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Psychiatric practices beyond psychiatry: the sexological administration of transgender life around 1980

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A central component of psychiatric expertise is the preparation of expert opinions in non-therapeutic settings. An obvious example is the evaluative role of forensic psychiatrists in assessing criminal responsibility in the courtroom (Skålevåg, 2016). Evaluative psychiatric expertise has developed hand in hand with modern bureaucracy and modern legal systems. However, the psychiatrist has also provided more diffuse, albeit expansive, evaluative expertise in clinical decisions about non-psychiatric treatment. At the interface between society and administrative bureaucracy, between medicine and public opinion, psychiatric expertise has sought to secure public trust and safeguarded bureaucratic intervention *beyond* the therapeutic qualifications of the psychiatrist. This expertise is an example of the social practice of psychiatry solving practical problems with expert knowledge as a precondition and enabler of change (Geisthövel and Hess, 2017).

The topic of this chapter is the co-constitutive relationship between the psychiatrist and the administrative bureaucracy in the role not of healer but of evaluator. In Scandinavian welfare states, such as Norway, the psychiatrist has cared not only for the individual patient, but also safeguarded the interests of the public and administrative bureaucracy. Extensive public health systems, free healthcare and strong public trust in state institutions have made the psychiatrist a key element of the state, which is understood as the institutional tools for communities and populations to negotiate with each other

(Skinner, 2012: 85–6). At least that is the argument of this chapter, in which I examine the psychiatric practice of assessing trans patients for hormonal and surgical treatment in Norway in the 1970s and 1980s as an example of this restrictive, evaluative psychiatric gatekeeping practice.[1] The role of psychiatric expertise in trans healthcare, i.e. the administrative function of psychiatrists in decisions about non-psychiatric hormonal and surgical treatment, is an example of the historical significance of psychiatry's non-formalised evaluative expertise – of psychiatric practices beyond psychiatry.

The historical importance of the psychiatrist in making decisions about hormonal and surgical treatment for medical transitioning is not unique to Norway. In various national contexts, the psychiatrist has been a crucial element in deciding who should have access to treatment, from the United States (Edgerton, 1974) to France (Sekuler, 2018: 99–115), Germany (Klöppel, 2010: 547–84; Meyer, 2018), Denmark (Holm, 2017), Finland (Parhi, 2018) and Iran (Najmabadi, 2014: 15–37). The evaluative role of psychiatrists has also been highlighted in the international Standards of Care guidelines, first published by the Harry Benjamin International Gender Dysphoria Association in 1979. These stated that the patient needed the approval of two psychiatrists or psychologists for sex reassignment surgery (The Harry Benjamin International Gender Dysphoria Association, 1979).

The history of psychiatric expertise in administering the lives of trans people is a history of the welfare state in miniature. The Scandinavian welfare state was built by the mobilisation of science, social science and medicine (Slagstad, 1998; Schiøtz, 2003; Sejersted, 2011; Bauer, 2014; Lie, 2014). While historians of the welfare state and public healthcare system have often taken a top-down approach, focusing on the role of grand ideas, ideology and central public institutions such as the Directorate of Health (Nordby, 1989; Berg, 2009), less attention has been paid to the significance of mundane medical and psychiatric practices. Using selected findings from my research on the history of transgender medicine in Norway in the twentieth century, this chapter takes a bottom-up approach to the welfare state and bureaucracy by centring psychiatric practices: their work in evaluation and in the distribution of welfare state benefits, their implementation in practice and their manifold logics, which include the consequences of administering trans life.

The chapter begins with an overview of the unformalised practices of trans medicine in Norway in the 1950s and 1960s. This provides historical background for the discussions in the 1970s about the institutionalisation and streamlining of medical practices. In a situation with little clinical experience and scientific literature to support treatment decisions, and in a context of professional disagreements and criticism, psychiatrists and psychologists sought to secure the legitimacy of diagnostic and therapeutic practices by anchoring them in a formalised public health structure. Following scholars in science and technology studies, this chapter argues that experts had to incorporate the epistemologies and infrastructures already in place – sexological expertise and the Oslo Health Council – to make diagnostic and therapeutic guidelines into a standard. But the administration of trans life also modified these networks and infrastructures. As a way of knowing and practicing psychiatry, sexology mobilised a network of patients, concepts, objects and spatial arrangements in which 'sex change' itself became an important vehicle. Sexology and the formalised structure of the Oslo Health Council secured the evaluative expertise of psychiatry in the space between bureaucracy and medicine.

Negotiating trans care: a troubled past and a hopeful future

After the Health Act was passed in 1860, the health councils formed the backbone of the Norwegian public health system.[2] Inspired by the reorganisation of British health laws, the act responded to major societal challenges, most importantly the cholera epidemics. The councils consisted of elected officials and were directed by a state-employed physician, the *stadsfysikus*, the chief city physician in the cities and the *distriktslege*, the medical district officer in the counties and communes. This body cared for the health of the population and ensured that doctors had a leading political role in the country's health system (Schiøtz, 2003: 41–50, 235–71). The *stadsfysikus* and the *distriktslege* cooperated closely with the centralised health administration.

After World War II, a new Directorate of Health was established within the Ministry of Social Affairs. The directorate was a hybrid creature, functioning both as a professional administrative body

making independent decisions in public health issues and as a policy-making body for the minister. The director general of health was throned at the top of the directorate, and with direct access to the minister was the most powerful person in the Norwegian health bureaucracy. Both Karl Evang, director general of health until 1972, and his successor Torbjørn Mork, who held the position until 1992, were physicians and specialists in epidemiology and public health. Both were members of the Labour Party and had been politically appointed to the post. The Directorate of Health and the health councils, with the Oslo Health Council as a prime example, became vehicles for implementing the health politics of the expanding welfare state, but also for creating new forms of medical expertise.

Hormone replacement therapy and sex reassignment surgery have been offered to trans people in Norway since the 1950s, albeit in a very restricted manner. In the early 1950s, the massive media spectacle surrounding the American Christine Jorgensen and her hormonal and surgical treatment in Copenhagen led many people to request the same treatment in Norway. As doctors were unsure whether such treatment was legally permissible, the issue was quickly taken to the highest level of the health bureaucracy. The authorities decided that such treatment should not be formalised in a public health facility or structure. Clinical decisions were left to experts, and in the following decades, a handful of interested physicians made decisions regarding treatment (Sandal, 2020). In Oslo, the capital, many trans feminine patients were assessed by a psychiatrist at Ullevål Hospital. The psychiatrist started hormone therapy before referring the patients to a plastic surgeon at Rikshospitalet, the national hospital. An endocrinologist at Aker Hospital, another Oslo hospital, together with a team of medical specialists, assessed most trans masculine patients and made decisions about androgen treatment and chest surgery.[3] Until the establishment of a specialised service for trans care at the Oslo Health Council, the routine for medical transition was unregulated and conducted in a non-standardised manner.

Sex reassignment was a marginal, albeit controversial, field of medicine. Among the harshest critics was the psychiatrist Johan Bremer, the chief physician of the women's department at Gaustad Hospital, the country's first state mental asylum. Psychiatry was too immature, he argued, too little was known about the nature of

mental illness to let surgeons conduct 'irreversible procedures' on patients. 'You don't give small children sharp objects to play with. A psychiatry that is on the stage of development that probably corresponds to the toddler stage should not play around with knives and scissors', he said (Bremer, 1982: 95). To justify his position, Bremer invoked psychiatry's recent past: the psychopharmacological 'era' had left psychosurgery on the ash heap of history,[4] and it was probably 'only a matter of time' before 'sex change surgery' would end there too. In one patient, for example, a multidrug cocktail consisting of 50 mg of nialamide once a day (a monoamine oxidase inhibitor), 0.40 mg of meprobamate three times a day (a tranquilliser) and 50 mg of chlorpromazine four times a day (a high-dose neuroleptic) had made the patient's desire to transition 'disappear' (Bremer, 1961). The best a psychiatrist could offer was psychotherapeutic support – or to institute a multidrug psychotropic regime.

Some psychiatrists disagreed. Several case reports about attempts to change the patient's gender identity, whether through aversion therapy or psychoanalysis, had shown that these interventions were not only useless but also harmful. Some psychiatrists argued that it was their professional duty as physicians to help patients as best as they could, even when this required the use of hormones or surgery to treat what they considered to be a psychiatric condition. In a 1957 article in the main Scandinavian psychiatric journal, psychiatrist Per Anchersen argued that 'it would be unjustifiable not to do everything possible to help him to a satisfactory psychosocial adjustment', writing about so-called 'male transvestites', ignoring the patients' identities and preferred pronouns (Anchersen, 1957). The task of the psychiatrist was 'To help the transvestites, not to cure genuine transvestism', he wrote, referring to the older term for transsexuality.[5] But only a very selected group of patients should undergo hormonal and surgical treatment: 'Surgical treatment seems to be advisable only for a proportion of those who approach doctors with a desire for "sex change".'[6] Anchersen distinguished between transvestism as a fetish associated with sexual desire and genuine transvestism as permanent desire for change of sex, which included a 'disgust' towards the genitals. In addition, he selected patients for surgery based on physical appearance, stature and personality according to an idea about who would pass well in society after treatment (Slagstad, 2022a).

Trans healthcare in a queer time

These opposing professional positions shaped the backdrop of the clinical assessment of patients in the 1970s. The psychiatric examination of trans patients in the Oslo Health Council, which became the main institution for trans medicine in Norway, developed from sexology.[7] Sexology was an emerging 'thought style' in some circles of Scandinavian psychiatry in the 1970s and 1980s (Fleck, 1980), but in social medicine there was a much longer tradition of viewing health and disease through the lens of sexuality. For the Director General of Health Karl Evang, sexuality was an integral part of health (Nordby, 1989; Berg, 2002). However, information and education were not enough; society had to be fundamentally reorganised to create the fundament for 'new forms of human sex lives more suited to human nature than the present ones' (Evang *et al.*, 1932). When the Kinsey Reports were published in the 1940s and 1950s, a ground-breaking study of sexual behaviour in the United States, Evang praised them for providing empirical evidence of the dissonance between people's lives and laws, conventions and conservative morality (*Æsculap*, 1948: 99).

Internationally, the 1970s were big for sexology, and it increasingly became a scientific, professionalised and clinically applied field. The International Academy of Sex Research was founded in 1973, followed by the World Association for Sexology in 1978. Following the publication of a World Health Organization report (1975) on the training of health professionals in a plethora of aspects of human sexuality, psychiatrists increasingly recognised *sexual health* as a fundamental concept for human well-being: 'Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love', the report stated (World Health Organization, 1975). During the same period, sexology also gained a firm foothold in European countries. In several European countries, sexology became a separate profession, with its own curricula for sexology training (although not necessarily officially recognised as a speciality), and sexologists published textbooks, organised conferences and founded professional organisations: the Nordic Association for Clinical Sexology (1978), the Norwegian Association for Clinical Sexology (1981), a Nordic journal of sexology

(1983) and the European Federation for Sexology (1988) (Langfeldt, 1981; Fugl-Meyer *et al.*, 1999).

To understand the role of sexology in the history of trans medicine in Scandinavia, it is necessary to shift the analytical focus from traditional professions to *expertise* broadly construed (Eyal, 2013). Sexology was not the expertise of *one* profession but was enacted by a network of professions, structures and objects. Moreover, sex reassignment legitimised sexology as a field of knowledge, for instance by creating transatlantic professional bonds between Scandinavia and the United States. The Norwegian psychologist Thore Langfeldt, the Danish psychiatrist Preben Hertoft, the American psychiatrist Richard Green and psychologist John Money were all sexologists and close friends working with trans patients.[8] Hertoft founded the Sexology Clinic at Rigshospitalet, the national hospital, in Copenhagen in 1986, and his textbook *Klinisk sexologi* (Clinical sexology), became a reference work in sexology and in the care for trans patients in Scandinavia (Graugaard and Schmidt, 2017).

Amid major societal changes such as student activism, the women's movement and lesbian and gay liberation, the Oslo Health Council became a laboratory for developing and experimenting with new ideas on sexology and social medicine on grand scale, not least in hammering out efficient responses to HIV/AIDS (Slagstad, 2020). Prejudices against homosexuals were firmly entrenched in society, and also among medical professionals. Sex between men had only been decriminalised in Norway in 1972 and homosexuality was still a psychiatric diagnosis.[9] This was the background for the establishment of a counselling service for homosexuals within the Oslo Health Council in 1977. The service was run by health professionals who themselves were lesbian and gay – general practitioners, nurses and social workers – and supervised by a group of psychiatrists and psychologists. Among their supervisors was Berthold Grünfeld. He was appointed to the country's first position in sexology in a new department of medical sexology in the council.[10] To Grünfeld, sexuality was 'a primitive force in life, a fundamental dimension. … The more one tries to suppress it, the greater worry it becomes. Suppression dehumanises it, turns it into something dirty and frugal, something we are ashamed of. Unfortunately, our culture has far too much of this destructive attitude towards sexuality' (Grünfeld, 1979: 114). Grünfeld became a leading expert in transgender medicine in Norway, and when patients applied for hormonal and surgical

treatment, they first had to convince the sexologists at the Oslo Health Council.[11]

Material preconditions for psychiatric expertise

The Oslo regime for sex reassignment was an attempt to safeguard professional decision-making in a situation where clinical knowledge and experience were sparse. None of the experts had any clinical experience with trans health. 'I don't know if I had heard the word "transsexualism" before. I was completely blank', one of the psychologists said.[12] The professionals were concerned that their interventions would harm the patients: 'I felt very strongly that I or we cared about the patients' situation, their feelings, their integrity, that bad things should not be made worse, that nothing should be started without a proper foundation.'[13] To support decisions, the clinicians wanted to formalise the assessment in a separate institution or clinic. If they had the support and security of an institutional framework, it would take some of the responsibility off their shoulders.

However, the Director General of Health Torbjørn Mork opposed the formalisation or institutionalisation of transgender medicine. The moment a clinic was established, more people would seek treatment, he argued. This was also an efficient strategy to keep thorny legal issues such as marriage rights and the change of name, personal identification number and legal gender at a bay.[14] Moreover, it kept medical transition out of the media spotlight. The health authorities generally tried to avoid public attention to sensitive and potentially controversial issues such as artificial insemination (Bjørvik, 2018: 76–7). In articles about transsexuality and sex reassignment published in the 1950s and 1960s, the *Journal of the Norwegian Medical Association* would often print a note in italics above the title: 'May not be mentioned in the daily press.' The medical practice was to remain secret and restricted.

Doctors and health authorities restricted medical transition to avoid public attention, circumvent legal issues and safeguard clinical decisions. Gatekeeping practices of trans medicine were not restricted to clinical practice but also included psychiatric-bureaucratic efforts to limit the dissemination of knowledge about treatment procedures and the refusal to institutionalise treatment. The authorities decided that this area of psychiatry and medicine would be better handled

by dedicated, independent doctors with a personal interest in the topic. And it was precisely this professionally independent but state-sanctioned position of providing expert opinions on issues of public importance on behalf of the bureaucracy that shaped the evaluative role of psychiatry.

Since the authorities refused to establish a specialised clinic, professionals looked for other ways to protect the credibility and legitimacy of clinical decisions. The healthcare workers met several times with the authorities and experts from abroad, and this process created the basis of formalised guidelines for sex reassignment. The guidelines stabilised a therapeutic system and secured the credibility of professional expertise, but they also changed the therapeutic system and institutional context. The guidelines streamlined the medical administration of trans patients by entrusting various professions with specific diagnostic and therapeutic tasks and setting the path for diagnostic and therapeutic practice. A new structure for trans health was established. This is what Stefan Timmermans and Marc Berg poetically described in another context as the crystallisation of an existing and changed world (Timmermans and Berg, 1997). And the existing world that secured the legitimacy of sexology was cast in concrete.

The Oslo Health Council was originally located in a school building from 1869, but this was demolished in 1969 and replaced by a new building. In the new building, all the different departments of the Oslo Health Council were brought under one roof, from the department of epidemic diseases, housing hygiene, venereal diseases and food hygiene to school healthcare and the department for mother and child. During the 1970s, eight new departments were added, in general practice medicine, community nursing, physiotherapy and medical genetics, as well as a support service for families with disabled children. As early as 1958, a large social-psychiatric department for outpatient services was added, dedicated to prophylactic and acute psychiatric care and follow-up of patients discharged from the mental hospitals. By the mid-1970s, the council coordinated the psychiatric services for the entire Oslo population (Borg, 1983), and by 1984 the council employed more than 1,200 full-time staff (Mellbye, 1987; Smith and Siem, 2020). Ironically, the counselling service for homosexuals, where trans patients were assessed, was part of the Department for Mother and Child. But even though

some of the clients and the professionals found this somewhat amusing, it also provided institutional credibility.

The brutalist building in natural concrete from 1969, with a building cost of 29 million kroner, was designed by Erling Viksjø and Inge A. Dahl (Figure 12.1). By this time, Viksjø had already established himself as one of the country's most sought-after architects. Ten years earlier, he had designed the high-rise government building in the city centre, just a stone's throw from the health council. It quickly became a prominent symbol of the social-democratic welfare state. Because of the location of the new health council, the architects gave the building a stringent triangular shape, and the architectural design, floor plan and choice of materials were evidence of a hyper-modern unified vision of architecture, science and medicine: a small laboratory was set up in the basement, each room was equipped with a sink, and the more than 1,000 windows were made of solid aluminium (Figure 12.2) (Dahl and Viksjø, 1969). In many ways, the two brutalist edifices in sandblasted natural concrete and conglomerate concrete – the government buildings and the Oslo Health Council – materialised a new muscular post-war policy and an ambitious modernist political programme. For politicians and doctors alike, the architecture of the new health council embodied a bright medical future, an expansive public healthcare system and the importance of medicine, science and psychiatry for the welfare state. In this programme, sexology now found its rightful place. In theory, sexology stood for gender equality and sexual liberation, a future 'reform psychiatry' that fit perfectly with ideals of a modern welfare state. The modernist, 'social-democratic' architecture and infrastructure of the Oslo Health Council legitimised sexological expertise in the eyes of the government and the public, which in turn secured the evaluative role and authority of the psychiatrist in trans issues. The new Oslo Health Council brought trans medicine under one roof, and the concrete cast concretised the role of sexology in trans medicine, psychiatry and the public healthcare system in general.

Making a psychiatric expert opinion

The professionals sought to protect the integrity of the treatment regime by anchoring it in the public health body but also in the

Figure 12.1 The Oslo Health Council anno 1969. The location posed several problems for the architects. The triangular shape was 'not particularly well-suited for an office building', the architects stated, and it had caused a range of technical and constructional problems. However, 'the client saw a central location as the best solution'. Photo by Leif Ørnelund. With permission from the Oslo Museum, Creative Commons 3.0. http://www.oslobilder.no/OMU/OB.%C3%9869/0319. Image available under a Creative Commons (CC BY-NC-ND 4.0) licence, https://creativecommons.org/licenses/by-nc-nd/4.0/.

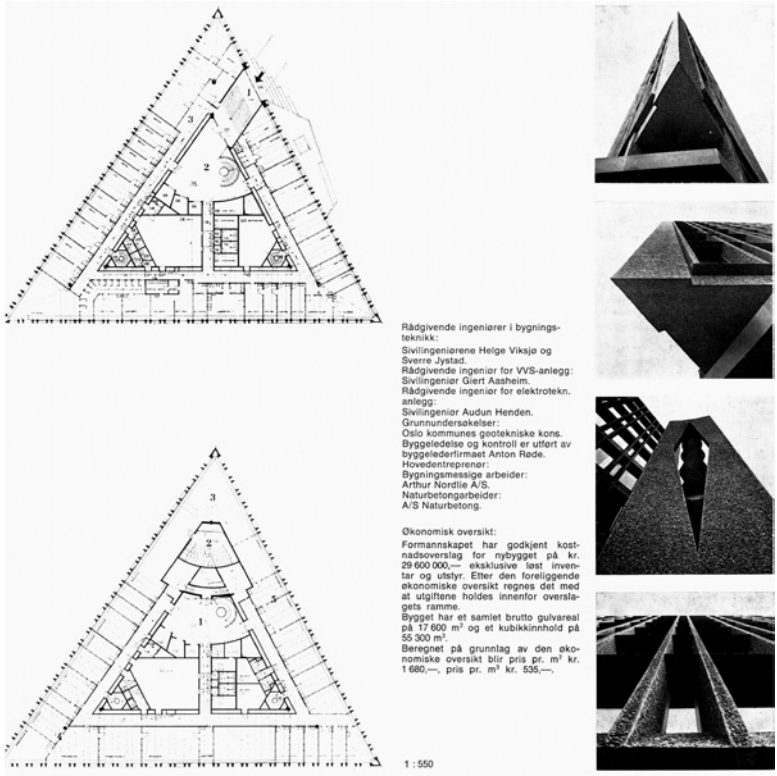

Figure 12.2 On the left, the architectural plan of the Oslo Health Council. The building had a triangular shape, and all offices were aligned along the outer walls. Stairs, elevators and facilities such as kitchenettes, toilets and locker rooms were placed in the core of the building. Separate windows in every office ensured bright working conditions for the health staff. On the right, details of the building and the entrance sculpture designed by Ramon Isern. Byggekunst, 1969. With permission from Arkitektur N and Tone Viksjø. Image available under a Creative Commons (CC BY-NC-ND 4.0) licence, https://creativecommons.org/licenses/by-nc-nd/4.0/.

clinical approach to the individual patient. Diagnostic and therapeutic decisions were made by a team of experts that included psychiatrists, psychologists, endocrinologists, social workers and plastic surgeons. From the beginning, the patient was examined by 'every potential

clinician' and all decisions were based on the views of 'all the aforementioned specialists'.[15] The team-based multidisciplinary approach ensured that each patient was thoroughly assessed from a range of biological, psychological and social viewpoints. A general practitioner or surgeon conducted a clinical examination to examine every aspect of the patient's 'somatic sex' to exclude 'genetic, hormonal or genital incongruence'. A psychiatrist carefully scrutinised the 'sexological state' of the patient, including sexual fantasies, self-perception, experience of femininity and masculinity, 'gender role behaviour' and sexual practice. A psychologist or psychiatrist examined the patient's personality using clinical interviews and testing instruments to decide whether concomitant psychiatric symptoms or conditions were primary or secondary to transsexuality. Finally, the social worker scrutinised the work situation and facilitated social transition in the workplace, even by arranging for occupational rehabilitation or, if needed, the relocation to a new job.

Broadly seen, the expert opinion on whether a patient was given hormonal and surgical treatment was shaped against two premises. There could be no contraindications and the patient had to fulfil the criteria of transsexuality. Contraindications ranged from age and social issues to physical characteristics and psychiatric illness. The professionals argued that the younger the patient, the better the prognosis; ideally, the patient should be in their twenties or early thirties. The barrier to access treatment was much higher if the patient had children or was married. The patient should preferably have a stable job and secure income, as well as social and psychological support among family, friends and colleagues. 'To exaggerate a bit', Hanna said in an interview, 'if everyone had said they wanted a husband, two children, a family car, a villa and a dog, they would've been very happy.'[16] She went through the diagnostic assessment in the early 1980s.

'Unsuitable body type' was another contraindication that primarily prevented access to treatment for tall trans women or patients with a sturdy body type. 'One of the criteria for sex change, which was very strict, was that one had to be able to pass as the other gender [*kjønn*]', one of the doctors recalled. 'So tall men didn't get treatment and people who had big shoes. I remember very well how this criterion of being able to pass was talked about. Talk about cultural production of masculinity and femininity and what is right and

wrong and normal and abnormal. It's very strange to think about today, I think.'[17]

'Psychotic traits' posed a firm contraindication to medical therapy, but the psychiatrists and psychologists did not relate psychotic symptoms to stigma or minority stress. In rare cases, the Oslo guideline stated, 'the desire for sex change' was part of a psychotic illness. Depression, on the other hand, could be the result of 'having waited for treatment for a long time and experienced many negative reactions along the way'.[18] Therefore, major depression was not a firm contraindication to treatment. The different approach to psychosis and depression established a hierarchy of contraindication. Psychosis became a separate disease entity unrelated to minority stress, while the professionals saw depression in relation to psychological and societal factors such as stigma. Professionals realised trans health was inextricably linked to the negative health effects of marginalisation, stigmatisation and ostracism. The different approach to patients with psychotic and depressive symptoms probably reflected a much longer tradition in psychiatry of distinguishing between severe and milder forms of mental illness, and of psychiatrists automatically attributing lower self-knowledge to people with psychosis and impaired decision-making capacity.

The second obligatory passage point was that the patient had to be diagnosed as a transsexual and not as a transvestite or homosexual. The diagnostic criteria for transsexuality corresponded to those of the ICD-9, published in 1978: the patients had to have the experience of 'belonging to the opposite sex' since childhood and 'feelings of disgust' towards their 'own biological sex', as well as the desire to be recognised as the 'opposite sex' and a wish for hormonal and surgical therapy to align the body with their gender identity.[19] An important objective of psychiatric expertise therefore was to probe the 'consistency' of the gender identity and the psychosexual development including 'sexual fantasies, self-image, experience of masculinity/femininity, gender role behaviour and sexual behaviour.'[20] The diagnostic reasoning was based on the idea that transsexuality had to be separated from so-called effeminate homosexuality. For trans women to pass through the diagnostic system, for example, they had to convince the professionals that they were only sexually interested in heterosexual men.

The unsolvable paradox of the restrictive Oslo model was that the medical treatment that would have made it easier for patients to fulfil the stereotypical gender conceptions of transsexuality was withheld until the very end. 'They were very afraid that people would regret it', Hanna said. 'If you were a heterosexual woman like me, everything was okay, but if you were a lesbian woman, it was not okay, then they would not operate on you.'[21] At first, the professionals concluded that she was an effeminate homosexual man since she also dated gay men. But at that time, Hanna did not really care much if the men she went on dates with were gay or straight, and besides, it was much easier for a trans woman to meet men in Oslo's gay scene. 'I tried to explain to Grünfeld all the things I tried to do that night without him [her date] trying to feel me up down there, which turned into a big mess, poor guy, but Grünfeld then decided to believe I was a gay man', Hanna said. 'But when I told him that I had gone out with straight guys, gone to the cinema and had a glass of wine, he asked me why it had stopped there. And I said: 'Look, I have not yet had genital surgery, and I don't have breasts either.'[22]

One of the doctors confirmed Hanna's experience: 'At that time, I think nobody believed that transgender people, or "sex change clients", as we used to say, could be anything but heterosexual. It was part of the definition that if they wanted to become the opposite sex, then they wanted a partner of the same sex as they were born. It was almost a requirement.'[23] The health professionals feared that trans patients requested medical treatment as a 'cheap solution' to self-repressed homosexuality:

> Back then it was much harder to be gay, and if you could disguise it with surgery, hormones, clothes, and social role, that was more attractive to some people. We thought we knew quite a lot about sexual orientation, so with some of the people we talked to, we concluded: he is gay, do not pursue this project, sex change is not the solution for this. But at the same time, there was a lack of understanding that transgender people could have a non-heterosexual orientation. At that time, sexual orientation was very binary, you were either homosexual or not. Any form of fluidity, which has become much more apparent the last ten years, did not exist in people's minds.[24]

According to the experts' self-understanding, sexology was about approaching human sexuality in sex-positive, health-promoting,

depathologising and non-normative ways. However, the Oslo model also reflected ingrained scepticism about the medicalisation of social and sexual issues. In sexology, transgender was not considered a minority condition or included in the human variation they otherwise advocated. The sexological legacy of sex, gender and sexuality, and how these concepts related to one another, became a barrier to accessing medical treatment for trans patients (see Gill-Peterson, 2018). Trans patients were subjected to a medical regime of psychiatric-sexological inspection and adjustment, and sexology became a tool for psychiatrists, psychologists and other sexologists to administer trans life. However, there would have been no sexology without the patients who willingly, but most often unwillingly, shared stories with the professionals and who had to surrender their bodies and identities to psychiatric, medical and sexological inspection, examination and administration. Ultimately, sexology became a gatekeeping model in trans medicine, a way of organising trans-specific healthcare which has faced much criticism (Stone, 1991; Spade, 2006; Alm, 2018; Horncastle, 2018; Ashley, 2019; Shuster, 2021).

Paradoxically, Grünfeld was aware of the hierarchical problems and unequal distribution of power in the system he overlooked: the paternalism of the doctors making these decisions often remained unconscious, he wrote, 'disguised as so-called medical reasoning' (Grünfeld, 1987: 203). In the end, very few patients succeeded in receiving treatment and most people were left to fend for themselves. There were simply few other ways of accessing hormones and surgery for trans patients within the public healthcare system.[25]

The manifold practices of psychiatric expertise

This chapter has attempted to extend a historical analysis of the psychiatric-bureaucratic administration of trans life beyond anachronism or moral indignation over the actions of individual actors. This would overlook the systemic role of psychiatric expertise in the welfare state in negotiating and resolving problems between the public and the bureaucracy. The psychiatric expert opinion was an attempt at providing an answer to a practical question – who should be allowed to change sex? – in a situation where the major goal of medicine and bureaucracy was to restrict and limit this type of care

to a minimum. The preparation of psychiatric expert opinions was not limited to the clinical encounter between the individual patient and psychiatrist or the evaluation of contraindications, aetiological reasonings or nosological demarcation. Psychiatric expertise was one building block in a comprehensive social fabric that also included medical publication culture and the health bureaucracy. Expert opinions gained their legitimacy and authority by tying together patients and health professionals, concepts and objects, paper and concrete, institutional and spatial arrangements. This included the old public health institution of the Oslo Health Council with its new architectural design, and it included the flowering field of sexology with its organisations, publication channels, conferences, textbooks and curricula.

Standardisation processes are central to modern medicine, scholars in science and technology have noted (Bowker and Star, 1999). However, standards cannot be seamlessly teleported to any social context. For standards to work, they must recruit and become embedded in pre-existing institutional and material relations and practices. Protocols and standards are 'technoscientific scripts which crystallize multiple trajectories', the scripts enable and modify pre-existing infrastructures (Timmermans and Berg, 1997). Sexology as reform psychiatry mobilised old institutions and structures while fostering new spatial, material and architectural arrangements.[26] As psychiatrists and sexologists developed diagnostic routines and treatment protocols for trans patients, they worked hard to embed these practices into the pre-existing Oslo Health Council and the counselling service for homosexual patients, expanding, transforming and modifying the infrastructure already in place. Faced with the 'new' issue of sex change, the professionals tried to secure expert authority and legitimacy by anchoring decisions in an interdisciplinary team. Trans care enabled new ways of doing psychiatry. This reform built on an old epistemological framework of sex and sexuality and their interrelations, and the old framework hindered a subversive and inclusive potential in sexology from being applied to the new field of trans health. This legacy continues to reverberate in the present. In the early 2000s, a new gender identity clinic was established at Rikshospitalet under psychiatric control. Yet people who transgress binary norms of gender are still excluded from treatment (Jentoft, 2019; Slagstad, 2022b).

The Oslo story of sexological expertise on trans issues is an example of psychiatric expertise as social practice. Sexology, as a form of psychiatric expertise, prepared, mediated and solved problems between the bureaucracy and the public. The sexological administration of trans patients was a response to the 'new' issue of medical transition which secured the evaluative role of psychiatry in the welfare state. Sexology became the fundament for a new diagnostic and therapeutic programme and standard of trans medicine that changed the existing world of psychiatry.

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Notes

1 One could argue that it is anachronistic to use 'trans' for a time when the term was not in use. However, I do not use it as an identity category but as an analytical category to avoid reproducing the pathologising terms of hegemonical actors (i.e. doctors).
2 The health councils (helserådene) were originally known as health commissions (*sunnhetskommisjoner*).
3 For the regulation of sex reassignment in the Scandinavian medico-judiciary system, see Alm, 2018; Hartline, 2020; Honkasalo, 2020; Alm, 2021.
4 For more on psychosurgery see the contribution by Florent Serina in Chapter 6.
5 Magnus Hirschfeld had already coined the term *Transvestitismus* in 1910. In Denmark and Norway, 'genuine transvestism' was in use in the 1950s and 1960s. In Sweden, 'transsexualism' was in use from the 1960s – see Wålinder, 1967. 'Transsexualism' gradually replaced 'genuine transvestism' in 1970s Norway. American doctors and psychiatrists mostly referred to 'transsexuality' or 'transsexualism' (Benjamin, 1953; Benjamin, 1966).
6 The National Archives of Norway, Oslo, RA/S-1286/D/Dc/L0611, Sosialdepartementet, Helsedirektoratet, Kontoret for psykiatri, H4, Dc,

Box 611, Folder Transseksualitet, Per Anchersen to the Directorate of Health, 31 July 1974.

7 For the role of social medicine see Slagstad, 2021.

8 Thore Langfeldt, interview with Ketil Slagstad, Oslo, 29 January 2020.

9 In 1977, the Norwegian Psychiatric Association recommended its members avoid using the diagnosis.

10 Oslo City Archives, Oslo (hereafter OCA), Oslo helseråd, Box 122, Homofile – transseksualitet, Hans Døvik, 'Rådgivningstjenesten for homofile – egen seksjon for medisinsk sexologi', 3 July 1979.

11 Berthold Grünfeld was born in Bratislava to Jewish parents, but was brought to Norway by the Nansen Relief before World War II.

12 Bodil Solberg, interview with Ketil Slagstad, Oslo, 20 January 2020.

13 *Ibid*.

14 OCA, Oslo helseråd, Box 122, Homofile – transseksualitet, Torbjørn Mork to Stadsfysikus in Oslo, Fredrik Mellbye, 'Transseksualitet', 16 February 1979.

15 OCA, Oslo helseråd, Box 122, Homofile – transseksualitet, Report, 'Utredning om transseksualitet', December 1979, p. 5.

16 Hanna, interview with Ketil Slagstad, 13 November 2019. 'Hanna' is a pseudonym.

17 Kirsti Malterud, interview with Ketil Slagstad, 24 October 2019. At the time, Kirsti Malterud worked as a general practitioner. She later became a professor in general practice with a research focus on qualitative methods and women's health.

18 OCA, Oslo helseråd, Box 122, Homofile – transseksualitet, Report, 'Utredning om transseksualitet', December 1979, p. 5.

19 *Ibid*., p. 6.

20 *Ibid*.

21 Hanna interview.

22 *Ibid*.

23 Malterud interview.

24 *Ibid*.

25 It was not possible to find out what happened to those patients who were denied treatment.

26 See also Chapters 4 and 9.

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