colonial conditions of its governing.

Conclusion

This article discusses findings from a critical analysis of trans health policy that works through the author's uncertainty about the transformative capacity of human rights to find a solid grounding from which to proceed. Important changes in trans health policy at the international level have occurred because of sustained efforts to reorganise care around a rights framework. The purpose of this analysis is not to discount or undermine the struggle for trans depathologisation but to focus attention on the underlying conditions and potential consequences of taking up a rights-based approach. Uncertainty does not necessarily mean letting go of rights. It means returning to the analytical tools offered by trans policy workers, scholars, and activists to keep asking difficult questions. Rights may help to change harmful practices and increase access while securing underlying colonial domination and oppressive state power. I believe that raising concerns about mobilising a human rights paradigm alongside or even to replace an illness model can strengthen the coalitions and the relations needed to create alternatives to that which maintains and normalises harm. Strengthening and sustaining work for depathologisation is necessary because overlooking the ways a policy contributes to, and maintains, a process of classification and containment in service of securing projects of colonial expansion has devastating effects.

It seems appropriate to end by highlighting the Guide's use of "we" as an essential component of its approach to depathologisation. An assertion of "continuing to fight tirelessly against the violence, stigmatization and marginalization to which we've been subjected" characterises the Guide as wanting change through being part of that change (STP, 2010, p. 5). Indeed, this statement is a precursor to the Guide articulating a hope that it "will stimulate debate over alternative ways to implement a non-pathologizing health care model" (STP, 2010, p. 29). The anticipation of being part of a continued and contested process is underscored by STP (2010) viewing this work "as another turning point in a historic struggle", one that "gives voice to the trans community, which invites all to join us in crafting new alternatives that replace the customary pathologization of our lives" (p. 29).

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References

Adler-Bolton, B., & Gill-Peterson, J. (2022, November 21). Body Politics w/ Jasbir Puar In *Death Panel*. https://www.deathpanel.net/transcripts/jasbir-puar-body-politics

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders-IV-TR*. American Psychiatric Publishing.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596

Ansara, Y. G., & Hegarty, P. (2014). Methodologies of misgendering: Recommendations for reducing cisgenderism in psychological research. *Feminism & Psychology*, *24*(2), 259-270. https://doi.org/10.1177/0959353514526217

Arjonilla, E. O. (2014). Reframing Care Practices on Transgender Health: The International Campaign Stop Trans Pathologization. In A. Bammé, G. Getzinger, & T. Berger (Eds.), *Yearbook 2014 of the Institute for Advanced Studies on Science, Technology and Society*. Profil.

Ashley, F., St. Amand, C. M., & Rider, G. N. (2021). The continuum of informed consent models in transgender health. *Family Practice*, 1-2. https://doi.org/10.1093/fampra/cmab047

Bacchi, C., & Goodwin, S. (2016). *Poststructural Policy Analysis: A Guide to Practice*. Palgrave Macmillan US.

Barker, J. (Ed.). (2017). *Critically Sovereign: Indigenous Gender, Sexuality, and Feminist Studies*. Duke University Press. https://doi.org/10.1515/9780822373162.

Billard, T. J. (2024). The politics of transgender health misinformation. *Political Communication*, *41*(2), 344-352. https://doi.org/10.1080/10584609.2024.2303148

Carlson, B., Day, M., O'Sullivan, S., & Kennedy, T. (2023). *The Routledge handbook of Australian Indigenous peoples and futures*. Taylor & Francis Group.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., & Meyer, W. J. (2012). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version*. The World Professional Association for Transgender Health.

Coleman, E., Radix, A., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, G. A., Knudson, D. H., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., . . . Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, *23*(sup1), S1-S259. https://doi.org/10.1080/26895269.2022.2100644

GATE. (2012). It's Time for Reform: Trans* Health Issues in the International Classification of Diseases. https://gate.ngo/knowledge-portal/news/its-time-for-reform-trans-health-issues-in-the-icd/

GATE. (2024). *Campaigns: Anti-Gender Movements*. Global Action for Trans Equality. https://gate.ngo/knowledge-portal/campaign/anti-gender-movements/

Gilmore, R. W., & Lambert, L. (2019). Making Abolition Geography in California's Central Valley with Ruth Wilson Gilmore. *The Funambulist*, *21*, 14-19.

Gossett, C. (2014). We will not rest in peace: AIDS activism, black radicalism, queer and/or trans resistance. In J. Haritaworn, A. Kuntsman, & S. Posocco (Eds.), *Queer Necropolitics* (pp. 31-50). Routledge.

Gould, W. A. (2024). Coconstructing (Trans-)Capitalist Realism: Trans Activisms Collude in the Political Economy Structuring Anti-Trans Laws. *TSQ: Transgender Studies Quarterly*, *11*(2), 214-238. https://doi.org/10.1215/23289252-11215470

Hattotuwa, S., Hannah, K., & Taylor, K. (2023). *Transgressive transitions: Transphobia, community building, bridging, and bonding within Aotearoa New Zealand's disinformation ecologies March-April 2023*. The Disinformation Project. https://www.thedisinfoproject.org/s/Transgressive-Transitions.pdf

Horton, C., & Pearce, R. (2024). The U.K.'s Cass Review Badly Fails Trans Children. *Scientific American*. https://www.scientificamerican.com/article/the-u-k-s-cass-review-badly-fails-trans-children/

Howe, R., Harper, A., & Hammoud-Beckett, S. (2019). Uncovering Games of Truth: A Collaborative Exploration of the Ways Transgender and Non-Binary young People Access Health Care and Support. In D. Baines, B. Bennett, S. Goodwin, & M. Rawsthorne (Eds.), *Working Across Difference: Social Work, Social Policy and Social Justice* (pp. 137-152). Red Globe Press.

Irving, D. (2013). Against the grain: Teaching transgender human rights. *Sexualities*, *16*(3-4), 319-335. https://doi.org/https://doi.org/10.1177/1363460713479746

Jacobsen, K. (2024). Prioritizing Trans Autonomy over Medical Authority in Gender-Affirming Care: The Role of Risk and Uncertainty. *Bulletin of Applied Transgender Studies*, *3*(1-2), 1-19. https://doi.org/10.57814/eay5-ey57

Malatino, H. (2020). *Trans Care*. University of Minnesota Press.

Meronek, T., & Griffin-Gracy, M. M. (2023). *Miss Major Speaks: Conversations with a Black Trans Revolutionary*. Verso Books.

Meyer, W., Bockting, W. O., Cohen-Kettenis, P., Coleman, E., Diceglie, D., Devor, H., Gooren, L., Hage, J. J., Kirk, S., Kuiper, B., Laub, D., Lawrence, A., Menard, Y., Patton, J., Schaefer, L., Webb, A., & Wheeler, C. C. (2002). The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version. *Journal of Psychology & Human Sexuality*, *13*(1), 1-30. https://doi.org/10.1300/J056v13n01_01

O'Sullivan, S. (2021). The Colonial Project of Gender (and Everything Else). *Genealogy*, *5*(3), 67. https://doi.org/10.3390/genealogy5030067

Pehl, E. (2024). On "Deadnaming" the "Vanishing Indian". *TSQ: Transgender Studies Quarterly*, *11*(1), 80-96. https://doi.org/10.1215/23289252-11131702

Platero, R. L. (2020). Redistribution and recognition in Spanish transgender laws. *Politics and Governance*, *8*(3), 253-265. https://doi.org/10.17645/pag.v8i3.2856

Puar, J. K. (2017). *The Right to Maim: Debility, Capacity, Disability*. Duke University Press.

Schwend, A. S. (2020). Trans health care from a depathologization and human rights perspective. *Public Health Reviews*, *41*(1), 1-17. https://doi.org/10.1186/s40985-020-0118-y

Sharman, Z. (2016). *The Remedy: Queer and Trans Voices on Health and Health Care*. Arsenal Pulp Press.

shuster, s. m. (2021). *Trans Medicine: The Emergence and Practice of Treating Gender*. NYU Press.

Spade, D. (2015). *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law* (Revised and expanded ed.). Duke University Press.

Stoff, M. (2023). Why gender essentialism is a white supremacist ideology. *Overland*. https://overland.org.au/2023/03/why-gender-essentialism-is-a-white-supremacist-ideology/

Stone, S. (1991). The Empire Strikes Back: A Posttranssexual Manifesto. In J. Epstein & K. Straub (Eds.), *In Body Guards: The Cultural Politics of Gender Ambiguity* (pp. 280–304). Routledge.

Stop Trans Pathologization (STP). (2010). *Best Practices Guide To Trans Health Care In The National Health System*. https://itgl.lu/wp-content/uploads/2015/04/STP_guide_health.pdf

Strauss, P., Cook, A., Winter, S., Watson, V., Toussaint, D. W., & Lin, A. (2017). *Trans Pathways: The mental health experiences and care pathways of trans young people.* Telethon Kids Institute. https://www.telethonkids.org.au/projects/past/trans-pathways/

Stryker, S. (2017). *Transgender History: The roots of today's revolution* (Second ed.). Seal Press.

Stryker, S., & Sullivan, N. (2009). King's Member, Queen's Body: Transsexual Surgery, Self-Demand Amputation and the Somatechnics of Sovereign Power. In S. Murray & N. Sullivan (Eds.), *Somatechnics: Queering the Technolisation of Bodies* (pp. 49-64). Routledge. https://doi.org/10.4324/9781315609867

TGEU. (2024, May 15). *Trans Rights Index & Map 2024 reveals polarisation in trans rights in Europe and Central Asia*. TGEU (Trans Europe and Central Asia) https://tgeu.org/tgeus-trans-rights-index-map-2024-reveals-polarisation-in-trans-rights-in-europe-and-central-asia/

Winters, K. (2022). Contradictions and Compromises of Principle in the SOC8. *Trans Policy Reform Blog*. https://transpolicyreform.files.wordpress.com/2023/02/202210soc8principlesj.1.pdf

World Health Organization. (2016). International Statistical Classification of Diseases and Related Health Problems (10th ed.). https://icd.who.int/browse10/2016/en

World Health Organization. (2019). *International Statistical Classification of Diseases and Related Health Problems, 11th Revision*. Geneva: World Health Organization

Worley, J. (2011). 'Street Power' and the Claiming of Public Space: San Francisco's 'Vanguard' and Pre-Stonewall Queer Radicalism. In N. Smith & E. A. Stanley (Eds.), *Captive Genders: Trans Embodiment and the Prison Industrial Complex* (2nd ed., pp. 41-56). AK Press.

Yogyakarta Principles. (2017). *Yogyakarta Principles Plus 10: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics to Complement the Yogyakarta Principles.* http://www.yogyakartaprinciples.org/principles-en/yp10/

Zoe Belle Gender Collective. (2021). *Transgender and Gender Diverse Inclusive-Care Guide for Hospital Based Healthcare Professionals*. Zoe Belle Gender Collective with Melbourne Health. https://zbgc.org.au/resources/zbgc-resources/zbgc-best-practice-for-tgd-healthcare/