

Effects of Standardization on Cultural Identity and Community Involvement:

Transgender Clients at the Vrije Universiteit Gender Clinic

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Abstract

In the Netherlands, treatment for transsexual individuals has been institutionalized through the protocol established at the Vrije Universiteit Gender Clinic. However, for the population of transgender-identified individuals, those who transgress the gender binary and who identify among or in-between genders, the four phases of transition often do not suit their unique needs and expressions of gender identity. In this study, I examined the narratives of 9 trans-identified individuals who have utilized the services at the Gender Clinic. To supplement my analysis of these interviews, I spoke with S. Leigh Thompson, founder and acting director of the TransMasculine Community Network, Jos Megens, coordinator of the Vrije Universiteit Gender Clinic, and Drs. Eliza Steinbock, who clarified cross-cultural trends of community involvement and theoretical phenomenon. The 12 interviews revealed that the unsatisfactory experiences of transgender-identified individuals at the Gender Clinic co-existed with a lack of community involvement and motivation for change. This phenomenon can be attributed to the legal atmosphere in the Netherlands, aspects of Dutch culture, and the de-politicizing effect of standardization on cultural identity and community participation. Analysis also revealed the manifestation of two kinds of community involvement, socially invested and that grounded in a political agenda.

Introduction

With mandatory national health insurance, the Netherlands has been one of the first countries to institutionalize treatment of transsexual and gender non-conforming individuals.¹ For those who professionals deem to be “gender dysphoric,” this treatment consists of hormone replacement therapy, as well as a series of gender affirming surgeries (commonly known as sex reassignment surgery), most of which are covered by the government’s national required health insurance, saving individuals with transsexual experiences tremendous personal expense. In this system, individuals who identify as transsexual get pathologized and then immediately shunted into the physical process of transition, encouraged by state-run organizations to go “all the way” in their transformation, to the full extent that modern medicine allows. The Vrije Universiteit Gender Clinic has served this role for gender non-conforming populations in the Netherlands for over 30 years, helping those who fit their strict protocol and denying services to others, who feel that they do not need the full treatment, or who present a narrative outside the norms of a traditional transsexual experience. This is drastically different from systems elsewhere, where transition is limited by economic and geographical issues, often making a full medical transition an unattainable and unrealistic target. At the same time, my preliminary impression is that in these very populations, which are without services, have the strongest community involvement.

The discrepancy at hand forced me to ask questions about community involvement. Specifically, have diverse transsexual and transgender communities been formed in response to a shared frustration in accessing services? Furthermore, if services are provided, is there still a critical need for community involvement? If not, what becomes of the variety of gender non-conforming

¹ In this paper, “transgender” is reserved exclusively for individuals identifying among or in-between genders. “Transsexual” is used to identify individuals who identify as male-to-female (MTF) or female-to-male (FTM), and “trans” is used as an umbrella term to include all gender non-conforming individuals, those who identify within a strict binary gender paradigm (transsexual) and those who identify as transgender. For additional explanation of these linguistic terms, please refer to the *Relevant Terminology* and *Methodology* sections of this report.

individuals, many of whom share anti-assimilationist sentiments and may otherwise immerse themselves fully in queer space? Since transsexuals in the Netherlands can access gender affirming surgeries and other transition-related healthcare, and seem to simultaneously lack a common thread of community involvement, I focused my research on the social implications of the institutionalized Dutch treatment plans for trans-identified people. This research aims to further clarify the effects of standardization on cultural identity and community organization.

Legitimizing Differences: Rights on Expression

Growing visibility of transgender-identified people, those who do not conform or identify with the gender expectations associated with the sex they were assigned with at birth (whether or not they pursue medical attention and/or bodily alterations), has sparked political debates and discussions about legitimacy, power, and certain freedoms. These debates have provoked the emergence of discourse around male/female dichotomies and the exclusivity of each group.

Transgender activists have been questioning the entire system of binary and polarized gender... This has coincided with an increase in the numbers of people who label themselves third-gender, two spirit, both genders, neither gender, or intersexed, and insist on their right to live without or outside of the gender categories that our society has attempted to make so compulsory (Califa, 1997, p. 245).

The International Bill of Gender Rights (IBGR) was adopted by the International Conference on Transgender Law and Employment Policy, Inc. (ICTLEP) in August of 1993. Striving to concretize fundamental human and civil liberties from a gender perspective, the 10 parts of the IBGR are universal rights that can be claimed and exercised by every human being. With no force of law behind it, the IBGR serves as a theoretical expression to liberate and empower those who acknowledge the guidelines, not as a dictating force or legal document.

The first and second rights listed read:

(A full version of this document is provided in Appendix A of this report)

The Right to Define Gender Identity

All human beings carry within themselves an ever-unfolding idea of who they are and what they are capable of achieving. The individual's sense of self is not determined by chromosomal sex, genitalia, assigned birth sex, or initial gender role. Thus, the individual's identity and capabilities cannot be circumscribed by what society deems to be masculine or feminine behavior: It is fundamental that individuals have the right to define, and to redefine as their lives unfold their own gender identities, without regard to chromosomal sex, genitalia, assigned birth sex, or initial gender role

Therefore, all human beings have the right to define their own gender identity regardless of chromosomal sex, genitalia, assigned birth sex, or initial gender role; and further, no individual shall be denied Human or Civil Rights by virtue of a self-defined gender identity which is not in accord with chromosomal sex, genitalia, assigned birth sex, or initial gender role (IBGR, 1993).

The Right to Free Expression of Gender Identity

Given the right to define one's own gender identity, all human beings have the corresponding right to free expression of their self-defined gender identity.

Therefore, all human beings have the right to free expression of their self-defined gender identity; and further, no individual shall be denied Human or Civil Rights by virtue of the expression of a self-defined gender identity (IBGR, 1993).

The fifth and sixth rights listed are as follows:

The Right to Control and Change One's Own Body

All human beings have the right to control their bodies, which includes the right to change their bodies cosmetically, chemically, or surgically, so as to express a self-defined gender identity.

Therefore, individuals shall not be denied the right to change their bodies as a means of expressing a self-defined gender identity; and further, individuals shall not be denied Human or Civil Rights on the basis that they have changed their bodies cosmetically, chemically, or surgically, or desire to do so as a means of expressing a self-defined gender identity (IBGR, 1993).

The Right to Competent Medical and Professional Care

Given the individual's right to define one's own gender identity, and the right to change one's own body as a means of expressing a self-defined gender identity, no individual should be denied access to competent medical or other professional care on the basis of the individual's chromosomal sex, genitalia, assigned birth sex, or initial gender role.

Therefore, individuals shall not be denied the right to competent medical or other professional care when changing their bodies cosmetically, chemically, or surgically, on the basis of chromosomal sex, genitalia, assigned birth sex, or initial gender role (IBGR, 1993).

The document emphasizes that the legitimization of the space between binaries is the first step towards inclusive representation in public services and social acceptance. By acknowledging those individuals who do not identify as the “male” or “female” commonly accepted in most Western societies, understanding the components of gender can be explored away from a hierarchical power structure in which those outside the realm of recognition essentially disappear. For all voices to be heard, the human rights all individuals are entitled to must be granted. Only then can the bounds of diverse gender expression be made visible.

The Importance of Trans Communities

When S. Leigh Thompson, founder and acting president of TransMasculine Community Network, talks about “community,” he uses the broadest of all qualifiers. He defines community as:

A group of people who interact based on a shared characteristic or trait. This characteristic can be rooted in place or proximity (such as a neighborhood), ethnic background (like Korean Americans), shared interest (perhaps stamp collecting), history (survivors of parental abuse), physical characteristic (Little People of America), personal identity (Butch/Femme), or any other characteristic (S. Leigh Thompson, e-mail interview, April 19, 2007).

He notes that, “People like to associate on base levels of commonality, no matter if that commonality is associated with the majority or the marginalized (S. Leigh Thompson, e-mail interview, April 19, 2007).” But his motivation for community organizing within the transgender population is clear: he feels that trans communities are essential to development and growth, and are “terribly vital” to some people who cannot find support in other settings. Thompson writes:

We need communities that don’t enforce a prescribed method of passing and belonging. We need communities that recognize differences and embrace experience over identity. We need communities that understand the intersection of multiple identities, and strive to learn from other people, other situations, and are guided by a common sense of mutual respect for all people (S. Leigh Thompson, e-mail interview, April 19, 2007).

For transgender-identified individuals, communities have historically been a safe-space, away from the cruelties and crossfire of mainstream society, which has proven, tragically so, to be overwhelmingly intolerant of gender-variance.

Transphobia is the irrational and unfounded fear, hatred, or discriminatory treatment of trans people (i.e., people who transgress the boundaries of the binary sex/gender model established by society). A society that is transphobic typically condones and often promotes a range of behaviors, from simple discrimination in housing and employment to cruel acts of intolerance and prejudice, from demeaning verbal harassment to vicious sexual and physical assaults, from the withholding of life-saving emergency services to outright murder. In a transphobic society, trans people often live in fear for their lives, especially those who do not “pass” well. Transphobic attitudes and actions underlie the high rates of social isolation, self-hatred, and high-risk behaviors found in the trans community. According to some sources, the rate of violence against trans people is on the rise in the United States and around the World (Shankle, 2006, p. 146).

Literature Review

To understand the ways in which the institutionalization of protocol affects gender non-conforming individuals, it is imperative to first look at the American Psychiatric Association's (APA) *Diagnostic Statistical Manual of Mental Disorders* (DSM-IV) diagnosis of Gender Identity Disorder (GID) and how the diagnoses has been implemented in the Vrije Universiteit Gender Clinic's protocol. Additionally, we must look at the body of research available about transgender identities in regards to the treatment they receive, as well as to community voices, in order to gain incite into the priorities of trans people and the content of community activism, when it is there.

The body of work that exists makes a clear and defined differentiation between sex, gender role, and gender identity. Sex has been defined as biological or anatomical sexual markers, with a 92% genetic overlap between female and male (Gender Identity Project [GIP], 2006). These markers, however, which include genitalia, hormone levels, and chromosomes, are only assigned meaning in a social context, are mutable, and can change over time (GIP, 2006). Gender role includes the "public, social, and perceived expectations of gendered acts or expressions (GIP, 2006);" these variable social norms change over time and vary from culture to culture. One's own gender identity is the self-conception of their gender, which may or may not have an organic component (GIP, 2006).

The DSM-IV classifies the criterion for GID as "a strong and persistent cross-gender identification" and a discomfort with the gender roles of their given sex (APA, 1994, p. 537). "In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live as or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex (APA, 1994, p. 537)." The diagnosis presumes that the client desires to rid themselves of primary and secondary sex characteristics, as well strong belief that they were born into the wrong body, causing "clinically

significant distress or impairment (APA, 1994, p. 537).” The other gender identity diagnosis in the DSM-IV is Gender Identity Disorder Not Otherwise Specified (GIDNOS). The diagnosis is intended for individuals who do not fit the criteria for GID, but who demonstrate a perceived struggle with gender-related issues, stress-related cross dressing behaviors, or a pre-occupation with castration (APA, 1994, p. 538). Intersex individuals, those born with a variation in anatomical sex, hormones, and/or chromosomes, cannot be diagnosed with GID. However, an intersexed person with gender dysphoria can fulfill the criteria for GIDNOS (APA, 1994, p. 538).

The International Code of Diseases (ICD-10), created by The World Health Organization (WHO), intends to provide consistency in diagnosing and documenting causes of death on an international level. The ICD-10 lists five gender identity disorders, with specific criteria for each diagnosis.

Jos Megens, who coordinates the Vrije Universiteit Gender Clinic, explained that the basis for diagnosis and treatment for their clients is the World Professional Association for Transgender Health’s (WPATH)² Standards of Care (SOC), which are based primarily on the gender identity disorder diagnoses in the DSM-IV and the ICD-10 (Megens, J., Lecture to SIT, February 28, 2007). These guidelines serve as the minimum requirements in the treatment of people with gender identity disorders, as well as protocol that are intended to be used as a tool to adapt to individual patients and their needs (Harry Benjamin International Gender Dysphoria Association, Inc. [HBIGDA], 2001, p. 3). WPATH notes that “The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well being and self fulfillment (HBIGDA, 2001, p. 2).” The SOC ultimately serve as both a guide for the mental health care professional, outlining diagnostic and therapeutic responsibilities to their gender dysphoric client, as well as a system of

² The World Professional Association for Transgender Health (WPATH) was formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA).

classification of the gender non-conforming, allowing the client access to services in a system that simultaneously pathologizes their unique gender expression.

The body of academic research that has addressed the medical treatment of gender non-conforming individuals is vast and varied. *Transsexualism: Introduction and General Aspects of Treatment* (Vrije Universiteit, n.d.) documents research conducted at the Vrije Universiteit. The thesis details observations over thirteen years of treatment, with specific regards to the side effects and metabolic changes occurring during cross-gender hormonal treatment. The piece provides insight into the treatment approach at the Vrije Universiteit and the general progress of the implementation of institutionalized protocol for trans-care. *Transsexualism: A Review of Etiology, Diagnosis, and Treatment* (Cohen-Kettenis & Gooren, 1999), addresses gender development in transsexual individuals, exploring management options in the Netherlands in terms of diagnosis, treatment, and the results of sex-affirming surgeries. *Changing Sex: Transsexualism, Technology, and the Idea of Gender* (Hausman, 1995), explores the various ways in which technology has aided transsexuals with tools to transition, as well as the limitations of these tools and implications on cultural identity. In *Made to Order: Sex/Gender in a Transsexual Perspective*, Ines Orobio De Castro identifies key concepts within the body of law, medicine, and sociology, which help explain transition within a social context, influenced by the norms, expectations, protocols and assumptions produced, implemented, and practiced by the greater public.

Only by understanding the studies on transsexuals can we begin to see the gaps within the protocol and research. Much of the above-mentioned research accompanies a plethora of additional studies that focus exclusively on the transsexual; the female-to-male (FTM) and male-to-female (MTF) individuals who undergo extensive reformation to become differently gendered individuals. What has often been left out, however, in research and in protocol, are the individuals who do not fit within a binary gender paradigm, who do not wish to transition to the “other,” who instead prefer

to live in a third space, “that which questions binary thinking and introduces crisis (Garber, 1993).” Only a handful of academic research has catered to this population. *Blending genders: Contributions to the Emerging Field of Transgender Studies* (Elkins & King, 1997), addresses the limitations of social scientists who are constrained by the medical categories of transvestism, transsexualism and gender dysphoria, which “presume pathology, limit our gaze to a narrow range of cross-dressing/sex-changing phenomena (Elkins & King, 1997, p. 1).” Elkins and King dissect the idea of blending gender categories, differentiating it from the idea of living “beyond gender” altogether.

Surya Monro contributes to the distinction between normative and non-conforming in *Theorizing Transgender Diversity: Towards a Social Model of Health* (2000). The paper identifies social structure as the key point in understanding how transgender inequality affects transgender-identified individual’s health and ability to participate in society as active citizens. Monro emphasizes that “The pathologization of trans has led to the silencing of trans people and to transphobia at structural and individual levels (Monro, 2000, p. 43).” Monro notes that her trans-identified participants wished primarily “simply for the right to live as equal human beings (Monro, 2000, p. 43),” a request that would not pose a threat to people with conventional gender identities or to the institutions of family and heterosexuality. Monro asks that instead of intolerance, “Pluralization could simply be seen as an indication of social evolution, allowing greater choice and means of self-expression concerning gender (Monro, 2000, p. 43).”

Community activists have adopted a similar sentiment, leading the discourse away from pathologization and into a sphere of recognition, equality, and celebrated diversity. Perhaps the leading advocate within this sub-body of work is Leslie Feinberg, who has served as an organizer, activist, speaker, and author for over 15 years. In Feinberg’s 1996 *Transgender Warrior; Making History*

*from Joan of Arc to Denis Rodman, ze*³ acknowledges cross-cultural gender liberation movements throughout time, providing profound incite in regards to the marginalization of gender non-conforming individuals accompanied with strategies for mobilization. Other community activists whose compositions have added to the body of work around the institutionalization of “gender care” include Kate Bornstein, Judith Butler, Judith/Jack Halberstam, Patrick Califia, and Riki Anne Wilchins.

With the Vrije Universiteit Gender Clinic’s protocol changing in the upcoming year (Megens, J., personal interview, April 25, 2007), this report serves as a benchmark analysis of where the community is, their experiences with the Gender Clinic, and their priorities for change. Their narratives, which illustrate transgender navigation within a binary system, reveal the possible effects of institutionalization on cultural identity and community involvement.

³ *Ze* and *hir* are gender-neutral pronouns, used instead of she and her or he and him. Many transgender and genderqueer-identified individuals prefer these gender-neutral pronouns.

Theoretical Framework

The norms that govern idealized human anatomy thus work to produce a different sense of who is human and who is not, which lives are livable and which are not.

-Judith Butler, *Undergoing Gender*, p. 4

In this current age, marked by an urgent need to categorize and label stimuli, “gender” has become not only a misinterpreted and highly contested linguistic term, but also a medicalized indexing by which a *one* opposes an *other*. In this section, I will utilize Judith Butler’s definition of gender, as “the apparatus by which the production and normalization of masculine and feminine take place along with the interstitial forms of hormonal, chromosomal, psychic and performative that gender assumes (Butler, 2004, p. 42).” A recent growth of the medical establishment has been the formal acknowledgement that differently gendered bodies exist, where hardwired brain functioning does not correspond with the “matched” genitalia. In this, we see the validation of transitioning individuals, particularly the transsexual, giving space for boys to grow up to be women and girls to grow up to be men. Still, the WPATH’s SOC, based on the DSM-IV and the ICD-10, insist on a polarized regime of gender identity. Currently, there lacks any medically acknowledged discourse on mixed or other gender identity.

To understand the social basis of gender identification, I will first point to the work of Althusser and his use of the concept of interpellation. A Marxist philosopher, Althusser used the term interpellation to describe the process by which ideology, “the system of representation by means of which we live in cultures as their products and agents (Grosz, 1991, p. 68),” addresses the individual subject and thus producing him as an effect. Althusser understood that “the function of ideology is the transformation or interpellation of biological individuals into social subjects (Grosz, 1991, p. 68),” an essential and inescapable process of cultural definition. Althusser maintained that gender and gender roles are produced by the discourses of the institutional Ideological State Apparatuses (ISAs), including but not limited to the family, the media, religious organizations, and

the education system. Coming into the world, our use of language is only a manifestation of our interactions with a system that pre-exists us. Having only these terms, Althusser maintains that agency as the ability to act does not exist, as we are constrained by a structure that controls our certainty as legitimate individuals.

In *The History of Sexuality Volume I*, Michel Foucault discusses the discursive operations that shape and construct gender and sexuality. Queer theorists have used his work as a departure into the continued analysis of the ways in which gender and sexuality are understood through the use of language as a tool that assembles knowledge, which for Foucault, is inescapably merged with power (Foucault, 1990, p. 100). Discourse, he discusses, imposes categories, social constructions applicable to a certain society in a certain place and time. This constructivist approach suggests that male and female are constantly being created through discourse, and that knowledge and power form these conceptions/creations of men and women. Unfixed, our notions of gender are directly tied to systems of ideas and knowledge that are expressed through communicative actions by which culture prescribes. Foucault notes that “Relations of power-knowledge are not static forms of distribution, they are ‘matrices of transformations, (Foucault, 1990, p. 99)” leaving room for constant change, constant resistance, and a constant need for recognition.

Judith Butler comments on the agency of one’s gender, stating, “One only determines ‘one’s own’ sense of gender to the extent that social norms exist that support and enable that act of claiming gender for oneself. One is dependent on the ‘outside’ to lay claim to what is one’s own. The self must, in this way, be dispossessed in sociality in order to take possession of itself (Butler, 2004, p. 7).” Butler’s statement is consistent with Althusser’s argument. She claims that gender is performed through and by the many social discourses around gender that are produced by the various ISAs.

If therefore, the medical institution serves here as an ISA, and the discourses it produces equates to the constant rigid pathologization of gender non-conformity, that very same discourse is the system by which ones own gender is shaped within, constrained by, and legitimized through. When considering transgender individuals, Butler points to the DSM-IV's GID diagnoses, which "assumes that 'gender dysphoria' is a psychological disorder simply because someone of a given gender manifests attributes of another gender or a desire to live as another gender (Butler, 2004, p. 5)." The model, she argues, imposes "a coherent gendered life that demeans the complex ways in which gendered lives are crafted and lived (Butler, 2004, p. 5)."

Relevant Terminology

Adapted from *Trans Inclusion Policy Manual for Women's Organizations* (Darke & Cope, 2002)

Androgynous refers to individuals whose characteristics are not limited to either of the two traditional gender classifications. These characteristics can include androgynous presentation, behavior, wardrobe, and social roles.

Assigned Sex refers to the sex assigned to each child at birth, typically based on a cursory examination of the genitals. Please note that assigned gender refers to assumptions made about a child's gender based on their assigned sex (i.e., babies with penises are assumed to be boys and babies with vaginas are assumed to be girls).

Binary Gender System/Paradigm refers to the division of human beings into two, mutually exclusive categories of male and female. Each is assumed to have its own biological and social characteristics. In this system, those born with vaginas must understand themselves to be female and feminine, to feel female and feminine, and to appear female and feminine to others. Those born with penises must understand themselves to be male and masculine, to feel male and masculine, and to appear male and masculine to others.

Cross-Dressing refers to wearing clothing and accessories typically associated with that of the “opposite” gender; for example, men wearing what are generally considered to be women's clothing and women wearing stereotypically male attire, sometimes for sexual arousal. Cross-dressing may be undertaken in particular situations, for specific occasions, or in all aspects of a person's life. It may involve some articles of clothing, or full cross gender clothing and appearance. The term cross-dresser is preferred to transvestite in many settings, though this is not the case in the Netherlands.

Drag is a form of cross-dressing and originally referred to gay men or lesbians who dressed in a “hyper” feminine or masculine way for the purpose of performance. Drag is not, however, limited to the queer community. In its broader definition, drag is about blurring rigid gender lines, redefining roles, and turning expectations upside down.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition) describes the classification system and diagnostic criteria for what are considered to be mental disorders. It is published by the American Psychiatric Association and is widely used all over the world. Diagnoses applied to trans people include Transvestic Fetishism and Gender Identity Disorders. There is considerable debate about the inclusion and interpretation of these diagnostic categories within, and outside, trans communities.

Estrogen is considered to be the “female” sex hormone. However, both male-bodied and female-bodied produce estrogen, women just tend to have more of it.

FTM (female-to-male, transman, transguy, or identifying on the transmasculine spectrum) is used to specify the direction of movement in identification from assigned sex (female) to gender identity (male/man). Individuals identifying somewhere on this transmasculine spectrum may or may not pursue sex reassignment surgery (all or in part), and may or may not take testosterone. Transmasculine-identified individual's expression of their masculinity may take many forms depending on personal preference, culture, sexual orientation, and class, among other considerations.

Feminine is the gender role assigned to girls and women. It involves the gendering of certain traits or characteristics, such as passivity, cooperation, emotional expression and verbal skills, making them the exclusive domain of those considered to be female.

Gender Identity is an internally felt sense of gender. It refers to the self-image or belief a person has about their gender as being female, male, both, or something altogether different. Gender identity does not always

match the sex assigned at birth. It is important to differentiate gender identity from sexual orientation (sexual identity).

Sexual Orientation refers to emotional and sexual desires for others, whereas gender identity refers to the experience of who we are, separate from attractions to others. Trans people are, therefore, heterosexual, bisexual, lesbian, gay, queer, and otherwise identified.

Gender Identity Disorder is a psychiatric diagnosis in the DSM-IV and is used to describe people whose gender identity does not match their assigned sex. A gender identity disorder is described as a strong and persistent cross-gender identification manifested by the stated desire to be the other sex and to dress, interact, live and be treated as the sex other than that assigned at birth. To be clinically diagnosed as having a gender identity disorder, a person must exhibit extreme discomfort with their assigned sex (dysphoria) and have a preoccupation with getting rid of primary and secondary sex characteristics (through requests for hormones, surgery, or other procedures to physically alter their sex characteristics).

Hormone Therapy consists of taking hormones (e.g., estrogen and progesterone or testosterone), and/or hormone suppressants, to induce changes in secondary sex characteristics. For a transwoman, hormones can facilitate breast development, soften the skin, change male-pattern body hair, reduce the size and function of the penis and testicles, and redistribute fat to cause some changes in body shape. Hormone therapy will not raise the voice or eliminate the growth of male-pattern facial hair. For a transman, hormones can facilitate the growth of male-pattern facial and body hair, enhance the development of muscle mass, lower the voice, stop menstruation, and increase the size of the clitoris. Hormone replacement therapy is used by non-transwomen to counteract the effects of menopause and by older non-transmen to replenish declining levels of testosterone.

Intersex people are born with sex characteristics other than XX or XY. They may have some of the sex and reproductive organs of both XX and XY, or they may have other discrepancies between chromosomal, gonadal, or hormonal sex. It is estimated that up to 1/500 people have chromosomal variations from the “standard” of XX or XY (Intersex Society of North America). Typically at birth, doctors decide which “sex” is more surgically or aesthetically viable (based on appearance of external genitalia, chromosome markers, and potential fertility, among other factors) and surgical alterations are made. In most cases, surgery is performed to designate a female gender and the child is raised accordingly. Many intersex people are then subjected to life-long hormone therapy to reinforce the gender chosen by the doctors. This gender may be in conflict with the person’s gender identity.

Masculine is the gender role assigned to boys and men. It refers to the gendering of certain traits or characteristics such as aggression, emotional reticence, competitiveness, and spatial skills, making them the exclusive domain of those considered male.

MTF (male-to-female, transwoman, or identifying on the transfeminine spectrum) is used to specify the direction of movement in identification from assigned sex (male) to gender identity (female/woman). Individuals identifying somewhere on the transfeminine spectrum may or may not pursue sex reassignment surgery (all or in part), and may or may not take estrogen and progesterone. Transfeminine-identified individual’s expression of their femininity may take many forms depending on personal preference, culture, sexual orientation, and class, among other considerations.

Non-Operative (non-op) refers to a transperson who has not had, cannot have, or does not want to have, sex reassignment surgery.

Pan-Gendered/Genderqueer refers to people who feel they have both male and female aspects to their identities. Pan-gendered people may refer to themselves as sometimes being male, sometimes female, both, or neither. Some pan-gendered people feel they constitute a third gender (or a fourth, fifth or sixth) and that

neither “male” nor “female” adequately describes their reality.

Post-Operative (post-op) refers to a transperson who has undergone sex reassignment surgery.

Pre-Operative (pre-op) refers to a transperson who is awaiting sex reassignment surgery.

Primary Sex Characteristics include penis, testes, vagina, uterus, and ovaries.

Real Life Test is required by many gender clinics and refers to the period of time in which transsexuals interact socially in the gender of their identity, sometimes prior to using hormones, but not always, and most often before undergoing sex reassignment surgery.

Secondary Sex Characteristics include facial and body hair, vocal timbre and range, breast size, and fat distribution.

Sex refers to a set of biological characteristics (chromosomes, hormones and anatomy). A female typically has an XX chromosome pattern, higher levels of estrogen, a vagina, uterus, and ovaries, while a male typically has an XY chromosome pair, higher levels of testosterone, a penis, testicles, and sperm.

Sex Reassignment Surgery/Sex Affirming Surgery (SRS/SAS) refers to the surgical procedures used to facilitate living in one’s felt gender and increase comfort with one’s body. These surgical procedures are designed to modify primary and secondary sexual characteristics from those of one sex to those of another. For transwomen, the surgeries can include: removal of the testicles, creation of a vagina and labia, electrolysis, breast implants, tracheal shaves and facial feminizing surgeries. For transmen, the surgeries can include: mastectomy and chest reconstruction, hysterectomy, oophorectomy (removal of ovaries), phalloplasty (creation of a phallus), or metoidioplasty (extension of the clitoris). Some trans people will choose to have all the surgeries relevant to them; others will choose only some, or none.

Testosterone is considered to be the “male” hormone. However, both male-bodied and female-bodied produce testosterone, men just tend to have more.

Trans (or transgendered or trans-identified) is a term that can include transsexuals, cross-dressers, drag queens and kings, intersex people, transgenderists, androgynists, transgender-identified individuals, and other variations and combinations of gender identity and expression. This is a large umbrella that embraces people who cross socially constructed gender boundaries with a gender identity, presentation, or behavior not typically associated with their perceived, or actual, biological sex.

Transitioning means moving into the life of one’s gender identity. This can, but need not, include making physical changes through hormones or sex reassignment surgery (also see Real Life Test).

Transphobia is the irrational fear and loathing of people who transgress conventional gender and sex rules in the binary system. Transphobia can take many forms: it can be covert and subtle, or blatantly hateful and violent. Like other forms of discrimination, transphobia is often invisible to those who are not its targets. There can be confusion between the concepts of transphobia and homophobia, with transphobia often being mislabeled as homophobia.

Queer has historically been used as a pejorative term for those with a same-sex orientation, conferring an unnatural, abnormal, and sexually deviant status. This word has been proudly reclaimed, and altered, by lesbians, gay men, bisexuals, and transgender-identified individuals to represent all those who diverge from the conventional heteronormative and a binary gender system.

Methodology

After spending the last few years casually reviewing medical literature and generally policy guidelines, my primary observation has been that that published information is incredibly gendered. Girls are said to be entirely different from boys, women different from men, and the small, yet researched portion of individuals whose chromosomes or genitals do not provide a clear answer to an appointed sex are given one of the many diagnoses of intersexuality. Jeered by the medicalization and constant pathologization of gender diversity, I began looking elsewhere. With transphobia rampant in Western, highly industrialized cultures across the world, I looked inward at community-based efforts and research, as well as to the organizations that specifically catered to the needs of gender non-conforming individuals.

As a transmasculine-identified individual from New York City, I realize my perspective and accessibility is one of privilege. I have been active with policy work and community organizing in the transgender community for the past three years, working both on an institutional level and collaboratively in grassroots activism. I feel a strong sense of community involvement among my peers, who are mostly university educated transmasculine-identified individuals in their 20's and 30's. In that community, our shared identification as "transgender" includes individuals all over the gender spectrum; those who pass and those who don't, those who are visibly queer, pre-op, post-op, non-op, heterosexual, gay, lesbian, bisexual, and something else entirely. Infighting has been there, and will remain, but common efforts around accessing medical care and legal rights, visibility, and diminishing violence targeted at trans-identified and perceived gender non-conforming individuals has brought a diverse group of individuals together. In my own experience, that community has been ready, willing, and able in times of desperation, and has united in opposition to what often feels like overwhelming sentiments of transphobia.

Relocating to the Netherlands brought a new perspective into my gaze. Here, gender non-conforming individuals were given the medical and logistical tools that they needed in order to gain access to services. The Vrije Universiteit had an established Gender Team. Papers and legal documents could be changed or altered, and if desired, trans people of various sexual orientations could marry. Blinded by what seemed like a trans-utopia, it took time for me to identify the paradox: trans people weren't visible in the same ways they were at home, nor were what I understood to be their "communities." Furthermore, there was a pronounced distinction between "transgender-identified" individuals and "transsexually-identified" individuals. Whereas in the United States, "trans," or "transgender" has been used almost exclusively as an umbrella term, in the Netherlands, people are said to be transsexual if they wish to transition fully, from male-to-female or female-to-male, utilizing all medical services available to them. Transgender, or "transgenderist," is an identity reserved only for those who prefer for whatever reason to live in-between or among genders, often without undergoing the "full treatment" that the Gender Clinic makes available. In this paper, I use the identifier "trans" to include both transsexual and transgender-identified individuals.

To establish groundwork for this study, I looked to the existing academic literature and theoretical models that would shed incite into the potential effects of institutionalization on cultural identity and community involvement. I utilized various forms of data collection, including 12 semi-structured interviews with local activists and trans people, individuals who have had experience as clients at the Vrije Universiteit Gender Clinic, as well as personnel who work at the Gender Clinic, who themselves contribute to the construction and definition of policies regarding the treatment of trans people and transition-related regulations. I chose these methods so that I could do in-depth case studies that would allow me to investigate a social phenomenon beyond statistical analysis. Furthermore, because of the personal and potentially controversial topic of study, face-to-face

interaction with participants allowed me to gain certain insights about their views that paper surveys could not fully capture.

Participants were located in and around Amsterdam and other major cities in the Netherlands, as well as via the Internet. Many of my contacts were individuals who I had met previously in a social or academic context, or individuals Gé Meulmeester, my project advisor, directed me to. Other participants were obtained on a snowball basis, where one participant suggested I speak with one of their friends, colleagues, or former partners. Online forums were accessed under unique and specific circumstances, and public law and policy were used in order to understand Dutch procedures and guidelines. As a transgender-identified person, I had the opportunity to access the community in peer-based settings, although I was unable to contact any individuals who no longer identified as trans or who did not assemble in queer-specific spaces.

As a white, educated, trans-masculine person from the United States, I have approached my study with various assumptions and limitations. Aspects of my background highlighted my initial reaction to the lack of a visible trans community in Amsterdam, as I come from a privileged place where allies form close networks and assemble for social, political, and economic reasons. I feel this support is necessary for development, especially for individuals who have not gotten support in traditional settings, such as the family. However, all may not share this assumption. Community is perceived and experienced differently for all individuals, and the basis of participation varies from social desire to the motivation to advance a political agenda. With a lack of legal representation and little transition-related care, trans communities in the United States have often merged these two approaches of community involvement and made them synonymous. In the Netherlands, however, with institutional setup around medical and legal support for trans individuals, the concept of “community” proves more complicating and more clearly divided on the axis of investment; social or political, respectively.

Interviews were conducted in English, which was not the primary language spoken at home nor among peers for many of my participants. Cultural and linguistic differences such as these have limited my research to a pool of participants who have been highly educated (to receive English language lessons in a country where it is not a national language), and willing to take time out of their busy schedules to speak with me. Additionally, due to the nature of my research and the relatively small population of trans-identified people in Amsterdam, most participants traveled in the same or similar social circles. This may have biased my research tremendously.

Results: The Interviews

I corresponded with 12 interviewees, all who had some connection with the transgender community in Amsterdam. Nine interviewees had personal experience with accessing services at the Vrije Universiteit Gender Clinic, many also active in community organizing, peer-based support groups, or served as institutional representatives in their professional organization's trans-care services. In addition to these nine, I met with PhD candidate Eliza Steinbock of The Amsterdam School for Cultural Analysis and Jos Megens, coordinator of the Vrije Universiteit Gender Clinic and first point of contact for individuals seeking services. On the topic of "community," I interviewed S. Leigh Thompson, founder and acting president of the TransMasculine Community Network. While his contributions were appreciated and exemplified an approach that regards trans communities as critical for development and cultural identification, they are not included in the analysis below, as he is based in New York City and is estranged from the Vrije Universiteit Gender Clinic.

The nine self-identified trans people who I interviewed are as follows:

Arianne van der Ven

Arianne van der Ven (45) is a transgender woman originally from a small town outside of Amsterdam. Her degree in psychology has led her to work within and outside of the transgender community as psychologist. From 1995-2000, van der Ven lived in the United States, both in Boston and within the New York area. Having gone through the majority of her medical transition in the US, van der Ven understands the Dutch medical system as well as the one in the US. Upon her return to Amsterdam, van der Ven had contact with the Vrije Universiteit Gender Clinic, as she received her facial feminizing surgery there. Now, van der Ven works as a journalist. We met for an hour and a half in her apartment in central Amsterdam (Van der Ven, A., personal interview, April 17, 2007).

Jurrian

Jurrian (34) describes himself as a transsexual, "but not a mainstream transsexual." His first contact with the Vrije Universiteit Gender Clinic was only a few years ago, after he came out in a public interview. For some time he had been writing organizations, asking them to register him as gender neutral, instead of male or female. After some time, however, he began moving towards the masculine side of the gender spectrum, eventually deciding to transition fully. Still in this process, Jurrian is very much interested in gender diversity. He grew up in a progressive home

in a small village outside of Amsterdam, and moved to the city to attend university. He is interested in gender issues, feminism, environmental issues, and history. We met for an hour in his apartment in the center of Amsterdam (Jurrian, personal interview, April 18, 2007).

Jonathan

I met with Jonathan (30) for 45 minutes outside a local bar. Jonathan identifies as a mixed race person from Canada, having relocated to Amsterdam five years ago, in 2002 for work related reasons. Jonathan identifies as genderqueer; he has found a small community of primarily fellow ex-patriots in Amsterdam. Having utilized the services at the Vrije Universiteit Gender Clinic, Jonathan has mixed feelings about his experience (Jonathan, personal interview, April 16, 2007).

J

J (30) is a transgender student born and raised in Amsterdam. His first contact with the Vrije Universiteit Gender Clinic was 3 years ago, in 2004. He approached the team with the request to have top surgery, but was told he could only pursue the procedure if he agreed to take hormones first, consistent with the official protocol. Firmly stating that he had no interest in taking hormones, J was told that if he underwent a series of psychological tests, he might then be able to get the surgery he wanted. After a year of rigorous testing and no answers, J left the gender clinic. He has not been back since, and has no plans for any further contact. We met for an hour in popular café in the center of Amsterdam (J, personal interview, April 17, 2007).

Lev

Lev (35) was born in the south of the Netherlands, and now lives in Amsterdam. Hir has been involved with a peer-support group, the Boys Hour, for 6 years. During hir intake at the Gender Clinic, ze never told the typical “transsexual” narrative. Instead, ze said that ze felt like a boy. The Gender Team told hir that it was impossible to get the chest surgery ze desired without undergoing hormone therapy first, a process Lev did not want to endure at the time. After much debate, Lev left the Vrije Universiteit Gender Clinic and consulted a surgeon in Haarlem, who ze knew had done male chest reconstruction surgery for other transguys in the past. Later, he returned to the Gender Clinic in order to obtain hormones, and has been in contact with the Gender Team ever since. For Lev, visibility is one of the most important things for trans communities—for people to see, and celebrate, gender diversity. I met with Lev for an hour at hir workplace, a scientific archive (Lev, personal interview, April 23, 2007).

Justus Eisfeld

Justus Eisfeld (33) is a transguy working as a consultant for policy and communications at COC Netherlands. Born in Germany, he has lived in Amsterdam for the last 10 years. After approaching the Gender Team in October of 2002, he has sought numerous services and surgeries at their clinic. While he is grateful that the service is there, Eisfeld is also active in community efforts to open up the doors to individuals of diverse gender expressions and identifications. Eisfeld has recently been involved with the formation of the European Union Transgender Network as

well as the Netherlands Transgender Network. We met for an hour at an outdoor café in the center of Amsterdam (Eisfeld, J., personal interview, April 18, 2007).

Kam Wai Kui

Born Hong Kong, Kam Wai Kui (38) immigrated to the Netherlands with his family in the mid 70's. After finishing his university studies in art history and film and television studies, Kui is now the founder of the T-Image Foundation and director of the Netherlands Transgender Film Festival. Additionally, Kui works as a policy adviser for an arts education organization. Kui's first contact with the Gender Clinic was in the early 1990's, when he approached the Gender Team seeking transition-related services. As a client of the clinic and community organizer, Kui has seen tremendous change regarding the treatment of transgender-identified individuals seeking services over the last 15 years. We met for an hour at an outdoor café in the center of Amsterdam (Kui, K.W., personal interview, April 24, 2007).

Judith

Judith (44) identifies hir gender identity as "transgenderqueer." Ze was born and raised in Haarlem and has been living in Amsterdam for the past 25 years, spending brief periods of time living in various German cities and parts of Paris. From 1995 until 2000, ze led the transwomen's group at Humanitas, a community health organization that offers volunteer-run self-help groups for trans-identified individuals. Now, active with the Noodles, a group that encourages gender diversity, Judith helps to organize community outreach and educational initiatives, such as the Transgender Day of Remembrance. Judith tells me that hir "gender changes when it's raining," and enjoys challenging himself and others when thinking about the limits of gender expression. Having hir first contact with the Vrije Universiteit Gender Clinic in the spring of 1993, Judith has been able to use the Gender Clinic's services to suits hir identity best, and acknowledges the tremendous changes the clinic has undergone since hir first contact. We met for an hour and a half in a café in the center of Amsterdam (Judith, personal interview, April 19, 2007).

Paul

Paul (34) grew up in a small town in the south of the Netherlands and has been living in Amsterdam for the past eight years. Employed as a social worker for trans-identified individuals at a national LGBT health organization, Paul is also active in community based efforts, such as with the Noodles Group. Paul's first contact with the Vrije Universiteit Gender Clinic was about 15 years ago, when he contacted them with requests to transition. Originally identifying as a FTM transsexual, Paul has now started to question the binary gender paradigm and what it means for him to be living in a world constrained by such extreme polarization. We met in his home in De Pijp for an hour (Paul, personal interview, April 20, 2007).

Part I

Protocol at the Vrije Universiteit Gender Clinic

The Vrije Universiteit Gender Clinic, established in 1975, abides under the directives and protocols established by WPATH in order to ensure proper treatment for their clients (Megens, J., Lecture to SIT, February 28, 2007). The team itself is multidisciplinary, including psychologists, psychiatrists, endocrinologists, cosmetic surgeons, gynecologists, speech therapists, nurses, and a dental surgeon (Vrije Universiteit, n.d.). The treatment of transsexuals is recognized in four phases; the diagnostic phase, the real-life test, where hormonal treatment begins, the surgical phase, and the re-adjustment (Vrije Universiteit, n.d.). This full treatment is in accordance with protocol of the Dutch Ministry of Health (Megens, J., Lecture to SIT, February 28, 2007).

The diagnosis of transsexualism is primarily self-determined, aided by a series of tests and interviews. Clients endure 4-12 months of psychodiagnoses before being given the “green light” to begin hormone therapy (Megens, J., Lecture to SIT, February 28, 2007). Hormone therapy lasts for 1-2 years before surgical procedures can commence (Megens, J., Lecture to SIT, February 28, 2007). During this time, individuals must live as their desired role in society to see whether or not personal suffering is relieved and if they are able to make the transition in their private and public lives (Megens, J., Lecture to SIT, February 28, 2007).

A table of the different hormones used in cross-gender hormonal therapy is listed in Appendix D of this report. For transfeminine individuals, the effects of estrogens can include breast growth, skin changes, and subcutaneous fat redistribution (Megens, J., Lecture to SIT, February 28, 2007). Estrogens have no effect on voice or hair growth (Megens, J., Lecture to SIT, February 28, 2007). Transmasculine individuals often proceed with androgen therapy, which can lower the pitch of the voice after approximately 6 weeks, promote male pattern hair growth, increase muscle mass, and end menstruation (Megens, J., Lecture to SIT, February 28, 2007). The third stage of treatment is the surgical phase, in which vaginoplasties and breast augmentation are provided for transfeminine

individuals, and mastectomies, hysterectomies, metoidioplasties and phalloplasties are recommended for transmasculine-identified individuals (Megens, J., Lecture to SIT, February 28, 2007). A list of possible surgical interventions for trans-identified individuals is provided in Appendix E of this report. Legally, all transsexuals can change their name and sex on official documents after these procedures have been completed and the client is assured to be sterile (Megens, J., Lecture to SIT, February 28, 2007).

For many transsexuals, the above-mentioned 1997 treatment plan provided is gracious and much appreciated. “It gives you a life,” Jos Megens, the coordinator of the Gender Clinic, told me (personal interview, April 25, 2007), boasting about the inclusive services that are covered almost entirely by government health insurance. Yet the protocol is very strict, and the Gender Clinic can officially only offer help to those clients who present with the desire to transition completely, utilizing all services offered. This, however, is changing. “A couple of years ago we were very strict, but we now realize that there are people who for different reasons don’t want to have the full treatment plan,” Megens comments (personal interview, April 25, 2007). With new protocol intended to be established next year, Megens and his team are now grappling with how to best tend to their transgender-identified clients, who do not wish to endure the entire treatment plan. “Nowadays, now we do two things. We absolutely send them to see one of our psychologists. If, after one or two meetings they still don’t want the full treatment, we will send them to a general practitioner or to an endocrinologist who will provide them with hormones (Megens, J., personal interview, April 25, 2007).”

For those who desire surgical intervention without hormones, a problem arises. Currently, it is very hard to bypass the system and rearrange the four phases, as hormone therapy must always come before surgical intervention. Referring to transmasculine-identified individuals who have approached the Gender Clinic with requests for chest surgery without hormones, Megens notes that

“In the last 30 years, I’d say that only 10 guys have had their wish (personal interview, April 25, 2007).”

The problem, however, seems not to be simply with the order of procedures for medical health purposes. Instead, Megens asks if there are “real” transgender people. “I think there are some people who are really in between,” he notes. “But why? Why in the middle?”

Twenty-five years ago, nobody knew anything about transsexuals. They were strange people who wanted to change their sex. And nowadays we realize that there are people who are in between who don’t want the full treatment. Okay. But what are the reasons that they don’t want the full treatment? ... You don’t see any good research on transgender people. And what I see, is that a lot of transgender people who came to our clinic in the 90’s saying that they were transgender, have now moved more to the transsexual side, and have wanted the full treatment (Megens, J., personal interview, April 25, 2007).

According to Megens, preliminary hypotheses are that most individuals presenting as transgender, as “in between,” are shunned away from the full process because they are afraid of the social circumstances or scared of the surgical procedures (personal interview, April 25, 2007).

Psychologist Arianne van der Ven comments on those transgender individuals who don’t identify as male or female, telling me that some certainly do belong somewhere in the middle, but for others, “what they are really saying is ‘I’m scared shitless.’ And they should be (personal interview, April 17, 2007).” Megens asks, “Even if you don’t want surgery, are you still a transgender? ... It’s very interesting. There are people who say there are no transgender people, just man and woman and no one in between. So it’s interesting to ask, what is a transgender person (personal interview, April 25, 2007)?”

Perhaps once that question is answered, issues around treatment will be easier to establish. Megens explains to me that studies to further investigate the needs of this population are underway, but that the Gender Team is running into problems finding “real transgender” people, not just those who identify as transgender because of perceived economic or social reasons. He thinks however, that the new 2008 protocol will state that the clinic has an open mind to transgender-identified

clients. In terms of the visibility of gender non-conformity, Megens tells me “in Holland we don’t have that, because you can get what you want here (personal interview, April 25, 2007).

Community activists would focus less on the root of gender diversity, leading the discussion away from etiology of identity formation and more in the direction of empowering these identities in ways that allow all individuals to live as active community members and legitimized human beings. With strict protocol, service providers at the Gender Clinic appear to be falling into the trap Elkins & King (1997) identify when they talk about the danger medical categories play when the goal is to provide comprehensive medical and mental healthcare.

Part II Transgender Experiences: When the System Doesn’t Fit

My interviews with nine gender variant individuals who have utilized the services at the Gender Clinic shed light onto their experiences with the strict protocol based on a binary gender paradigm. For some, the protocol has allowed them the opportunity to live in bodies that feel most suitable to them, whether it was by undergoing the “full treatment,” or by following the four phases until a point to which they were satisfied. For others, the strict ordering of protocol has served as a barrier to them receiving care, forcing them to pursue services elsewhere.

Jurrian’s story was mainly positive. He found the staff at the Gender Clinic very respectful, friendly, and supportive. “Their hearts are in the work,” he told me (personal interview, April 18, 2007). Still in the process of his transition, the protocol has allowed him to see knowledgeable therapists, access hormones, and begin the process of surgical transition. Upon the point of entry, Jurrian told me that the psychologists “try and see what your social attitude is about your gender, if you have support, and how do you deal (personal interview, April 18, 2007).”

Mainly it’s what is it that you want and why, and what your expectations are, and if they are way beyond the horizon. I thought that was quite a good thing, but it did make me pretty insecure at times. I thought, “Okay, I know that I am transsexual but

I'm never going to be able to convince them" But at some point, it turned. Then they gave me the green light (Jurrian, personal interview, April 18, 2007).

Excited for his upcoming surgery, Jurrian has been generally pleased with the medical staff.

However, he notes that the team is very busy, with little time to support their clients and answer questions in full detail. He feels that he has not gotten enough information regarding the medical aspects of his transition. "People are very dependent on what they hear from others and on the Internet, but I don't have the Internet, so I don't have that information," he tells me (personal interview, April 18, 2007). "And at the gender clinic, you always have to ask for whatever you want (Jurrian, personal interview, April 18, 2007)."

Justus Eisfeld, who approached the Gender Clinic in October 2002, has followed through with the full treatment plan. After being put on a 6-8 month waiting list, Eisfeld was able to see a "very good and very knowledgeable" psychologist who he felt that he could trust, and who was willing to examine his particular interests and concerns (personal interview, April 18, 2007). As far as his surgeries, he told me that he has had "good experiences with them," except for a lot of insecurities about dates. Eisfeld tells me that "I think I've had twice as many surgery dates than surgeries now," and thinks that the Gender Clinic could be a lot better about planning (personal interview, April 18, 2007). Looking back, Eisfeld says that one thing that went too fast was the hysterectomy. "It was three months after chest surgery, and in hindsight, I don't think I was emotionally ready for that. And I think that for me, it was more a question of changing my papers than actually wanting to get rid of my ovaries (Eisfeld, J., personal interview, April 18, 2007)." In our interview, Megens told me that they often perform the mastectomy and hysterectomy at the same time, in a double procedure (personal interview, April 25, 2007).

Jonathan, who approached the Gender Clinic after already starting on hormones at his home gender clinic in Canada, also said that the lineup of surgeries went too fast. "They're just too good at their job," he told me (personal interview, April 16, 2007). "They don't mean any harm by it. Once

the ball is rolling, it's really up to you to have a voice and slow the process down (Jonathan, personal interview, April 16, 2007).” He appreciates the system and is gracious that the entirety of his transition has been paid for by insurance, but points out his personal frustration with the setup of the team. “You don’t get to choose your surgeon. It’s an academic hospital with student doctors. I had interviewed with my surgeon beforehand and woke up from anesthesia to find out that one surgeon closed one side of my chest and another did the other. You just don’t know who you are going to get (Jonathan, personal interview, April 16, 2007).”

Some of the individuals I spoke with started with the Gender Team presenting as a “typical transsexual” who had every intention of completing the full protocol, and then dropped out of the program somewhere along the way. Paul’s first contact with the Vrije Universiteit Gender Clinic was when he was 20 years old, 14 years ago. He spoke with his assigned psychologist for three-quarters of a year before getting the “go ahead,” a process that for him has included hormone therapy, a double mastectomy, and a hysterectomy.

If I wasn’t a girl, than I was a boy, and I didn’t question that. I thought, “Yeah, transitioning, that’s what I needed to do.” I spoke to a psychologist, but I didn’t think they really questioned me as to see if there were other possibilities. They stayed with their protocol. It was simply: did you want to switch? And at that point, it seemed really attractive. Within three-quarters of a year they said, “Okay. We’re fine (Paul, personal interview, April 20, 2007).”

Following his hysterectomy, Paul hesitated before undergoing genital surgery. “It was so fast,” he told me (personal interview, April 20, 2007). “I thought, wait, what am I doing (Paul, personal interview, April 20, 2007)?” Paul recounts:

So I told them I don’t want any more surgery right now. I knew there were a lot of complications, but really soon it was clear that it was about me. I didn’t need this, and if I did, I should wait at least two years. And also, I felt like, after being medicalized for 2 years—and that’s how I felt—so many things changed. My social life wasn’t so big, and I was like, okay, you are going to go get a job, go back to school, make some friends, and see what that social life does to you... I don’t think they were too surprised when I decided to hold off on surgery, because it had so many complications. They didn’t talk about it, and they didn’t ask too many questions—it wasn’t about being transgender then, that was not the topic, it was

more yeah, okay, if you can live your life being a guy this way than that's okay (Paul, personal interview, April 20, 2007).

Questioning the limitations of the protocol after having already gone through the system seems safer to Paul. "I don't feel threatened by questioning these things, but people who are just transitioning, for a number of good reasons, they need to get out of it all that they can—and the medical treatment that's there, they need to use it (Paul, personal interview, April 20, 2007)." If we refer back to Althusser's use of the ISAs, which shape identity and experience, we can interpret the Gender Clinic's standardization of protocol as having legitimized the transsexual over the transgender-identified client. The implication of this phenomenon has led to the silencing of transgender voices, a reluctance to self-define as transgender, and a severe lack of visibility.

Judith entered the Gender Clinic in 1993 and expresses a frustration with the process of delegitimizing transgender bodies and identities through the strict protocol (personal interview, April 19, 2007). Ze tells me, "You decide who and what you are, not them (Judith, personal interview, April 19, 2007)." Commenting on the complexity of hir gender, Judith tells me that "Traditionally, I'm a female, but actually, I'm not. There are several levels of being male or female; genetically, hormonally, physically, in your genitals, in your genes... All sorts of levels change in that processes... And I cannot imagine my life without my genitals. I have no problem with them (personal interview, April 19, 2007)." Van der Ven tells me "you always find yourself in different places in your identity. It's like a landscape (personal interview, April 17, 2007)."

Many of my interviewees described the clinic's strict protocol as not fitting their needs. Jonathan told me "the narrative that the Vrije Universiteit [Gender Clinic] is looking for is of a very certain trans experience. I feel like you do have to tailor your needs to how it fits in their protocols and their criteria. And if it fits for you, than it's available to you (personal interview, April 16, 2007)." In the way of tailoring, J told me that he knows some people who wanted top surgery so badly that they began taking hormones against their wishes just to please the staff and have the

surgery approved (personal interview, April 17, 2007). Lev told me that ze felt so desperate and dependent on the Gender Clinic to approve top surgery that ze began taking testosterone without truly wanting it (personal interview, April 23, 2007). Eisfeld reflects on the order of protocol and states:

I think, especially the first two [phases], are not in the right order for a lot of people. A lot of people want to have the mastectomy first and then go for hormones, or start hormones and then have surgery shortly after. And there are a lot of transguys who are very clear about wanting to have surgery and less clear about whether or not they want to take hormones, because the hormones feel to have a more drastic effect than the surgery. Also, because chest surgery changes one thing, and hormones change so many things. And still, if you ever decide to go back, it's easier to live as a flat chested woman than a woman with a very low voice and facial hair. So the reversibility of surgery versus hormones is very different... And a lot of trans people stick to the traditional trans story to get their services and get through quicker and easier, and I can't blame them because that's the way it goes. But at the same time, it makes it harder to change the system for those people who don't feel like are 150% transsexual (Eisfeld, J., personal interview, April 18, 2007).

For instance, J approached the Gender Clinic three years ago seeking chest surgery without hormones. J told me that the staff pushed him to start hormones even after he stated multiple times that he had no interest. "I was really sure I didn't want to do it, but they said I could start and then stop, and that it wouldn't do so much to my body, and that most of the changes would change back anyway. But I knew better (J, personal interview, April 17, 2007)." J has a lot of trans-identified friends and has seen the impacts of potent hormones on their bodies, and knows it is not for him. Still, he stayed with the Gender Clinic for a full year, undergoing a battery of psychological tests before leaving. "It's good that it's available [the Gender Clinic], but they push you a certain way, a way you might not want to go (J, personal interview, April 17, 2007)." For J, and others who don't fit traditional narratives of transsexuality, the navigation of a system bounded by strict protocol has proven trying, at best.

Part III
Transgender Community: A Snapshot

“Transsexual community is something else than gay community,” van der Ven tells me (personal interview, April 17, 2007). I had to clarify—of course there would be a difference between a community of common gender identification and sexual preference. She continues:

Gay community is centered around places [bars]. It’s a community about doing things together. The transgender community is not grounded in venues and bars, not even around activities. It’s a recognition. It’s that someone else is busy doing something similar to something that you are doing, and you can recognize the importance of that in each other. It gives sense of familiarity. It’s not so much a community, but more of a family, which goes at the same time deeper than a community and less deep. Because a family doesn’t have necessarily a space, but a family, when they are together, can have bigger quarrels, and bigger hugs (Van der Ven, A., personal interview, April 17, 2007).

Drs. Eliza Steinbock commented, saying that the transgender community in the Netherlands wasn’t about advancing an agenda, but feeling a political affinity towards on another, a sense of solidarity (personal interview, April 11, 2007). My interviews with Jonathan, J, and Jurrian revealed that this was a shared sentiment.

Most of the participants I spoke to had very specific ideas about community, ones that seemed drastically different from conversations about community happening in the United States. Various organizations provide support for transgender individuals, but many are exclusive to certain sub-groups of gender non-conforming individuals (Jonathan, personal interview, April 16, 2007). Additionally, participant attendance shows that many of these services are only accessed in and around the actual transitional period (Judith, personal interview, April 19, 2007). Visibility seems to be one of the most pressing issues around community building, compounded with a more general distrust of the “third-space,” existing in a state of in-between.

Kam Wai Kui jokes with me, “It is not without reason that there 35 trans organizations. There are 35 people out there. But it’s too bad they can’t work together, and it’s too bad they

couldn't have the sense to come together, not just differentiate themselves from each other (personal interview, April 24, 2007).” Additionally, many of the community services are in provinces outside of Amsterdam. The main four that I came into contact with were Humanitas, the Boys Hour, the Noodles Group, and Landelijke Kontakt Groep TenT (TenT). All peer-based support, each group has a particular emphasis. Humanitas offers monthly meetings for transsexual men and women, gay transsexual men, gender variant children and their families, and transgender-identified individuals. The Boys Hour attracts transmasculine individuals in the early stages of transition, while TenT’s visitors are primarily transfeminine-identified participants. The Noodles Group crosses the gender spectrum, as they promote visibility for gender diversity. The group meets at a monthly social event and also organizes the few trans-specific political and educational efforts, such as the Transgender Day of Remembrance.

Perhaps the most visible event focused around transgender community is the bi-annual Netherlands Transgender Film Festival, organized by the T-Image Foundation.

There’s a lot of discussion that we have about what is a trans community here, and I think it’s a lot different than in New York or other big cities. We don’t have a trans parade, or pride, we’re not at that level yet. The trans film festival is that for us... Only then do you actually feel a sense of community. It’s the only time when people from all over the country will come together. (Jonathan, personal interview, April 16, 2007).

But festival director Kui tells me that most people who help out with the festival are in the early stages of transitioning. “They just found themselves and they’re really excited and active (Kui, K.M., personal interview, April 24, 2007).” Following the initial high, Kui tells me that community participation becomes negligible. “They don’t feel comfortable or safe to do it. There are very few people who want to attach their names to the festival... Basically it’s the safety issue. And also, this country is so well provided when it comes to care, people have very high and unrealistic expectations of what really needs to get done (Kui, K.W., personal interview, April 24, 2007).”

Van der Ven notes that transgender communities are generally not visible, mainly because “most transgender people don’t want to be visible (personal interview, April 17, 2007).” “Being transgender isn’t something I want to be all my life,” she told me (personal interview, April 17, 2007),

It’s not like being gay, where there was an investment. Being gay was something I would always be and being gay was good for me. But I want people to relate to me like they would any other woman, not a trans person. And, if I want, I can suppress certain aspects of my identity, which allows me some privacy, and also makes it easier for people to accept me and relate to me as a woman (Van der Ven A., personal interview, April 17, 2007).

The space between the transsexuals and the transgender-identified individuals has become drastically bigger since services have become more available. Transsexuals who wish to transition fully can do so in this system, often leaving them with little motivation to stay active in politically-based community involvement. Simultaneously, here emerges the salience of the client who stops services, or who doesn’t wish to undergo the full treatment. Van der Ven notes the difference between the medical treatment of transmasculine and transfeminine-identified individuals. Since the most drastic surgeries are offered at the same time for transwomen (vaginoplasty and breast augmentation), there is a perceived “all-or-nothing” effect (Van der Ven, A., personal interview, April 17, 2007). “And that also tends to generate much more of a division between people,” she explains (personal interview, April 17, 2007). “Transsexuals don’t look at transgenderists as women (Van der Ven, A., personal interview, April 17, 2007).” For transmen, the dividing line is harder to establish, as multiple surgeries are gradual and can take a few years to complete. Many transmen also opt out of the “final” phalloplasty because of high surgical and sensational risk (Van der Ven, A., personal interview, April 17, 2007).

However, even though van der Ven asserts that at least physically, most transmasculine-identified individuals are “transgenderists (personal interview, April 17, 2007),” with a greater need to stay visible, Jurrian tells me that he often hears his peers say that they do not want to be too

involved with transgender- specific activities, as they are just “normal guys getting on with their lives” (personal interview, April 18, 2007). He reflects on his own experience, stating, “For me there is a need [for community]. There is something I get from transsexuals that I don’t get in the rest of my life. But apparently, there are a lot of people who don’t need it (Jurrian, personal interview, April 18, 2007).” J tells me, “Transsexual men disappear in to the straight crowd. As soon as they have their operation, you will never see them again (personal interview, April 17, 2007).” “They go through their transition and maybe its something they can acknowledge that they went through, but ultimately it comes down to them just wanting to live as a girl or a boy,” Paul says (personal interview, April 20, 2007).

Yet, that visibility is still a top priority for some. Paul explains his frustration with the apparent reluctance for trans people to get involved. The paradox, he says, is that they are not satisfied with services; transgender individuals are systematically overlooked and left out of protocol.

People working at the gender clinic are not transgender people. From that point of view, they do not experience a transgender identity. That’s why it is so important for us to communicate to the world about what we find important. And what we don’t find easy, that’s a reason to build community (Paul, personal interview, April 20, 2007).

Jurrian tells me that there is not a supportive community to fall back on. “I think many people are suffering because they get support neither from their families nor from a trans community. And they start to doubt themselves and lose their self confidence,” he says (Jurrian, personal interview, April 18, 2007). One major obstacle is empowerment. Eisfeld explains that a lot of trans people accept their lives and their treatment as a given. “I think it has a lot to do with empowerment and feeling powerful enough to get mad (Eisfeld, J., personal interview, April 18, 2007).”

According to my interviewees, the trans community in the Netherlands is in a similar place to where the gay community was in the 1980s. There are peer facilitated self-help groups, as well as basic structures and basic facilities, but little policy development as of yet, and virtually no

government funds being provided to boost advancement. “I feel like it’s about to develop now,” Eisfeld tells me as he outlines the priorities of Centre for Culture and Leisure (COC) Netherlands (personal interview, April 18, 2007). Others are not as hopeful. “Its not like elsewhere where it is so hard to organize for yourself,” Paul says (personal interview, April 20, 2007). “You have to work so much harder, and I think it forces you to think about ways to deal with yourself and the complexity of that. And here, it is easier to present yourself and get service... Where is the motivation (Paul, personal interview, April 20, 2007)?”

The split between socially-based community involvement and politically-based community involvement in the Netherlands can be recognized as two separate entities. This is not the case in other cultures such as within the United States, where more blatant forms of oppression provoke the congregation of minority groups who must fight, often forcefully so, for their rights to be recognized and legitimized. The problem that has presented is a diminished sense of urgency, where there emerges an extreme danger around entitlement. In a system that recognizes basic rights for transsexuals, the need for community involvement may appear negligible. However, without implemented services for transgender-identified individuals, politically-based community involvement is necessary. With no pre-existing discourse around “community,” this has proven to be an obstacle for transgender community activists who strive for mobilization and visibility. Monro, who emphasizes the effects of pathologization on community involvement at structural levels (2000), may understand the current situation of transgender individuals in the Netherlands to be a direct result of the exclusion of representation and protocol at an institutional level. These embodiments of agency, or lack thereof, are explained further in the following section.

Part IV

A Dutch Perspective: Possible Political and Theoretical Implications on Cultural Identity

It is an old argument: oppression builds community. Fighting systematic injustices brings people of shared frustrations together. Stigmatized individuals stand united against an oppositional power, often a majority injuring minority rights, liberties, and expressions. These sentiments encourage individuals to join forces and unify. One United Nations document defines community participation as, “The creation of opportunities to enable all members of a community to actively contribute to and influence the development process and to share equitably in the fruits of development (United Nations, 1981).” Jack Rothman identifies three distinct types of community organizing:

Locality development typifies the methods of work with community groups used by settlement houses and in ‘colonial’ community development work. A major focus is on the process of community building. Working with a broad, representative cross section of the community, workers attempt to achieve change objectives by enabling the community to establish consensus via the identification of common interests. Leadership development and the education of the participants are important elements in the process. In this approach, great store is set by the values of both participation and leadership.

Social action is employed by groups and organizations, which seek to alter institutional policies or to make changes in the distribution of power. Civil rights groups and social movements are examples. Their methods may be, often are, abrasive, and participation is the value most clearly articulated by those who use this approach. Both leadership and expertise may be challenged as the symbolic ‘enemies of the people.’

Social planning is the method of community organization traditional to health and welfare councils although its scope and arena were enlarged in the 1960s to encompass city planners, urban renewal authorities and the large public bureaucracies. Effort is focused primarily on task goals and issues of resource allocation. Whereas the initial emphasis of this approach was on the coordination of social services, its attention has expanded to include program development and planning in all major social welfare institutions. Heavy reliance is placed on rational problem solving and the use of technical methods such as research and systems analysis. Expertise is the cherished value in this approach, although leadership is accorded importance as well (This outline of Rothman's argument is taken from Smith, M.K., 2006).

Rothman's outline helps point attention to dimensions such as process, the direction of progression, as well as the tension between the state and dominant groups and those who believe themselves to be excluded. He poses political agency as the primary motivator for congregation.

In the Netherlands, transsexual individuals are legitimized in medical discourse and in legal policy. A relative safety diminishes the incentive to "fight" against a perceived enemy. Van der Ven reveals, "If I lived in the [United] States I would be more of a political animal because I would be suppressed in so many ways. But the idea of a sexual or gender identity is not a political activism, and is not to be a political identity, unless you are being harassed. We're not getting harassment from our government (personal interview, April 17, 2007)." Jurrian tells me that "Generally speaking, Dutch people aren't very political and aren't very angry (personal interview, April 18, 2007)." He continues:

Transsexuals are mainly very happy that the services are available... It really does make life easier. And then, when they are done, they really want to go on with their lives and do the things they were never able to do. There's little solidarity among transsexuals and transgender people, and I think a big reason is that there is no real push or need for emancipation (Jurrian, personal interview, April 18, 2007).

During my time in the Netherlands, I've heard similar remarks about gay and lesbian communities. Following the legalization of same-sex marriage in April of 2001, an overwhelming "the fight is over" attitude has been expressed.

However, while the institutional structures are there, social acceptance still appears to be lacking. Much like the medical establishment, doors are more open to those who fit the gender binary than those who don't, transsexuality-identified or not. "When I told my mom that I wanted to be a girl, when I was 11, she said okay, lets go to the next town and you'll be a girl," Van der Ven shares with me (personal interview, April 17, 2007). She explains that in Dutch culture, the umbrella of "normal" is much wider than what is commonly accepted in most North American societies. "It's very much about the way you act. If people are able to relate to you, than you are normal (Van der

Ven, A., personal interview, April 17, 2007).” Governmental support has aided in this process, opening up comprehensive services to those who fit typical polarized transsexual narratives.

Switching from *one* to the *other* isn’t as threatening as remaining in between. J tells me the following:

They [the medical establishment] want to keep society as normal as possible. So okay, you don’t feel like a woman, than you feel like a man. Or you don’t feel like a man, than you feel like a woman instead. So if we don’t help you, than you go out dressing all weird, and we can’t have that, of course. So we’ll fix you up and nobody will notice anymore (J, personal interview, April 17, 2007).

For transgender-identified individuals, it is clear that the fight for emancipation is not over. The idea of “Dutch Tolerance,” only goes so far, and certainly, is inequitable to acceptance. Transsexuals have received media exposure as so far as they are seen on national television on soap operas and in cultural performances and competitions, but to show pride around one’s identity is not yet socially acceptable. “This is a society that still thinks in boxes,” Kui comments (personal interview, April 24, 2007). “The irritating thing is that they think they are tolerant (Kui, K.W., personal interview, April 24, 2007).” Remaining in perceived middle space, in-between or among genders is very threatening. “You’re crossing a charged line of representation in having that identity,” Steinbock notes (personal interview, April 11, 2007), a clear contradiction to the Dutch tendency to “just act normal” and subscribe to mainstream ideology (Jurrian, personal interview, April 18, 2007).

Perhaps, however, this has not always been the case. During the 1980’s and 1990’s Amsterdam was known as the “Queer Mecca” of Europe, if not the entire world. There was a variety of active communities and a sizable population with diverse needs to support rich cultural expressions and organizations. Now, it seems the scene has migrated to Berlin, evidently taking with it the so-called “tolerance” surrounding its prosperity. Jurrian accounts the decreased level of tolerance in the Netherlands to the trend of globalization (personal interview, April 18, 2007). “The Netherlands has adopted a fear-based way of looking at the world. Everything is becoming so big

and so large scale, people are becoming scared... And Dutch people are so rich. They can buy everything they want, so they don't have to be tolerant (Jurrian, personal interview, April 18, 2007)."

Much like the process of differentiation between social and politically-based community involvement, a tendency to form within-group splinters has emerged. It appears as though people have forgotten about visibility and have instead chosen to re-situate themselves into smaller and smaller categories (Kui, K.W., personal interview, April 24, 2007). Van der Ven uses the exclusive label of transgenderists to illustrate this development:

People say "I'm neither a man nor a woman, but I want to have characteristics of both," and I mean physical characteristics. And sometimes they call themselves "transgenderists." That's more of a Dutch thing, as I never met it until I came back to Holland. I found it really weird because it was so contrary to the idea of transgender. The idea of transgender was to liberate people from the categories and limits of things like transsexual, where the narrative was so strict, the whole treatment and everything... And, the idea that you can tie all the transsexuals and transgenders and cross dressers together is really very dear to me. Then, I came back to Holland [from the United States], and they had already found a way to make another shelf in it, so to speak, forming a new little cast. So now, instead of unifying things, they had split it up, not in two, but in three. And that's such a very Dutch thing to do (Van der Ven, A., personal interview, April 17, 2007).

Kui expresses a similar frustration. "It doesn't help your community to keep splitting up all the time, and to keep giving yourselves another name, because we all come from different colors and different sides anyway. Why not actually go for the common ground and work with that (Kui, K.W., personal interview, April 24, 2007)?"

For the few who are trying to organize the community, splinter groups with selective agendas are inhibiting growth and progress. The question of entitlement becomes again salient. With generous healthcare coverage and more legal rights than gender non-conforming individuals anywhere else in the world, the unifying issues bringing trans-identified people together are becoming harder and harder to find. The process of standardization has essentially de-politicized trans-specific issues and made the motivation for mobilization less salient. The effects of this have been carried over unto the perceptions of need in regards to socially-based community involvement.

While groups and services exist, a lack of urgency has served as a barrier in congregating trans-individuals.

Part V

A Turn Towards Change: In-Community Priorities

The small contingent of trans-community voices has raised visibility about a number of issues. COC representative Eisfeld outlines the three axes of change for the transgender “movement” in the Netherlands. These priorities fall under the headings of legal rights, fighting discrimination, and inclusive healthcare coverage (Eisfeld, J., personal interview, April 18, 2007).

Currently, the primary legal arguments revolve around the necessity of sterilization in order to change one’s legal sex on documents, as well as the question as to whether or not the state has to register citizens as male or female if there is no legal difference in terms of their rights (Eisfeld, J., personal interview, April 18, 2007). Lev tells me that ze wants to change hir documents, but currently cannot because ze has not had a hysterectomy (personal interview, April 23, 2007). Patient privacy and individual liberties seem contradictory to this practice, especially when sterilization has effects not only on the reproductive status of an individual but also on the synthesis of vital hormones within their body. Lev explained to me that getting a hysterectomy would make hir completely dependent on synthetic hormones for the rest of hir life (personal interview, April 23, 2007). Many trans activists claim that it is not the government’s place to make this decision for individuals, especially when the long-term effects of hormone therapy is still fairly unknown. However, if legal documents remain unchanged, trans-identified individuals are immediately “outed” as gender non-conforming and may be at higher risk to be targeted in transphobic hate crimes.

According to Eisfeld, the fight around reducing prejudice and hate crimes targeted at trans-identified individuals is a primary concern on the discrimination axis of change (Eisfeld, J., personal interview, April 18, 2007). “But we also want to make the community more aware of their own

rights and empower people to stand up for themselves,” he says (Eisfeld, J., personal interview, April 18, 2007). “No one knows about legal rights because it falls under Gender Discrimination, and it’s not trans specific (Eisfeld, J., personal interview, April 18, 2007).”

The third push for change revolves around inclusive healthcare coverage, both at the Vrije Universiteit Gender Clinic and in the care made available by primary healthcare providers (Eisfeld, J., personal interview, April 18, 2007). “There is a huge lack of knowledge. There is by far not enough support for transgender people, especially for people who do not identify as completely transsexual (Eisfeld, J., personal interview, April 18, 2007).” The desire for services to become more comprehensive includes expanding healthcare insurance coverage to finance procedures such as facial feminizing surgery for transwomen and liposuction of the hips for transmen, but also a redefinition of protocol, so that surgeries and hormone therapy are made autonomous from each other. With this model, individuals of diverse gender expressions can live in bodies that manifest closest to the ways they feel inside.

The implementation of treatment for gender non-conforming and transgender-identified individuals would increase visibility, something groups like the Noodles have already initiated. However, there is a vocal push for social congregation and socially-based community involvement to be independent of the Vrije Universiteit, depathologizing identities and making individuals seeking treatment feel less medicalized. According to van der Ven, professional mental healthcare support should be established outside of the Gender Clinic as well (personal interview, April 17, 2007). In this model, the apparent monopoly of the Vrije Universiteit would be made subtler, and a network of trained psychologists could check up on each other, promoting a more reliable system of diagnosis and care (Van der Ven, A., personal interview, April 17, 2007).

Building a social community has proven to be a priority, evident by growing efforts around the Netherlands Transgender Film Festival and the presence of localized support groups around the

country. However, lacking an overwhelming feeling of oppression, the motivation to organize and congregate is significantly less than in other places where services are less available and the political atmosphere proves to be less tolerant around variations of the norm.

Conclusion

The research above presents some of the implications of standardization on cultural identity and community involvement, specifically in regard to the transgender community utilizing services at the Vrije Universiteit, Amsterdam. The implemented protocol at the Gender Clinic is not inclusive of transgender identities, and does not allow clients to receive care at a pace comfortable for them. The four phases of transition have ultimately served as a barrier to care to these individuals; those who do not fit a strict transsexual narrative in terms of their transition are forced to pursue services elsewhere, or tailor their needs in order to gain surgical approval. For some, these modifications in presentation and requests have included undergoing procedures, such as hormone therapy, against their initial desires. For individuals who subscribe to a binary narrative of their gender migration, the Gender Clinic has been a tremendous help. By utilizing the services offered, transsexual individuals are able to live in bodies that better present their gender identity to the outside world. Many trans people and their healthcare providers believe that being comfortable in one's skin is essential for personal development, as well as for their social and psychological well being.

A new edition of protocol at the Vrije Universiteit Gender Clinic is crucial. Unfortunately, as of now, transgender-identified individuals have not yet formed a visible political community central for agitating change and successfully articulating needs. While this population is not unified, there exist various established sub-communities of transgender individuals throughout the country. There are peer facilitated self-help groups, as well as basic structures and basic facilities, but little policy development as of yet, and virtually no government funds being provided to boost advancement. There is a sense of socially-based community involvement, however an atmosphere of relative tolerance around queer identities in the Netherlands makes the need for congregation less dire. Trans communities elsewhere may have established because they had to in order to survive, cope, and function as social animals.

One of the most explicit barriers around mobilizing trans-identified individuals is a lack of common priorities. Many trans-identified individuals feel a strong need for a cohesive community. For others, this is not the case, as they are receiving support in other settings, such as born and/or chosen family and within various lesbian and/or gay communities. Furthermore, since medical protocol has been established and trans-identified people receive basic legal rights, there is no unifying agenda for change. The political situation is tame; trans people aren't angry, and with the relative ease in navigating the logistical aspects of transition, assimilating back into heteronormative non-trans culture is easier than in other societies where geographical, legal, cultural, and economic barriers often limit physical transition.

Additionally, aspects of Dutch culture, which promote a trend of assimilation, hinder trans-visibility. In this system, MTF and FTM transsexuals are legitimized and accepted more than transgender-identified individuals who often present a more complicated gender narrative. Like many other highly industrialized Western societies, living among or in-between genders is less tolerated and understood. However, this effect is exacerbated in an atmosphere such as the Netherlands, where protocol has been institutionalized for MTF and FTM transsexuals and not for other gender non-conforming individuals whose transition cannot easily be defined exclusively and entirely towards one end of the gender spectrum. My interviewees also expressed a shared sentiment in regards to the general political atmosphere in the Netherlands, where there exists ambivalence towards activism and being perceived as alternative. With generous healthcare coverage and legal equality, the government has provided for trans communities, hence avoiding an overwhelming response of antagonism.

With no preexisting cultural norm of community activism, trans-identified individuals currently find themselves in a predicament. Generally satisfied with services, the responsibility of trans-visibility has not yet been established. For transsexuals, there is significantly less agency and

motivation to become politically involved. Transgender individuals, those who transgress the gender binary, must find a way to establish themselves away from the Gender Clinic in order to gain visibility and claim the services they are entitled to.

While the aforementioned research serves as a comprehensive qualitative analysis of experience, cultural identity, and community involvement for trans-identified individuals accessing care at the Vrije Universiteit Gender Clinic, there are a number of methodological flaws that warrant discussion. All interviewees had an investment in community building and change, and were willing to speak passionately about their experiences and desires for change. My sample was not representative of the trans-community in that it did not include primary contact with “strict” transsexually-identified individuals, many of whom no longer identify within queer-specific spaces, or may no longer identify as trans. As a researcher, I have aimed to depathologize trans-identities. I have used “trans” as a self defined term and have chosen to respect and acknowledge the gender identities of my participants without scrutinizing their bodies. While I advocate this approach, this research may present discrepancies with past, present, and future studies that qualify identity based on bodily attributes and the specificities of surgical and hormonal intervention. All participants were of Dutch, German, or Canadian descent; non-Western ideology and experiences were not presented in this study. Time constraints limited the process to fully analyze a complete cultural comparison.

With new protocol being developed at the Vrije Universiteit Gender Clinic in the upcoming year, future studies should aim to analyze trans community needs, in hopes to gain representation and inclusive care. Reassessment of the protocol and an inspection of care should follow to ensure that change is in the direction of progression. Additionally, future research should investigate cross-cultural phenomenon of cultural identity and community involvement in regards to the relative ease in accessing services and social acceptance.

Appendix A

The International Bill of Gender Rights

The International Bill of Gender Rights (As adopted June 17, 1995 Houston, Texas, U.S.A.)

“The International Bill of Gender Rights (IBGR) strives to express human and civil rights from a gender perspective. However, the ten rights enunciated below are not to be viewed as special rights applicable to a particular interest group. Nor are these rights limited in application to persons for whom gender identity and gender role issues are of paramount concern. All ten sections of the IBGR are universal rights which can be claimed and exercised by every human being.”

The International Bill of Gender Rights (IBGR) was first drafted in committee and adopted by the International Conference on Transgender Law and Employment Policy (ICTLEP) at that organization's second annual meeting, held in Houston, Texas, August 26-29, 1993.

The IBGR has been reviewed and amended in committee and adopted with revisions at subsequent annual meetings of ICTLEP in 1994 and 1995.

The IBGR is a theoretical construction which has no force of law absent its adoption by legislative bodies and recognition of its principles by courts of law, administrative agencies and international bodies such as the United Nations.

However, individuals are free to adopt the truths and principles expressed in the IBGR, and to lead their lives accordingly. In this fashion, the truths expressed in the IBGR will liberate and empower humankind in ways and to an extent beyond the reach of legislators, judges, officials and diplomats.

When the truths expressed in the IBGR are embraced and given expression by humankind, the acts of legislatures and pronouncements of courts and other governing structures will necessarily follow. Thus, the paths of free expression trodden by millions of human beings, all seeking to define themselves and give meaning to their lives, will ultimately determine the course of governing bodies.

The IBGR is a transformative and revolutionary document but it is grounded in the bedrock of individual liberty and free expression. As our lives unfold these kernels of truth are here for all who would claim and exercise them.

All human beings carry within themselves an ever-unfolding idea of who they are and what they are capable of achieving. The individuals sense of self is not determined by chromosomal sex, genitalia, assigned birth sex, or initial gender role. Thus, the individuals identity and capabilities cannot be circumscribed by what society deems to be masculine or feminine behavior. It is fundamental that individuals have the right to define, and to redefine as their lives unfold, their own gender identities, without regard to chromosomal sex, genitalia, assigned birth sex, or initial gender role.

Therefore, all human beings have the right to define their own gender identity regardless of chromosomal sex, genitalia, assigned birth sex, or initial gender role; and further, no individual shall be denied Human or Civil Rights by virtue of a self-defined gender identity which is not in accord with chromosomal sex, genitalia, assigned birth sex, or initial gender role.

The Right To Free Expression Of Gender Identity

Given the right to define ones own gender identity, all human beings have the corresponding right to free expression of their self-defined gender identity.

Therefore, all human beings have the right to free expression of their self-defined gender identity; and further, no individual shall be denied Human or Civil Rights by virtue of the expression of a self-defined gender identity.

The Right To Secure And Retain Employment And To Receive Just Compensation

Given the economic structure of modern society, all human beings have a right to train for and to pursue an occupation or profession as a means of providing shelter, sustenance, and the necessities and bounty of life, for themselves and for those dependent upon them, to secure and retain employment, and to receive just compensation for their labor regardless of gender identity, chromosomal sex, genitalia, assigned birth sex, or initial gender role.

Therefore, individuals shall not be denied the right to train for and to pursue an occupation or profession, nor be denied the right to secure and retain employment, nor be denied just compensation for their labor, by virtue of their chromosomal sex, genitalia, assigned birth sex, or initial gender role, or on the basis of a self-defined gender identity or the expression thereof.

The Right Of Access To Gendered Space And Participation In Gendered Activity

Given the right to define one's own gender identity and the corresponding right to free expression of a self-defined gender identity, no individual should be denied access to a space or denied participation in an activity by virtue of a self-defined gender identity which is not in accord with chromosomal sex, genitalia, assigned birth sex, or initial gender role.

Therefore, no individual shall be denied access to a space or denied participation in an activity by virtue of a self-defined gender identity which is not in accord with chromosomal sex, genitalia, assigned birth sex, or initial gender role.

The Right To Control And Change One's Own Body

All human beings have the right to control their bodies, which includes the right to change their bodies cosmetically, chemically, or surgically, so as to express a self-defined gender identity.

Therefore, individuals shall not be denied the right to change their bodies as a means of expressing a self-defined gender identity; and further, individuals shall not be denied Human or Civil Rights on the basis that they have changed their bodies cosmetically, chemically, or surgically, or desire to do so as a means of expressing a self-defined gender identity.

The Right To Competent Medical And Professional Care

Given the individual's right to define one's own gender identity, and the right to change one's own body as a means of expressing a self-defined gender identity, no individual should be denied access to competent medical or other professional care on the basis of the individual's chromosomal sex, genitalia, assigned birth sex, or initial gender role.

Therefore, individuals shall not be denied the right to competent medical or other professional care when changing their bodies cosmetically, chemically, or surgically, on the basis of chromosomal sex, genitalia, assigned birth sex, or initial gender role.

The Right To Freedom From Psychiatric Diagnosis Or Treatment

Given the right to define one's own gender identity, individuals should not be subject to psychiatric diagnosis or treatment solely on the basis of their gender identity or role.

Therefore, individuals shall not be subject to psychiatric diagnosis or treatment as mentally disordered or diseased solely on the basis of a self-defined gender identity or the expression thereof.

The Right To Sexual Expression

Given the right to a self-defined gender identity, every consenting adult has a corresponding right to free sexual expression.

Therefore, no individual's Human or Civil Rights shall be denied on the basis of sexual orientation; and further, no individual shall be denied Human or Civil Rights for expression of a self-defined gender identity through sexual acts between consenting adults.

The Right To Form Committed, Loving Relationships And Enter Into Marital Contracts

Given that all human beings have the right to free expression of self-defined gender identities, and the right to sexual expression as a form of gender expression, all human beings have a corresponding right to form committed, loving relationships with one another, and to enter into marital contracts, regardless of their own or their partner's chromosomal sex, genitalia, assigned birth sex, or initial gender role.

Therefore, individuals shall not be denied the right to form committed, loving relationships with one another or to enter into marital contracts by virtue of their own or their partner's chromosomal sex, genitalia, assigned birth sex, or initial gender role, or on the basis of their expression of a self-defined gender identity.

The Right To Conceive, Bear, Or Adopt Children; The Right To Nurture And Have Custody Of Children And To Exercise Parental Capacity

Given the right to form a committed, loving relationship with another, and to enter into marital contracts, together with the right to express a self-defined gender identity and the right to sexual expression, individuals have a corresponding right to conceive and bear children, to adopt children, to nurture children, to have custody of children, and to exercise parental capacity with respect to children, natural or adopted, without regard to chromosomal sex, genitalia, assigned birth sex, or initial gender role, or by virtue of a self-defined gender identity or the expression thereof.

Therefore, individuals shall not be denied the right to conceive, bear, or adopt children, nor to nurture and have custody of children, nor to exercise parental capacity with respect to children, natural or adopted, on the basis of their own, their partner's, or their children's chromosomal sex, genitalia, assigned birth sex, initial gender role, or by virtue of a self-defined gender identity or the expression thereof.

Appendix B

Excerpt from The Harry Benjamin International Gender Dysphoria Association's Standards Of Care

The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version

February, 2001

(For the full guide, refer to http://www.wpath.org/publications_standards.cfm)

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The Purpose of the Standards of Care. The major purpose of the Standards of Care (SOC) is to articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders.

The Overarching Treatment Goal. The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.

The Standards of Care Are Clinical Guidelines. The SOC are intended to provide flexible directions for the treatment of persons with gender identity disorders. When eligibility requirements are stated they are meant to be minimum requirements. Individual professionals and organized programs may modify them.

Two Primary Populations with GID Exist -- Biological Males and Biological Females. The sex of a patient always is a significant factor in the management of GID. Clinicians need to separately consider the biologic, social, psychological, and economic dilemmas of each sex. All patients, however, should follow the SOC.

Cultural Differences in Gender Identity Variance throughout the World. Even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of these conditions. Moreover, access to treatment, cost of treatment, the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place.

The Five Elements of Clinical Work. Professional involvement with patients with gender identity disorders involves any of the following: diagnostic assessment, psychotherapy, real-life experience, hormone therapy, and surgical therapy. This section provides a background on diagnostic assessment.

The DSM-IV. In 1994, the DSM-IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder. Depending on their age, those with a strong and persistent cross gender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender

role of that sex were to be diagnosed as Gender Identity Disorder of Childhood (302.6), Adolescence, or Adulthood (302.85). For persons who did not meet these criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS)(302.6) was to be used. This category included a variety of individuals, including those who desired only castration or penectomy without a desire to develop breasts, those who wished hormone therapy and mastectomy without genital reconstruction, those with a congenital intersex condition, those with transient stress-related cross-dressing, and those with considerable ambivalence about giving up their gender status.

The ICD-10. The ICD-10 now provides five diagnoses for the gender identity disorders (F64):

Transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment;
2. The transsexual identity has been present persistently for at least two years;
3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Dual-role Transvestism (F64.1) has three criteria:

1. The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex;
2. There is no sexual motivation for the cross-dressing;
3. The individual has no desire for a permanent change to the opposite sex.

Gender Identity Disorder of Childhood (64.2) has separate criteria for girls and for boys. For girls.

Other Gender Identity Disorders (F64.8) has no specific criteria.

Gender Identity Disorder, Unspecified has no specific criteria.

The Ten Tasks of the Mental Health Professional. Mental health professionals (MHPs) who work with individuals with gender identity disorders may be regularly called upon to carry out many of these responsibilities:

1. To accurately diagnose the individual's gender disorder;
2. To accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment;
3. To counsel the individual about the range of treatment options and their implications;
4. To engage in psychotherapy;
5. To ascertain eligibility and readiness for hormone and surgical therapy;
6. To make formal recommendations to medical and surgical colleagues;
7. To document their patient's relevant history in a letter of recommendation;
8. To be a colleague on a team of professionals with an interest in the gender identity disorders;
9. To educate family members, employers, and institutions about gender identity disorders;
10. To be available for follow-up of previously seen gender patients. Goals of Psychotherapy. Psychotherapy often provides education about a range of options not previously seriously

considered by the patient. It emphasizes the need to set realistic life goals for work and relationships, and it seeks to define and alleviate the patient's conflicts that may have undermined a stable lifestyle.

Options for Gender Adaptation. The activities and processes that are listed below have, in various combinations, helped people to find more personal comfort. These adaptations may evolve spontaneously and during psychotherapy. Finding new gender adaptations does not mean that the person may not in the future elect to pursue hormone therapy, the real-life experience, or genital surgery.

Activities:

Biological Males:

1. Cross-dressing: unobtrusively with undergarments; unisexually; or in a feminine fashion;
2. Changing the body through: hair removal through electrolysis or body waxing; minor plastic cosmetic surgical procedures;
3. Increasing grooming, wardrobe, and vocal expression skills.

Biological Females:

1. Cross-dressing: unobtrusively with undergarments, unisexually, or in a masculine fashion;
2. Changing the body through breast binding, weight lifting, applying theatrical facial hair;
3. Padding underpants or wearing a penile prosthesis.

Both Genders:

1. Learning about transgender phenomena from: support groups and gender networks, communication with peers via the Internet, studying these Standards of Care, relevant lay and professional literatures about legal rights pertaining to work, relationships, and public cross-dressing;
2. Involvement in recreational activities of the desired gender;
3. Episodic cross-gender living.

Processes:

1. Acceptance of personal homosexual or bisexual fantasies and behaviors (orientation) as distinct from gender identity and gender role aspirations;
2. Acceptance of the need to maintain a job, provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority than the personal wish for constant cross-gender expression;
3. Integration of male and female gender awareness into daily living;
4. Identification of the triggers for increased cross-gender yearnings and effectively attending to them; for instance, developing better self-protective, self-assertive, and vocational skills to advance at work and resolve interpersonal struggles to strengthen key relationships.

Reasons for Hormone Therapy. Cross-sex hormonal treatments play an important role in the anatomical and psychological gender transition process for properly selected adults with gender identity disorders. Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity, which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone, and testosterone-blocking agents to biologic males, patients feel and appear more like members of

their preferred gender.

Parameters of the Real-Life Experience. When clinicians assess the quality of a person's real-life experience in the desired gender, the following abilities are reviewed:

1. To maintain full or part-time employment;
2. To function as a student;
3. To function in community-based volunteer activity;
4. To undertake some combination of items 1-3;
5. To acquire a (legal) gender-identity-appropriate first name;
6. To provide documentation that persons other than the therapist know that the patient functions in the desired gender role.

Sex Reassignment is Effective and Medically Indicated in Severe GID. In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental," "investigational," "elective," "cosmetic," or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.

Breast Surgery. Breast augmentation and removal are common operations, easily obtainable by the general public for a variety of indications. Reasons for these operations range from cosmetic indications to cancer. Although breast appearance is definitely important as a secondary sex characteristic, breast size or presence are not involved in the legal definitions of sex and gender and are not important for reproduction. The performance of breast operations should be considered with the same reservations as beginning hormonal therapy. Both produce relatively irreversible changes to the body

The approach for male-to-female patients is different than for female-to-male patients. For female-to-male patients, a mastectomy procedure is usually the first surgery performed for success in gender presentation as a man; and for some patients it is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Female-to-male patients may have surgery at the same time they begin hormones. For male-to-female patients, augmentation mammoplasty may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role.

Genital Surgery Eligibility Criteria. These minimum eligibility criteria for various genital surgeries equally apply to biologic males and females seeking genital surgery. They are:

1. Legal age of majority in the patient's nation;
2. Usually 12 months of continuous hormonal therapy for those without a medical contraindication (see below, "Can Surgery Be Performed Without Hormones and the Real-life Experience");
3. 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion;
4. If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the

- patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;
5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;
 6. Awareness of different competent surgeons.

Readiness Criteria. The readiness criteria include:

1. Demonstrable progress in consolidating one's gender identity;
2. Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health; this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance.

Genital Surgery for the Male-to-Female Patient. Genital surgical procedures may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. These procedures require skilled surgery and postoperative care. Techniques include penile skin inversion, pedicled rectosigmoid transplant, or free skin graft to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Other Surgery for the Male-to-Female Patient. Other surgeries that may be performed to assist feminization include reduction thyroid chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift, and blepharoplasty. These do not require letters of recommendation from mental health professionals. There are concerns about the safety and effectiveness of voice modification surgery and more follow-up research should be done prior to widespread use of this procedure. In order to protect their vocal cords, patients who elect this procedure should do so after all other surgeries requiring general anesthesia with intubation are completed.

Genital Surgery for the Female-to-Male Patient. Genital surgical procedures may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, the patient should be clearly informed that there are several separate stages of surgery and frequent technical difficulties which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one surgery. The plethora of techniques for penis construction indicates that further technical development is necessary.

Other Surgery for the Female-to-Male Patient. Other surgeries that may be performed to assist masculinization include liposuction to reduce fat in hips, thighs and buttocks.

Post-Transition Follow-up. Long-term postoperative follow-up is encouraged in that it is one of the factors associated with a good psychosocial outcome. Follow-up is important to the patient's subsequent anatomic and medical health and to the surgeon's knowledge about the benefits and limitations of surgery. Long-term follow-up with the surgeon is recommended in all patients to ensure an optimal surgical outcome. Surgeons who operate on patients who are coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable,

local, long-term aftercare in the patient's geographic region. Postoperative patients may also sometimes exclude themselves from follow-up with the physician prescribing hormones, not recognizing that these physicians are best able to prevent, diagnose and treat possible long term medical conditions that are unique to hormonally and surgically treated patients. Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. The need for follow-up extends to the mental health professional, who having spent a longer period of time with the patient than any other professional, is in an excellent position to assist in any post-operative adjustment difficulties.

Appendix C: Vrije Universiteit Gender Clinic Intake Protocol

Appendix D

Hormones Used in Cross-Gender Hormone Treatment of Transsexualism

From: Asscheman, H & Gooren, L. J.G (1992) Hormone Treatment in Transsexuals

Antiandrogens:

LHRH analogues:	leuprorelin	Lucrin depotR	3.75 mg/ months s.c.
	triptorelin	Decapepty1-CRR	3.75 mg/ months i.m

Interference with testosterone or DHT production:

	spironolactone	AidactoneR	100-200 mg/day p.o.
	finasteride	not registered	
	flutamide	EulexinR	250 mg t.i.d., p.o.

Antiandrogens:	cyproterone acetate	AndrocurR	100-150 mg/day p.o.
	medroxyprogesterone	ProveraR	5-10 mg/day p.o.
		Depo-ProveraR	150 mg/month i.m.
		FarlutaiR	5-10 mg/day p.o.
		Farlutal depotR	100 mg/month i.m.

Androgenreceptor blockers:

	cyproterone acetate	AndrocurR	100-150 mg/day p.o.
	nilutamide	AnandronR	300 mg/day p.o.
	spironolactone	AldactoneR	100-200 mg/day p.o.

Estrogens:

	ethinyl estradiol	LynoraiR	100 µg/day p.o.
	conjugated estrogens	premarinR	5-10 mg/day p.o.
	17β estradiol	progynovaR	2-4 mg/day p.o.
		Progynon depotR	10 mg/2 weeks to 100 mg/ month i.m.
		Estraderm TTSR	50-100 µg/day
		transdermally	
	estriol	SynapauseR	4-6 mg/day p.o.

Androgens:

	testosterone esters	TestoylronR	250 mg/2 weeks 1.m.
	sustanonR	250 mg/2 weeks i.m.	
	testosterone undecanoate	AndrinR	160-240 mg/day p.o.

Appendix E

Possible Surgical Interventions for Trans-Identified Individuals

For individuals identifying on the transmasculine spectrum, surgeries may include:

Chest reconstruction:

Often including a bilateral mastectomy, or liposuction, and male chest contouring.

Hysterectomy:

Surgery to remove the uterus (partial hysterectomy) and, sometimes, the cervix (total hysterectomy).

Salpingo-oophorectomy:

Surgical removal of the fallopian tubes and ovaries.

Vaginectomy:

The surgical removal of the vagina.

Metaidoioplasty:

The surgical process of “freeing up” the clitoris from its connective tissue so that it is presented on the body in a more phallic or penis-like manner.

Phalloplasty:

A type of genital reconstruction surgery in which a phallus/penis is constructed from an individual's own donor tissue (usually taken from the forearm, leg, and/or abdomen) that has been shaped and grafted into place. Phalloplasty operations are usually done in stages requiring multiple surgeries.

Urethroplasty:

The dilation/elongation of a prostatic urethra.

Scrotoplasty:

Surgery to construct scrotum, often by inserting testicular implants into the labial lips.

*Additional procedures to masculinize facial and body contours

For individuals identifying on the transfeminine spectrum, surgeries may include:

Orchiectomy:

Surgery to remove one or both testicles.

Penectomy:

Surgical removal of the penis.

Vaginoplasty:

A procedure to construct or reconstruct the vagina.

Breast augmentation:

A procedure to reshape the breast in order to make it larger.

Facial Feminization/Tracheal Shave:

Refers to surgical procedures that alter the face to increase its femininity.

Surgery to elevate voice pitch:

Surgeries focused on the larynx, to higher the pitch of the voice.

*Additional procedures to feminize body contours

Appendix F
Interview Guide

- From a Dutch perspective, what are the differences between a transgender and a transsexual identification? Is there a “genderqueer” label? What are some other identifiers trans people use?
- How does medicine/treatment at the Gender Clinic approach each group? How do they differ? How are they similar? How has the medical establishment supported and/or denied services to each group?
- What has been your experience with the Gender Clinic here in Amsterdam? What were you most satisfied with? What were you least satisfied with?
- How do you feel about the Gender Clinic's protocol? Do you feel it allows space for people transition at a pace/in a way that is comfortable for them? Can people “partly” transition? Do you think there is room at the VU Gender Clinic for individuals who identify as transgender or genderqueer?
- Do you see a “community” among transgender or transsexually-identified individuals?
- How has that community, or lack there of, affected your own transition/transitioning people you work with?
- What do you think some of the barriers are to community organizing in the Netherlands for trans-identified people?
- If there isn't much of a trans-community, where else does support come from?
- How does Dutch culture view trans-identified people? Can trans people assimilate as “normal” Dutch men and Dutch women? What are the implications of this for people who don't identify as men or women?
- If services became less available, how do you suppose that would affect the “community” (or lack there of)?
- What are some priorities for the trans-community in the Netherlands? Is there an “agenda?” If so, what is next?

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