“It was like I had to fit into a category”
People with trans experiences navigating access to trans-specific healthcare and health

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Like racism and all forms of prejudice, bigotry against transgendered people is a deadly carcinogen. We are pitted against each other in order to keep us from seeing each other as allies. Genuine bonds of solidarity can be forged between people who respect each other’s differences and are willing to fight their enemy together. We are the class that does the work of the world, and can revolutionize it. We can win true liberation.

Leslie Feinberg (2006, p. 220)
# Table of Contents

Abstract ........................................................................................................ iv
Sammanfattning på svenska ......................................................................... vi
Glossary and Abbreviations ....................................................................... viii
Original Papers ............................................................................................ x

## Introduction
Starting points .............................................................................................. 3
Positioning the thesis ................................................................................ 5
  ... within the field of public health......................................................... 5
  ... within the field of trans studies...................................................... 7
  ... in relation to interdisciplinary academic work ................................ 9
Choice of terminology.................................................................................. 10
  Trans experiences, linear gender and cisnormativity ................................ 10
  Conceptualisation of health .................................................................. 12
  Other key concepts .............................................................................. 12
Outline of the thesis.................................................................................... 13

## Background
Trans experiences and health ..................................................................... 15
  Health status in the group .................................................................. 15
  Explanations for health inequalities .................................................. 16
Trans experiences and healthcare ................................................................ 18
  Non-trans-specific healthcare ............................................................ 18
  Trans-specific healthcare .................................................................... 19
Identifying a knowledge gap....................................................................... 22

## Aim and research questions
............................................................................................................. 23

## Theoretical and conceptual framework
Different perspectives on trans(gender) – from psychomedical discourses to trans studies ......................................................................................................................... 24
  Psychomedical discourses on trans experiences .................................. 24
  Feminist, queer and trans studies discourses on trans experiences .......... 26
Phenomenology and Foucauldian theory – towards a conceptual framework ............................................................................................................................... 33
  Queer phenomenology ....................................................................... 33
  A Foucauldian power analysis ............................................................. 35
  Conflicting understandings of the subject and experiences ................ 39

## Research context
Legal situation for people with trans experiences ...................................... 42
Swedish trans politics.................................................................................... 43
The Swedish healthcare system and trans-specific healthcare .................. 44

## Methods
Study design.................................................................................................. 49
Interview studies (sub-studies 1 and 3) ...................................................... 51
Results .......................................................................................................................... 64
How do care-seekers experience navigating and negotiating access to trans-specific healthcare and gender-confirming medical procedures? (sub-study 1) ........ 64
Orienting towards trans-specific healthcare ............................................................... 64
Navigating one’s way to the evaluation ..................................................................... 66
Negotiating access to gender-confirming medical procedures – meeting the evaluating team ................................................................. 68
Experiences of gender governing ............................................................................. 73
How are problems of evaluation, diagnosis and access to care represented in the Swedish guidelines for trans-specific healthcare? (Sub-study 2) ............ 81
The problem of (non)linear gender ........................................................................ 81
The mental health paradox ..................................................................................... 83
Gender dysphoria as a psychiatric problem .............................................................. 84
The psychosocial problem ...................................................................................... 85
How are experiences of safety/unsafety related to perceived health in public, semi-public and community spaces? (Sub-study 3) ................................. 86
Unsafety, limited living space and invisible violence ............................................ 87
Being one among others is a basic need ................................................................. 89
Discussion ................................................................................................................. 92
Diagnostic tools and decision models – Experts, objectivity, and governing .......... 92
Available diagnostic tools ..................................................................................... 92
Experiences and modes of governing ................................................................. 94
Gate-keeping and alternative decision-models ......................................................... 95
Governing of/through gender ............................................................................. 97
(Trans)gender identity and orientation towards trans-specific healthcare ........ 97
Straightening of gender ...................................................................................... 98
An extra stereotypical performance, transvestites and sexuality ....................... 100
Psychomedical constructions of gender as rationale ........................................ 101
Temporality, waiting and future lives ................................................................. 104
“Trans-specific healthcare: Please hold” – waiting and health ......................... 104
Temporality as a governing technique ............................................................... 105
Suffering but psychosocially healthy ................................................................. 107
Mental ill-health as a state of incapacity and critical dis/ability perspectives 109
Trans in itself as a mental illness .................................................. 110
Asylum seekers and undocumented migrants as undeserving ............ 111
Neoliberal shifts in the welfare state and (some) individual moral responsibilities . 112
A trans-specific healthcare in transition – and future struggles ............ 113
(Un)safe spaces, needs of belonging and health ................................... 114
Feminist, LGBTQ and trans-separatist spaces – an ambiguous inhabitancy ... 116
Material conditions and health – an area in need of research .................. 118
Affective labour and health .................................................................. 119
The body going to work and health consequences ................................. 120
Methodological discussion ................................................................... 123

Conclusions and implications ............................................................... 125
Future research .................................................................................... 127

Epilogue ............................................................................................... 128

Acknowledgements and gratitude ........................................................ 129

References ............................................................................................ 132
Appendix 1. Biographies of the participants ............................................ 146
Appendix 2: Diagnostic categories ......................................................... 148
Appendix 3. Advertising material ........................................................... 149
Appendix 4: Summary of interview guide ............................................... 150
Abstract

Background: Trans issues have received increased attention over the last couple of years and important changes have been made in the legislation relating to gender reassignment and in trans-specific healthcare practices. At the same time, many people with trans experiences report poor mental health, bad experiences when encountering the healthcare and a tendency to postpone seeking care due to being badly treated. Previous research has also shown that gender norms guide the evaluation that precedes access to gender-confirming medical procedures. Critical studies examining practices within trans-specific healthcare in the Swedish context and health among people with trans experiences are limited, especially qualitative interview studies involving people with trans experiences.

Aim: To analyse how constructions of trans experiences and gender can affect trans-specific healthcare practices, experiences of navigating access to gender-confirming medical procedures, inhabitancy of different spaces and, ultimately, health.

Conceptual framework: Three areas of theory are used for the conceptual framework: trans studies, queer phenomenology and Foucauldian theories of power and governmentality.

Methods: The thesis includes three sub-studies (generating four articles): two interview studies that build on interviews with 18 people with trans experiences, and a policy analysis of the guidelines for trans-specific healthcare published by the Swedish National Board of Health and Welfare. For the interview studies, grounded theory and thematic analysis were used as the analytical method. The guidelines were analysed using Bacchi’s method: “What’s the problem represented to be?”.

Results: The participants experienced trans-specific healthcare as difficult to navigate due to waiting times, lack of knowledge and/or support and relationships of dependency between healthcare users and providers. In the evaluation, gender is reconstructed as linear – stereotypical, binary and stable – and the space for action available to care-seekers is affected by discourses existing both inside and outside trans-specific healthcare. The difficulties in navigating access to care were experienced as creating ill-health. In order to negotiate access to gender-confirming medical procedures, the participants took responsibility for the care process by, for example, ordering hormones from abroad, acquiring medical knowledge and finding alternative support. The linear gendered positioning was variously resisted, negotiated and embraced by the participants.
The analysis of the guidelines showed that gender identity is constructed as a fixed linear essence but that the guidelines also open up space for a non-linear embodiment. Gender dysphoria is closely constructed in relation to psychiatric knowledge and mental health and the gate-keeping function among mental healthcare professionals is reconstituted in the guidelines. Hence, care-seekers are constructed as not competent enough to make decisions concerning access to gender-confirming medical procedures.

The participants experienced several different spaces, such as bars, public toilets and changing rooms, gyms and cafés, as unsafe and as contributing to ill-health. In order to overcome the barriers to comfortably inhabiting spaces, the participants performed a kind of labour; for example, preparing in order to visit public baths and to answer transphobic comments and questions. Some spaces, such as trans-separatist, feminist and queer spaces, were experienced as safer and contributed to improved health through experiences of belonging, being able to share bad experiences and being able to relax.

**Conclusions:** Trans-specific healthcare practices need to become more affirming and change so that care-seekers have more space for self-determination. Trans-specific healthcare needs more resources in order to decrease waiting times, improve knowledge and support, and hence to improve access to gender-confirming medical procedures. Actions need to be initiated to make spaces safer in order to improve the health of people with trans experiences.
Sammanfattning på svenska

Bakgrund: De senaste åren har transfrågor uppmärksammats allt mer. Viktiga juridiska förändringar har skett, såsom borttagande av krav för sterilisering vid juridisk könsbekräftelse, och transvården har fått sina första officiella riktlinjer för vård vid könsdysfori. Samtidigt visar flera rapporter att många personer med transerfarenheter rapporterar ett dåligt allmänt hälsotillstånd, psykisk ohälsa och brister i mötet med vården. Tidigare forskning visar också att normer kring kön påverkar utredningen som personer med transerfarenheter måste gå igenom för att få tillgång till könsbekräftande vård. Syftet med den här avhandlingen är att analysera hur konstruktioner av transerfarenheter och kön kan påverka praktiker inom den trans-specifika vården, erfarenhet av att navigera tillgång till könsbekräftande vård samt upplevelsen av olika typer av rum och hälsa.

Metod: Avhandlingen bygger på fyra artiklar som är uppdelade i tre delstudier. Två av delstudierna bygger på totalt 18 intervjuer med personer med transerfarenheter och en delstudie bygger på en policyanalys av Socialstyrelsens riktlinjer för transfektiv vård. Intervjustudierna har analyserats med grundad teori respektive tematisk analys och riktlinjerna har analyserats med Bacchis metod som undersöker hur problem framställs i en text. Delstudie 1 handlar om hur vårdsköande personer med transerfarenheter navigerar och förhandlar sig till att få könsbekräftande vård. I den andra delstudien undersöker jag hur utredning, diagnostisering och kriterier för tillgång till könsbekräftande vård är beskrivna i riktlinjerna från Socialstyrelsen för transspécifik vård. I den sista delstudien har jag undersökt hur trygghet och otrygghet i olika typer av rum kan påverka hälsan hos personer med transerfarenheter.


Analysen av riktlinjerna för transvården visade att kön konstrueras som en fixerad linjär essens, dvs. att könsidentiteten bör vara stabil över tid och matcha

Deltagarna upplevde en rad olika rum och platser som otrygga eller obekväma vilket påverkade deras hälsa. Till exempel berättades många deltagare om barer och pubar som otrygga platser där de hade erfarenheter av att bli utsatta för fysiskt våld, verbala trakasserier och ifrågasättande. Könsupplevelse av otrygga eller obekväma platser som omklädningsrum och könsmata var andra viktiga platser i berättelserna om otrygga rum. Deltagarna upplevde att det var svårt att välja vilken toalett eller vilket omklädningsrum dom skulle besöka och att det kunde vara svårt att passa in i något av dom. Transseparatistiska, feministiska och HBTQ-rum upplevdes av många som trygga platser och viktiga för att kunna dela med sig av erfarenheter, känna gemenskap och återhämta sig från erfarenheter av otrygghet. Dock fanns det erfarenheter av att dessa rum också kunde vara excluderande.

**Slutsatser och implikationer:** Sammanfattningsvis har transvården har genomgått flera förbättringar, men den upplevs fortfarande som problematisk av vissa vårsökande och även i riktlinjerna konstrueras kön och könsdysfori på problematiska sätt. Att få tillgång till könsb克拉ftande vård är viktigt för många personer med transfarenheter, men vägen till vård kan i sig själv ha negativa hälsokonsekvenser för de vårsökande. Transvården återskapar kön som binärt, stabilt och stereotypt vilket inte stämmer överens med vissa av de vårsökandes förståelse av sig själva. Vårdgivare inom psykiatrin har fortsatt makt att bestämma vilka som ska få tillgång till vård vilket kan bidra till att transpersoner har svårare att få tillgång till adekvat vård för psykisk ohälsa. Flera olika vardagliga platser upplevs som otrygga och skapa ohälsa. För att överkomma hindren, både inom transvården och i andra rum, utför deltagarna ett affektivt arbete som också kan innebära negativa hälsokonsekvenser. Utifrån studien resultat behövs flera förändringar för att skapa utrymme för mer självbestämmande hos de vårsökande och för att förbättra tillgången till könsb克拉ftande vård. Det behövs även mer resurser till transvården för att minska väntetiderna, öka tillgången till stöd för de vårsökande och kunskap hos vårdgivarna. För att förbättra hälsan hos personer med transfarenheter är det nödvändigt att skapa fler trygga rum.
Glossary and Abbreviations

Binary gender – People, both cis and trans, who identify as men or women

Cis – From Latin “on the same side”, used to denote people who identify as the gender they were assigned at birth (not an abbreviation).

DSM – Diagnostic and Statistical Manual of Mental Disorders (published by the American Psychological Association)

EPATH – European Professional Association for Transgender Health

FPES – Full personal expression Sweden (trans organisation)

FtM – Female to Male

FtX – Female to X (non-binary)

Gender–confirming medical procedures – Medical procedures that aim to alter the gendered body, such as hormones, breast surgery, genital surgery, hair removal.


KIM – Sex, Identity, diversity (Swedish trans organisation)

LAB – Legal Advisory Board (at the National Board of Health and Welfare).

LGBTQ – Lesbian, Gay, Bisexual, Transgender, Queer

MtF – Male to Female

MtX – Male to X (non-binary)

Non-binary gender – People who do not identify as either men or women can have a non-binary gender identity.
Passing – Being perceived by others as having the gender identity you identify with.

RFSL – The Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Rueer Rights

RLE – Real-life experience (a part of the evaluation when care-seekers usually have to live for 6-12 month in the gender with which identify, sometimes also called the Real-life test (RLT))

SKS – Swedish Knowledge Support (guidelines for Swedish trans-specific healthcare)

SOC – Standards of Care (international guidelines for trans-specific healthcare released by WPATH)

SFTH – Swedish Association for Transsexual Health (association for professionals working clinically with trans-specific healthcare)

Trans – From Latin “across” or “on the other side”, used to denote people who do not identify with the gender assigned at birth.

Trans experiences – Used in this thesis as an umbrella term to denote experiences of transcending the normative expectations that the gender assigned at birth should be in line with the gender identity, and the social and bodily expressions of gender.

Transgender – In English used as either an umbrella term for the trans community or for people who fall outside the transsexualism category.

Trans person [transperson] – Often used in Swedish as an umbrella term for the trans community.

Transsexualism – A medical diagnosis in ICD. Transsexual is sometimes used to describe people who want access to gender-confirming medical procedures and then contrasted against “transgender”.

WPATCH – World Professional Association for Transgender Health
Original Papers

This thesis is based on the following papers:


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Introduction

For this study, I interviewed 18 individuals with trans experiences. One of them said, regarding the trans-specific healthcare:

It was very difficult for me to even get a referral to [trans-specific] healthcare. /.../ And I didn't know everything and no one in the chain of care knew how I was supposed to get my referral. I went to my family doctor, who did not understand anything, and then to the psychiatrist. And then the actual evaluation. /.../ [the evaluator] had a very strict understanding of how a transsexual person should be and not be. /.../ I had to take a timed test using building blocks, and all those kinds of humiliating parts that are still present on some evaluation teams. And I felt like the whole evaluation was humiliating. /.../ When I posed questions about my options concerning hormones and injections, the endocrinologist interpreted me as being unsure and thought that maybe I should wait for hormone treatment. Simply because I wanted to know the risks and the advantages. Because I wanted to know what I got myself in to, and what kind of treatment I would have for the rest of my life. And then I was interpreted as insecure. So, I have thought trans-specific care is so-so. And it also consists of much responsibility, to put pressure [on care-providers] to get the care you want. And I have been able to nag my way past the queue. (Elias)

In this quote, Elias points out several issues that people with trans experiences can face when they try to access, and when they meet, trans-specific healthcare. Barriers for access to care include, for example, a lack of knowledge among care-providers, responsibility shifts, encountering fixed ideas of how the care-seeker ought to identify and behave in order to gain access to gender-confirming medical procedures (the ideal is for them to be secure and to fulfil the diagnostic criteria for a transsexual). Elias’ quote also illustrates that access to trans-specific healthcare can be unequal depending on one’s ability to adopt an active role as a care-seeker. Meeting trans-specific healthcare also means meeting perceptions about gender as binary and stereotypical (the transsexual position). Together, Elias experiences demonstrate different barriers to access to gender-confirming medical procedures and poor quality of care, which can also affect the health of care-seekers.

The work on this thesis started in 2013, the same year as the legal requirement for sterilisation was removed from the Swedish law on legal gender reassignment (SOU, 2017:92). This requirement was, however, initially removed in practice through jurisdiction in 2012 after a long fight by trans activists and organisations. During the legal process, in 2012, it was also suggested in a proposition that the demand for sterilisation ought to be taken out of the law. The quote below is part
of the formal comment on the proposition from the County Council of Västerbotten (VLL 2012:1889):

Secondly, there are other reasons for retaining the requirement for sterilisation/castration. The county council considers that it unreasonable that, for example, a Woman-to-Man could theoretically could pregnant. Thus, that a biological woman who now lives as a man and is on testosterone treatment could get pregnant and give birth to a child if “he” stops taking these hormones. And, in the same way, if a Man-to-Woman who after legal gender reassignment could fertilise another woman and in that way be a biological “father” to the child. These possibilities/risks appear unreasonable and are likely to create a lot of confusion and formal and emotional complications respectively.

With this quote, I want to exemplify some of the naturalised ideas about trans experiences that exist in parts of the psychomedical scientific community and in trans-specific healthcare. This statement was officially published by the County Council of Västerbotten but was formulated by the psychiatrist who at the time was responsible for the “gender-identity evaluation” at Norrland University Hospital in Umeå (private conversation, March 11, 2015). The statement can be seen as exemplifying a psychomedical discourse in which trans embodiment is constructed and categorised as pathological and trans bodies are constructed as in need of sterilisation, at least if one wants access to gender-confirming medical procedures (Alm, 2006; Davis et al., 2016; Ekins, 2005). Furthermore, it reveals the ambition, or belief, that someone else, in this case the state, should decide upon people’s ability to become pregnant and/or genetic parents. The quote also represents the naturalised idea within psychomedicine that gender is binary and that the categories man and woman are mutually exclusive (eg. Butler, 2004b; Fausto-Sterling, 2000). The psychomedical understanding of trans can be seen as a dominant one and has significant ramifications for care-seekers’ access to and experiences of trans-specific healthcare.

This thesis deals, among other things, with the research problem that appears between the different positions, perspectives and experiences represented by the two quotes above. It deals with encounters between people with trans experiences, and trans-specific healthcare and the psychomedical discourse more broadly. The encounters that will be analysed took place in a context – Sweden – that has one of the world’s longest histories of providing state-funded gender-confirming medical procedures and where trans-specific healthcare has previously been considered internationally to be at the forefront (G. R. Brown, 1990). Nevertheless, previous research and reports show that care-seekers within Swedish trans-specific healthcare experience long waits, suffering and narrowly defined gender norms during the evaluation for access to gender-confirming medical procedures (Bremer, 2011; The National Board of Health and Welfare, 2010). Despite this, with few exceptions, the experiences of care-seekers have not
been studied, especially within medical academic fields. This study also takes place during a time of change; the legal requirement for sterilization was removed in 2013, and in 2015 the National Board of Health and Welfare published the first official guidelines for Swedish trans-specific healthcare. These guidelines will be analysed in this thesis.

In 2015, the Swedish Public Health Agency released a report focusing on the health of people with trans experiences. The results were striking: during the previous year, 36% of respondents had seriously considered suicide, 28% reported bad experiences in encounters with healthcare and 40% had postponed seeking care due to fear of being badly treated. Among the general population in Sweden, 6% have seriously considered suicide during the previous year (The Public Health Agency of Sweden, 2015). Hence, these figures reveal a prominent inequality in mental health between people with trans and without trans experiences. The Public Health Agency (2015) concludes that inequality depends on values and norms that exclude people with trans experiences. In order to understand these norms and their mechanisms, and to begin to disentangle and combat the health gap, qualitative studies are needed. However, such studies were lacking in the Swedish context when I started this project.

With this as a backdrop, the aim of this thesis is to analyse how constructions of trans experiences and gender can affect trans-specific healthcare practices, experiences of navigating access to gender-confirming medical procedures, inhabitancy of spaces and, ultimately, health. When analysing the narratives of people with trans experiences about trans-specific healthcare and the guidelines for Swedish trans-specific healthcare, I am interested, for example, in how the participants understand their gendered self in relation to the constructions of gender appearing in trans-specific healthcare. My interest also lies in exploring what other factors are constructed and experienced as important in order to gain access to gender-confirming medical procedures, both in the participants’ narratives and in the guidelines. This study also sets out to explore how experiences of safety and unsafety in public, semi-public and community spaces can contribute to perceived levels of health among people with trans experiences. This additional focus can facilitate an exploration of differences and similarities between different spaces that are important in people with trans experiences’ lives and also to show how trans-specific healthcare and the psychomedical arena are not isolated entities but are both affected by and affect societal discourses on trans experiences and gender.

**Starting points**

When I started this project, I had a totally different idea about the aim of the thesis and the topics for different papers. I intended to use the interviews and the
participants’ experiences to theorise sex/gender and disregard their lived experiences, as others had done before me (for a critique see Spade, 2006). What made me redirect my focus was my meetings with trans activists and my encounter with the field of trans studies, which made me aware of the historical context of researching and theorising trans. When I realised that starting from the participants’ experiences felt more ethical for me, I thought that I would focus on health experiences and experiences of healthcare that were not trans-specific, as Bremer’s thesis (2011) about trans-specific care had been published only a few years before I started. However, as I conducted the interviews and realised that many participants’ experiences of health were deeply connected to experiences of trans-specific care and that many of their experiences of healthcare were from trans-specific care, it felt ethically important to write something about trans-specific care. This, together with the fact that there was a lack of critical studies originating from the medical field about Swedish trans-specific care, made me redirect my focus.

Trans studies also led me to a transfeminist position. This thesis is transfeminist in the sense that it is informed by trans politics and trans studies as well as by feminist activism and theory, an approach that Straube (2014) summarises as dealing with the “deconstruction of gender essentialism, gender hierarchies and discrimination on the basis of one’s gender identity” (p. 21). For me, this approach includes striving towards a deregulation of gender expression and, hence, striving towards the abolition of institutional incentives to perform gender in binary, stereotypical and fixed ways. The basis of this approach is the promotion of self-determination regarding gender expression, legal gender and gendered embodiment (see also Spade, 2006).

Connected to the transfeminist position as a political position, I have been driven during the work with this thesis by an aspiration for social change. An aspiration for transformation or intervention can be said to be a shared feature of feminist scholarship (Pulkkinen, 2015), and also of much public health research (Green & Labonté, 2007). Apart from conducting the included studies, during these five years I have found it important also to lecture and talk about my research on courses for future and current healthcare providers, with politicians, the public, governmental investigators and NGOs, such as RFSL (see for example SOU, 2017:92; Transgender Europe, 2017). At the same time, it has been difficult to balance this point of departure with my theoretical interest and the academic format, with the consequence that the papers might be less accessible to non-academics and people without previous knowledge about the topic or the theories used. I will return to this tension in the Methods chapter.

One more thing before I move on. In this thesis, the focus will be on the participants’ trans experiences and their experiences of trans-specific care, health
and (un)safe spaces. The thesis will deal with themes such as gender performance, gyms, bars and baths; however, mainly in relation to the participants' trans experiences. So, while reading this thesis it is important to remember that their trans experience does not (fully) constitute who these people are. They are lovers, siblings, students, athletes, old and young persons, politically active, hardworking, fighting the social security system while on sick leave, healthy, somatically ill, mentally ill, and they are also people with trans experience. Also, as one of the participants nicely pointed out:

Well, I think that it’s a challenge to talk about how a certain group have bad health because at the same time there are of course also many people who feel good and it’s really sad to be treated all the time like you’re going to kill yourself. (Elias)

<table>
<thead>
<tr>
<th>Snapshot¹ (the genealogy of my research interest and focus)</th>
</tr>
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<tbody>
<tr>
<td>- Second year of high school: got a scholarship in natural sciences, travelled to Stockholm and learned from the examples of “cutting-edge research” that homosexuals’ response to pheromones were atypical (Berglund et al., 2006)</td>
</tr>
<tr>
<td>- Second semester of medical school: a course on epistemology taught me that my sexual orientation could be calculated from my finger length and from a MRI scan (see, for example, Hall &amp; Love, 2003).</td>
</tr>
<tr>
<td>- Took a break from medical school, took a course in gender studies: found out that sexual orientation and gender identity do not have to be biological essences (ok, I had suspected this before). Wrote my final paper about the relation between queer, trans and feminism.</td>
</tr>
<tr>
<td>- Started working with this thesis. Thought that I would use people with trans experiences’ narratives to theorise sex/gender, and the biological/social.</td>
</tr>
<tr>
<td>- Went to Berkeley for summer school: discovered that theorising experiences can be rather difficult and rather problematic.</td>
</tr>
</tbody>
</table>

**Positioning the thesis**

... within the field of public health

I want to situate this thesis within the tradition of critical public health (critical in the epistemological sense, not as in being against something that is considered bad or undesirable) (Green & Labonté, 2007; Krieger, 2000). Doing so means that I aim to challenge concepts and lines of thought that are taken for granted in

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¹ The “snapshots” are a recurring section of this cover story, written in a slightly different voice from the rest of the thesis. Some snapshots are based on memos and others have developed during the writing of this cover. Several of the snapshots are based on questions I have been asked others during this PhD process. The function of the snapshots is to invite the reader “behind the scenes” of my work with this thesis.
mainstream public health research and more broadly in psychomedical research and thought (see Green & Labonté, 2007). The approaches to, and understandings of, critical work and theory can be very different (Code, 2002), but what I want to emphasise, besides the challenging of taken-for-granted assumptions, are the accounts of a situated knowledge production and a power analysis which includes a constant asking of: who benefits, why, and what can we do about it (Green & Labonté, 2007)?

Public health is a broad interdisciplinary field and also a practice as much as it is a science. A commonly used definition of public health can be found in Acheson (1988): “Public health is the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society” (p. 29). In the same year, the Institute of Medicine (US) (1988) defined public health as: “Public health is what we, as society, do collectively to assure the condition in which people can be healthy” (p. 1). These definitions thus highlight the importance of collective effort at a societal level, which includes both research and interventions. This thesis is situated in one of these two branches, the research part, but the included studies also indicate directions for action and, as mentioned in the previous section, it has also been important to give back to community in terms of, for example, educating current and future healthcare professionals during this thesis process.

One of the overarching goals for Swedish public health politics is to “create conditions for good and equal health for the entire population and close the avoidable health gap within one generation” (The Public Health Agency of Sweden, 2018, online). According to the Public Health Agency of Sweden (2018, online), in order to be able to reach this goal, a healthcare system that is equal and health promoting is an important aspect. So, the healthcare can be seen as playing an important role in public health politics and practices, and it is as such an institution that healthcare is understood in this thesis in relation to public health.

The history of western public health consists of radical political claims and a dedication to analysing and overcoming inequalities in health (Green & Labonté, 2007). However, the focus of public health research and practice over recent decades has been criticised from Marxist, feminist and Foucauldian perspectives for being occupied with governing and disciplining of populations (Lupton, 2012; Petersen & Lupton, 1996). The increasing focus on individuals’ lifestyles and risks, and surveillance through mass screenings, surveys and health education has turned certain aspects of public health into a moral enterprise that privilege particular types of subjectivities and politics (Petersen & Lupton, 1996). The critique of the transformation of medicine since the mid-1980s that A.E. Clarke et al. (2003) include in their biomedicalisation framework also covers public
health practices. The critique highlights the increasing individualisation of public health concerns and practices and an analysis of how health has become an individual moral responsibility (A.E. Clarke et al., 2003). Hence, positioning this thesis within critical public health includes an awareness of how public health research can include the exercise of a particular form of power, which includes defining, and separating the healthy from the sick, and how public health studies can contribute to the governing of the population (Petersen & Lupton, 1996).

The critical positioning of this thesis also encompasses an epistemological aspect. The justification of the aforementioned public health claims is often made in the name of objective and disinterested science (Petersen & Lupton, 1996). This is also connected to the strong tradition within public health of conducting quantitative studies. Being based on only qualitative studies this thesis takes a different point of departure, emphasising the importance of qualitative inquiries and an engaged and situated knowledge production in order to explore public health concerns for people with trans experiences.

I see the positioning within critical public health as particularly important and fruitful in relation to the topic of this thesis. Asking who or what is silenced, an important part of critical academic work, is especially important in relation to people with trans experiences, who have been largely neglected by public health research and policies. Furthermore, it is vital to understand how categorisations and separations into sick and healthy contribute to governing, as trans peoples’ identities, experiences and bodies have been pathologised by the psychomedical establishment. Taking a critical power perspective on institutional regulation and disciplining is crucial, since many people with trans experiences have to negotiate access to gender-confirming medical procedures with healthcare institutions in order to be able to live full lives. Thus, a critical public health perspective is important in order to understand experiences of health and healthcare, and the relation to healthcare, among people with trans experiences.

... within the field of trans studies

Academic attention to transgender issues has shifted over the span of those ten years [1995–2005] from the field of abnormal psychology, which imagined transgender phenomena as expressions of mental illness, and from the field of literary criticism, which was fascinated with representations of cross-dressing that it fancied to be merely symbolic, into fields that concern themselves with the day-to-day workings of the material world. “Transgender” moved from the clinics to the streets over the course of that decade, and from representation to reality.

Stryker (2006, p. 2)
Trans studies (also called “transgender studies”) is a growing, diverse academic field that began to develop during the 1990s out of a critique of how trans subjects were portrayed within academia, especially within medical discourses (S. Stone, 1991; Stryker & Aizura, 2013). Similar to gender studies, trans studies is an interdisciplinary field where activism and academic thinking have developed in dynamic collaboration (and conflict). While the relationships with queer- and gender studies have been somewhat complicated (see the theoretical chapter), trans studies has developed in close collaboration with these fields; for example the first network for trans studies scholars was founded at the “Queer Studies Conference” in 1994 (Engdahl, 2010).

Sandy Stone’s “The ‘Empire’ Strikes Back: A Posttranssexual Manifesto” (1991) marks one of the starting points for trans studies. Stone’s text was a response to Janice Raymond (1979), and other second-wave feminists, who had accused transsexual women of appropriating (raping) (cis) women’s bodies and argued that trans is just a result of oppressive sex roles and, hence, people with trans experiences’ proclaimed gender identity was not real. Stone also discusses how the medical community constructed the category of transsexualism as a “correctable problem”, and how western (medical) discourses have constructed one correct and desirable body for each of the two categories of gender, man and woman. This is just one example of how, right from the start, trans studies has investigated in and analysed medical practices and discourses (Stryker & Aizura, 2013; Stryker & Whittle, 2006).

Trans studies includes a variety of ontological positions, theories, ethical considerations, methodology and empirical material. It is thus impossible to briefly sketch out shared features of this field of studies, but some tendencies can be described. As already mentioned, studies originating in the medical sciences are scarce while humanist and social science studies dominate the field. Trans studies thus consists not simply of “studies about trans” (such studies exist within the medical sciences), but takes certain points of departure and is usually located within critical academic work. Trans studies is interested in how “gender” is “lived, embodied, experienced, performed and encountered” in a complex way that goes far beyond the binary sex/gender ideology (Stryker, 2006, p. 3).

According to Stryker (2006), trans studies is a field consisting of “subjugated knowledges” of and about people with trans experiences, but it is “far from being an inconsequentially narrow specialisation dealing only with a rarified population of transgender individuals, or with an eclectic collection of esoteric transgender practices” (Stryker, 2006, pp. 3–4). The field consists of studies that question, make visible and denaturalise those normative lines that are assumed to exist between differentiated biological bodies, as well as the social roles and status that some bodies are expected to occupy. Furthermore, it examines and
analyses how people experience the gendered self in relation to normative
gendered expectations and how such norms are materialised into social
hierarchies and both reconstructed and resisted (Stryker, 2006). It is precisely
these kinds of theories and empirical analyses that are relevant for my study, to
examine how the participants experience their gendered self in relation to how
gender is constructed in trans-specific healthcare and the psychomedical arena
more broadly; and to examine how social hierarchies in different spaces
contribute to (un)safe experiences.

... in relation to interdisciplinary academic work
I am situated in the field of public health, in a department organised within the
medical faculty. Public health can in itself be understood as an interdisciplinary
field, influenced by, among others, medicine and sociology. The thesis is also
situated in gender studies through my involvement in the interdisciplinary
Graduate School for Gender Studies. I have also had the privilege to be supervised
by four supervisors working in three different disciplines. Furthermore, the
theories used derive from social sciences, humanities and public health. Thus, the
thesis itself is interdisciplinary both with regard to organisational structure and
content.

I have gained several advantages from this interdisciplinary position. It has
helped me to gain the confidence to be on the periphery of my own discipline,
public health, as I have had my work validated by people from other fields. The
interdisciplinarity has also extended my “tool box”; for example, by making me
aware of other theories which have made it possible to see other things in the
material. The interdisciplinary position has also forced me to question my own
assumptions in a way that I do not think would have happened otherwise. It has
made me think of my points of departure and situatedness. Furthermore, it has
helped me to gain an understanding for other disciplines by repeatedly reading
and commenting on other people’s academic work.

However, the interdisciplinarity has also had its downsides. An interdisciplinary
position creates tension with regards to disciplinary traditions, epistemological
and ontological perspectives, methodological choices and publication strategies.
It has sometimes been difficult to navigate across several fields, deciding on form
and writing style in relation to my intended audience (maybe this has become
most obvious in the comments from reviewers during the peer review process).
For example, finding journals within the public health field that encourage
theoretical discussion and qualitative methodology has not always been easy.
There is also an aspect of defending ones work in two directions, for example,
using too much/too little theory.
The divide that sometimes exists between social sciences and medical sciences in the field of trans health and healthcare became especially apparent when I attended the European Professional Association for Transgender Health (EPATH) conference in Belgrade in 2017. Presenting at the conference, I was considered to be a social scientist (which I certainly do not mind) and my presentation ended up in the social science stream. But it also became clear that the activists and social scientists attending the conference had one ontological understanding of trans experiences, while a large proportion of the medical researchers and clinicians had another.

The conference had a code of conduct emphasising its importance as a safe space and a policy prohibiting the use of pathologising language. Despite this, there were several plenary sessions during which medical providers repeatedly used pathologising language; for example, using the concept of “disordered” when discussing aetiology (see also Hird, 2003). Some plenary sessions were also very problematic from another ethical point of view. One endocrinologist working in Belgrade showed naked care-users with just a small black square over their eyes, for example when talking about breast development after gaining access to hormones. This was especially problematic as several people with trans experiences were volunteering at the conference, and the people on display were from their community.

Choice of terminology

Scholars studying knowledge production, like Foucault and Haraway, have argued that the practice of defining, naming and categorising is a normative act and involves the exercising of power (Foucault, 1990; Haraway, 1988). This does, not mean, however, that we should not define the concepts we use, but that it is important to understand how such a process establishes fixed meanings for processes that are contextual and contingent. Below, I will describe how I use the key concepts in this thesis.

Trans experiences, linear gender and cisnormativity

As much as possible, I have tried to adopt terms used by trans activists, which is an ethical choice and follows a tradition within trans studies. I have consciously been trying to move away from the transgender/transsexualism dualism (see also the theoretical chapter) and also the medical diagnoses and in this thesis I have instead used the concept of “trans experiences”. I use “trans experiences” as a broad concept referring to experiences of transcending the normative expectation of a linear gender. In the same way as Ahmed (2006b) analyses how a queer sexual orientation deviates from the “straight line”, Bremer (2011) argues that trans experiences can be seen as experiences of deviating from the normative “linear gender”. Linear gender is the social expectation that the assigned gender
at birth is in line with the gender identity and that the body and social expression of gender appear to be in line with that identity (Bremer, 2011).

I have several reasons for using the term trans experiences. Firstly, trans experiences is an attempt to include all the participants in the study, since not all participants see trans as an identity but, for example, described themselves as having a transsexual history. Secondly, the concepts of transsexualism and gender dysphoria have psychiatric connotations and using trans experiences is an attempt to avoid pathologising people with trans experiences. Thirdly, the concept of trans experiences has been increasingly used by trans activists in the Swedish context over the last couple of years. Fourthly, I think “trans experiences” has the potential to open up space for a less dichotomous understanding of cis/trans, because claiming identities can be a complex and tortuous route and identities can be diversely and inconsistently connected to particular forms of embodiment, care-seeking behaviour, and experiences. Furthermore, using “trans experiences” also connects to a health perspective; no matter how a person currently identifies, former (social and bodily) experiences leave marks on/in the body which can/will continue to affect their inhabitancy of the world. Concepts like “trans persons”, “transgender”, “transsexualism” and “gender dysphoria” will also appear in the text when referring to other sources that use these terms (see also Glossary and Abbreviations).

“Cisnormativity” can be described as the social discourses and practices that assume that individuals have linear genders. Cisnormativity contributes to the construction of trans experiences as unintelligible, and can also be a part of institutional pathologising discourses (see, for example, Enke, 2012; Kennedy, 2013; Spade, 2006). Cisnormativity as an analytical concept has the potential to problematise the normative category and how this category, the linear gender or the cis-position, is defined through repeated construction of the deviant position (see, for example, Spade, 2006). Such a focus is often lacking, and instead a non-linear gender or trans experiences are often the only categories that are seen as being in need of explanation, while the normative categories are naturalised (Kennedy, 2013; Spade, 2006). I will return in the theoretical chapter to why it is important to understand why people without trans experiences are also implicated in the cisnormative discourse.

The language concerning trans is changing rapidly; a concrete example is how the medical processes within trans-specific care, in the Swedish context, were once talked about as a “sex change” and after activist critique were then called “gender correction” and now the most common term is “gender-confirming” or “gender-affirming” procedures. I use the term “gender-confirming medical procedures” to capture the notion that the medical processes aim to confirm the gender identity that individuals often feel that they already have. Thus, gender-confirming
medical procedures include genital and breast surgery, hormones, voice training and hair removal. In this study, “trans-specific healthcare” is used to denote the parts of healthcare that deals with evaluating the need for, or providing, gender-confirming medical procedures (for a description of the care process and trans-specific healthcare see p. 44-46). I have considered it important to avoid, as far as possible, terms like “treatment” and “patient” in relation to trans-specific care in order not to imply that people with trans experience are ill in any given way or that medical procedures are treating a pathological condition.

**Conceptualisation of health**

In relation to the interview studies, I understand health as something that gets to be defined by the participants (Baum, 2016). This means that health can be understood, for example, as not being ill, as having social relationships, a reserve to cope with life and illness, and/or psychological wellbeing (Baum, 2016). This understanding of health is quite broad; for example, understanding health as more than the absence of disease or seeing wellbeing as an important part of good health (Vilhelmsson, 2014). From a healthcare perspective, it is important to have a holistic perspective on health in order to meet and treat care-seekers as individuals in a social context. This might be especially important at a time when the welfare state is being downsized and when other societal institutions might not be able to contribute to the wellbeing of citizens. Understanding health in such a broad way can, however, come with the risk of medicalising social problems and also risks individualising societal problems (see also Rose, 2006; Vilhelmsson, 2014). But, if the social issues are handled in the right arena, then having a broad conceptualisation of health in the healthcare setting might not become an issue.

**Other key concepts**

In some places, I use the pronoun “they” as a singular gender-neutral pronoun. I have chosen “they” as a pronoun over, for example, “ze” or “s/he” because all the non-binary identified individuals in this study preferred the pronoun “den” in Swedish, and “they” is the best translation of this Swedish pronoun. However, in Paper I “ze” appears as a gender-neutral pronoun after feedback from a language editor. I have chosen not to use a gender-neutral language everywhere in the text since many of the participants preferred gender-binary pronouns. Many of them have also struggled to be referred to by these pronouns. Using a gender-neutral language throughout the thesis would also obscure important differences between men, women and non-binary participants.

I have chosen to almost exclusively use the concept of gender, and almost never sex (in Swedish I would, however, have preferred “könn” (see also Bremer, 2011)). This is connected to the fact that I find the distinction between sex and gender
problematic and as reproducing ideas about gender being (only) social and sex as something (only) biological (see also Kessler, 1990; Kessler & McKenna, 1978; Moi, 2001). For example, Butler has scrutinised the distinction between sex and gender, and argued that it is based on the idea of a pre-discursive and independently existing body and subject (Butler, 1990, 2011; see also Repo, 2015; Wickman, 2001).

“Psychomedical” is used to denote the arena and discourses that have held a dominant position with regard to knowledge production around trans experiences. The portmanteau concept, derived from “psycho” and “medical”, is used to emphasise the psychiatric location of a considerable amount of knowledge production and clinical practice and, at the same time, the (bio)medical understandings of trans experiences (see also Dewey & Gesbeck, 2017, p. 9, for a discussion of how psychiatry has used categorisations with specific criteria in order to link its practices to the powerful biomedical model).

Outline of the thesis

In the following chapter I will describe previous research about trans experiences in relation to health and healthcare followed by the aim and research questions. After that comes the theoretical chapter, in which I outline the framework in relation to which the results of this thesis are understood and interpreted. There might be some overlaps between the background and theoretical chapters. However, the idea is that the background chapter describes empirical results from previous studies while the theoretical chapter focuses on conceptual issues and my position in relation to different discourses on, for example, trans experiences.

I will then describe the Swedish context and the Swedish trans-specific healthcare. The methods chapter describes the study design, the data collection, the analysis and epistemological and ethical considerations. In the results chapter I will present the analysis of the material. I have decided to include a considerable number of quotes in order to make the participants more visible and the analysis more transparent. The results section contains some initial interpretations because I believe it is easier for the reader to follow the interpretation when it comes close to the results and limits the need to repeat the results in the discussion. In the discussion, the results are discussed in relation to the theoretical framework and previous research. The final chapter presents the conclusions and implications, and is where I summarise the most important contributions of this thesis and suggest actions, both practical and further research, to improve access to trans-specific healthcare and the health of people with trans experiences.
Background

The health of people with trans experiences and their encounters with healthcare have not been major topics within the field of public health. Within medicine, trans experiences have mostly been studied within the field of psychiatry, but, as Lombardi noted in 2001:

*Health-related research, policies, and materials do not (except for rare exceptions at the expense of local agencies) mention or deal with the actual lives of transgender persons.* (Lombardi, 2001, p. 870)

Over the last couple of years, there have been a growing number of studies concerning trans within public health; however, more knowledge is needed (Bränström & van der Star, 2016; Reisner et al., 2016). For example, in their literature review, Reisner et al. (2016) conclude that social and structural contextual factors related to health remain understudied. Furthermore, they argue that increased attention needs to be directed towards non-binary people in public health research. A major topic in public health research about trans experience is mental health and HIV, and other themes include other sexually transmitted infections and access to healthcare (Baral et al., 2013; Bränström & van der Star, 2013; Factor & Rothblum, 2008; Reisner et al., 2016). Some studies have included people with trans experiences in research about the LGBTQ group, but often this is done without any account of the specific living conditions of people with trans experiences (Bränström & van der Star, 2013).

I will describe in more detail below research dealing with health status and access to healthcare for people with trans experiences. However, some of the studies that will be described later in terms of health and healthcare have also revealed other important aspects of the group of people with trans experiences. The TRANSpulse project was a community-based research project conducted in Ontario, Canada (Travers et al., 2013). Only a minority of the respondents in that project reported a linear transition, from one sex to the another, a trajectory that is often considered to be the norm (Scheim & Bauer, 2015). In Zeluf et al.’s study (2016) (using data from the Public Health Agency of Sweden), 44% of the 796 respondents had a non-binary identity (among the remaining respondents: 19% women, 24% men, 14% transvestites). In Cruz’s (2014) US-based study, 38% of the participants (total n = 4059) did not identify as either male or female. These demographic results illustrate the diversity within the group of people with trans experiences, and strongly challenge the binary gender norm (see also Transgender Europe, 2017). However, studies unfortunately also show that many people with trans experiences cannot live (full time or part time) in their identified gender (Scheim & Bauer, 2015; The Public Health Agency of Sweden,
Transgender Europe’s report (2017) shows that participants living in Sweden with a non-binary identity were less likely to be able to live according to their gender identity compared to (trans) men and (trans) women.

Trans experiences and health

**Health status in the group**
Some conclusions that can be drawn from previous studies and reports that are relevant to this study are: a large proportion of the group of people with trans experiences report poor general health (The Public Health Agency of Sweden, 2015; Transgender Europe, 2017); a large proportion of the group tend to report mental illness and symptoms (Couch et al., 2007; Marshall et al., 2015; The Public Health Agency of Sweden, 2015; Zeluf et al., 2016), and this proportion is often larger than the proportion of the general population (Reisner et al., 2015; The Public Health Agency of Sweden, 2015).

The mental health outcomes that have been most widely studied includes mood disorders, suicidal and non-suicidal self-injury and anxiety disorders (Reisner et al., 2016). Depending on context, sampling method and measurement, 34.4% (clinical diagnosis, Ireland) to 63% (transgender women, screening tool, USA) of participants in different studies have reported depression (Judge et al., 2014; Nuttbrock et al., 2013). Several studies conducted in Sweden, and in other contexts, have shown that young and non-binary people with trans experiences report worse mental health status at a group level compared to binary and older people with trans experiences (Connolly et al., 2016; Kreiss & Patterson, 1997; The Public Health Agency of Sweden, 2015; Transgender Europe, 2017; Zeluf et al., 2016). For example, in the report from the Public Health Agency of Sweden (2015), 57% of respondents aged 15–19 years old reported that they had considered suicide during the previous year, compare to 36% of the whole sample and 6% in the general population. In Transgender Europe’s report (2017), non-binary respondents living in Sweden more often had poor self-reported health and more self-reported disability than the women and men with trans experiences. In Zeluf et al.’s study (2016), having a non-binary identity was associated with self-reported disability.

Previous research has shown that access to gender conforming medical procedures improves the mental health and quality of life for those wanting such care, both among adults and youth (Cole et al., 1997; de Vries et al., 2011; Dhejne et al., 2016; Smith et al., 2005). However, even if the health improves after receiving gender-confirming medical procedures, a Swedish study reported a continued elevated risk of overall mortality, suicide attempts and psychiatric inpatient care (Dhejne et al., 2011).
Following mental health, sexual and reproductive health is the second most widely studied aspect of the health of people with trans experiences (Reisner et al., 2016). Globally, women with trans experiences have a high risk containing HIV, and women racialised as non-white tend to be even more exposed (Clements-Nolle et al., 2001; Nemoto et al., 2004). An international review comprising of 15 countries showed a 50 times increased risk among women with trans experiences compared to the average adult of reproductive age (Baral et al., 2013). The situation in Sweden is to a large extent unknown; in the report from the Public Health Agency of Sweden (2015) one person (0.2%) with trans experiences reported being HIV-positive, but 46% of the respondents had never been tested for HIV.

According to previous research, specific health issues in the group include problems related to chest binding and unsupervised hormone use (Peitzmeier et al., 2016; Rotondi et al., 2013). Furthermore, gender-confirming medical procedures can have negative side-effects. One study showed that women with trans experiences have a higher incidence of venous thromboembolism and ischemic stroke than women with only cis experiences, a fact that the authors connect to their oestrogen use (Getahun et al., 2018). Transdermal oestrogen use has been shown to decrease the risk of venous thrombosis compared to oral oestrogen use (Streed et al., 2017). However, many issues concerning the side-effects of gender-confirming medical procedures remains understudied (Maraka et al., 2017), and, as far as I understand these studies, they have not controlled for the effects of, for example, transphobic violence, which might contribute to cardiovascular events through allostatic load.

Despite this alarming health situation in the group it is, however, important to note that many people with trans experiences report good overall health. For example, in the report from the Public Health Agency, the majority of respondents reported good or very good general health (The Public Health Agency of Sweden, 2015). This is important to point out in order to avoid constructing poor health as inherent in the trans narrative.

**Explanations for health inequalities**

The inequality in mental health between people with trans experiences and people with only cis experiences has been explained by, for example, the minority stress model, which was originally developed to explain why lesbian, gay and bisexual persons had worse mental health than heterosexual persons (Hendricks & Testa, 2012; Meyer, 2003). This model considers different factors that can cause stress, such as discrimination, violence, the anticipation of stressful events, hiding one’s identity and internalised negative attitudes. According to this model, the “hostile and stressful environment” can explain the higher incidence of
Mental illness among LGBTQ people (Hendricks & Testa, 2012; Meyer, 2003). Meyer (2003) also discusses positive aspects of belonging to a minority; for example, the effect of group solidarity and of developing coping and resilience strategies together with others.\(^2\)

While there is a limited number of studies exploring the association between health determinants and mental health (Reisner et al., 2016), several of the aspects that are dealt with as determinants of mental health in the minority stress model for lesbian, gay and bisexual people have also been studied among people with trans experiences. For example, a high proportion of people with trans experience are exposed to violence. Studies have shown that 39–60% report experiences of physical violence and 30–46% report having been subjected to sexual violence (Hendricks & Testa, 2012; Kreiss & Patterson, 1997; Lombardi et al., 2002; The Public Health Agency of Sweden, 2015). Clements-Nolle et al. (2006) demonstrated that experiences of sexual violence and discrimination are independently associated with attempted suicide.

Qualitative and theoretical studies have shown how people with trans experiences are rendered invisible in societies that only acknowledge two static genders (Kennedy, 2013; V. Namaste, 2000). People with trans experiences’ marginal position also makes them vulnerable to ending up in prostitution/sex work and homeless (see Reisner et al., 2016). People of colour with trans experiences are even more likely to be exposed to disadvantaged social conditions. For example, in a study about HIV prevalence and risk factors among young women with trans experiences in San Francisco, a higher proportion of participants belonging to an ethnic or racial minority reported low income, curtailed education and unstable housing than white participants (Wilson et al., 2015).

Something that has been less studied is how socioeconomic factors contribute to the health inequalities between people with and without trans experiences (Reisner et al., 2016). In the Public health Agency of Sweden’s report (2015), a large proportion of the respondents (total n=800) had a monthly income below subsistence level. Among respondents aged 30–64 years old, around 30% had a monthly income below 13 999 SEK (subsistence level). Furthermore, many of the respondents were unemployed and/or on sick-leave.

Studies have shown that encounters with healthcare, or avoidance thereof, can contribute to the health gap between people with and without trans experiences. Zeluf et al. (2016) published a study based on data from The Public Health Agency  

\(^2\) I think the label “minority stress” is a bit unfortunate and conceals several of the power dimensions that contribute to LGBTQ peoples’ higher prevalence of mental ill-health. However, the model does provide a framework for understanding determinants of mental health on several levels and through different mechanisms.
of Sweden showing that bad experiences of healthcare among people with trans experiences were associated with lower self-rated health, self-reported disability and lower quality of life. Studies and reports also shown low levels of trust in healthcare institutions and a tendency to postpone healthcare visits, which will be further described in the next section.

To conclude, there are several studies that have shown in different ways that many people with trans experiences have an adverse living situation which affects their health. While the minority stress model might help to explain some of the pathways for the mental health inequalities between people with, and without, trans experiences, many public health studies do not look at wider structures and discourses that reinforce these pathways or, as Bauer et al. (2009) argue: “the tendency had been to attribute the marginalization as a consequence of transphobia” (p. 350). Violence, discrimination, bad experiences of healthcare etc. are not isolated incidents that only stem from individual transphobic actions but are connected to normative constructions of (cis)gender, or cisnormativity (see also Bauer et al., 2009; Kennedy, 2013). Thus, public health research that aims to understand the full scope of health inequalities between people with and without trans experiences, and propose relevant actions to combat them, has to also explore such norms and their connections with socioeconomic factors.

Trans experiences and healthcare

Non-trans-specific healthcare
Studies have shown that people with trans experiences face several different barriers when trying to access healthcare (Bauer et al., 2009; Bauer et al., 2014; Cruz, 2014; Grant et al., 2010; Poteat et al., 2013; Riggs et al., 2014; Sanchez et al., 2009; The Public Health Agency of Sweden, 2015; Transgender Europe, 2017; Whittle et al., 2008). Specific barriers that have been studied include: experiences of stigma, prejudice, discrimination, financial barriers, and a lack of knowledge and visibility when seeking healthcare (Bauer et al., 2009; Cruz, 2014; Grant et al., 2010; Poteat et al., 2013; The Public Health Agency of Sweden, 2015; Transgender Europe, 2017; Whittle et al., 2008).

A large proportion of people with trans experiences postpone healthcare visits, even if they are in need of them (Bauer et al., 2014; Cruz, 2014; Transgender Europe, 2017). Cruz (2014) examined the postponement of primary curative care among transgender and gender non-conforming people in a US context (n=4,049) and found that 50% of the participants reported having postponed seeking care due to discrimination or affordability, which in the study is contrasted against 20% in a national average sample. Transgender Europe’s report (2017) shows that 62% of the Swedish participants had delayed visits to a
general practitioner (total n=472), and the report from the Public Health Agency (2015) shows that 40% had postponed healthcare visits due to fear of being badly treated (total n=800).

Poteat, German and Kerrigan (2013) studied stigma in healthcare encounters in the mid-Atlantic region of the USA, interviewing both transgender people (their way to denote their participants) and healthcare providers. They found that the transgender participants did not believe that care-providers would meet their needs. Furthermore, their results highlight the fact that care for transgender people is excluded from medical training due to social and institutional stigma. This makes care-providers uncertain and ambivalent in meetings with transgender patients, which upsets the power relation in the medical encounter between care-provider and patient. However, stigma reinforces the power and authority of the care-provider and the authors conclude that stigmatisation contributes to maintaining systems of inequality, which in themselves contribute to health disparities.

In Lindroth’s (2016) qualitative study, conducted in a Swedish context, the transgender participants’ experiences of meeting sexual healthcare providers included having to educate the healthcare providers, being questioned and asked irrelevant questions, and getting comments and questions about body parts. Furthermore, non-binary participants had experiences of being binary gendered in healthcare settings. These bad experiences led to an unwillingness to seek healthcare, or fear of doing so, and a tendency to postpone healthcare visits. Siverskog (2014) studied transgender ageing in a Swedish setting from a life-story perspective. The participants in Siverskog’s study had experienced narrow gender norms throughout their lives and a lack of knowledge around trans in care contexts. Siverskog’s study also showed that the participants had both physical and mental scars from previous transphobic experiences (Siverskog, 2014). Carroll-Beight and Larsson (2018) found that the transgender individuals in their study did not experience the mental healthcare as a safe space and that several barriers hindered them from accessing the mental healthcare they needed. For example, they experienced that, if they came out as trans, the mental healthcare providers tended to focus only on issues connected to trans, even if they had sought care for other reasons.

Trans-specific healthcare
As previously mentioned, the concept of “trans-specific healthcare” refers to the parts of the healthcare that are responsible for evaluating the need for gender-confirming medical procedures and also for providing such care. By no means all people with trans experiences wants access to such care (Transgender Europe, 2017) but, for many, access to gender-confirming medical procedures is vital for
their wellbeing and possibilities for living a full life (Cole et al., 1997; Murad et al., 2010; Smith et al., 2005). However, several studies have pointed out that access to gender-confirming medical procedures is limited in different ways. In some national contexts, trans-specific healthcare does not exist, in other contexts access is limited due to a lack of coverage by healthcare insurances, which means that care-seekers are dependent on their own financial means to access vital care (Whittle et al., 2008). In some countries, such as Sweden, Denmark, Germany, France, Finland, the Netherlands, and the United Kingdom, most gender-confirming medical procedures are publicly funded (for citizens or people with permanent residency) (Whittle et al., 2008). However, research has shown that access to gender-confirming medical procedures is limited in other ways, independent of the financial system. Two specific barriers are formal and informal demands for mental health evaluation and the gatekeeping role of mental healthcare providers (i.e. the control over access to medical procedures). The pathologisation in the form of psychiatric diagnoses (in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and in the International Statistical Classification of Diseases and Related Health Problems (ICD), see also Appendix 2) has been reported to be experienced as stigmatising and as hindering access (Burke, 2011; Butler, 2004a). The close connection between legal and medical gender reassignment can also constitute barriers for access to gender-confirming medical procedures. In some contexts, having undergone gender-confirming medical procedures is a precondition for legal gender reassignment. This situation constitutes an additional barrier for access to medical procedures.

In many countries, the clinical evaluation that often precedes access to gender-confirming medical procedures has been shown to govern gender performances among care-seekers. Thus, the way in which care-seekers perform and embody gender has been shown to affect their access to medical procedures and in order to gain access to gender-confirming medical procedures care-seekers alter their gender performance. In other words, the trans-specific healthcare, and related legislation, tends to reproduce gender norms (Bremer, 2011; Dewey & Gesbeck, 2017; Spade, 2006; S. Stone, 1991). For example, a Swedish government report has shown that care-users within trans-specific care in Sweden have to exhibit signs that they have adopted the character of the gender with which they identify (The National Board of Health and Welfare, 2010, p. 53). Furthermore, analyses of preparatory work leading up to the Swedish legislation concerning legal gender reassignment have shown that the system privileges unambiguous gender and relies on a practice in which experts have to evaluate the individual’s need for care, motivated by the risk of regret (Alm, 2006; Edenheim, 2005).

Interview studies with people with trans-experiences in the Swedish context have shown that care-seekers experience stereotypical gender norms within the evaluation (Bremer, 2011; Carroll-Beight & Larsson, 2018; Lindroth, 2016; von
Vogelsang et al., 2016). Another recurring result in these studies is that participants have used strategic narratives in order to negotiate access to medical procedures (Bremer, 2011; Carroll-Beight & Larsson, 2018; Lindroth, 2016). For example, participants in Lindroth’s (2016) study experienced that they had to tell strategic narratives when it came to questions about binary gender and sexual orientation in order to increase their chances of gaining access to gender-confirming medical procedures; some described how they have to “fit into the pattern in order to get help” (p. 3517). Carroll-Beight and Larsson (2018) argue that this need for a strategic narrative is reinforcing a single view of how trans people are supposed to be.

Another result that reappears in several of the Swedish interview studies is that care-seekers have experienced a lack of knowledge in their meetings with the trans-specific healthcare providers (Carroll-Beight & Larsson, 2018; Lindroth, 2016; von Vogelsang et al., 2016) The participants in Lindroth’s (2016) study also experienced a lack of follow-up and described their dependent position due to the care-providers “hold[ing] all the keys that will, well, let you begin your life” (p. 3517). Furthermore, the participants found that they did not get help with their sexual health within trans-specific healthcare. In von Vogelsang et al.’s (2016) study, the participants experienced a clinical encounter as good if the providers showed respect, preserved their integrity, acted in a professional manner and were responsive. However, similar to the results of Lindroth’s study, the participants in von Vogelsang’s study experienced that many of the care professionals exploited the power of their position and had withheld information. The participants in Carroll-Beight and Larsson’s (2018) study also testified to excessive waiting times, which caused mental health problems. Similarly, Bremer (2011) argues that the evaluation process for gender-confirming medical procedures creates unnecessary suffering for people with trans experiences. At the same time, both Bremer (2011) and Carroll-Beight and Larsson (2018) show that mental ill-health can be a barrier for access to gender-confirming medical procedures.

Armuand et al. (2017) explored transgender men’s experiences of fertility preservation. The journey to fertility preservation was experienced as frustrating, for example, due to waiting to get it done in order to be able to start or reinitiate testosterone use. The participants experienced that their gender dysphoria worsened during the process; for example, in relation to genital examination and the discontinuity of testosterone or hormone stimulation.

Researchers who have studied care-providers’ narratives around trans and trans-specific healthcare have argued that discourses of uncertainty and ambiguity regarding gender are subjugated and negated during the evaluation process, and instead discourses of certainty, maturity, stability and polarisation regarding
gender identity are privileged (Bertilsdotter Rosqvist et al., 2014; Hird, 2003). Studies have also shown that practitioners within trans-specific care express essentialist ideologies about sex and gender and that trans experiences are understood in terms of problems (Davis et al., 2016; Spade, 2006).

**Identifying a knowledge gap**

Since my doctoral project started (2013), the number of publications concerning trans, health and healthcare has rapidly increased (Reisner et al., 2016). In 2013, the knowledge production in a Swedish context around trans, health and healthcare included reports from the National Institute of Public Health (now the Public Health Agency) (Larsson et al., 2008; Roth et al., 2006)(2006, 2008), The Swedish National Board for Youth Affairs (2010), RFSL Youth (2008, 2009) and Bremer’s (2011) thesis in ethnology. Edenheim (2005), Alm (2006), and Kroon (2008) had in different ways analysed constructions of gender, sexuality and transsexualism in governmental reports and psychiatric research. Psychiatric, endocrinological, surgical and neuroscientific research existed, dealing with trans-specific healthcare and trans experiences in terms of psychiatric profiles and the follow-up of care-seekers, regret, aetiology, surgical techniques, vocal interventions, incidence and sex ratio (Berglund et al., 2008; Bodlund & Kullgren, 1996; Dhejne et al., 2011; Eldh, 1993; Eldh et al., 1997; Henningsson et al., 2005; Johansson et al., 2010; Landén et al., 1998b; Landén et al., 1996; Olsson & Möller, 2003; Savic & Arver, 2011; Savic et al., 2010; Söderpalm et al., 2004). However, public health research in the Swedish context was, to the best of my knowledge, lacking. As seen in the previous section, besides Bremer’s thesis, there are now at least four studies that have qualitatively explored the encounters of people with trans experiences with the trans-specific healthcare in the Swedish context (Armuand et al., 2017; Carroll-Beight & Larsson, 2018; Lindroth, 2016; von Vogelsang et al., 2016). Some of these studies, however, are not in conversation with the field of trans studies or have not used theory to understand the participants’ experiences of trans-specific healthcare.

There is one report from the Swedish National Board for Youth Affairs (now the Swedish Agency for Youth and Civil Society) (2010) that deals qualitatively with health experiences among young people with trans experiences and one mixed-methods study about sexual health in the group (Lindroth et al., 2017). Except for these studies, the predominant knowledge production around health among people with trans experiences in the Swedish context is quantitative, with a focus on mental health.
Aim and research questions

The overall aim of this thesis is to analyse how constructions of trans experiences and gender can affect trans-specific healthcare practices, experiences of navigating access to gender-confirming medical procedures, inhabitancy of different spaces and, ultimately, health.

The following research questions have guided the analysis in the sub-studies and are also used to structure the results chapter:

1. How do care-seekers experience navigating and negotiating access to trans-specific healthcare and gender-confirming medical procedures? (Sub-study 1, corresponding to Papers I and II)
2. How are problems of evaluation, diagnosis and access to care represented in the Swedish guidelines for trans-specific healthcare? (Sub-study 2, corresponding to Paper III)
3. How are experiences of safety/unsafety related to perceived health in public, semi-public and community spaces? (Sub-study 3, corresponding to Paper IV)
Theoretical and conceptual framework

The conceptual framework for this thesis draws upon three lines of theory. Firstly, I use theoretical perspectives from the field of trans studies. This branch of theories ties into both phenomenological and Foucauldian theory and has been important for conceptualising trans experiences and for critical perspectives on the trans-specific healthcare. It was partly insights from trans studies that oriented me towards queer phenomenology, which I use in order to analyse experiences of trans-specific healthcare and inhabiting (un)safe spaces. Thirdly, I draw on Foucauldian theories in order to analyse governing and power relations within trans-specific healthcare.

Different perspectives on trans(gender) – from psychomedical discourses to trans studies

In this section, my intention is to describe how trans experiences have been theorised and understood in different disciplines and within different discourses. I see the relevance of this section in three ways. Firstly, it describes the background that made me to turn towards phenomenology as a way to construct knowledge. Secondly, the description of psychomedical discourses provides a context for the participants’ experiences of trans-specific healthcare. Thirdly, this section deals with feminist and queer discourses on trans experiences in order to contextualise people with trans experiences’ orientation towards trans-specific healthcare and the participants’ experiences of inhabiting queer and feminist spaces. I will begin by describing psychomedical discourses on trans experiences, followed by discourses from feminist, queer and trans studies. The description of the different discourses of trans experiences below should not be seen as a complete description, which I believe is not possible. Neither is it a chronological description; the later discourses have not replaced the previous ones.

Psychomedical discourses on trans experiences

Thus the transsexual phenomenon may have a different central nervous system (CNS) pathology in biological males and females, respectively. (Landén et al., 1998a, p. 193)

Research on trans experiences, or more specifically transsexualism and transvestism, was dominated for quite a long time by psychiatric research and, to a lesser extent, research from other medical fields (Denny, 2004; Hines, 2007; King, 1996; Stryker, 2006). This research has often been conducted in close collaboration with clinical trans-specific healthcare and by clinicians who work clinically with evaluating the need for gender-confirming medical procedures or
who provide such care (Denny, 2004; C. B. Stone, 1977). While “corrective” psychotherapy has been tried and has previously found support within the psychomedical community (Billings & Urban, 1982), providing gender-confirming medical procedures became the established standard during the second half of the 20th century (Denny, 2004; Dewey & Gesbeck, 2017; Ekins, 2005). Belief in “corrective” or “reparative” treatment still exists, perhaps especially in care and research that focuses on children and young people (for an overview of different care approaches for children with trans experiences see Ehrensaft, 2017).

Within psychomedical discourses, trans experiences have often been considered a matter of individual pathology and since 1980 have been classified as a psychiatric disorder in the DSM (Denny, 2004; Hird, 2003), through a variety of terminology (see also Appendix 2) (Dewey & Gesbeck, 2017). However, as Denny (2004) has noted, medical clinicians have been influenced by changing societal discourses on trans experiences. Many trans-specific healthcare providers and psychomedical researchers have expressed depathologising understandings of trans experiences (Dewey & Gesbeck, 2017; Lev, 2013). Such understandings have gained more and more traction over the last few decades within the psychomedical scientific community and were one of the reasons for changing “gender identity disorder” to “gender dysphoria” in the latest version of DSM.

Within the psychomedical discourse on trans experiences, gender has often been constructed as binary and tied to stereotypical gender performances (Denny, 2004; Dewey & Gesbeck, 2017; Hines, 2007). Furthermore, gender identity, similarly to sexual identity, has often been understood through a biological determinist lens, and as the natural extension of sex; thus, sex causes gender in terms of identity, behaviour, personality and interests (Elliot, 2016; Sanger, 2008). This understanding of gender has driven research that aims to explain “what went wrong” when “people are born in the wrong body”. Psychomedical researchers have, for example, suggested that trans experiences or gender dysphoria are caused by an exposure to sex-contrary hormones during critical periods of the foetal stage. According to this hypothesis, such exposure makes the physical sex characteristics develop in “one direction”, while the brain is affected in “the other direction” (Savic et al., 2010). This understanding can be seen in the still ongoing search for aetiological “causes” of trans experiences (for Swedish examples, see, among many more, Berglund et al., 2008; Feusner et al., 2017; Savic & Arver, 2011; Savic et al., 2010). Using MRI (magnetic resonance imaging) researchers have searched for sexual differences (i.e. variations in the size of a specific brain structure or variations in activation patterns), studying, for example, whether women with trans experiences share certain sizes of brain structures or activation patterns with people assigned female at birth (Savic et al., 2010). This kind of research has been scrutinised and criticised by researchers
from different disciplines, and a lot can be said about the ethics (e.g. the eugenic tendencies), the language used (e.g. pathologising), methodology (e.g. the construction of study groups, exclusion and inclusion), and the gap between results and conclusions (e.g. the conflation of correlation and causation) (for a critique see, for example, Eliot, 2010; Fausto-Sterling, 2000; Fausto-Sterling, 2012; Lawrence, 2007). But what is interesting is that these hypotheses and results, which the researchers themselves sometimes interpret with caution, travels far and wide outside academia, are transformed and become sensational news in both traditional and social media (Fausto-Sterling, 2012; O’Connor et al., 2012; O’Connor & Joffe, 2014).

It is important to note that psychomedical discourses on trans experiences, as well as being constraining, can also be enabling (like all discourses) (Dewey & Gesbeck, 2017; Ekins, 2005). For example, an explicit reason for keeping a diagnosis of trans experiences in the latest version of DSM was to enable people to gain access to gender-confirming medical procedures (Drescher, 2014). Biologically determinist theories about trans experiences have been used to argue that people with trans experiences have not chosen to be trans and to criticise conversion psychotherapy (however, how effective such arguments are in altering transphobic discourses has also been questioned) (Barasch, 2018; Grzanka et al., 2016). Considering the enabling aspect, for example, in terms of access to care, it is not surprising that people with trans experiences have picked up and used psychomedical discourses to explain and make sense of their trans experiences (Billings & Urban, 1982; Stone 1991). Thus, the use of psychomedical discourses by some people with trans experiences has to be understood in relation to the desire to be granted access to gender-confirming medical procedures that are guarded by medically trained (mental health) care-providers (Spade, 2006). Researchers have also shown how psychomedical discourses on trans experiences become reinforced in a circular way as care-seekers use certain narratives in order to be granted access to medical procedures, which are then seen by the psychomedical community as proof of the nature of trans experiences (Denny, 2004; Spade, 2006; S. Stone, 1991).

Feminist, queer and trans studies discourses on trans experiences

[W]e find the epistemologies of white male medical practice, the rage of radical feminist theories and the chaos of lived gendered experience meeting on the battlefield of the transsexual body. (S. Stone, 1991, p. 294)

Feminist, gender and queer scholarship has a long tradition of critiquing psychomedical discourses and the disciplining of gender and sexuality within the psychomedical arena and society more broadly. These fields also were important locations for early critical scholarship around transsexuality and gender (see, for
example, Garfinkel, 1967; Kessler & McKenna, 1978). Within feminist research, there is a range of understandings of gender. Compared to a binary, biological reductionist understanding of gender, many feminist and queer scholars have put forward understandings of gender, and some also of the body, as a social construct. Hence, gender is something that is continuously constructed and viewing biological body parts as essential male and female is also a sociocultural process (Kessler & McKenna, 1978; see also Wickman, 2001; Hines, 2007).

Feminist scholars who, in different ways, are interested in materiality have, however, criticised radical constructivist understandings of gender and the body, which they argue frame the body as a passive object and just a projections site for cultural inscriptions (see, for example, Alaimo & Hekman, 2008; Bremer, 2011; Lundgren & Kroon, 1996). The critique has also been put forward that mainstream feminist theory has neglected an analysis of the body (Alm, 2006). Some of this critique has been directed towards Butler (see, for example, Alaimo & Hekman, 2008), who, however, does not disregard the bodily or material aspects of sex/gender (Bremer, 2011; Ahmed, 2008 in Bremer, 2011, p. 47; Alm 2006). Bremer (2011) claims instead that Butler is arguing for a return to materiality as something contingent and unfinished, and Alm (2006) describes Butler’s attempt to overcome the distinction between materiality and signification. Butler (1990) has also criticised the distinction between sex and gender on the grounds that the separation of the two is based on an idea of pre-discursive bodies, hence the idea that bodies exist before and independent of social norms, ideas and knowledge. Butler argues that gender (sex) is repeatedly constructed through performative acts, and is not the expression of an inner truth.

Feminists interested in materiality have tried to overcome the dichotomous view of the body as either socially created or already there as a pre-discursive entity (as in biologically determinist/essentialist accounts of the body), and, for example, have emphasised the dynamic body, which is both socially created and at the same time has agency and can resist (see, for example, Barad, 2007; Bremer, 2011; Lundgren & Kroon, 1996). Bremer (2011) and Lundgren and Kroon (1996) have been influenced by this kind of understanding in their studies of transpecific healthcare and have shown, for example, how the body’s materiality becomes important in the evaluation process for determining access to gender-confirming medical procedures. Feminists have also used phenomenological theory to overcome the dichotomous view of the body. For example, Ahmed (2006b) understands the subject as always embodied. Hence, the body becomes central to lived experience in phenomenological lines of thought (Bremer, 2011; Folkmarsson Käll, 2009; Merleau-Ponty, 2005). Among some feminist medical researchers, phenomenology has become a useful theoretical tool to criticise the
cartesian split between mind and body, through and with, for example, the concept of *embodiment* (Wiklund, 2010).

Some feminists understand growing up as a girl to be essential to their gender analysis and argue that such experiences are central to one’s individual relation to the patriarchy. From such perspectives, women with trans experiences are not seen as (real) women. Some radical and lesbian feminists have argued that giving children and young people with trans experiences puberty blockers is a form of eugenics (Jeffreys, 2012), that women with trans experiences are men in women’s clothes who exploit (cis)women’s spaces and rape women’s bodies (Raymond, 1979) and that men with trans experiences are suffering from patriarchy-induced self-hatred (see Nataf, 2006). Interestingly, as Wickman (2011) notes, to a certain extent, radical feminists have used a kind of queer critique in their critique of trans subjects. For example, both Raymond (1994) and Jeffreys (1997) have argued that women with trans experiences are performing gender in normative ways and that having gender-confirming medical procedures is conservative and undermines the work to disrupt and challenge gender roles (for an overview see also Wickman, 2011).

Thus, the category of “woman” is not open to women with trans experiences in the eyes of these radical and lesbian feminists. On the contrary, trans is seen as undermining the feminist project (Jeffreys, 1997; for an overview see also Wickman, 2011). Furthermore, as Heyes (2003) argues, the exclusion of women with trans experiences has been justified by attempts to define a single feminist subject (see also Connell, 2012; Koyama, 2006). While queer and queerfeminist theory could be said to have the opposite goal, criticising the attempts to define a single woman subject, queer scholarship has also been criticised by trans activists and scholars on the grounds that is erases lived experiences and instead uses trans as an objectified category for proving their own theories or to develop new theories (Connell, 2012; V. Namaste, 2000). Wickman notes that “transgenderism” has served as an illustrative example in queer theory, to demonstrate “the performative character of gender” (2001, p. 47) and that people with trans experiences have been seen as embodying the deconstruction of the gender binary (2011, p. 15). Connell (2012) writes that the work of Butler (who can be said to use queer theory) “rests on an appropriation of transsexual and transvestite experience” (p. 862) and Namaste (1996) has voiced a similar critique. Researchers using post-structural theory have also been criticised by trans studies scholars for solely analysing/deconstructing how trans as a category/identity is constructed (e.g. such a critique is directed towards, for example, Hausman, 1995; Billing and Urban, 1992), instead of (also) accounting for experiences (for a critique see Rubin, 1998; Spade, 2006).
In addition, within trans studies and trans activism there have been different political and ideological positionings generating debates. One of the debates that has received much attention is the one constructed as being between transsexualism and transgender (Elliot, 2016; Roen, 2002). However, as Roen (2002) notes, this is a complicated debate and is not a question of “two discrete political approaches taken up by two discrete groups of people” (p. 502). It is also important to note that this conflict is partly tied to positions and perspectives previously mentioned, where the transgender position has often been connected to a queer perspective on gender and sexuality and a post-structuralist accounts of power and the deconstruction of binaries (Roen, 2002). The transsexualism position has thus been described as a “subversive crossing, public and politically strategic transcending, [that] is seen as one step on the road towards gender transgression, gender transcendence, and (ultimately) ridding the world of gender oppression” (Roen, 2002, p. 502; see also Bornstein 1995). The transsexualism position has on the other hand been connected to a liberal rights perspective, concerned with rights and access to care for transsexual people and a willingness to pass in the identified gender (Roen, 2002).

The subversive potential of trans and orientation towards trans-specific healthcare

The transgender and transsexualism positions can also be tied to a debate regarding the subversive potential of trans and gender non-conformity, which is a debate that intersects with the criticism directed against queer studies of using trans as merely for theoretical interests. Connell (2012), Rubin (1998), and Spade (2006) have noted that some researchers have had a tendency to commend non-normative and transgressive gender performances (sometimes allocated to the transgender position), while normative gender performances (and full participation in gender-confirming medical procedures, allocated to the transsexual position) have been regarded as conservative and without subversive potential (see also K. Namaste, 1996). Thus, one of the conclusions of previous queer and post-structural research is that undergoing gender-confirming medical procedures is to adhere to gender conformity; however, this conclusion has been criticised by, among others, Rubin (1998) and Spade (2006).

Connell (2012) has argued that the transgender turn and deconstructionist theory in transgender writings has had implications for transsexual women. Connell identifies two main problems; firstly, she claims that they use an identity discourse that does not account for major social issues in transsexual women’s lives, for example the nature of transition, the labouring transsexual body, workplace relations, poverty and health policy. Secondly, according to Connell, the literature has a tendency to degender the group they talk about by claiming, for example, that gender identity is fluid or unstable, only emphasising the non-normative or transgressive status, and ignoring gender location. Connell argues
that researchers instead have to recognise the specificity of transsexuality at the level of social practice and the problems connected to those social practices. Furthermore, Connell (2012) argues that this is why feminism is important, because these problems concern the structure and dynamics of the gender order.

Jack Halberstam approaches trans studies from a quite different perspective compared to Connell, but has also voiced a critique of an identity discourse, mainly in trans activism (Halberstam, 2014). Halberstam (2006 as cited in Elliot, 2016) has also argued for a more cautious approach to legitimising and stabilising the non-normative gender positions that trans can represent. According to Halberstam, a monolithic (uniform, single) conceptualisation of trans enables the continuing exoticification of trans and undermines the ability of trans to challenge the stabilisation and intelligibility of gender. Hence, Halberstam argues for an unintelligibility that can resist incorporation. As Elliot (2016) writes, such a conceptualisation, however, leaves us with questions such as: “If non-normative embodiments are to be celebrated only in their unintelligible forms, what becomes of those who embrace more conventional or intelligible gender categories?” (p. 2).

Namaste (2000), and to a certain extent also Connell (2012) argues, among other things, that the problem within the transgender and queer scholarly work about trans lies in the theories used (e.g. post-structural or queer theory). While it is important to take this critique into account, I, like others before me, want to argue that it is not so much a question about the use of a particular set of theories as it is an ethical concern and a failure to capture some critical aspects. Spade (2006) and Rubin (1998) have come to similar conclusions, that it is not the theories in themselves that are the problem. For example, in a critique of Hausman’s book “Changing sex”, Rubin (1998) writes:

*Hausman’s interpretation of transsexualism leads us back to the dream of a world without gender identity and places on transsexual men and women a revolutionary burden to refuse gender. A more rigorous Foucauldian approach, however, would not criticize transsexuals for having gender identities or for the supposed capitulation to gender normativity that Hausman implies but would rather have us ask what function these identities serve for the subjects who claim them. (Rubin, 1998, p. 266)*

Thus, it is not the Foucauldian theory in itself that Hausman is using that is the problem, according to Rubin (1998), but a particular way of using Foucault. Drawing on Rubin’s argument above, the function of claiming a certain gender identity could, for example, include being a recognisable subject (see Butler, 2009) or gaining access to gender-confirming medical procedures in order to be comfortable with your body. Or, thinking with Rubin (1998) and Ahmed (2006b),
one function could be connected to the desire to be what in queer phenomenology is described about as being “oriented” (see more below), being comfortable and extending the reach of the body. These are things that many people with only cis experiences take for granted, and such experiences need to be studied and analysed. Thus, as, for example, Rubin (1998) and Spade (2006) show, it is possible to use post-structural theory (e.g. Foucauldian or queer theory) to explore and theorise trans experiences in ethical ways.

What some queer or feminist scholars who use post-structuralism fail to see is that people without trans experiences also have their gender performances disciplined, that they conform to gender norms and employ a range of techniques to do so (Spade, 2006). According to Spade, this failure is a consequence of locating the problem with gender conformity in the act of seeking access to, and having, gender-confirming medical procedures. Connected to Spade’s argumentation, Butler (2014) has said the following concerning the misunderstanding of social constructionism as a theory:

*One problem with that view of social construction is that it suggests that what trans people feel about what their gender is, and should be, is itself “constructed” and, therefore, not real. And then the feminist police comes along to expose the construction and dispute a trans person’s sense of their lived reality. I oppose this use of social construction absolutely, and consider it to be a false, misleading, and oppressive use of the theory.* (Butler, 2014, online)

Similarly to Spade (2006), Butler (2014) is further arguing that this (mis)understanding of social constructionist understandings of gender identity fails to acknowledge that all people, having trans experiences or not, are active in dealing with and figuring out how to live with or against the constructions or norms that are part of constructing us.

What some researchers have also failed to see and understand is that some people with trans experiences have used strategic gender-stereotypical performances in meetings with healthcare providers, in order, for example, to gain access to care (Spade, 2006). Spade argues that we should locate the problems concerning gender normativity, in relation to trans-specific healthcare, in the process in which access to gender-confirming medical procedures is negotiated, and that we need to acknowledge that people without trans experiences also apply a range of techniques in order to conform to gender norms. Understanding gender normativity in relation to trans experiences in such a way would enable us to retain the critique of the medical practices and discourses expressed in previous queer and post-structural studies, but avoid “paint[ing] transsexuals as brainwashed victims who have failed to figure out that they are only undermining a revolution that seeks to save them” (Spade, 2006, p. 318).
Finalizing this section on different understandings of trans(gender), I want to explicitly spell out my position in relation to the aforementioned positions. I understand gender as embodied and repeatedly reconstructed through both sociocultural and material processes (which is in itself a problematic divide, but to be explicit here). Power is essential in the reconstruction of gender and produces desirable gendered subject positions. This understanding of gender does not mean that gender location is insubstantial, quite the opposite; both trans and cis gender locations have to be understood in relation to institutional and societal incentives to perform and embody gender in different ways, which have concrete material effects. The issue of subversive potential in relation to trans experiences, as well as the connected question about orientation towards trans-specific healthcare, have to be understood as very context-specific phenomena and need to be empirically investigated, not theoretically decided upon beforehand. I will not, however, say anything about possible prediscursive gender difference (which at least would certainly not be binary), which I actually believe lies beyond the scope of this thesis. Instead, my interest lies in examining how specific understandings of trans experiences and gender can have effects on care-seekers’ experiences of trans-specific healthcare, how gender-confirming medical procedures are represented in guidelines and the inhabiting of different kinds of spaces.

*Final remarks on the feminist, queer and trans studies debates*

It is important to note that the problematic conclusions in certain kinds of feminist and queer theorising, or the exclusion of people with trans experiences is not something that has happened in another time and place, but has very much been an active debate during the last couple of years in both Sweden and in other geographical contexts. The well-known feminist Kajsa Ekis Ekman started the Swedish debate and, much like Jeffreys (1997) and Raymond (1994), accused the trans movement of undermining the feminist movement and of trying to erase “woman” as an analytical concept. Similarly to previous feminist critiques of people with trans experiences adhering to gender conformity, Ekis Ekman also criticised trans people for preserving gender roles (Ekis Ekman, 2018). Thus, people with trans experiences’ bodies continue to be battlefields (S. Stone, 1991). What is at stake in these debates are of course the rights, material conditions, living spaces and well-being of people with trans experiences but the debates in themselves also cause ill health within the group (see also Elliot, 2016). Thus, it is also important to note that the stakes with which one enters these debates truly vary; people without trans experiences can participate in the discussions based on a primarily theoretical or ideological interest, while for people with trans experiences much more is at stake (Elliot, 2016).

The conflict lines described above are, of course, not as clear-cut as they are portrayed here. For example, some queer theory is feminist, some is not. There
are transfeminist perspectives and both trans studies and feminist theory display several different conceptualisations of gender. There is also a branch of radical feminism that is trans inclusive. What is also important to note in relation to the above debates is how the genealogy of trans studies might differ with regards to such aspects as race. In the Transgender Studies Quarterly’s “Issue of Blackness”, the guest editors show how black trans studies scholars have had a different relationship with feminist and queer studies, especially black feminist and queer studies (Ellison et al., 2017). Another example is how queer studies in the Swedish context has been developed within gender studies and thus has been highly influenced by feminist perspectives. In USA, in contrast, queer studies developed partly out of the independent field of lesbian and gay studies. Hence, the historiography/genealogy and debates described here might look different in other contexts and from other kinds of situatedness.

Phenomenology and Foucauldian theory – towards a conceptual framework

When I started this PhD project, I was about to do what several other scholars had done before me; I planned to use the experiences and narratives of people with trans experiences to theorise sex/gender. However, becoming aware of the historical context concerning trans and academic work made me revise my previous position and look more closely at phenomenology as a way of producing knowledge. Turning towards phenomenology provided me with an opportunity to account for the experiences and to position myself in a way that I found to be ethical but still provided me with a possibility to theorise. In addition, talking with trans activists made me aware of urgent needs in relation to everyday living conditions, which I thought would best be examined by focusing on their experiences. Below I will firstly introduce queer phenomenology and the Foucauldian understanding of power and then move on to discuss the potential conflict in combining phenomenology and Foucauldian theory, and my position in relation to these different understandings of the subject and experiences.

Queer phenomenology

Phenomenology is a broad field of studies. In common for several phenomenological traditions is the emphasis on the experiencing and lived subject, the body as a point of view on the world and that the lived experiences are a legitimate source of knowledge (Code, 2002; Rubin, 1998). Engaging with classical phenomenologists such as Husserl, Merleau-Ponty and Heidegger, together with feminist, queer and post-colonial scholarship, Ahmed develops a queer phenomenological framework that accounts for situated knowledge production and the familiar/domesticity of life (Ahmed, 2006b). Ahmed argues that Husserl’s phenomenology includes an account of a rather general orientation
towards the world in which what is given should be “bracketed” or kept in the background (Ahmed, 2006a). When queering phenomenology, Ahmed (2006a, 2006b) instead wants to highlight, with help from feminist, queer and critical race theorist, how our orientation towards the world depends on our social orientations. However, Ahmed’s ambition is both to queer phenomenology and to move queer theory closer to phenomenology. It is in “the importance of lived experience, intentionality of consciousness, the significance of nearness or what is ready-to-hand, and the role of repeated and habitual actions in shaping bodies and worlds” (2006b, p. 2) that Ahmed finds something in phenomenology that can contribute to queer studies. Furthermore, queer phenomenology can help us to analyse how bodies are shaped by history (Ahmed 2006a, p. 552). This creates a concrete usefulness in relation to health as it enables an analysis of health experiences in relation to how bodies are oriented in the world over time.

In *Queer phenomenology*, Ahmed (2006b) starts with the question of orientation and what it means to be oriented in the world. More specifically, Ahmed is interested in “sexual orientation” and what difference it makes in terms of what and who we direct our desires towards. Ahmed (2006b) argues that a queer sexual orientation entails being “out of line” and that “straightening devices” work to pull queer bodies back onto the straight line. As I briefly described in the introductory chapter, Bremer (2011) uses the concept of linear gender to illustrate similar norms/lines for trans experiences, and this has influenced the understanding of trans experiences in this thesis. Similar to how Ahmed describes heteronormativity as a straightening device (2006a), cisnormativity can be seen as such a device that (tries to) straighten up, and silence, trans experiences.

From Ahmed’s queer phenomenology (2006a, 2006b), I have taken a couple of analytical concepts that have helped me to understand, for example, norms and normalisation and how they are lived and experienced. According to Bremer (2011), Ahmed’s “lines” can be seen as a spatialisation of the concept of norms (p. 42). According to Ahmed, repetitive bodily action makes up lines, the normative, and what is present and near us is not a coincidence but a result of lines we have already followed; hence, in Ahmed’s queer phenomenology, the *background* gets to be important (2006a, 2006b). As experiencing subjects, we are touched by “what” is near us, or what is near enough to be reached, a touch that can leave marks on the body (Ahmed, 2006a, p. 552). Gendered performance (and sexual orientation in Ahmed’s case) affects the ability to take up space with the body; bodies that appear to be line can comfortably take up space. It is not only bodies that are oriented; spaces and objects are also oriented, and these support the linear body and allow it to extend its reach (Ahmed, 2006a, p. 563). Hence, spaces become cisnormative due to repetitive actions, and bodies that follows these lines can more easily feel at home and a sense of belonging, while others might feel
discomfort, unsafe and/or be required to do work in order to be able to take up more space. This kind of understanding of norms and inhabitancy in spaces is especially important for my analysis of (un)safe spaces and health, but also for understanding the orientation towards, and meeting with, trans-specific healthcare.

**A Foucauldian power analysis**
I have not found phenomenology alone enough to describe and analyse the experiences of the participants or to answer my research questions. Therefore, along the way, I have added other theories, which could be seen as having a somewhat different ontological and epistemological foundation. Foucauldian concepts and theories have been important in this thesis to understand, for example, power and subjectification and are more specifically used to understand the encounters between care-seekers and care-providers within trans-specific healthcare, and to understand and analays the policy material included in the thesis.

A Foucauldian understanding of power takes as a point of departure the idea that power is not only suppressive but also productive and positive in the sense that it creates things; for example, power is an essential part of subjectification processes and in producing knowledge and truth claims (Foucault, 1982; Lauri, 2016). A more structuralist understanding of power might assume that a certain social group possesses power, that there is a central political rationale behind it and that it is exercised through direct coercion or violence (Lupton, 1997). A Foucauldian understanding might, on the other hand, emphasise the disperse and relational nature of power, that the techniques and rationalities of power are diverse, and that power is something that opens up possibilities for action (Axelsson & Qvarsebo, 2017; Lupton, 1997). The relational aspect of power means that there is always also negotiation with and resistance to it (Foucault, 1980; Lupton, 1997).

The meetings between care-seekers and care-providers in trans-specific healthcare and the guidelines for trans-specific healthcare can be understood in terms of governing. In Foucault’s later works, he introduces the concept of “governmentality” to mark the increasingly dispersed nature of power. To govern, according to Foucault, “is to control the possible field of action of others” (Foucault, 1982 p. 790). Lauri (2016) argues that governmentality is “both a particular manner of exerting power and the total arrangements that such power has at its disposal” (p. 12). According to Dean (1999), governmentality as a framework can open up possibilities for analysing how, for example, questions of

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3 Note that Foucault uses the word “government” to describe a much broader concept than just dealing with political structures or the management of states (see Foucault 1982, p. 790).
the self and identity are linked with modes of governing and politics. Sanger (2008) argues that governmentality is useful for analysing the regulation of gender and can make visible “taken-for-granted” norms about gender, in both healthcare and in everyday life.

Lauri (2016) argues that governing can be analysed in terms of rationalities and techniques. Lauri refers to Brown (2006), who argues that political rationality “is a specific form of normative political reason organizing the political sphere, governance practices and citizenship. A political rationality governs the sayable, the intelligible, and the truth criteria of these domains” (Brown, 2006, p. 693). I will use the concept of rationality in my discussion to analyse the underlying normative reasons in trans-specific healthcare that form boundaries for what is intelligible and steer clinical practice. Governing techniques are in this study used to refer to certain ways of acting that “mediate the exercise of power” (Lauri, 2016, p. 15). To give a concrete example, I consider the use of time as a diagnostic tool in trans-specific healthcare to be a governing technique that builds on a psychomedical rationale of a stable gender, and thus that gender identity and behaviour are assumed to be consistent over time, and as such gender becomes intelligible. Another example of a rationale is the neoliberal rationale that has been central to the theorisation of governmentality (see, for example, Lauri, 2016; Brown, 2006), which I will for example discuss in relation the increased responsibility that care-seekers are expected to take for their health (see also A.E. Clarke et al., 2003).

With a Foucauldian understanding of power, a specific kind of gender dysphoria is constructed through trans-specific healthcare, and the psychomedical arena more broadly. As touched upon above, some scholars have argued that it is not only specific forms of gender dysphoria that are constructed through the psychomedical establishment, but that the entire trans subject (at least among those who seek trans-specific healthcare) is constituted through psychomedical discourses (Billings & Urban, 1982; Hausman, 1995). From such a positions, people with trans experiences become defined through their demand for gender-confirming medical procedures and there is no room for trans subjectivity outside the psychomedical model for trans experiences/ transsexualism.

In contrast to such positions, I see the psychomedical institution as a part of producing truth claims about the nature of, and suitable actions for, people with trans experiences. But these truth claims and actions are contested sites that (some) people with trans experiences challenge in different ways, both explicitly and by performing gender and transness in other ways. Furthermore, as trans studies scholars have argued before, people without trans experiences cannot be left out of these analyses, since the preconceptions about gender that constitute the foundations for evaluation in trans-specific healthcare do also affect people
who do not have trans experiences. With this understanding, trans-specific healthcare and psychomedical knowledge production contribute to forming and controlling care-seekers (in certain respects or for some), while at the same time it liberates and creates possibilities (in other respects or for others) (see Axelsson & Qvarsebo, 2017).

**(Bio)medicalisation critique of psychomedical discourses**
Trans experiences have been discussed with a focus on processes of medicalisation, by several different researchers, in different disciplines and with different focuses (Billings & Urban, 1982; Burke, 2011; Dewey & Gesbeck, 2017; Ekins, 2005; McGann, 2011). Medicalisation theory began to develop during the 1970s in order to understand and analyse processes by which social phenomena are redefined and reconstructed to fall properly within the medical domain (A.E. Clarke & Shim, 2011; Conrad, 1992; Zola, 1972). According to Conrad (1992), medicalisation processes occur on at least three levels: 1) the conceptual, 2) the institutional, and 3) the interactional (the clinical encounter). A traditional understanding of medicalisation processes often includes a perspective on power as suppressive, and as part of a conscious or intentional process (Lupton, 1997).

The medicalisation of trans experiences has primarily been analysed through explorations of how the conceptualisation and labelling of trans experiences relate to the terminology in DSM and ICD; the advantages and disadvantages of different conceptualisations have also been discussed, including by the medical establishment responsible for these documents (Burke, 2011). The medicalisation of trans experiences has also been discussed in relation to healthcare models, and specifically how some healthcare models require a diagnosis in order to provide access to care through health insurances or other reimbursement systems (Dewey & Gesbeck, 2017).

Consequently, the part of the trans community that needs gender-confirming medical procedures has had an ambivalent relation to medicalisation, because on the one hand it has the ability to facilitate (but not promise) access to needed medical procedures, but on the other hand it stigmatises and pathologises trans identities and experiences. This ambivalent relationship makes the issue of demedicalisation and depathologisation a more difficult one compared, for example, with the activist movement to remove homosexuality from the DSM. Burke (2011) argues that one way to escape from or modify this ambivalence is to distinguish between medicalisation and pathologisation and to defend the medicalisation (to facilitate access to care and legitimacy) while at the same time working to depathologise the condition. What is also important to note is that the original understanding of medicalisation does not have an inherent direction, even if though overmedicalisation is most commonly implied (Conrad, 1992).
Thus, an analysis of the medicalisation of trans experiences can account for both positive and negative outcomes.

As Lupton (1997) notes, from a Foucauldian perspective, demedicalisation would not mean that individual subjectivities or embodiments would be more authentically, or accurately, represented, only that they would be differently represented (p. 107). This connects to the Foucauldian understanding of the subject, that the subject is not already there, but is constituted in relation to discourses of power. Thus, if psychomedical discourses were to lose their dominant position in constructing specific trans experiences, other power relations would instead contribute to the construction, which would then be constraining and enabling in other ways.

While Foucault is often referred to in the literature on medicalisation, Foucault himself and others using a Foucauldian framework have mainly used other terms alongside ‘medicalisation’ (Lupton, 1997). There are, however, several similarities between the critical approaches to medicalisation that the very term connotes and Foucault’s analysis of Western medicine (Lupton, 1997). For example, Zola (1972) argues, similarly to Foucault, that medicine has taken over the role of social control that was previously implemented/authorised by religious and legal domains. But, generally, traditional medicalisation frameworks have different understandings of power compared to Foucauldian ones, which was one of the aspects that A.E. Clarke et al. (2003) developed in their biomedicalisation framework.

In 2003, A.E. Clarke et al. introduced the framework of ‘biomedicalisation’ in order to capture what they thought was a transformation in the organisation and realm of biomedicine. According to them, technoscientific developments played a central role in this transformation of biomedicine, which included a shift “from a control of biomedical phenomena to a transformation of them” (p. 161). In the biomedicalisation era, not only illness, disease and injury are incorporated in the medical jurisdiction, but also health itself. Through improved access to knowledge, self-surveillance, assessment, treatment, prevention of risk, and consumption of self-help services, health is becoming an individual moral responsibility. Theories of biomedicalisation can be seen as an extension of the medicalisation framework, and A.E. Clarke et al. (2003) argue that the term biomedicalisation captures the increasingly complex, multi-sited and multidirectional processes of medicalisation. Even if A.E. Clarke et al. does not explicitly mention neoliberalism, the rationalities described in the biomedicalisation framework exhibit several similarities to neoliberal rationality.
Conflicting understandings of the subject and experiences

Discourse in general, and the scientific discourse in particular, is so complex a reality that we not only can, but should, approach it at different levels and with different methods. If there is one approach that I do reject, however, it is that (one might call it, broadly speaking, the phenomenological approach) which gives absolute priority to the observing subject, which attributes a constituent role to an act. (Foucault, 2005, p. XV)

Quite early on in the research process, I became aware of the potential conflict involved in using phenomenology together with Foucauldian theory. While I still combine phenomenology and Foucauldian theory in one way, in this cover story and sub-study 1, perhaps I have mainly used them in parallel to explore different things in the material and for different analyses and research questions. However, having put a lot of thought and effort into understanding and trying to overcome this tension, I will introduce this potential conflict and try to make clear how I position myself in relation to the different understandings of such issues as the subject and the phenomena of experiences. As will be introduced in more detail below, I have also come across perspectives that may see possibilities for a more coherent or stringent combination of the two perspectives.

Joan W. Scott, feminist scholar and historian, could be described as combining post-structural approaches with psychoanalytical theory and has argued that:

When [experience] is defined as internal, it is an expression of an individual’s being or consciousness /.../ talking about experience in these ways leads us to take the existence of individuals for granted (experience is something people have) rather than to ask how conceptions of selves (of subjects and their identities) are produced. It operates within an ideological construction that not only makes individuals the starting point of knowledge, but that also naturalizes categories such as man, woman, black, white, heterosexual, and homosexual by treating them as given characteristics of individuals. (Scott, 1991, p. 782).

Scott claims that we cannot assume that something exists outside of discourse, thus not assuming the existence of anything pre-discursive (except perhaps for fantasy in a psychoanalytical sense (see Scott, 2011)), and based on such claims Scott argues that knowledge production based on experiences fixates and naturalises identities, taking them for granted and reproducing the discourses that we might aim to challenge and ultimately change. This poses a challenge to the desire to combine a phenomenological and Foucauldian approach in a coherent way, as the understanding of the subject and of consciousness can be seen as different. Phenomenology inquiries sometimes assume a social agent prior to discourse; however, within a phenomenological approach the social agent could also be understood as “an object rather than the subject of constitutive acts”
(Butler, 1988, p. 519). In line with such an argument, I would like to argue, as others have before me, that within a phenomenological framework it is possible to account for experiences as derived from “external discursive forces” (Rubin, 1998, p. 267). So, the phenomenological approach used here could be described as informed by discourse theory (Rubin, 1998). It could also be said to not be “properly phenomenological” (Ahmed, 2006b, p. 2) but instead what Ahmed calls a “queer phenomenology”, in all its meanings. As Ahmed (2006b) points out, a queer phenomenology might enjoy failing to be a proper phenomenology (pp. 2, 29). However, it is important to point out that accounting for experiences as connected to discourses does not make them any less “real” for the experiencing individual.

It is not only orthodox phenomenology that I have taken a step away from, I have also been hesitant about parts of Foucauldian theory. Lupton (1997) argues that there is in Foucault’s work little discussion

about how people respond to the discourses and strategies that attempt to discipline them. Nor is there much discussion of how these responses are mediated through such factors as gender, age, social class, sexual identity and ethnicity (Lupton, 1997, p. 103).

Thus, according to Lupton we need to empirically analyse how people respond to, for example, to the clinical gaze and to “bring them alive” (1997, p. 103) instead of only representing them as docile bodies that are constrained by dominant discourses. Lupton (1997) emphasises that a phenomenological inquiry alongside a Foucauldian one can help us to explore the “mutual dependencies and the emotional and psychodynamic dimensions of the medical encounter, [instead of] preferring to rely upon a notion of the rational actor” (p. 108). Additionally, in some of Foucault’s work, the distance to phenomenology might not be as big as displayed above. According to Lupton (1997), Foucault “turns towards the ontology of experience, moving towards a phenomenology of everyday life” in his later works (p. 104). Bremer (2011) also points out that Ahmed’s queer phenomenology shares a clear genealogy with Foucauldian accounts of power.

Maybe it is precisely in the field of trans studies that we find excellent examples of how it is possible to combine a focus on experiences (not necessarily phenomenology) and post-structural theory (see, for example, Bremer, 2011; Hines, 2007; Rubin, 1998; Spade, 2006). In studies combining a focus on experiences as a basis for knowledge production and post-structural theory, it is possible to understand, for example, how discourses play out on individual bodies and the materialisation of difference discourses.
To conclude, I use the participants’ experiences as a point of departure for a large part of this thesis. I do not see these experiences as independent of discourses, but that different discourses affect how subjects actually experience different events/phenomena and also how they talk about and make sense of their experiences. One example is that I interpret some of the participants’ experiences as being grounded in very low expectations of their surroundings, which might be related to an internalising of cisnormative discourses (see also Hendricks & Testa, 2012). To start from the participants’ experiences was initially an ethical choice, but it is a choice that I have also come to appreciate in other ways, in terms of facilitating an exploration of particularity (e.g. in relation to the subversive potential or orientation towards the trans-specific healthcare), social context and connections to health, as well as a way of avoiding theoretical determinism. A queer phenomenological approach can contribute to important knowledge of how discourses are lived, embodied, and experienced by the participants. For example, as I will show in the results and discussion chapters, my empirical focus on the participants’ experiences makes it possible to analyse and draw conclusions about how power and governing are experienced, which can also add theoretical insights to theories about governing.
Research context

Sweden is a Scandinavian country in the north of Europe. Although influenced by neoliberal processes over the last few decades, Sweden is still considered to be a welfare state with healthcare insurance for all Swedish citizens. In 1972, Sweden became the first country in the world to pass a law on legal gender reassignment and since then it has been possible to have legal gender reassignment. However, Sweden only has two legal genders. All citizens and legal residents of Sweden have a personal identification number, which is binary gendered. This identification number is used in many arenas and can constitute a problem for people with trans experiences if it does not match their gender.

Legal situation for people with trans experiences

Before 1972, there were some people who had had some gender-confirming medical procedures and had changed names. With the 1972 law, it became possible to change legal gender, but not without demands. The applicant had to go through a psychiatric evaluation, be diagnosed as transsexual, had to be unmarried, over 18 years old, sterilised and a Swedish citizen. In 1972, the healthcare system also more formally began to provide gender-confirming medical procedures. Further changes in legislation were not made until 2009, but then there were three changes: (1) the name law was changed so that people over 18 years old could choose any names, regardless of legal gender; (2) transgressive gender identity or expression was included as a ground for discrimination; (3) people who were married and wanted to change legal gender did not have to divorce since the marriage legislation became gender neutral. That same year (2009), the psychiatric diagnosis for transvestism was removed by the National Board of Health and Welfare (Transformering, 2018).

As of 2012, people over 12 years of age can change names, with consent from their legal guardians. In 2012, trans activist were able to overthrow the requirement for sterilisation when the administrative court of appeal decided that it was in violation of European conventions, so from 2013 people with trans experiences are no longer required to be sterilised in order to gain access to legal gender reassignment. In 2013, the law on legal gender reassignment was changed so that applicants no longer need to be a Swedish citizens, but one still needs to be a legal resident. From 2018, people who were forcibly sterilised can apply for damages. In 2018, the parliament also decided that people with trans experiences will be included in the law on hate crime, discrimination (a broader category than in the law of 2009) and insult. A first step has also been taken to include people with trans experiences in the law on agitation against a group (Transformering, 2018).
Over the years, several governmental reports on trans issues have been published. The report of 1968 was the legal preparatory work for the 1972 law (SOU 1968:28). In 2016, the government appointed an investigator to map the situation for trans persons and to propose action in order to strengthen their rights and improve their living situation. The governmental report was published in 2017 (SOU 2017:92). The extensive report (921 pages) covers several areas, of which trans-specific healthcare is one. One of the suggestions in the report, echoing a previous governmental report (SOU, 2014:91), is that the legislation should be reformed so thoroughly that the legal and medical gender reassignment processes become two separate things, regulated by separate legislation. The government has also suggested such a change, but no decision has been taken (The Swedish Ministry of Health and Social Affairs, 2018).

**Swedish trans politics**

In Sweden, there are four larger organisations working with trans issues which have dominated the activist scene. FPES (Full Personality Expression Sweden) was established in 1966 and historically has mainly organised transvestites but is now open to anyone with trans experiences. PF Benjamin/Transsexuals in Sweden (Patient organisation) started in 1979 and was exclusively for transsexuals; the organisation considered transsexualism to be a disorder of sexual development. PF Benjamin was closed down in 2017. RFSL and RFSL youth (The Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights), previously an organisation for the LGB population, decided in 2001 to include people with trans experiences as one of their target groups. KIM (Gender-Sex Identity-Diversity) started in 2007 and is open to all persons with trans experiences (SOU, 2017:92; Transformering, 2018). These four groups have differed, and still differ, with respect to their target groups (within the group of people with trans experiences) and also with regards to how they understand trans experiences and how, and in what way, they work for social change.

There have also been smaller networks and organisations that have been active during different times; some of these have criticised the associations above for being too focused on rights and assimilation. Examples of such groups are Transmilitanta brigaden [Trans militant brigade] in Gothenburg, Cis-semester [Cis-vacation] in Malmö, Anarchopride in Stockholm and Transförsvar [The trans defence]. These groups have often taken an anti-capitalist, intersectional and queer approach to trans issues (Bremer, 2011; Siverskog, 2016). In 2012, Anarchopride occupied the stairs of the National Board of Health and Welfare and demanded that the psychiatric diagnoses on trans should be taken away. But, unlike when homosexual activists occupied the stairs in 1979 and accomplished a change, several of the activists in 2012 were convicted of encroachment (Siverskog, 2016; SOU, 2017:92). In 2016, Transförsvar once again occupied
the National Board of Health and Welfare. They demanded, among other things, that the National Board of Health and Welfare should no longer have a role in trans-specific healthcare; non-binary people and asylum-seekers should have increased access to trans-specific healthcare, and waiting times within trans-specific healthcare should be decreased by removing unnecessary meetings and obligatory “trial periods” (what I interpret as Real-life Experience) (Voss, 2016).

The Swedish healthcare system and trans-specific healthcare

Sweden’s general healthcare insurance also covers gender-confirming medical procedures. This does not mean that healthcare visits are free of charge; depending on which part of the healthcare one is visiting, one has to pay 100–300 Swedish kr. (10–30 EUR) for each visit. However, in any 12-months period one does not have to pay more than 1200 kr. (115 EUR) in patient costs. Prescribed medicines are subsidised, but one may pay up to 2200 kr. (200 EUR) during any 12-months period. People with trans experiences who are going through the evaluation and using hormones will reach these maximum costs quickly, and thinking of how hormones are often used for the rest of a person’s life, they would have an annual cost of 2200 kr.

The National Board of Health and Welfare of Sweden is the governmental agency responsible for healthcare. The National Board of Health and Welfare is responsible, for example, for creating and publishing guidelines for healthcare and has published the guidelines for trans-specific healthcare that are analysed in this thesis. However, healthcare is mainly the responsibility of county councils in Sweden. This means that the 20 county councils have a partially autonomous responsibility for providing healthcare and working preventively to ensure a good health for the population. However, there are only six official teams in Sweden that evaluate the need for gender-confirming medical procedures. These teams are located in Lund, Allingsås, Linköping, Stockholm, Uppsala and Umeå. Even fewer clinics provide surgical gender-confirming medical procedures. This means that there are geographical differences with regards to distance to a gender identity evaluation team and healthcare facilities that provide gender-confirming medical procedures. These differences are especially noticeable in the northern part of Sweden, where the Umeå team is the only formal gender identity team north of Uppsala, and hence covers the four northern county councils, which constitutes around 50% of the country in terms of land area. Due to long distances between some care-seekers and the specialised team in Umeå, individual healthcare providers have collaborated with the them to undertake parts of the evaluation or to provide services such as speech therapy or hair removal.

People with trans experiences in Sweden who seek gender-confirming care are obliged to undergo a clinical evaluation (see Figure 1). In order to get to the
evaluating team, care-seekers often need a referral from a general practitioner and/or a psychiatrist (step 1 in Figure 1) (SOU, 2014:91). Special multidisciplinary teams (often located in psychiatric clinics or sexological centres) are responsible for the evaluation, for diagnosing gender dysphoria/transsexualism, and for referrals to medical procedures. The evaluations consist of psychological, physical, social and psychiatric evaluations and a real life experience (RLE), i.e. that the person lives according to their gender identity for about 6–12 months (step 2) (The National Board of Health and Welfare, 2010). If they pass the evaluation, the care-seeker can get access to hormones, speech therapy, hair removal and/or breast surgery (step 3). Access to some of these procedures might also be initiated alongside the evaluation.

If the care-seeker wants access to legal gender reassignment and genital surgery, the evaluation team (often the psychiatrist) writes an assessment to the Legal Advisory Board (LAB) at the National Board of Health and Welfare (step 4). The LAB decides on the applicant’s right to legal gender reassignment and grants permission for genital surgery based on the law on legal gender reassignment (step 5). The law demands that applicants are over 18 years of age, have experienced for a long time that they belong to the “other sex”, have behaved accordingly for a period of time, and that they are expected to live in the new gender identity in the future (SFS, 1972:119). It is important to note that several of the changes in the law described above (e.g. removing forced sterilisation)
occurred after several of the participants in this study sought trans-specific healthcare.

Although the law does not demand a gender dysphoria (DSM-5) or transsexualism (ICD-10) diagnosis (see Appendix 2 for diagnostic categories and criteria), the practice has been to require a diagnosis in order to approve genital surgery and legal gender reassignment (Dhejne et al., 2011). A diagnosis has often been needed to access hormones; however, approval from LAB is not needed to receive hormones, body-hair removal, vocal training or mastectomy. As mentioned above, gender-confirming medical procedures that are accessed through the Swedish system are paid for by the county councils. However, some people pay for medical procedures themselves; for example, ordering hormones from abroad or visiting private clinics for hair removal (The National Board of Health and Welfare, 2010).

Until around 2010, non-binary people did not have formal access to gender-confirming medical procedures in Sweden. Non-binary-identified individuals cannot fulfil the diagnostic criteria for transsexualism in ICD-10, which was the diagnosis care-seekers needed (not formally, but in practice) to gain access to care (The National Board of Health and Welfare, 2010). Non-binary individuals have instead received the diagnoses “gender identity disorder, unspecified” or “other gender identity disorders” (Arver et al., 2015). However, in 2010, the team in Stockholm started a project in which they provided gender-confirming medical procedures for adult non-binary people, and since then it has been possible (but differently difficult under different teams) to gain access to care for non-binary people (or binary people who do not want all the gender-confirming medical procedures) (Lagerblad, 2017).

The length of the whole evaluation process varies and should be individually adapted according to the guidelines for trans-specific healthcare. However, the LAB states that the starting point is a two-year evaluation, including a one-year RLE (The National Board of Health and Welfare, 2017a). The governmental report on trans persons’ living situation did not, however, find any legal support or support in international healthcare guidelines for these specified demands for evaluation and RLE times. Despite this, the report showed that several applications to the LAB has been rejected because the evaluation or RLE was considered to be too short, despite the applicant having a certificate from an evaluating psychiatrist (SOU, 2017:92).

Over the last few years, and especially since 2013, there has been a drastic increase in the number of people seeking trans-specific healthcare and applying for legal gender reassignment; this tendency is probably partly connected to the removal of the sterilisation requirement in the legislation (SOU, 2017:92). Figure
2, below, shows the proportion of the Swedish population that has been diagnosed with gender dysphoria (all ages) and Figure 3 shows the number of referrals to the youth gender identity team in Stockholm. According to the National Board of Health and Welfare (2017b), this means that in 2015 it was 0.04\% of the population that had a gender dysphoria diagnosis. According to the SOU (2017:92), the trend for adults has continued upwards since 2015. For example, between 1 January–31 August in 2017, the Legal Advisory Board received 270 applications, which can be compared to an average of 165 application each year between 2013–2016 (SOU, 2017:92). The first population-based numbers (compared to clinical numbers) for Sweden were published in 2018, based on a survey from 2014 of people living in the area of Stockholm County Council. Of a totally of 50,157 respondents, 2.3\% of the people above 22 years old did feel to some degree that they belong to another gender/sex and 0.5\% wanted to change their body with hormones or surgery (1\% among those aged 22–29 years old). The authors suggest that this could imply that the number of care-seekers will continue to increase (County Council of Stockholm, 2018:3). An increasing number of care-seekers can also be seen in other contexts such as the USA, Canada and the Netherlands (Cartaya & Lopez, 2017; Lane et al., 2018).

**Figure 2:** Number of individuals per 100 000 that have been diagnosed with gender dysphoria from 1998 up until 2015. Taken from: The National Board of Health and Welfare, 2017b.

**Figure 3:** The number of referrals to the team for gender identity evaluation for youth at Astrid Lindgren’s children’s hospital in Stockholm during the period 2006–2016. (On the y-axis it says “number of care-seekers” which I think is not really correct, the graph shows referrals to the specialised team for youth). Taken from: Frisén, Söder and Rydelius 2017.
The above question has been posed on several occasions when I have been out lecturing about trans issues. This is also a question that has been posed quite often in psychiatric research on trans experiences and many of the estimates of the trans population has been based on clinical samples. The question also seems to assume that the answer is a fixed proportion of the population (but not everyone might be aware of or open about their trans experiences). This assumption can also be seen in psychiatric studies discussing the increase in the number of people seeking trans-specific healthcare and where they suggest, for example, that the increase is due to “increased publicity” (Wålinder, 1971, p. 196), or “increased public awareness, easier access to information, and increasing societal acceptance” (Dhejne et al., 2014, p. 1542); however, “the figures should not represent any real increase of transsexuals” (Wålinder, 1971, p. 196). Trying to answer the above question also requires defining who is trans, and the answer would certainly differ if trans is only considered as an identity or if it is constructed as experiences. Hence, it is a complicated question with several different answers. In one way I also think the question is quite uninteresting; no matter how big the population is, the same social rights, living conditions and quality of care practices should be demanded and deserved. However, calculations of the number of people likely to seek trans-specific healthcare can be important in order to allocate the right amount of resources.
Methods

Study design
For this thesis, I have used a qualitative and emergent study design. The qualitative methodology has facilitated an in-depth exploration of the participants’ experiences from their own point of view. This in-depth exploration of participants’ own experiences can be seen as an important complement at a time when several quantitative studies have shown that people with trans experiences report poor health and bad experiences of the healthcare at a group level (The Public Health Agency of Sweden, 2015; Transgender Europe, 2017; Zeluf et al., 2016).

In sub-study 1 (see also Table 1), I have used interviews with people with trans experiences to explore care-seekers’ experiences of trans-specific healthcare. Sub-study 2 is a policy analysis of the guidelines for trans-specific healthcare (SKS) and provides important information in relation to sub-study 1 in at least two ways. These guidelines were published after the interviews for sub-study 1 about trans-specific healthcare were finished, and thus provides an opportunity to analyse whether the guidelines might change some of the issues addressed in the interview study. Secondly, the SKS provides an opportunity to analyse the “other side”: how care-providers and decision-makers construct the evaluation process and access to gender-confirming medical procedures. I thus see the combination of the participants’ experiences of trans-specific healthcare and the SKS as knowledge claims from different perspectives and situatedness, and as such they become interesting to analyse together and compare. Sub-study 3 is an interview study and concerns experiences of (un)safety in relation to perceived health. Hence, in this sub-study I move outside the trans-specific healthcare arena, which provides an opportunity to analyse whether there are differences in (trans)gender discourses in the different spaces.

I have used three different analytical methods for the different sub-studies; constructivist grounded theory, thematic analysis and Bacchi’s approach to policy analysis: “What’s the problem represented to be?”. For sub-study 1 (see also Table 1), I was inspired by Charmaz’ (2014) constructivist grounded theory. With no previous experiences of qualitative methodology, Charmaz’ guide to grounded theory, with thorough explanation of the process and step-by-step description, was useful for me. At the time of the next interview study, sub-study 3, I was a bit fed up with all the steps in grounded theory and the urge to develop models and new theory, and the extensive coding in grounded theory had almost driven me crazy (see more below). I think thematic analysis at that point gave me a bit more of creative freedom.
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<th>Sub-study 1</th>
<th>Sub-study 2</th>
<th>Sub-study 3</th>
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<td><strong>Study design</strong></td>
<td>Qualitative interview study</td>
<td>Policy analysis</td>
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<td><strong>Material</strong></td>
<td>14 interviews</td>
<td>Swedish knowledge support (SKS) for trans-specific healthcare</td>
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<td><strong>Data analysis</strong></td>
<td>Grounded theory (Charmaz, 2014)</td>
<td>What’s the problem represented to be? (Bacchi, 2009)</td>
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*Table 1: The different sub-studies, their aims, methods and correspondence to papers.*

**Snapshot:** (Somebody asked: “Was the process this linear?”)

That this thesis became a totally qualitative thesis or a thesis dealing “only” with people with trans experiences was not the plan from the beginning. I began my PhD process by developing my (quantitative) master's thesis into a paper dealing with the relation between various socioeconomic measures and psychological distress among men and women. Alongside writing the ethical application for the interviews for this thesis, I worked on another paper which I planned to include in the thesis; a cluster analysis and an attempt to make a quantitative analysis of gender and mental health without using sex/gender only as an independent dichotomous variable. I did a lot of analyses and learned a lot about cluster analysis but for various reasons we were not able to finalise that paper. The plan was also to conduct interviews with intersex people, but this was never done as the interviews with people with trans experiences became rich and I decided to write three papers on this material instead.
Interview studies (sub-studies 1 and 3)

Development of interview guide, pilot interviews, and sampling procedure

When I was working on developing the study design for the interview studies, I first met with three trans activists. With two of them, I had more formal meetings in which we discussed the study design and they gave me advice on recruitment, topics to explore, things to read and ethical issues I should consider. The third meeting was more informal, but I gained important insight into what it can be like to be invited to similar studies and also into his experiences of trans-specific healthcare. One of these activists was an acquaintance, while I had just recently met the other two. With these conversations in mind, and together with inspiration from previous research and theory, I prepared a preliminary interview guide. I first piloted this with a friend with trans experiences and after that I changed it quite substantially after I read the transcripts and after feedback from the pilot participant. After that, I contacted an acquaintance, whom I had only met on a few occasions, for a second pilot interview. Based on feedback from her, the interview guide worked quite well, which I and Lisa Harryson (LH), my co-author, also thought after reading the transcripts. The second interview provided valuable information about the study topic and was included in the material for the thesis (for a summary of the interview guide see Appendix 4).

The first set of recruitment and data collection was conducted between November 2014 and September 2015. I contacted a number of organisations and networks for people with trans experiences, of which the following agreed to distribute the ad or approved me to distribute it through their channels: RFSL, FPES, and KIM. The advertising material was disseminated through their websites, email lists and social network pages and groups. The material was also disseminated via other online social forums by interested persons and individuals connected to these networks. Therefore, the participants are not limited to individuals directly connected to the above networks. In order to minimise the informants’ feelings of dependency in relation to healthcare, participants were not sought through healthcare channels.

For sub-study 3, after a preliminary analysis of the first 14 interviews, I found that the unsafety/safety theme could be investigated further. I conducted four more interviews in February and March 2017. The last four participants were contacted through Facebook pages and groups for LGBTQ persons in a middle-sized town. Interested people spread the advertising material, which resulted in a couple of people living in other places contacting me. The first four people who were able to book a meeting were interviewed.
The advertising material contained brief information about the study and contact information (see also Appendix 3). When the presumptive participants contacted us, they were sent a letter with more comprehensive information about the study and its aim, how the interviews were to be conducted, data handling and anonymisation of the interview material. If interested, they contacted us again, after which an interview was booked.

Snapshot (I asked: “can you disseminate this?”)
I asked one of the trans organisations if they could disseminate the advertising material through their homepage and/or Facebook page. I got this as a reply: “Hi, thanks for your email. No one in XX group identifies as transsexual or trans*. Transsexualism is a disease, not an identity. Please read our article about how transsexualism is neurologically caused /.../. Given the criteria to be included in the study we can unfortunately not contribute with participants, but we wish you luck with the interviews.”

This means that I might have missed a spectrum of people who have encountered the trans-specific healthcare but understand their trans experiences in another way than some of the participants who were included. However, it seems that the advertising material also reached participants with similar understandings of trans experiences. For example, some participants described themselves as having a trans background (compared to an identity) and some spoke about trans having a neurological cause.

In the first round of advertising, 22 people contacted me with an interest in participating. The participants for sub-study 1 consisted of the first nine people who were able to participate after receiving comprehensive information about the study, as well as the participant from the second pilot interview. Because of the predominance of people identifying as women among the first nine participants, I purposively invited two men and two people identifying as non-binary among those that had contacted us (the fourteenth participant is the one from the second pilot interview). In the second round of advertising, five people who were interested in participating contacted me. Four of them were interviewed (the final person did not respond to my emails).

Participants
The 18 participants lived in different parts of Sweden and their ages ranged from 19 to 69 years (see Appendix 1 for short biographies of the participants). Of the 14 included in sub-study 1, ten people had experiences of meeting an evaluating team within the previous seven years (at the time of the interview), one had tried to get a referral for evaluation and three had considered seeking trans-specific care. Out of the last four participants, three had met an evaluating team and one
had considered seeking trans-specific healthcare. Of the total of 18 participants, seven people defined themselves as women, six as men and five participants defined themselves as non-binary or intergender. No participant identified or described themselves as a transvestite. Twelve people had started or completed university studies; out of those, four were still students. At the time of the interview, eight were in paid employment, two were unemployed, one was retired, and three were on long-term sick leave. Seven participants had a partner, and one was the legal guardian of a child. In the “Results”, the names of the participants are replaced with fictitious names of my choice. When choosing the names, I have focused on giving them names that correspond to their gender identity (e.g. names that are typically recognised as gender-neutral were given to the non-binary participants) and that are similar to their real names in terms of style; for example, thinking about what kind of names are common in different generations. Preferably they would have chosen their own fictive names, but this crossed my mind too late in the process.

**Data collection**

I conducted the interviews in places chosen by the participants, including cafes, libraries, participants’ homes and workplaces, and my office. One interview was conducted by telephone as the participant thought that was more comfortable than a face-to-face interview. Before the interviews started, I carefully went through the information letter and collected written consent. For the telephone interview, oral consent was collected and recorded.

The interviews were semi-structured with open-ended questions covering themes such as: experiences of healthcare, health and ill-health, close relationships, and experiences of stigmatisation, violence and discrimination (for a summary of the interview guide see Appendix 4). In the second round of interviews (4), the same interview guide was used but with slightly more focus on the theme of (un)safety. For those who had experiences of trans-specific healthcare, this topic was also included in these last interviews. The interviews were digitally recorded and carried out according to an emergent design, in which each interview was initially analysed before the next was carried out (Charmaz, 2014). Small changes in the interview guide were made after the interviews and during the analysis process. The interviews lasted between 50 and 135 min, and were transcribed verbatim. I have transcribed some and two external transcribers did the rest. The first data collection continued until very similar experiences were described in the last interviews compared to the previous interviews, and, together with my co-authors, I did not think that additional interviews would reveal more useful information corresponding to our aims. After preliminary analysis of the last four interviews, I found that very similar experiences and topics were emerging in
relation to the (un)safety themes in those interviews as in the first 14 interviews; thus, I decided to not advertise for more participants.

**Analyses**
For the two sub-studies based on the interviews, I have performed two rounds of coding and analysis. Thus, Papers I and II are based on the same coding and Paper III on another round of coding.

Sub-study 1: In the first analytical step, LH and I together read the transcribed interviews thoroughly and discussed their content and preliminary interpretations. Memos were written during and after the discussions and compared. In the second analytical step, I imported the transcripts to MAXQDA 11, which was used for initial coding. I did the initial coding by quickly labelling text segments with codes that were close to the material with limited abstraction. In a third analytical step, Excel 2010 was used for focused coding, during which relevant initial codes were recoded (Charmaz, 2014) with a focus on the aim, the social processes involved and by comparing initial codes. In the fourth step, I performed axial coding, involving the creation of categories and subcategories by comparing focused codes, finding common themes, analysing the empirical material in relation to the theoretical framework and abstracting the content. Subcategories were merged with the aim of creating categories that were as internally homogeneous as possible and as heterogeneous as possible from other categories. Categories and subcategories were discussed in detail with the co-authors and revised based on their feedback.

The results were split into two parts in the fourth step and reported separately in Papers I and II respectively. The split was made so that everything that concerned constructions of gender was allocated to Paper II and the rest was dealt with in Paper I. This provided an opportunity to engage more deeply engage with the issues described in each of the papers, as the word-limit had been exceeded at an early stage. However, the disadvantage was that some issues, such as the relation between waiting time and constructions of a stable gender identity, were dealt with in two different papers.

Sub-study 3: For this, I performed a new round of coding and analysis, now using constructivist thematic analysis (Braun & Clarke, 2006). The analytical process consisted of a mixture of inductive and theoretical thematic analysis, moving between the empirical data and the theoretical framework in an abductive way. In the first analytical step, I carefully read and re-read the transcripts with a focus on meanings and repeated patterns, and made analytical notes. In the second step, I coded those parts of the transcript that responded to the aim and made analytical notes, including preliminary themes. In the third step, I reviewed and
sorted the codes into emerging overarching themes. The codes and themes were discussed in detail with the other co-authors and the themes were revised. The analysis was performed using a latent approach (Braun & Clarke, 2006), trying to identify, analyse and interpret underlying assumptions, ideas and meaning in the empirical data.

**Snapshot (blindly looking for ways to handle thousands of codes)**

I coded the first 14 interviews in MAXQDA and ended up with 4391 codes. How can anyone even handle over 4000 codes? I was overwhelmed and did not have a plan to systematically handle the codes or to take the next step. So, I ended up drawing, downloading several programs that could potentially help me on the way. I ended up using excel to do the focused coding. I firstly picked out those codes that concerned healthcare, 2580 codes. And out of these I did a focused coding of the codes that concerned the road to, and the trans-specific healthcare, 2049 codes. However, mind maps (digital and analogue) were a central step in developing subcategories and categories. They were also a beginning for several working figures. Below, you see two of these.

**Figures 4-5:** Models for the results of Sub-study 1.
The policy analysis (sub-study 2)

Analytical approach
The policy analysis of the guidelines for trans-specific healthcare (SKS) was inspired by a poststructuralist approach to policy analysis. In her approach to policy analysis, “What’s the problem represented to be?” (WPR), Bacchi (1999, 2009) draws on Foucauldian perspectives on power and problematisation in order to develop a tool for critically analysing policies. Bacchi argues that policies do not (only) address problems but “give shape to problems”. Similarly, A.E. Clarke et al. (2003) describe how policy in a medicalisation framework is often understood as problem-solving while the biomedicalisation framework understands health governing as problem defining. The WPR approach stems from the understanding that problematisation is not about representing a pre-existing object, but a set of practices which enters into a terrain of competing constructions of truth and falsity (Bacchi, 2009). Hence, it is impossible to represent, or have contact with, a value-free or interpretation-free reality, and therefore the representation of problems in policies is not an objective description, but a contested claim about the nature and existence of social problems (Bacchi, 1999). Analysing proposals in policies that are supposed to fix the problem can reveal how that problem is constituted.

Using Bacchi’s approach to policy analysis in this study means asking which problems are being represented to be in the guidelines for the trans-specific healthcare, what underlying assumptions the construction of the problems are based on and how these problems have been thought about before. Furthermore, it means asking what implications these particular representations of the problems have. Bacchi (2009) accounts for three effects of representations of problems in policies: discursive, subjectification and lived effects. The discursive effects include asking what can be thought or said in relation to the problems, and what is silenced in these discourses. Subjectification effects means asking what kinds of subject positions become available in the policy’s specific representations of the problems. Lived effects means looking at material effects of the problem representations.

Material
The Swedish knowledge support (SKS) was published in 2015 by the Swedish National Board of Health and Welfare. These guidelines are the first formal guidelines for the Swedish trans-specific healthcare. The document is 117 pages long and contains 37 recommendations for trans-specific healthcare.
**The analysis – step by step**

Bacchi (2009) suggests seven questions for analysing policy documents of which I have used six for analysing the SKS:

1. What are the problems represented to be in the guidelines for trans-specific healthcare, especially concerning diagnosis of gender dysphoria evaluation and criteria for access to care?
2. What presuppositions or assumptions underlie this representation of the problem?
3. How has this representation of the “problem” come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the “problem” be thought of differently?
5. What effects are produced by this representation of the “problem”?
6. How/where has this representation of the “problem” been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced? (Bacchi, 2009, p. 2)

In the first step of the analysis, I read and reread the material with these questions in mind. In the second analytical step, I focused on the recommendations, specifically those that concerned evaluation, diagnosing and criteria for access. These were analysed in detail in relation to Bacchi’s questions 1-3 and in relation to the descriptions and explanations of the recommendations. The analysis of the recommendations based on questions 1-3 resulted in four problem representations, which will be presented in the results chapter. These four problem representations were then analysed using questions 4-6. Parts of this analysis will be presented in the discussion chapter.

**Translation**

The analysis of all the three sub-studies was conducted in Swedish and quotes were chosen from this material to be translated into English. Translating always carries the risk of losing content or nuances and of adding meaning that the participants did not intend. In translating the quotes, I have strived to make them as readable and understandable in English as possible without losing important content. Thus, they are not translated word-for-word. For example, in order to make the quotes understandable in English, I have changed the word order and deleted small words that the participants have used as fillers. Similar to the rest of the thesis, the quotes have also been language edited.

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4 A seventh question, or urge, is to: “Apply this list of questions to your own problem representations” (Bacchi, 2009, p. 2).
Epistemological and ethical considerations

During this research process, I have been thinking continuously about epistemological (the question of how we can gain knowledge) positions. The reason for this is connected to my position as an interdisciplinary researcher, and hence situated in two disciplines with very different epistemological traditions, but it also depends on the specific research context, where the field of research concerning trans has been debated from different epistemological perspectives (Stryker & Whittle, 2006).

Firstly, I understand knowledge production as always partial and situated. Haraway (1988) argues, and I agree, that the social position of the researcher affects the work and the results of the research. Furthermore, research develops in relation to what both the researcher and the participants bring into it (Charmaz, 2014). The social context within which the research is situated, as well as the research tradition to which the researcher belongs, affects which questions are posed, the points of departure, and the theories and methods used. I also argue for proximity rather than distance in relation to the research subject and the study participants, and engagement rather than disengagement (Haraway, 1988). This has ethical implications because it makes me as a researcher available for critical assessment, as I am not pretending to be a neutral observer or a “modest witness” (see Haraway, 1988; Rönnblom, 2002). Secondly, the academic position is one of a particular social kind, one with status and a certain power. As Foucault (1995, p. 27) has argued, “power and knowledge directly imply one another”, and he (1980) has also pointed to the power imbedded in acts of categorisation, which are tightly connected to the act of knowledge production. This also means that knowledge production has social consequences and, because researchers contribute to the construction of reality, knowledge production is always accompanied by responsibility (Edenheim & Rönnblom, 2014; Jørgensen & Phillips, 2002).

From this epistemological point of departure, the question about the researcher subject becomes different than within a positivist paradigm. What I hope my contribution will be is to put the experiences of the participants into context and in relation to theory. I also aim to put their experiences in relation to one another. I hope that I am able to do this alongside a reflexive writing and research practice, whereby I make myself visible and I situate myself in relation to the research practice and topics. The knowledge claims in this thesis are also made in the specific social context that academia represents, where peer review is part of the praxis. To avoid a radical relativistic position concerning knowledge production, I want to argue for a couple of important concepts in order to discuss academic work. The first is “transparency” (Mason, 2002). Transparency, in terms of a
comprehensive description of the study process, makes it possible to follow the interpretations that the researcher makes (Mason, 2002). Mason writes that:

I think this concern should be expressed in terms of ensuring – and demonstrating to others – that your data generation and analysis have not only been appropriate to the research questions, but also thorough, careful, honest and accurate. (Mason, 2002, p. 236)

Transparency mean, for example, a thorough description of the social context and the research context (Graneheim & Lundman, 2004). Being transparent also includes acts of reflexivity. By reflexivity, I mean a critical thinking about the decisions I have made and challenging of my own assumptions. Connected to the epistemological position, reflexivity includes acknowledging that the researcher’s positionality affects the research process; for example, the access to interviewees and the nature of the researcher–researched relationship and which conclusions that are drawn (Berger, 2015).

I think that demands for different kinds of reflexivity could be connected to the research topic, and within trans studies I think there is sometimes a demand for “confessional tales” (see Mason, 2002); for example, a demand that researchers come out as trans or cis (for a discussion around insider/outsider position in relation to trans studies, see Elliot, 2016). As I have mentioned regarding media debates about trans, it is important to note that different researchers have different stakes in researching, theorising and discussing topics related to gender, feminism and trans. There can certainly be advantages to what is sometimes called an “insider” position, but often in the debate around articulating such positions there is either a firm line drawn between trans and non-trans researchers or such articulations are dismissed as just dealing with identity politics. I think both positions in these debates – the embracing of the trans or non-trans researcher position or the dismissal of such positioning – are overly simplistic understandings of the lived researcher experience, and its relation to the research subject/participants.

For example, compared to Elliot (2016), who discusses the researcher position and draws a firm line between trans and non-trans researchers, I do not think this is only a question of identity, but a question of certain experiences and contexts. Regardless of identity, in different ways, researchers can recognise and identify with certain aspects of their participants’ experiences or their theoretical material, and not with others. However, if you as a researcher do not come out as trans this might assume and hence perhaps also naturalise a cis position; however, the cis/trans dichotomy can also undermine a trans, queer, and feminist movement by investing in gender stability (Enke, 2012). I have no clear-cut answer to how to deal with this dilemma, but, when important for the research
process, I have, and will, mention aspects of myself; for example, experiences, professional training and disciplinary positions. But I will not occupy either of the aforementioned positions – I will not come out as either one or the other, or dismiss such coming out as totally unimportant.

**Approach to research ethics**

Understanding the researcher position as (re)creating the “reality”, I have to take political and ethical responsibility for my research (Edenheim & Rönnblom, 2014). Researching a marginalised group also comes with a risk of epistemic violence (Spivak, 1988), thus the risk of constructing “the other” as problematic or inferior. I think the concept of “the other” is relevant here, although I partly recognise myself in some of the participants’ narratives. To use the participants’ generously shared experiences and to highlight some parts of their narratives while not putting emphasis on others, within the frame of knowledge production of a research project, put me in a position where I have the power to define what is problematic and what is not.

In our relationships with others, feminist and literature researcher Moi argues that we have a responsibility to try to see “the other’s” living situation (Moi, 2017). Then we have to try to find the right words to describe “the other’s” situation. Only if we do that can we relate to “the other” in an ethical and politically relevant way. I am aware of Moi’s sceptical position towards postmodern theories, but Moi is partly situated within the phenomenological tradition (Moi, 2001) and I think it is in Moi’s (2017) description of the “attention towards others” that I feel appealed to phenomenology in an ethical sense. I thus see my choice of using lived experiences to make knowledge claims as an ethical choice that can help me to find the words and improve my understanding of the participants’ living situation.

I think I have tended to understand research ethics as primarily dealing with avoiding doing harm, and thus I have partly overlooked the aspect of benevolence (which does not have to be only the opposite of not doing harm). However, by choosing this research topic, I hope that I can contribute to the growing number of studies about trans, health and healthcare that have the potential to improve the health and healthcare situation for people with trans experiences. I also see this study as important because it is a critical qualitative study with a trans-affirmative goal within the medical field, which hopefully can have positive outcomes. Another risk of having a “negative” understanding of ethics is that I as a researcher do not see or acknowledge the participants’ ability to critically assess my studies. Such a paternalistic approach can also be seen in relation to my decision to make all participants anonymous (they were not given any other option), which prevents them from getting credits for their contributions.
Ethical considerations in practice

Some specific aspects of conducting interviews have required ethical considerations. Conducting face-to-face interviews means that I have knowledge of who the participants are and where they live. Being part of the queer community myself has made this somewhat more complex as I have sometimes run into participants both before (however, not knowing before the interviews that I had seen them before) and after the interviews at queer events and in other spaces. After this had happened once, I started asking those who were part of the queer community how they wanted me to act if we were to meet in other situations. These shared social circles were also manifested during one interview when a shared acquaintance of myself and the participant walked into the café where we were talking. This closeness has made me somewhat uncomfortable and, on some occasions, also more touched by some of the participants’ stories, but I also think it has provided me with an opportunity to ask questions and form alliances with participants that would not have been possible otherwise.

I think that my queer appearance and perhaps the fact that some participants knew that I was part of the queer community has affected how much and what kind of information they were willing to share. Some interviews were marked by a silent consensus on the order of things, and when transcribing or reading the transcript I noticed that some issues were not expressed because of this assumed shared understanding. In other interviews, I think my position as a medical doctor was of more importance. My impression was that this position had two different functions; firstly, as a status position conferring legitimacy, someone in whom people have confidence. Secondly, as someone who can potentially affect the current medical order, a notion that might be based on a belief that “critique from within” has more potential than critique from activists, social science researchers or care-seekers. This second function was sometimes visible, for example, in relation to the hopes they articulated about the effects of the study.

In relation to this potential impact of the study, but also in relation to the availability of the research, I have struggled with decisions regarding theory, writing style, audience, publication strategies and epistemological position. As I understand it, both critical scholars within other academic fields and, for example, RFSL have had problems gaining access to care-providers and decisions-making spaces concerning trans-specific care (this has, however, begun to change). Based on this, I have been told by other researchers that my partly insider position could be an advantage and that I may have easier access to these arenas. However, then perhaps I should not have used so much theory (which I think has been really fun) and I should have published in other kinds of journals in order to better reach the care-providers and decision-makers within trans-specific healthcare. My approach to partly getting around this dilemma has been to think of my work during these years as two-fold; I have conducted the included
studies in one way, with theoretical discussions and within an academic format, and simultaneously lectured and in other ways talked quite a lot about health and access to healthcare for people with trans experiences to a broader audience than the academic fields with which I engage with. In the outreaching part of the work, I have tried to make the study results as understandable and relevant as possible. My medical training might have been important in this process, since it has, for example, provided me with opportunities to lecture at the medical school about trans issues and to participate in the process of providing LGBTQ diplomas to clinics within the County Council of Västerbotten (the gender identity clinic being one example).

Regarding the design of the study and recruiting participants, a couple of steps were taken in order to make sure that the study was conducted in an ethically responsible way as possible. The pilot interviews ensured that the questions in the interview guide were formulated in an inclusive and respectful manner. To avoid putting pressure on presumptive participants, I asked them to contact me if they were interested, even after a first contact. To some, I have sent a reminder email and asked if they were still interested in participating, but I did not do so repeatedly. Due to this procedure, I might have lost some potential participants, but I felt it was important that they did not feel under any pressure to participate.

On two occasions, reviewers have asked for more information about the participants. This has been difficult to balance from an ethical and epistemological perspective; the challenge being to provide enough information to ensure some level of transparency but still not risking making the participants trackable. The short biographies in Appendix 1 are the result of this feedback. The biographies are very short, which might be a limitation in terms of putting the participants, along with their quotes and experiences, into context. However, an extensive focus on the participants’ biographies could also steer both my own analysis and interpretation and that of the reader in a stereotypical way.

**Ethical approval**
The Regional Ethics Committee in Umeå approved the study (Dnr: 2014/61-31Ö).
Snapshot (someone asked: “why you”?): Excerpt from memo, 5 March 2015 (in the middle of data-collection): “Since, for a large part of my grown-up life, I have been hanging out in queer spaces, this has of course affected my thesis. I think it has affected the choice of topic, the points of departure, the interview guide, the interviews and the analysis. For example, I experienced that it was much easier for me to do interviews with participants who also hung out in queer spaces or defined themselves as queer than it was with participants who didn’t. My experiences have also made it easier to relate to and identify with some stories more than others. However, there are many aspects of their stories that I do not have experiences of. I have never been a care-seeker in trans-specific healthcare. I have never requested gender-confirming medical procedures from healthcare with the risk of being denied. I have not told care-providers in detail about my life in order for them to assess my gender identity. I have never experienced relatives rejecting me for who I am. I have not felt the pressure to go through sex reassignment surgery just because an evaluator imagines gender to be linear. Considering this, is it then wrong that I, who in many situations and spaces have cis-privilege and lack many of these experiences, am writing a thesis about trans-specific healthcare? It has been a question that has chafed in me for a long time. I still do not know. What I am sure about is if someone else wrote it, it would be another thesis.”
Results

Below, I present the findings from the three sub-studies, organised through the three research questions. Firstly, I describe how the participants navigate and negotiate their way to gender-confirming medical procedures. After that, the policy analysis of the guidelines for the Swedish trans-specific healthcare is presented. Finally, I move beyond trans-specific healthcare and look at (un)safe experiences in relation to perceived health.

How do care-seekers experience navigating and negotiating access to trans-specific healthcare and gender-confirming medical procedures? (sub-study 1)

This first part of the results deals with the participants’ experiences of navigating and negotiating access to trans-specific healthcare and gender-confirming medical procedures. This section takes on a kind of stepwise structure; firstly, it deals with the participants’ orientation, in the sense described by Ahmed (2006a, 2006b), towards the trans-specific healthcare, or to put it differently, motives for seeking, or not seeking, trans-specific healthcare. Secondly, it deals with their experiences of navigating towards the evaluation team through other parts of the healthcare system. The third part deals with experiences of meeting the evaluation team and negotiating access to gender-confirming medical procedures, one significant aspect being constructions of gender.

Orienting towards trans-specific healthcare

For some participants, the orientation towards trans-specific healthcare was describes as almost the only available option. This orientation was connected to a desire to be read by others as the gender you identify with, and thus being able to pass. For others, the orientation towards trans-specific healthcare was more ambivalent, and resisted in different ways. One of the non-binary-identified participants (Robin) had sought trans-specific healthcare, while the other four non-binary participants had considered seeking access to gender-confirming medical procedures. The 13 binary-identified participants had all sought trans-specific healthcare, but one, Alex, had not been able to get a referral.

Both the participants who had sought trans-specific healthcare and those considering doing so expressed an ambivalent orientation. For example, participants described how they had balanced advantages and disadvantages

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5 In this first section of the analysis, I mainly draw on the first 14 interviews. However, I have also included parts from the last four interviews, when I have considered them to add aspects to the analysis. As here, for example, where Robin is a non-binary person from the last four interviews who had met trans-specific healthcare, which none of the non-binary persons among the first 14 had.
before seeking care. One fear was that trans-specific care would create suffering through pushing them into an undesirable gender position. In describing why they had not sought care, the four non-binary participants mentioned that they feared being rejected if seeking care, that the evaluation would create ill-health and they would encounter disrespect. Mio said: “But it also feels like people have become ill by going through the evaluation; people do not feel taken care of, or respected” (Mio). Mika elaborated on why they had not sought care but also said that changes have been made:

I guess a lot has happened within trans-specific healthcare concerning the attitude towards care-seekers. But I have not sought care, because it has been very binary, and since I don’t feel like a man in a woman’s body I have felt that I would have to lie throughout the evaluation, which I know that other people have done. But things have changed, so now you can seek care as a non-binary and get help, but I feel that my confidence in healthcare has been damaged.

Hence, the resistant orientation also has to be understood in relation to the historical context, within which it has been difficult to occupy a non-normative position within the trans-specific healthcare if wishing to be granted access to gender-confirming medical procedures. The ambivalent or resistant orientation can also be understood in relation to passing (i.e. being perceived by others as having the gender identity that you identify with); access to gender-confirming medical procedures does not promise the same possibilities of passing for non-binary individuals as it does for binary-identified individuals because it is very difficult to pass as non-binary. Those who had oriented towards the trans-specific healthcare and wanted access to gender-confirming medical procedures described the orientation as important in several different ways. For example, Elias said:

Well, I think it’s very nice to be seen as the person you are. And then it’s a privilege to be able to do so, because not everyone can be that. And it’s very difficult to pass as something other than a girl or a boy. It was never possible, it didn’t work well for me to pass as intergender when I identified as intergender [non-binary]. Except in some queer contexts. But for me it’s very pleasant and very important in different ways and I think I didn’t understand how good it would feel until I started to pass as a guy. And felt like, this is really, really nice. (Elias)

Thus, passing as the gender with which you identify is a nice feeling and something that gender-confirming medical procedures can increase the possibility to do. But, as Elias points out, it is not self-evident that everyone who gains access to gender-confirming medical procedures will be able to pass. Several participants problematised the concept of passing and argued that it implies that there are specific ways to be feminine or masculine. Participants also
said that in a utopian world, a striving towards passing would not be necessary. Still, some of the participants described their orientation towards trans-specific healthcare as an effort towards passing, which for example was described as a longing for relaxation. This longing was connected in the participants' narratives with experiences of not being acknowledged in the gender with which they identified if they were not passing.

Another aspect was that having an embodiment that does not match your gender identity can be an obstacle to initiating different kinds of romantic and sexual relationships. Alice explained:

“Well, I'm a bit afraid to go into relationships so to speak. Since I pass, relationships become hard before the operation, in case it becomes intimate. Then it becomes like 'oh, what's this?'. So, then it's like you have to tell such things beforehand and then I'm scared that it would end very quickly.

Thus, for several participants, orienting towards trans-specific healthcare was connected to the wish to be able to meet a partner and to be able to have romantic relationships. But it was also described as important in a broader sense: without gaining access to gender-confirming medical procedures, life as expected couldn't move on. For example, Johanna described her feelings before seeking trans-specific healthcare:

They [my old friends] had found a girlfriend, had a family of their own, kids, and I felt, I wasn't even on that square in life. I can't even go to that square, that's impossible for me. I will be at a standstill and be the same thing until, I don't know, some operation. And it really felt like I had internal panic, and panic attacks, more and more often. Because it was so obvious that I was stuck.

Thus, an orientation towards trans-specific healthcare could be understood as a linear orientation, an orientation that is imagined as opening up possibilities for a continued life course.

**Navigating one’s way to the evaluation**

In order to be referred to the evaluating team, many of the participants had sought help from a general practitioner and/or from general psychiatry. Several participants experienced the care-providers within these settings as unknowledgeable and as lacking basic information about such issues as where to refer them. Alex described his experience: “I contacted the psychiatric clinic / ... / their first question was 'Does that concern sexual orientation?'”. Several participants said that they felt it necessary to acquire extensive knowledge themselves before seeking care, to make sure that they ended up with a knowledgeable care-provider or in the right place. Johanna said:
In [my hometown] I was referred to a woman who, it was her job to collaborate [with the team] and send referrals to the team in [a bigger city]. So, she was like quite competent, even if she was not so well educated on trans issues. But she had the right approach, she understood how to treat people. And that I [ended up meeting her] was because I emailed a lot before in order to end up in the right place. So, when I went there I got a referral to [a bigger city].

As seen in this quote from Johanna, she had put in work in order to end up in the right place and then the process became quite smooth. However, what is interesting in the quote above is that Johanna met a person whose job is to collaborate with and send referrals to an evaluating team and still her knowledge on trans issues was experienced as inadequate. Similar to Johanna, other participants tended to report a good overall impression of a care-visit if care-providers were respectful, even if their knowledge of trans was (somewhat) lacking. For example, Anna said regarding a visit to a general practitioner whom she met that “they have been very kind, but maybe not so knowledgeable about trans. /.../ but they did at least check it up afterwards.” In contrast to Anna’s experience, however, other participants described lack of knowledge among healthcare providers as creating a bad experience of the clinical meeting; for example, Robin said regarding their meetings with child psychiatry:

Well it was some kind of person who I was very uncomfortable with because they didn’t really understand what I was talking about. The most recurring thing was that I had to repeat everything over and over again, to an infinite number of people.

Also in contrast to Anna’s experiences, other participants did not experience that care-providers took responsibility for their lack of knowledge but instead that they themselves had to educate the care-providers during the clinical meetings. In the words of Elias regarding his referral process: “Neither my general physician nor the psychiatrist had dealt with this before. So, well I had to tell them what they should do.” Thus, the experiences of several of the participants reveal how the lack of knowledge among care-provider created a responsibility shift; for example, Elias had to take responsibility for being referred to the right clinic.

Another issue experienced by some of the participants was that they got stuck in other care units, instead of being referred to the evaluating team. Alex, who at the time of the interview had still not been referred to the team, said:

I ended up with a physician who said, ‘no, I lack education, I can’t refer you [to the team], a psychiatrist has to do that’. Then I was referred to the adult psychiatry and there he [the doctor] sat and was hesitant, and finally he decided that they have to do an evaluation [before referring to the team for a formal evaluation], just to be sure. And then the whole thing like disappeared, because...
I – How disappeared? Was it like you were never recalled?

A – I was never recalled. Maybe it was because I was not clear with ‘then I guess I have to do such an evaluation’.

Alex’s experiences illustrate the lack of knowledge around trans issues that exists in some parts of the healthcare system. His quote also shows that care-providers who do not have the right knowledge or are employed to conduct a gender identity evaluation may initiated their own evaluations before sending referrals to the formal evaluating team.

The participants experiencing that care-providers lacked knowledge and that they, the care-seekers, sometimes had more knowledge bring into question whether those considered to be experts really are the experts, in some of the care contexts. This lack of knowledge creates a responsibility shift and in one way this disrupts the expert–lay relationship, but on the other hand the ability to acquire and use such knowledge can be stratified along the lines of age, class, ethnicity, gender and geographical location, and can thus contribute to unequal access to the evaluating team.

**Negotiating access to gender-confirming medical procedures – meeting the evaluating team**

When participants (finally) got their referral to the formal evaluating teams, many participants experienced a long wait before the first meeting with the team. Louise described the waiting period for the evaluating team like this:

*But then [after getting a referral from the general psychiatry] it was 13 months of waiting to get to the evaluation, and that was frustrating. And then I had already started on unsupervised hormones, so I felt that I was on a good path [in my transition process]. So, when I came to the first meeting [with the team] I, myself, felt that I was ready. And then they wanted to start [from the beginning].*

Hence, Louise had to wait 13 months before getting a first meeting with the evaluation team. Before and during this time, she came quite far in her transition process with the help of unsupervised hormones and felt quite ready once she got to her first appointment with the team. However, it was not only waiting to get the first appointment that the participants experienced as frustrating, the evaluation and then waiting for access to gender-confirming medical procedures were also experienced as hard. For example, Annika said regarding the waiting within the evaluation: “In [middle-sized town] they always say, ‘see you in three months’. Then you meet them again in six months, every time”.

68
Many of the participants described the waiting as causing anxiety, sleep problems and distress. Alice described the following when asked how she felt during the evaluation:

*During the waiting times, I have generally had large dips. It has gone up and down, it can also have to do with my diagnosis [bipolarity] as well, it’s type 2 so with deep dips and flat peaks. When I received the letters [and was summoned to different things], I have felt better. And then you realise that now the next step starts and the waiting, and the mood goes down again. And hopefully it goes up again. But it’s those kind of dips between the different steps [in the evaluation] that are the worst. And then we have the powerlessness, that I can’t do anything about it. Then I’m just some number in a system that is supposed to reach zero in the big bureaucratic equation.*

Despite the fact that both the long waits and the encounters with the evaluation team were described as generating ill-health – and many of the participants described having mental health problems prior to meeting the evaluation team – the participants still experienced a lack of psychosocial support. Instead of receiving professional support, the participants described a shift in responsibility, that friends, family and themselves had to take responsibility for such support. In the words of Anna: “He [her partner] has been more of a psychologist for me than the whole of psychiatry has ever been”. At least two of the participants had got other psychiatric diagnoses during the evaluation, Leon said:

*I sit at home in peace and quiet and go through the referral [for surgery] and then I see that they have put another diagnosis on me, that they haven’t told me about. That made me really angry. They’ve put “emotionally unstable personality disorder”, aka borderline. /.../ And I was like, “sorry but emotionally unstable personality disorder?” No shit! I mean, I’m trans, what the hell?!”*

Hence, during the evaluation, Leon was given a diagnosis without his knowledge and without asking for help with such problems. The last part of Leon’s quote could also symbolise his experiences of the arbitrary lines between different psychiatric diagnoses. Alice was more grateful for the diagnosis and treatment of her diagnosis of bipolar disorder that she received during the process of being evaluated for gender-confirming care. However, the diagnosis was still something she worried about, wondering if it would affect her access to surgery. She asked the surgeon about this, but received a positive answer, that it was not a problem.

In her quote above, Alice also touches upon her sense of powerlessness, which Leon’s quote also reveals. Several participants described experiences of powerlessness and getting stuck while waiting to be granted access to gender-confirming medical procedures. These experiences were connected to not being able to influence decisions about such aspects as getting the trans diagnosis,
which medical procedures to undergo and/or when; this is indicative of the gatekeeping function that care-providers still have. Their dependent relationship also led to participants restraining themselves from voicing criticism, since they believed it might risk their access to care or legal gender reassignment. The evaluators’ gate-keeping function was understood and described in different ways; when asked what her experiences of meeting the healthcare providers were like, Elsa said:

Well, generally they’re good. I’ve met many people during this time, I’ve met counsellors, evaluators, physicians and so on. The only negative experience I’ve had is with the evaluator who worked here [city removed to retain anonymity]. That was not the person I had expected it to be. But partly I understand their position, to try to reveal the right personality. /.../ It can be due to their task being to question as much as possible during this evaluation. So then they should be a bit provocative. I fully understand that. But the people should maybe think twice before they pose these provocative questions and [have a provocative] attitude. But I think that they do the right thing, because it should never happen that a person takes all the steps and then comes to a point when they don’t like themselves. That’s a disaster for both parties [care-seeker and care-provider]. That’s the thing you have to avoid, according to me, by all available means. Maybe it’s because of that [risk of regret] that they’re a bit provocative at the beginning.

As seen in Elsa’s quote she defends the provocative questions and attitudes and motivates it with the care-providers’ desire to minimise the risk of regret. But still, something with about these questions and attitudes made her experience these meetings as her only encounter with the healthcare that was not good. I asked her what those provocative questions were, and she answered:

Luckily, I’ve forgotten the most of it. But the only thing that was a bit difficult, that they pointed out, was this thing with my age, that when I started the evaluation I didn’t have so many years left.

Thus, to only have a few years left to live in the differently gendered body was seen as something negative. Elsa described the evaluators function as trying to “reveal the right personality”, and several participants described the evaluation as a process of proving to, or convincing, the evaluators that you really needed gender-confirming medical procedures, or, as Annika said; “you’re supposed to prove that you’re a woman”. This was also connected by some participants to available diagnostic tests. Elias said:

Sometimes I cried afterwards [after meeting the evaluation team]. /.../ I was also terrified since I didn’t know if I would get the diagnosis, because they don’t say anything about how you perform. But also, I experienced it as very humiliating, mainly the psychological tests, with different intelligence tests, I
thought it was unpleasant. In another way, I was happy to be in the chain of care and felt that it was moving forward, and I thought it would work out. It’s also special to be wanting a diagnosis that you don’t know if you’ll get. And when there are in fact no other tests, but basically you’re going to convince these people that this is the right thing for you.

Hence, apart from the psychological tests that Elias experienced as humiliating, he pointed out that there are no available tests, so the evaluation instead becomes a process of convincing the evaluators. Alice identified a difficulty with this:

I know that I’m sure that I want to do this, but it’s hard to convince the other person with words. Because words are limiting, and it’s hard to describe a feeling. And then you’re going have to prove your feelings.

Negotiating access by being your own project manager
Some participants described the long evaluation process and the waiting as partly intentional on the part of the care-providers; for example, in relation to the real-life experience. In the words of Mona; “Well, it’s said that you are supposed to have time to think it through, so that people don’t regret it. I guess that’s the reason for waiting.” One way to deal with the waiting times was to order unsupervised hormones from abroad; Louise, for example, said regarding her experiences of the waiting:

Since I started taking unsupervised hormones it felt more manageable. A full year of evaluation to get there [access to hormones] feels like a very long time. For me, it was mostly one year of waiting to get access to hair removal, which was my main goal. So that was very frustrating when I already felt ready at the beginning [of the evaluation]. It [the evaluation] didn’t take more than four months until both the psychological and the social evaluation were done. And then it was just another eight months of waiting until one could move forward [in the process].

In Louise’s experience, it is thus shown that it was not an individualised time of evaluation; she had to wait another eight months to move forward. Other participants also experienced unsupervised hormone use as important, because “the body was going in the wrong direction”. For example, Johanna said:

Hormones were something I wanted to start with, like I would have liked to start with that on day 1. Because that was so important to me, because it felt like it just became worse and worse. And like, when I started the hormones [unsupervised] it was like things went in the right direction. And I started to get the effects I wanted. So that felt very good, and because the waiting was very tough, like all those meeting and the wait for the diagnosis. And then there is waiting after you’ve received the diagnosis until you get to meet the endocrinologist.
Some participants who had started taking unsupervised hormones had experiences of being denied access to state-funded hormones and were also left without the opportunity to have check-ups focusing on hormone levels. When I asked Louise if she was given the possibility to take blood samples when telling the evaluators that she had started on hormones, she answered: “No, not at all, they left it all up to me”. Thus, the medical responsibility and risks connected to the unsupervised hormone use were in some cases left to the participants. For other participants, taking unsupervised hormones was experienced as leading to faster access to state-funded care; when the participants told the evaluators about unsupervised hormone use they got referrals to endocrinologists and were given access to state-funded hormones. In line with the proving and convincing discussed above, unsupervised hormone use and other kinds of taking charge was experienced by some participants as signalling a strong commitment and desire and hence a seriousness to the evaluators, and in that way it could move the evaluation forward. Johanna again:

_I think they want you to take the lead a little bit, like you should take the initiative and push it forward, like making contact with the evaluators so that things happen. So I think you have to do a little bit yourself also to prove to them that you really want this._

Similarly, Mona said; “So I’ve, well, been pushing them [the evaluators] all the time and sent in paperwork. /.../ So I’ve, well, been my own project manager.” The charge-taking, risk-taking (unsupervised hormone use) and the fact that the participants restrained themselves from voicing criticism could be seen as negotiating the waiting times. Through signalling seriousness and willingness, the participants experienced that they could show that they were ready for care and as such minimise the use of time as a diagnostic tool. Thus, by adopting a charge-taking and risk-taking role, some participants negotiated access to gender-confirming medical procedures in relation to the dependency on care-providers as gate-keepers and those responsible for evaluating the need for care. However, the ability to adopt such a role can vary; for example, unsupervised hormones were described by participants as expensive, and those who had done it described themselves as fortunate to have the means to do so. Hence, this can make access to gender-confirming medical procedures stratified by class and income in terms of time until access.

The participants also experienced a lack of knowledge in their meetings with the evaluation teams and care-providers responsible for providing gender-confirming medical procedures, such as endocrinologists. In these cases, health issues that could arise included: side-effects of hormones, planning pregnancy while taking testosterone, the effects of testosterone on premenstrual syndrome, and the need for physiotherapy to alleviate problems arising from the use of
binders (for breast binding). The participants experienced that there were no care-providers within the healthcare system who had sufficient knowledge about some of these issues. The lack of knowledge among care-providers, together with lack of psychosocial support and the waiting, led to some of the care-seekers seeking out other care providers, in order to gain access to services such as psychotherapy, advice on pregnancy or hair removal.

This far, I have explored the participants’ experiences of waiting, of being in a position of dependency, of shifts of responsibility, taking charge and risks and lack of knowledge. All of these aspects affected the care-seekers’ experiences of meeting the evaluation team and their opportunities to negotiate access to gender-confirming medical procedures. However, one of the most prominent aspects that many participants talked about as affecting their journey towards gender-confirming medical procedures and their encounters with the evaluation team was their gender performance, which will be described next.

**Experiences of gender governing**

Constructions of gender were a central theme in many of the participants’ descriptions of their experiences of trans-specific healthcare. I will begin by describing a few examples of how governing can work and be experienced in relation to gender, and then move on to which specific gender norms the participants experienced as being important. Below follows a long quote. I have chosen to include it in its entirely because I think Mark’s description very significantly shows how the governing of gender expression can work within the trans-specific healthcare and also how it is experienced. I asked Mark how he experienced the real-life experience (RLE), and he answered:

\[M – I’ve always liked to express myself with my hairstyle and clothes and so on. So, I thought it was really tough to, like it felt like there were so many things I couldn’t do, that were communicated without words. My psychologist never said straightforwardly that “this you cannot do”. [But instead] like, “well maybe you shouldn’t colour your hair because that’s perceived more queer”. What I thought was hard with the real-life experience was that I was not allowed to be androgynous in any way. I had to be, like, excessively masculine. Couldn’t colour my hair, maybe like think twice about what kind of clothes I wear and like those kinds of things. That I thought was really hard at the beginning. But then eventually you grow into it. Like now, I don’t think it’s tough anymore and the more secure you become in yourself, the less energy you put into clothing and such things. But it was tough.\]

\[I – How was that expressed in relation to the psychologist, or like, was it like different criteria that she spelled out?\]
M – Well, we talked a lot about it, and like what kind of things, and like I got the opportunity to think a lot myself [about] what is masculine. But I remember I thought it was tough that I felt like I couldn’t colour my hair.

I – That was something she said? That you couldn’t do that?

M – Well, it was not like she said that in so many words, but we talked about it a lot. I don’t think she ever said like “no, this you absolutely cannot do”. But she said, “you should consider that this and this might not be perceived as masculine”. And I felt that was tough, that she put up a lot of rules. But afterwards I also understood why she did it. At some point, she also said that she’s not the one who sets the rules, but that she has to play according to the book of rules. I don’t know. It’s hard to explain. It’s not like I put any blame on her but more how our society looks. That it’s perceived as queer if guys colour their hair or dress in a certain way. And then I have to relate to that. Like in a utopian world I could have dressed and coloured my hair exactly how I wanted and people would still not doubt my gender identity. But now we don’t live in that society, so you have to adjust to the society we live in. I remember in particular that she wanted me to start wearing jeans, and I had never liked jeans. But then I started to wear jeans, and then it wasn’t hard anymore. So, it was like those small things all the time.

What becomes obvious in Mark’s narrative is that governing in this case was not performed through strict rules, or through the psychologist saying yes and no, but still Mark picked up on the governing and experienced it as rules. The psychologist gave advise about what is perceived as masculine and what is perceived as queer. The psychologist was not only informing Mark about what is masculine or queer, but the direction of the advices constructed the masculine position as the desirable one, the one that Mark should strive for, while the queer expression became something that Mark should reject or try to move away from. This advice appealed to Mark’s wishes to be perceived as a man – that people would not doubt his gender identity – and constructed incentives to self-regulate according to the advice, which Mark also did, and eventually became comfortable with. These incentives also have to be understood in relation to the position of the psychologist who, together with others, had the power to approve or deny access to gender-confirming medical procedures, procedures that in turn had the potential to help Mark to be perceived as a man.

The “book of rules” that Mark said the psychologist referred to, I interpret as more of a metaphor than an actual book. But it spurs interesting questions about what the role of the evaluators actually is, and what they are supposed to be diagnosing. Connected to the “book of rules”, Mark reflected upon how the psychologist’s advice is grounded in a society where there are certain norms for how men and women should be. Thus, the governing of gender expression within trans-specific healthcare is closely connected to norms of intelligible gender outside of trans-
specific healthcare. The psychologist reconstructed a normative line between being a man and being masculine. The advice could also be seen being about intelligibility, that in order to be intelligible as a man you have to be perceived as masculine. However, the things that Mark used as examples, to colour one’s hair and not wear jeans, could also be understood as signalling a request from trans-specific healthcare for people with trans experiences to be even more normative/stereotypical than people with only cis experiences, since not all men without trans experiences wear jeans or refrain from colouring their hair. Thus, the risk of appearing “queer” is closely connected to the construction of an intelligible gender identity.

I think it is important to note, however, for Mark these pieces of advices were experienced as rules, as do’s and don’ts; this feeling of his, of being subjugated to rules, is probably (and correctly) connected to the psychologist’s gate-keeping position. I think this is an important aspect to consider in relation to the Foucauldian understanding of power; that even though power here operates in a very complex way, appealing to societal norms of gender expression and techniques of self-regulation, Mark still experienced it as an encounter with an absolute or disciplinary power that has rules for what is acceptable for a man and sets the criteria for how to become eligible for medical procedures. Furthermore, we do not know whether Mark would have been granted access to gender-confirming medical procedures if he had not followed the advices; it may have affected his access in both relative (time) and absolute (being granted access or not) ways.

In Mark’s quote, we can also see how these pieces of advice and the governing of gender expressions affected him. Mark repeatedly described his encounter with the psychologist and the effects as “tough”, and that it made him think twice about which clothes to choose. Likewise, other participants also described thorough preparations and thinking twice before, and during, their meetings with trans-specific healthcare, as Elias’ experiences below illustrate. I asked Elias if he had experienced that a stereotypical gender expression mattered in trans-specific healthcare:

What scared me was of course, that this other person did not get access, and then ze [Sw: hen] told me things like, “well, you can’t look like that”... and those things affect you. There are many myths around how you’re supposed to be [within the evaluation to be granted access] /.../ On the other hand, I didn’t want to be the one who took a risk. To put my diagnosis at stake by testing to see how queer can I be [in order to gain access to care]. So like, in a way I went into a role that I thought was secure [in order to gain access]. But maybe they would have given me a diagnosis anyway, even if I hadn’t gone into that role. For example, I had a pink belt that I usually wore. That one I never wore there [in meetings with trans-specific care]. So, it was like small things that I modified in my
appearance. Also in what I said and how I expressed myself. I felt like I sat there all the time and really thought about my body language.

Elias’ quote illustrates the labour that he carried out in order to increase his chances of gaining access to care. Similar to Mark’s reflections about the utopian society, Elias’ quote also shows that is was not only things that happened within trans-specific healthcare that decided the room for action and how care-seekers performed gender in the healthcare setting. As seen in Mark’s quote, the queer position is not something that is considered desirable, and similarly Elias did not put his diagnosis at stake by expressing gender in a queer way. Anna also described a kind of labour with regard to gender expression:

*During the evaluation it was like I had to fit into a category. It was not enough that I wore clothes from the women’s clothing department, they had to be very feminine, they couldn’t be androgynous even. There was this one time, like one situation when I was wearing only clothes from the women’s clothing department, but that wasn’t enough, I had to be even more feminine. It wasn’t until I wore a pink blouse that I was complimented by the evaluators and psychologist. But to wear trousers was maybe not right, and the psychologist said: “but I guess that’s ok nowadays, that women actually wear trousers”.*

Trying several different kinds of clothing when meeting the evaluation team, last Anna received compliments. Several of the participants said that positive feedback could contribute to the governing of gender expressions, and they described receiving compliments for having a stereotypical gender expression or a voice pitch that matched their identified gender.

**Reconstructing a linear gender**

Some of the specific norms around gender that the participants encountered in trans-specific healthcare have already been demonstrated in the experiences of Mark, Louise, Elias and Anna. However, in the participants’ narratives there were several more examples of gendered norms. These norms can be divided into three aspects: a stereotypical gender performance, a binary gender identity and a stable gender identity.

Concerning the stereotypical gender performance, different participants’ experiences illustrate that the position of “woman” was constructed as someone wearing make-up, pink blouses and long hair, who invested time in her hairstyle, and sits with her legs together. Furthermore, a “woman” should talk in an uncertain way, using words such as adorable, and should reject a penis and desire a vagina and breasts. These norms concerning body parts were apparent in advice about surgery. The position of “man”, on the other hand, was constructed as someone who wears jeans, sits with his legs spread wide, does not colour his hair and talks in direct ways. Furthermore, a man should not desire to be pregnant. In
this way, man/woman were constructed as opposites and as mutually exclusive categories. These standards in the evaluation were experienced by the participants as triggering embodied experiences; for example, stomach pain, anxiety and fatigue.

Some of the participants described a resistance to and negotiation of these gender stereotypical demands. For example, some participants performed gender differently outside the trans-specific healthcare environment or after gaining access to gender-confirming medical procedures. Participants had also withheld their application to the legal advisory board until the requirement for sterilisation was abolished from the legislation. However, these standards were also experienced by some participants as contributing to a feeling that they were losing themselves. When asked how she felt during the evaluation, Anna said:

_I felt pretty bad, I felt bad during the time I was waiting for the diagnosis and then during the time I was waiting for the approval from the Legal Advisory Board. But after that I felt that I could decide myself how I wanted to look, and I didn’t need to have long hair anymore, so I cut my hair short. Because long hair was something the healthcare had decided that I should have. And from the very beginning I had chosen to present myself as quite androgynous, feminine androgynous and that was what I liked, but it faded away, which made me feel bad because I didn’t get to be myself. So, now that I can be myself, I feel much better._

Thus, feedback from the evaluators created a feeling of disorientation, while getting the diagnosis and approval for legal gender reassignment could be seen as gaining a foothold and a larger space for action. As seen in Mark’s narrative, Real-Life Experience (RLE) was one of the parts of the evaluation where the governing of gender became evident. Johanna described her anticipation of the RLE as this; “It feels a bit like, for me, RLT [real-life test] is a bit of an impossibility, and I feel that I’ll look like a horrible transvestite and so on, so it was a big barrier [to start RLT]”. For Johanna, the transvestite position is a horrible position and a position she anticipated having to inhabit if she was forced to start RLE without receiving hormones first. Similarly, Anna described one of the reasons for starting to take unsupervised hormones as avoiding “going another summer as a transvestite”. The fear of the transvestite position might be connected to its being more of a middle position in relation to the gender binary and/or to the impossibility of passing as a woman, which both Anna and Johanna longed for. A binary gender identity was experienced as crucial for gaining access to care and, in fact, one participant described how he emphasised a binary gender identity during the evaluation despite identifying as intergender at that time.

_I identified as intergender for quite a long time, including when I sought care. But then [during the evaluation] I strongly emphasised that I was transsexual._
wouldn’t say that I faked it, but I chose to present my trans identity in a way which assured me that I would get care. (Elias)

This standard of a binary identity could also be seen in descriptions of evaluators talking about an androgynous face as an advantage. While such assertions might seem to contradict the experience of not being able to have an androgynous/queer gender expression during RLE, both can be interpreted in relation to a normative goal of crossing all the way to the other side of the binary, where an initially androgynous face becomes an advantage in the journey to a fully feminised or masculinised face, but the desired androgynous or queer expression becomes a threat to the binary construction of gender.

The norm of a stable gender over time emerged from experiences of being questioned about childhood desires, appearance and behaviour. Elias said: “Well, they wanted the whole, well the classic childhood story. Like how you were as a child, what kind of toys you played with.” Thus, cross-gender behaviour from early in life was experienced as an advantage and as something that was assessed in the evaluation. Information about childhood was also sometimes obtained from meetings with relatives, and both Elias and Leon described how they felt as though the evaluators went behind their backs to obtain this information. Leon had given approval for his parents to meet the social worker in the team for one meeting so that the social worker “could get answers to their questions from another perspective, to help them understand what I was going through”. However, when he asked his mother how the meeting went, she said:

*It went really well, and she was really nice, Christ, we almost had no time to talk, because we started with your childhood, like how it was, and suddenly the whole hour was gone so we booked another appointment.*

Leon felt as though the social worker had betrayed him and told her: “I know you’ve booked another appointment, you’ve done that behind my back, I haven’t approved that, they have nothing to do with my evaluation.” Leon’s experiences not only reveal the focus on childhood but also the ethical dilemma with involving relatives in the evaluation in ways that the care-seekers have not approved. The construction of a stable gender was also visible in experiences of intentional waiting times; for example, in relation to real-life experience.

So far, I have mainly focused on when the participants encountered straightening devices in relation to their embodied ways of performing gender. It is thus important to point out that many of the participants understood their gender as norm-conforming, binary and stable. Some of these participants – who did not aim for an androgynous or queer presentation or who did not themselves have experiences of getting advice on how to dress or wear their hair – could, however,
also see “through the system”. For example, Louise had read her own medical records after having requested for them to be released:

You could see in their assessment in the medical records that every time you meet them they do an assessment of you as a person. They describe your clothing and appearance. And they describe it based on very stereotypical feminine norms. Well, I have a stereotypical feminine appearance and a gender expression that matches that. It’s clear that they perceive it as matching, and that that’s an advantage.

Louise embraced a stereotypically feminine appearance, while, as seen above, other participants negotiated and resisted linear gender in different ways. The point here is not to acclaim these non-linear ways to perform gender but to highlight how the advice, comments and questions from the evaluators and the societal norms for gender expression are rewarding certain gender constructions and performances – the linear gender – and downgrading androgynous, queer or non-linear gender performances. Combined with the evaluators’ gate-keeping positions, this limits room for action to perform gender in non-linear ways and, thus, limits the possibilities for self-determination regarding gender for some of the care-seekers within trans-specific healthcare.
Snapshot (somebody asked: “is the trans-specific healthcare really that bad?”)
The above question has been posed to me several times and in different ways during these past few years; for example, in relation to the inclusion of participants, my interpretations, theoretical perspectives, opinions about the evaluation etc. I think the advantage of the Foucauldian power perspective and the critical approach is that it focuses less on who is doing wrong and more on what effects different things have and how power functions. It removes the focus from individual care-providers to focus instead on a system/discourses that are encouraging some actions while suppressing others. However, I also understand the care-providers as having greater room for action, and some opportunities to change the practices within trans-specific healthcare. So, taking the care-seekers’ perspectives can be seen as highlighting subjugated knowledges. This does not mean that I do not see and understand that the care-providers’ work in a care system with limited resources or that I believe that they are not confronted with difficult decisions. I also think that the quote from Mark above could symbolise that “good intentions” can have constraining and controlling effects. I don’t think Mark’s psychologist had bad intentions; on the contrary, I imagine that she wanted to help him to be perceived as he identifies. However, being affected by gendered discourses, as we all are, and being in a decision-making position makes this kind of advice reconstruct gender in a certain way and can create ill-health among care-seekers.

I would argue that one of the functions of critical research is to expand the perception of what it is possible to think and do. This means that taking into account what is possible within a system also limits the scope and possibility of research. This is the advantage of my partially outsider-perspective on trans-specific healthcare (compared to researchers who work within trans-specific healthcare and might have a harder time seeing certain taken-for-granted norms), that I am not limited by the context and the established practices in the same way. Of course, at the same time this is a limitation, as some of the things I suggest or criticise could be constrained and constituted by factors I am not aware of. But I see it partly as someone else’s work to make these considerations, and that critical researchers are responsible for the work to push the limits of what it is possible to think about a certain phenomenon.
How are problems of evaluation, diagnosis and access to care represented in the Swedish guidelines for trans-specific healthcare? (Sub-study 2)

Above, I presented the participants’ experiences of negotiating and navigating access to gender-confirming medical procedures. In this section, I will present the analysis of problem representations in the guidelines for Swedish trans-specific healthcare. In the following section, I will describe the four principal problem representations, based on an analysis responding to Bacchi’s questions 1-3; the problems, their assumptions and the genealogy. In the discussion, I will come back to silences and the effects of these problem representations and how they can be thought of differently (questions 4-6).

The problem of (non)linear gender

The recommendation for the evaluation length states:

_The length of the evaluation should be individualised according to the person’s social and medical situation. You [the evaluator] should be especially careful before initiating treatment that includes physical change if the patient has just recently begun to explore their identity or alternative gender expression. It is not necessary for the person to have lifelong knowledge about their gender dysphoria, but caution is needed if the gender dysphoria is episodic or recently discovered._ (p. 35)

This suggests that there is a problem with a standardised evaluation length, but also a problem with granting access to medical procedures for care-seekers who have episodic or recently discovered gender dysphoria. Conceptualising gender dysphoria as something that can be “discovered”, or that the care-seeker can lack “knowledge about”, assumes that gender dysphoria is an inherent essence, something already there within the individual. This essence can be explored, sometimes with help from care-providers. This assumes a stable construction of gender dysphoria, and consequently also of gender identity. The problem of unstable gender dysphoria is also seen in recommendations for surgery which specify that, in order to gain access to surgery, the care-seeker needs to have had “persistent, well-documented, gender identity problems” (p. 52). A similar focus on persistent cross-gender identification is found in the Swedish governmental report of 1968, which is also the legal preparatory work for the current law on legal and genital gender reassignment (SOU 1968:28).

The recommendation for RLE also contains temporal aspects:

_Healthcare should offer persons who are evaluated for gender dysphoria help to plan and adjust a period of time when they live in the social role that matches the gender identity that they want to be confirmed in._ (p. 36)
In the motivation for this recommendation, the guidelines state that RLE decreases the risk of regret. Hence, RLE is supposed to solve the problem of regret. But there is also an issue of matching the social role with the gender identity, as seen in the above quote, something that is also present in the recommendation for tools (p. 37). In relation to the legal demand to “appear in accordance with that [the other sex in the first paragraph] gender identity” (SFS 1972:119), the guidelines state that the care-seeker should have “consistently appeared in accordance with that gender identity, for example in the family, in school, at the workplace and in other public contexts” (p. 13). Hence, there is a problem of mismatching or inconsistent gender appearance, hence a non-linear gender. As this is a part of the evaluation, it might suggest, or assume, that if such an inconsistency is present the authentic gender identity is hard to determine for the evaluators. Hence, as the social role should match the gender identity, this constructs the social gender role as the linear extension, and visible dimension, of the gender identity.

In contrast to the problem of a non-linear gender, the guidelines argue that care-seekers do not have to want to undergo all the medical procedures in order to be eligible for access and point out that “two individuals who have the same diagnosis will not necessarily have the same care interventions” (p. 22). Hence, the guidelines seem to intend to solve a problem of a rigidly standardised care approach and a problem that care-seekers have received inappropriate care (p. 22). An “all or nothing” approach can be visible in the governmental report of 1968 (SOU 1968:28), which states that a “strong demand for all interventions” (p. 29, my emphasis) is an important diagnostic sign. Similarly, critical scholars have shown that a demand for surgery is implicitly constructed as a symptom of transsexualism (Alm, 2006, 2018; Kroon 2007). This has been argued to be a way of ensuring that the trans embodiment becomes as linear as possible (see Alm, 2018). It thus seems as though the guidelines take a step away from these assumptions and demands and instead open up the possibility for care-seekers to just have some medical procedures if they do not want or need or are unable to have them all.

To summarise, the problem of (non)linear gender is represented in terms of an inconsistency or mismatch between the social gender role and gender identity, unstable gender identity or non-persistent gender dysphoria, and an overly standardised care model in terms of medical interventions. Hence, the (non)linear gender problem is double-edged. On the one hand, there is a problem of non-linearity in the relation between the social gender role and the gender identity and in relation to the stability of gender identity. Such non-linearity is a problem that is supposed to be solved by an individualised evaluation length, Real-Life Experience (RLE) and tools that can facilitate a matching between the social gender role and the gender identity. On the other hand, there is a problem...
that in the past all care-seekers have been required to wish for a linear embodiment by requiring all medical procedures. This is solved by recommending flexibility with regard to which medical procedures care-seekers wish to undergo. Hence, this suggests that a non-linear embodiment is not a problem but a non-linear relationship between the social gender role and the gender identity is (still) a problem.

**The mental health paradox**

Gender dysphoria is defined in the guidelines as “psychological suffering and/or impaired functioning in everyday life that is caused by the gender identity not matching the registered sex” (p. 113). Hence, in order to be diagnosed with gender dysphoria, suffering or impaired functioning must be present. However, if the care-seeker’s suffering is so distinct that it might be classified as a mental illness, this might become a problem for access to gender-confirming medical procedures. In a recommendation for access to surgery, the following criteria apply:

1. **Persistent, well-documented, gender identity problems** (F.64.0, F64.8, F64.9)
2. **If pronounced medical or mental issues exist, they have to be evaluated and treated as far as possible** (p. 52)

This recommendation suggests that care-seekers have a problem with their gender identity and that it is problematic to provide access to surgery for a care-seeker with untreated medical or mental health issues. This assumes that healthy care-seekers are more appropriate candidates for surgery. The requirement to be as mentally healthy as possible before access becomes paradoxical in relation to research showing that care-seekers who receive gender-confirming medical procedures experience improvements in their mental health (see, for example, Dhejne 2016). It is also problematic in relation to studies showing that the evaluation process is itself causing ill-health (Bremer, 2011). Care-providers might become aware of mental health issues during the evaluation, for which it is recommended that:

*The psychological, psychosocial and psychiatric parts of the evaluation for gender dysphoria are preferably performed with an evaluating conversation and validated evaluation methods. Standardised and normalised tests can be included if they are seen as warranted in the individual case.* (p. 32)

This assumes that people with trans experiences who need access to medical procedures need psychological and psychiatric evaluation, and that there might be something wrong with their minds, which might be interpreted as an individual problem. However, the guidelines also point out that mental illness
among people with trans experiences can stem from cisnormativity and heteronormativity. This suggests that it is society which is problematic, but no solutions are recommended for this problem. The guidelines state that mental illness might make the evaluation more difficult, but that the evaluation (note evaluation, not access) “should not be unnecessarily delayed by psychiatric comorbidity” (p. 32, my emphasis). Hence, in some cases, mental illness might necessarily delay the evaluation. The concept of comorbidity suggests that there is a second, or perhaps primary, psychiatric problem, which in this case should be the gender dysphoria, a problem I will examine more closely in the next section.

**Gender dysphoria as a psychiatric problem**

In a recommendation for psychiatric and psychological evaluation, it is stated:

> Diagnosing gender dysphoria should be done by care-professionals who have competence to use the DSM and ICD systems, and who have documented capacity to recognise and diagnose coexistent psychiatric problems and differential diagnoses. In addition, those who are diagnosing should have good knowledge and experience of gender dysphoria, or alternatively be supervised by someone who has. (p. 32)

As I have already touched upon, this suggests that care-seekers have a problem of a psychiatric or psychological character that only care-providers with psychiatric or psychological knowledge can deal with. Together with writings about “suspected gender dysphoria” (pp. 40–42), gender dysphoria is constructed as something that can be diagnosed and decided by a mental health care-provider. Hence, it is not something the gender dysphoric individual is considered able to know about or decide upon. In relation to the previously mentioned use of comorbidity and coexisting psychiatric problems in the recommendation above, gender dysphoria is assumed to also be a psychiatric problem. In the guidelines, psychiatrists are not only competent to diagnose gender dysphoria and the coexisting psychiatric problems but also “all hormone treatment should in these cases [unsupervised hormone use] be dealt with in close collaboration with a psychiatrist” (p. 48). Hence, psychiatrists are assumed to occupy an expert position in relation to a range of medical problems. Gender dysphoria as a psychiatric problem is nothing new. Trans experiences have been categorised as psychiatric illness since 1980 and were also connected with mental illness before then (Dewey & Gesbeck, 2017). At least since 1965, psychiatrists have had a central role in determining who will gain access to gender-confirming medical procedures (Denny, 2004).

The recommendation above can also be seen as suggesting that the regulatory power should remain within the formal evaluation teams, which is assumed in
the guidelines to be a specialised kind of care. This is also made more explicit in writings suggesting that other care-providers should “refer patients to specialised evaluation teams if there is a suspicion of gender dysphoria” (p. 21). This is crucial according to the guidelines because “support, counselling and the evaluation of gender dysphoria requires specific knowledge” (p. 21).

**The psychosocial problem**

In the recommendation for psychosocial evaluation, we read:

> Psychosocial dimensions that are relevant to the evaluation of gender dysphoria include the person’s access to support from those close to them. In addition, areas such as finances, accommodation, employment, relationships, children and plans for the future can be relevant. (p. 34)

This suggests that many social aspects need to be evaluated in order to diagnose someone with gender dysphoria. The guidelines suggest that this is important in order to assess the care-seeker’s psychosocial resources and possible non-medical needs that the care-seeker may have in order for the “treatment” to be successful. It is, however, not explicitly stated how this part of the evaluation may affect access to care. In the SOU of 1968, “social circumstances should be under control and as good an environment as possible should be created” (p. 31) before providing access to medical procedures. According to the SOU (1968:28), the social situation can also be a reason for limiting medical interventions. The guidelines also recommend that the psychosocial evaluation should include meetings with close family and friends. This might be to assess any possible problems with support from the care-seeker’s intimate circle. However, exactly what kind of information these meetings can provide or which problems they can solve is not made explicit in the guidelines. However, as seen in the interviews with participants in this study, these kinds of meetings have been used by evaluators to assess cross-gender behaviour/identification over time, sometimes without care-seekers’ knowledge or consent. This lack of consent might explain why the guidelines emphasise that meetings with close family and friends have to be preceded by consent from the care-seeker.

In this section, I have thus far explored the psychosocial evaluation. However, “psychosocial interventions” are also the first kind of interventions suggested by the guidelines (before, for example, hormones or surgery). The recommendation for therapy and counselling states: “The healthcare system should offer persons with gender dysphoria or suspected gender dysphoria therapy and counselling in order to explore their gender identity and limit mental ill-health” (p. 41). Hence, it is suggested that potential psychosocial problems among care-seekers are solved by therapy and counselling, and also by psychosocial support (p. 42). The recommendation above assumes that care-seekers need to explore their gender
identity, that therapy and counselling are a way to do that, and that therapy and counselling can limit mental ill-health. As well as limiting mental ill-health and exploring the gender identity, psychosocial interventions are suggested as a way of helping the care-seeker deal with internalised transphobia, improving support from their social network, improving their body image and contributing to better social adaptation. Several of these issues are clearly linked to cisnormativity, but the guidelines suggest solving these problems, and assume that it is possible to solve them, by offering counselling, therapy and support to care-seekers. Psychosocial support can also have the ability to solve the problem of regret according to the guidelines. Psychosocial interventions are also important in assisting the evaluation team to make well-informed decisions with regard to “treatment” (p. 8). This implies that psychosocial interventions are a part of the evaluation process.

According to the guidelines, therapy and counselling can also “create realistic strategies to achieve success in one’s relationships, in education and working life” (p. 40). Similarly, all the recommendations in the guidelines are seen as having the ability to improve the care-seeker’s “functioning and assimilation in working life” (pp. 90, 92). Hence, gender-confirming medical procedures, including psychosocial interventions, are assumed to have the ability to create success in working life, which is also used to argue that the recommendations are cost effective in the long run.

Care-seekers’ psychosocial problems are also represented in writings about “especially vulnerable groups”. One such group consists of people without a residence permit, for which the guidelines recommend that the medical doctor should assess what is “healthcare that cannot wait” (the legal requirement for providing care for people without a residence permit). This assumes that, for this particular group, gender-confirming medical procedures are not in and of themselves healthcare that cannot wait. An exception is made, however, for those who have started on hormones before arriving in Sweden. Hence, continued hormone treatment is assumed to be healthcare that cannot wait.

**How are experiences of safety/unsafety related to perceived health in public, semi-public and community spaces? (Sub-study 3)**

So far, the results have focused on trans-specific healthcare from two perspectives: the participants’ own experiences and the guidelines. This next section deals with the participants’ experiences of (un)safety and how these experiences are connected to perceived health. The analysis focuses on public, semi-public and community spaces. This part of the results can be seen as connected to the previous part in the way in which it provides a glimpse of how
cisnormative discourses are constructed and experienced outside trans-specific healthcare, and provides an opportunity to discuss similarities and differences between the different spaces, including trans-specific healthcare. This section could also serve, in relation to the rest of the thesis, to situate trans-specific healthcare within a wider context. Hence, trans-specific healthcare should not be understood as detached from the rest of society; its practices are affected by, and affect, societal discourses.

The participants experienced several different spaces as unsafe and uncomfortable. Experiences of unsafety were connected to health insofar as they limited the use of health-promoting spaces such as gyms and public swimming baths, but also social spaces. Furthermore, unsafety seemed to contribute to ill-health by creating stress and the participants described experiences of feeling unsafe as connected to depression, sadness, anxiety and fatigue. In relation to unsafe spaces, the participants also described a kind of labour that they had to perform in order to overcome the barriers to inhabiting certain spaces and to respond to experiences of different forms of violence. Safer spaces among the participants’ narratives included, for example, trans-separatist, feminist and queer spaces. These spaces contributed to feelings of belonging and being able to share bad experiences, and in such ways they contributed to positive health experiences; but they were also experienced by some participants as containing excluding norms.

Unsafety, limited living space and invisible violence
The participants’ experiences revealed how it is difficult to comfortably navigate in many everyday spaces with trans embodiment. Inhabiting these unsafe or uncomfortable spaces had concrete health consequences. Eli, for example, described:

*That people do not at all want to respect the fact that I’m neither man nor woman, it feels like a kind of violence. But, it’s not physical; instead it feels like something is turned inwards, in thin, thin layers, layer on layer. And eventually it becomes too much, like wearing, exhausting. And then it starts all over again, and continues like that. It is kind of dangerous, because it’s invisible in the way that you carry it with you until you reach a certain point when you have to let it out, or end up in a depression.*

The repeated misgendering and disrespect of their non-binary gender identity becomes for Eli a form of repeated violence that can end up causing depression. Similarly to Eli, other participants pointed out how a disrespect of their identity became unbearable when it happened repetitively, which was often the case. The participants’ experiences of unsafety also contributed to feeling a need to recover, thus retiring from social events to rest and heal from unsafe experiences.
Even though the following quote concerns more private spaces, I think Mio very significantly describes feelings of unsafety:

> For me, it feels like I always have parts of myself that don’t show, that are a bit secret or that I choose to not take up space with or talk about. And [this] makes me feel that I have a larger distance from many of my close friends and my family members in my biological family and relatives and like all acquaintances and everyone. So, well, I think it creates a feeling of unsafety, that you feel that you’re not so close [to others], and you don’t take up the space that you need to take up.

Thus, being unsafe is a matter of not being able to take up space with your experiences and becoming distant from other people. The participants also described being shouted and laughed at, being questioned, getting threats of violence and being involved in fistfights after transphobic comments, and receiving threats online. For example, in relation to public and semi-public spaces, participants mentioned bars and clubs as threatening environments, where people came up to them and questioned their identity and presence. Elias said:

> I’ve also been involved in a fight in a bar. There were some dudes who were discussing me and my friends. What gender identity we had, if we were girls, boys, if we were lesbians. What kind of people we were. That actually escalated into a downright fistfight.

Even though many of the participants did not have experiences of actual physical violence, the threat of physical violence was for many of them a naturalised part of life and several described themselves as fortunate to not have been exposed (yet). Such experiences were also connected to having friends with trans experiences who had been exposed to physical violence.

Certain unsafe or uncomfortable experiences were connected to more unarticulated norms, and thus not connected to direct interaction with others in space; for example, in relation to inhabiting gender-segregated spaces. Navigating gender-segregated spaces (e.g. public toilets and changing rooms) were experienced as difficult, and the use of these spaces was described as limited. Elliot described:

> When you’re out eating at some restaurant or go to a stand-up show /.../ and you can’t pee for 4–5 hours and then you have to go home earlier just to go to the toilet, because it doesn’t feel safe to visit any of the toilets, no matter which one I would choose.
The well-trodden lines in gender-segregated spaces can be seen as not recognizing some kinds of trans embodiment and contributing to experiences of unsafety. The access to gender-segregated spaces also included experiences of internalised cisnormativity in terms of doubting whether they were eligible for access to the gender-segregated space of their identified gender. These experiences also reveal how the dominant constructions of gender as linear and binary create a limited living space for the participants. This also has concrete health effects because the spaces that participants avoided included gyms, swimming baths and social spaces, thus spaces that can work in health-promoting ways.

In order to be able to more comfortably inhabit certain spaces or to defend themselves when exposed to different kinds of violence, the participants conducted a kind of affective labour. These experiences, for example, included having to develop arguments to defend one’s identity and presence in a space and having to explain and educate others about one’s situation and trans experiences. Elliot, for example, said:

_People get more curious when they’ve been drinking alcohol, and then the questions start coming. Sometimes I’ve responded and to some I’ve said “no, it doesn’t feel ok to talk about this”. With others, I’ve talked about it and it has felt ok._

Furthermore, participants describe preparations before, for example, visiting public swimming baths and gyms. Alice said: “I’ve been to the public swimming baths once since I came out as transsexual. Then it was a lot, a lot of preparations so to speak.”

**Being one among others is a basic need**

The participants experienced some spaces as safer or more comfortable. These mainly included trans-separatist, queer and feminist spaces and also LGBTQ spaces. These spaces were described as important for health in terms of providing a place for feeling that one belonged, countering loneliness, and sharing negative experiences with others with similar experiences. I asked Lo how the political spaces they talked about as safer could contribute to well-being, and Lo answered: “Well, I guess it’s the fellowship/affinity, and to believe in something, that you can actually change things.” Similarly, participants talked about safer spaces as a place to transform anger about, for example, transphobia into political energy.

For some, a feeling of being totally safe was not attainable at all, but some spaces were experienced as safer; when I asked Mio if the “queer oases” they talked about were like safe spaces they said:
Safer at least, because it’s like that for me, that I always, that I never feel totally safe, but certainly safer.

I – What do you think those kinds of spaces mean for your health?

Mio – It has a very positive effect of course, you feel respected, and confirmed and as part of a context. It’s like Maslow’s hierarchy of need, to be part of something is like a basic need.

Thus, feeling safe or safer was experienced as important for health. Similarly to Mio, Elias described his experiences of being at a film festival focusing on trans films: “It was just so nice, just to be able to be one amongst many.” To be able to be one amongst many can be seen as being in line with the orientation of the space, and the others and the objects in that space, and hence being able to take up space. Other participants were more hesitant when it came to the importance of sharing trans experiences with others in a space. Alex, for example, said:

Practically trans persons, or more specifically transsexuals, don’t have anything else in common than that their physical, like biological, sex does not match their experiences, the one you want to be. That’s the only thing. People sit there and think they have something in common, but they might have nothing in common, not political opinions, nothing really to discuss, and at the same time they need to feel safe in the group and it makes them create a lot of rules and there are, indeed, some people who claim that, who think that someone else is not a real trans person and stuff like that.

Hence, the experiences of feminist, trans-separatist and queer spaces differed in the participants’ narratives. For Alex, sharing trans experiences with others in a space did not constitute a safe space in itself; on the contrary, he experienced that these spaces contained new rules and norms about, for example, who is considered to be a “real” trans person. However, for others, as described, sharing their trans experiences with others in a space could contribute to feelings of safety, and even as life-saving. In the words of Elias:

Well, I often say that the queer bubble has saved my life. /.../ And my social life, I have no contact with my biological family, it’s like instead a self-selected group of people that I hang around with. And I’ve also had the privilege of working and being an activist in contexts where the LGBTQ knowledge is very good. It’s been very crucial I think, otherwise I would have been totally destroyed in different ways.

Hence, in Elias’ experience, the “queer bubble” is a life-saving device. In spaces that were experienced as less good, he described being misgendered and not confirmed, and hence being referred to with the proper name and pronoun and being confirmed in one’s identity seems to contribute to a safer or more
comfortable experience. Examples of spaces that were experienced as safer also included spaces that the participants had been part of developing themselves. Jens described such a space; ”[Those I run it with] have become close friends, and it’s a context where I have felt very safe, where I belong, and where I feel appreciated.” Hence, being part of constructing a space could perhaps contribute to belonging and gaining appreciation and as such be experienced as safer. This could also be connected to having social control, hence being able to partly control what is happening in a space. Above, Elias points out that LGBTQ knowledge is an important factor for feelings of safety; however, Robin, for example, said:

I quite seldom feel safe, maybe in my own room, or if you’re with your trans friend downtown then you might have your own small bubble, but it’s not really enough. And then also like LGBTQ, like at Pride it’s quite ok and chilled, but it’s just happening once a year. And like LGBTQ parties, but at such events I’ve also been in situations where it’s been really bad, even if it is supposed to be an LGBTQ place, people in the community have been like transphobic.

Thus, spaces that might be thought of as safe, or safer, can also contain transphobic elements. Trans-separatist spaces, LGBTQ and feminist spaces could also be experienced as problematic in terms of not including a trans-political analysis, generating a “false” group feeling, and creating new, excluding, rules. One example was feminist spaces which claimed to be trans-inclusive but did not have a trans-political agenda. Mika (non-binary) said, regarding the 8th of March, which is said to be trans-inclusive: “at the celebration I have felt less and less welcomed over the years, it’s so clearly a women’s focus, just on cis-women.” In feminist spaces, participants also had experiences of being questioned. Which kind of politics that are pursued in a space and whether the presence of people with trans experiences is being questioned could be understood in relation to the existing lines/norms in a space; when a person with trans experiences arrives at, or is present in, for example a feminist space, this very presence can reveal the fallacy of constructing the unified woman with universal experiences of oppression.
Discussion

In the previous chapter, I presented the results of my analysis of the participants’ experiences and the guidelines for Swedish trans-specific healthcare. Below, I will discuss these results further. I will begin by discussing trans-specific healthcare practices and the participants’ experiences of navigating access to gender-confirming medical procedures. This section starts with a more general discussion about decision-making and the modes of governing within trans-specific healthcare, and then I move on to some of the specific techniques and rationales that I have identified as important in the process of becoming eligible for access to gender-confirming medical procedures. More specifically, I take a close look at gender, temporality, psychosocial health, people without residence permits and the neoliberal shifts in the Swedish welfare system. I finalise the section about trans-specific healthcare by looking ahead; for example, by considering contemporary psychomedical research and upcoming legal changes. This will be followed by a discussion about (un)safety, the need to belong and its relation to health, and a short section in which I discuss the importance of material conditions for the health of people with trans experiences. The discussion ends with a section about affective labour and health. This final section can be seen as tying together the experiences of trans-specific healthcare on the one hand, and (un)safe space on the other. Here, I propose affective labour as one of the potential connections between cisnormativity and mental ill-health among people with trans experiences.

Diagnostic tools and decision models – Experts, objectivity, and governing

It is clear that the participants’ experiences of navigating and negotiating access to gender-confirming medical procedures are affected by the evaluators’ gate-keeping position. The gate-keeping role of the evaluating team, and especially mental health care-providers, is also present in the guidelines. The dependence on care-providers, who take the final decisions about access to gender-confirming medical procedures, could be understood as top-down regulation, whereby the medical authorities hold the power to make the final decision. However, the diagnostic process, or the evaluation, that leads up to such decisions is a far more complex process. For example, as described in the results, the governing of gender stereotypical performances appeals to techniques of self-governing and is in itself affected by societal norms about linear gender.

Available diagnostic tools

Decision-making in trans-specific healthcare have to be understood in relation to available diagnostic tools for gender dysphoria. Participants pointed out the lack
of tests for it. The analysis of the participants’ experiences showed, however, that waiting, gender performance, real-life experience and taking charge might be used as diagnostic tools. The analysis of the guidelines revealed the use of time, psychosocial support and real-life experiences as tools for the care-providers to make well-informed decisions. Care-providers within the trans-specific healthcare argue that there is a lack of objective diagnostic tools for gender dysphoria; for example, care-providers working in the team in Stockholm write that “[t]he diagnosis is based on an assessment of the anamnesis and the behaviour. There are no diagnostic tests to confirm the diagnosis on objective grounds, but it is important to exclude other explanations for the gender dysphoria” (Arver et al., 2015). Judging from this description by care-providers, what seems to matter, apart for the care-seekers’ testimony (anamnesis), is “the behaviour”. What kind of behaviour, and how it is assessed, is not further explained. Similar descriptions of the lack of objective diagnostic tools can be found in the legal preparatory work leading up to the 1972 law, and it is further explained that: “In transsexualism, however, the symptomology connected to the social expressions are in typical cases so clear that any doubts around the diagnosis seldom arise” (SOU 1968:28, p. 28, my emphasis). Thus, there seems to be a consensus that there are no “objective” tools available for diagnosing gender dysphoria.

These experiences and narratives about the lack of diagnostic tools, and the governing within trans-specific healthcare more broadly, has to be understood in relation to the psychomedical knowledge production around trans. Foucault has argued that, in order to govern, you need to know the population (Foucault, 1984, p. 65). Thus, the care practices and the care-providers’ specific positions as experts have to be understood in relation to the psychomedical knowledge production around trans, which includes a search for aetiological causes, studies of the nature of sex/gender, analysis of follow-up and regret statistics, psychiatric (co)morbidity, case-studies, sex-ratio and population size (for Swedish examples see Berglund et al., 2008; Bodlund & Kullgren, 1996; Dhejne et al., 2011; Dhejne et al., 2014; Eldh et al., 1997; Feusner et al., 2017; Henningsson et al., 2005; Johansson et al., 2010; Landén et al., 1998b; Landén et al., 1996; Savic & Arver, 2011; Savic et al., 2010).

Psychomedical knowledge production can be seen as part of the rationale that contributes to forming which kind of subjects that becomes intelligible as needing or deserving access to gender-confirming medical procedures. But, to remind the reader, this should not be seen as a fixed set of criteria that is passed down from one identifiable powerful position to a subordinate position. Thinking about the focus of parts of this knowledge production, I think it is possible to consider whether the stated lack of objective tools might rather be a lack of, and perhaps also a desire for, “biological” diagnostic tools, including imaging techniques. The
desire to use MRI, for example, can be seen in research on the aetiology of trans: “Unfortunately, the sex difference in the BSTc volume [part of the brain] does not become apparent until early adulthood /.../ meaning that this nucleus cannot be used for early diagnosis of transsexualism” (Savic et al., 2010, p. 51).

Experiences and modes of governing
Despite this lack of “objective” diagnostic tools, the participants experienced that care-providers did not find them trustworthy, and that their self-narrated need was not enough to grant them access to care. Instead, the participants experienced that they had to prove themselves, or convince the evaluators that they needed access to gender-confirming medical procedures, and the evaluators’ function was described by one participant as revealing the right personality. This convincing and negotiating for access was achieved, for example, by taking charge and running risks (through taking unsupervised hormones). Based on the participants’ experiences and the analysis of the guidelines, it seems that there is some kind of imagined “genuine need” that the evaluators are able to assess or reveal, a need that is hidden beneath the stated, self-experienced, need. It is perhaps within the “behaviour”, the “social expression”, or in the taking charge, that this imagined hidden, genuine, need is sought for or imagined to be found.

In relation to the care-providers’ positions as experts and gate-keepers, several participants negotiated access to care by employing strategic narratives and gender performances and by taking on a proactive role. This can be understood as narrating/signalling readiness and eligibility (Hale, 2007; Speer & Parsons, 2006), and was also experienced as generating faster access to care. However, taking charge and running risks might be connected to other factors, such as class, age or geographical position, rather than to the level of need for gender-confirming medical procedures. It could also be connected to different care-seekers’ ability or opportunity and willingness to perform gender in stereotypical ways or to pass in society. Hence, this can contribute to stratified access to gender-confirming medical procedures.

The participants in Dewey and Gesbeck’s (2017) study also used their knowledge about medical praxis in strategic ways to negotiate access to care. Interestingly, in their study, it was not only care-seekers who used strategic approaches, participating care-providers also used, for example, strategic diagnoses to ensure that medical procedures would be covered by the care-seekers’ healthcare insurance (Dewey & Gesbeck, 2017). In a similar vein, a recent governmental report (SOU 2017:92) revealed that Swedish care-providers word their certificates to the Legal Advisory Board in ways designed to improve the applicant’s chances of gaining access to legal gender reassignment and genital surgery. I think it is important to point out here that such affirming intentions
and practices among care-providers is something that my study does not capture. We do not know if care-providers disregard some of the recommendations in the guidelines in order to provide more affirming trans-specific healthcare; for example, with regard to asylum seekers or people with mental illnesses. In line with Foucault’s understanding of power, I also want to point out that governing practices are present regardless of psychomedical discourses, and that they can be carried out using different techniques and be based on different rationalities.

Scholars drawing on Foucault’s theory of governmentality argue that governing is increasingly exercised by means of self-regulation in today’s neoliberal society (Lauri, 2016; Miller & Rose, 2008; Rose, 1996). Similarly, the governing of gender performances in trans-specific healthcare appeals to means of self-regulation and the best interests of the care-seeker, as seen, for example, in Mark’s description, given in the results above. Hence, potentially bad or constraining effects on the health or gendered expressions of care-seekers do not necessarily derive from bad intentions on the part of care-providers. While some scholars have talked about self-governing as a more liberating governing technique, at least for privileged people (Wacquant, 2012), in Lauri’s (2016) study about social work, he shows that self-governing among social workers is not primary liberating but produces suffering. Similar to Lauri’s (2016) results, the participants in this study did not experience self-governing, in relation to such issues as gender performance to be essentially liberating, but they rather narrated the governing in terms of “rules”, having to be a certain way, and also in terms of suffering. Furthermore, different forms of governing reinforce each other (Lauri, 2016), and the self-governing technique in trans-specific healthcare is clearly connected to the more disciplinary form of power embedded in the gate-keeping function. For example, participants self-regulated their gender expression in order not to put their diagnosis at risk.

**Gate-keeping and alternative decision-models**

The participants’ experiences of not being considered trustworthy – that the way in which they express their needs for gender-confirming medical procedures is judged as not sufficient proof – could be interpreted as expert discourses being privileged over self-determination. Alm (2006, 2018) has argued that Swedish legal preparatory work frames trans-specific healthcare in a paternalistic way, with a need for expert knowledge and evaluation, and this study shows that this notion is reproduced in the guidelines (SKS). Gate-keeping as a decision-model within trans-specific healthcare has been widely discussed; criticised by care-seekers, scrutinised by trans studies scholars and both questioned and justified by care-providers (Bockting, 2008; Cole et al., 1997; Lev, 2009; Pimenoff & Pfäfflin, 2011). Analyses of decision-making practices in contexts such as the USA and UK show that, while the diagnostic categories and criteria have changed, the
gate-keeping position of mental health professionals still remains, at least in relation to surgery (Dewey & Gesbeck, 2017; Speer & Parsons, 2006). Healthcare providers are gate-keepers within many parts of the healthcare system, this is not something that is unique to trans-specific healthcare. However, I think there are some issues that are specific to trans-specific healthcare, which makes the gate-keeping role of the evaluating team different, and in certain ways more problematic. Firstly, as shown above, there are no “objective” diagnostic tools. This is also true for other conditions classified as psychiatric diagnoses; however, as Speer & Parsons (2006) point out, gate-keeping becomes particularly acute when care-seekers’ “desires for a certain medicine or treatment /.../ may also be interpreted as a symptom of their ‘condition’” (p. 785), which can be seen in my participants’ experiences of being interpreted as serious when they take charge. Secondly, as several previous studies have shown, and as this study confirms, the gate-keeping model is partially bypassed by some care-seekers, who develop strategic narratives and actions. Together with studies showing that care-seekers using such narratives “achieve equally good results” (p. 37), this has even made care-providers state that the gate-keeping role “likely has become outdated” (Pimenoff & Pfäfflin, 2011, p. 43).

Hale (2006) has analysed the ethical problems of gate-keeping within trans-specific healthcare. Hale argues that mental health providers’ gate-keeping role is undermining care-seekers’ autonomy and “constructs the request for hormonal and surgical interventions as a phenomenon of incapacity in a sociocultural and political context that already denies gender variant people full moral status” (2006, p. 493, my emphasis). Hale argues that, in terms of ethics, the gate-keeping role is a matter of balancing autonomy (self-determination) with possible harms, such as: irreversible loss of reproductive capacity and other irreversible changes, medical risks, social risks, and possible later regrets. Hale’s main argument is that these potential risks do not justify the compromise with respect for autonomy.

Adding to Hale’s argument, the participants in this study also testify to how encountering the gate-keeping power is experienced as getting stuck, feeling powerless and not being able to influence decisions. In the words of Ahmed (2006b, 2007), encountering a gate-keeping power could be understood as coming up against a stopping device, a chain of actions that is stopped. This can be disorienting for the target, and it requires work to reorient. Ahmed (2007) describes how the stopping device makes the object of the device a “suspect” and requires a response. Similarly, encountering the gate-keeping power leads to a request for the care-seeker to undertake actions to be granted access. It is thus not a passive or purely repressive power, that only says “no”, but a power that is productive and appeals to actions among its targets. As shown in the results, the participants also put in work to gain access to gender-confirming medical
procedures, work that will be discussed in more detail below. The participants’ experiences further show that this stopping is causing ill-health in terms of, for example, anxiety and sleeping problems (see also Bremer, 2011).

Based on the above discussion, I think that we have to begin to think about, and consider, alternative decision-models. Discussions about decision-models within trans-specific healthcare are already ongoing in several contexts (Davy, 2015; Deutsch, 2012). One of the alternatives to gate-keeping is informed consent models in which care-seekers have the opportunity to begin on hormones without prior mental health evaluation (Deutsch, 2012). When they are used, such models have usually applied to hormones, while access to surgical procedures has often still been preceded by an evaluation conducted by mental health professionals. I have no final answer to what an optimal model might look like in the Swedish healthcare system or to the question of whether it should be one model for all medical procedures. But, based on the participants’ experiences, it ought at least to be a development towards a more supportive ‘evaluation’ and a distancing from testing and asking care-seekers to prove their need. Decision-models, such as informed consent models, that place a lot of responsibility on care-seekers, also have to be considered in relation to the increased individual responsibility for health and different people’s ability to take on such responsibilities (A.E. Clarke et al., 2003). Hence, besides considering how the current gate-keeping model is causing ill-health, waiting and powerlessness, it is important to consider how alternative decision-models affect care-seekers, in terms of future responsibilities (after receiving gender-confirming medical procedures) and ensuring subsidised care and equal access to care.

Above, I have discussed in general terms the decision-making and governing within trans-specific healthcare. I will now move on to discuss some of the techniques and rationales that I identified as important for being considered eligible for care, in the analysis of the participants’ narratives and in the guidelines.

**Governing of/through gender**

*(Trans)gender identity and orientation towards trans-specific healthcare*

As discussed in the theoretical chapter, the orientation of people with trans experiences towards gender-confirming medical procedures has been criticised for preserving social gender roles, and some scholars have drawn firm lines between the transsexual and the transgender positions. In contrast to such conclusions, this study shows that participants identifying as transsexuals or former transsexuals negotiate linear constructions of gender in their meetings
with trans-specific healthcare. Furthermore, it shows that an orientation towards trans-specific healthcare can be ambivalent for both binary and non-binary individuals, with participants from both groups considering several advantages and disadvantages before seeking care and before initiating medical procedures. The results also show that some people with trans experiences see access to gender-confirming medical procedures as the only available path to change, and that such access is essential in their striving towards passing. The participants’ ambivalent relation towards the concept and meaning of passing also exemplifies how “transsexual becoming is dependent on a lived experience of being gendered” (Rubin, 1998, p. 266); i.e. how striving towards passing is done with a consciousness of how people are gendered in everyday life. Hence, in order to become intelligible and live more livable lives, passing becomes crucial for some people with trans experiences. This range of experiences of orienting and being oriented towards gender-confirming medical procedures has to be considered in order to avoid the double bind that has been prevalent in previous research: on the one hand people with trans experiences are exoticised for their transgressive gendered embodiment and on the other hand they are critiqued for reproducing binary gender norms. Thus, as Hines (2006) has argued, we have to bring particularity into studies about trans by exploring a range of different material and embodied experiences (see also Davy, 2010).

The five non-binary participants in this study had all considered seeking trans-specific healthcare but only one had actually sought such care. In the report from Transgender Europe (2017), some of the Swedish non-binary people stated that they were not interested in gender-confirming procedures, but a substantial number also said that they had not sought care because they were afraid of being badly treated, because they had been badly treated before in the healthcare system or because they did not know where to turn to gain access. These answers were analysed in the SOU 2017:92; the authors concluded that non-binary people have far less trust in the healthcare system than binary-identified people with trans experiences.

**Straightening of gender**

In many of the participants’ narratives, gender stereotypical performances were central aspects in their meetings with the evaluation team. Stability of gender identity seems to be considered important in the diagnostic process in the guidelines. The construction of the RLE in the guidelines and the emphasis on the matching of “the gender identity” and “the social gender role” might reward a stereotypical, or at least a particular, gender performance. However, there are no explicit recommendations in the SKS to take the care-seeker’s gender stereotypical performance into account during the evaluation. While some participants experienced a binary gender identity as crucial in order to gain access
to care, the guidelines seem to open up space for non-binary people to have access to care. However, matching the gender identity with the social gender role might be more difficult for non-binary people in a social context where gender is constructed in binary ways.

Similarly to our results, previous studies have shown that gender performances are not only taken into account in the evaluation but are also governed during the evaluation (Bremer, 2011; Davy, 2010). The advice, comments and feedback on their gender performance that the participants received during the evaluation can be understood, in the words of Ahmed (2006b), as encountering straightening devices. According to Ahmed, these devices contribute to alignment, to keeping things in place. Hence, the evaluation has a straightening effect on gender. Furthermore, as Ahmed puts it: “you only straighten what is already bent” (Ahmed, 2014, p. 7), which can also be used to understand why not all the participants experienced such devices. However, as shown in the results, even those participants who did not receive feedback from evaluators on their gender performance could see (for example, in their medical records) how their way of embodying gender was compared to similar standards as those who did experience straightening devices. However, as they appear to be in line, or not bent, straightening devices become redundant.

In order to fulfil the gendered standards that participants experienced as important in the evaluation process, some participants employed a strategic gendered performance, which several previous studies have also shown (see, for example, Carroll-Beight & Larsson, 2018; Lindroth, 2016). These gender performances were not only a matter of narrating but also brought in the material body as important in the evaluation (see Bremer, 2011). For some participants, the material body could act in line with their (and the evaluators’) interests, but the body was also something that could be unruly and a hindrance, for example described as developing in the wrong direction (see also Bremer, 2011, pp. 100–105). Swedish governmental evaluators and psychiatrists who have worked with the evaluation have explicitly talked about the bodily potential among care-seekers (Alm, 2006; Bremer, 2011). The participants in Bremer’s (2011) study had also experienced receiving value-based appraisals about their physical body. Researchers have argued that the importance attributed to the material body during the evaluation builds on an idea of an authentic embodied masculinity and femininity (Alm, 2006; Bremer, 2011; Lundgren & Kroon, 1996).

The previous requirement for sterilisation can also be understood as a straightening of gendered embodiment and the future gendered life. I do not assume that everyone wants to have children, but I think the fact that only one of the participants was the legal guardian of a child still has to be understood in relation to this previous requirement for sterilisation. This small proportion can
also be connected to the potentially dysphoric effects of becoming pregnant for non-binary persons or men (who are assigned female at birth) (Armuand et al., 2017). However, when the law was designed and during discussions about removing the requirement for sterilisation, it was not primarily the difficulties for people with trans experiences that was in focus. As can be seen in the quote from the County Council of Västerbotten (2012:1189) in the introduction, and by looking at previous research and reports, becoming pregnant as a (trans) man in one’s new legal gender has been actively opposed by some decision-makers and care-providers. For example, governmental investigators and care-providers have argued that society is not ready to have pregnant men and that it is an inherent part of the gender dysphoric condition to want to get rid of one’s ovaries or testes (SOU 2007:16; Alm’s (2006) analysis of the SOU 1968:28; County Council of Västerbotten 2012:1889; Bremer, 2011).

Bremer (2011, p. 211) describes how some care-providers, for example through formal comments to governmental reports, have implicitly argued that care-seekers have to pay a price for their gender reassignment, and this price is their reproductive ability. It is important to mention that some individual care-providers and (parts of) the Swedish Association for Transsexual Health (SFTH) took a stance in favour of removing the requirement for sterilisation. The guidelines (SKS) highlight the importance of counselling and information about how gender-confirming medical procedures might affect fertility and the ability to become genetic parents. The SKS does not, however, provide any clear recommendations for referral, or access, to fertility clinics (The National Board of Health and Welfare, 2015, pp. 65–68). Hence, it seems that it is up to the individual healthcare providers or care-seekers to take such initiatives.

**An extra stereotypical performance, transvestites and sexuality**

The fact that some participants experienced the standards within the evaluation as meaning that they had to be more stereotypical than people without trans experiences can be understood in relation to constructions of transvestism and homosexuality. Edenheim (2005), similarly to Alm (2006), has analysed the governmental report from 1968. Edenheim (2005) argues that in the SOU (1968:28) it is constructed as crucial to differentiate between the transvestite, the homosexual and the true transsexual (p. 119). Kroon (2008) has drawn similar conclusions from analysing psychiatric research. Bremer (2011) describes how the transvestite (male-to-female) functions as the constitutive outside, the abnormal Other, in the evaluation and also sometimes in the participants’ narratives, something which arose a couple of times among the participants in this study. A request for care-seekers to be more stereotypical or “more ‘normal’ than ‘normal’ people” (Spade, 2006, p. 323) might be connected to a desire to find a defining difference between people with trans experiences who are eligible for
access to care and the transvestite, the butch lesbian or the sissy faggot (see also Halberstam, 1998).

Compared to some participants in Bremer’s study (2011), who experienced that their evaluator “suspected” transvestism if they were “excessively feminine”, no participant in this study testified to such experiences. This possible change in discourse, and in care practice, might also be seen in the removal of transvestite fetishism from the Swedish version of the ICD in 2009 (Transformering, 2018). However, demands to perform gender in stereotypical ways in trans-specific healthcare seem to persist, both for women and men. Another issue that has been highlighted before is that a heterosexual orientation in one’s “new” gender identity has been prioritised in the diagnostic process (Alm, 2006; Edenheim, 2005; Kroon, 2008; Lindroth, 2016). I asked an explicit question of those who identified as queer, homosexual or bisexual: whether sexual orientation had been important during the evaluation. No individual in this material had such experiences, and they had been open about their sexual orientation during the evaluation.

One phenomenon that is described in previous research is that men and women are looked upon differently, and consequently also treated differently, in trans-specific healthcare, a phenomenon that might be partly connected to the relation between the (threatening) transvestite and (trans) women (Bremer, 2011; Kroon, 2008). It could also be connected to transmisogyny, i.e. the interaction between cisnormativity and sexism that positions trans women in more marginalised and stigmatised positions than men with trans experiences (Serano, 2007). In this study, it is clear that the standards for gender stereotypical performances for men and women are very different within trans-specific healthcare, but in this material I have not been able to identify differences with regard to, for example, care-provider/care-seeker interaction or diagnostic praxis. The only tendency to differences between the participating men and women that I could see in the material is that the women worried more about passing in the future. This might be connected to previous research which has identified that men with trans experiences who have had gender-confirming medical procedures find it easier to pass afterwards (Schilt & Wiswall, 2008). Furthermore, as only one non-binary participant in this material had actually encountered trans-specific healthcare, not a lot can be said in relation to non-binary people’s experiences of the evaluation in relation to gender performances. This is an area that is in urgent need of further studies.

**Psychomedical constructions of gender as rationale**

The rationale behind the use of gender-stereotypical performances might be what I described in the theoretical framework as the psychomedical constructions of
gender and gender identity. If gender identity is seen as a fixed, and perhaps biological, essence, as something stably hardwired into the brain structures or the genes, and as causally connected to, and causing, behaviour, interests and attributes, then taking the social gender role into account in order to assess this gender identity becomes logical. If we adhere to this hypothesis, the social gender role (and the rewarding of a gender-stereotypical performance) can be logically understood, and used, as the litmus test for gender identity. It might also explain the emphasis in the guidelines on meetings with relatives during the evaluation, and how it is related to the participants’ experiences of care-providers asking both the participants and their relatives questions about behaviour in childhood. The information that is collected through such practices and during the evaluation process can thus help care-providers to establish that care-seekers have engaged in a stable gender performance over time, and in this way they can assess the authenticity of their masculinity or femininity (see also Bremer, 2011).

However, as feminist and trans studies research has shown, understanding the social gender role as a pre-discursive entity, untainted by power structures or discourses, is highly problematic and disregards the way in which gender performances are connected to the sociocultural context (see, for example, Hare-Mustin & Marecek, 1994; Jordan-Young, 2011; Spade, 2006). Using gender performances as a regulatory technique also disregards the fact that the differences (physical, psychological, behavioural, as well as differences in interests and attributes) within the two (socially constructed) categories of gender might be larger than or as large as the ones between the categories (see Hyde, 2005, 2014; Hyde & Linn, 2006; Sanz & Guadarrama, 2012). “Man” and “woman” are thus far from mutually exclusive categories, no matter whether they are understood as biologically derived, socially constructed or constructed in a complex interplay between discourse and materiality. I want to argue that this underlines the impossibility of using social gender role/stereotypical gender performance as a litmus test or indicator for gender identity or gender dysphoria, and the need for gender-confirming medical procedures. In other words, how people perform gender through their behaviour, interests, body language, choice of words or attributes are poor indicators of gender identity.

As far as I have been able to follow the research about the aetiology of gender dysphoria/trans experiences, it very often assumes that gender/sex is binary (see, for example, Berglund et al., 2008; Savic & Arver, 2011; Savic et al., 2010). This assumption silences the growing body of transfeminist literature that reveals much more diverse experiences of gender. Aetiology research can also be scrutinised against findings from studies showing that “sexual difference” is much more complicated and messy than a binary construct and the findings that suggest biological patterns, which have often been assumed to be inherent and stable, are in fact malleable and affected by social factors (Fausto-Sterling, 2000,
This research can sometimes be found within the same fields as the aetiology research. Hence, it is possible to criticise the use of linear gender as a regulatory technique in trans-specific healthcare by using a logic and research from within the same paradigm as that within which the regulation takes place; i.e. we can find arguments for the messiness of gender within psychomedical research. I am not saying that this is more important to consider than, for example, the care-seekers’ experiences or feminist critiques of psychomedical research on gender essences; quite the opposite, but I think there can be strategic gains to also put forward such arguments, because the epistemological divide might be difficult to overcome.

**Snapshot (somebody asked: “transgender vs transsexualism?”)**

Excerpt from memo April 20, 2017: “At a symposium for gender studies at the university, I presented my second paper, about the regulation of gender in trans-specific healthcare, and afterwards I was asked a question by a visiting gender studies professor about the relationship between the more stereotypical transsexuals in my study and the non-binary or queer people. I think this question ties into several discussions in trans studies. Firstly, I think there is a tendency to assume a tension or a conflict that is not there, certainly I assumed such a conflict and asked the participants about this during the interviews. A lot of the answers did not confirm my preconceptions but instead they emphasised the wide range of experiences and identities within the community; for example, people identifying in very binary and stereotypical ways emphasised the importance of non-binary people getting access to care. Thus, it was solidarity rather than conflict that emerged from many of the interviews.

Secondly, sometimes this question is tied to ideas about some identities, expressions and experiences being more radical, transgressive or subversive, which places a larger burden for revolutionising/reforming gender on people with trans experiences than we do on people with only cis experiences. I think that is a too superficial analysis which does not consider different contexts or experiences. A good counter-example is when one of the participants in this study, who defines herself in a very stereotypical and binary way, describing herself as being like a “typical feminine woman”, talks about choosing not to have genital surgery and thereby embracing a non-linear or queer embodiment. Such a presentation and embodiment would probably be considered more non-normative in some queer communities than a queer presentation, and it certainly causes her problems in several kinds of spaces. In order to capture such experiences, academics who are interested in subversive or transgressive gendered positions and politics have to be grounded in experience and be context-specific. This also brings me back to the starting point of this thesis, the transfeminist one. The deregulation of gender is not concerned with aiming for an increase or an elevation of certain radical or non-confirming people or performances; instead, it is precisely about a deregulation, regardless of whether that regulation is stemming from healthcare practices or from feminist, queer or trans academics elevating and celebrating certain gender expressions.”
Temporality, waiting and future lives

“Trans-specific healthcare: Please hold” – waiting and health
Waiting was described as one of the most challenging aspects of navigating access to gender-confirming medical procedures by the participants and as something that contributed to ill-health. Much as Bremer (2010) describes the waiting among care-seekers in trans-specific healthcare as a desperate and anxious time, my participants’ experiences of waiting consisted of much frustration, distress, anxiety and feelings of powerlessness. The experience of moving forward in the evaluation at one point, only to be put on hold and having to wait again in the next moment, was described as being torn between hope and despair. The despair brought on by the waiting is also shown in the use of unsupervised hormones, a risk (which the participants were aware of) that the participants experienced could lead to a negotiation of the waiting times (see also Repka & Repka, 2013).

Similar to the gate-keeping, waiting is far from a unique phenomenon in trans-specific healthcare. However, as I will discuss further below, the waiting within the evaluation was experienced as partially intentional. Waiting for gender-confirming medical procedures was also, for some, a matter of becoming stuck in life. Halberstam (2005) has written about queer temporalities, and, for example, how queer people might organise their life course differently than the expected, normative life course (see also Ahmed, 2006b, p. 21). In this study, some participants had organised their lives in alternative ways; living in shared housing or having children for whom they considered themselves to be a significant adult, although not their legal guardians. Others expressed a longing for a normative life course, but said that their lack of a linear embodiment and the waiting for medical procedures became “stopping devices” (Ahmed, 2006b) in relation to their ability to continue life in a linear way. For example, several participants felt restrained from initiating romantic or sexual relationships or from having a family of their own. Significantly, Ahmed (2006b) argues that bodies that do not follow the normative linear progression might be stopped and that such a blocking of action becomes “stress points”. This was evident in the participants’ narratives, in which the waiting was described as a source of several mental health symptoms.

Apart from being a stopping device, waiting in trans-specific healthcare can be seen as a state of liminality (originally used to signify the threshold state in the middle of rites). At the point of reaching the evaluation team, the participants had often told their friends and families about their trans experiences and several stated that they had already come quite far along in their mental, social or embodied (with help of unsupervised hormones) transitioning by the time they started the evaluation. But still they had to wait for access to (some) medical
procedures and legal gender confirmation. Thus, the waiting is a “lived experience of facing at least two directions: toward a home that has been lost, and to a place that is not yet home” (Ahmed, 2006b, p. 10; see also Bremer, 2010). Hence, in some spaces they might no longer pass, or feel comfortable passing, as cis in the gender they were assigned at birth, but neither might they be able to pass in their identified gender or present themselves in the ways that they want.

It might seem from these descriptions that some participants invest a whole lot of hope in their access to gender-confirming medical procedures. Or, to put it in another way, the arrival (an arrival that requires work) at the other side of the gender-confirming medical procedures is perhaps like a promise of happiness (Ahmed, 2010). Some of the participants did express quite high hopes and those who had arrived on the other side described a relaxing feeling, for example, in relation to being able to pass. However, much as I discussed the ambivalent orientation towards trans-specific healthcare above, many participants seemed to have quite ambiguous hopes when it came to the outcome of their access to gender-confirming medical procedures. On the one hand, for some, this access was vital for continuing life, but for the same participants, it was not self-evident that this access would open up all kinds of possibilities; they were, for example, still worried about whether they would ever be able to pass.

The fact that some participants held back their application to the legal advisory board for approval of legal gender reassignment and genital surgery until the law no longer required sterilisation can also be seen as contradicting the idea that all the hopes are put into the gender-confirming medical procedures and/or legal gender confirmation. It is thus not a “no matter what”, but a process of considering the pros and cons of different actions. Still, the temporal aspect of having to wait for proper legal gender markers can result in unsafety when the legal documents do not match one’s gender presentation (SOU 2014:91).

Another temporal aspect is that, for many people with trans experiences who want and need access to hormones, it is a matter of a life-long (bio)medicalisation and dependence on the healthcare system, it is not a process that stops with gaining access to gender-confirming medical procedures. How gender-confirming medical procedures, and especially hormones, affect the health at different ages and in the long run was something that the older participants in particular talked about, and this is an area in need of further research (see also Gooren & T’Sjoen, 2018; Maraka et al., 2017).

**Temporality as a governing technique**

As already mentioned, waiting for access to gender-confirming medical procedures was experienced as partially intentional. An inconsistent gender
identity over time, or newly “discovered” gender dysphoria, was considered in the Swedish Knowledge Support (SKS) a reason for evaluators to be cautious in relation to the length of the evaluation period. Thus, it seems that time is used as a diagnostic tool within the evaluation. Using time as a diagnostic tool can be seen as a governing technique that is based on the rationale of a stable gender and, as will be discussed further below, the connected issue of regret also becomes a rationale for the use of time.

Aspects of temporality are present in the diagnostic praxis described in the SKS (e.g. length of evaluation, Real-Life Experience (RLE)) and in the law on legal gender reassignment (see also Alm, 2006; Bremer, 2010). The law states that, in order to be granted access, the applicant should be someone who is expected to have the new legal gender in the future. The question is: how is it possible to assess and evaluate this expected future? Is the diagnostic process a matter of considering the past and present in order to predict the future? If understood in such a way, the future automatically becomes a linear extension of the past and present (see also, Alm, 2018). The past becomes important in the evaluation in terms of childhood behaviour, which is assessed by questions to the care-seekers and their relatives. In the present, suffering, seriousness and gender performance seem to be important, based on the participants’ experiences and the SKS. Furthermore, the RLE, as it is described in the SKS, becomes a period of time when it is possible, or imagined to be possible, to thoroughly document a consistent gender appearance over time. If the care-seeker passes such a period, the risk of regret is assumed to have decreased, hence the problem of the future.

The narrative around regret can be seen as so strong that it is becoming a constitutive part of the psychomedical trans narrative, and it was also something that some participants talked about in terms of a risk among other care-seekers. It is such a central issue that it is privileged, for example, over the care-seekers’ safety and mental well-being, as the SKS states that care-seekers should go through RLE despite the risks of uncomfortable and anxiety-provoking situations. Alm (2018) argues that medical discourses around sex/gender have centred on temporal aspects such as stability, predictability and futurity. In order to secure the future and avoid the risk of regret, the psychomedical discourse of trans experiences needs predictability. This predictability requires past and present stability as this is imagined to be a sign of an authentic gender identity (see Alm, 2018; Bertilsdotter Rosqvist et al., 2014). The present is, however, not only a question of appearance over time, it is also a question of “consistency” or, as Spade (2006) writes: “I need to be willing to make the commitment to ‘full-time’ maleness, or they can’t be sure that I won’t regret my surgery” (p. 322, my emphasis). The logic seems to be that, through using temporality as a technique of governing and a diagnostic tool, there might be an imagined decreased risk of (leaking) rupture – that care-seekers might follow unpredictable routes and
gendered lines. This becomes important as rupture would reveal that the system – of gender, or evaluation – is not stable, certain, objective or natural (see also Roen, 2011). In relation to the above discussion, temporality as a diagnostic tool can be seen as a discouraging governing technique. Inherent in the idea of using time as a diagnostic tool is the belief that those who are not sure enough will drop off. Hence, it builds upon an idea of certainty and motivation among care-seekers (see also Bertilsdotter Rosqvist et al., 2014; Roen, 2011).

Bertilsdotter Rosqvist et al. (2014) showed that age is important in Swedish evaluators’ talk about which care-seekers are understood as authentic. Paradoxically, both a young and an advanced age could be a factor leading to hesitation among healthcare providers. A very young age could imply immaturity and uncertainty, but these care-seekers may become ready at a later point. Among care-seekers who sought care at an advanced age, authenticity was questioned (Bertilsdotter Rosqvist et al., 2014). One of the older participants in this study had been questioned based on her age, while the other older participant described her age as an advantage, that the evaluators interpreted her as especially certain in her decisions. This might be connected to a quote from one of the evaluators in Bertilsdotter Rosqvist et al.’s (2014) study, who said that among older care-seekers you have to look for signs during upbringing (p. 30). Hence, independently of age, both the past and the future (when young people are more mature) become important.

**Suffering but psychosocially healthy**

Gender dysphoria, and access to gender-confirming medical procedures, are clearly constructed as relating to psychological suffering in the SKS. Recommendations in the SKS also state that mental illness should preferably be treated before care-seekers receive access to gender-confirming medical procedures. The question is: how can care-seekers improve their mental health before gaining access? The participants had experienced “falling between the cracks”; several had experienced that mental ill-health was not something the evaluating team took responsibility for and, at the same time, participants had also experienced that other mental health professionals did not want to take them on. For example, some care-providers outside trans-specific healthcare referred to all mental health issues as associated with the individual’s trans experiences (even when they were not) (see also Carroll-Beight & Larsson, 2018), and hence as something that trans-specific healthcare should deal with. Additionally, as mental stability has been rewarded in the evaluation (Bremer, 2011), and the SKS constructs mental health issues as an obstacle in the evaluation, mental ill-health might not be something care-seekers dare to bring up. As a consequence, the responsibility for psychosocial support fell on the care-seekers themselves, or their intimate circle. Additionally, mental health care-providers’ function as gate-
keepers might also constitute a barrier to developing a trusting and productive therapeutic relationship (Deutsch, 2012; Hale, 2007), which can also be seen in the participants’ strategic performances. Hence, mental health care-providers’ role as gate-keepers might hinder people with trans experiences from accessing appropriate mental healthcare.

According to the guidelines, the psychosocial support given during the evaluation can help the care-seeker to become a respectable citizen (i.e. “create success in relations, education and working life” (The National Board of Health and Welfare, 2015, p. 40)). The focus in the guidelines on the care-seeker’s social life and potential life ahead can be placed in a historical context of continuity dating back to at least the legal preparatory work of 1968 (SOU 1968:28, Alm, 2006). In the SOU of 1968, there is a clear focus on constructing people with linear genders; socially, biologically and legally (Alm, 2006). It is hence not only mental health that should be evaluated before granting access, but also the social life, which might have socioeconomic aspects. In the SKS, aspects such as finances, plans for the future, accommodation, relationships and children are said to be relevant in the evaluation (p. 34). A similar paradox appears in the SOU of 1968 and in the SKS; on the one hand, a well-ordered psychosocial life should preferably be reached before being granted access, or at least be carefully evaluated; on the other hand, through access to medical and legal intervention, “patients have regularly been helped to better social adaption and improved psychological balance” (SOU 1968:28, p. 32).

In the SKS, something that is called “standardised and normalised tests can be included if motivated in the individual case” (p. 32). Care-seekers in Swedish trans-specific healthcare have testified to the use of IQ tests, mental arithmetic, Rorschach’s test and being forced to solve ciphers and riddles during the evaluation (SOU 2017:92). Only a few of the participants in this study described experiences of such tests, but this might say more about my inability to capture such elements in the interviews than it does about the use of such tests. Still, those who had such experiences described the tests as humiliating. Thus, based on the analysis of the SKS and previous research and reports (Bremer, 2011; Alm, 2006; SOU 2017:92), it seems that a linear life to date and a future respectable life are considered in the evaluation and that access to gender-confirming medical procedures is connected to a normative understanding of intelligence, psychosocial health and social life. Similar to the governing of gender, there might not only be a consideration of these factors during the evaluation process, but there might also be a straightening of mental health and the social life in normative ways.
Mental ill-health as a state of incapacity and critical dis/ability perspectives

Previous research has shown that access to gender-confirming medical procedures improves the mental health of care-seekers (Dhejne et al., 2016). What then is the problem, or rationale, behind recommendations stating that mental illness should preferably be treated before granting access? Good mental health might be connected to a “capacity to make a fully informed decision” (p. 187), as it is described in the international guidelines for trans-specific healthcare (SOC-7) (Coleman et al., 2011). If following such a line of thought, mental illness is constructed as a form of “incapacity” to make informed decisions. The demand for treatment and the construction of mental ill-health as a hindrance in the evaluation become particularly acute problems in relation to those conditions that are categorised as psychiatric disorders where there is no “treatment” or where the condition is typically lifelong.

The proportion of care-seekers in trans-specific healthcare who are diagnosed during the evaluation with autism spectrum disorder or have such a diagnosis prior to the evaluation has been an increasing topic for discussion (Van Der Miesen et al., 2016). While it is important that people who want and need help from the healthcare system with issues connected to autism spectrum disorder get access to care, there has been a tendency to connect this co-occurrence (or as it is often called: “co-morbidity”) with biologically determinist models of trans experiences and autism. For example, a hypothesis has been posed that the co-occurrence is due to autism being a result of an extreme male brain and that both autism and gender dysphoria among men with trans experiences are caused by prenatal testosterone exposure. But also social and psychological explanation models have been proposed (Van Der Miesen et al., 2016). Without further reinforcing a stigmatisation of neuroatypicality, future studies have to critically analyse what consequences this type of research has for the construction of trans experiences (and gender), and access to care for people with trans experiences and an autism spectrum diagnosis.

Furthermore, the use of intelligence tests has to be problematised from a critical dis/ability point of view (see, for example, Bylund, 2016; McRuer, 2006). One informant in the governmental report (SOU, 2017:92) says: “[m]y evaluator clearly spelled out that because of my high intelligence they could hurry up my evaluation” (p. 607). Thus, people who do not perform well in normative intelligence tests might have a harder time getting access to gender-confirming medical procedures. Previously, the only absolute contra-indication for access to gender-confirming medical procedures was intellectual dis/ability; however, this is no longer the case (Arver et al., 2015). Hence, these care-seekers’ experiences of navigating access to gender-confirming medical procedures needs to be further studied.
At the beginning of this project, I met a psychiatrist who is responsible for one of the evaluation teams and we started to talk about my research. I had just discovered critical research and was excited about taking a critical perspective on care-seekers’ experiences of trans-specific healthcare. A bit naively, I told the evaluator about my approach and got the answer “I am very sorry to hear that” (I guess they understood the word “critical” in its lay meaning). They then continued to justify their practices and one of their arguments went something along the lines of “I have even given the diagnosis [transsexualism] to a patient with autism spectrum disorder”. As I understood it, this was seen as the ultimate evidence of progressive trans-specific healthcare.

**Trans in itself as a mental illness**

The SKS attempts to conceptualise mental ill-health among care-seekers as a consequence of cisnormativity and heteronormativity. However, by focusing on psychiatric/psychological knowledge, psychosocial support and therapy, the SKS reconstructs trans in itself as a psychiatric/mental problem. Dewey and Gesbeck (2017) argue that the focus of the diagnostic categories in the DSM has shifted from diagnosing gender variation to diagnosing stress caused by gender variation. Based on Dewey and Gesbeck’s argument, gender dysphoria and suffering could be understood as inseparable categories. The American Psychiatric Association, the organisation that publishes the DSM, states that the change to “gender dysphoria” in DSM V is a way to denote the distress that comes with gender incongruence, and they further point out that not all people with gender incongruence experience such distress. Gender dysphoria is thus “the clinical problem, not identity per se” (American Psychiatric Association, 2013, p. 451). The diagnostic criteria in the DSM, besides criteria for cross-gender desires, state that: “the condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association, 2013, pp. 452–453, see also Appendix 2). While the depathologising ambition to disconnect the distress from the gender incongruence, both in the SKS and in the DSM, is promising, the emphasis on distress and suffering might reconstitute trans experiences among those who seek care as psychopathology.

By constructing psychological suffering as inherent in the subject, the guidelines not only tend to reconstruct trans as mental illness, but also silence the possibility of a gender-euphoric subject; that is, a subject who does not employ gender-altering techniques due to suffering but due, for example, to joy or certain social advantages (see Feinberg, 1993; Preciado, 2013). Such individuals might not be considered eligible for state-funded gender-confirming medical procedures but are not given room in the SKS either inside or outside specialised trans-specific healthcare.
Asylum seekers and undocumented migrants as undeserving

The analysis of the SKS spurs questions about people who do not have a Swedish residence permit and their access to gender-confirming medical procedures. In the governmental report of 2017 (SOU 2017:92), all teams answered questions about what kind of care they provided for asylum seekers and undocumented migrants. Continuing with hormonal treatment that has already started seems to be considered, and constructed, as “healthcare that cannot wait”, which is the legal requirement for providing healthcare for asylum seekers and undocumented migrants above the age of 18. However, no team seems to provide evaluation or referral to medical procedures for migrants without a residence permit who have not already begun such procedures. As arguments for not providing care, the care-providers highlighted that the bodily effects of gender-confirming medical procedures might have stigmatising effects in the home country if the asylum seeker is denied residency. The care-providers also highlighted the issue of treatment not being continued if the care-seeker does not get residency, and they argued in relation to the law on legal gender reassignment which demands that the applicant is a Swedish resident (SOU 2017:92).

It seems as though the denial of treatment is partly argued in terms of looking out for the best interests of the care-seeker. The law on healthcare for asylum seekers, and the SKS, state that what constitutes “healthcare that cannot wait” is up to the individual care-providers to determine (The National Board of Health and Welfare, 2015). Some teams seem to partially apply such individual judgement, i.e. they book a first meeting, but “starting an evaluation on an asylum seeker is very uncommon” (SOU 2017:92, p. 667). Other teams do not even provide this first meeting, which makes it impossible to evaluate the need on an individual basis. While the SKS in other aspects connects an expressed need for gender-confirming medical procedures to the increased risk of premature death (p. 38), asylum seekers and undocumented migrants’ potential health risks of not gaining access to gender-confirming medical procedures seem not to be considered. While people with trans experiences and residence permits need a long evaluation to have their need for medical procedures assessed, one meeting seems to be enough for asylum seekers and undocumented migrants. In other words, gender-confirming medical procedures are constructed as healthcare that can wait (at least for some).

I think this is a very problematic conclusion for the evaluating teams to draw. Asylum seekers and undocumented migrants with trans experiences are a marginalised group who encounter several obstacles in their process of obtaining residence permits (SOU 2017:92). Evaluators saying that they do not want to interfere with the asylum process (SOU 2017:92, p. 669) are making assumptions about how their actions would affect the asylum process, and as such are taking
on a responsibility that is not theirs. But, primarily they are disregarding a responsibility that is theirs: providing healthcare on equal terms. In expressing concerns about the stigmatising effects of gender-confirming medical procedures if the care-seeker is not allowed to stay in Sweden, the evaluators are also making paternalistic decisions about the individual’s risks of encountering transphobia. Such a risk is also prevalent for people who will continue living in Sweden, an issue of which care-providers within trans-specific healthcare are aware (The National Board of Health and Welfare, 2010, p. 79). The medical profession is ignoring its ethical responsibilities in favour of implementing problematic (racist) state policies (see also Ghelichkhan, 2018). Or, in this case, they might be overlooking their professional responsibility as the law gives them the function to perform individual assessments instead of adhering to absolute criteria of what constitutes “healthcare that cannot wait”.

Neoliberal shifts in the welfare state and (some) individual moral responsibilities

It is evident that neoliberal shifts in the Swedish welfare regime have facilitated access to knowledgeable healthcare providers for some participants. But this is not achieved without work or consequences; previous bad experiences or extensive knowledge acquisition and exchange of information with other care-seekers has often preceded the choice of healthcare providers. As previous research has shown, this increased access that the liberalisation and deregulation provides (in terms of non-governmental providers’ ability to provide healthcare and care-seekers’ ability to choose a care-provider) can be stratified, and as such contributes to inequalities in health (Burström, 2009).

Neoliberal developments can also be understood in relation to the LGBTQ-certifications and diplomas that healthcare clinics can get after undertaking education on LGBTQ issues (from, for example, RFSL). Such teaching interventions can help fill important knowledge gaps, gaps which this study has shown to exist in many parts of healthcare. However, combined with the liberalisation and deregulation of healthcare, LGBTQ-certification can also function as a selling-point in the rush to attract care-seekers, who have become (or are imagined to be) rational customers. There might also be a problem in that those who are already interested or somewhat knowledgeable ask (and pay) for LGBTQ-certifications, and to this date there have been very few centralised decisions about having such certification (exceptions exist where some municipalities or county councils have taken decisions for several welfare providers). In some geographical areas, there might not be any LGBTQ-certified providers to access. Hence, the education of healthcare providers might not be distributed equally or provided to those who need it the most. Among other
things, this demonstrates the importance of knowledge on trans issues being already implemented in the education of care-providers.

Neoliberal discourses were manifested not only in discussions about choosing care-providers, but also in narratives about taking charge and running risks, which points towards a shift in responsibility. This is significant for the biomedicalisation era, with increased individual responsibility for health (A.E. Clarke et al., 2010) and can also be understood in relation to self-governing, as I have previously discussed. It is, however, important to point out that the shift in responsibility in the study of participants’ experiences of trans-specific healthcare did not include all kinds of responsibility, but mainly psychosocial support, the use of unsupervised hormones, and certain kinds of knowledge (non-biomedical knowledge). It also seems that care-seekers have a responsibility to prove themselves and convince the evaluators that they really need, and are sure about their decision to seek, access to gender-confirming medical procedures. In other respects, as discussed above, the participants did not feel that they could influence decisions about the care process. This might be connected to a tendency within healthcare to focus on biological and individual factors and an increasingly specialised healthcare in which a few healthcare providers are responsible for a small part of the care-seeker’s body. As such, healthcare becomes inadequate in dealing with complex phenomena and loses sight of biopsychosocial/holistic approaches in the care meetings. One way of making sense of the experiences of the participants is to understand their encounters with trans-specific care as instances when they are being subjected to a (bio)medical gaze, a gaze that separates between different responsibilities, but also separates between the person and the condition for which they are seeking care (Foucault, 1973). This might seem contradictory in relation to the discussion above, which argued that trans-specific healthcare is interested in everything from childhood to the future. But my point here is that what trans-specific healthcare takes responsibility for, and what it refuses to take responsibility for, can be connected to a centring of the evaluators’ ability to make well-informed decisions, while the care-seekers’ interests or opportunities to make well-informed decisions are not prioritised in the same way.

A trans-specific healthcare in transition – and future struggles

It is evident that trans-specific healthcare and the related legislation and diagnoses have been, and are, in a state of rapid transition. Some of the participants talked about trans-specific healthcare improving; for example, that there was now more room for action regarding gender performance. The requirement for sterilisation has been removed which means, for example, that participants’ experiences of postponing applications to the Legal Advisory Board to avoid having to be sterilised are no longer relevant results. If the SKS were
implemented in all evaluating teams, we would hopefully get a more geographically equal trans-specific healthcare and non-binary identified care-seekers would gain access to the medical procedures they need. Further changes are to be expected; in the next version of the ICD (version 11, released but not implemented), the diagnosis for trans experiences will be removed from the psychiatric chapter and added to a chapter on sexual health (World Health Organisation, 2018). The Swedish government has put forward a proposal that, if passed, will implement a separation between medical and legal gender reassignment procedures, and reduce the lower age limit for legal gender reassignment (The Swedish Ministry of Health and Social Affairs, 2018). The National Board of Health and Welfare will probably release a revised version of the guidelines for trans-specific healthcare within the next couple of years.

Many of the upcoming changes aim to depathologise trans experiences and improve self-determination in relation to legal gender reassignment. However, over the past few years, feminists and feminist organisations have protested against legal and healthcare-related changes that would facilitate easier access to gender-confirming medical procedures and legal gender reassignment, both in Sweden and in other countries, such as the UK (see, for example, Ekis Ekman, 2018; Miles, 2018). Furthermore, psychomedical researchers, including healthcare providers within trans-specific healthcare, are still searching for evidence of the trans brain, and other aetiological pathways. One of the most worrying ambitions expressed by these researchers, or presented in popular media based on their results, is to use imaging techniques to diagnose people eligible for gender-confirming medical procedures, especially young people (see, for example, Savic et al., 2010). A development in praxis along these lines would undermine care-seekers’ autonomy and self-determination.

The discourse in which gender is understood as a biological essence has quite a long historical continuity. However, something that strikes me when reading, for example, the SOU of 1968 and comparing it with contemporary research is that what was once formulated as a hypothesis or one of several explanatory models for the nature of sex/gender and trans experiences is today often proclaimed as the only possible truth/hypothesis (see also Alm, 2006). This means that the challenging of dominant understandings of trans(gender) might be more acutely needed than ever.

(Un)safe spaces, needs of belonging and health

Ahmed (2006b) argues that a queer orientation is matter of everyday negotiation and that:
This is not about romance of being off line or the joy of radical politics (though it can be), but rather the everyday work of dealing with the perception of others, with the “straightening devices” and the violence that might follow when such perceptions congeal into social forms. (p. 107).

Many of the participants’ ways of performing gender are not a conscious subversive act, but some of them, in specific contexts, lead to participants encountering different kinds of violence and straightening devices in a range of spaces. This applies both to the participants’ experiences of unsafe spaces and the experiences of inhabiting trans-specific healthcare as a space, as I have explored above. Unsafe and uncomfortable spaces contribute to ill-health in terms of being exposed to different kinds of violence, a demand to perform labour, and limited use of health-promoting spaces. Unsafety and discomfort also led to participants retiring from social spaces in order to rest and heal from previous unsafe experiences.

Although some previous queer researchers might have lost sight of the lived experiences of people with trans experiences, they are nevertheless right in stating that trans experiences challenge (even if not intentionally) several different conceptualisations of gender. Cisnormativity – the expected normative linear gender – sometimes render the participants’ way of living gender unintelligible, in specific situations, and put them at risk of harassment and violence in particular spaces such as bars, public swimming baths and cafés (see also Butler, 2009). In her autoethnographic work, Doan (2010) shows how her gender expression could be seen by others in public spaces as an offence against the others’ sense of appropriate gender behaviour. Similarly to the participants in this study, Doan (2010) testifies to being positioned as a deceiver, as someone who fools others. Among the participants, these experiences were most prevalent in bars and other spaces where people drink alcohol, but they also gave similar examples from other spaces, such as cafés. Participants described it as people losing their mental barriers when they have been drinking alcohol. Alcohol has been conceptualised as a “disinhibitor” in relation to violence (Plant et al., 2002). This does not mean that alcohol is an excuse (Plant et al., 2002); quite the opposite, but it might contribute to people expressing cisnormative or transphobic ideas and performing acts of violence that they would not otherwise express or enact (at least in public).

Other spaces that were a focus in relation to unsafety and discomfort were public toilets and changing rooms. Browne (2004) suggests that “the bathroom problem” appears because these are spaces that are often separated by presumed binary biological distinctions and are sites where bodies are (re)placed with sexed categories. Hence, gender-segregated public toilets and changing rooms reproduce the illusion of gender as a natural, biological binary. Similarly to my
participants’ experiences, access to public toilets is, according to Browne (2004) a matter of access to public spaces. Browne shows that the participants in her study had experienced verbal abuse and violence in public toilets. The participants in my study talked rather about difficulties in choosing which gender-segregated space they would go into, said that they refrained from using them or felt uncomfortable when entering them. Such experiences were connected to a perceived risk of violence, but no participant talked about experiences of physical violence or verbal abuse in gender-segregated spaces. But, regardless of getting explicit feedback on one’s presence in a public toilet or changing room, the highly gendered character of gender-segregated spaces makes it difficult to orient towards either/or, or within either/or, with an embodiment that does not conform to the linear gender. For non-binary people, it becomes almost impossible. The narratives around choosing gender-segregated space also included a kind of internalised cisnormativity; some of the participants did not know if they were eligible for access to gender-segregated spaces. Internalised cisgenderism might be damaging to the self-esteem and coping capabilities (Hendricks & Testa, 2012), and as such contribute to ill-health. It could also be seen as the participants being hyper aware of the gendered norms and potential risks of entering either space. Their limited access to gender-segregated spaces also has health consequences in terms of limiting their opportunities to work out. Working out was experienced by participants as important for one’s health and has also been shown in previous research to improve both physical and mental health (Penedo & Dahn, 2005).

Feminist, LGBTQ and trans-separatist spaces – an ambiguous inhabitancy

The debate around “safe spaces” has become polarised and the urge of people with trans experiences to develop and inhabit such spaces has been criticised in terms of only pursuing identity politics and employing narratives of individual pain (Halberstam, 2014). A detour from the linear gendered line requires a gathering of, and approaching, other objects (see Ahmed, 2006b). In the results, it is clear that approaching spaces where others also have trans experiences can contribute to feelings of safety. In these spaces, objects and others might be oriented in a similar way as yourself, which can increase the reach of the body, and the possibility to take up space (see also Ahmed, 2007). Hence, the urge to create safe spaces with others who have similar experiences is important for people with trans experience to be able to take up space with their bodies and experiences, and to feel a sense of belonging. This request for safer spaces can also be understood in relation to theories about coping and health. According to the minority stress model, developing group solidarity and cohesiveness can be important for alleviating the effects of a violent social context (Hendricks & Testa, 2012; Meyer, 2003). Party as a response to Halberstam’s critique (2014), it is
important to also see that several of the safer spaces were also political spaces and important in terms of both collective resistance, and collective resilience.

While feminist spaces were important for some participants to feel safer and to organise politically, they were also experienced as unsafe or uncomfortable. In feminist space, there might be slightly different aspects of cisnormativity and the linear gender that creates unsafety, discomfort and exclusion. Feminist spaces and struggles that centre on reproductive abilities or experiences of being raised as a girl to define their political subject render women with trans experiences unintelligible as women, and both women with trans experiences and non-binary people as inappropriate feminist subjects. This kind of exclusion can be explicit, which we have seen in several examples of media debates over the last year (see, for example, Ekis Ekman, 2018). However, the participants in this study rather talked about feminist spaces that proclaimed themselves open to people with trans experiences, but in practice, for example, lacked a trans-political agenda or where the actions in the feminist space reconstructed and centred upon the (cis)Woman; hence, a woman with universal experiences of oppression. Participants also described a kind of transmisogyny in feminist spaces; for example, how feminists without trans experiences might express transphobic ideas about who a trans woman is.

Similarly to feminist spaces, LGBTQ-centred spaces were experienced as both safer and also entailing transphobic elements. Exclusion in LGBTQ spaces could be connected to a focus and centring on non-normative sexual desires (sexuality) rather than non-normative gender identification or experiences. Hence, it might rest on a notion that sexual desire and gender are distinct phenomena (Butler, 1990; Valentine, 2003). It might also be connected to the idea that categories such as homosexual and bisexual are based on a binary construction of gender (Hines, 2007). There seemed to be slightly different experiences of queer spaces compared to other LGBTQ spaces. Queer spaces were described, by those participants who inhabited such spaces, as life-saving and important for feeling a sense of belonging. Compared to more mainstream LGBTQ spaces, perhaps queer spaces to a larger extent also encompass gender (besides sexual desire) in their critical analysis of social normativities. However, participants also talked about new bodily norms in queer spaces; for example, the skinny androgynous body getting a high-status position. It is also likely that some of the participants who did not inhabit queer spaces would not feel comfortable in such spaces, as their understanding of gender, for example, might be different from the queer understanding. Hence, this points both to the diversity within the trans community and within the LGBTQ community and the need for diverse spaces (see also Hines, 2007).
Some participants also voiced criticisms of some trans-separatist spaces, saying, for example, that such spaces contained ideas of who a real trans person is. One participant said that such rules appear because of the need “to feel safe in a group” (Alex). When many other spaces are experienced as unsafe or not comfortable, the need for trans-separatist, feminist or LGBTQ spaces to be safe or comfortable might be greater, and the expectations of such spaces might be higher. For example, there might not be the same expectations of public spaces, that they should include a trans-political agenda, compared to feminist or LGBTQ spaces. These different expectations are important to consider, but do not mean that critiques of trans, feminist or LGBTQ spaces are less important. People with trans experiences voicing critiques of feminist or LGBTQ spaces can be understood as a necessary killing of joy (Ahmed, 2010). The “killjoy” can reveal how some bodies are left behind in certain kinds of politics and can open up space for a new kind of resistance and politics (Ahmed, 2010; Cowan, 2014).

**Material conditions and health – an area in need of research**

Three of the participants were on long-term sick-leave at the time of the interview (one on short-term sick-leave). Furthermore, some of the participants described hesitancy in applying for work, saying that they were afraid of discrimination and being badly treated. Many of the participants had quite high levels of education but there were also examples of people dropping out of higher education because their meetings with trans-specific healthcare took so much energy and time and caused ill-health. These are all factors that contribute to their socioeconomic position and can be compared to the high proportion of people with trans experiences of working age in the Public Health Agency Report (2015) who had an income below poverty level.

In a study about inequalities in health between heterosexual people and non-heterosexual people that I co-authored with two colleagues, we found that the inequalities in health were explained by both degrading treatment and also material conditions and unmet care needs (Gustafsson et al., 2017). Material conditions have been partially overlooked in studies about people with trans experiences’ health (Reisner et al., 2016) and we lack studies in a Swedish context about how such factors contribute to the health disparities between people with and without trans experiences. Thus, this knowledge gap requires further exploration, and study designs that have been lacking in Sweden, a country that is often considered to be heaven for population-based and register-based research (see also SOU, 2017:92). There has been a lack of questions on self-identified gender and trans experiences in many national public health surveys (which explains the lack of population-based data). This is finally starting to change as such questions are now included in some of the Public Health Agency’s surveys and hopefully we will soon see studies exploring material conditions and
their effect on health inequalities and healthcare utilisation between people with and without trans experiences.

**Affective labour and health**

*I think of social privilege as an energy saving device: less effort is required to pass through. For other some [sic!] bodies so much more effort is required to get through, to stand up; to stay standing. (Ahmed, 2013, online)*

A recurrent theme in the participants’ narratives is the repetitive work that they undertake in order to be able to live more liveable lives. This work might have health consequences that have not previously been explored and could contribute to the high proportion of people with trans experiences reporting mental ill-health. Many of the feminist and neo-Marxist theories that deal with affective or emotional labour refer either to (1) the work that has historically been done by women but has not been paid, mainly reproductive (or unproductive) labour, as contrasted against productive (this is in itself a problematic distinction (Weeks, 2007)); (2) the increasing amount of labour that is carried out in paid work in order to change the emotions or affects of customers/clients/patients and meet (partially new) work demands (the classic example being a flight attendant) (Hochschild, 1983; Oksala, 2016; Weeks, 2007).

The labour described and explored in this study, which the participants undertake in order to negotiate access to gender-confirming medical procedures and to orient themselves in (un)safe spaces, does not fall neatly into either of these two broad and partially overlapping categories. However, I think that several parallels can be drawn between the results of this study and theories of affective/emotional labour. I also believe they can help to understand why the participants feel pressured to undertake this labour and how it affects them as subjects and their health. With that said, the concept of affective labour is not unproblematic and might, as Oksala (2016) argues, be so broad that we lose specificity in our critique of different kinds of labour if not being careful. Hence, I want to point out that the affective labour I refer to here is unwaged labour that aims to alter affects, and also an unpaid labour of caring. It is thus not a commodified or waged labour, and perhaps neither it is reproductive labour in its traditional sense (Oksala, 2016, pp. 290–291).

One of the insights from theories of affective labour that I see as useful for understanding the work that the participants do is the *intimate nature* of affective work (Hochschild, 1983; Oksala, 2016). The participants described being confronted with questions, and being questioned, in relation to their identity, their body alterations, and their motives behind seeking trans-specific healthcare.
As Ahmed (2007) argues about the stopping device, these questions request an answer, and the answers are often intimate in nature. Furthermore, the participants described experiences of having to repeatedly explain, inform and educate others about their situation and trans experiences (both inside and outside the healthcare system), having to develop arguments and get into fights to defend their identity, pronoun and presence within a space. Such experiences involve both the heavy work of handling the affects that such questioning and harassment trigger in oneself, and also work to alter the hostile affects incorporated into these violent stopping devices.

The affective labour also included putting up resistance, both in relation to trans-specific healthcare, and also in unsafe spaces. This is a labour that the discourses constraining the participants demand – e.g. a psychomedical construction of gender in trans-specific care, the linear gender in public and semi-public spaces, and the norm of a cis-woman with universal experience in feminist space. At the same time, it is a labour that the participants undertake in order to resist such norms and with hopes of changing these very same discourses (see also Butler, 2003, p. 116).

A central aspect of Hochschild’s (1983) account of emotional work is that it has transformative effects on the doer. Thus, there is a cost to doing this work: the worker becomes estranged or alienated from an aspect of the self (in this study, the self is not understood as an authentic/true self (Oksala, 2016)). Thus, it is important to consider the costs of the strategic gender performances that some participants adopted in their meetings with the evaluation team, and the preparations they made before, for example, visiting public swimming baths and gyms. Participants described one of the effects of this strategic stereotypical gender performance as that of making them fade away because you lose yourself and your own expression. Part of the labour they undertake in order to negotiate access to gender-confirming medical procedures involves such aspects as alterations in their body language, hairstyle and clothes, and for some of the participants these new gendered expressions became parts of the self (see, for example, Mark’s experiences in the results). Furthermore, although it is not explored in this study, we have to ask how the withholding of criticisms of trans-specific healthcare, in itself a kind of self-control, affects the self.

**The body going to work and health consequences**

To make it explicit, it is not only the minds of the participants that are at work here. Their affective labour is an embodied practice that involves, for example, changing how one’s body is oriented in the room, how it is sitting on the chair, changing the sound of one’s voice and covering or exposing one’s naked body in specific ways in the changing room. In relation to the cartesian split between
mind and body, where being in the mind is often considered the status position, I see these experiences as being forced to be body, to be more body, to be more in the body, than people who have cis privilege. This affective labour demands a repeated consciousness of the body, how it is moving, dwelling, and talking. Furthermore, sometimes it involves work against the body, when it is “going in the wrong direction”, when it is resisting the mind. I understand parts of this work as an expression of the self, and thus work that has intended transformative effects. But it is sometimes also bodily work that is undertaken in order to meet the imagined idea(l)s held by others of an authentic or true self, as in the meetings with the evaluation team. Both kinds of work might have health effects, but the latter is especially problematic as it may have alienating or estranging effects, such as feelings of losing oneself.

In relation to health, we have to ask what kind of consequences such a repetitive consciousness of the body can have. Some might argue that all of us are always embodied (which we are), but, as already mentioned, and as feminist research about eating disorders has shown in relation to constraining norms about the female body (see, for example, Bordo, 2004), different groups of people are differentially forced to be conscious of their body in less salutary ways. Hence, perhaps this consciousness and the work with the body could be a trigger for an unhealthy attention to the body and could be connected to the high proportion of people with trans experiences reporting a problematic relationship to food and eating (The Public Health Agency of Sweden, 2015).

The affective labour that the participants perform in terms of taking charge – sending in paperwork, calling and cajoling trans-specific healthcare and acquiring knowledge before seeking care – and seeking alternative healthcare providers, also has to be understood in relation to neoliberal shifts in healthcare. While the affective labour of care-providers has been quite widely studied and discussed in relation to the commodification of healthcare (Oksala, 2016), to the best of my knowledge, how neoliberal changes contribute to care-seekers’ affective labour has not been studied to the same extent. However, the affective labour that care-seekers do can be connected to other kinds of conceptualisations of the practices of care-seekers, such as A.E. Clarke et al.‘s (2003) description of how health has become a moral responsibility of the individual. Previous research has also shown how care-seekers in the biomedicalisation era have to be active and take responsibility for the care process (which can be signified, for example, in the increasingly often used quote “you have to be healthy to be sick”) (Nilsson, 2014). But there might be a slightly different aspect in relation to trans-specific healthcare, because the affective labour relevant in this context could be interpreted as indicative of the diagnosis, and hence that taking charge could be seen as signalling seriousness and, ultimately, a need for care.
Oksala (2016) argues that one of the shortcomings of Hardt and Negri’s account of affective labour is that it becomes so broad that there is no “outside” of capitalism. Oksala argues that such a conceptualisation obscures the fact that “we are also daily engaged in social practices and human relationships that are based on very different normativities that would make no sense if assessed strictly economically” (p. 289). Oksala mentions care and solidarity as alternative values that can be pitted against the economic rationality embedded in capitalism. In relation to the participants’ experiences of lack of knowledge among healthcare providers, psychosocial support and experiences of cisnormativity in several different spaces, they described a kind of care for each other, sharing experiences and strengthening each other in safer spaces. It can be problematic to understand such care as labour, but this caring for each other is triggered by cisnormative discourses that create unsafe spaces and a lack of knowledge and support among healthcare providers. Hence, this is a kind of work that other groups might not be forced to undertake to the same extent. Or, in other words, care work and being exposed as vulnerable subjects might have subversive effects or become positions for resistance (Butler, 2009), but they are nevertheless effects of a vulnerable, cisnormative healthcare system that fails to provide proper care for people with trans experiences.

Thus, the analysis of the participants’ narratives shows that repeatedly, in their everyday lives, they conduct a kind of affective labour. It is clear that the participants’ experiences of unsafe spaces and their encounters with the trans-specific healthcare, and thus the demand for affective labour, are connected to their perceived health, but what I want to discuss below are the biopsychosocial pathways for such health experiences. Previous research on affective and emotional labour (mainly connected to paid labour) has shown that it is related to risks of stress, burnout and physical and depressive symptoms (Mann & Cowburn, 2005; Näring et al., 2006; Schaubroeck & Jones, 2000). The labour that the participants undertake could also be understood as related to the results of studies showing that cis-women’s norepinephrine (stress hormone) levels increases or stay the same while the norepinephrine levels among cis-men decreases when coming home from paid labour (corresponding to the continued work the participating women did at home) (Lundberg & Frankenhaeuser, 1999). To have temporarily high levels of stress hormones (cortisol and epinephrine) does not pose a health problem, but repeated or continued high levels (which cause allostatic load) have been shown to be associated with several poor health outcomes, such as depression, burnout, anxiety and cardiovascular disease (Ehler et al., 2001; Juster et al., 2011; Mattei et al., 2010; Ogłodek et al., 2014). Thus, the labour that people with trans experiences are repeatedly forced to undertake might cause repeated or continually high stress responses and contribute to the ill-health within the group.
Previous research has also shown that alterations in cortisol slopes among LGB (lesbian, gay and bisexual) people mediate the relation between stressful events (what I would call homophobia) and depression (Parra et al., 2016). The violence and discourses that force the participants in this study to undertake the labour, and the labour in itself, could pose a risk of increased allostatic load and further ill-health. This is, of course, a speculative discussion; however, I think it is important to consider affective labour a potential partial pathway between cisnormative discourses and ill-health among people with trans experiences. Ahmed (2006b) argues that “[t]he work of reorientation needs to be made visible as a form of work” (p. 100). Similarly, I believe that it is important to further study the labour that people with trans experiences have to undertake to reorient after disorienting experiences in the healthcare system and in unsafe space, in order to disentangle the health of the group.

**Methodological discussion**

By interviewing people with trans experiences and analysing guidelines, I have been able to develop both a detailed and broad understanding of the complex processes of trans-specific healthcare. The combination of materials, along with different theoretical perspectives, has made it possible to capture a range of experiences and different perspectives and has allowed an analysis of not only the different governing techniques and rationalities in trans-specific healthcare, but also how such governing is experienced and embodied. By also including experiences of spaces outside trans-specific healthcare, I have been able to explore, for example, how affective labour is conducted in several different arenas in the lives of the participants and how this can affect their health.

I hope that some of the methodological considerations have already been visible throughout the text; however, some specific limitations of the study are worth discussing a bit more in depth. I was not able to recruit any participants of colour or other people who have experiences of racism for this study, which is a clear limitation. During the second round of advertising, I explicitly searched for people who had experiences of racism, but no one with such experiences contacted me. There could be several reasons for this: that I do not have such experiences so individuals who do are not comfortable contacting me or do not feel attracted to participate. It could also be connected to the fact that the dominant and visible part of the community of people with trans experiences in Sweden is a very white community and people of colour are more marginalised within the community and were not reached by my ads. Still, this is a clear disadvantage of the study and means that I cannot draw conclusions about whether, and if so how, people of colour might have different experiences of access to trans-specific healthcare (see also Bremer, 2010). I have, however, been able to discuss access to trans-specific healthcare for asylum-seekers and
undocumented migrants, based on my analysis of SKS. With regard to (un)safe spaces, it is likely that experiences of unsafety connected to cisnormativity intersect with racist discourses and construct different experiences compared to those of white people. Unfortunately, I cannot draw such conclusions based on this material and this shortcoming needs to be addressed in future studies.

Another limitation is that none of the non-binary participants had undergone gender-confirming medical procedures and only one of them had sought trans-specific healthcare. While I do think the representation of non-binary participants is unusually high in this study, the possibility to say something about their experiences of trans-specific healthcare is limited. Neither have I been able to distinguish whether there are more extensive stereotypical expectations of women who meet trans-specific healthcare than of the men. This is partly connected to the study design; i.e., potential differences in experiences or narratives between participating men and women is difficult to consider as group differences instead of individual differences. Hence, these kinds of issues are probably better captured in quantitative research, or possibly focus group discussions.

This study is conducted in a Swedish context and thus the transferability to other contexts needs to be discussed. Healthcare practices in the biomedicalisation era are increasingly internationalised through, for example, international diagnostic manuals, international healthcare guidelines, and exchanges of information online between both care-providers and care-seekers, facilitated by technical developments (see, for example, A.E. Clarke et al., 2003). Furthermore, topic-specific conferences, can contribute to the alignment of care practices and discourses. By comparing and referring to research from other contexts, I also hope to have shown that similar care practices and discourses exist in other contexts. In light of these internationalised practices, I think that many of the results about trans-specific healthcare can also be relevant to other contexts. However, there are of course differences between healthcare systems and legislation that create specific experiences within Swedish trans-specific healthcare and, while the SKS is influenced by international guidelines (SOC), it is also different in some respects; for example, with regard to RLE and the need for mental health evaluation. However, I hope that I have been transparent enough in my description of the study context, the material and the study process that it is possible for others to determine the transferability and applicability.
Conclusions and implications

This study shows that, over the last few years, trans-specific healthcare has developed in a promising way; the requirement for sterilisation has been removed and it is slowly opening up for non-binary people to have access to gender-confirming medical procedures. However, trans-specific healthcare still reconstructs gender as stable and binary, and ties gender identity closely to particular or stereotypical gendered performances. In the process of negotiating access to gender-confirming medical procedures, the gender of care-seekers is straightened according to this psychomedical construction, sometimes in ways that do not conform to the participants’ experiences of their gendered self. Access to gender-confirming medical procedures are important for some people with trans experiences, but navigating and negotiating access to such procedures can in itself have negative health consequences. The gate-keeping role of the evaluators persists and is unproductive in terms of creating a trusting healthcare meeting and can also hinder people with trans experiences from gaining access to appropriate mental healthcare. Mental health is not only evaluated but also privileged in the evaluation. The emphasis on psychiatric knowledge, suffering and gate-keeping by mental health professionals risks reconstructing trans experiences among those who seek trans-specific care as a psychiatric issue. People without a residence permit who have not started on hormones before arriving to Sweden seem not to have access to gender-confirming medical procedures at all.

The participants encountered cisnormativity both inside and outside trans-specific healthcare. Several everyday life spaces were described as unsafe or uncomfortable, which contributes to ill-health and a limited living space. People with trans experiences have restricted access to spaces that work in health-promoting ways, such as gyms, public swimming baths and social spaces. Safer spaces, such as activist and community spaces, are important to feel a sense of belonging, to share experiences, organise politically, and improve health. Unsafety in a range of spaces and the psychomedical understanding of gender and trans experiences contribute to the participants having to undertake affective labour in order to negotiate access to gender-confirming medical procedures and to more comfortably navigate everyday spaces. This affective labour that the participants undertake to live more livable lives might help to explain part of the mental health gap between people with and without trans experiences.

Although several changes have been made in trans-specific healthcare over the last couple of years, further changes are urgently needed to meet the needs of care-seekers and to provide a good quality of care that is equal for all regardless of gender identity and expression, mental health status, class, residence permit
or geographic location. While LGBTQ issues are often addressed in terms of care-provider/care-seeker interaction [Sw: bemötande] and lack of knowledge, this study shows that the barriers to access in trans-specific healthcare are also a matter of inescapable power relations and lack of resources (revealed in experiences of waiting and lack of support or follow-up). It is thus important that access is improved in terms of such aspects as decreased waiting times, increased access to support and better education of healthcare providers, but also that structural changes are made in the healthcare system to counterbalance the relationship of dependency between care-seekers and care-providers. More specifically, this study demonstrates that the road to access to gender-confirming medical procedures needs to be more affirming and centred around the needs of care-seekers.

In order to develop in an affirming and self-determining direction, trans-specific healthcare needs a new model for assessing “need”. The meaning and understanding of the diagnostic process and the gate-keeping model need to be challenged, especially the idea of an expert profession conducting an objective assessment of the need for gender-confirming medical procedures. Instead, the diagnostic process has to be understood as a negotiation of power and space for action influenced by social normativities. Such an awareness among the actors involved might facilitate a critical relation to the diagnostic process. A separation between medical and legal gender confirmation could be one step in the right direction and could facilitate a better healthcare-provider/care-seeker relationship. Together with a move away from the gate-keeping model, this could also improve access to mental healthcare for people with trans experiences. Relabelling the diagnosis, or moving it to another chapter in the diagnostic tools, might have discursive/symbolic effects. However, if the regulatory power over access to gender-confirming medical procedures remains allocated to professionals with psychiatric knowledge, such changes will probably have limited lived effects. Hence, in a Swedish context, it might be at least as important to change the location of the care practice and the decision-making. This could mean, for example, that endocrinologists become responsible for assessing the need for hormones.

Answering a question about how trans-specific healthcare could be improved, Alice said: “More grassroots bureaucracy, that they [the care-providers] really are in contact with us, that they don’t sit in an office far away and don’t know who we are or what we’re doing.” Hence, the work to change trans-specific healthcare practice needs to include care-seekers. In order to implement these aforementioned suggestions, trans-specific healthcare needs more resources, which is also important for meeting the needs of the increasing number of care-seekers. There is a lack of knowledge about trans issues in other parts of the healthcare system, and interventions such as LGBTQ certification might be
insufficient to address these on a broad scale, and might have stratified effects in terms of geographical and socioeconomic factors. Hence, knowledge about trans experiences and basic medical issues connected to gender-confirming medical procedures needs to be an obligatory part of the training of care-providers. Non-binary public changing rooms and toilets is an obvious improvement that can improve access to several health-promoting spaces for people with trans experiences. The creation of diverse community spaces needs to be facilitated so that it is possible for people with trans experiences to share experiences and feel a sense of belonging. The creation of these spaces needs to include people with trans experiences, as this seems important for feelings of safety.

While I have tried to be as concrete as possible about the implications above, the issues explored in this study cannot be fully remedied by legal and policy changes because many of the issues are closely connected to normative societal constructions of trans experiences and gender – cisnormativity. To remedy the violent elements and effects of cisnormativity, both inside and outside trans-specific healthcare, there is a need to challenge dominant understandings of gender and trans experiences. Understanding discourses as never finally fixed opens up the possibility for a rearticulation of meaning and for new meanings to be created. These kinds of discursive struggles are, of course, already ongoing and social changes will not be achieved overnight. However, this study, together with similar critical and trans-affirming studies, can serve as a basis for revealing taken-for-granted assumptions regarding trans experiences, gender and trans-specific healthcare practices and to imagining alternatives.

Future research
Although the number of studies researching trans experiences has rapidly increased over the last couple of years, many aspects still require further research. Below, I have listed a few of the most important areas in need of future studies:

- The causes of, and need for, affective labour and how it is connected to health among people with trans experiences.
- How racism intersects with cisnormative discourses and how this affects the experiences of people racialised as non-white of trans-specific healthcare and (un)safety.
- People with non-binary trans experience’s access to and experiences of trans-specific healthcare.
- Critical analyses of contemporary psychomedical research into the aetiology of trans experiences and its effects on clinical practice.
- How class and other material aspects affect the health gap between people with and without trans experiences.
• People with trans experiences’ access to and experiences of other (not trans-specific) parts of the healthcare system, especially mental healthcare.
• Critical research looking into “comorbidity” and how it reconstructs both neuro/psychiatric normativity and (trans)gender.
• Children and young people’s experiences of, and access to, trans-specific healthcare.

Epilogue

More than five years have passed since this project started. Some say that we have had a trans revolution since then (Magnusson, 2014). In May 2014, the highly reputed Time magazine published an issue called the “The Transgender Tipping Point” (Steinmetz, 2014). How this period of time will be understood in the future is hard to say, but I doubt it will be seen as a revolution, despite that several important changes have been accomplished. In fact, some of these years may even be understood as a time of backlash due to attacks on trans rights and inclusion came from both the far right and trans-exclusive feminists.

While the visibility of trans issues and the legal status of people with trans experiences have clearly improved in some contexts, including Sweden, we also have to ask what kind of real, lived differences this makes for people in their everyday lives. I do not want to trivialise the importance of representation, being acknowledged by the state or of having (successful) role models; these things certainly matter to a lot of people. But we have to ask for whom these changes matter more and whether some of these changes might actually have some negative side-effects as they may overshadow some social/material inequalities and the need for other kinds of action (see also Spade, 2011).

It is also important to remember that, while things have developed in affirming and self-determining directions, these changes have not come about by chance or due to top-down decision-making. Almost every achievement has been preceded by trans activists and organisations’ persistent efforts and frequently legal cases have been preceding legal changes (Alm, 2018). These struggles need to be acknowledged, and my hope for future social changes lie in similar struggles.
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References


Halberstam, J. (2014, July 5). *You are triggering me! The neo-liberal rhetoric of harm, danger and trauma*. Retrieved from: [https://bullybloggers.wordpress.com/2014/07/05/you-are-triggering-me-the-neoliberal-rhetoric-of-harm-danger-and-trauma/](https://bullybloggers.wordpress.com/2014/07/05/you-are-triggering-me-the-neoliberal-rhetoric-of-harm-danger-and-trauma/)


SFS. (1972:119). *Lagen om fastställande av kön i vissa fall* [The law on determination of sex in some cases.]. Stockholm: Justitiedepartementet.


Vilhelmsson, A. (2014). Psykisk ohälsa, folkhälsa och medikalisering: Har det egentligen någon betydelse vilket hälsobegrepp som används? [Mental illness, public health and medicalisation: Does it matter which health concept that is used?]. *Socialmedicinsk Tidskrift*, 91, 63–73.


Appendix 1. Biographies of the participants

The following participants are included in Sub-studies 1 and 3:

**Alex** is 20–25 years old. He has no partner, lives in a big city and is studying at university. He has tried to gain access to gender-confirming medical procedures.

**Alice** is 25–30 years old. She has no partner, lives in a medium-sized city and is studying at university. She has had gender-confirming medical procedures.

**Anna** is 25–30 years old. She lives with her partner in a medium-sized city and works in the public sector. She has had gender-confirming medical procedures.

**Annika** is 25–30 years old. She has no partner, lives in a small city, is on sick leave and is unemployed. She has had gender-confirming medical procedures.

**Elias** is 30–35 years old. He is married, lives in a big city and works in the public sector. He has had gender-confirming medical procedures.

**Elsa** is 65–70 years old. She has no partner, lives in a medium-sized city and is retired. She has had gender-confirming medical procedures.

**Johanna** is 25–30 years old. She has no partner, lives in a small city and works in the private sector. She has had gender-confirming medical procedures.

**Leon** is 30–35 years old. He is engaged, lives in a big city and works in the private sector. He has had gender-confirming medical procedures.

**Lo** is 25–30 years old. They have no partner, lives in a big city and is on long-term sick leave. They have considered, but not yet had, gender-confirming medical procedures.

**Louise** is 35–40 years old. She has no partner, lives in a medium-sized city and works in the public sector. She has had gender-confirming medical procedures.

**Eli** is 25–30 years old. They have no partner, lives in a big city and is on sick-leave. They have considered, but not yet had, gender-confirming medical procedures. (Eli has the pseudonym Love in the appendix of Paper II).

**Mark** is 20–25 years old. He has no partner, lives in a medium-sized city and is studying at university. He has had gender-confirming medical procedures.

**Mio** is 35–40 years old. They have a partner, lives in a big city and works in the public sector. They have considered, but not yet had, gender-confirming medical procedures.

**Mona** is 55–60 years old. She is married, lives in a big city and works in the private sector. She has had gender-confirming medical procedures.
The following participants are included in Sub-study 3:

**Elliot** is 30–35 years old. He has a partner, lives in a medium-sized city and works in the public sector. He has had gender-confirming medical procedures.

**Jens** is 25–30 years old. He has a partner, lives in a medium-sized city and works in the private sector but at the time of the interview was on sick-leave. He has had gender-confirming medical procedures.

**Mika** is 25–30 years old. They has no permanent partner, lives in a small town, and is temporarily employed in the public sector. They has considered, but not had, gender-confirming medical procedures.

**Robin** is under 20 years old. They has no partner, lives in a medium-sized city and is currently unemployed. They has had contact with trans-specific healthcare but has not had any gender-confirming medical procedures.
Appendix 2: Diagnostic categories

ICD-10 (World Health Organisation, 1992)

F64.0 Transsexualism:
Description: A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one’s anatomic sex, and a wish to have surgery and hormonal treatment to make one’s body as congruent as possible with one’s preferred sex.
Diagnostic guidelines: For this diagnosis to be made, the transsexual identity should have been present persistently for at least 2 years, and must not be a symptom of another mental disorder, such as schizophrenia, or associated with any intersex, genetic or sex chromosome abnormality

F64.8 Other gender identity disorders (no description)
F64.9 Gender identity disorder, unspecified (no description)

DSM IV-TR (American Psychiatric Association, 1994 and revised 2010)

302.85 Gender identity disorder:
Criteria: A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:
1. repeatedly stated desire to be, or insistence that he or she is, the other sex
2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4. intense desire to participate in the stereotypical games and pastimes of the other sex
5. strong preference for playmates of the other sex
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
C. The disturbance is not concurrent with a physical intersex condition.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM V (American Psychiatric Association, 2013)

302.85 Gender dysphoria
Criteria: A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration, as manifested by at least two of the following:
1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender).
B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning
Appendix 3. Advertising material

Forskningsdeltagare sökes till intervjustudie

[Rekrytering 1:] Identifierar du dig som trans*, transgender, transsexxuell, intergender, genderqueer, bigender, non-gender eller någon annan transidentitet? Vi söker nu dig som skulle vilja delta i en intervjustudie om vilka erfarenheter personer som identifierar sig som trans har av hälsa, ohälsa och vården i relation till normer kring kropp, kön och genus. Vi söker personer som bor över hela Sverige.

[Rekrytering 2:] Har du transerfarenheter eller identifierar du dig som trans*, transgender, transsexxuell, intergender, genderqueer, bigender, non-gender eller någon annan transidentitet? Vi söker nu dig som skulle vilja delta i en intervjustudie om erfarenheter av hälsa och ohälsa, särskilt i relation till upplevelser av trygghet och otrygghet i olika typer av sammanhang och platser. Vi är särskilt intresserade av dig som också har erfarenheter av rasism eftersom majoriteten av våra tidigare deltagare saknade sådana erfarenheter, men vi söker även personer som saknar sådana erfarenheter. Vi söker personer som bor över hela Sverige.

[Gemensamt för båda:] För att kunna delta i studien ska du:
- Var minst 18 år
- Tala och förstå svenska

Jag som genomför studien heter Ida Linander och är läkare och doktorand i folkhälsa vid Umeå Universitet. Studien där intervjuerna ingår i heter "Kön, genus och hälsa - en intervjustudie med transpersoner och personer födda med atypisk könsutveckling" och är godkänd av etikprövningsnämnden i Umeå.

Är du intresserad av att delta och vill få mer information om studien? Kontakta Ida Linander på ida.linander@umu.se eller på telefon: 0736-98 64 83.

Om du hör av dig så binder det dig inte på något sätt att delta i studien, deltagandet är helt frivilligt. Om du beslutar att delta och sedan ångrar dig, kan du när som helst, och utan orsak, avbryta ditt deltagande. Forskningshuvudman är Umeå Universitet och förutom Ida Linander ingår också Anne Hammarström, Erika Alm och Lisa Harryson i forskargruppen.
Appendix 4: Summary of interview guide

Themes 1–3 were discussed in relation to health, e.g.: “How did that make you feel?” Follow-up questions not mentioned here were used to further explore emerging themes and topics.

General information about the participant:
- Pronoun?
- How do you define your gender identity? Trans identity?
- Age?
- Education?
- Current occupation [Sw: sysselsättning]? Previous occupation?
- Partner(s)? Children?
- Gender-confirming medical procedures? When?
- How long have you been open about your trans experiences?

Opening questions: What do you think of when I say trans and healthcare, based on your own experiences? What do you think of when I say trans and health, based on your own experiences?

Theme 1: Experiences of encountering healthcare:
- What kind of experiences do you have of meeting healthcare?
  - Trans-specific? Other parts of healthcare?

Examples of questions regarding trans-specific healthcare, used depending on the answer to the previous question:

- Why have you not sought trans-specific healthcare?
- What did you do to access trans-specific healthcare? How did you experience your meeting with healthcare on the way to the evaluation?
- How did you experience your meeting with the evaluation team?
- What are the pros and cons of how trans-specific healthcare works?
- Do you have any suggestions for improvements? Have you given any feedback to trans-specific healthcare?
- How does gender become important in the evaluation? (E.g. is it important how you express femininity or masculinity? How is that expressed?)
- Have you gone through RLE? How did you experience that?
- What do you think about passing? Is it different within and outside the evaluation?
- How do you experience the fact that the evaluation is within psychiatry?
- How have you experienced the gender-confirming medical procedures you have received? Has the access been conditional in any way?
- Have you been self-medicating? If so, how, when, why? Did you tell the evaluation? What happened then?
- Was your sexuality discussed during the evaluation? If so, how?
Other parts of healthcare:

- Have you sought care for other reasons? How did you experience those encounters?
- Was there any lack of knowledge?
- Have you postponed or refrained from seeking care? If so, why?
- Do you experience that you can give feedback if there is something you are unhappy with?

**Theme 2: All themes are discussed in relation to health, but here more specifically about health.**

- What kind of situations/factors/places have you experienced that have improved your health?
  - (For interviews 15-18 also: Are there any spaces that you feel safe in? Why? How does that make you feel?)
- What kind of situations/factors/places have you experienced that have impaired your health?
  - (For interviews 15-18 also: Are there any spaces that you feel unsafe or uncomfortable in? Why? How does that make you feel?)
- A specific factor mentioned before is the opportunity to participate in physical activity. How has that been for you?
- Have you been organised in any way socially or politically in relation to trans issues?
- How do you experience that your trans experiences have affected your close relationships?

**Theme 3: Experiences in society: experiences of discrimination, stigmatisation or violence.**

- How was it to come out/tell others about your trans identity/trans experiences?
- Do you have any experiences of discrimination, violence, harassment? If so, where, when, how? How did that make you feel?

Final question: Is there anything you would like to add?

Recording stopped. How did you experience the interview?