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Gender Affirmative Monopoly: Who is "Trans* Enough" to Receive Gender Affirmative Treatment In Norway?

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GENDER AFFIRMATIVE MONOPOLY: WHO IS “TRANS*
ENOUGH” TO RECEIVE GENDER AFFIRMATIVE
TREATMENT IN NORWAY?

by

EMILIE KRISTINE KRUMSVIK

A master’s thesis submitted to the Graduate Faculty in Liberal Studies in partial fulfillment of
the requirements for the degree of Master of Arts, The City University of New York

2019

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Affirmative Treatment in Norway?

by

Emilie Kristine Krumsvik

This manuscript has been read and accepted for the Graduate Faculty in Women’s and Gender
Studies in satisfaction of the thesis requirement for the degree of Master of Arts.

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ABSTRACT

Gender Affirmative Monopoly: Who is “Trans* Enough to Receive Gender Affirmative Treatment in Norway?

by

Emilie Kristine Krumsvik

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This thesis elaborates on the current practice and monopoly of the National Treatment Center for Transsexualism, which covers gender affirmative treatment through universal health care in Norway. This thesis examines this topic in the context of a broader debate regarding trans* people’s rights in Norway. This debate, which took place in multiple national newspapers, was incited by the decision of the Norwegian government to change the law regarding an individual’s right to change their legal gender in 2016. The debate was held between two main participants; The first group composed of critical voices who do not consider being trans* a real experience and the second group made up of trans* activists who defend the legitimacy of trans* experiences.

Elaborating on this debate in Norway, this thesis aims to answer the question of who should truly be acknowledged as experts on trans* issues. It argues, along with trans* activists, that the complex nature of gender identity renders “expert” perspectives that understand trans* people only through pathology an insufficient view. It is impossible to have complex conversations about trans* rights, treatment and experience in a pathologized framework as this approach is unable to account for the complexity of these conversations and leads to false conclusions. Intervening on this debate is an urgent project as conversations that primarily view trans* as a disorder in need of cure contribute to the persistent lack of recognition trans* persons experience and, furthermore, undermine the agency of the group the conversation set out to help in the first place. Therefore, it argues, a shift of focus is desperately needed, because, intent aside, the consequences of the debate are being suffered by trans* people in Norway.

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CHAPTER 1: INTRODUCTION

Indeed, the problem with Rikshospitalet is that they are looking for patients to fit their diagnoses, and not looking for diagnoses that fits their patients.

- Dakota Zaraki (own translation)

In 2014, Amnesty International published a report regarding trans* persons rights in Europe. The report uncovered that in over 20 European countries, trans* people are systematically discriminated against by the state: "...Transgender people can obtain legal gender recognition only if they are diagnosed with a mental disorder, agree to undergo medical procedures such as hormones and surgeries..."¹ The report was entitled: "The State Decides Who I Am: Lack of legal recognition for transgender people in Europe,"² and Norway was no exception. As a result of this report, the Norwegian government, represented by health minister Bent Høie, altered the law in July 2016 making it possible to change one's legal gender and making transition more accessible. Bent Høie stated: "In fact, you know who you are. It should be up to the individual, not the state, to decide which gender you belong to."³ Before this law change, trans* persons who wanted to change their legal gender needed a diagnosis of gender dysphoria.⁴ Additionally, one had to be "irreversibly sterilized" (the individual's uterus and ovaries, or testicles, had to be removed) at the National Treatment Center for Transsexualism (NBTS), located at the National Hospital in Oslo

¹ Amnesty International, "The State Decides Who I Am: Lack of Legal Gender Recognition for Transgender People in Europe," 2014, 7.

² Amnesty International, "The State Decides Who I Am: Lack of Legal Gender Recognition for Transgender People in Europe."

³ Anne Wæhre and Kim Alexander Tønseth, "Vi har fått en eksplosiv økning i antall tenåringsjenter som ønsker å skifte kjønn.," *Aftenposten*, March 21, 2018, <https://www.aftenposten.no/article/ap-BJvg49.html>.

⁴ The diagnoses in Norway follows the World health organizations (WHO) classifications over diseases, International Classification of Diseases (ICD). The WHO classification of gender dysphoria has the code ICD-10 The Norwegian edition is administrated through helsedirektorate and have the code F64.0.

(Rikshospitalet, OUS), before one could legally change gender.

Before the law alteration was passed, the Norwegian Directorate of Health assembled an expert group with the purpose of evaluating the conditions for changing legal gender status in Norway: the expert group would also assess the need for changes in treatment services available for trans* people in Norway. The expert group presented a report with recommendations for the conditions and requirements for changing one's legal gender status, and these recommendations were put in place by the government in 2016. However, the recommended changes regarding the accessibility for gender affirmative treatment were not implemented, even though the report advised comprehensive changes. The report delivered by Amnesty also critiques the monopoly that NBTS' holds on gender affirmative care, since it only provides a very small, specific group with gender affirmative treatment. This thesis elaborates on the current practice and monopoly of one institution, NBTS, which covers gender affirmative treatment through universal health care. This thesis will discuss this inside a broader debate regarding trans* people's rights in Norway which took place in multiple national newspapers.

The Norwegian law change started a public debate, mostly conducted in national newspapers online, which focused mainly on trans* women in women designated public spaces – bathrooms and locker rooms. It later shifted into a discussion regarding trans* men, rejection from treatment at NBTS and concern about self-surgery. This further led to a greater discussion on determining who are the experts on trans* issues and therefore be a provider of healthcare, such as gender affirmative treatment. The debate was extremely heated and many different individuals, both trans* activists and critical voices, participated. The contributors varied from doctors, sexologist, self-proclaimed feminist, parents of trans* people, NBTS, members of the appointed expert group, and trans* people. It is indeed a controversy that NBTS, who holds the national monopoly on gender affirmative treatment covered by universal health care, participated in the debate in the manner they did. This

thesis presents and elaborate on new articles published regarding the issues and most importantly elaborates on the motivating opinions that drives these debates. The debate is truly complex and includes important issues such as trans* peoples experiences of discrimination and recognition. Even though there are many different participants in the debate, their views can be divided into two groups: The ones who do not consider being trans* as a real experience through a medical diagnosis perspective, the critical voices. In contrast to the ones who consider being trans* as a real experience, the trans* activists.

In this thesis, I elaborate on the full debate in Norway, trying to answer the question of who truly should be the acknowledged experts regarding trans* issues. The answer is complicated, due to the complex nature of gender identity and what is recognized as legitimate experiences. I present and elaborate on the reactions and opinions presented by the critical side of the debate and show how their underlying notion of trans* is, in fact, that the critical voices believe it is a mental disorder. Rhetorical use is of importance to understand the underlying fears and opinions fronted by the critical voices, and how there is an underlying notion of transphobia⁵ in the Norwegian society. This transphobia dictates the conclusions reached by the critical voices and creates a framework unable to discuss and comprehend the complexity of the conversation they started. The debate also shows a lack of recognition that when they discuss issues regarding trans* experience, the critical voices are discussing the experience individuals have had and their lives. Being trans* has been treated as a phenomenon rather than the lived reality of Norwegian citizens, which again shows the level of stress and discrimination trans* people in Norway face every day.

After presenting the critical voices I analyze their arguments, which proves the underlying transphobic notions and highlights which worries are legitimate and which are not. I then use trans*

⁵ Irrational fear of, aversion to, or discrimination against transgender people.

studies and academic discussions to underline that some of the arguments and worries fronted by the critical voices are being discussed in pro-trans* circles as well. I bring the two voices into a debate with each other in a way they have not been. Additionally, both sides often refer to international guidelines while arguing their point, and I, therefore, present some of the international guidelines and compare these to the arguments provided by both sides. The critical voices often argue that lack of research makes it difficult to provide treatment for trans* people. In this thesis I also present and prove that the research in question has in fact been made. Finally, I compare the arguments made in the Norwegian debate with the international guidelines to clarify who should be considered the experts, why and if there is common ground to be found.

TERMINOLOGY

As Jack Halberstam explains in his book *Trans*: A Quick and Quirky Account of Gender Variability*: naming is powerful in nature and that having a name for oneself can be just as damaging as not having one. Therefore, will I not provide a definition of being trans*. In this thesis I use Halberstam's term Trans*: "...specifically because it holds open the meaning of the term 'trans' and refuses to deliver certainty through the act of naming."⁶ I do this most centrally because the danger of naming and diagnosis is one of main motivation for this thesis, but also because, as a non-trans* person myself, I will not contribute to the trend of limiting gender expression by defining trans* experiences through binaries. To highlight the rhetoric of the NBTS and Trans Exclusionary Radical Feminists (TERF)⁷ authors who mis-gender trans* experience by referring to them with the incorrect gender, I use quotation marks to avoid contributing to mis-gendering. The public debate involves

⁶ Jack Halberstam, *Trans*: A Quick and Quirky Account of Gender Variability*, 2018, 3, <http://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=1579466>.

⁷ "Urban Dictionary: TERF," Urban Dictionary, accessed March 6, 2019, <https://www.urbandictionary.com/define.php?term=TERF>. feminists that claim that trans women are not really women, as biological determinism is only a fallacy when it used against them, not when they use it against others

multiple participants and can mainly be divided into two groups: The critical voices: TERF's, NBTS and The Scandinavian Parent Network, and trans* activists: Doctors, sexologists, trans* people and activists. When I refer to arguments, I will use these collective terms.

BACKGROUND:

AMNESTY REPORT: THE STATE DECIDES WHO I AM

In 2014, Amnesty International⁸ published a report regarding trans* persons conditions in Europe, in which over 20 countries were investigated. The report was called: "The State Decides Who I Am: Lack of Recognition for Transgender people in Norway" and stated that: "In many countries, even though those with a reputation for championing equality and human rights such as Belgium, Denmark and Norway, as well as about 20 other countries in Europe, transgender people have to undergo surgeries to remove their reproductive organs, resulting in irreversible sterilization"⁹. The report highlights how the procedure for altering an individual's legal gender violates basic human rights in seven European countries, including Norway.

Amnesty concluded their chapter on Norway arguing that: "Norway violates the rights of transgender people to attain the highest standard of health and to be free from inhuman, cruel and degrading treatments by requiring them to undergo unnecessary medical treatments, including removal of their reproductive organs, in order to obtain legal recognition of their gender."¹⁰ Further, the report states that there is a broad agreement between trans*- and other civil rights organizations that the current law on legal gender recognition needs to be reformed; the has tasked the Director of

⁸ Amnesty international is a global movement that has over 7 million supporters, members and activist in over 150 countries and territories who campaign to end grave abuse of human rights. They are independent for any governments, political ideology, economic interest or religion and are funded mainly by their members and public donations.

⁹ Amnesty International, "The State Decides Who I Am: Lack of Legal Gender Recognition for Transgender People in Europe."

¹⁰ Amnesty International, 77.

Health with putting forward a proposal on access to health care and legal gender recognition for transgender individuals.¹¹ The Ministry of Health and Care Services also tasked the Directorate of Health to appoint an interdisciplinary expert group to review the practice of legal gender recognition, and develop recommendations for what the new practices should look like within a year from its appointment. The appointed expert groups were also tasked with assembling a complaint mechanism for trans* persons who are denied health care services from the NBTS.

APPOINTED EXPERT GROUP: THE RIGHT TO THE RIGHT GENDER

The expert group was appointed by the Norwegian Directorate of Health in December 2013, even before the final Amnesty report was published, to review the conditions of changing legal gender status in Norway. The expert group was also going to evaluate the need for treatment services for individuals who experience gender dysphoria and propose appropriate changes to the current system. The Norwegian government decided in 2014, after pressure from Amnesty International and multiple transgender and social justice organizations, to change the law regarding legally changing one's gender on the base of the non-statutory requirements of castration.¹² The expert group recommended that the right to the recognition of one's legal gender must be separate from forms of medical treatment and invasive surgeries, such as castration and permanent sterilization.¹³ The expert group also presented their recommendations for the best practices of changing one's legal gender.

Most of the report is dedicated to the current practice of gender affirmative treatment and to ensure that a wider group of trans* persons and non-gender confirmative persons get access to health

¹¹ Amnesty International, 77.

¹² "Retten til rett kjønn - Helse til alle kjønn" (Oslo: Helsedirektoratet, April 2015), 1, https://www.regjeringen.no/contentassets/d3a092a312624f8e88e63120bf886e1a/rapport_juridisk_kjonn_100415.pdf.

¹³ Mari Lilleslåtten, "The Rocky Road to Sex Change Treatment in Norway," Kilden, February 7, 2018, <http://kjonnsforskning.no/en/2018/07/the-rocky-road-to-sex-change-treatment-in-norway>.

care provided by universal health care.¹⁴ In their report, the expert group state that many receive the medical assistance they require, but there are also a number of trans* persons who fall outside the current health care systems requirements to qualify for their desired medical assistance: “The expert group recommend that a greater number than those who are currently offered treatment in the health service are offered treatment and follow-up in connection with distress and discomfort relating to gender incongruence.”¹⁵ Hence, it recommend extended services for people who experience gender dysphoria and gender incongruence. The expert group explain that the number of people who require medical assistance for gender dysphoria and gender incongruence is and will remain at a low level. It is, therefore, not realistic that patients will meet specialist at every level of the health care system nationally. Still, the expert group recommends that health personnel must be provided with sufficient knowledge and information to meet patients in a sufficient manner.

SERVICES OFFERED BY SPECIALIST HEALTH SERVICES: NBTS

In the cases when the expert group did not reach consensus, they divided into groups referred to as a minority and a majority. There is no information regarding the division of the expert group. In the recommendation for services offered to adults, the expert group was divided into one majority and two minority recommendations. The majority recommended an expansion of the medical services which offer treatment to adults who experience gender dysphoria to ensure service to groups who are not currently offered treatment. If the need of the patient can only be met by highly-specialized expertise, they are to be referred to the NBTS at OUS.¹⁶ The minority recommends that only the medical assistance be offered at the NBTS and that should strengthened: “The minority is of the view that the majority’s recommendation could have serious consequences for the continued

¹⁴ “Retten til rett kjønn - Helse til alle kjønn.”

¹⁵ “Retten til rett kjønn - Helse til alle kjønn,” 175.

¹⁶ “Retten til rett kjønn - Helse til alle kjønn,” 176–77.

operation of NBTS.”¹⁷

In the recommendation for treatment of children and adolescents, the expert group was divided into a majority and a minority recommendation. The majority recommended the need for treatment for children and adolescents at special health level, that the main rule should be that treatment is in the domain of the regional healthcare system. Children and adolescents should only be referred to the NBTS when there is need for high-level expertise.¹⁸ The minority opinion expressed a fear that the recommendation of the majority would result in the discontinuation of the present national treatment service for children and adolescents with gender dysphoria as the NBTS is the only place in Norway with multi-disciplinary specialized expertise. Therefore, children and adolescents should always be referred to the NBTS.¹⁹

NATIONAL GUIDELINES:

The expert group concluded that: “The lack of clear, transparent and professional reasons for identifying who is considered to benefit from gender confirming medical assistance may have contributed to people who experience gender dysphoria not to seek medical assistance or some people receiving more treatment than they in fact required.”²⁰ The work of the expert group highlighted the need for national guidelines regarding medical assistance for people who experience gender dysphoria.

THE NATIONAL HOSPITAL: NBTS

NBTS is located at OUS and is currently the only treatment facility that has patients who experience gender dysphoria as their main responsibility. NBTS offers diagnosis and treatment for

¹⁷ “Retten til rett kjønn - Helse til alle kjønn,” 176.

¹⁸ “Retten til rett kjønn - Helse til alle kjønn,” 176.

¹⁹ “Retten til rett kjønn - Helse til alle kjønn,” 177.

²⁰ “Retten til rett kjønn - Helse til alle kjønn,” 178.

the diagnosis of transsexualism – F64.0.²¹ For patients over 18, the treatment requirements provided by the NBTS states that: “If transsexualism is suspected, your local doctor should refer you to your local District Psychiatric Outpatient Clinic (DPS).”²² After a psychiatric investigation is conducted, the patient is referred to NBTS at Oslo University Hospital. When the patient arrives at NBTS the patient goes through several interviews and meets with several therapist whom are part of the investigation team. One of the leaders at NBTS stated in an interview that before any treatment starts, trans* people must go through a comprehensive examination that normally takes about two years in collaboration with psychiatrists and psychologists. The argumentation is that this is done to make sure the patient has a permanent conviction of being the opposite sex and the patient does not have too many other psychiatric disorders: “Some surgery needs a lot of after-treatment. If one cannot deal with instructions after surgery, then it does not work.”²³ If the patient fulfills the requirements to be diagnosed with transsexualism F.64.0, and shows stable mental, physical and social health, they are recommended for endocrinological assessment.²⁴ If the patient fulfills the criteria they are offered hormone treatment, where specialists in hormones and hormone therapy (endocrinologist) elaborates the expected effects of treatment with the patient. “Both favorable and unfavorable effects of physical, mental and sexual character are described.”²⁵ After approximately a year of hormonal treatment, the patient is referred to the surgical department at OUS, Department of Reconstruction and Plastic Surgery. NBTS states on their home pages under follow-up, that based on the law change

²¹ The diagnoses in Norway follows the World health organizations (WHO) classifications over diseases, International Classification of Diseases (ICD). The WHO classification of gender dysphoria has the code ICD-10 The Norwegian edition is administrated through helsedirektorate and have the code F64.0.

²² “Nasjonalt behandlingstjeneste for transseksualisme,” Oslo universitetssykehus, accessed March 7, 2019, <https://oslo-universitetssykehus.no/fag-og-forskning/nasjonale-og-regionale-tjenester/nasjonalt-behandlingstjeneste-for-transseksualisme>.

²³ Nareas Sae-Khow, “Rikshospitalet fraråder selvkirurgi på det sterkeste,” *NRK*, January 22, 2018, <https://www.nrk.no/trondelag/rikshospitalet-frarader-selvkirurgi-pa-det-sterkeste-1.13861935>.

²⁴ “Nasjonalt behandlingstjeneste for transseksualisme.”

²⁵ “Nasjonalt behandlingstjeneste for transseksualisme.”

regarding legal gender as of July 1, 2016, it is no longer a requirement that individuals who wish to change their legal gender status must first undergo diagnosis, medical treatment and sterilization. “That is, if you are a resident of the Norwegian State and experience belonging to the other sex than you are registered with in the National Population Register, you have the right to change your legal gender.”²⁶

The NBTS website also includes a paragraph regarding patients referred to the NBTS who have received gender-affirmative treatment both hormonal and surgical treatment, outside of the NBTS. They state that: “The investigation and diagnosis of transsexualism (F64.0) is affected by the fact that the patient initiates gender-confirming hormonal/surgical treatment outside the NBTS. NBTS does not have the opportunity to make a safe diagnosis when this type of treatment is commended before completion of the investigation at NBTS. This puts NBTS in a very difficult situation, because then we cannot know what the right subsequent treatment for that patient is. The onset of hormonal/surgical treatment based on the wrong indications can have serious irreversible consequences. For this reason, NBTS has asked the health authorities for a decision relating to these situations.”²⁷

THE LAW CHANGE: MORE ACCESSIBLE

The Norwegian Ministry of Health and Care Service wrote about its proposal for the law change,²⁸ stating that: “Norway is on the forefront when it comes to LGBT rights. But our current

²⁶ “Nasjonal behandlingstjeneste for transseksualisme.”

²⁷ “Nasjonal behandlingstjeneste for transseksualisme.”

²⁸ §1. Definition: By legal gender means the gender a person is registered with in the population register. §2. Right to change legal gender: Residents in Norway who feel that they belong to the other gender that the person in question is registered with in the population register, have the right to change their legal gender. the ministry may issue regulation that the Act shall apply to Norwegian national residents who live abroad.

§4. Change of legal gender for children: Children who are between the age of 6 and 16 must apply for a change of legal gender with the person or persons who have parental responsibilities for the child. If parents have joint parental responsibilities, but the application is filed with only one of them, the legal gender

system for changing legal gender is unacceptable and has been unchanged for nearly 60 years. This proposal is in accordance with human rights.”²⁹ The bill states that a person who experiences that their gender differs from the sex they were assigned at birth, has the right to change this based on their own experience: “To change your legal gender, you have to fill out a document and send it to the nearest Tax Office. There will be a clear distinction between medical treatment and the process of changing legal gender.”³⁰

CHAPTER TWO: THE TERFS CRITIQUE OF THE LAW CHANGE

After the legal alteration to make changing one’s legal gender more accessible, the public debate flourished; above all since there was no impact assessment conducted before the law in question was ratified, especially regarding trans* women’s rights to enter all women-designated public spaces. Many critical voices made arguments against allowing “men” access to women dedicated spaces like changing rooms and public bathrooms. They argue that trans* women would never be able to become “real women”, that they are only “men” with identity issues and mental illnesses. Indeed, these self-identified feminists claim that this law was directly hurting women, not respecting their wishes, or consulting them before making a law permitting “men” access to spaces that have been created to protect women.

This side of the debate was led by a group of activists and public intellectuals who have been described as TERFS by trans* activists in the debate. This group include radical lesbian activists, doctors, feminist activists, public intellectuals and parents of children who are transgender. One of

²⁹ Ministry of Health and Care Services, “Easier to Change Legal Gender,” Pressemelding, Government.no, March 18, 2016, <https://www.regjeringen.no/en/aktuelt/easier-to-change-legal-gender/id2480677/>.

³⁰ Services.

the feminists most actively contributing to this debate is Tonje Gjevjon, a Norwegian art- and performance artist as well as self-proclaimed activist. Gjevjon has published multiple opinion pieces in national newspapers on the subject, with headlines like; “What decides if you are a woman or a man?”, “Vagina or front hole?”, “What are we doing when we think that six-year-olds can decide their gender?” and “From a boyish girl who is doing fine.” Gjevjon continuously claims that trans* activists are trying to intimidate and silence opinions that are critical of trans* people’s experiences.

After the law change, Gjevjon has voiced her concerns for protecting women’s rights in public women-designated spaces in Norway. She writes: “So here we stand, with the practical consequences of the law change regarding legal gender, and of a new, legal understanding of gender. Gender has become an identity, freed from biology.”³¹ Furthermore, Gjevjon argues that the new law regarding legal gender is undermining the history of women fighting for equal rights, and further argues that since women’s organizations involved in the expert group appointed by the state did not question this, women did not have the opportunity to be represented on an issue that is about them and their safety. Indeed, Gjevjon claims that trans* activists are presenting their politics by attacking feminists, claiming that everybody must abide by trans* activist theories and terminology. At the base of her argument, Gjevjon posits that this law change is altering the definition of gender so that gender becomes indefinable. “When the government changed the law in 2016, they also created a base where the definition of gender becomes a non-definable inner essence - an essence impossible to verify.”³² Gjevjon argues from a biological essentialist perspective, which assumes that no matter what gender affirmative treatment a person may undertake, or how they identify, gender is a reality that can only be proven through biology.

³¹ Tonje Gjevjon, “Hva er det vi driver med når vi mener at seksåringer skal kunne velge kjønn?,” *Dagbladet.no*, May 2, 2017, <https://www.dagbladet.no/a/67534452>. (own translation)

³² Tonje Gjevjon, “Hva avgjør om du er kvinne eller mann?,” *Dagbladet.no*, July 29, 2018, <https://www.dagbladet.no/a/70053234>.

While Gjevjon is worried about the erasure of the biological differences between “men” and “women,” she also, paradoxically, sees trans* people and experiences as imposing a rigid and narrow definition of gender. Gjevjon states: “I see two problematic trails to follow: trans* persons rights against women’s rights, and the idea that the body, emotions and behavior have to be adjusted to narrow gender definitions.”³³ These two trails are the dominant ones in this debate, the first is central to several other critical voices from the feminist perspective. Kari Jaquesson, who is a public commentator, has similar opinions and wrote an article called: “Man cannot become a woman.”³⁴ Jaquesson refers to an article published on *Spiked* entitled: “trans activism is now just misogyny in drag” and states that she fully agrees with this article. She argues that: “trans is colonialism, occupation and imperialism of women and women’s history and our spaces. The hatred and envy for the female is obvious from these extremists.”³⁵ Jaquesson argue that these “men” are pretending to be women and that they are free to do so, but that they will never become “real women;” a quick blood test will prove that they are biologically men. Women had to fight for their right to vote, speak in public, the right to education, be economically independent, the choice to become mothers or not, and be politically active and Jaquesson states that these rights are: “privileges previously reserved for men, that is, persons with penises and testicles.”³⁶

Like Gjevjon, Jaquesson is arguing that the new law regarding legal gender is a violation and disrespects women’s rights and security: “men are not exposed to threats or violence, it is us women they are threatening.”³⁷ Jaquesson argues that with the new law, there is nothing that prevents a man from changing his legal gender just to gain access to women in designated safe spaces. They draw from examples in the United States and the United Kingdom where men who have been arrested for

³³ Gjevjon, “Hva er det vi driver med når vi mener at seksåringer skal kunne velge kjønn?”

³⁴ Kari Jaquesson, “Mann kan ikke bli kvinne,” *Dagbladet.no*, July 24, 2018, <https://www.dagbladet.no/a/70040157>.

³⁵ Jaquesson.

³⁶ Jaquesson.

³⁷ Jaquesson.

sexual assault and rape demanded to do their time in women's prisons because they changed their legal gender: "The crime is registered as committed by a woman, despite the fact that the perpetrator has used his penis to carry out the rape."³⁸ Both Gjevjon and Jaquesson voice their concern regarding the lack of conversation around the presence of a person who identifies as a woman, who also still has the penis of an adult "man", in public locker rooms. They argue that the lack of conversations and limited frames around them prohibit women from voicing their discomfort regarding sharing spaces with a person who has the characteristics of an adult male. Ultimately, these critiques argue that trans* activists are further silencing women's concerns through the threat of labelling them transphobic and intolerant, by utilizing the term TERFs.

Margretha Hamrin, who writes for the magazine *Vårt Land*, wrote an open letter to health minister Bent Høie where she addresses some of the issues that were not discussed before the law was altered. Hamrin presents problems that women have presented to her, including one who works with traumatized women and children. Personal beliefs, religion, and personal traumas can be reasons for women to feel discomfort with trans* women, who have a penis, in women only designated public spaces. Hamrin points out that many of the women who are active at gyms are survivors of rape, and/or refugees that have been victims of human trafficking: "And did you know that for many of these women a penis is a more feared weapon than a machine gun? Therefore, having to shower next to a strange naked 'man' with a penis will be very traumatic for many of these women."³⁹ Hamrin is also concerned for children who have been victims of sexual abuse for whom seeing a penis in an all women designated space would prove traumatic. This assertion is based on a conversation with a child psychologist who told her that abused children often draw people with penises that look like dangerous weapons or spears. Gjevjon responded to this article by writing an own open letter to

³⁸ Jaquesson.

³⁹ Margaretha Hamrin, "En Feminismens Parodi," accessed February 27, 2019, <https://www.dagsavisen.no/nyemeningen/en-feminismens-parodi-1.936358>.

health minister Høie where she raises the question of religion, by claiming that the presentation of a “man’s” penis in public locker rooms will be counterproductive to integration of Muslim women who have a different relationship to nakedness than Norwegian women: “Wasn’t it that immigrants should participate in our community to be well culturally integrated?”⁴⁰

THE NATIONAL TREATMENT CENTER OF TRANSSEXUALISM’S CONCERNS

NBTS has also voiced its opinions in the national newspapers regarding trans* persons in society. Here the debate changes and shifts away from trans* women trespassing into women designated areas, to trans* men’s rights and who should qualify for gender affirmative treatment. NBTS proclaimed their worries regarding the increasing numbers of trans* persons that are referred to NBTS and the level of knowledge and science on what treatment should be provided to whom. The conservative and strict acceptance, in combination with the increase of trans* persons seeking gender affirmative treatment, has resulted in more trans* people being rejected by NBTS. In January 2018, Kim Alexander Tønseth, on the behalf of NBTS completed an interview named: “The National Hospital Advises Strongly Against Self-surgery.”⁴¹ Tønseth is one of the leaders at NBTS and leader of clinic for head, neck and reconstructive surgery at the OUS in Norway. The article is a response to Pavla Aleksandrova Kovrigina’s desperate actions who, after being rejected from NBTS, cut off her penis and both testicles at home.⁴² Kovrigina’s suffers from OCD and therefor have been rejected from the NTBS multiple times.⁴³ In the article Tønseth explains that every year over 500 patients are referred to NBTS, five years ago it was only 100 and the reason for the increase might be more

⁴⁰ Tonje Gjevjon, “Kjønn er ikke en følelse, Bent Høie,” *Dagbladet.no*, April 19, 2017, <https://www.dagbladet.no/a/67497701>.

⁴¹ Sae-Khow, “Rikshospitalet fraråder selvkirurgi på det sterkeste.”

⁴² Nareas Sae-Khow, “Den Tanssibirske Jerndamen,” *NRK*, January 21, 2018, https://www.nrk.no/trondelag/xl/holdt-ikke-lenger-ut-a-vaere-mann_-skar-av-seg-penis-og-testikler-1.13824841.

⁴³ Sae-Khow.

openness in society around gender.⁴⁴ He further explains that to be eligible for gender affirmative treatment at NBTS, a diagnosis of Gender Dysphoria (F64.0) is necessary: of the approximately 500 people who are now referred annually to the National Hospital, there are just over 100 people who are diagnosed and offered treatment:⁴⁵ “We have been very conservative. The reason is that we do not want to perform surgery on people who subsequently regret it. In the course of 15 years, we have only had three cases where people want to return to their old gender...”⁴⁶ What worries Tønseth is a new issue that has emerged in recent years, that some patients only require partial treatment, meaning only a wish for certain medical adjustments, such as hormone replacement treatment and no surgical procedures, or some surgical procedures. Tønseth says that: “We do not have any scientific literature to treat these patients. Because we do not know whether hormone therapy alone, or partial surgery, has the desired effect on this group of patients, due to lack scientific evidence.”⁴⁷ He ends the interview by saying: “But I think these patients should get a better offer, follow-up and support.”⁴⁸

THE NATIONS DAUGHTERS: A NATIONAL RESPONSIBILITY

The leaders at NBTS, doctor Anne Wæhre and surgeon Kim Alexander Tønseth both at the National Hospital in Oslo also wrote an open letter to Bent Høie called “We Have had an Explosive Increase in the Number of Teenage Girls Who Want to Change Their Gender. Do You Take Responsibility, Bent Høie?.” The article described an “explosion” of teenage “girls” who suddenly identify as boys and the authors wrote that this increasing demand is met by “treatment eager sexologists” who are creating a dangerous situation for the “nation’s daughters.” As stated above, before the law changed, trans* persons who wanted to change their legal gender needed to be

⁴⁴ Sae-Khow, “Rikshospitalet fraråder selvkirurgi på det sterkeste.”

⁴⁵ Sae-Khow.

⁴⁶ Sae-Khow.

⁴⁷ Sae-Khow.

⁴⁸ Sae-Khow.

diagnosed and castrated at NBTS, which gave them a definition power over who qualified as true trans* or not. While the NBTS no longer has sole definitional power, they still have monopoly on gender affirmative treatment covered by universal health care in Norway. In order to qualify this treatment as a part of universal health care you need the diagnosis from this institution. Therefore, despite the economic burden, many Norwegians seek help in form of gender affirmative treatments from sexologists and private plastic surgeons, operating outside of NBTS.

Wæhre and Tønseth argue that this increase is present worldwide and two-thirds of these teenage “girls” have in common is that: “they suffer from severe depression, anxiety, self-harming, trauma, autism spectrum illnesses, hallucinations, or suicidal thoughts.”⁴⁹ Wæhre and Tønseth argue that they do not know why this increase is happening and raise the question: “Can this be a reaction to increased openness in society related to gender? Or is this a reaction to extensional burdens (in this case their mental illnesses) that might only be a temporary feeling?”⁵⁰ By referring to international discussions and expertise, they point to the lack of knowledge and science regarding this group and conclude that treating these teenage “girls” is not advised. Since there is little knowledge of young people who experience a mismatch between their gender identity and the gender they were assigned at birth after they have reached puberty, Wæhre and Tønseth argue therefor that treatment should be withheld. Wæhre and Tønseth do not site the research in which they claim that this is present worldwide. Ultimately, they argue that trans* identity is legitimate, but for the group in question more research is necessary before treatment is recommended. In other words, some very concrete trans* identities are legitimate, but only if they fit the definition provided by NBTS. The authors end the article by talking directly to the health minister and writing: “Dear Bent Høie: keep

⁴⁹ Wæhre and Tønseth, “Vi har fått en eksplosiv økning i antall tenåringsjenter som ønsker å skifte kjønn.” (own translation, as direct as possible to provide with rhetoric context.)

⁵⁰ Wæhre and Tønseth.

treatment-eager sexologists on a short leash, they are buying/giving beards and deep voices to the nation's daughters, left we have lost fertility and an uncertain future.”⁵¹

THE RESPONSIBILITY OF JOURNALISM: PRESENT THE WHOLE PICTURE

Anki Gerhardsen responded to NBTS worries by writing articles entitled: “Do You Wonder if You’re Transgendered? Do Not Read the Paper!”⁵² and “The Dream of the True I: The Worst That Happened to the Conversation About Trans* Identity Was That It Ended Up In the Same Box As the Homosexual Case.”⁵³ In the first article Gerhardsen criticizes journalists for presenting gender dysphoria and gender confirmative treatment as exclusively positive and does not offer the public a more nuanced picture based on science and research. Gerhardsen writes in this article that since the “trans field” ended up in the LGB-group it is almost impossible to problematize the “phenomenon” without being labeled transphobic. “For homosexuality should not be treated. It should just unfold and just be. Hormones for young children and irreversible surgery on teens are something completely different.”⁵⁴ Gerhardsen argues from a medical perspective regarding what she refers to as the “trans-phenomena” and critiques the national media for contributing to ignorance when they consult sexologist and LGBTQI+ organizations as qualified expert sources of information. In doing so, she refers to the article written by NBTS and warns the Norwegian population about what Wæhre and Tønseth refer to as an “...growing group of sexologists and other therapists outside the national treatment service who start treatment at a low threshold level.”⁵⁵ NBTS, like Gerhardsen, Gjevjon and Jaquesson, argue that sexologists, trans* activists and LGBTQI+ groups are lobbying towards a

⁵¹ Wæhre and Tønseth.

⁵² Anki Gerhardsen, “Lurer du på om du er transkjønnet? Ikke les aviser! | Anki Gerhardsen,” *Aftenposten*, accessed March 7, 2019, <https://www.aftenposten.no/article/ap-AKWWn.html>.

⁵³ Anki Gerhardsen, “Anki Gerhardsen om transidentitet: Drømmen om det sanne jeg,” *Aftenposten*, May 21, 2018, <https://www.aftenposten.no/article/ap-yvrgWA.html>.

⁵⁴ Gerhardsen.

⁵⁵ Wæhre and Tønseth, “Vi har fått en eksplosiv økning i antall tenåringsjenter som ønsker å skifte kjønn.”

vulnerable group without the caution, research and science necessary to treat them.

In Gerhardsen's opinion the press has a responsibility to challenge the public healthcare system's knowledge and expertise around trans* persons conditions and what kind of treatment is accessible for whom. "Instead of widening the gender framework, the press knocks in a notion that deep within everyone is something genuine, fully formed. Something that nature has gotten wrong, but which the surgeons can fix."⁵⁶ At the same time she is critical of the medical facilities outside of the public system such as sexologists who provide gender affirmative treatment for individuals who are not treated at NBTS. "Is a one-year long program in sexology enough to provide expert status, while the researchers (at NBTS) are consistently assigned the role of sticks in the wheels of the individual's liberation struggle?"⁵⁷

All these critical voices interact with each other, reference each to others articles and try to present themselves as representatives of research and science. Indeed, all these voices criticize trans* activists for not taking the lack of knowledge about gender dysphoria and how treatment will be experienced long-term, seriously. Gjevjon writes in her article, "Gender Is Not an Emotion, Bent Høie": "The new law regarding legal gender is moving the definition-power away from science to an individual's own experience of gender identity. How is that possible? Are we not living in a knowledge society?"⁵⁸ As I have demonstrated above, the conversation constructed by the critical voices in the debate is dominated by a scare rhetoric to argue for their beliefs. I now turn to another participant in the debate; The Scandinavian Parents Network for Persons with Rapid Onset Gender Dysphoria," who are questioning the expertise of sexologists in Norway. To understand the standpoint of this parent organization, I first present what Rapid Onset Gender Dysphoria is and how this phenomenon is present in the Norwegian debate.

⁵⁶ Gerhardsen, "Lurer du på om du er transkjønnet?"

⁵⁷ Gerhardsen, "Anki Gerhardsen om transidentitet."

⁵⁸ Gjevjon, "Kjønn er ikke en følelse, Bent Høie."

RAPID ONSET GENDER DYSPHORIA

In the “Nation’s Daughters” article by NBTS, the authors argue that an “explosive increase of teenage ‘girls’ suddenly feeling like boys” has occurred in Norway and that it is present worldwide. Although the NBTS does not cite the “international discussion” they seem to be influenced by the alleged phenomena “Rapid Onset Gender Dysphoria in Adolescence” (ROGD). First published on August 18, 2016 this research was sponsored by Brown University’s School of Public Health and was authored by just one researcher, Lisa Littman, MD, MPH at Mt. Sinai in New York and published on PLOS ONE.⁵⁹ The study was conducted through a 90-question anonymous online survey completed by 256 parents on Survey Monkey (SurveyMonkey, Palo Alto, CA, USA) and on three different blogs: 4thWaveNow, Transgender Trend, and Youth TransCritical Professionals. The survey was exclusively completed by parents who reported having children who experienced a rapid onset of gender dysphoria when they reached adolescence.⁶⁰ To get the survey out to a larger audience, Littman used a technique called “snowball sampling” which means that anyone can share the information and the link to the survey to any community or group that might include eligible participants.⁶¹ The forums and blogs used for this survey are known for their transphobic opinions and the survey only takes into consideration the parents’ experiences of their children’s gender identity. The survey covered demographics, sexual orientation, friend groups and social media use, as well as mental health and well-being, and quality of relationship to one’s parents.⁶² In the discussion Littman writes that 62.5% of the children in question were diagnosed with one or more mental health disorders or neurodevelopment disabilities and many had

⁵⁹ Lisa Littman, “Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports,” *PLOS ONE* 13, no. 8 (August 16, 2018): e0202330, <https://doi.org/10.1371/journal.pone.0202330>.

⁶⁰ Littman.

⁶¹ Becky McCall, “‘Rapid Onset Gender Dysphoria’ in Adolescents Stirs Debate,” *Medscape*, accessed November 29, 2018, <http://www.medscape.com/viewarticle/901951>.

⁶² Littman, “Rapid-Onset Gender Dysphoria in Adolescents and Young Adults.”

experienced trauma or stressful events.⁶³ This “research” is the basis for “Scandinavian Parents Network for Persons with Rapid Onset Gender Dysphoria” work and the organization uses Littman’s study to legitimize their own work.

INTERNATIONAL PARENT NETWORK WITH CHILDREN WHO EXPERIENCE ROGD

In Norway, the Scandinavian Parents Network for Persons with Rapid Onset Gender Dysphoria have been active in the debate on trans* youth. The Scandinavian network is part of a bigger support group for parents internationally.⁶⁴ On their official webpage this parent organization states their young, naive and impressionable children with emotional or social difficulties are strongly influenced by their peers and media. The “trans* lifestyle now is popular and their kids view this as the only solution to their issues.”⁶⁵ The organization also argues that these kids are misled by authority figures such as teachers, doctors and counselors who rush to affirm their chosen gender without asking why.⁶⁶ “We are horrified at the growing number of young people whose bodies have been disfigured, their physical and mental health destroyed by transitioning, only to discover – to late – that it did little to relieve their dysphoria.”⁶⁷

Contributing to the debate, The Scandinavian Parent Organization wrote an article called “Should Populism Trump Biology in Health Care?”⁶⁸ In the article the anonymous author summarizes NBTS’s article on the “nation’s daughters” and thanks them on behalf of relatives and parents of these children for their caution. The author argues that issues of mental illness are being

⁶³ Littman.

⁶⁴ “Speak Out,” Speak Out, accessed April 7, 2019, <https://www.parentsofrogdkids.com/>.

⁶⁵ “Speak Out.”

⁶⁶ “Speak Out.”

⁶⁷ “Speak Out.”

⁶⁸ Skandinavisk foreldrenettverk for personer med raskt oppkommen kjønnsdysfori, “Skal populisme trumfe biologi og vitenskap i helseomsorgen?,” *Aftenposten*, April 22, 2018, <https://www.aftenposten.no/article/ap-21lk9G.html>.

silenced by eager trans* activist who defy the expertise at NBTS. The author also questions if the trans* activist side of experts have the interdisciplinary competence as NBTS who work with pediatricians, psychiatrists, and psychologists, and the author accuses Esben Esther Pirelli Benestad, who is a doctor, professor, specialist in clinical sexology, a trans* person and part of the appointed expert group, of offering hormone treatment to young children.⁶⁹ “Sexologist P. Benestad has for many years treated children and adolescents with hormones, and ‘he’ has been under the investigation from the Norwegian Board of Health Supervision for the same reason.”⁷⁰ The situation the author refers to is a case between Benestad and a doctor who accused Benestad for incorrect medical treatment of a child who was provided with puberty blockers. The patient in question had shown consistency with gender dysphoria since they were two years old and the puberty blockers were prescribed in line with international guidelines.⁷¹ Benestad won the case against the Norwegian Board of Health, and the doctor in question, who in Benestad’s opinion showed little knowledge of the matter at hand, began to offer the same treatment after six months.⁷² The author ends the article stating that NBTS are the only ones fit to follow up on research, diagnosis and treatment for these patients, and they urge the Health minister to listen to science rather than populism.⁷³

⁶⁹ Skandinavisk foreldrenettverk for personer med raskt oppkommen kjønnsdysfori.

⁷⁰ Skandinavisk foreldrenettverk for personer med raskt oppkommen kjønnsdysfori.

⁷¹ Thomas Holst-Hansen, “Transefar i lia,” *Dagbladet.no*, July 7, 2008, <https://www.dagbladet.no/a/66495470>.

⁷² Holst-Hansen.

⁷³ Skandinavisk foreldrenettverk for personer med raskt oppkommen kjønnsdysfori, “Skal populisme trumfe biologi og vitenskap i helseomsorgen?”

CHAPTER THREE: FEMINIST CRITQUES

THE SCARY “TRUTH”: WHAT ARE THE REAL CONCERNS?

The critical voices in this debate argue the law alteration has had severe consequences. These voices also incite panic as they circulate a view of women facing the horror of a penis in the locker room, by equalizing being trans* with being severely mentally ill children and by describing how children are being hunted down by treatment-eager sexologists and the “intrusive rainbow family.” It is portrayed as a threat to Norwegian society, both in the loss of fertility of the “nation’s daughters” and as a physical threat to women. The call for expertise is indeed a difficult conversation when viewed through the framework built up by these critical voices. The dominant understanding of being trans* in these critical narratives is that it is a mental disorder and that ideally most trans* people will become better without permanently crossing over the normative gender lines. Yet, there are worries highlighted by the critical side that are legitimate. In the next section, I put the arguments constructed by these critical voices into a framework that consider trans* feelings as legitimate. In that section I also give a brief overview of the conversation happening in trans* studies, where these concerns must be considered carefully. I argue that some of the concerns presented by these critical voices are in fact worth discussing, but when these issues are discussed in a transphobic and pathologized terms, they lead to false conclusions. Consequently, this also impacts the requirement of acknowledging who should be called experts regarding trans* issues.

ANSWER TO THE TERF’S: FEMINISM AND TRANSGENDER STUDIES

Tonje Gjevjon has been criticized for her rhetorical methods and transphobic attitudes, where health care professionals, activists and feminists have made clear statements about how horrifying they find her opinions. A journalist, Martine Aurdal, is responsible for the debates published in the

national newspaper Dagbladet, where Gjevjon is also a writer. She contributed to the debate in an article called: “Transphobic in Norwegian.”⁷⁴ Aurdal summarizes Gjevjon’s argumentation against trans* women and addresses Gjevjon’s claim that trans* activists are trying to silence her by labeling her as a TERF and transphobic. Aurdal claims the terms “TERF” and “transphobia” are in fact appropriate characteristics of Gjevjon’s arguments, criticizing her for claiming that trans* women are not women based on her own irrational fears.

Like Gjevjon, Jaquesson uses the argument that the new law undermines women’s history of liberation and that “trans is colonialism, occupation and imperialism of women and women’s history and our spaces.”⁷⁵ In this way, both Jaquesson and Gjevjon articulate their own version of biological essentialism. While Gjevjon is worried about the erasure of the biological differences between “men” and “women,” she also paradoxically sees trans* people as imposing a rigid and narrow definition of gender. As Susan Stryker argues in her book *Transgender history*,⁷⁶ many people believe that “...gender identity – the subjective sense of being a man or woman or both or neither – is rooted in biology, although what biological ‘causes’ of gender identity might be has never been proven.”⁷⁷ Both Gjevjon’s and Jaquesson’s arguments are based on a framework in which an inherent biological cause defines who is a woman or a man. Andrea Long Chu summarizes the TERF argument in an interview on her essay “On Liking Women”: “Trans women are in fact men; they are interlopers who are here because they have some kind of perverted interest in invading women’s spaces; and they (notably) reinforce gender roles, when in fact the feminist project should be dismantling those roles.”⁷⁸ In other words, Gjevjon, Hamrin and Jaquesson’s arguments contradict themselves by taking

⁷⁴ Martine Aurdal, “Transfobi på norsk,” *Dagbladet.no*, July 27, 2017, <https://www.dagbladet.no/a/68542171>.

⁷⁵ Jaquesson, “Mann kan ikke bli kvinne.”

⁷⁶ Susan Stryker, *Transgender History* (Berkeley, UNITED STATES: Seal Press, 2009), <http://ebookcentral.proquest.com/lib/cunygc/detail.action?docID=680024>.

⁷⁷ Stryker.

⁷⁸ Amia Srinivasan, “Wanting Bad Things: Andrea Long Chu Responds to Amia Srinivasan,” *The Point Magazine*, July 18, 2018, <https://thepointmag.com/2018/dialogue/wanting-bad-things-andrea-long-chu-responds-amia-srinivasan>.

a stand from a feminist project, yet they argue for a deconstruction of essentialism. They assert that the presence of the intrusive rainbow family blurs the lines of biological essentialism and use such arguments to justify denying trans* women their rights because they are not “real women”. The fight for women’s liberation proves there is no biological essence that defines one’s gender identity, which is key in the fight for women’s position as full citizens. Using the same argument to limit a minorities’ equal rights is at best pure ignorance and at worst done in bad faith and shows that their underlying opinion of trans* people are that they are in fact not full citizens of society.

WHAT IS A “REAL WOMAN”?

In addition to their contradictory understanding of biological gender, the arguments of Gjevjon, Hamrin and Jaquesson reflect the transphobic attitude at the heart of TERF rhetoric, which fundamentally invalidates the experiences of trans* women. Classic anti-trans* feminism is Janice Raymond’s book *The Transsexual Empire: The Making of the She-Male*, first published in 1979.⁷⁹ In this book, Raymond argues that sex exists prior to culture and that membership of the group “woman” is determined by chromosomes. She further asserts that every person’s individual experience is assigned to a sex role⁸⁰ and that gender dysphoria is to be understood as unhappiness with the existing sex-role system.⁸¹ Therefore, in Raymond’s understanding, trans* women have not suffered under the historical discrimination ciswomen have experienced through a lifetime of discrimination under patriarchal society. Indeed, Raymond, as Gjevjon, Hamrin and Jaquesson, fails to consider that trans* women experience sexual discrimination and sexual harassment after they transition. As the conversation has shown, many of the trans* women in question have identified as trans* for a substantial period of time, therefore also experiencing discrimination most of their lives.

⁷⁹ Janice G Raymond, *The Transsexual Empire: The Making of the She-Male* (New York ; London : Teachers College Press, 1994).

⁸⁰ Raymond refers to gender as sex-roles.

⁸¹ Raymond, *The Transsexual Empire: The Making of the She-Male*.

In reality, the conversation constructed by Gjevjon, Jaquesson, and Hamrin is an example of the discrimination trans* women suffer while claiming their fundamental human rights. As Stryker writes: “Because most people have great difficulty recognizing the humanity of another person if they cannot recognize that person’s gender, the gender-changing person can evoke in others a primordial fear of monstrosity, or loss of human-ness.”⁸²

Indeed, gender identity is rarely considered something everybody has, except when it deviates from the dominant experience. Members of the dominant group – in this case non-transgendered people – think of themselves as having a gender or being a gender and rarely questions the choices made when gender identity is performed.⁸³ As Stryker says: “Being transgendered is like being gay – some people are just ‘that way’, though most people aren’t.” In this case, the people being “that way” are not accepted as the premise for the discussion. Rather, the presentation of a gender identity which deviates from the dominate group is described as a mental disease. Gerhardsen, seemingly anticipating the way that critics might compare her attitude toward trans* people to early attitudes toward lesbian and gay people, makes the point to say that trans* people are not equitable to homosexuals based on the fact that trans* identity, per her understanding, is fundamentally tied to medical treatment. Gerhardsen argues that since the ‘trans field’ ended up in the LGB-group, this makes trans* a phenomena impossible to criticism, arguing that homosexuality should not be treated, but “...hormones for young children and irreversible surgery are something completely different.”⁸⁴ In this case, defining trans* as young children getting hormone treatment and surgeries contributes to a pathologized view of being trans* and is a scare tactic. Furthermore, both Gerhardsen and the representatives from NBTS paint a picture where all trans* people are severely mentally ill children, which entails that they do not have the capacity to give an informed consent. In reality, the group in

⁸² Stryker, *Transgender History*.

⁸³ Stryker, 4.

⁸⁴ Gerhardsen, “Anki Gerhardsen om transidentitet.”

question are much more diverse than what is portrayed by these critical voices. Since Gerhardsen defines being trans* as hormone treatment and irreversible surgery on children, of course she does not believe it has a place among accepted sexual minorities represented by the LGB-community.

As presented in the section above, the critical voices in the Norwegian debate treat being trans* as a false phenomenon and they do not differentiate between a medical model and a model of politics of recognition. The critical questions of who the recognized experts should be regarding trans* issues do not have an easy answer. To use Stryker's understanding, "Because transgender issues touch on fundamental questions of human existence, they take us into areas that we rarely consider carefully."⁸⁵ The issue is not only about medical treatment and who gets it, but also about trans* people as a marginalized group and as such trans* people are often victims of discrimination from both society and the state. Indeed, the law change that started this debate is acknowledging trans* persons rights to be legally recognized as who they are, without having to permanently change their bodies in form of castration. Hence, it provides a first step in granting trans* people their agency and subjectivity. Indeed, asking who the real experts are while arguing from a framework that defines trans* persons as severely mentally ill is problematic. However, the claim of seeing the issues surrounding trans* people as a problem fixed by altering one's body with hormones and surgery is an important worry worth discussing and has been discussed for decades. In the next section, I present a small fraction of the conversation regarding the medicalization of the trans* body and the agency inside feminist studies and transgender studies.

THE CONTROVERSY OF MEDICALIZING THE TRANS* BODY

Gerhardsen and Gjevjon problematize the medicalization of being trans*, accusing the press of narrowing down the gender framework. As Gerhardsen claims that instead of widening the gender

⁸⁵ Stryker, *Transgender History*, 7.

framework, the press is knocking a notion of something genuine inside everyone. Something that nature has gotten wrong, but surgeons can fix. The medicalization of being trans* is a matter worth discussing seriously and this conversation has also been present in trans* activist and academic work. One result of Raymond's work, *The Transsexual Empire*, was her feminist critique of transsexuality as a medical phenomenon. Sandy Stone wrote a reply to Raymond called "The Empire Strikes Back: A (post)transsexual Manifesto," which became a founding essay for transgender studies.⁸⁶ Stone to some extent agrees with Raymond, worrying about what she calls the uptake of sexist stereotypes by some MTF⁸⁷. This, she argues, is because of an absence of any middle or more complex gender ground. Stone maintains that there is no space for talking about transsexuals as "transsexuals", because the medicalization of transsexuality requires both sexist behaviors and a strict gender binary.⁸⁸ Stone calls for transsexuals to come out, tell their stories and describe their experiences. "The Empire Strikes Back" started a large debate surrounding gender binary, subjectivity, medicalization and trans* people theorizing about themselves for themselves. Further, in *Gender Trouble* and *Bodies that Matter*, Judith Butler argues that heterosexual bias obscures gender and theorized in queer contexts, claiming that the social construction of both gender and sex is through performativity.⁸⁹ Bernice Hausman's work in *Changing sex: Transsexualism, Technology, and the Idea of Gender* puts transsexualism inside a Foucauldian paradigm, where transsexuality and a deep distrust of medical intervention are put onto the body. Hausman discusses transsexual subjectivity as dependent upon medical technology, where surgery produces the "the standard account" for trans*

⁸⁶ Stryker, 124–25.

⁸⁷ Male to Female

⁸⁸ Sandy Stone, "The Empire Strikes Back: A Posttranssexual Manifesto," in *Body Guards: The Cultural Politics of Gender Ambiguity* (Routledge, 1991), 280–304.

⁸⁹ Talia Bettcher, "Feminist Perspectives on Trans Issues," *Spring 2014 Edition*, Spring 2014, https://plato.stanford.edu/entries/feminism-trans/?fbclid=IwAR2Vd-jjBs8HbkkQ6ld2aaJmdghe6XGEr_2HNTI8WllRqljgtDVkdsYaSPs#EmpStrBac.

persons and through medical technology, “engineer oneself as a subject.”⁹⁰ These trans* academics do not only discuss the medicalization of trans* people, but also discuss the issues surrounding trans* subjectivity and how medical treatment constructs the “correct trans* body.” There are, however, disagreements inside this narrative, where trans* academics discuss at length the complexity of the issue at hand. Therefore, the medicalization of the trans* body is indeed an issue pro-trans* activist and trans* academics address. The conversations presented above all consider trans* a legitimate feeling and most of the authors discussed are trans* people themselves. The fundamental difference between them and critical trans* narratives is the investment in subjectivity and agency for the group in question.

TRANSGENDER STUDIES AND PSYCHOANALYSIS:

As NBTS’ narrative show, there is a need to unravel the pathologized way trans* people mental health is used to discredit their experience and further portraying them as too unstable to be able to give informed consent. In “Transgender, Queer Theory, and Psychoanalysis,” Stryker asserts, “The existence of homosexual feelings is rarely doubted. Transgender feelings, on the other hand...still often tend to be trivialized, ridiculed, explained away, or denied as such.”⁹¹ When we look at the complex body of literature and different theoretical approaches to being trans*, medicalization of transsexuality and the subjectivity and how being trans* feels, the worries presented by the critical voices are addressed. What is predominant on the critical side of the Norwegian debate is the doubt that “trans* feelings” are real, in fact, the pathologized diagnosis approach is dominant of all the participants presented above. As Stryker writes:

“Trans* studies, as opposed to queer studies’ focus on homosexual desire, takes as some of its starting position that ‘transgender feelings’ are real, that agnosticism is an

⁹⁰ Bettcher.

⁹¹ Susan Stryker, “Transgender, Queer Theory, and Psychoanalysis,” in *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory* (Goleta: Punctum Books, 2017), 422, https://www.dropbox.com/s/4hi93y11bm6pbae/Giffney_Watson_Clinical_Encounters_in_Sexuality_EBook.pdf?dl=0.

adequate stance regarding their origins, and that skepticism is the best stance regarding any monocausal etiology offered to them; that understanding the sources and implications of these feelings is a non-trivial pursuit that can offer substantive critiques of epistemological and discursive frameworks that marginalize, deny, or dismiss such feelings and perceptions; and that psychopathology offers an extremely reductive and impoverished framework for addressing the question of how these feelings emerge, how they are to be lived, or what is to be done about them at both the individual and societal level.”⁹²

Trans* studies offers important views in the debate, as it recognizes trans* people experiences and does not deny their lived experience as a marginalized group. Even though we do not know why people develop gender dysphoria or lack identification with dominant gender identities, being skeptical to the approach of defining these feelings as a mental disorder is key. The understanding of why ‘trans* feelings’ are considered not real is essential to criticizing the discrimination and marginalization trans* people experience. To highlight the psychopathology which is contributing to a narrow framework that does not offer a good approach when addressing how these feelings create a lived experience and how it is for individuals living in a society where they are not recognized.⁹³ What Stryker is pointing out is that the critical narrative is denying trans* persons their subjectivity through a pathologized view of the trans* feelings. This is outlined in NBTS’s guidelines for deciding who is “trans* enough” to receive the diagnosis of gender dysphoria also gives these individuals right to treatment covered by universal healthcare. NBTS have been arguing that since we do not know a lot about the new emerging group, caution is the best action. On the contrary, I argue that we in fact know a lot about the field of being trans*, but the continuous focus on the cause of why people are trans* instead of focusing on the lived experience is limiting the level of understanding of NBTS expertise.

⁹² Stryker, 422.

⁹³ Stryker, “Transgender, Queer Theory, and Psychoanalysis.”

THE FEMINIST PROJECT: A NEW NEEDED DISCUSSION

Jack Halberstam is a professor at Columbia and a well-known trans* activist writes in his book *Trans*: A Quick and Quirky Account of Gender Variability*, that a new discussion has emerged between feminist and trans* feminists, named transfeminism.⁹⁴ Indeed, instead of reviewing the conflicts between feminism, trans* women and men in the past, feminism in itself need to be reconstructed. This builds upon the work of Julia Serano's, who recognized that feminism needs to move away from the dominant framework used today. Serano claims that we must work to empower femininity and separate it from the inherit reputation it has – weakness, helplessness and passivity. “Those meanings will continue to haunt every person who is female and/or feminine.”⁹⁵ Indeed, when we look back at the conversation constructed by Hamrin and NBTS, they utilize the example of vulnerable women and teenage “girls” – vulnerable because of the distress and discrimination they have met – which makes them defenseless and unable to show agency. This view is relied by Gjevjon, Jaquesson, Hamrin, and Gerhardsen in their view of feminist project which justifies the disregard of trans* women in this debate and contributes to the view of femininity as a weakness. Halberstam writes that: “Serano’s work is important because it recognizes who feminism has managed to be *about* women and has worked hard to expose gender hierarchy but has not done so without reinvesting in femininity in the prosses.”⁹⁶

Reinvesting in a feminist discourse that permits the victories of women’s liberation as an argument against another minority group contradicts the goals of feminism. Feminism is to ensure political, economic and social equality regardless of gender, class, sexual orientation, race and gender identity. As Halberstam argues, as feminists we need to empower femininity and take into

⁹⁴ Jack Halberstam, *Trans*: A Quick and Quirky Account of Gender Variability* (Jackson: University of California Press, 2017).

⁹⁵ Halberstam, 119.

⁹⁶ Halberstam, 119–20.

consideration that feminism has played along the terms of the understanding of womanhood created by patriarchal societies. Not only does the feminist project aim to ensure equality of all humans, it also needs to challenge the dominant sexist societies and definition system within which it exists. As Jack Halberstam states, historically there has been conflicts between feminism and trans* activism where they have been casted as opposed. The radical feminist critique has done serious damage, but it is time to seek common ground for collaboration and solidarity.⁹⁷

Indeed, as I have unraveled in the section above, the premise of using a pathologized view of being trans* makes the arguments difficult to interact with. There are many arguments made by the TERF's and NBTS that are not legitimate concerns. When the critical voices discuss worries that are legitimate, the premise of these discussions lead the conversation into transphobic notions, which creates false conclusions. Both the TERF's and other critical voices in the debate have accused trans* activist of limiting the conversation about trans* experiences to only positive accounts. In fact, when the critical voice asks complex questions, they are unable to truly consider them since they base such conversations on a transphobic framework. In the next section I present trans* activists' sides of the debate, demonstrating that there has been a diverse conversation in national newspapers. However, since the trans* activists operate from a basic understanding where being trans* is consider legitimate, they have been ignored.

⁹⁷ Halberstam, 126–28.

CHAPTER FOUR: UNDERNEATH THE PANIC

THE TRANS* SIDE OF THE DEBATE

The importance of self-determination and the individuals' need for health care is a key component in the arguments made by trans* activists, while the narratives presented by the doctors at NBTS and the critical voices in the debate further pathologize this view. The underlying contradiction is important to understand why the conversation regarding experts has become such controversy in Norway. As both Stone and Stryker emphasize, the lived experiences of trans* people are in fact a very important tool to create theories and approaches to their lives in general. In this next section I elaborate the other side of the public debate in Norway. Many of the trans* activist are health care professionals, doctors, sexologist, and/or trans* persons themselves. The diverse group who represent the other side of this debate hold personal experiences with what treatment works for them and have a unique expertise since they are theorizing for themselves about themselves. In this section I show that the expertise that the critical voices is looking for is present in the group they are criticizing. First, I present the "treatment eager sexologist" answer to criticism raised by the critical voices. The conversation created by these voices gives us a better understanding of why so many people seek treatment outside the NBTS. Specially, as described above, only 100 trans* people out of 500 are offered treatment at NBTS which raises the question; what are the 400 people who do not meet the requirements to obtain treatment to do?

"THE TREATMENT EAGER SEXOLOGIST" ANSWERS THE CRITIQUE

Thomas Mørk Tønseth, doctor, specialist in general medicine, university professor, specialist sexologist and a part of the appointed expert group, wrote an article called: "I Am One Of The 'Treatment Eager Sexologist Who Treat Hair Growth and Darker Voices to The Nation's

Daughter's'.”⁹⁸ In the article, Mørk Tønseth addresses Gerhardsen’s worries regarding gender affirmative treatment for children, which he says does not exist and he directs critique to NBTS’ article regarding what they called the “nation’s daughters.” He states that “if gender dysphoria in children continues when they hit puberty, one can offer puberty-delaying treatment to buy more time for investigation, which is in line with international guidelines. No one under the age of 16 receives hormonal treatment or gender affirmative surgery.”⁹⁹ As an answer to Gerhardsen’s questioning of sexologists’ level of expertise, Mørk Tønseth says that he has been a doctor for 23 years, a specialist in general medicine for 15 years, a sexologist for 10 years and now a university lecturer. In collaboration with experienced doctors, sexologist and psychologist they come together to discuss patient histories, research and experience. “Therefore, I have some more experience than a one-year study of sexology,”¹⁰⁰ arguing that the doctors at NBTS are not the only experts in the field. Mørk Tønseth explains that he has met many individuals with a lot of mental pain after a life where body and soul do not agree with each other, who have been rejected by the NBTS. He states that NBTS choose not to offer treatment is an active choice with unknown consequences.¹⁰¹ He explains that he has seen mental symptoms disappear when patients with gender incongruence receive treatment and he has seen “isolated and unhappy people flourish and participate in society”¹⁰² when people are met with understanding and they are believed.

The criticism of “treatment eager sexologist” is seemingly just an attempt by the NBTS to reserve their monopoly on gender affirmative treatment. As previously noted, the NBTS wrote on their webpages that they are not able to provide a patient with a diagnosis if they have started gender

⁹⁸ Thomas Mørk Tønseth, “Jeg er en av «de behandlingsivrige sexologene som spanderer hårvekst og mørkere stemme på nasjonens døtre»,” *Aftenposten*, accessed November 24, 2018, <https://www.aftenposten.no/article/ap-vmP2vj.html>.

⁹⁹ Tønseth.

¹⁰⁰ Tønseth.

¹⁰¹ Tønseth.

¹⁰² Tønseth.

affirmative treatment outside the NBTS,¹⁰³ which highlights that in the view of the NBTS is that they are the only professionals with the knowledge to treat trans* people in Norway. It also demonstrates how far the NBTS is willing to go to reserve their monopoly. As Mørk Tønseth states in his article, sexologists are not hunting down trans* people; in fact, they are accepting a wide range of trans* people who do not qualify for needed treatment at the NBTS. Importantly, Mørk Tønseth argue that he has more experience than a “one-year study in sexology” by explaining that, as any other health professional, he conducts an assessment of the person in question in collaboration with colleagues in line with international guidelines to determine what treatment would be beneficial for the patient. In response to the NBTS’ and Gerhardsen’s attempt to undermine the professional expertise of sexologist, Mørk Tønseth asserts his professional background, and his qualifications to treat trans* people. He is not the only sexologist who take responsibility for a group of trans* people who are rejected by NBTS.

Additionally, Ronny Aaserud, former psychologist specialist / specialist in sexological counseling at the Health Center for Gender and Sexuality in Oslo (HKS), answers the critics in an article entitled: “No, We Do Not Buy/Give Beards and Deep Voices to the Nation’s ‘Daughters’.” He claims that NBTS’s article regarding the “nation’s daughters” testifies more as a desperate attempt to protect their treatment monopoly than to meet patients with understanding and respect. “The fact that we do not know much about the field does not preclude the recognition and validation of gender identity of these young people, whether temporary or permanent.”¹⁰⁴ Aaserud also agrees that there is a great need for investigation and caution in complex and complicated cases and states at HKS they also work with people who suffer from severe mental illnesses. “Unlike NBTS, we do not refuse these patients... Complex issues require complex solutions. Is it not it ironic that a highly

¹⁰³ “Nasjonal behandlingstjeneste for transseksualisme.”

¹⁰⁴ Aaserud Ronny, “Nei, vi spanderer ikke hårvekst og mørk stemme til nasjonens «døtre,” March 27, 2018, <https://www.aftenposten.no/article/ap-qnbLXm.html>.

specialized service will not investigate when it becomes too complicated?”¹⁰⁵ Aaserud explains that NBTS rejects patients if they are “too mentally ill” and tell them to go seek psychological help and come back when they have a better mental health. In fact, it is not sexologists who are standing in line to provide hormone treatment to young people, there is a queue extending out the door of people seeking the right diagnosis from NBTS so they can be provided universal healthcare. Aaserud refers to London in England where people with mental diagnosis are being offered treatment, so why cannot NBTS learn from other institutions? He ends the article by stating that there is no wonder that young people get in line for gender affirmative treatment from sexologist when the waiting time at NBTS is over a year. Especially when NBTS produce and publish articles where they invalidate and disrespect the group in question.¹⁰⁶

Ingun Wik who is a specialist in sexological counseling, the leading nurse at HKS and part of the appointed expert group wrote an article where she seeks the persons who received gender affirmative treatment and then regretted it.¹⁰⁷ Wik argues that it is important to be critical when discussing today’s medical practice and the assessments that form the guidelines for gender-affirmative treatment. One mistake in medicine is one to many and Wik states that it should be health professionals full and complete responsibility: “Not for the individual’s decision regarding their own life, but for the burden of proof that all relevant and available knowledge has been provided, so that the individual can give an informed consent regarding their own health.”¹⁰⁸ Indeed, Wik argues that as health care professionals, it is their job to make the distinction between gender identity and gender roles, claiming that they are not treating identity, but making the body easier to live in. The fear of people possible regretting gender-affirmative treatment has, to a great extent, prevented people from

¹⁰⁵ Ronny.

¹⁰⁶ Ronny.

¹⁰⁷ Ingun Wik, “Velkommen til anonym som angrep på kjønnsbekreftende behandling,” *Aftenposten*, accessed November 24, 2018, <https://www.aftenposten.no/article/ap-dd22zB.html>.

¹⁰⁸ Wik.

receiving vital treatment. “Stopping 98 percent from getting help, in fear of that two percent who statistically would change their minds, is a demanding medical argument.”¹⁰⁹

A MEETING BETWEEN TWO RECOGNIZED EXPERTS

As the sexologists above argue, the NBTS’ approach to a group of trans* men/boys and others who fall outside the requirements creates a need for a second opinion regarding their lived experience. The conflict between the NBTS and these sexologists is a result of a patient group who are not given the help and guidance they need; therefore, they have no choice but to seek help elsewhere. There is a consensus between sexologists and the NBTS on this matter and both sides are claiming to follow international guidelines regarding treatment of minors who experience gender incongruence. However, both Aaserud and Wik argue that one must be critical to current medical practice and the guidelines used when assessing treatment for trans* people and the complexity of the matter is not taken seriously by the NBTS. Instead of providing guidance for patients who suffer from severe mental illnesses, the NBTS sends these patients to other mental health institutions, asking them to come back when they are mentally stable. As the appointed high-expertise institution in Norway, they should offer treatment and provide help to a variety of trans* people, not restricting their help to one specific experience. The NBTS’ approach also shows the fundamental understanding portrayed by the institution: either you are the right kind of sick, hence qualifying to be diagnosed and are offered treatment, or you are the wrong kind of sick and therefore do not qualify the diagnosis. The sexologists’ views, as presented above, are in line with international guidelines since they individualize treatment for the patient at hand and are not searching for patient that fit their requirements. After all, to complete the research NBTS claim to be missing, trans* people in question are the most important source of information, since it is them who are supposed to benefit

¹⁰⁹ Wik.

from treatment.

INTERNATIONAL COLLECTIVE OF KNOWLEDGE: AN INTERDISCIPLINARY CONVERSATION

Mørk Tønseth points out that, in line with international guidelines, “No one under the age of 16 receives hormonal treatment or gender affirmative surgery.”¹¹⁰ There is a body of work done by Jack Drescher, Jack Pula and William Byne regarding the special controversy of treating gender dysphoria/gender variant in children and adolescents.¹¹¹ Drescher and Pula writes in the Hastings Center Report¹¹² that among older adolescents and adults who experience gender dysphoria, it rarely desist and their treatment of choice is, therefore, gender or sex reassignment.¹¹³ “On the subject of treating children however, as the World Professional Association for Transgender Health (WPATH)¹¹⁴ notes in their last *Standard of Care*, gender dysphoria in childhood does not inevitably continue into adulthood, and only 6 to 23 percent of boys and 12 to 27 percent of girls treated in gender clinics showed persistence of their gender dysphoria into adulthood.”¹¹⁵ This report summarizes the controversy of treating minors who experience gender dysphoria, as the majority of minors desist by or during adolescence and turn out to be homosexual rather than transgendered. However, for the group that persist with the feeling of gender dysphoria into adolescence is more likely to persist into adulthood.¹¹⁶ There is in fact a great body of work being done by clinics,

¹¹⁰ Tønseth, “Jeg er en av «de behandlingsivrige sexologene som spanderer hårvekst og mørkere stemme på nasjonens døtre».”

¹¹¹ Jack Drescher and William Byne, “Gender Dysphoric/Gender Variant (GD/GV) Children and Adolescents: Summarizing What We Know and What We Have Yet to Learn,” *Journal of Homosexuality* 59, no. 3 (March 2012): 501–10, <https://doi.org/10.1080/00918369.2012.653317>; Jack Drescher and Jack Pula, “Ethical Issues Raised by the Treatment of Gender-Variant Prepubescent Children,” *The Hastings Center Report* 44, no. 5 (2014): S17–22.

¹¹² Drescher and Pula, “Ethical Issues Raised by the Treatment of Gender-Variant Prepubescent Children.”

¹¹³ Drescher and Pula, 17.

¹¹⁴ The World Professional Association for Transgender Health is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respectful transgender health.

¹¹⁵ Drescher and Pula, “Ethical Issues Raised by the Treatment of Gender-Variant Prepubescent Children,” 17.

¹¹⁶ Drescher and Pula, 18.

academics and activist on an international level. For example, Drescher and Byrne's book *Treating Transgender Children and Adolescents: An Interdisciplinary Discussion*. The book is a collection of both academic and clinical work from the United States and Europe and was intended for clinicians and researchers, but also as a resource to inform parents of these children. This complex work explores the ethical, cultural and clinical questions that these children present to parents, researchers and clinicians.¹¹⁷

This work explores some of the worries raised by the critical side of the debate and NBTS. As stated above, the majority of children who experience gender dysphoria does not continue to have these feelings into adolescence and adulthood. The dilemma resides with the children in which continue suffer with gender dysphoria in adolescence, who show an increased likelihood of sustaining this feeling into adulthood.¹¹⁸ NBTS is worried about a group of children who "suddenly" in adolescence experience gender dysphoria and if this group will have a consistent feeling of gender incongruence is unknown. Drescher and Byrne's collection discusses the dilemma highlighted by the NBTS and the sexologists mentioned above: when is it appropriate and effective to begin medical treatments? As both the NBTS and the sexologists presented before state, we do not know enough about the best approach of treatment for minors, or adolescence who "suddenly" are trans*. However, Aaserud claims that we need more research on the group at hand and he and his colleagues continue to meet with persons who suffer from severe mental illnesses. My argument aligns with Aaserud: we need more research and knowledge about treatments for children and adolescence, but we cannot refuse help to persons who experience gender dysphoria and justify it by the fact that more research is needed. In fact, following these adolescences through their teenage years are of essence to obtain the knowledge needed to offer them treatment. The best resources at hand now is resources like

¹¹⁷ David J. Ley, "A Review of 'Treating Transgender Children and Adolescents: An Interdisciplinary Discussion,'" *Journal of Sex & Marital Therapy* 40, no. 1 (February 1, 2014): 69–70, <https://doi.org/10.1080/0092623X.2013.854548>.

¹¹⁸ Ley.

Drescher and Bryne’s collective. In this way, health care professionals, together with both parents and children can find the best approach with the research at hand and contribute to future research. Also, there is new research being conducted in Europe that has the potential to improve treatment for trans* people. In fact, some of the research the NTBS claims are missing is already been conducted.

THE EUROPEAN NETWORK OF THE INVESTGATION OF GENDER INCONGRUENCE: THE NEEDED RESEARCH

Guy T’Sjoen, an endocrinologist started a study in 2010 called: “The European Network for the Investigation of Gender Incongruence (ENIGI).”¹¹⁹ This is the first study of its kind and it follows trans* people through their transition and for years afterwards. It is also the largest study on transgender people in the world due to the large volume of participants. Currently, the study has 2600 participants across four clinics in Europe.¹²⁰ ENIGI and some other studies are setting out to provide data on the best treatments and outcomes for trans* people. The research they are conducting has already revealed results: “Tantalizing hints are already beginning to emerge about the respective roles of hormones and genetics in gender identity. And findings are beginning to clarify the medical and psychological impacts of transitioning.”¹²¹ In fact T’Sjoen argues that the field is growing rapidly and already showing the potential of improving the care that trans* people receive. T’Sjoen states: “Saying you you’re not informed about this topic is not really valid any more, it is just that you are lazy.”¹²² Even though the NBTS is arguing that there still is not sufficient research on the impact of long time treatment, these studies are being conducted. ENIGI researchers have concluded that, so far, hormone treatments seem to be safe, with only a few side effects. “The most common complaints

¹¹⁹ Sara Reardon, “The Largest Study Involving Transgender People Is Providing Long-Sought Insights about Their Health,” *Nature* 568 (April 24, 2019): 446, <https://doi.org/10.1038/d41586-019-01237-z>.

¹²⁰ Reardon.

¹²¹ Reardon.

¹²² Reardon.

from people are lowered sexual desire and voice change. But the most significant change the researchers have measured is something positive – a decrease in anxiety and depression after treatment.”¹²³

As mentioned above, Alexander Tønseth and the NBTS argue that due to lack of research we do not know if ‘partial treatment’ will provide the wished-for result. In fact, a report published in 2014: “Effects of Different Steps in Gender Reassignment Therapy on Psychopathology: A Prospective Study of Persons with a Gender Identity Disorder,” where T’Sjoen was co-author explores how gender reassignment therapy affects psychopathology and other psychosocial factors.¹²⁴ The aim of the study was to figure out if psychoneurotic distresses – anxiety, agoraphobia, depression and so on – decreased or increased after receiving gender reassignment therapy. The result showed that the most prominent decrease occurred after initiation of hormone therapy: “The effect of complete treatment is not more pronounced than that of hormone therapy alone.”¹²⁵ Indeed, this research shows that partial treatment, such as hormone treatment, provides the wished-for effect. Also, research on when and what treatments should be providing for children is taking form. The US National Institutes of Health’s (NIH) launched a prospective study of 400 transgender adolescence in 2017. “It will be the first study to examine the effects of drugs that block puberty until a teenager’s body and mind is mature enough to begin cross-sex hormone treatment.”¹²⁶

T’Sjoen points out that researchers must be careful not to make things more difficult for an already stigmatized group, and also argues for the individuals experience, wishes and priorities, instead of only focusing on only questions that are scientifically interesting.¹²⁷ Indeed, the NBTS

¹²³ Reardon.

¹²⁴ Gunter Heylens et al., “Effects of Different Steps in Gender Reassignment Therapy on Psychopathology: A Prospective Study of Persons with a Gender Identity Disorder,” *The Journal of Sexual Medicine* 11, no. 1 (2014): 119–26, <https://doi.org/10.1111/jsm.12363>.

¹²⁵ Heylens et al.

¹²⁶ Reardon, “The Largest Study Involving Transgender People Is Providing Long-Sought Insights about Their Health.”

¹²⁷ Reardon.

claim for lack of research is not supported by the work that is being done both in Europe and the United States. What all these different studies have in common is individualization of treatment and focusing on the wishes and experiences of trans* people. T'Sjoen says: "But even though scientific societies have produced medical guidelines, each person's treatment is still generally a matter of an individual physician's judgement."¹²⁸

THE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH: INTERNATIONAL GUIDELINES

The referral to international guidelines and expertise is not cited by Tønseth or the NBTS. However, since the debate address de-pathologizing being trans*, "Standard of Care: for the health of transsexuals, Transgender and Gender Nonconforming People" (SOC)¹²⁹ written by The World Professional Association for Transgender Health (WPATH), is presented by other healthcare professionals and trans* activist who participate in the debate. The goal for SOC is to provide clinical guidance for health care professionals when they assist transsexuals, transgender and gender non-conforming people, to employ "...safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment."¹³⁰ In the introduction to this version of SOC the authors write that meeting trans* people and gender non-conforming people with respect is very important. "The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judge as inherently

¹²⁸ Reardon.

¹²⁹ *Standard of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 7 vols., Standard of Care (The World Professional Association for Transgender Health, n.d.), <https://www.wpath.org/media/cms/Documents/Web%20Transfer/SOC/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf>.

¹³⁰ *Standard of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 1.

pathological or negative.”¹³¹ The SOC states that since stigma is attached to gender nonconformity, this can lead to prejudice and discrimination resulting in minority stress. Experiencing minority stress is socially based and might make trans* people and gender nonconforming individuals more vulnerable to develop mental health issues, such as anxiety and depression.¹³²

The sexologists above argue that the NBTS’ negative and pathologized presentation of trans* people in national newspapers intensifies their mental health issues. Their arguments follow the international guidelines provided by WPATH and their critique of the NBTS’ approach regarding patients who suffer from mental health issues is justified by the guidelines SOC presents. In fact, I argue that the NBTS shows a lack of insight in the updated instructions provided by the organization who provide research and guidelines for clinics all over the western world. SOC also write that treatment is available to assist people with distress to explore their gender identity and find a gender role that provides them comfort. “Treatment is individualized: What helps one person alleviate gender dysphoria might be very different for what helps another person. This process may or may not involve a change in gender expression or body modification. Medical treatment options included...Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.”¹³³

As SOC’s guidelines clearly state that treatment should be individualized and what works for one individual, does not necessarily fit another person, Tønseth at NBTS’ concludes that insufficient research in the area must result in a “all or nothing approach” to treatment, is misinformed. As SOC’s guidelines clearly states that treatment should be individualized, and what works for some individuals does not work for others. The question then is, what does Tønseth believe the “desired effect is”? In line with international guidelines and the trans* activists: the desired effect a maximization of overall

¹³¹ *Standard of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 4.

¹³² *Standard of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 4.

¹³³ *Standard of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 5.

health, psychological well-being and self-fulfillment. Contrary to Tønseth's claims, there is no research that states an unwanted effect of "partial treatment." Rather, hormonal treatment or acknowledgement and being believed can have the desired effect. Since Tønseth is arguing for an all or nothing approach, it can be contended that for him, you have to fully transition to become the opposite sex. Hence, the definition of gender is closely tied to having the "right" genitals. In the next section I present the patient experiences of some trans* people in Norway, which also confirm the NBTS "one size fits all" approach to gender affirmative treatment. More importantly, these experiences show the extent to which the NBTS is breaking international consensus by pathologizing the experience of trans* people in Norway.

TRANS* PERSONS EXPERIENCE IN MEETING THE NBTS

In this debate, many young trans* people have written articles about their personal experience with the NBTS, where some left after years of treatment at the NBTS due to the extreme negative effect this experience had on them. Lukas Anderson, a 19-year-old man with personal experience as a patient at NBTS wrote: "The doctors talk to you like you being trans* is a pathological condition. They are pressing gender into a tiny little box that might fit a few selected ones. It is worse for the rest of us."¹³⁴ He explains that the treatment he received at NBTS was so traumatizing and degrading that he could not do it anymore. The doctors at the NBTS challenged his identification as a trans* man due to his sexual experiences. Identifying as a trans* man who in the past has had male sexual partners was a clear indicator for his doctors that he most likely was not a trans* man after all. As Anderson explains: "...because I have had sex with other men, or because I had sex in the first place, they told me that this is not normal for a trans* person."¹³⁵ He refused to say that he was "changing

¹³⁴ Lukas Andersen, "Rikshospitalet Har All Makt over Oss Transpersoner. Derfor Er vi Livredde for å Snakke," accessed December 11, 2018, <https://www.aftenposten.no/meninger/sid/i/1kBeBM/Rikshospitalet-har-all-makt-over-oss-transpersoner-Derfor-er-vi-livredde-for-a-snakke--Lukas-Andersen>.

¹³⁵ Andersen.

gender”, because in his eyes he had been a man his whole life. For him to admit that his body was wrong was the same as giving up, like admitting that he would never be good enough. “I only have one body, and I refuse to try not to accept it.”¹³⁶ He also writes: “the NBTS has all the power over you. There is no other choice of treatment, it is all or nothing.”¹³⁷ Anderson is no longer a patient there because the treatment he received so negatively impacted his self-esteem that he could not continue: “I have made peace with the fact that I am trans*, that people call me sick. That there is no dignified health care for me in Norway... But I will never accept that those who come after me will have to go through the same as me.”¹³⁸ Dorian Gabriel Norheim wrote an article called: “When Am I Trans* Enough for You, NBTS?” Norheim describes his meeting with the Norwegian healthcare system, after his referral to the NBTS was denied because of “uncharacteristic symptoms”, their reasoning being that he did not fit the stereotypical image of a trans* man. “I am too feminine, not man enough, not stereotypical enough. So, what is good enough for you?”¹³⁹

NBTS DIAGNOSIS APPROACH: NOT TOO SICK, BUT SICK ENOUGH

Underlying NBTS’s monopoly and form of treatment is that transsexuality has long been treated as a very serious psychiatric diagnosis in Norway. While international guidelines have been working to de-psychopathologize trans* as a condition since 2010, the NBTS has not been following this development. The WPATH stated that “...the expression of gender characteristics, including identities, that are not stereotypically associated with one’s assigned sex at birth is a common and culturally-diverse human phenomenon that should not be judged as inherently pathological or negative.”¹⁴⁰ Indeed, NBTS treatment of trans* people in Norway directly contradict the international

¹³⁶ Andersen.

¹³⁷ Andersen.

¹³⁸ Andersen.

¹³⁹ Dorian Gabriel Norheim, “Når er jeg trans nok for dere, Rikshospitalet?,” *Aftenposten*, accessed November 29, 2018, <https://www.aftenposten.no/article/ap-a2nnvL.html>.

¹⁴⁰ *Standard of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 4.

guidelines they claim to follow and also, ironically, the guidelines they use to justify their discrimination of teenage trans* people in the articles mentioned above. The NBTS also uses their connection to international guidelines and expertise to demonstrate their role as experts, by constantly point out the lack of research. This is also echoed through their strong encouragement to trans* persons not to undertake “self-surgery”, when the case in question was a woman who had been refused treatment at the NBTS and tried to cut off both her testicles and penis at four different occasions. Even though this action was a clear cry for help, NBTS did not take any responsibility for her situation, just further stating that she was too mentally unstable to receive the surgery that she clearly needed. Instead of reviewing her individual case and her need for treatment, NBTS maintained the claim that, due to lack of research, they could not help her. They never stated which international guidelines or research they referred to, taking for granted what Gjevjon described as a “knowledge society.” In the Norwegian “knowledge society”, the NBTS’ position as experts gives them higher authority commenting the subject in question, without being questioned despite international guidelines and expertise presented by WPATH clearly condone NBTS approach. Also, to answer Gerhardens call for the national media to take responsibility to question the public health care system and the expertise around trans* persons conditions. Even though NBTS is claiming that there is no research and use this claim in tread with international guidelines to limit treatment, as stated in the section above; there is research.

THE POWER OF DIAGNOSIS:

Doctor Anne Kviem Lie, a doctor and associate professor at the Department of Health and Society, University of Oslo and Ketil Slagstad, a doctor and the medical editor of *Tidsskriften* addressed the issue of stigmatizing trans* people. In their article called: “The New Diagnosis of Gender Incongruence is an Acknowledgment – Of Trans* Persons Rights to Decide for Themselves

Who They Want to Be”¹⁴¹ they state that: “Diagnoses are not innocent. Diagnoses distinguishes diseased from healthy and defines the limits of normalcy. Diagnosis have power.”¹⁴² Gender and gender identity is changing both nationally and internationally, especially after the de-pathologizing of being trans* in the new diagnosis manual ICD-11.¹⁴³ This is the result of a long battle from a marginalized and stigmatized group in our society, but also societies understanding of gender as an identity. They stress that historically diagnosis of gender variants that deviates from the dominate understanding is a good example of how diagnosis functions in medicine. “For over 100 years, Western medicine has put labels on gender identities and gender expressions that have separated them from (and thus threatened) what society has perceived as normal.”¹⁴⁴ Lie and Slagstad explain that the diagnosis of gender identity has contributed to an increased stigmatization of trans* people, but medicine has also allowed trans* people to realize their identities, bodies and lives. Accordingly, the expert group who worked on the new ICD-11 - with support of many activist – decided that it is important to keep the diagnosis because “diagnosis ensures rights, such as health care services and social security benefits.”¹⁴⁵ Lie and Slagstad emphasize that the change in diagnosis is important because it recognizes that gender identity is fluid. Concepts such as “anatomical sex” and “opposite sex” has been removed and the Transsexual diagnosis in ICD-10 (F-64.0) removes the diagnosis which targeted those who felt like they were born in the “wrong body.” Instead, the new diagnosis of gender incongruence is defined as a: “mismatch between ones gender identity and primary or secondary gender characteristics, accompanied by strong desire to remove or alter some or all of them.”¹⁴⁶

¹⁴¹ Anne Kveim Lie and Ketil Slagstad, “Kjønn, seksualitet og strid. Den nye diagnosen anerkjenner transpersoners rett til å være seg selv,” *Aftenposten*, October 6, 2018, <https://www.aftenposten.no/article/ap-BJEp3l.html>.

¹⁴² Lie and Slagstad.

¹⁴³ Lie and Slagstad.

¹⁴⁴ Lie and Slagstad.

¹⁴⁵ Lie and Slagstad.

¹⁴⁶ Lie and Slagstad.

Further, Lie and Slagstad note that only people who are given the diagnosis of transsexualism by NBTS are offered gender affirmative treatment which is covered by universal healthcare. This practice increases the risk of dangerous self-medicalization for the group who fall outside treatment options due to economic restrictions, restrictive policies, or lack of knowledge among health personnel. The new diagnosis manual provided by The World Health Organization broadens the definition of persons with different gender identities who should be offered gender affirmative treatment. The recent increase in trans* people in Norway who seek private health care services for gender-affirmative treatment can be explained by the fact that the country has too restrictive treatment practices.¹⁴⁷ Lie and Slagstad conclude their article stating “...we need prospective treatment studies, also for the medical treatment of the wider group of patients who fall under the new diagnostic criteria for gender incongruity. While we are waiting it is time for a health care system that, above all, does not hurt the people it is meant to help.”¹⁴⁸

CHAPTER FIVE: ACKNOWLEDGE EXPERTICE

THE STATE APPOINTED EXPERT GROUP: REVISION OF CURRENT HEALTH CARE FOR TRANS* PERSONS

As mentioned in the introduction, the law alteration that started the controversial debate on trans* health care was a reaction to Amnesty’s report “The State Decides Who I Am: Lack of Gender Recognition for Transgender People in Europe.” In this report the current health care system and monopoly in Norway was criticized. The expert group who was appointed by the Norwegian Directorate of Health in December 2013 was given two mandates: to review the present conditions

¹⁴⁷ Lie and Slagstad.

¹⁴⁸ Lie and Slagstad.

for changing legal gender recognition in Norway and to assess the requirements for and propose changes to the current patient and treatment services offered to people who experience gender dysphoria.¹⁴⁹ The recommendations of the expert group was to decentralize the health care monopoly at NBTS, expand treatment opportunities provided for trans* people and create an approach that secures a wider group treatment. In other words, the expert groups recommendation aims to liquidate the gender affirmative treatment monopoly that the NBTS currently holds. In the next section I elaborate the critiques some of the experts in the appointed group had regarding the NBTS. As Gerhardsen accurately stated, it is the press' responsibility to challenge the public health care systems knowledge and expertise. The narratives told by the next group of people show that there has indeed been a diverse presentation regarding trans* issues in national newspapers, where NBTS expertise has been questioned.

TRANS* PROFESSIONALS: THE IGNORED EXPERTISE

Esben Esther Pirelli Benestad is a doctor, professor, specialist in clinical sexology and a part of the appointed expert group. Hen¹⁵⁰ was also the first trans* person who came out publicly in Norway. In connection to Amnesty's report, Professor Benestad did an interview in 2014, called "Treatment of Transgender People in Norway: Absolute and old-fashioned."¹⁵¹ In an article Benestad published before the new law was put into place, hen criticizing the Norwegian government for not treating trans* persons in Norway as full citizens by law, but mainly hen is criticizing NBTS's monopoly on gender affirmative treatment as discriminatory and a direct violation of international standards. The World Professional Association for Transgender Health (WPATH) provides

¹⁴⁹ "Retten til rett kjønn - Helse til alle kjønn," 173.

¹⁵⁰ In Benestad case Hen is pronoun wished to use, and hen explain this as: Hen are a pronoun for people who feel they are too much woman and too much man to be only one the ordinary sense.

¹⁵¹ Esben Esther Pirelli Benestad, "Behandling av transpersoner i Norge: Eneveldig og gammeldags," *Amnesty Internationl*, February 5, 2014, <https://amnesty.no/behandling-av-transpersoner-i-norge-eneveldig-og-gammeldags>.

guidelines on how trans* people should be met in public sectors. “It says that this should not be seen as a psychiatric diagnosis, but that this is a part of human diversity.”¹⁵²

Benestad claims that the reason for the NBTS’ monopoly is that transsexualism has been viewed as a severe mental diagnosis, something special and exotic. Benestad argued that NBTS only offer the diagnosis and then treatment to trans* persons who have communicated their gender dysphoria from early childhood. Also, to get treatment at the NBTS, one must either engage in education or have a job. If one is depressed or for other reasons not able to perform these roles in society, it prohibits individuals from receiving the diagnosis of transsexualism at NBTS and are therefore, not eligible for treatment.¹⁵³ According to Benestad, NBTS is only conducting full objective, sex-confirming treatment and does not give the opportunity to adjust in relation to what each person thinks they need. “Here it is all or nothing, and it is discriminatory.”¹⁵⁴ Indeed, Benestad claims that people have received much more treatment than they initially wanted and needed, because if they express their wishes for “partial treatment” they will not receive any treatment at all.¹⁵⁵ This “all or nothing” approach is also supported through Tønseth argument towards NBTS’ statement that they do not know if “partial treatment” will result in an outcome that pleases the patient.¹⁵⁶ Benestad concludes the article by stating that if NBTS followed international guidelines regarding deciding who needs hormonal treatment and possibly gender affirmative surgery, NBTS would offer more people gender affirmative treatment. This statement is supported by the international guidelines and research presented above. Benestad expresses hope regarding the expert committee which reviewed the health care services for trans* persons. “It is my heartfelt hope that this will make Norway a good

¹⁵² Benestad.

¹⁵³ Benestad.

¹⁵⁴ Benestad.

¹⁵⁵ Benestad.

¹⁵⁶ Sae-Khow, “Rikshospitalet fraråder selvkirurgi på det sterkeste.”

country to live in, also for this group of people.”¹⁵⁷

SURVEY ON GENDER INCONGRUENCE IN NORWAY:

The reports from Amnesty, resulted in appointing the expert group mentioned above and changing the law regarding legal gender. However, NBTS still has monopoly on gender affirmative treatment covered by universal healthcare. In 2018, Benestad, with Silje-Håvard Bolstad a specialist in clinical psychology and a specialist in sexology guides, and Tor-Ivar Karlsen a PhD associate professor at the department of Health and Nursing Science wrote an article called: “Born in the “Wrong Body” in the Wrong Country: New Survey on Gender Congruence in Norway Gives Alarming Results.”¹⁵⁸ As a result of the growing debate in national newspapers arguing against gender affirmative treatment, the authors of the article create a study with the aim to find out how gender incongruent persons experienced gender affirmative treatment, and 180 trans* people participated.¹⁵⁹ The result showed that over 80% of the participants have experienced suicidal thoughts and 30% had attempted suicide, which is a 250 times higher risk than in the general population. Another result from this survey, was that almost all of these thoughts disappeared after the individual commenced hormone therapy.¹⁶⁰ “The most dangerous period is therefore before treatment starts.”¹⁶¹ What this survey also showed was that more than 60% of the participants have been discriminated against by health professionals and out of the 180 participants only one out of five felt that they had been met in a satisfactory manner at the NBTS, and only one fourth were very

¹⁵⁷ Benestad, “Behandling av transpersoner i Norge.”

¹⁵⁸ Esben Esther Pirelli Benestad, Tor-Ivar Karlsen, and Silje-Håvard Bolstad, “Født i «feil kropp» i feil land: Ny undersøkelse om kjønnsinkongruens i Norge gir alarmerende resultater,” *Aftenposten*, November 20, 2018, <https://www.aftenposten.no/article/ap-A2nJOr.html>.

¹⁵⁹ “Velkommen til KHOM-studien: Kjønn, helse og medborgerskap,” Universitetet i Agder, accessed April 4, 2019, <https://www.uia.no/forskning/khom/velkommen-til-khom-studien-kjoenn-helse-og-medborgerskap>.

¹⁶⁰ Benestad, Karlsen, and Bolstad, “Kronikk.”

¹⁶¹ Benestad, Karlsen, and Bolstad.

satisfied with the treatment they had received.¹⁶²

The authors stress that the diagnoses F64.0 Transsexualism has been seen as so rare that it was put under a system that gave NBTS a national hospital monopoly on treatment for trans* people. This monopoly is now being challenged because of the large group of people who experience gender incongruence but do not fit into the criteria within which NBTS operates. These group must, therefore, seek help elsewhere.¹⁶³ Benestad and Bolstad are calling for a broader understanding of treatment necessary for this group: “Some just need conversation with a competent professional to find their identity. Others need someone who can inform family, school or the workplace. Some want more or less comprehensive hormonal support, someone wants to remove breasts, feminizing facial surgery, or surgically changing their genitals. There is no one size fits all.”¹⁶⁴ They are calling for a expanding treatment for people who experience gender incongruence outside of the NBTS and compliment it with regional health professionals with relevant education who can investigate and provide hormonal treatment, and refer to possible surgery and provide to assistance doctors, psychologists and others in the “first-line service.”

Also, it is necessary to develop treatment on a third level, where they can treat and investigate complex neuropsychiatric conditions or other serious mental problems, as well as taking responsibility for sex-confirming surgery.¹⁶⁵ This model is an example from Sweden where they have five different treatment places and where full evaluation rarely takes more than six months. In Sweden, nobody is rejected from treatment. Instead, the individual in question, in collaboration with health professionals, can develop a personal treatment plan. If this process results in no treatment at all, it still is in collaboration with the person in question and there is no scenario where they are left

¹⁶² Benestad, Karlsen, and Bolstad.

¹⁶³ Benestad, Karlsen, and Bolstad.

¹⁶⁴ Benestad, Karlsen, and Bolstad.

¹⁶⁵ Benestad, Karlsen, and Bolstad.

without any help at all. The end of Benestad and Bolstad's article states that "Many of those who do not receive help today are not only born in the "wrong body", they are born in the wrong country!"¹⁶⁶ The central question is, what happens when you do not fit into the "one size fits all" model?

IS THERE COMMON GROUND TO BE FOUND?

The question remains, is there any common ground to be found between these two dominant approaches towards trans* people? Since the two fundamental approaches are in oppositions to each other the answer is no. However, as the conversation presented and constructed in this thesis demonstrates, there is no doubt that most of the participants in the debate, namely the trans* activists, the parent network and NBTS care about the lives of trans* people in Norway and do not act in bad faith. A shift of focus is desperately needed, because no matter of intent, the consequences of the debate is suffered through the lived experience of trans* people in Norway. In the next section, I present a conversation created after The Scandinavian Parent Network, in collaboration with Tonje Gjevjon, create a webpage called "secure in ones body." Although, one can argue that "secure in ones body" as a concept in itself fully recognizing that there are in fact no wrong bodies and that you can inhabit your body with your gender identity freely, this language, while seemingly inclusive, is a rosy cover for material that fundamentally views trans* as a pathology. Even though one can claim that the creators of the webpage meant well, by forwarding an argument inside a framework that is transphobic, the conclusion will be false. Hence, this webpage represents an extremely transphobic notion where there is no place for trans* people in society.

SECURE ON ONE'S BODY: SHALLOW ACCEPTANCE

In the spring of 2017 The Scandinavian Parents Network for Persons with Rapid Onset Gender Dysphoria, in collaboration with Tonje Gjevjon, created a webpage called "secure in ones

¹⁶⁶ Benestad, Karlsen, and Bolstad.

body (tryggikroppen.com).” Their goal was for this webpage to work as an information channel for what they called the “trans trend – an alleged increase in children and youth who feel they are born in the wrong body.”¹⁶⁷ This webpage is no longer active and not possible to find online, the only information available is articles published in critique to the page. The website claimed there is no such thing as being “born in the wrong body” and they encourage parents who have children that express these feelings to reach out to them. It received critiques such as, “Some of the ugliest and most transphobic language I have seen,”¹⁶⁸ “It represents an ideology where there is no room for transgender people.”¹⁶⁹ Others found that “The therapy method ‘tryggikroppen.com’ strongly advertises reminds one of the homotherapy found in the US.”¹⁷⁰

Indeed, since trans* activists in Norway are, according to Gjevjon and the Scandinavian Parent Network, “transing” their children through social media, they encourage parents to seek help elsewhere. Gjevjon writes: “Let youth grow up without the political agenda of the somewhat intrusive rainbow family”¹⁷¹, claiming that trans* activists are forcing “transgender-ness” onto kids who could just grow up outside of the gender norm. Gjevjon was listed as the responsible web editor and if someone contacted the site, they were actually referred to an “anonymous mother” who is a part of the Scandinavian Parent Network. The Scandinavian Parent Network states that “we see it as necessary to be anonymous because some of us have children who think they are trans-children and because many of us fear hatred and labels from the trans and queer movement.”¹⁷² Due to this fear,

¹⁶⁷ Tekst: Pelle Bamle, “Tryggikroppen.com: «Noe av det styggeste og mest transfobe jeg har sett»,” *NATT&DAG*, August 2, 2017, <http://www.nattogdag.no/2017/08/tryggikroppen-com-noe-av-det-styggeste-og-mest-transfobe-jeg-har-sett/>.

¹⁶⁸ Bamle.

¹⁶⁹ Bamle.

¹⁷⁰ Ingrid Frivold, “– Terapimetoden det reklameres for minner sterkt om «homoterapien» man kan finne i USA,” *NATT&DAG*, August 2, 2017, <http://www.nattogdag.no/2017/08/terapimetoden-det-reklameres-for-pa-tryggikroppen-com-minner-sterkt-om-homoterapien-man-kan-finne-i-usa/>.

¹⁷¹ Tonje Gjevjon, “Fra en guttejente som har det bra,” *Dagbladet.no*, June 28, 2018, <https://www.dagbladet.no/a/69969977>.

¹⁷² Bamle, “Tryggikroppen.com.”

Gjevjon assumes the position of the “scape goat” so the worried parents of trans-children could still create a supportive network without dealing with trans* activists, who Gjevjon refers to as an “...aggressive and intolerant movement who wants the entire world to form after their emotions, theories and terms.”¹⁷³

THE INTERACTION THAT COULD CREATE COMMON GROUND:

This webpage was treated as a big controversy and received massive critique. Musician and trans* woman Ingrid Frivold and gender diversity advisor for FRI and trans* man Luca Espseth shared their concern about the webpage in an interview. Frivold stated that this webpage represents an ideology where there is no place for trans* people and advises everyone who experience confusion regarding gender to contact their local doctor or the organization FRI who works for gender and sexual rights in Norway.¹⁷⁴ Espseth argued that the webpage had a clear agenda without it being supported with academic content.¹⁷⁵ Espseth explains that all the sources listed on the webpage are all conspiracy websites, stating that trans* persons are an undesirable social phenomenon. In an article written by Pelle Bamle, Frivold and Espseth state that “tryggikroppen.com [is] the ugliest and most transphobic [website] I have ever seen”¹⁷⁶. The reason the website met such strong critique is that the webpage states that nobody is born in the wrong body and that the present gender incongruence in children is a trend contrary to the children’s best interest. Aurdal consider the webpage is a reminiscent of previous attempts to cure homosexuality.¹⁷⁷ The pathologized treatment of children with gender incongruence is truly worrisome due to the nature of the stress such mis-recognition represents.

¹⁷³ Tonje Gjevjon, “Vagina eller fronthull?,” *Dagbladet.no*, February 15, 2017, <https://www.dagbladet.no/a/67038855>.

¹⁷⁴ Frivold, “– Terapimetoden det reklamerer for minner sterkt om «homoterapien» man kan finne i USA.”

¹⁷⁵ Bamle, “Tryggikroppen.com.”

¹⁷⁶ Bamle.

¹⁷⁷ Aurdal, “Transfobi på norsk.”

Pelle Bamle contacted Gjevjon for a comment and was referred to an anonymous mother who is the person behind the webpage. The anonymous mother stated that she agrees with the statement that counseling and guidance are important while dealing with such a complex situation, and that this should be done in collaboration with experts. “But where are the professionals with real knowledge in Norway?”¹⁷⁸, The anonymous mother argues that Norway only have a tiny professional environment closely linked to organizations run by and for gender diversity and trans* people: “We feel it is important to point out that the experts are not neutral.”¹⁷⁹ She ends her argumentation saying they are looking for a “drug-free approach” to gender dysphoria/gender incongruence, and they are calling for neutral professional practitioners without any connection to the trans* community. “We believe that anyone experiencing these kinds of difficulties should get safe and good help.”¹⁸⁰

THE TRANS* COMMUNITY: A CONSTRUCTED ENEMY PICTURE

Espeseth describes this critique of the trans* community as a constructed enemy picture, arguing that one of the patient organizations in Norway has a collaboration with NBTS. “If the experts are to be criticized for something it must be that they are too restrictive when it comes to providing gender-confirming treatment.”¹⁸¹ Espseth also argues that having therapists and experts with some connection to trans* people is an advantage, since they will know about the challenges people have and where they can receive the help they require. “Knowing trans* people and actually understanding the challenges we face does not make you less, but more fit to do a good job.”¹⁸² Espseth finishes his argument by encouraging parents who want advice and guidance to contact him and the organization FRI. As a parent you are allowed to think it is difficult and frightening if your

¹⁷⁸ Bamle, “Tryggikroppen.com.”

¹⁷⁹ Bamle.

¹⁸⁰ Bamle.

¹⁸¹ Bamle.

¹⁸² Bamle.

child “comes out” as anything you did not expect, and that FRI wants to look after parents as well, so that their reactions and fears do not affect their kids in a negative way.¹⁸³

It appears that the requirement to obtain expert status by the Scandinavian Parent Networks is to not recommend any treatment at all. It is in this interaction we get to the heart of the question: who are the Norwegian experts? Since the fundamental understanding of what being trans* entails are different in the two group, it is not likely that they can find common ground right now. However, I argue that the trans* activists’ strong critique to NBTS also compliments the Scandinavian Parent Networks wishes for a less invasive treatment practice for their children who experience gender incongruence. Before the law was changed, NBTS’ guidelines demanded their children, when they become old enough, undergo substantial surgery to change their legal gender, something that neither trans* activists nor the Scandinavian Parent Network support.

CONCLUSION:

The experiences trans* people describe at NBTS highlight the consequences their approach has had, and how the lived experience impacts the physical bodies as well as the mental state of the patients. Also, NBTS justifies their cautious approach to treatment by refereeing to international guidelines. NBTS’ main argument is that there is not enough information about the patients at hand, and that they cannot do anything for them. This, I argue truly show the extensive measures the NBTS is willing to take to find other explanations and solutions for these individuals rather than accepting the fact that they are trans*. It also shows the underlying notion of viewing trans* as a mental disorder, which is contradictory to international guidelines and research presented above. There are contributors in this debate who are actively doing research on trans* people experience of medical

¹⁸³ Bamle.

treatment in Norway in collaboration with Norwegian sexologists to improve healthcare services for trans* people.

Indeed, the arguments on both sides of the debate are challenging the label of trans* experts, and who qualifies as an expert. If one believes, as the TERF's and NBTS do, that gender incongruence is a mental illness, the experts in the field cannot be trans* themselves or pro-trans* as it would cloud their judgement. However, if one believes, as Frivold, Espseth and the other trans* activists, that being trans* is a part of a person's gender identity, the experts need to have personal experience with trans* persons to fully understand the complexities of their situation. On the other hand, if one believes the Scandinavian Parent Network, the experts in the field can only be health care professionals who promote a "drug-free approach" to gender incongruence. The expert in this scenario would argue that there is no "one size fits all" approach, since gender identity is different in each individual. This is also one of the reasons the de-pathologizing of being trans* is important, to provide individually tailored healthcare. What the critical side of the debate is continuously doing is denying trans* people their agency, while claiming that their experience is nothing less than mental illness. The wish for a "drug free" approach is not possible as many trans* persons have a vital need for gender affirmative treatment. Still, what Espseth and the trans* activists are arguing for is an approach that centers around the individual's need for treatment. This approach is less invasive than the current NBTS practices as it opens up for choosing just how much treatment one needs rather than forcing an "all or nothing" approach on all trans* people. Not only that, it also secures the fundamental human rights everyone has to agency and recognition.

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