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Playing the game of law and healthcare - Non-binary people's access to and experiences of trans-specific healthcare in Finland

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Master Thesis (SOLM02)
Spring 2022

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Title: Playing the game of law and healthcare – Non-binary people's access to and experiences of trans-specific healthcare in Finland
Degree: Master of Science in Sociology of Law
Department: Sociology of Law
Supervisor: Martin Joormann
Year: 2022 **Pages:** 77

ABSTRACT:

For non-binary people the law is not securing trans-specific healthcare in Finland. The current regulation is built on understanding of gender as binary and according to *the Act on Legal Recognition of the Gender of Transsexuals (563/2002)* a person can be confirmed to belong to the "opposite gender" if she/he fulfils the preconditions. One of the requirements is a mental health diagnosis prior to a non-binary or a transgender person can receive gender-affirming care or have their legal gender recognised. Depending on the diagnosis a care-seeker may not receive all the treatment they need. The task of this thesis is to discover how non-binary people experience the accessibility of trans-specific healthcare and trans-specific healthcare itself in Finland as well how the Finnish law drafting material represents accessibility of trans-specific healthcare. The data consists of 13 interviews, and minutes of Parliament's plenary sessions which are both analysed by using thematic analysis. As a theoretical starting point the Foucauldian concept of power is applied.

According to the results, a starting point for the current regulation has been the historically dominant medical discourse portraying transgender people as mentally ill and highlighting a normative understanding of gender as binary. During the Parliament's plenary sessions statements of importance of psychiatric expertise, abnormality of transgender people, and traditional values have been used for entitling medico-legal control over transgender people while ignoring self-determination entirely. Non-binary people's access to the trans-specific healthcare is defined by unpredictability and arbitrariness of the healthcare system. The trans-specific healthcare itself is experienced as a game that a care-seeker has to survive as the healthcare system has the power to deny one's treatment. Overall, encounters with healthcare professionals are defined by the uneven power structure that occurs during the process through healthcare professionals' assumptions of gender as binary, and inappropriate and questioning behaviour towards care-seekers.

Results show that the obstacles non-binary people face in Finland within trans-specific healthcare are tied up with healthcare system's and professionals' assumptions of gender as binary, the uneven power structure, the diagnosis criteria and the process as a game. The current regulation should be revised so that it is based on a self-determination of a person seeking gender-affirming care and/or legal gender recognition, and so that the medical and legal processes are not bound together. Further research is needed especially regarding experiences of non-binary and transgender youth of trans-specific healthcare and access to it.

KEYWORDS: non-binary, trans, gender reaffirmation, trans-specific healthcare, legal gender recognition

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GLOSSARY AND ABBREVIATIONS

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

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

Gender-confirming/gender-affirming medical procedures – Medical procedures that aim to alter gendered bodily features that are commonly assigned a specific (binary) gender, such as masculinizing or feminizing hormone therapy, breast surgery, genital surgery, hair removal.

Gender dysphoria – A concept designated in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* as clinically significant distress or impairment related to a strong desire to be of another gender, which may include desire to alter primary and/or secondary sex characteristics. Not all transgender, non-binary or gender diverse people experience dysphoria.

Gender identity – Refers to a person's deeply felt, internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth.

ICD – International Statistical Classification of Diseases and Related Health Problems

LGBTQ – Abbreviation for Lesbian, Gay, Bi, Trans, Queer

Non-binary – People who do not identify as either men or women may have a non-binary gender identity. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do. Non-binary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid.

Passing – Being perceived by others as having the gender identity you identify with.

Sex/gender assigned at birth – Traditional designation of a person as "female," "male," or "intersex" based on anatomy (external genitalia and/ or internal reproductive organs) and/or biology (sex chromosomes and/or hormones).

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

Transgender – A term used for/by (some) people who do not identify as the gender they were assigned at birth, although not all such persons identify with the term. Transgender can also be seen as an umbrella term compassing persons of binary (trans women, trans men) and non-binary genders alike; however not all of them identify with the umbrella term.

Transsexual - This was used in the past as a more medical term (similarly to homosexual) to refer to someone whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. The term is also used in the Finnish law text, but it is outdated as it refers to sexuality, and many people prefer the term trans or transgender.

Transsexualism – A medical diagnosis in International Classification of Diseases (ICD).

1. INTRODUCTION

A binary understanding of sex or gender refers to the idea that there are only two social genders, man and woman, based on two binary sexes which are male and female. Generally, gender is considered to be cultural, and sex, biological (Stryker 2017). If you identify as a cisgender, a word used to denote people who identify as the gender they were assigned at birth, you probably do not in your everyday life think of how you know what your gender is, or in situations where showing your ID is required, worry if the ID is questioned. These may be everyday issues for gender-nonconforming people, such as transgender and non-binary people, who do not conform to binary notions of the alignment of gender, and sex. For people who do not confirm with a society's norms regarding gender many kinds of routine administrative procedures in a modern bureaucratic society make their lives difficult. Documents, such as birth certificates, school and medical records, and passports, identify a person with a particular gender and problems may arise for example when crossing national borders, applying for jobs, and gaining access to health and social services. (Stryker 2017.)

The social expectation that people who are assigned male at birth will be men and people assigned female at birth will be women, is something that transgender people do not confirm to. The word transgender has come into widespread use not so long ago as it has been in use more broadly only in the past couple of decades, and it is under constant construction. (Stryker 2017.) A transgender person's gender identity does not match with their birth-assigned sex, and they may identify with the "opposite" sex, or for example as a non-binary. Some transgender people need medical gender reassignment and/or legal gender recognition, but not all transgender people need or want these. (Gender Diversity & Intersex Centre of Expertise 2022.) People who do not identify as either men or women may have a non-binary gender identity. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. The term can be also used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid. (Gender Diversity & Intersex Centre of Expertise 2022.) Some non-binary people need medical gender reassignment and/or legal gender recognition.

In Europe 39 countries have legal or administrative measures which make legal gender recognition available for transgender people. Mental health diagnosis is prescribed in 28 countries, including e.g., Finland, and Sweden. Sterilisation is required in 10 countries, Finland included. Alaattinoğlu (2020) emphasises how problematic sterilisation requirement targeting trans people is as there are only bad alternatives. The first one is preserving your fertility but not having identification documents matching with your gender identity, and the second one is attaining legal gender recognition but then have to undergo sterilisation (Alaattinoğlu 2020). In its case *A.P., Garçon and Nicot v. France* the European Court of Human Rights (ECtHR) ruled that the condition of compulsory sterilizing surgery or treatment for legal gender recognition violated Article 8, the right to private and family life, of the European Convention on Human Rights. However, ECtHR's case law is limited regarding cases of involuntary sterilisation targeting different groups, and hence, it is too early to reach any conclusions (Alaattinoğlu 2020).

There are only eight countries in Europe[1] that base legal gender recognition procedures on self-determination of the person, but only two countries, Iceland and Malta, provide full legal recognition to non-binary people. Different legal and administrative measures include e.g., name change, requirements of diagnosis or psychological opinion, requirements of compulsory medical and/or surgical intervention, requirement of sterilisation, requirement of divorce, and different age restrictions. (Trans rights map 2021.) In other words, even if a country has legal and/or administrative measures for legal gender recognition, it does not mean that these measures would not be problematic.

1.1 Aim, purpose, and research questions

The overall aim of this thesis is to analyse how the medico-legal discourse of trans-specific healthcare can affect to non-binary people's access to and experiences of trans-specific healthcare in Finland. This thesis brings out a significant issue on both legal and societal level regarding non-binary people's rights and position in a society particularly in a context of trans-specific healthcare. The concept of trans-specific healthcare, or

[1] Belgium, Denmark, Iceland, Ireland, Luxembourg, Malta, Norway, and Portugal.

gender-confirming care, is used in this thesis to refer to the process which takes place at one of the transclinics, i.e. gender identity clinic, in Finland and includes different phases, such as examination and diagnosis phase, and the phase where medical care including for example hormone therapy and surgical treatment is carried out. In the second chapter of thesis the Finnish trans-specific healthcare is represented more closely. Since there are still obstacles, such as a requirement of a specific medical diagnosis, for non-binary and trans gender people in Finland to receive trans-specific medical care and legal gender recognition, with this research these issues are brought forward and knowledge about non-binary people's position both in a legal and societal system is increased. The topic in the broader social context, however, has been largely invisible as the data of law drafting material in this thesis shows, and even though in recent years research has been conducted regarding non-binary and trans gender people's situation within the Finnish trans-specific healthcare it has been mainly within the fields of health sciences and social work, while no socio-legal studies have been conducted on the topic.

The thesis seeks to answer the following research questions:

1. How is access to trans-specific healthcare represented in the Finnish law drafting material?
2. How do non-binary people approach the binary medico-legal discourse of trans-specific healthcare in Finland?
    2a. How do individuals experience the accessibility of trans-specific healthcare?
    2b. How do individuals experience the trans-specific healthcare itself?

With the help of question number one I examine what reasons and arguments are behind the law regulating trans-specific healthcare in Finland. With the question number two my thesis examines how trans-specific healthcare is accessed and experienced by non-binary individuals, and how overall the medico-legal discourse of trans-specific healthcare is approached by non-binary individuals.

Research on trans-specific healthcare and non-binary people in Finland is scarce yet on the rise lately. Research regarding transgender people and trans-specific healthcare has been mainly conducted within fields of health sciences and social work, e.g., Hyvönen & Väänänen (2014), Salakka (2015), and Kivikallio (2019). Talalas (2019) study on trans-specific healthcare's effects on the mental health of non-binary individuals shows that mental health was perceived as having improved because of gender-confirming procedures. In 2019 medical research on the effectiveness of gender-affirming medical care among non-binary individuals was published and the study concludes that effects are positive and no disbenefits follow (Kettula, Tynkkynen, Sintonen, Tuisku, Puustinen 2019). In Loponens (2021) study within the field of social policy gender minorities' experiences of general healthcare and trans-specific healthcare it was concluded that the gender affirmation process was affected by the power structures in patient care relationship, diagnosis criteria, gender norms, and inappropriate conduct and underestimation from the healthcare professionals' side.

In this thesis the approach is socio-legal, and I examine particularly non-binary people's access to and experiences of trans-specific healthcare in Finland as well the background for legislation regulating this field. There are no former socio-legal studies on this topic in Finland, and this thesis aims to produce knowledge on non-binary people's experiences within trans-specific healthcare, which is in general a topic that has not been widely researched.

1.2 The current regulation in Finland

In Finland there is no legislation ensuring trans-specific healthcare for non-binary people seeking for care. The current regulation is built on the binary distinction between female and male sex. In principle, the law has a starting point where a transgender person can be confirmed to belong to the 'opposite gender' (i.e. 'opposite' of how one's gender is legally recognized) if they meet the preconditions stated in *the Act on Legal Recognition of the Gender of Transsexuals 563/2002*. These requirements are as follow:

1) presents a medical statement stating that he or she permanently feels to belong to the gender opposite to that assigned to him or her and lives in that gender role, and that he or she has been sterilised or is for some other reason infertile;
2) is of age; and
3) is a Finnish national or has his or her place of residence in Finland.

Furthermore, it is the Trans Decree[2] that determines how trans-specific healthcare is organised, what it includes and when it should be applied. In the Trans Decree it is stated that *when a person is seeking treatment because of transsexualism or his or her gender identity calls for clarification he or she should be referred to one of therefor mentioned hospitals for further examination* (Trans Decree 1053/2002). Trans-specific healthcare is concentrated in the Helsinki University Central Hospital (HUS) and the Tampere University Central Hospital (TAYS). All persons seeking gender-confirming medical care who are referred to further treatment are thus referred to one of these hospitals.

The World Health Organisation's (WHO) International Classification of Diseases version 10 (ICD-10) was published in 1992 and was put into operation in Finland in 1996 (Finnish Institute for Welfare and Health 2022). ICD-10 includes a disease group called "gender identity disorders", which consists of the following diagnoses: *F64.0 Transsexualism, F64.1 Dual-role transvestism, F64.2 Gender identity disorder of childhood, F64.8 Other gender identity disorders, and F64.9 Gender identity disorder, unspecified*. These diagnoses are still in use, almost 30 years after their publication. In practice this means that, in Finland, people needing and willing to get gender-affirming care are forced to accept a mental health diagnosis, and even then, they might not get access to care they need and want. For example, to get genital surgery as part of trans-specific healthcare one is required to have a diagnosis *transsexualism*, and this excludes people who have been diagnosed with a diagnosis *other gender identity disorders*. It is evident that the present legislation in Finland, which is tied up with medical requirements, is problematic as people seeking gender-affirming healthcare may be denied access to it based on being a transgender or non-binary in "a wrong way".

[2] A decree of the Ministry of Social affairs and Health on the organisation of the examination and treatment aiming at the change of gender as well as on the medical statement for the confirmation of gender of transsexual 1053/2002.

1.3 Outline of the thesis

The thesis outline is the following. First, I will present more closely both the historical background and the situation nowadays regarding trans politics and trans-specific healthcare in Finland and globally through existing literature in the field. In the chapter three I will go into theoretical starting points of the thesis, and then move on to methods in chapter four. I will present results and analysis based on the law drafting material and interviews in chapter five which is followed by the last chapter where I discuss and reflect on the conclusions of this research.

2. CONTEXT OF THE STUDY IN THE EXISTING LITERATURE

In this chapter the historical background of the societal and academic debate about the lives, plight and rights of transgender people is presented. First, the state of trans-specific healthcare and trans politics in Finland is introduced. As the knowledge on the lives of transgender people has mainly been produced within the medical science, which has then continued to dominate the field through healthcare and legal practices, the historical development of the medico-legal discourse is presented as well. Also, the research in the Finnish context is brought up in more detail in the last part of this chapter.

2.1 Trans-specific healthcare in Finland

Trans-specific healthcare includes different parallel stages where the first one is getting a referral to the examination of gender identity. This referral can be made by any doctor from public or private healthcare and no further investigations are required to access it, although in practice not all healthcare professionals are familiar with the gender reassignment process and that a person seeking for a trans-specific healthcare has the right to get the referral at once. (Trasek ry 2020.) The next stage is the examination phase that usually starts with the appointment at one of the transclinics in Helsinki or Tampere a few months after getting the referral, and it usually takes at least one year, sometimes even longer, before the diagnosis is given. This part of accessing the trans-specific healthcare includes appointments with different healthcare and social work professionals that are part of the multidisciplinary team in charge of the examination, care, and follow-up of trans-specific healthcare. (Gender Diversity & Intersex Centre of Expertise 2020.) A specialist in psychiatry oversees the team, and the team must have at its disposal specialists in gynaecology and specialists in internal diseases that are qualified in endocrinology. The team in Helsinki must also have a specialist in plastic surgery qualified in the surgery of reproductive organs as these operations are carried out there. (Trans Decree 1053/2002.) The evaluation made during this phase is based on discussions between the care-seeker and different members of the healthcare team, as well on psychological tests that are used as part of the evaluation. The examination phase aims to rule out any psychiatric conditions or disorders which might explain the feelings

concerning gender. The team is also evaluating individuals' resources to go through the gender-confirming care and if there are any other matters that should be taken care of first. (Gender Diversity & Intersex Centre of Expertise 2020.)

After the year-long, or in some cases longer examination stage, it is possible to receive a diagnosis *F64.0 Transsexualism* or *F64.8 Other gender identity disorders*. The latter includes different non-binary identities. Though, it needs to be pointed out that there is no guarantee of getting a diagnosis, and in some cases the research unit may refuse diagnosis and ask the care-seeker to get back later if they evaluate that the person in question has not thought through the matter. (Trasek ry 2020.) With the diagnosis *transsexualism* both the medical process and recognition of legal gender are possible. In contrast, the diagnosis *other gender identity disorders* do not enable legal gender recognition and makes it also harder to access trans-specific medical care, such as surgical treatment, as the present interpretation of legislation regulating gender reassignment is that these are ensured for only those who have the transsexualism diagnosis (Gender Diversity & Intersex Centre of Expertise 2020).

With a diagnosis it is possible to start the medical care process. Non-surgical care includes hormone therapy; testosterone or oestrogen and antiandrogens. Epilation and laser treatment is included in the feminising process. Voice therapy is included as well and surgical care may include vocal cord surgery and/or tracheal shave to reduce the Adam's apple. (Gender Diversity & Intersex Centre of Expertise 2022.) However, the voice therapy, removal of facial hair, and vocal cord surgery are included only when the social ability to function according to "a new gender role" requires these (COHERE Finland[3] 2020). Surgical care includes possible breast implants for trans women and transfeminine individuals, and mastectomy (top surgery) for trans men and transmasculine individuals. To access genital surgery, it is required that one has their legal gender recognised[4] , but as the law tends to be interpreted so that it is only possible for those with the diagnosis

[3] The Finnish range of public health services is monitored, defined and assessed as a whole by the Council for Choices in Health Care in Finland (COHERE Finland). The Council issues recommendations on including or excluding health technologies in the range of public health services. The Council's recommendations gradually complement and update the range of service choices.
[4] Tampere University Central Hospital 2020.

transsexualism, the genital surgery is usually not available for those with a diagnosis *other gender identity disorders.* (Gender Diversity & Intersex Centre of Expertise 2022.)

2.2 Trans politics in Finland

The government proposal for the Act on Legal Recognition of Gender of Transsexuals in 2001 validates the need for law by stating that the lack of regulation of transgender people's right to have their legal gender recognised and to related healthcare has led to a situation where people seeking care and legal gender recognition are not treated equally. Register offices have different practises on granting a new identity number, and health care practitioners are not following a uniform course of actions when it comes to providing trans-specific healthcare, such as hormone therapy. The proposal underlines that legislation does not ensure the possibility for transgender people to become treated according to their gender identity within those legislation fields where gender matters. This might lead to continual invasions of privacy, and alone a new name and an identity number will not ensure transgender people's position within different fields of legislation. (The Government bill to Parliament 56/2001.)

Furthermore, fundamental and human rights are brought up as a reason for the proposal. The Council of Europe's recommendation *Condition of transsexuals* (1117/1989), which states that the discrimination of transgender people and the invasion of their privacy results from a lack of precise regulation is brought forward. It is highlighted that according to the European Convention on Human Rights article 8 everyone has the right to respect for family and private life, and according to article 12 men and women have the right to marry and start a family. Also, other countries and their legislation regarding legal gender recognition is discussed in the proposal. Using the Sterilization Act and Castration Act is not considered to be effective in the case of transgender people and that is one reasoning. The Sterilization Act is proposed to be changed so that *sterilization can be performed because of transsexualism* and the Castration Act is proposed to be revoked. (The Government bill to Parliament 56/2001.)

Requirements of sterilization, medical report, and the prohibition of being married or in a registered partnership[5] are not justified from the perspective of fundamental and human rights or analysed so that their effects would be considered. The proposal mentions shortly how it is not necessary to have a hormone treatment subject to licensing as this might lead to a black market of hormones and increase health risks. Although this is mentioned, it is not broadly considered if the medical requirements lead to this kind of results anyway. Different countries' legislations regarding legal gender recognition are used as examples in the proposal. This might be one reason why requirements, such as sterilisation, are not seen as violations of human rights. The Finnish proposal thus mainly follows the Swedish Act on legal gender recognition from 1972 *(Lag om fastställande av könstillhörighet i vissa fall*) and adopts the same requirements. The proposal does not consider non-binary people's position and it does not discuss any situation where a gender identity includes other than the binary distinction between woman and man.

Already in the late 1980s a draft for a government proposal regarding legal gender recognition was prepared by Finnish National Board of Health and Ministry of Social Affairs and Health. In the draft the requirements for legal gender recognition were the following: a person has since adolescence felt that he or she belongs to the opposite gender than the one assigned to him or her, is 20 years old, is unmarried and childless, is sterilised or for some other reason infertile, and is a Finnish national. Unmarried means that a person has never been married. However, the draft was never advanced. It was especially criticized for making a hormone treatment subject to licencing, and for demanding that one needs to be childless and that one has never been married. Also, legal effects of legal gender recognition were not figured out efficiently. In 1998, the Parliamentary Ombudsman requested reports from the Ministry of Social Affairs and Health and from Ministry of Interior regarding transgender people and their position in society. A work group was set to investigate the matter and possible needs for legislative revisions. The work group gave its report including propositions for the government proposal, guidelines for health care of transgender people and rules concerning organising the healthcare in year 2000. (The Government bill to Parliament 56/2001.)

[5] The prohibition of being married or in a registered partnership was repealed later as on 1st of March 2017 the so called "Equal" Marriage Act (234/1929) came into force in Finland.

In year 2017 a bill to amend Finland's trans law did not receive enough support in the Parliament (YLE 2017). In September 2021 citizen's initiative[6] titled "The Right to Be" progressed to the Parliament as it received the required 50 000 signatures. The initiative calls for reform of Finland's transgender legislation. (Kansalaisaloite 2022.) Earlier in May 2021 a working committee was set by the Ministry of Social Affairs and Health to prepare reform of trans law (STM 2022). In the draft of government's bill is stated that the aim is to separate the legal gender recognition and the medical examinations and treatment to strengthen self-determination of a person. The application of legal gender recognition would be based on one's own explanation regarding their gender and the sterilisation requirement would be removed as a prerequisite for the legal gender recognition. (The draft for Government bill to Parliament 2022.) However, the citizen initiative and the draft of government's bill differ fundamentally since in the government's draft the requirement of age limit for the legal gender recognition would be 18 years in the future as well. In the citizen's initiative the legal gender recognition would be enabled both to adults and minors on the principle of self-determination. The draft of government's bill was circulated for comment during the spring 2022 and next it will be handed to the Parliament. The new regulations would come into effect in the beginning of year 2023. (STM 2022.) However, many organisations and NGOs focused on human rights and specifically on the rights of gender minorities, such as Amnesty International Finnish section[7], Seta ry[8], and Trasek ry[9], have criticized the draft of government's bill especially for it excluding people under the age of 18 and therefore not respecting self-determination of transgender, non-binary and intersex youth and children.

2.3 The dominant medical discourse

Historically, the definition of transgender people being mentally instable has been formed mainly in the hands of medical practitioners. Physicians have described

[6] A citizens' initiative can propose the enactment or drafting of new legislation. It can also concern the amendment or repeal of existing legislation. (Parliament of Finland 2022.)
[7] Amnesty International Finnish Section 2022.
[8] Seta ry 2022.
[9] Trasek ry II 2022.

"transsexualism"[10] differently, but the focus has been on a standpoint which classifies transsexual people as mentally ill. (Stryker & Whittle 2006, p. 21.) The literature from medical and psychological perspectives represented being trans as *an individual psychopathological deviation from social norms of healthy gender expression and tended to reduce the complexity and significance of a transgender life to its medical or psychotherapeutic needs* (Stryker 2017, p. 2). In 1877 *Psychopathia Sexualis* was published by von Krafft-Ebing, a professor of psychiatry whose assumption was that anything that deviates from heterosexual behaviour indicates physical or emotional disease. He described individuals who identified as members of the "opposite" sex being profoundly disturbed, and the desire for self-affirming transition to be psychotic. (Stryker & Whittle 2006, p. 21.) Departing from von Krafft-Ebing's viewpoint, a German medical doctor and sexologist, Magnus Hirschfeld, founded the world's first gay rights organization, the Scientific Humanitarian Committee, in 1897, and in 1919 in Berlin opened the world's first Institute for Sexology that was destroyed in 1933 by the Nazis who burned the research collection. He was also the first one to use the term "transsexualism" as part of his term *seelischer Transsexualismus* or "psychic transsexualism". Hirschfeld argues in his book *The Transvestites,* which was published in 1910, that *transgenderism is a complex phenomenon that cannot be reduced to homosexuality, fetishism, or some form of psychopathology.* (Stryker & Whittle 2006, p. 28). Hirschfeld used a theory of intermediaries to describe people who were not strictly men or women (Hirschfeld 1910).

David Cauldwell's article *Psychopathia Transsexualis* (1949), is about a female-to-male case study. Cauldwell was a medical doctor whose starting point was that transsexualism is *an unusual sexual deviation* which results from *poor hereditary background and highly unfavourable childhood environment.* (Cauldwell 1949.) Stryker (2006) criticizes the article being problematic and pathologizing despite its frequent citation. Later it was a physician Harry Benjamin who followed Hirschfeld's footsteps and became the leading advocate, although paternalistic one, for transgender people (Stryker & Whittle 2006.) Benjamin (1954) argues that transsexualism requires psychiatric help but that it cannot

[10] The words *transsexualism* and *transsexual* are used in this thesis occasionally as they are used in some of the sources of reference.

be cured by psychotherapy. He highlights the role of a psychiatrist as an expert having the last word concerning the possible "reverse procedure" including hormone treatment and surgery (Benjamin 1954, p. 51-52). Benjamin also popularised the term "transsexual", and his work, including the book *The Transsexual Phenomenon (1966)* determines much of the modern medical approach to transgender phenomena. (Stryker & Whittle 2006.)

In the Finnish context, there is a state mental hospital record from year 1919 when a person called Impi (female first name) was treated because of *degeneratio psychopathica.* According to medical records, Impi wanted to be a man, work like a man and live like a man. Impi wanted to take the male name Esko and when the vicar refused to change the name, Impi/Esko forged the name in the register. When that was covered, Impi/Esko was put on trial and ordered a forensic psychiatric assessment. (Parhi 2018.) In the same study Parhi (2018) has conducted research on patients diagnosed with *Transvestitimus* in the Psychiatric Clinic of the Helsinki University Central Hospital during the years 1954-1968. Parhis analysis show that people were seeking for medical help so that their bodies would correspond to their identity but the care-providers which were psychiatrists at the clinic did not recommend surgical or hormonal treatment since they saw the problem in psychiatric terms. However, this view started to change in the 1970s and 1980s when more international knowledge of surgery was available, and because of interaction with the patients (Parhi 2018). In Finland, the medical standpoint on how "transsexualism" should be understood has been the main knowledge producer for the political decision-making concerning transgender people, and the Trans Act is based on that medical understanding. (Huuska 2010, p. 155-156.)

2.4 The community discourse

Transgender issues have been presented from a viewpoint which emphasizes the individualism of the experience leaving outside the understanding of transgender issues in a wider social context (Stryker 2017). Stryker (2017) argues that instead of collectivizing the trans experience it has been mainly individualised by medical and self-

help literature even if written from a transgender perspective. Feminist theoretician Janice Raymond's book *The Transsexual Empire: The Making of the Shemale* published in 1979 is one of the first non-medical texts concerning transsexual issues. Raymond's standpoint is social constructionist in relation to gender and transsexuality, while it is also highly negative towards transgender people. (Hixson-Vulpe 2008.) She claims that all transsexuals are raping women's bodies (Stone 1991) and demonizes especially transwomen as she states that transwomen exist only because of the medical community's desire to infiltrate women's spaces and feminist movement, and at the same time Raymond ignores the existence of transsexual men (Hixson-Vulpe). The text was also an attack against Sandy Stone, a trans woman working as a sound engineer at Olivia Records, women-only feminist music collective, and the book has had damaging effects to the whole trans community. (Stryker & Whittle, 2006, Hixson-Vulpe 2008.)

Sandy Stones text *The Empire Strikes Back: A Posttranssexual Manifesto* was published in 1991. Stone has poststructuralist analysis of gender identity as a starting point to create new possibilities for transsexual people and for those who are "differently gendered" so that there would be space to escape both medical and feminist discourses that have been denying the agency of trans people. (Stone & Whittle 2006.) Although the text is partly response to Raymond's text, it focuses on critically examining the narratives constructed by medical practitioners and male-to-female transsexuals. Descriptions of woman in autobiographical texts that concern male-to-female processes are all similar in their way how "woman" is described as Western white male's perception of it (Stone 1991). Stone (1991) criticizes the narrative for maintaining and producing the binary representation of gender and for presenting the transition as there were a specific moment when one's sexual identification changes from a male to a female.

Stone (1991) aims for making transsexual people visible and encourages them to keep their histories and make them visible instead of erasing a big part of their life to "pass" in a way a normative society requires. She argues that acceptability in society gained through erasing one's history and *constructing a plausible history* leads to losing the authentic representation of lived experiences with all the complexities and ambiguities. Through these complex histories and the visibility of different narratives it is possible to

create a shift from a binary gender narrative to posttranssexualism, which is not based on "passing" and a discourse centred around a "wrong body". (Stone 1991.) Stone's text has been followed by increasing amount of academic and creative work by transgender people with new critical perspectives on gender (Stryker & Whittle 2006).

Transgender Liberation: A movement whose time has come, written by Feinberg (1992), highlights the history of transgender people and the ongoing battle transgender people face in society. Anti-transgender laws and attitudes produced by Europe's elites, including the church, are criticized by Feinberg (1992) who notes that despite these instances' attempts to destroy transgender people, people have been and still are fighting. Feinberg also gave the term "transgender" a new radical meaning, referring to a "pangender" movement that consists of oppressed minorities – transsexuals, drag queens, cross-dressers, butch lesbians and others (Stryker 2006, p. 205). Stone's (1991) critique focuses on binary gender narratives and performative gender's role within those narratives whereas Feinberg's critique falls upon the common misunderstanding of transgender person always being a gay or lesbian, and how this leads to a situation where it is not acknowledged that these communities overlap only partially (Feinberg 1992). Also, the problem of "passing" is highlighted in the text as Feinberg (1992) argues that it has not existed always as transgender people themselves have, and when one needs to pass it means hiding and invisibility.

Stryker (2006) writes about language games when addressing what kind of position transgender people used to have in discussions. She points out that it was the medical discourse, police reports and feminist and gay liberation discourses that were defining their position. In the dominant medical discourse, for many decades, transgender people were objects rather than subjects, and within discourses of feminist and gay liberation transgender people had the position of outcasts. In the early 1990's, this started to change, and transgender people fought their way into speaking positions. (Stryker 2006.) Both Stone's and Feinberg's texts were part of shaping this community discourse as they were calling *for a movement in which individuals overtly identify their gender identity* and *individuals alike to speak out by creating a space and name under which they can fight* (Hixson-Vulpe 2008, p. 94). As Stone (1991) described, she wanted to create a possibility

to escape the medical and feminist discourses which were positioning transgender people as not having an agency.

2.5 The Finnish context

Access to gender-confirming medical procedures is restricted partly because of legal and medical gender reassignment's close connection (Linander 2018). In the Finnish context, the problems of the medico-legal gender reassignment process have been highlighted by different actors (Trasek 2020, Gender Diversity & Intersex Centre of Expertise 2020) as the consequence for care-seekers might be the denial of access to a medical process and legal gender recognition. This is especially the case when it comes to people who are not receiving the diagnosis "transsexualism" as other diagnosis can be used as a reasoning to not start the gender-affirming process. The situation when one is seeking trans-specific healthcare is highly problematic since care-providers are in a position of power and control over care-seeker's needs and desire. The access to medical procedures is limited in different ways around the world. In some countries, there is no process or specific healthcare at all and in some cases, these are not included in the public healthcare, which makes it impossible for many to access gender-confirming care. (Whittle et al., 2008.)

The ways in which care-seekers perform gender has been shown to affect their access to medical procedures (Spade 2006, Stone 1991). In Finland, research concerning transgender people's experiences of trans-specific healthcare shows that attitudes, normative expectations, ignorance and power relations between care providers and care-seeker cause harm and problems (Hyvönen & Väänänen 2014, Kivikallio 2019). Research has been conducted regarding transgender people and working life (Lehtonen & Mustola 2004), transgender people and healthcare (Aarnipuu 2007) and human rights (Aarnipuu 2008). In the 2010s research increasingly focused on trans and intersex issues. Studies have been concerned with transgender people's experiences of domestic violence (Köngäs 2013), intersex children's self-determination (Silkkola 2014), the position of trans and its formation through discursive practices (Susi 2014), and trans people's narratives and activism, and their effects on trans people's self-definition (Tuominen 2018).

Lately, research on the effectiveness of gender-affirming medical care among non-binary individuals was published in Finland. The study concludes that effects are positive and no disbenefits follow (Kettula, Tynkkynen, Sintonen, Tuisku, Puustinen 2020). Other than that, Finnish research concerning non-binary people and trans-specific healthcare is scarce. Talala's (2019) study on trans-specific healthcare's effects on the mental health of non-binary individuals shows that mental health was perceived better because of gender-confirming procedures. In Mustonens (2019) study, invisibility, unequal treatment, and the lack of a third legal gender came up as problems that non-binary people face in their everyday life. The binary gender system and gender norms complicate relationships, work, and studies significantly, while this causes practical problems when it comes to e.g., gendered spaces such as locker rooms and restrooms, hobbies and forms. (Salakka 2015.) Some previous research exists on transgender individual's experiences of trans-specific healthcare in Finland. However, research is conducted mainly within health sciences and social work, so there are no specifically socio-legal studies on the topic.

3. THEORETICAL FRAMEWORK

Foucauldian concepts and theories are important in this thesis to understand power and its dimensions. Particularly these will be used to understand the encounters between non-binary people seeking care and care providers within trans-specific healthcare. The notion of disciplinary power has an important role in understanding how psychiatry functions, and therefore it is helpful for understanding the contemporary medico-legal discourse of trans-specific healthcare that has its roots on psychiatry. Governmentality is a useful tool for analysing gender regulations and making visible "taken-for-granted" norms regarding gender (Tanger 2008).

3.1 Foucauldian concept of power

In society, there is a strong connection between power and knowledge. Foucault argued that to be effective, power required knowledge, whereas knowledge generates power. For example, knowing a legal system makes it possible for one to evaluate and act when facing something that does not adhere to the norms set by a legal system. According to Foucault, power is present in every interconnection between human beings, and therefore one has possibility to rule over the other one and limit their actions and freedom to make decisions or resist. The exercise of power also includes an attempt to legitimate it through intellectual justification which are often formulated by those who are in positions of power and authority. This tends to include a picture of those in dominant positions acting in the interests of the majority of citizens and justifying certain acts, like for example treating minority groups differently and not providing the same rights as the majority of citizens have. Exercising power, from a Foucauldian perspective is more like a complex network of relationships than a vertically manifesting part of hierarchy. Foucault thus highlights the difficulty of recognizing and defining power and its influence on individuals who are affected by it, even if it is usually easy to identify the feeling of being regulated by different institutions and social pressures. (Oliver 2010.)

Systems of power and the exercise of it have changed over time. In many pre-modern societies, power was highly centralized and there was a one person ruling the society. When societies became more complex it was not possible for a one ruler to hold the

position, and in the modern period some types of power have been delegated to those who were not in positions of power before. Foucault describes the medieval concept of a person as being highly individualized which enabled acts that would identify people differently whereas in the modern period, people were categorized and seen through groups not as individuals. (Oliver 2010.) These power mechanisms are also described as "sovereign power", and "disciplinary power" by Foucault. The first mentioned has not disappeared but disciplinary power has become increasingly pervasive. (Armstrong 1994.) According to Foucault (1976) the sovereign exercised his right of life by exercising his right to kill, or by reframing from killing, and therefore it was instead of "power of life and death" the right to take life or let live. This ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death, and starting in the seventeenth century this power of life evolved in two forms: in an anatomo-politics of human body and in a bio-politics of population, formed somewhat later. The form of sovereign power with the right to death was replaced by the administration of the bodies, and different ways for achieving the control of the bodies and populations. (Foucault 1976.)

During the classical period (from 1660 to the end of 19th century) different institutions such as universities and secondary schools, as well within the political and economic field, saw the emergence of problems of birth rate, public health, housing, and migration which led to arising of diverse techniques for achieving the subjugation of bodies and control of populations, and therefore this marks the beginning of an era of "bio-power". (Foucault 1976.) The two forms of bio-power, an anatomo-politics of the human body and the regulatory controls over the population are regulatory aspects of governmentality. The anatomo-politics of body has focus on body as it is to be a machine, which is ruled by disciplinary power to optimise its capabilities, usefulness, and docility as well its integration into systems of efficient and economic controls. Experts such as medical doctors and psychiatrists often perform the central role on defining "the normal" and, thus, normalising the population. The second form of bio-power, regulatory controls over the population, has the human body as the base for a biological process on its focus. A reproduction, births, mortality, health and all the factors that cause them to vary are central when it comes to bio-power of this form. (Huxley 2002). According to Foucault

(1976) one of the innovations in the techniques of power in the eighteenth century was the emergence of "population" as an economic and political problem. In modern societies population was a key to wealth, and therefore it had to be efficiently governed to ensure the labour force the new capitalist economy needed. The techniques of regulation include, for example, studies of health and fertility within a population, improvements of hygiene in the cities, applications of statistics, and classifications of wealth. (Foucault 1976.)

With the notion of governmentality, Foucault seeks to analyse and understand the complex relationship between power and knowledge that operates through different governing techniques over individuals. In this understanding power is unstable, flexible, and non-stratified whereas knowledge is stratified, segmented and stable. (Wickham 2013.) Governmentality can be understood both as *a particular manner of exerting power and the total arrangements that such power has at its disposal.* Self-regulation is one of the ways in which governing is deployed, and Foucault refers to it as *a gradual process of governmentalization.* (Lauri 2016, p. 12.) Governing can be analysed in terms of techniques which *refers to specific ways of acting and to certain devices that allow or mediate the exercise of power* (Lauri 2016, p. 15). Linander highlights that different techniques are used to carry out governing practices which can be based on different rationalities (Linander 2018).

Foucault emphasizes the meaning of disciplinary power when talking about the mechanisms of psychiatry. He argues that how psychiatry functions cannot be analysed by focusing on institutions or on discourse of psychiatry, but instead through understanding disciplinary power. In disciplinary power's focus is the individual and the individual's time, life, and body in contrast to sovereign power, which has its focus on different kinds of units, like families. Sovereign power does not have an individualizing function even though the relationship of sovereignty applies for example political power to the individual's body. In the disciplinary system there is no need for ceremonies whereas in the relationship of sovereignty there needs to be an act that constituted the relationship between the ruling sovereign and the one who pledges themselves. Instead, disciplinary power refers to a final or optimum state accomplished through continuous control which posits one in a situation of being under constant observation. This will

eventually lead to a state where discipline has become a habit and requires only a virtual supervision. (Foucault 1973/2006.)

The continuous control over everything and everyone is supported by an instrument of writing. Its purpose is to ensure that everything the individual says and does is graded and recorded so that it can be passed through the hierarchical system to the top, and then make the information accessible so that the principle of omnivisibility is fulfilled. Foucault (1973, p. 48) argues that *the use of writing is absolutely necessary for disciplinary power to be total and continuous.* The visibility that writing enables leads to a promptness of the reaction of disciplinary power. In contrast to sovereign power, which intervenes violently in the form of war, exemplary punishment or ceremony, discipline power intervenes beforehand through supervision, rewards, punishments, and pressure. In other words, punishment plays an important role as another side of the disciplinary relationship. The continuous punitive pressure is to help to spot the potential behaviour before performed to disciplinary power to intervene. (Foucault 1973.) Foucault (1973, p. 52) uses the term *panoptic character* of discipline power to describe these aspects of constant observation supported by the instrument of writing and a punitive and constant action on potential behaviour. One more distinction between sovereign and disciplinary relationships is how they are organized. Relationships of sovereignty have no common measure, and they do not constitute a systematic hierarchy between them, whereas a disciplinary system is hierarchical, and every element has its defined place. Due to hierarchy, the movement within disciplinary system is produced by different examination, competition, and seniority whereas dispute and favour produce movement in the case of sovereign power. However, all disciplinary power has its margins as there are those who cannot be classified, those who escape supervision and those who cannot enter the system of distribution. As for sovereign power, the different systems of sovereignty are in constant conflict. (Foucault 1973.)

4. METHODS

In this chapter the methodological approach, empirical material, and data collection are presented as well the discussion of ethical considerations.

4.1 Study design

My empirical material consists of interviews and law drafting material, and I applied reflexive thematic analysis to analyse both sets of data. Thematic analysis focuses on identifying patterns of meaning within the material, and by doing this, helps answering to the research questions. Reflexive thematic analysis is theoretically flexible and different orientations are possible. (Braun & Clarke 2020.) The methodological basis of my research is interpretive research. It has its roots, in anthropology, sociology, and psychology, and has been available since the early nineteenth century (Bhattacherjee 2012).

Interpretive research employs a theoretical sampling strategy, where respondents or cases are selected based on theoretical considerations such as whether they fit the phenomenon being studied. In interpretive research the role of the researcher is approached critically, and the researcher is considered as part of the social phenomenon, and the involvement of the researcher must be clearly brought up during data analysis. (Bhattacherjee 2012.) The approach where a researcher conducts interviews based on the belief that there are multiple perceived and/or experienced social "realities" concerning what happened instead of believing that there is a singular "truth" reflects a constructivist-interpretivist methodology. Accessing these multiple "truths" requires interaction between researcher and researched as they seek to interpret events and make the interpretations clear to each other. (Schwartz-Shea & Yanow 2012.) Furthermore, interpretivist analysis is holistic and contextual, rather than being reductionist and isolationist. Instead of statistical techniques, interpretive interpretations often focus on language, signs, and meanings from the perspective of the participants. Interpretive research enables that data collection and analysis can proceed simultaneously and iteratively which is not possible in positivist

research, where modification of a research project is not possible once the data collection has started, or it would require redoing the entire project. (Bhattacherjee 2012.)

Braun and Clarke (2020) describe six phases that reflexive thematic analysis follows. First step is familiarisation with the data that requires reading and re-reading the data. After that follows coding where different suitable labels are created for important features of the data. Third step is to generate initial themes. Different codes are analysed to identify broader patterns of meaning and the material is divided under these patterns. Fourth phase is reviewing themes so that they correspond to the dataset and answer to the research question. Fifth step is defining and naming the themes, and this includes developing analysis of each theme and defining focus of different themes. The last step is writing up the analysis. (Braun & Clarke 2020.)

One of the benefits of thematic analysis is its flexibility. Different qualitative analytic methods can be divided into two. On the one side are those based on a theoretical or epistemological position, such as conversation analysis, grounded theory, and discourse analysis. On the other side, there are methods independent of theory and epistemology, such as thematic analysis that provide theoretical freedom and enables flexible and useful research tool for analysing data. (Braun & Clarke 2006.) Braun and Clarke (2006) underline the importance of making clear the theoretical position of thematic analysis as any theoretical framework includes assumptions about the data, and these are made transparent in a good thematic analysis. Thematic analysis can be used within different theoretical frameworks, and it can be an essentialist or realist method reporting experiences, meanings, and the reality of participants, or it can be a constructionist method finding out the ways in which e.g., events, realities and experiences are result of discourses operating within society. (Braun & Clarke 2006.)

Flexibility needs to be retained when determining what is a theme within the data. The research question sets boundaries for themes as they capture something important related to a research question. A theme is also based on patterned responses or meanings within the data. Although, more instances do not automatically mean that the theme itself is more crucial. There are no strict numbers of proportion of evidence to be considered as a theme

since thematic analysis is used to analyse qualitative data. Prevalence can be counted in different ways, such as at the level of data item, like one particular document or an individual interview, or it could be counted in terms of the number of different speakers who articulate the theme, across the entire data set, or each individual occurrence of the theme across the entire data set. (Braun & Clarke 2006.)

4.2 Interviews

The interview request concerning this thesis was published on my Facebook page as a public post so that anyone could see and share it. I received many replies and therefore decided not to share my interview request through other channels. This decision, however, limits my research since my request spread through social media and therefore did not probably reach those who do not use social media. Additionally, because the request was published on my Facebook page, it is possible that it has reached mainly people who are my friends' friends, although the publication was public. However, all the participants were people whom I did not have contact beforehand, although I have met or run into some of the participants before or after interviewing them since the queer scene in Finland is not that huge.

Before interviewing the research participants, I received comments about my interview guide from a person who could have been a participant in the research. Altogether, I conducted 13 interviews, of which 12 were online interviews through Zoom or Skype and one interview was conducted through email. Interviews were semi-structured and lasted from 30 minutes to 1 hour and 20 minutes. Few days before the planned interview, I sent the written informed consent to participants, in which the intention of the thesis and information about the interview being recorded and handling of the data were explained, as well the rights of the interviewees to cancel or stop the interview at any point. In the beginning of the interviews I went shortly through the written informed consent, which was followed up by me asking for confirmation of participant's consent for participation in the study. The interviews consisted of me asking quite open questions which I specified more when needed, and the participants could interpret and answer according to their own

interpretation. I made some slight changes to my interview guide during this phase when I noticed that some questions needed to be modified.

First step to be able to analyse the interview material was transcribing interviews to text. Then I moved on to the coding as part of my thematic analysis phase where I read all the interviews and took preliminary notes and then created a table where I put all the text parts to be coded on the one side and on the other side the codes. Altogether, I got 227 codes which I then collated into potential themes and revised them through thematic maps until I ended up with my final themes.

4.2.1 Participants

I interviewed 13 participants who identified as non-binary. The participants are from different parts of Finland and their age range is between 18-35. Some of the participants have experience from the Helsinki (HUS) transclinic and some from Tampere (TAYS), and some participants were or had been planning to start the gender-affirmation process. Every participant had the possibility to come up with a pseudonym which would be used in this research to differentiate participants from each other, and some participants came up with their own pseudonym while some told me to invent one for them. Additionally, I asked every participant of their pronouns in English since the thesis is written in English.

4.2.2 Reliability and validity

On a general level, empirical measurements have two basic properties, which are reliability and validity. The first one, reliability, concerns how repeated measurements of the same phenomena yields the same results. Consistency found in repeated measurements raises the reliability of the measuring procedure. However, the repeated measurements never yield the exact same results and therefore unreliability is always present. The second one, validity, *concerns the crucial relationship between concept and indicator i.e. if the measuring device does what it is intended to do.* Also, with the validity it is not possible to achieve a perfectly valid indicator that represents only the intended, and therefore validity is a matter of degree. In the social sciences sources of random measurement error which effects are unsystematic in character, include errors due to

coding, instructions, differential emphasis on different words during an interview, interviewer fatigue, and so on. As for the nonrandom error, it has *a systematic biasing effect on measuring instruments*. Validity is related to the extent of nonrandom error whereas reliability is related to the amount of random error. (Carmines & Zeller 1979, p. 3–5.)

In qualitative research validity together with notions of reliability and generalizability relate more broadly to the quality of research. According to Kuzmanić (2009) *valid qualitative research is about credibly representing different social worlds or different interpretations to the readers*. Through interviews the researcher seeks to understand the meaning of phenomena from the interviewees perspective and so enter and understand the world of those interviewed. Regarding the interviews conducted for this research and their reliability, i.e. the same results yielded by repeating the interviews, I am aware of that there can never be the same interview twice since the communication occurs between those who are present and different directions take place during that specific interview (Kuzmanić 2009). However, in my research I have thoroughly analysed the data by applying thematic analyses and therefore revisited the data several times and evaluated and re-evaluated the findings to increase the reliability of the results. As this research seeks to answer questions regarding non-binary people's access to and experiences of trans-specific healthcare in Finland, the choice of interviewing non-binary people who have sought or are seeking gender-affirming care is thus a suitable source of data. Additionally, regarding the research question of how the access to trans-specific healthcare is represented in the Finnish law drafting material, the choice of data is also valid, since the minutes of Parliament's plenary sessions contain the discussion of the Government's legislative proposal. Regarding the validity, I relate to Kuzmanić's (2009) understanding about the fact that unavoidably there are always part of meaning or knowledge that is not communicated because of different expressions of the interviewed or misinterpreting or overhearing by the interviewer, and that there is no pre-given validity since it is constructed together with meaning through the process of interview.

4.2.3 Translation

All the interviews were conducted in Finnish, and all the law drafting material was in Finnish as well. I translated those quotes I chose from the material into English. I have tried to make the quotes as readable in English as possible without losing the content, changed the word order and deleted small words which were used as fillers when I thought it was needed to keep the quote understandable.

4.3 Ethical considerations and positioning myself

In the process of conducting research multiple ethical issues are often faced. Some of these are common ethical issues, such as those regarding anonymity and confidentiality, but more specific issues may arise during the research process as each research project is unique and therefore situated and contextual. Different professional guidelines, disciplinary norms, ethical and legal regulation and an individual's ethical and moral outlook influence on decisions a researcher makes about ethical issues. (Wiles 2013.) Doucet and Mauthner (2014) highlight the importance of ethics in data analysis processes within qualitative research since through data analysis academic, theoretical and policy-related knowledge is produced from participant's everyday accounts, and the researcher's own theoretical and personal background influence how they construct knowledge and draw conclusions from it. In this research qualitative interviews form an important part of the empirical data. I acknowledge that because of my own background, both personal and theoretical, the research I have conducted is situated and contextual. The analysis of the data and findings I make from it are not loose from my own way of being and interpreting the world, and a completely different research project would have been conducted by someone else with the same data. Like underlined by Doucet and Mauthner (2014) knowledge produced from the interviews is influenced of my way of constructing knowledge and drawing conclusions from it.

4.3.1 Anonymising the data

In ethical research practice, issues of anonymity and confidentiality are at the centre. Confidentiality in the research context means that identifiable information concerning research participants will not be disclosed and that the identities of participants will be

protected through different processes to anonymise them. Confidentiality of data includes also not deliberately or accidentally disclosing the information collected during the research in ways that an individual might be recognised. The process of anonymisation is the primary way researchers use to protect research participants from the accidental breaking of confidentiality, and to anonymise the data pseudonyms that are applied to participants, organisations, and locations. Research participants' anonymity is a central feature of ethical research practice, although complete anonymity may be difficult to achieve. (Wiles 2013.) I interviewed people who identify as non-binary, and in a small country like Finland, it might be possible to recognise a participant if the data would have not been anonymised properly. I have anonymised the data carefully and tried to avoid any unnecessary information of participants to emerge. Even so, I recognise that it is almost impossible to achieve complete anonymity as Wiles (2013) argues.

5. RESULTS AND ANALYSIS

In this chapter I present my empirical findings and analysis of the results of both law drafting material and interviews. Analysis of the results consist of themes I have identified by using thematic analysis and which are discussed through theory and earlier research. The results are illustrated by using dataset examples. Interview quotations are accompanied by referring to the interview participants with pseudonyms. I have changed all mentions of times, places, and names in these quotations to protect anonymity of interviewees and added context words in square brackets when needed.

5.1 Access to trans-specific healthcare represented in the law drafting material

For my first research question "How is access to trans-specific healthcare represented in the Finnish law drafting material?" I analysed law drafting material which consists of the minutes of Parliament plenary sessions in years 2001 and 2002 where the proposal was discussed. Altogether, there were seven sittings where politicians took a stand on the proposal to the Parliament on the Act on Legal Recognition of Gender of Transsexuals which came into effect later in January 2003. As earlier discussed in the second chapter of this thesis the need for regulation of transgender people's right to have their legal gender recognised and to trans-specific healthcare was validated in the proposal by stating that a lack of regulation had led to a situation where transgender people seeking care and legal gender recognition were not treated equally since registry offices have different practices on granting a new social security number and healthcare providers are not following an equal course of action when it comes providing trans-specific healthcare. Additionally, fundamental and human rights were brought up as a reason for the proposal. First, some of the statements which supported the proposal are represented and after that follow the themes, *denying self-determination of transgender people*, and *representing transgender people as abnormal*, I have identified within the Parliament's plenary sessions.

Even if the statements of politicians during the Parliament's plenary sessions were mainly negative in different ways that questions transgender people, there were still support for

the proposal, and for the beginning three quotations in which support for the proposal is shown are represented.

> *It is depressing that a good will to help in this matter of a few miserable people has gotten this kind of characteristics as it has gotten here. I defend the statement of Legal Affairs Committee. Whereas if the objection would be accepted [and therefore divorce would be required when one's legal gender is recognised] there will be problems. It is unacceptable that these married [transgender] people should face problems like divorce when they are finally finding a solution for a difficult situation. The age limit is the only matter that can be discussed.* (Erkki Kanerva, the Social Democrats, PTK 46/2002.)

> *In question are miserable people who have gotten in a trap of life or in a bureaucratic trap. Is it ethical to not to intervene in this? I agree with MP Kanerva, in the Parliament these matters should be considered with heart… this is an excellent step into better direction compared to a non-regulated situation. Legal security increases significantly.* (Henrik Lax, the Swedish People's Party of Finland, PTK 46/2022.)

> *Reason for the Government's proposal is public authority's duty to ensure fundamental and human rights. As we know, the number of transsexuals is a small so if the government proposal will be carried out, it concerns a very small group, but for them it is an important question. The proposal will harmonise the current practice.* (Marjatta Vehkaoja, the Social Democrats, PTK 45/2002).

Even if the proposal is supported in the above quotations, it is underlined that the regulation concerns only a small group of people. Politicians do not consider it as an option that legislation might contribute to an increasing amount of transgender people who will have possibility secured by law to access the trans-specific healthcare they need and want. Additionally, representing transgender people as miserable is used to forward the proposal, which however, does not consider diversity of transgender people and their experiences. In the third quotation above fundamental and human rights are brought up as a reasoning for the proposal. However, fundamental and human rights did not receive that much attention when issues, such as a sterilisation requirement was discussed during the Parliament's plenary sessions as the analysis and discussion later on point out.

5.1.1 Denying self-determination of transgender people

The second theme I have analysed is about denying transgender people's self-determination. Within the theme I have identified *bodily autonomy,* and *mental illness* as sub-themes.

5.1.1.1 Bodily autonomy

Within the sub-theme bodily autonomy, I identified two patterns of meaning that are used for denying autonomy of transgender people when it comes to a body and how it should or should not look. These concern appearance, and sterilisation. The first one, appearance, is strongly linked to a normative idea that one has to be able to identify someone's gender by looking at them, and that the possible options are female or male. If this is not the case, it is experienced as problematic.

> *I think that it's not very appropriate that gender is presented here as it were subject to declaration. I can just announce that I belong to another sex than I have been registered earlier. These surgical operations of external organs are not required. I think, when and if a person is registered to opposite sex than he or she biologically and physically looks like, we might run into different problems in a society. Think about swimming pools etc. They go and show a women's card, and how does it look when there are different genders mixed etc? Yes, I see many problems here. Similarly, people might get surprised when someone shows an identity card that she is a woman, and later when they are ending up in a more intime intercourse they notice oh, she is this kind of a different woman.* (Paula Kokkonen, the National Coalition Party, PTK 46/2002.)

In the above quotation it is made clear that the whole society gets into trouble if the binary gender division is not followed. Importance of appearance matching to expectations is underlined and as part of it genitals are discussed. Politicians' discussion about appearance of transgender people is strongly linked to the genitals, as the following quotations show.

> *Now this law that we are handling does not require that a person's sexual characteristics correspond to her/his new legal gender, or that she/he lives outwardly according to a [new] legal gender. In other words, the bill enables a situation where a person has a woman's legal gender but a man's genitals under a skirt.* (Päivi Räsänen, the Christian Democrats, PTK 45/2002.)

This law leads to a situation where a completely healthy body might be changed by painful operations to make it correspond to the opposite gender. Although, this is not a requirement according to this law, and it is inconceivable. A surgical operation is not a requirement for a sex change, it is only depending on one's own way of thinking, on how one experiences oneself. It is inconceivable that this is how the proposal ended up, I would say a little halfway indeed. (Toimi Kankaanniemi, the Christian Democrats, PTK 46/2002.)

In other words, I repeat once again, that when and if a person's external characteristics are changed by hormone treatment and everything else, I think it is inconceivable that genitals are kept as they were according to earlier identity, and this person gets a new identity card. I encourage everyone to think what kind of problems will follow. (Paula Kokkonen, the National Coalition Party, PTK 46/2002).

In the first quotation both genitals that do not correspond with a legal gender, and the possibility that one does not outwardly live according to a new legal gender is described as problematic. So, expectations of one's gender cover not only the body but also how it is used, and if it is used in a way that is proper for that gender. On the one hand, surgical operations are seen as *painful operations* destroying *a completely healthy body*, and at the same time necessary to avoid problems following if a body does not fit into a binary understanding of gender, as presented in the second quotation. Additionally, it is brought up how one's own experience of gender is not a valid identity and surgery should be required because of one's own experience of self alone could not entitle "the sex change". In both second and third quotations it is stressed how the situation where a person cannot be defined based on their appearance is unacceptable. The requirement of surgery is seen as acceptable and right because it would prevent difficulties that follow if one's genitals and appearance do not match.

Gender is understood as an integral part of what it is to be a person. If you are a human, you are to be a woman or a man. The failure to conform to the binary categories of gender results often in being treated as some sort of monster, not fully human. (Oksala 1998.) This can be identified in the quotations regarding transgender people's bodily autonomy since in the discussion of appearance and genitals it is made clear that if one does not conform to the binary gender categories it is confusing and inconvenient for other people. Spade (2006) points out that transition being successful without using non-trans

normative measures of "true femininity and masculinity" is not seen as possible, although there are various different reasons for seeking gender-related body alteration, such as access to different sexual practices, ability to look different in clothing, and public disruption of female and male codes.

The second pattern of meanings I identified within the sub-theme bodily autonomy is sterilisation. The requirement of sterilisation was included in the government proposal, and it is one of the requirements in the Trans Act. Additionally, a requirement for legal recognition of gender is that a person is of age, which means at least 18 years old in Finland. It is interesting how the discussion about sterilisation did not include reflection on how it has an influence on transgender people's self-determination and fundamental and human rights but mostly focuses on paternalistic concern over young adults who would get sterilized at the age of 18.

> *In our objection the proposition is that sex change is postponed to a more mature age and possibly defectively considered decisions taken at the age of 18 are prevented, even though the process before it would have been long. However, these decisions influence significantly to a future adult life. We propose this correction also to an amendment of sterilisation act where the government and majority of committee want to see these just 18 years old girls and boys, mentally problematic people, and make an exception to the general age limit of sterilisation. We propose that the age limit would be 30 years. Sterilisation of a young person is an operation that affects permanently to her/his future, and this should be avoided.* (Niilo Keränen, the Centre Party, PTK 45/2002.)

> *According to the Sterilisation Act people would be put in a very different position depending on what are the reasons for them wanting a permanent infertility. If a person absolutely wants to stay as a childless and she experiences infertility as an essential part of own identity, she can't get a permission even though being of age, but under 30 years…*(Päivi Räsänen, the Christian Democrats, PTK 53/2002.)

> *But now we would allow 18 years old whose gender identity is disturbed, a permission to sterilisation and even castration, mutilation of genitals and breasts. If we consider boys, they are in their late puberty at that point and they have no experience of adulthood in their own sex* (Päivi Räsänen, the Christian Democrats, PTK 53/2002).

The mental instability is underlined in the first and third quotations above and it is used as reasoning for why the age limit for sterilisation should not be 18 years. Also, the aspect

of sterilisation being an irrevocable operation is underlined. Sterilisation and its consequences are described as serious and having a great impact on the future life but at the same time sterilisation is not seen as a problematic or harmful requirement in general. In the second quotation above comparison between transgender people and people who want to be sterilised is made. The situation where transgender people would have a possibility to be sterilised at the age of 18 is expressed to be unfair as other people wanting the same operation would have to wait until the age of 30. In the above quotation transgender people are represented as they would want a sterilisation instead of being forced to it, and no critical stand is taken on a statement like this.

In the sub-theme *bodily autonomy* politicians' discussion focuses on bodies of transgender people. The appearance of a body that does not clearly follow the normative idea of a binary gender and perform gender according to it is seen as a threat to other people because they might not be able to categorize this person and therefore become confused. The sterilisation requirement is discussed in a manner that presents the requirement itself as unproblematic and the actual question being if young adults under 30 years old should be granted the permission for a sterilisation. In the discussion anything that deviates, gender performance or how the body looks, from normative ways is portrayed as abnormal. This is how the disciplinary power is exerted to bodies to constitute a "normal" individual. Through the complete control of both bodies and time is enabled the control of an entire life (Nethery 2013) and regarding to sterilisation requirement which is discussed as a suitable measure the entire lives of transgender people become under the control of disciplinary medico-legal system, since sterilisation is an irreversible medical intervention which will have a considerable effect on one's life ever since.

5.1.1.2 Mental illness

Second sub-theme under the main theme *denying self-determination of transgender people* is mental illness. Compared to the first sub-theme, bodily autonomy, the excerpts analysed within the mental illness theme are strongly against surgical operations as a treatment, when surgery was presented necessary in meanings of bodily autonomy theme

to avoid problems following if one's appearance and sex characteristics do not match with understanding of gender as binary. Historically, the definition of transgender people being mentally instable has been formed mainly in the hands of medical practitioners. The focus has been on a standpoint which classifies transgender people as mentally ill. (Stryker & Whittle 2006.) The following excerpts highlight how "transsexualism" is portrayed as a mental disorder and therefore requires psychiatric treatment instead of surgical procedures:

> *I paid attention to that that in this proposal possibilities of psychiatric treatment of transgender people are not considered, not even as a precondition for a castration, at least that was a practice earlier. I think there is a danger that this bill supports the idea that gender identity disorders are solved rather with a knife.* (Päivi Räsänen, the Christian Democrats, PTK 50/2001.)

> *If I heard correctly, the previous speaker considers this as a question of individual freedom. I think that this can't be a question of individual freedom. I remember several cases from the past where a person has had a psychic illness and experienced being another gender. I don't think it is legitimate to treat psychiatric disorders by mutilating people and carry out genital surgery.* (Paula Kokkonen, the Centre Party, PTK 50/2001.)

In the quotations above, psychiatric treatment is compared with surgical operations. Operations are described here as if they were the main or only treatment accessed without any previous consideration. Expressions like *gender identity disorders are solved rather with a knife* and *to treat psychiatric disorders by mutilating people* re-construct the notion of transgender people as mentally ill. The second quotation above highlights how individual freedom is not an appropriate aspect to discuss since one's own experience of gender identity is not considered as valid.

> *As a starting point, I think that a psychiatric disease should be prevented and treated with psychiatric measures. I believe that in the future this kind of medicine which treats psychiatric disease, including antipathy towards own gender, by mutilating genitals, is wondered.* (Päivi Räsänen, the Christian Democrats, PTK 45/2002.)

> *And when it's known that changing sex includes very profound ethical and social problems, as well psychological and theological questions, and these have not been*

pondered here. In this case juridical-technical questions have been pondered too much. As in some speech has been mentioned, a transsexual person and this matter and question must be approached with a psychiatric expertise. (Leea Hiltunen, the Christian Democrats, PTK 45/2002.)

For a person experiencing transsexualism should be given a possibility to get ever better psychiatric help, so that he or she could find his or her physiological sex as a mental gender. I think this would be absolutely better, and I don't mean involuntary treatment. (Kari Kärkkäinen, the Christian Democrats, PTK 47/2002.)

All the three excerpts above suggest that psychiatric treatment is the right way to help transgender people and that expertise within psychiatry is necessary because transgender people are considered mentally ill. Since early on the need of psychiatric expertise has been emphasized when it comes to transgender people and their treatment (von Krafft-Ebing 1877, Cauldwell 1949, Benjamin 1954). The first quotation above includes an idea about a future where it would be understood that "mutilating genitals" is not an appropriate psychiatric measure to treat psychiatric disorder. Also, talk about genitals here highlights how it is not transgender people themselves who are deemed suitable for deciding on their own bodies, but other people holding suitable expertise, like psychiatrists. The role of a psychiatrist as an expert having the last word concerning the possible procedures including hormone treatment and surgery was brought forward since the discussion of transgender people's treatment started (Benjamin 1954). The relevance of psychiatric treatment is made clear in the third quotation above by stating that with the help of it transgender people could experience their "physiological sex" as their own. This understanding of gender as something that is defined by physiology and outward appearance brings forward the idea of gender as a binary.

In the sub-theme *mental illness* politicians' discussion shows how not only the bodies of transgender people are controlled but also their actions. The psychiatric expertise and therefore psychiatric treatment are described as necessary for transgender people since "a psychiatric disease should be prevented and treated with psychiatric measures" and psychiatric treatment could help to "find one's physiological sex as a mental gender". The psychiatric expertise is a way to exert the disciplinary power on transgender people since it ensures the constant observation of transgender people as they are portrayed mentally

ill, and also posits a certain criterion that have to be fulfilled by those who are to access the process controlled by psychiatric expertise. In the disciplinary system one is under someone's constant observation. The optimum state of it, according to Foucault, is when there is no need for any particular person to run it, but it is carried out through internalization of disciplinary power within the individual. (Nethery 2013.) With highlighting transgender people being mentally ill and the need of psychiatry certain continuous observation over transgender people is exerted in the politicians' discussion, since the requirement of a mental health diagnosis became a requirement in the final law regulating trans-specific healthcare and access to it, as well the legal gender recognition.

5.1.2 Representing transgender people as abnormal

> *But what I could mention regarding this matter, is that changing sex and craving for it, from wherever roots or spiritual life it comes from, from illness or healthy way of thinking, might not be very normal and right-minded, at least not normal, that I can confirm here* (Seppo Lahtela, the Centre Party, PTK 47/2002).

The above quotation crystallizes the third main theme I identified in the law drafting material, *representing transgender people as abnormal.* Talk about transgender people within this theme is marked with opinions that are mainly justified by stating something being wrong, not normal, and dubious. From early on anything that deviates from heterosexual behaviour has been portrayed as indicating physical or emotional disease and transgender people have been described as profoundly disturbed, and the desire for self-affirming transition to be psychotic (Stryker & Whittle 2006). Within this theme biology and how because of it is impossible to anyone's gender to be anything else than the "sex assigned at birth" since no medical procedures can change the "biological facts" are brought up. Additionally, the abnormality of transgender people is discussed by the politicians in relation to the traditional family, and values and institutions linked to it, like marriage.

In the following two excerpts biology is used for representing transgender people as abnormal.

> *Regardless of the fact which is also basis for the whole proposal that this is about a person's own understanding of sexuality, that is a sex, anyway a biological chromosome system that everyone has, and which primary defines the sex in a biological form, remains. Despite of changing identity number, and performing surgical operations or hormone treatments, it remains unchangeable, so it is there on the background.* (Pentti Tiusanen, the Left Alliance, PTK 50/2001.)

> *Already this short conversation shows how problematic this matter is. The verb "experience" is used here. Of course, gender is not a matter of opinion but "experiencing" is much more. It's more profound matter. However, on the background there is a biological fact which controls that two dads can't have children but the other one has been a mom when having a child. I refer here to MP Kokkonen's very competent speech, that a person remains always as a mom to a child because she has given birth, although a mom changes her gender role later and becomes as if a dad. But two dads can't have a child. It is known that the mom exists always.* (Pentti Tiusanen, the Left Alliance, PTK 50/2001.)

In the first quotation one's own understanding and experience of gender is put against the notion of biological sex. Biological sex is described as fundamental and something that defines everyone. Different measures like hormone treatment, surgeries, or legal recognition of gender to affirm gender identity are portrayed as worthless because of the "biological sex" that remains. In the second quotation the experience of gender is compared with biology since it is underlined who is not able to have children, and if one has given birth how one always remains as a mother. This kind of argument considers other ways than normative hetero relationships formed by cis-gender people not as real by stating that biologically there is always something wrong within these relationships. The biological sex determines the gender identity causally according to the standard conceptualization, and transgender identity is seen as an error or disorder according to it (Oksala 1998). This understanding is brought up in the statements above where *a biological chromosome system* and *a biological fact* controlling who can have children are described as determining one's "unchangeable" sex.

Sharpe (2011) discusses the modern concept of monstrosity which can be found in Foucault's figure of abnormal individual that transgender offers an example of. The concept of monstrosity has expanded from only being associated with the materiality of body to cover the mind or psyche. Transgender people can be viewed as being presented

as contemporary monsters because of the double breach they represent, of law and nature. They challenge the sex/gender order and in this way pose a problem for law. As the stability of a binary division of "sex" is challenged, it is problematic for the legal order, and transgender identity as well the process of transitioning, can be constructed to involve a breach of nature (Spade 2011.)

Apart from "biological facts" the traditional form of a family is used as an argument in politicians' discussion. Different viewpoints of what is acceptable, right, and wrong are expressed through fear of the future, concern over the position of children, and concern over the institutions of marriage and church. The government proposal enabling legal recognition of transgender people is seen as a gate that enables different reforms pass in the future as well. Reforms, like this one, are described to be immoral and ethically suspicious. In the following two excerpts the future is portraid as scary as the consequence of this and other possible reforms:

> *I'm worried about this kind of proposal which might lead to infertility treatment and perhaps even internal adoption that have been mentioned in this hall. Liberalism, which MP Ylä-Mononen referred before, according to experts, leads to a situation where sex change operations might increase, and orientation to relate to opposite gender since a child strengthens.* (Inkeri Kerola, the Centre Party, PTK 45/2002.)

> *Rainbow government is creating a bunch of rainbow families in Finland. Just a question for those supporting Christian values: has our Creator made so many mistakes that our government wants to fix? In deep down it is about broken lives of people and consequences of it, right? Yeah, government wanted to registrate relationship of homosexuals like a marriage, even though gays' social injustices could have been fixed with the so-called cohabitant model. Now it is transsexualism which shines in our government's rainbow. Hopefully, the day won't come when pedophilia is registered as a parenting relationship between an older and younger man.* (Kari Kärkkäinen, the Christian Democrats, PTK 47/2002.)

In the first quotation above infertility treatment, internal adoption, increase in "sex change operations" and children relating to opposite gender are threats described that will follow if the bill goes through. Here the speaker refers to expert opinions but does not offer any more information about these experts or their statements. The second quotation implies criticism against the government by calling it a "rainbow government" and demands

Christian values. Also, in this quotation it is strongly underlined how "transsexualism" is just a next step after gay rights, and how this will lead to worse reforms. Scenarios of pedophilia are brought up as an example to show what might be the consequences of this kind of "rainbow reforms." Described as especially problematic for the church is the marriage of a couple where the other party would be a transgender person. Reasoning in this case also includes the concern for a person's appearance not meeting the normative expectations. The position of the church and Christian values is brought up in the following statement.

> *If there would be a couple asking for a marriage but both of them are physically men, have lived in a registered relationship, but the other one now has an identity of a woman, then yes, church will be put in even more narrow position in a conflict between constitution and church's own values* (Päivi Räsänen, the Christian Democrats, PTK 45/2002).

Values are described being threatened on a wider societal level as well, as represented in the two quotations below:

> *Yet these are really profound questions of values which also influence in many other ways amongst other things to families, close ones, but above all naturally to a person in question in other ways than just as a legal or technical question. So, it is unfortunate that preparation of proposal has been so superficial and insufficient.* (Toimi Kankaanniemi, the Christian Democrats, PTK 46/2002.)

> *I agree what MP E. Kanverva just mentioned about how these are sensitive questions and there's no reason to cause more problems in these matters. However, wide societal view and specific ethical and value starting points we can't dismiss in any case, like now is unfortunately happening here, when this kind of proposal is in question.* (Toimi Kankaanniemi, the Christian Democrats, PTK 50/2001.)

In both quotations values are addressed on an abstract level without specifying what kind of values are considered to be threatened. In the first quotation reference is made to other people who will be influenced, and in this way, values are brought to the centre of discussion. Values are stated to be something that should be considered at least on the same level with "the legal and technical questions", or even over those. Comparison between the matter of transgender people's rights, *sensitive questions,* and common basic

values is made in the second quotation. The *wide societal view* and *specific ethical and value starting points* are described to be against advancing the rights of transgender people.

Additionally, a standpoint which describes transgender people as incapable parents and causing harm for children is represented by the politicians as described in the following quotations:

> *The Right Honourable Speaker! Committee must discuss this proposal quite thoroughly, I think. Firstly, if a person already has biological children, is it reasonable to enable sex change with legal and medical procedures? I understand that according to this bill it would be in principle possible. It is the government's wish and line. It could be thought that for a child own father's or mother's gender identity crisis and change of sex risks child's healthy development when a father becomes a mother or the other way around. Shouldn't society in these cases guide a transsexual person to a treatment that would support her/him in finding previous biological gender identity?* (Sakari Smeds, the Christian Democrats, PTK 50/2001.)

> *Other parent's change to an opposite gender identity is very stressing and conflict creating experience for a child who is forming own identity, also gender identity, according to experts. Society must protect children from this with all the possible means. This kind of exposure might cause severe psychical damages which exceed the mental problem caused to a transsexual if sex change is postponed until the child is at sufficient age and mature to handle the event. Therefore, we propose in the objection that a person changing sex can't have dependent children under the age of 16.* (Niilo Keränen, the Centre Party, PTK 50/2001.)

The possibility of denying transgender people who have children legal and medical gender-affirming procedures is brought up in a light of consequences that children would suffer if a child's parent went through any procedures. In both quotations it is described as problematic if the roles of mother and father are deviant from the idea of what they should "normally" be. This abnormality is described to damage children's development. Also, here the underlying assumption of normal is that families are formed by a cis-gender hetero couple, and this normality is destroyed by "transsexualism" causing mental health problems for children. The solution presented is that a person who has children would not be eligible to any gender-affirming care, at least if children are under 16 years old.

Within the theme *representing transgender people as abnormal* normality and abnormality are confronted. In the politicians' discussion abnormality of transgender people is underlined in regard to biology, and traditional family and institutions linked to it. It is through this disciplinary power that the bodies, actions, behaviours, habits, and words are constituted towards the "normal" individual (Nethery 2013). First, biology is used to argue that the gender one has been assigned at birth is one's "real" gender no matter what and that the "gender roles" are permanent. In this way transgender people are portrayed as deviant compared to "normal" cisgender men and women. Secondly, the traditional family which consists of cis-gender mother and father and their children is argued to be in danger because of consequences that follow if one of the parents will start gender-affirmation process. Especially children and their development are seen to be in danger if a parent is a transgender person, and "severe psychical damages" to the children are argued to follow. So, the abnormality of transgender people is highlighted through arguments of them causing harm for children and therefore being incapable parents. Additionally, the institution of marriage and church's values are discussed by politicians in a manner that portraits transgender people as a trouble for church since they do not fit into the category of a "normal married couple" if the other one has had their legal gender recognised. The knowledge is produced from power relations (Nethery 2013) and within the identified theme *representing transgender people as abnormal* the politicians' discussion gives rise to the constitution of transgender as abnormal through disciplinary power.

5.2 Interviews

In my thematic analysis of the interview material I ended up with the following themes: *unpredictability of gender-affirmation process, institutions' power through gender* which has two subthemes *judicial power* and *healthcare system's power,* and *playing the game – ensuring diagnosis and treatment*. In this chapter these themes are presented and analysed.

5.2.1 Unpredictability of the gender-affirmation process

Unpredictability of the gender-affirmation process became evident in many research participants' experiences, and it grounds the following themes about power and game-like experience since it is closely linked to the relationship between the care provider and care-seeker. In the following quotation I have identified uncertainty as a factor that impacts on the decision if one seeks gender-affirming care. The knowledge that at the transclinic access to medical procedures could be denied based on something the care-seeker says causes uncertainty.

> *Generally, about the transclinic and the process, there is more negative information and experiences than positive in internet. I was really reserved when I went there, and nervous about what I might say would cause them to deny my treatment. And I had for very long time thought about it, maybe for five years I had known that at some point I'm gonna seek to the process there.* (Joonatan)

Also, fear of not having a binary gender identity or not being "enough trans" and that leading to not been taken seriously at the transclinic, is described by the participants.

> *I have that as a fear, that I should experience it strongly through binary and know that. I kind of fear that if I don't honestly describe my feeling, then it won't be taken seriously, or it will be thought that I'm not enough something. That might be the biggest fear regarding it.* (A)

> *I still have periodically doubts about if I'm trans enough, or somehow, I don't even think that I could get to the process because I don't have dysphoria so much. It feels like they [care providers] will be there like, hey, you are too unsure, or you are a cis woman.* (Niki)

> *And what I've heard about the process and transclinic and these things, it feels like… You must somehow point that you are not your birth gender, and how you can show your non-cisness to others is through body dysphoria but I'm non-binary and I don't have that body dysphoria so much. So, I feel that they can tell me that you are a woman because you don't feel enough body dysphoria to be something else. Of course, there is a possibility of lying.* (Niki)

Both A and Niki describe in the above quotations fear and doubts about if they will be told at the transclinic not having binary gender identity enough or not having enough

gender dysphoria, and hence their non-binary identities being questioned. Seeking gender-affirming care as a non-binary person is experienced as an unpredictable process where it is hard to predict if one will receive the treatment needed, or if it is completely denied.

One factor causing unpredictability is that there is not enough information available about the process at the transclinic.

> *You could not see beforehand how it should go. So, there was nothing like in their web site about how it usually goes. A big part of the information came through peer support, and when you know that not everyone has access to that.* (Aarni)

> *There was surprisingly little information. From Trasek [a Finnish association for transgender and intersex rights] web site you could get information like how you get the referral, but you had to search a lot for others' experiences, like written posts. So, there wasn't anything official or like deeper available. It was like you can apply but what would happen after that is a question mark.* (Halla)

In above the lack of information is described by Aarni and Halla. Both experience that the "official information" from the clinics was not comprehensive and did not help to understand the different phases of the process at the transclinic. Peer support was highlighted by the research participants as a main source of information regarding the process. However, as Aarni brings forward, it is not available for everyone. Halla describes how they had to search for others' experiences, and in the following excerpt Tuukka talks about their experience of not knowing other trans people and how the whole gender-reaffirmation process felt therefore impossible.

> *For a long time, I thought that the gender-reaffirmation process was something that I could never achieve, something that was not for people like me. I believe it was because I didn't know other trans people otherwise than through internet, and therefore everything felt so distant. When I finally started to do research about the process in Finland, I knew it's something I want and that it would improve my life. Based on the information I found, I knew to expect long queuing times, penalties and professionals who won't believe me.* (Tuukka)

Additionally, that there are different procedures between Helsinki and Tampere transclinics is mentioned as a reason causing uncertainty.

> *This is partly because of between Helsinki and Tampere it's a bit different. When someone tells that it goes like this and then someone else is like, no, it goes like this, it might be because they have been in different cities. But I would say there's not enough information. For me it hasn't been clear at all that what for all those visits were*. (Ruska)

> *It was contradictory that in which clinic you would get what treatment. I had heard that in Tampere it would be easier to get treatment as a non-binary*. (Joonatan)

The gender-affirmation process being experienced as unpredictable by non-binary care-seeker is because of different factors. Lack of information together with different procedures between Tampere and Helsinki clinics, and doubts if a binary gender identity or gender dysphoria is required to be taken seriously at the transclinic are causing uncertainty. The healthcare system should consider offering comprehensive, transparent and easily accessible information of the gender-affirmation process. The transclinic in Tampere (TAYS) provides nowadays information in Finnish on their website of "clinical pathway for a transgender patient"[11].

5.2.2 Institutions' power through gender

The second main-theme I will be presenting is *institutions' power through gender*. I identified this theme through different parts of the interviews since it became evident in the participants' experiences regarding law and legal gender recognition, the healthcare system and its professionals, and on how uncertain the whole process of accessing the trans-specific healthcare is. Within this theme I identified two institutions, healthcare system and law that are closely linked to the participants' lives because of their practices and limits they set to the trans-specific healthcare and legal recognition of gender. Hence, the main theme is divided into two sub-themes *healthcare system's power* and *judicial power*. First, I will present shortly the sub-theme judicial power which underlies the sub-theme of healthcare system's power.

[11] Accessed on 10.5.2022: https://www.tays.fi/fi-FI/Palvelut/Transsukupuolisuus/Transpotilaan_hoitopolku(93688).

5.2.2.1 Judicial power

In the following quotations legal gender and the fact that it only recognises the binary gender categories is described as problematic by Joonatan and C.

> *Mentally it has affected all life, it has distressed to be forced in that one juridical role. There is no choice to be myself. And when I got from the transclinic, or got through from there, and then I got the paper that I have been accepted as a man and I can apply for the man's identity number... It was a weird situation that it was only a paper that expressed that now I have gone from a one cross to another. It didn't really move me. At the same time, it was weird because I knew and felt that for someone that paper is a remarkable turning point.* (Joonatan)

> *It feels like you are detached from that legal gender marker, although earlier it created a lot of anxiety and made me nervous, and all the situations where you had to show your ID felt bad… Or like authenticate yourself as a woman. And when it came that you could change your identity number to a man's, it was the first time when it hit me hard that I don't have juridically a place in this society. And it hit me hard. Although I had known it before that you can't get your own gender marker on your passport, anyway not at the moment. And then like, okay, from one choice to another of these bad options. It felt bad, like yeah right, I don't exist to this state as myself. It was a weird feeling, and then it's more like having an agent feeling somehow, with the gender marker and the legal name.* (Joonatan)

> *Sometimes, especially when I went to the transclinic, I was thinking that it doesn't matter to change [the gender marker] I have on my passport. If it says "female" and it would be changed to "male" it would not help. Even so it is not my experience of myself. You just have to resign yourself to it, to that you don't exist somehow.* (C)

Both Joonatan and C mention in the above quotations how changing the legal gender marker does not matter because it would however not be correct. Joonatan describes there only being two bad options and how this forces one into a certain juridical role which does not allow being yourself. Joonatan and C both talk about existence and how they feel like not existing in this society because of a dichotomy that the binary legal gender system upholds.

In the below excerpt effects of there being only two binary gender categories in everyday life is described by A. A describes how it is hard to be out of the closet because of a lack of words outside the binary gender categories which are the norm.

> *I'm not out of the closet with this matter at all. So, it's like always when gender is somehow on the table, and there's generally only those two binary genders in use, it's kind of like I don't have an easy way to be out of the closet or like it would be natural somehow. If there would be already some other words which were commonly known, it would simplify the matter.* (A)

Niki brings forward the idea of a third gender category which would create more freedom of action regarding the legal gender marker.

> *It feels narrow, the idea of there being only an option A or B. Because gender is so much more than a man and a woman. It feels like it only takes into account the existence of a binary trans woman and trans man. It would be good if there were a third choice as well, such as the "other" because the gender is so flexible and fluid experience.* (Niki)

5.2.2.2 Healthcare system's power

With the sub-theme *healthcare system's power,* I identified the healthcare system as having a notable role in non-binary people's access to and experiences of trans-specific healthcare. Both, the system in a more general level as well the single healthcare professionals' role is described as problematic by the participants. It has been the medical field and medical practitioners that have historically formed the definition of transgender people being mentally instable (Stryker & Whittle 2006). The power which medical practitioners have had and continue to have in the gender-reaffirmation process is clearly brought forward by the participants as they describe the treatment they have received in encounters with healthcare professionals. Nordmarken and Kelly (2014) talk about trans-specific microaggressions which occur during the interactions between care providers and care seekers. Through misunderstanding or misinterpreting trans people's identities, using incorrect pronouns or demanding information of their "real" identity, and denying or failing to acknowledge trans people's gender identity, a cis-normative understanding of gender and stereotypes of trans people are brought out by the care providers (Nordmarken & Kelly 2014).

In the following quotation problems of the healthcare system are described.

> *The whole system is twisted in a way that cis-gendered medical people define what is normal and what is desirable, what is good life and what is a mental disorder. Here is a structural power setting, a problem, and I don´t even know how to start tearing it down. But they are not even aware of it, they don´t admit it at all. It would be maybe the first step, to recognize that this group of people who is treated should be heard and not think of them only as a pathologized patient group*. (Paju)

Above in the quotation the "system" includes healthcare professionals and the institution they represent. Paju mentions the issue that it is cis-gendered medical people who decide over one's treatment by defining what is normal and good. It is made clear that the system is not on the side of those who want and need help of it but more like against them. Also, Paju describes how the system itself is not capable of admitting the problematic setting although it would be essential for a change.

Also, in the following excerpt the system as a whole is portrayed as problematic and patronizing.

> *I experience that it was quite patronizing, I feel like the whole system is about others deciding over your body. For me, it covers the whole experience. I didn't feel like we were discussing as equals about my stuff, somehow it was like I tried to get those people to understand that I really have this need and it is not like I came here to wonder.* (Aarni)

A specific power relation becomes recognisable as the discussions at the transclinic are not between two equals but more like the care-seeker must convince the healthcare professionals. In Loponens (2021) study the healthcare professionals' power structure as gatekeepers of gender-reaffirming care is found to cause anxiety, unpleasant experiences, and delays for the care seekers. Also, experiences of not being heard and having to prove one's gender identity at the transclinic for healthcare personnel who question it are described (Loponen 2021). According to Butler (2004, p. 90) Foucauldian way of expressing it is that one has to be *"*subjected to a regulatory apparatus*"* before anything in freedom becomes possible. In this case trans and non-binary people have to accept both

the uneven power relations with the healthcare system, and the diagnosis to achieve treatment enabling them to have a body that corresponds one's own identity, and hence achieve the freedom. Butler (2014) argues that when being diagnosed with gender identity disorder is at the same time to be found wrong, out of order, abnormal, and as a consequence of the diagnosis given is to suffer stigmatization.

The following quotation describes how it does not matter if there are single individuals within the system that are nice because the institution cannot however be trusted.

> *My psychologist [at the transclinic] was actually nice. So, it felt almost a little bit bad to lie, but then it is, when you can't trust. Or it is however the institution, so it doesn't matter if a one certain person is nice because there may be bombs coming.* (Eemi)

Also, in the following quotations Nanette makes a difference between the system and individuals working within it. They highlight the aspect that it is the system which questions you but not the healthcare professionals.

> *The beginning with a nurse, I think, was pretty interesting and opening experience. With the nurse I wrote kind of a life story from the beginning until now. And then we did some kind of an inquiry. Things started to repeat themselves pretty quickly. And when you are meeting with three different persons it gives you a strong feeling that even if they as people don't seem like you have to convince them, the system seems like you need to convince this system and somehow win this game. If I would somehow reconsider this matter, I would absolutely reduce the amount of [healthcare] professionals.* (Nanette)

> *It was one of the nice things that I heard from many there [at the transclinic] when they said from the beginning that no one here can tell you your gender, we don't do that in here, and that is what you come and tell us here. It felt good, because I had been nervous that I come and tell my own story and at the end they will tell that according to their tests I'm not. So, it didn't happen. I experienced it positive that they clearly stated that we are not gonna question you, even if they did. The system questioned, but not they as human beings.* (Nanette)

Also, how knowledge is used to argument against and for when it comes to treatment affecting on care-seeker's body is described on the following. Theo had been using testosterone on their own for a while before starting the process at the transclinic.

They tried really hard to ask about all the effects [of testosterone], but when you still don't know what's their power on your body and your treatment, I told some things, but didn't feel like talking about it to them… (Theo)

It's weird that you must wait for two and half years to be able to get hormones. And then they are like they don't have any information they can give. And that is, however, how they argue for their gatekeeping. That they should ensure people having enough knowledge. But they don't themselves have the knowledge then. (Theo)

In Theo's case the doctor would like to have the information shared which Theo has of using testosterone. However, the healthcare professionals have the power to decide over one's treatment and even deny the access to it, and Theo did not want to share the information, as the consequences were unclear. Physicians warning their patients about the risks of hormone treatment regarding gender affirming care are perceived mainly as gatekeepers using their power and hence creating unsafety in the health care system (Irni 2017). Linander (2018) describes the experience of care-seekers where they feel the care-provider lacking knowledge and they themselves having more knowledge creating a responsibility shift. This shift disrupts the expert-lay relationship, but on the other hand factors, such as age, gender, class, ethnicity, and geographical location, can affect the ability to acquire and use the knowledge (Linander 2018). The complex relationship between power and knowledge operates through different governing techniques over individuals (Wickham 2013), and knowledge is used by the healthcare system to justify for example the long waiting times in the trans-specific healthcare. The system wants to ensure that care-seekers have enough knowledge but as Theo describes above, the healthcare system is itself lacking knowledge.

In the following quotation it is described how on a general level limiting the different treatments available for trans people is part of the healthcare system enforcing its power.

The selection of treatments for trans people in Finland is pretty narrow so that the treatment would include for example facial feminization and surgeries… It is weird that it's decided that one's life can be improved this much but not that much, when one would perhaps have better chances to get closer to that where cis-gendered people start their lives. I think all those limitations are a wrong way to deal with

things. Or it is a harsh way to decide over ones' life, that they can't get the treatment to live their life. (Theo)

Both Helsinki and Tampere clinics stopped processes and treatment for non-binary people in 2018. The clinics argued that there was a lack of scientific evidence regarding non-binary people's treatment. (Helsingin Sanomat I, II 2018.) For some care-seekers it meant that their treatment was not continued as already planned or was not started at all. In the following quotation Ruska stated that it was something that they feared would happen and how it caused a feeling that the treatment could be taken away at any moment.

They stopped the treatment for non-binary people and somehow it became real what I had feared, that this could happen. And because of that, the feeling stayed that it can be taken away at any given moment. (Ruska)

In the following quotations the healthcare system's power becomes evident as C describes how they were denied the access to the treatment after the evaluation period at the transclinic.

It felt awful. I was broken back then. And it took weeks to somehow recover from it, I was depressed, and it felt like I didn't exist at all. I had no power to decide over myself… (C)

And until that, the process had given hope and excitement, it had been a hard year, so it was kind of a supporting power. But then, I had pretty much the feeling of being beaten. (C)

During the interviews I asked about how participants experienced the role of healthcare professionals as part of their gender-reaffirmation process. Although, it was also brought up by participants themselves in different parts of the interviews because of the healthcare professionals' superior status. In the following quotations healthcare professionals are described as gatekeepers who decide over other people's lives without having understanding, and who need to be passed to get the actual health care.

I experience them [healthcare professionals] as gatekeepers who don't really understand these things so well, and they have own perception of what genders I should perform and then they decide if I will get to live my own life or not. And you

have to go there [transclinic] to perform and to dance to their tune and say the right things. (Paju)

I pretty much experience them as gatekeepers. It's like, you need to get pass them before I get to those professionals who can prescribe hormones or perform surgeries. If we talk about those psychical professionals, there. There's like couple layers, and then you can get the treatment you need. (Aarni)

Earlier research regarding the Finnish trans-specific healthcare has shown that the position of healthcare professionals is experienced as gatekeepers (Irni 2017, Loponen 2021). The gatekeeping power creates insecurity and even experiences of the healthcare system being an institution of violence instead of care (Irni 2017).

In the following K describes intimate questions that were asked during the process by healthcare professionals of transclinic.

And intimate questions are asked several times about sexual experiences, what do you like, can your breasts be touched during sex and what do you think about it, and so on. And I don't really want to describe everything what I want is done to me during sex. (K)

Sexualization, like focusing on the genitals of a care-seeker, is faced by many who seek gender-affirming care, and most of the questions the healthcare professionals ask are perceived as intrusive, aggressive as well dehumanizing. This behaviour is linked to healthcare professionals' need to define whether a trans person is "real". (Nordmarken & Kelly 2014.) According to Foucault, there is no "determinate identity" that could be revealed but instead it is the mechanisms of power that produce this idea as power shapes our identity, behaviour, acts and desires (Oksala 1998, p. 41). In the following quotation Nanette describes how intimate questions which focus on sex and body parts were asked during the process at the transclinic. These questions include binary assumptions, and even though Nanette felt uncomfortable in the situation the healthcare professional continued asking the questions.

They have long lists of questions, and after the more freely structured biography of your own life starts the more structured questions. There are many questions which steer to if you would after all be one of the binaries. And perhaps, what felt most

> *insulting, was that those binary assumptions were directed to sex and sexuality. Questions were like, do you get excited of breasts or how do you masturbate. What I wished for, was that the nurse as a professional would have seen me being avoidant and that it was too much for me. I even tried to tell that I feel uncomfortable, but the nurse just pushed forward. So, the thought and assumption of sex and sexuality being directly focused on to binary and at the first place being focused on those organs, felt sensitive, oppressive and insulting*. (Nanette)

According to Irni (2017) the assumption of binary gender is one of the ways the system controls those involved. One has to *"*falsify themselves*"* and present themselves in a different discourse with a different language as freedom including one's own body is conditioned to the diagnosis (Butler 2004, p. 90–91). The binary assumptions of healthcare professionals and how those had an effect on how Theo and Halla represented themselves at the transclinic are described in the following quotations.

> *It was kind of like ensuring your own treatment that you perform a bit like stereotypically masculine or somehow queer. For example, how you talk there. Or how you are in those situations.* (Theo)

> *You had to somehow all the time regulate the image they get, because there were so many presumptions all the time. I was asked why I'm not wearing a binder, and I got to fight, that I can't wear it because my shoulders and arms can't take it. Physically I can't do it. But it was seen as a factor against me when it comes to my identity.* (Halla)

On the other hand, in the following Theo describes how some healthcare professionals might understand how problematic the situation is, however, it does not diminish the power structures.

> *I feel that those nurses I met in both times were nice but of course one feels the repressive structure around, so, it's a really false situation. And I think it is hard for those nurses as well. At least some of them get how unpleasant the whole system is. But I was reserved all the time, or it was not like, okay, now we discuss through some things.* (Theo)

In Loponens (2021, p. 85–86) study good experiences of encounters with healthcare professionals at the transclinic are described as "positive surprises" as they are rather the exception than the rule. Healthcare professionals' understanding of problems related to

the process at the clinic and regretting the situation have created respectful and understanding encounters. However, even those care-seekers who themselves have had good experiences at the transclinic have criticized especially the power relations and criteria for diagnosis. (Loponen 2021.) Similar results can be found in this thesis. Some of the research participants describe good and respectful encounters but they are aware of the uneven power structure and unpredictability of the process, and hence, do not trust the healthcare system or professionals.

Within the identified theme *healthcare system's power* care-seekers' bodies, actions, and time are on focus when it comes to on how the healthcare system affects and controls the care-seekers. The healthcare professionals have a significant role on defining how much time the process will take, on what kind of body is made possible for the care-seeker, and on what kind of actions and behaviour is required from the care-seeker for one to access the medical procedure and legal gender recognition. All the time during the gender-affirmation process care-seekers are under constant observation of a healthcare system since the system evaluates if one is "fit" to access the healthcare, procedures, and legal gender recognition which are all behind the gatekeeping. It is through this disciplinary power that individuals within a society or community are normalized and *bodies, actions, behaviours, habits and words figure into the constitution of a "normal" individual* (Nethery 2013, p. 116). Foucault emphasizes the meaning of disciplinary power when talking about the mechanisms of psychiatry since through understanding of disciplinary power the function of psychiatry can be analysed. In the focus of disciplinary power is the individual and individual's time, life, and body. (Foucault 1973/2002.) The disciplinary power's principle of complete control covers the idea of one's body, time, and life being under control of disciplinary power (Nethery 2013). When it comes to trans-specific healthcare and healthcare system's power it is important to highlight that it is not only within the encounters between care providers and care-seekers when the bodies, lives, and time of a care-seeker are controlled, but the actions outside the healthcare system are on focus as well. For example, the interviewees describe how they were asked intimate questions at the transclinic regarding their bodies and sex. Like in one of the above quotations K describes that they were asked if their breasts could be touched during the sex. Additionally, healthcare professionals' assumptions of a binary

gender and certain ways of performing gender are controlling the lives of care-seekers, since they have to carefully prepare for the encounters at the transclinic to make sure to fulfil the requirements and expectations of the healthcare system. Therefore, control over the care-seekers through disciplinary power covers broadly their lives, bodies, and time.

5.2.3 Playing the game – ensuring the diagnosis and treatment

The third theme, *playing the game – ensuring the diagnosis and treatment,* was identified through the data about the participants' experiences of balancing binary gender assumptions with their own needs and desires. Many participants had had to think about if they were or are willing to somehow alter their own identity and story for the transclinic to ensure outcome of the gender-affirmation process. The process at the transclinic was described something that needs to be won, like a game, or a track that needs to be survived, and in the following quotations these game-like experiences have been identified.

> *I became to a result that I can for my own wellbeing and health play with those rules what the transclinic and law give at the moment. For the sake of my own wellbeing.* (Joonatan)

> *I knew the process because of friends' experiences, so I knew that there's no point for me to go and get a non-binary diagnosis. If I would speak truth to them, I would not get what I want because I don't fulfil their criteria that needs to be fulfilled. And my trust to that place so that I would get some understanding from there, is zero. So, it went straight to that, that I come and play this game to get what I want. I know what I need to say to get what I want, and in practice this was the process from beginning to the end.* (Eemi)

In the above quotations Joonatan and Eemi describe their choices to approach the situation at the transclinic. Joonatan names both the transclinic and law which set the rules for the game that has to be won for one's own wellbeing and health. Eemi names criteria that should be fulfilled and lack of understanding regarding non-binary identities at the transclinic as reasons for why they decided "to play the game" from the beginning to receive a diagnosis and treatment they needed.

Where in the beginning there was a little bit hope, that hey, I will tell the truth and I expect that a person who is working there [at the transclinic] that this person wants to help me, and this will work. It didn't go like that. Now I have much more negative image of this process and law and a bit about everything else as well… So, by being fair, you won't get any understanding back. I should have just lied. It is so disgusting thought that you should go for this process by playing it. You must project some kind of a different figure for that, so that you could have got better treatment, more understanding. It is unfair, deeply unfair. (Halla)

Halla describes how they expected there to be understanding at the transclinic but that being honest was not worth it as they did not receive any understanding at the end. Also, the idea of that one must play through the process is described as unfair by Halla.

It [when treatment for non-binary people was on pause] created more pressure that you should define yourself as a binary. Somehow it creates immediately a wrong setting. If you start a huge process like that, I think you should be able to be honest in it. There are those stories that you have to say the right words and tell a certain story so that they believe you. I don't want to go for that, so that I would monkey around there and think through what those things are I have to tell if they are not completely true in my case. (A)

In the above quotation A describes how they are aware of that at the transclinic people may use a certain story to ensure a treatment. However, they highlight that it should be possible to be honest in the process and how they themselves do not want to create a story that would not be accurate.

In the following quotation Aarni describes how altering their own identity to a binary identity required them to play.

I think it made it harder that I had to think at every step even more what I will say and how I dress and how I express some things. I don't have that kind of a male identity or hobbies that society keeps masculine or character or something, therefore it had to be played somehow cunningly. It was much of balancing. (Aarni)

Beside experiencing the process at the transclinic as a game, many participants described how they had been thinking through before starting the process if they somehow need to change their own story, they are going to tell at the transclinic. For some this meant consciously choosing to use different words of their gender identity or especially being

careful not to mention the word non-binary during the process. Aiming to receive the diagnosis "transsexualism" instead of "other gender identity disorder" and by this ensuring treatment needed and wanted was described as a clear choice from the beginning for some, whereas some described that they did not want to or could not change their own story, and it was seen as a right to be honest and still be respected and listened.

> *I had this really nice nurse whit whom I got along well, and I waited for those meetings. And there I went for the diagnosis of a trans man. I avoided expressing that I'm a man or kind of a direct lying. Giving wrong information felt really bad for me, and that was also one reason why I didn't seek care earlier. I was not ready for that that I should say something else, that I would go as a non-binary precedent, or I was not sure of how much people went or had been going there as non-binary.* (Joonatan)

> *[When treatment for non-binary people was stopped]… I was really happy that I directly lied. You could guess that something like this could come, so I was really happy that I had been lying from the beginning. I didn't have to stress about how it would end.* (Eemi)

In the following quotations participants describe how they wish that they would have lied so that the process would have been easier, or that it was not worth of being honest.

> *I wished for the best, so I started like I didn't want to lie about my experience. And I have to say that at this point I really feel like I should have lied. Because I would have gotten the treatment I wanted with little suffering instead of having to fight with everyone about it.* (Halla)

> *That thought about it [the process] taking a fucking long time and it being really humiliating and awful. And feeling like should I create a story of what they want to hear, what I can say to them. Because that's what it is. Generally, it is like that, you have to tell the right words to the right person and then it works. But when you didn't know what you should say, so you thought that maybe you should be honest this time. And it didn't pay off.* (K)

Both Austen and Tuukka describe in the following quotations how they did not want or could not lie at the transclinic even if they knew that it might have been easier in that way for them to receive the treatment.

> *Many non-binary people had said that those visits are really weird, and you have to lie if you want anything. Anyhow, I thought that I don't want to lie there, I want to be myself. I didn't really know what would happen there.* (Austen)

> *First, I considered seeking care as a boy, because I believe it would have made it easier to get the treatment. Anyway, I came to a result that I couldn't lie about it. When going to the transclinic I try anyway dress as masculine as possible to be more credible.* (Tuukka)

The different choices research participants have made regarding the process at the transclinic illustrate how hard it is to navigate in a process that may be one of the most important ones in one's life. Knowledge of process being slow and difficult to "survive" is not made easier by the healthcare system that constantly questions non-binary identities and creates pressure for care-seekers to represent themselves in a way that fit in to normative binary understanding of gender. This healthcare system's way to question non-binary identities through assuming and supporting binary gender can be seen as a governing technique over the care-seekers. The complex relation between power and knowledge operates through different governing techniques, and with the notion of governmentality Foucault seeks to analyse and understand this relationship (Wickham 2013). The interviewees describe the process at the transclinic being ruled by "rules" and "criteria" which have to be followed and fulfilled to ensure that one will receive the treatment needed. These rules and criteria relate to the taken-for-granted norms of gender which are deployed during the encounters of care-seekers and care providers and hence allow the exercise of power as a governing technique. The taken-for-granted gender norms manifest through assumptions of binary gender and what are "correct" and acceptable ways of being a woman or a man, and masculine and feminine. Some of the interviewees describe that they decided from the beginning "to play the game" with given rules and criteria, and therefore changed or modified their own stories and behaviour at the transclinic. This self-regulation is one of the ways in which governing is deployed (Lauri 2016), and in relation to gender performance in trans-specific healthcare is connected to the form of disciplinary power regarding the gatekeeping by healthcare system and professionals (Linander 2018). The participants self-regulated their gender expression at the transclinic through language, clothing, and behaviour. As one of the interviewees, Aarni, described "I had to think at every step even more what I will say and

how I dress and how I express some things." The self-regulation is described as necessary by some care-seekers to make sure to receive a diagnosis and treatment needed, however it is at the same time experienced as "balancing" and tiring because of one had to give wrong information to the care providers. In Linander's (2016) research the self-regulation in relation to gender performance was found to be experienced in similar ways, in terms of "rules", having to be a certain way, and also in terms of suffering.

6. CONCLUSIONS AND DISCUSSION

In this research I have studied how non-binary people experience the accessibility of trans-specific healthcare and the care itself in Finland and how the medico-legal discourse of trans-specific healthcare has been reinforced through current regulation. The data I gathered is extensive including both law drafting material which consist of the Parliament's plenary discussions, and qualitative interviews from which I, by using thematic analysis, identified themes which I analysed to answer to the research questions. In this chapter the central conclusions of this thesis are revisited and discussed.

Under the first research question I studied how the Finnish law drafting material represents access to trans-specific healthcare. The results of my research show that the historically dominant medical discourse has had a considerable effect on the current regulation since during the law drafting phase the "abnormality" of transgender people and a need for psychiatric expertise when it comes to a treatment of transgender people have been highlighted throughout the Parliament plenary discussions. The definition of transgender people being mentally instable has been historically formed mainly in the hands of medical practitioners who have described transgender people differently, but the focus has been on a standpoint which portrays transgender people as mentally ill (Stryker & Whittle 2006). In Finland during the 1950s and 1960 there were people seeking for medical help to have their body corresponding their identity, but psychiatrist did not recommend surgical or hormonal treatment since they saw the problem in psychiatric terms. Later in 1970s this view started to change when more international knowledge of surgery was available, and because of interaction with the patients. (Parhi 2018.) So, a clear continuum on portraying transgender people as mentally ill and in need of psychiatric expertise can be identified still nowadays.

During the Parliament's plenary sessions transgender people's self-determination was completely forgotten and both their bodily appearance and mental state questioned. The discussion focuses on how a person who is not clearly identifiable as a man, or a woman, would cause problems for other people. A body that corresponds to a binary understanding of gender is seen as a solution which can be achieved in this case by

surgical procedures. On the other hand, it is seen as problematic if mentally instable people are being treated with a knife when their treatment should be carried out by psychiatrists. So, transgender people are governed both by denying their bodily autonomy and categorising them as mentally ill. The requirement of sterilisation was discussed as it was a suitable measure and its problematic nature related to fundamental and human rights was ignored. Since it is through the complete control of both body and time that the control of an entire life is enabled (Nethery 2013), through the sterilisation requirement which was seen as an acceptable intervention the entire lives of transgender people became under the control of disciplinary medico-legal system, since sterilisation is an irreversible medical intervention which will have a considerable effect on one's life ever since.

With highlighting transgender people being mentally ill and the need of psychiatry certain continuous observation over transgender people is exerted in the politicians' discussion since the requirement of a mental health diagnosis became a requirement in the final law regulating trans-specific healthcare and legal gender recognition. This constant observation is essential in regard to disciplinary power since in the disciplinary system one is under someone's constant observation. The optimum state of it, according to Foucault, is when there is no need for any particular person to run it, but it is carried out through internalization of disciplinary power within the individual. (Nethery 2013.) Additionally, talk about abnormality was present throughout the plenary sessions. Arguments about "biological sex", traditional family, and institutions of marriage and church were all used to support the idea of transgender people as abnormal. Fear of marriage and family being threatened by transgender people is brought forward in statements which for example question the capability of transgender people as parents.

The Finnish law drafting material represents the access to the trans-specific healthcare as medically and morally governed through the normative understanding of gender as binary. Also, requirements of certain bodily appearance and portraying transgender people as mentally ill can be seen in a current regulation which includes prerequisites of diagnosis and infertility.

My second research question focused on non-binary people's experiences of trans-specific healthcare and its accessibility. Overall, the medico-legal discourse of trans-specific healthcare is approached with critical and thorough pondering by non-binary individuals. The problems of current regulation regarding gender-affirming care and legal gender recognition are both well-known. Non-binary individuals who are or have been seeking gender-affirming care are prepared for long waiting times, inappropriate and questioning attitudes of healthcare professionals, and a game-like experience at the transclinic. At the same time, research participants highlighted that there is lack of information regarding the process, or the information might be contradictory depending on which one of the clinics, Helsinki or Tampere, is in question. Most of the information research participants had received through peer support.

Non-binary research participants experience the unpredictability of the gender-affirmation process at the transclinic as problematic and causing stress, uncertainty and anxiety. Unpredictability of the process affects on a decision if one seeks gender-affirming care at all as the end result might be that access to the treatment is suddenly denied based on reasons that are hard to predict. According to my analysis, the uneven power structure which takes place both on a more general level at the everyday life through the current regulation and during the gender-affirmation process at the transclinic through healthcare system's power, defines the whole experience of trans-specific healthcare. The lack of recognition of anything else than a binary gender in the current Finnish legislation denies the existence of non-binary people in a societal level like some research participants described themselves "not existing in a society's eyes" because of there not being any options for them to be legally recognised. Apart from the judicial power which defines the legal status or in this case lack of it, it is the healthcare system's power that dominates the trans-specific healthcare. Both the system as an institution and healthcare professionals has a role of a gatekeeper when it comes to experiences of non-binary individuals. Questioning, diminishing, and inappropriate behaviour is experienced by non-binary people during the gender-affirmation process at the transclinic. The disciplinary power's principle of complete control covers the idea of one's body, time, and life being under control of disciplinary power (Nethery 2013). When it comes to trans-specific healthcare and healthcare system's power it is important to recognise that

it is not only within the encounters between care providers and care-seekers when the body, life, and time of a care-seeker are controlled, but the actions outside the healthcare system are on focus as well.

Apart from uneven power structures, the trans-specific healthcare is experienced as a game that needs to be survived by the care-seeker. Healthcare professionals' assumptions of binary gender and its desirableness, a diagnostic requirement, and unpredictability of the process create pressure for non-binary care-seekers to perform as binary, and therefore, questions that non-binary people ponder before and during the process are whether they are willing to alter their own identity and story for one that can be interpreted as more binary. This is seen to help to receive a diagnosis and treatment needed, and hence it might ensure the desired end result of the process although there is not any guarantee of it. The ways in which care-seekers perform gender has been shown to affect their access to medical procedures (Spade 2006, Stone 1991). To adapt to the assumptions and requirements of healthcare some research participants had made a clear choice from the beginning to modify their own story so that it would ensure the diagnosis and treatment. This self-regulation is one of the ways in which governing is deployed (Lauri 2016), and in relation to gender performance in trans-specific healthcare is connected to the form of disciplinary power regarding the gatekeeping by healthcare system and professionals (Linander 2018). At the same time some described that they did not want to or could not alter their own story and identity even if they were aware of that it might make it easier to receive the diagnosis and treatment. Also, thoughts about that it is everyone's right to be themselves in an important process like a gender-affirmation process and ponder different thoughts, even uncertain ones, regarding own identity and the process, were underlined by some research participants. Different choices research participants had made to cope with the requirements, assumptions and unpredictability of the gender-affirmation process appear well understandable.

6.1 Comparison to the findings of earlier research

The results of this thesis have commonality with the earlier research conducted. The healthcare systems and professionals' gatekeeping position has especially been recognised and analysed in earlier studies (Linander 2017; Irni 2017; Loponen 2021) and it is evident in the experiences of care-seekers in this research as well. This gatekeeping is linked to the uneven power structure that is present in the encounters between healthcare professionals and care-seekers which Butler (2004) has analysed and argues that when being diagnosed with gender identity disorder is at the same time to be found wrong, out of order, abnormal, and as a consequence of the diagnosis given is to suffer stigmatization. Besides Butler (2004) who mentions the abnormal it has been Sharpe (2011) analysing the abnormality which in this research proved to be one of the main arguments during the law drafting process used for entitling the medico-legal control over transgender people.

In my research same kind of microaggressions are described by research participants as in Nordmarkens and Kellys (2014), as well in Loponens (2021) research. Questioning and diminishing non-binary care-seekers' identity as well sexualization of them are present in participants' experiences. Altogether, negative experiences of the trans-specific healthcare are common as concluded in earlier studies as well (Irni 2017; Loponen 2021; Linander 2017). Adaptation to gender norms as a way to navigate the healthcare is analysed in the Finnish context by Loponen (2021), and also covered by Irni (2017) and Butler (2004). Similar adaptation by non-binary care-seekers to assumptions of gender as binary to ensure a diagnosis and treatment needed is found in this research too.

6.2 Future research

Due to a limited scope of this thesis not everything is included, and possible future research areas are presented shortly. In this research all the participants are of age, in other words, at least 18 years old. Some of the younger participants brought forward that their gender identity had been questioned by healthcare professionals because of their age. Hence, healthcare professionals' diminishing and questioning attitudes might be even a bigger problem for younger care-seekers and therefore research regarding experiences of non-binary and transgender youth of trans-specific healthcare and

accessing it is needed. Another topic that came up in some interviews were healthcare system's approach towards those care-seekers who were told to lose weight and reach a "normal" body mass index (BMI) before receiving mastectomy. The research participants described them being left alone without support from healthcare professionals, and with contradictory instructions of a BMI that should be achieved. More broadly intersectionality of aspects, such as gender, sexuality, class, race, and disability, should be studied in the context of trans-specific healthcare in the future.

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