Master Thesis Femke van den Buuse

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5646413

Supervisor:

Domitilla Olivieri

Second reader:

Edward Akintola Hubbard

The personal experience of transgender children and adolescents in The Netherlands: an oral history

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Table of contents

Introduction……………………………………………………………………………2
Chapter 1: Theoretical Framework…………………………………………………6
Chapter 2: Methodology...…………………………………………………………15
Chapter 3: The VU Medical Centre as regulatory power (and the need to convince them).………………….....……………………………………………………………...20
Chapter 4: Gender norms at the VU Medical Centre: is there enough room for everyone?.......................…………………………………………………………..35
Chapter 5: Conclusions……………...…………………………………...………..48
Bibliography………………………………………………………………………50

Introduction

VU Medical Centre in Amsterdam was the first in the world to open a specialised Centre of Expertise on Gender Dysphoria for children and adolescents in 1987. This clinic, which is specialised in transgender children and adolescents under the age of eighteen, offers a complete package of multidisciplinary care.

The opening of this clinic has given children and adolescents the opportunity to start their transition at an earlier age. Right after puberty starts children are given the option to start with puberty blockers to stop the body from developing secondary sex characteristics. This way, they have more time to decide for themselves if they truly are "trapped in the wrong body"[1] and want to make a transition or not. The average age to start with these blockers is fourteen years old.[2] From the age of sixteen, when they still want to transition, there is a possibility for hormone treatment and eventually sex reassignment surgery (de Vries, Cohen-Kettenis 301).

Since the opening of this clinic, the number of children and adolescents that got referred to the clinic has slowly but consequently increased over the years. Whereas in the late 80s and early 90s no more than ten children and adolescents came in per year, in 2008 this number had already increased to forty to fifty children and adolescents per year (de Vries Cohen-Kettenis 302).

Data regarding the procedure is widely available, but the information that is disseminated mostly comes from a medical point of view (de Vries, Cohen-Kettenis; Campo; Smith). These data show that new developments in the gender reassignment procedure have created great possibilities and are a tremendous progression for transgender children and adolescents. From a young age, guidance is available, the development of secondary sex characteristics can be slowed down (which makes eventual transitioning easier), and follow-up studies show that transgender children and adolescents who go into the gender reassignment procedure before the age of eighteen, have a decrease in depression, and feel no regrets towards their transition (Smith, et al. 472). Reading the existing research, I stand behind the idea that this procedure is a tremendous progression, but questions regarding the chosen approach of the research do come into mind: what about these transgender children and

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[1] "trapped in the wrong body" is the language discourse that is used often concerning the matter. I do not

[2] Information from a press release of VUmc in Amsterdam:
http://www.vumc.nl/afdelingen/over-vumc/nieuws/4781404/

adolescents? How have they experienced the procedure? And what about the transgender people who identify as something other than male or female? Is there room for them in this procedure to be the person they identify with, without feeling the pressure to comply with the gender binary, and feeling the need to choose between male or female?

The main research question of this thesis is: "To what extent does the oral history of the personal experiences of transgender children and adolescents in The Netherlands, offer new insights in the gender reassignment procedure at the VU Medical Centre, as practiced until 2014?"

To come to an answer the main research question is divided in the following sub-questions:

1. What are the general needs and wishes of transgender people before going into the procedure?
2. What are the prohibitions, taboos, and social constructions they carry with them when going into such a procedure?
3. Is the gender team at the VU Medical Centre in Amsterdam viewed as disconnected and uncaring or are medical professionals viewed as compassionate heroes in these stories?
4. To what extend is there a visible power structure between the gender team at the VU Medical Centre in Amsterdam and the transgender children and adolescents?
5. To what extend did the interviewees experience a need to comply to the idea of a gender binary?
6. How are thoughts about "gender" and the physical body constructed in their narratives?

By conducting interviews with transgender people from age twenty to thirty, and by asking them about the experiences they have had with medical doctors and gender teams during their adolescent years, I aim to provide an oral history of their personal experiences.

The reason I am mostly interested in transgender children and adolescents is twofold. Firstly, because a child's/adolescent's brain is still growing, and still very sensitive to influence from outside. Studies show that the period of adolescence, with

its changing social environment and the onset of physical puberty, seems to be crucial for the development of a non-normative gender identity (Steensma 289). And this is precisely why, with the treatment of trans youth, it is of great importance to take into account that they need all the space to develop their identity without any interference from the outside.

Secondly, it sparks my interest because of the ethical debate regarding the treatment of transgender children and adolescents, with, on the one hand scholars who claim that even though going into the procedure at a fairly young age can be dangerous and has a huge impact on the person's life, it is better than not intervening at all (de Vries, Cohen-Kettenis 301). And on the other hand, scholars who claim that children and adolescents are not fully-grown and therefore are not in a position to make such a decision (Padawer).

The reason I chose to focus on The Netherlands, and on the VU Medical Centre in specific is, besides practical reasons (I live in The Netherlands and I speak the language), because The Netherlands is known for its tolerance towards LGBTQI[3] people. With regard to transgender history, The Netherlands was one of the first countries in which the government chose to add the gender reassignment procedure of transgender people to health insurance packages. Also, The Netherlands took the lead by enacting a law on sex change in 1985, which made it possible for transgender people to change their sex on official registration papers, and in 1988 the first professor in "Transseksuologie" was officially appointed in The Netherlands (Demmers 17). The reason I chose the practices at the VU Medical Centre in Amsterdam as my specific field side is, as I mentioned earlier, because this Medical Centre was the first one to open a gender clinic that specifically targets transgender and adolescents. Besides the fact that Amsterdam is also the only city in The Netherlands where, if one wants to start the procedure as an adolescent, one can undergo the complete procedure - from puberty blockers until hormone treatment and, potentially, gender reassignment surgery. Even though there are also gender clinics in Leiden and Groningen, Leiden only practices the procedure on persons eighteen years and over, and Groningen does not have a special department for transgender people under eighteen.[4]

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[3] LGBTQI stand for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex

[4] For more information: see website Genderteam Leiden https://www.curium-lumc.nl/patienteninfo/afdelingen-en-teams/genderteam/ and UMC Groningen

The aim of this research is to contribute to the existing medical transgender discourse, and to approach that discourse from another perspective, namely from the perspective of the trans people[5] themselves. Research that is done from a medical perspective is very leading when it comes to discussions regarding the wellbeing of transgender children and adolescents. But where is their story? I claim that currently the personal experiences of transgender children and adolescents are not taken into account enough. Besides that, the existing research focuses solely on male-to-female and female-to-male transgender people. Research (from a medical point of view) about transgender people who prefer to be genderqueer is very rare.[6]

I aim to fill these gaps, and contribute a more qualitative research centered around the personal narratives of the experiences of trans people during the process of transitioning. I expect that this research will provide valuable qualitative data for medical professionals seeking to understand the impact of the past gender reassignment procedure on the lives of people who underwent it. Hopefully it will also provide new insights that can be used to look critically at how the procedure is currently done.

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http://www.umcg.nl/NL/Zorg/Volwassenen/zob2/Genderteam_Informatie_voor_transseksuele_patiënten/paginas/default.aspx

[5] Throughout this research I will use the words transgender as well as trans people/trans youth and so on. In the section theoretical framework I will eloborate more on this choice

[6] I will elaborate more on this in the Methodology chapter of this research

Chapter 1: Theoretical Framework

"In the end, we took the easy way out and pragmatically acknowledged that the term "transgender," for all its limitations and masked agendas, was the term in most common usage that best fit what we were trying to talk about. What began as a buzzword of the early 1990s has established itself as the term of choice, in both popular parlance and a variety specialist discourses, for a wide range of phenomena that call attention to the fact that "gender," as it is lived, embodied, experienced, performed, and encountered, is more complex and varied than can be accounted for by the currently dominant binary sex/gender ideology of Eurocentric modernity." (Stryker, "(De)Subjugated Knowledges" 3)

As Susan Stryker, American professor in Gender and Women's Studies, and very prominent scholar within transgender studies sets out here, there are a lot of limitations in the terms we use. This is why it is important to be very precise with the terminology. In this chapter I will expand on how I will use this terminology. Besides that I will expand on the theories I will use during my research. This is to get a clear image of the framework that will be used throughout the analysis of the interviews.

Terms like transgender, transsexual, and genderqueer are used differently by different kinds of people, and change rapidly over time. That is why I will choose to specifically use the terms that are preferred by the transgender community in The Netherlands. Transgender is an umbrella term for people who feel a mismatch between the biological sex that is assigned at birth, and their gender identity or gender expression. The term 'transgender' took on its current meaning after appearing in a pamphlet by Leslie Feinberg in 1992. Feinberg used the term as an adjective rather than a noun, and addressed "all individuals who were marginalised or oppressed due to their difference from social norms of gendered embodiment" (Stryker, "(De)Subjugated Knowledges" 4). Feinberg made transgender into a "pangender" umbrella term for an imagined community encompassing all possible ways in which people don't fit in the gender binary (Stryker, "(De)Subjugated Knowledges" 4). I prefer not to use the term "transsexual" since this term sets the focus too much on the gender binary (you can be either male or female). Besides that, the transgender community does not prefer to use the term since it leads to thinking that being transsexual only affects your sex, and not your gender.[7]

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[7] For more information see: https://www.transgenderinfo.nl/2-2/transgender/wat-is-het/

The word "trans," referring to a "trans woman" or "trans man" (or any other subtype of trans identity) is a very recent take on the umbrella term "transgender." (Whittle xi). When referring to transgender people I will use either transgender or trans, but always followed by people, adolescents, children, man, woman, to name a few. Using the word transgender(s) as a definition in itself is, as people from the trans activist community have told me, a very impersonal way of addressing a person.

If I specifically need to address only transgender people who don't necessarily want to be male or female, I will use the term genderqueer, since this is the term that is widely used on websites of Dutch transgender organisations, like for instance Transgender Network Netherlands (TNN). They refer to genderqueer as "people who feel neither male nor female; see themselves as 'without gender'; identify with several genders; politically state themselves against the schematic division of humanity into 'males and females'.[8] If a genderqueer interviewee identifies differently I will of course use their desired term.

In a lot of the existing research the terms "gender dysphoria"[9] and "treatment" are used. I will avoid these terms as much as possible, since they are insinuating that transgender people have a disorder that needs treatment. This presumption I want to avoid at all times. The pathologising of transgender people, which can be defined as the idea that transgender people have a disorder that needs to be cured (Stryker, "My Words To Victor Frankenstein" 249)[10], is also something that is fought against in transgender theory. As Stephen Whittle, prominent transgender activist in the United Kingdom, and editor of the Transgender Studies Reader, puts it:

> "The work of trans academics and theorists is increasingly moving trans people away from the discredited status of being mentally disordered, towards having expert knowledge of those who struggle to maintain the current strict gender regime, referred to by Kate Bornstein (1997) as "gender defenders." Finally being able to accept our own sanity, trans people have created gender disorder by becoming "gender outlaws." (Whittle xiii)

This is also a reason why I prefer the term gender reassignment procedure, instead of using the words treatment or surgery. In this research, the gender reassignment

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[8] For their complete list of definitions visit https://www.transgenderinfo.nl/2-2/transgender/woordenlijst/

[9] Gender dysphoria is the official medical term that is used nowadays for the diagnose of a transgender person

[10] Throughout this research I will use the word 'pathologisation', as well as the word 'medicalisation' when I describe this phenomenon

procedure entails the entire medical and psychological procedure that a child or adolescent experiences. This starts with the first appointment with the gender team in the VU Medical Centre, followed by sessions with a psychologist, puberty blockers, hormone treatment, and eventually surgery.[11]

Constructed bodies, Constructed Minds

A major question that is still very visible within transgender theory is the question: "Is the basis of gender identity essential and biologically based, or is it socially constructed?" (Whittle xiii). Several scholars from the transgender studies field (as well as gender studies) stress out the fact that the gender binary is a social construct that heavily influences us, and if this binary would lose importance more space could be created for genderqueer identities (Bornstein; Butler; Spade; Rubin). These claims show that we should rather look at the structures within our social systems, and see where the problems are there. Later on in this chapter I will go more in depth on how these theorists envision this.

Judith Butler's theory will be of great importance for my research. According to Butler - American philosopher and lesbian feminist who is most well known for her performativity theory - gender is something that is performed repeatedly. But besides that, sex is also something that is seen as not entirely natural. "The body is not merely matter but a continual and incessant materializing of possibilities. One is not simply a body but, in some very key sense, one does one's body" ("Performative Acts" 521). The cultural discourse of what is male and what is female is incorporated so deeply that it even influences how we perceive our sex, something that is seen as so natural and purely biological. In other words, "the body becomes its gender through a series of acts" (Butler, "Performative Acts" 523).

But what if one does not fit in this cultural discourse? According to Butler, "gender is a performance with clearly punitive consequences. Discrete genders are part of what 'humanizes' individuals within contemporary culture; indeed, those who fail to do their gender right are regularly punished" ("Performative Acts" 522).

In her later work, Butler reconsiders her earlier view on gender performativity and sees that now, if we look at gender we also have to look at the varieties in gender identity. By doing so she includes much more of transgender politics and theory in her

[11] For more practical information on the procedure visit https://www.vumc.nl/afdelingen/zorgcentrum-voor-gender/

work (“Undoing Gender” 6). With regard to trans people, Butler recognises that, “choosing one’s own body invariably means navigating among norms that are laid out in advance and prior to one’s choice” (“Undoing Gender” 7). So even though we as individuals can exercise self-determination with respect to what body and what gender to have and maintain, this self-determination is still determined by the social construct we live in. Or in other words, “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” (Butler, “Undoing Gender” 7).

It is too simplistic to argue that these social constructs are all-determining though: “The transsexual desire to become a man or a woman is not to be dismissed as a simple desire to conform to established identity categories” (Butler, “Undoing Gender” 8). Here Butler refers to Kate Bornstein, stating that this desire is much more complex, and can also arise from a desire for a stable identity, a transformation, or a pursuit of identity as a transformative exercise (“Undoing Gender”, 8). It is important to recognise that these social constructs exist, and that they have an effect upon our judgement of what is “normal.” But we must not forget that we have our own agency in doing so. These social constructs about our bodies, and our gender influence us on a daily basis. They influence trans people in how they envision their identity, but they also influence the medical staff in how they envision the identity of transgender people. The need to comply with these constructs is felt, because it has punitive consequences for the ones who fail to comply. That is why I think it is important to be very aware of this during my research.

VU Medical Centre as Regulatory Power

Social constructs regarding gender and sex are incorporated deeply into our system, and they influence us on a daily basis. They are the norm, and if one does not fit within this norm it has clearly punitive consequences. But within these social constructs, who gets to decide what is the norm, and what is not? To look more closely at what power structures are at play here, I will draw from French philosopher Michel Foucault, who states that power creates knowledge, and that power and knowledge are always intertwined. In ‘The Subject and Power’ Foucault states “what is questioned is the way in which knowledge circulates and functions, its relations to power” (Foucault 212). We always have to look at power and knowledge in relation to each other. By looking at the personal experiences of transgender children and

adolescents it is important to note that the VU medical centre can be seen as regulatory power here, and that the medical articles regarding the gender reassignment procedure of transgender children and adolescents in The Netherlands that are produced by them, are the ones who determine the knowledge about it. But these two are always intertwined. What is perceived by the transgender children and adolescents as knowledge might as well be a product of the power of the VU.

Butler also derives from Foucaultian scholarship when she writes about regulatory power and claims that "(1) regulatory power not only acts upon a pre-existing subject but also shapes and forms that subject… and (2) to become subject to a regulation is also to become subjectivated by it, that is, to be brought into being as a subject precisely through being regulated" ("Undoing Gender" 41). When we look at the power relations between at one hand the VU medical centre as the regulatory power and at the other hand the transgender children and adolescents in The Netherlands as the subject, we need to recognise that this subject is shaped by the regulatory power, but is also brought into being by this power. Or in other words, "the regulatory discourses which form the subject of gender are precisely those that require and induce the subject in question" (Butler "Undoing Gender" 41). What is also brought into being is the way that the VU Medical Centre looks at transgender children and adolescents in The Netherlands. By using the term "gender dysphoria", a certain view (namely that trans people have a disorder) is brought into being and also has its influence on trans people.

But not only the VU Medical Centre can be seen as a regulatory power, the naturalisation of gender itself is also a regulatory power. According to Butler, a gender discourse that insists so heavily on a binary of man and woman as the only way to understand gender "performs a regulatory operation of power that naturalises the hegemonic instance and forecloses the thinkability of its disruption" ("Undoing Gender" 42). Another way of naturalising gender is when we look at Michel Foucault's politics of truth, which I will use here as interpreted by Judith Butler. Butler sees it as a politics that involves a power relation that defines in advance what will count as truth, and this truth is what one comes to accept as knowledge ("Undoing Gender" 57). We can ask ourselves question like: "What counts as a person? What counts as a coherent gender?" Or "Who can I become in such a world where the meaning and limits of the subject are set out in advance for me" ("Undoing Gender" 58)? When these questions get asked beforehand, this already reinforces the

gender norm. By questioning beforehand what counts as a coherent gender, gender gets naturalised, because it leaves no room for genders that are not within the norm. This way it leaves no room for genderqueer people. For transgender children and adolescents, this means they must navigate between existing norms that they might not identify with.

<u>"Pass" or "No Pass"? The Pathologisation of Trans People</u>

Within the naturalisation, or one could say normalisation, of the gender binary the 'politics of passing' is highly important. Starting with the gender reassignment procedure at a fairly young age increases the "passability" of a transgender person. This so called 'politics of passing', which can be explained as the desire to "pass" as a privileged identity in order to mask a non-privileged identity (Squires and Brouwer 283), is in itself already problematic because it supports the naturalisation of the gender binary. It has as a starting point that, to be accepted as a "normal" human being, one has to fit in this gender binary.

But what exactly is a "normal gender"? What does it mean to "pass"? To go more in depth on this I will again use Judith Butler and her explanation of normalisation. According to Butler "the question of what it is to be outside the norm poses a paradox for thinking, for if the norm renders the social field intelligible and normalises that field for us, then being outside the norm is in some sense being defined still in relation to it" ("Undoing Gender" 42). One can only define what is outside the norm by looking at what is the norm, because without that norm the 'outside of the norm' would not exist. Applying this to the gender binary and the politics of passing, one can say that the desire to pass can only be seen from looking at the existing gender binary. This is something to be very aware, and very critical of during this research.

And why is it important to fit within this norm to begin with? Why do we feel the need to comply to the gender binary? As I mentioned earlier, several scholars from the transgender studies field (as well as the gender studies field) claim that the gender binary is a social construct. According to them, we should not feel the need to pass at all. American author and gender theorist Kate Bornstein for instance, refuses to be categorised on either side of the gender divide, and wants to make the partitioning of gender meaningless. Bornstein aims for gender fluidity on a day-to-day basis:

"Instead of saying that all gender is this or all gender is that, let's recognize that the word gender has scores of meaning built into it. It is an amalgamation of bodies, identities, and life experiences, subconscious urges, sensations, and behaviors, some of which develop organically, and others which are shaped by language and culture" (Bornstein 182).

Sandy Stone, American media theorist, and trans woman, claims in her 'The Empire Strikes Back: A Posttranssexual Manifesto'[12], that the desire to pass has a negative influence on the acceptance and understanding of transgender people. It withholds the possibility of generating a counter discourse. According to Stone, the highest purpose of a transgender person is to "pass", and to fade into the "normal" population as soon as possible. By doing so, one must construct a 'plausible history', to be accepted in society. But if they do this, 'the ability to authentically represent the complexities and ambiguities of lived experience' is lost (Stone 230). Stone acknowledges that for many people "passing", which she describes as living successfully in the gender of choice, to be accepted as a "natural" member of that gender, is of highest importance (Stone 231). But by doing so, they deny a considerable portion of their personal experience. She thinks we have to make those people, who have disappeared in their plausible history, visible again:

"To generate a true, effective and representational counter discourse is to speak from outside the boundaries of gender, beyond the constructed oppositional nodes which have been predefined as the only positions from which discourse is possible" (Stone 230).

Susan Stryker claims that the desire to pass is something that is strived by the medical staff. For them the naturalness of a trans body is more important than the functionality of that body. Stryker claims that the procedure's "cultural politics are aligned with a deeply conservative attempt to stabilize gendered identity in service of the naturalized heterosexual order" ("My Words To Victor Frankenstein" 248).

To go more in depth on the medicalisation of trans people – which can be

[12] Stone wrote her manifesto as a direct response to Janice Raymond's 'The Transsexual Empire', in which Raymond accused Stone of plotting to destroy the all female Olivia Records Collective – a popular women's music label where Stone used to be a member of- with her "male energy" (Stryker, "Desubjugated Knowledges" 4)

understood as the process of defining transgender people as having a medical condition, through which they become subject of medical discourse[13] - I will use the critical research from Dean Spade and Sally Hines. In 'Mutilating Gender', Dean Spade – lawyer and associate professor of Law in Seattle, with special interest in transgender studies - uses the work of Michel Foucault to "examine the relationship between gender normativity and technologies of gender-related bodily alteration" (Spade 315). He states that the medical professionals who have the power to say "no" or "yes" to a request for transition by a transgender person, only reinforce the gender binary, since only a small group of transgender people (the ones who desire a full transition including a sex reassignment surgery) are "allowed" to go into a transition. Spade also states that the way transgender people construct their idea of what gender is, is completely different from how medical professionals see it. To work around this transgender people feel the need to lie about themselves, to be able to get the procedure they want. Spades view on the naturalisation of the gender binary is a view I share, and that I want to explore more in this thesis. But one also needs to be critical against this idea of transgender people only using this narrative to get access to hormones and surgery. According to Henry Rubin, American sociologist known for his work in transgender studies, it is a narrative that is used in a very welcoming way by trans people to make sense of their own identity as well. As Rubin puts it, "the belief that they have a chromosome out of place, or a hormonal imbalance, is not just instrumental, but also provides a narrative that makes sense of their identities" (Rubin 498).

Associate professor of sociology and gender studies at the University of Leeds Sally Hines explores in her book 'Transforming gender: Transgender practices of identity, intimacy and care' how "social structures of gender and sexuality impact upon understandings, practices and experiences of transgender, and the way in which these issues feed into debates around identity, intimacy, care, social movements and citizenship" (Hines 3). According to Hines, being "trapped in the wrong body" is a highly medicalised, and highly debated term. From a social constructionist framework, the idea of being "trapped in the wrong body" follows medical discourse and reinforces the notion of a naturalised gender. There has been much debate in transgender studies about the contradictions between this social constructionist notion

[13] "Transsexualism was not accorded the status of an "official disorder" until 1980, when it was first listed in the American Psychiatric Association Diagnostic and Statistical Manual" (Stone 223)

that speaks negatively about the term "wrong body" on the one hand, and the numerous transgender autobiographies that reinforce the idea of a core gender and the benefits of making this gender visible on the outside with hormones and surgery, on the other hand (Hines 60). It is very important to keep this friction in mind during my research, to protect me from going too far in social constructionist thinking. In many cases, transgender people feel a disharmony between the imagined body and the material body (Hines 62) and I cannot ignore this. But the 'wrong body' narrative is also seen as deeply unsatisfactory, and is often told by trans people because it is the only way to get access to hormone treatment and surgery (Hines 62).

To make sense of the narratives told by the interviewees, and to put them in a broader theoretical context, theories like these are of great importance. They give me tools to research to what extent the interviewees feel the desire the pass, feel inside or outside the norm, and to what extent the VU Medical Centre has any influence in this.

The reason I also use other research that does not focus solely on The Netherlands – Sally Hines focuses her research on the transgender care in the UK for instance - is because this research has a similar Western framework. Research on transgender care that is done in other Western countries shares a similar view on gender norms, how gender is perceived, and shows similarities in how the gender reassignment procedure is practiced. Besides that, if I would solely use research done in The Netherlands, my theoretical framework would not be dense enough.

In sum, I have given more insight in the preferred terminology that will be used throughout the chapters. I have made clear how Judith Butler's performativity theory can be of use to envision how social constructs about our bodies, and our gender influence trans people in how they see their identity, but also influence the medical staff in how they envision the identity of trans people. With Foucault's understanding of power structures I will hopefully shed a light on how to look at the VU Medical Centre as a regulatory power in relation to the information they distribute, and how this influences the transgender children and adolescents in The Netherlands. I also have shown where I stand when it comes to the medicalisation of transgender people and the politics of passing, and how these theories can be used as tools to research to what extent the interviewees feel the desire the pass, feel inside or outside the norm, and to what extent the VU Medical Centre has any influence in this. Throughout the chapters I will refer back to these theories to build up my arguments.

Chapter 2: Methodology

"Oral history is the systematic collection of living people's testimony about their own experiences. Historians have finally recognized that the everyday memories of everyday people, not just the rich and famous, have historical importance. If we do not collect and preserve those memories, those stories, then one day they will disappear forever." (Moyer 1)

Before going in depth with the analysis it is necessary to explain how I did my research, which methodology I used, why this methodology is relevant to study the subject matter, and how precisely I incorporated it into my research.

To determine to what extent the personal experiences of transgender children and adolescents in The Netherlands offer new insights in the gender reassignment procedure at the VU Medical Centre, as practiced until 2014, I made use of a feminist approach to oral history. Oral history is a tool that is used in feminist research "to incorporate the previously overlooked lives, activities, and feelings of women (and other underrepresented groups) into our understanding of the past and of the present" (Anderson, et al. 104). Unlike any other tool, oral history makes it possible to reveal hidden realities, because it lets underrepresented groups speak for themselves. And as the quote mentioned above by Judith Moyer exemplifies so beautifully, if we do not collect and preserve these stories, then one day they will disappear forever.

Oral history is a particularly important methodological approach for feminist research because it lends itself very well for studying marginalised social groups. It gives voice to groups that dominant cultures often fail to acknowledge, and it offers qualitative research that lets the subjects speak for themselves. But it needs to be said that, although oral history lets the subjects speak for themselves, the final choices for how their voices are heard are up to the researcher. During the research it is important to acknowledge my role, power, and authority as a researcher. [14]

Oral history has also been widely criticised over the past years. One of the biggest critiques against oral history is that it rests on memory, which is deemed as unreliable by many (Abrams 5). Oral history is a methodology that cannot be rigorously tested. But as an answer to these critiques, pioneering oral historians used to go to great lengths to justify their methodology, for example by cross-checking

[14] Many feminist theories, and feminist scholars have stressed the importance of oral history for feminist research. From standpoint theory to Donna Haraway, many have claimed that we should marginalised social groups speak for themselves.

with documentary sources to "test" if the interviewee was speaking the truth (Abrams 5). Besides reliability, oral history has also been criticised for its validity, and concerns about the representativeness of interview subjects are still being heard today (Abrams 6). But instead of trying to justify their methodology, oral historians nowadays acknowledge that oral history is a subjective methodology, recognise that memory stories are often fluid, and argue that "oral sources must be judged differently from conventional documentary materials, but that this in no way detracts from their veracity and utility"(Abrams 6). Oral historians argue that the so-called unreliability of memory is also its strength, since the "subjectivity of memory provides clues not only about the meanings of experience but also about the relationships between past and present, between memory and personal identity, and between individual and collective memory" (Perks and Thomson 3).

Alessandro Portelli, oral historian and Italian scholar of American literature and culture, made a research contribution on what makes oral history different. According to Portelli one should see the speaker's subjectivity as a unique and precious element, instead of as a weakness. Oral history might not add up on existing facts on a certain history, but it offers a whole new insight into that history, namely the psychological costs that were paid by the people experiencing that history (Portelli 36). Oral history tells more about meaning instead of an event. It gives insight into the effects that certain events have had on people's lives, and into their own personal experiences. But this does not mean it is less valid. These types of interviews often "reveal unknown events, or unknown aspects of known events" (Portelli 36). Portelli does acknowledge that oral sources are not objective, but also states that this applies to every source, and that "the holiness of writing often leads us to forget it" (Portelli 38). The difference though is that content from a written source acts independent, and the content of an oral source always relies on two parties, the interviewer and the interviewee (Portelli 39). The objectivity of written knowledge is something that is also cricitised by several feminists. Donna Haraway for example, who is a prominent scholar in the field of science and technology studies, critiques the existing notions on objectivity by claiming that all knowledge is theorised as "power moves, not moves towards truth" (Haraway 576). According to Haraway, objectivity as we know it is solely destined for the group within a given society that is part of the norm. With her 'situated knowledges' she wants to propose a new way of acquiring knowledge:

"I am arguing for politics and epistemologies of location, positioning, and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims. These are claims on people's lives" (Haraway 589).

She wants to show that there is no such thing as one universal objectivity, and that you always have to place knowledge into a specific context. This is exactly what I want to do with my research as well, and this is exactly why documenting oral history is so important.

According to Portelli, oral history relies on the questions that the interviewer asks, the relationship between interviewer and interviewee, and the kind of dialogue they are having (Portelli 39). To protect myself from influencing the stories too much I had to be aware of the relationship with my interviewees, and about the fact that complete objectivity was something I could not strive for. I did this by doing the interviews as unstructured as possible. But I will explain more about my relationship towards the interviewees further on in this chapter.

The Oral History of transgender children and adolescents

Since the existing research about the gender reassignment procedure of transgender children and adolescents in The Netherlands is mainly written from a medical point of view, it is of great importance that the personal experiences of these children and adolescents get collected. That is why for this research, oral history is a particularly useful methodology to uncover these personal experiences. By collecting these stories, and by putting them in an accurate historical context, I add up to existing research on transgender children and adolescents, which can also be of use for medical professionals working with transgender children and adolescents.

Using oral history as a methodology enables me to give voice to a group that is often overlooked and marginalised by the dominant culture. It creates a space to let them tell their own story. It reflects upon the experiences of the interviewees, and lets them choose for themselves which experiences and feelings are central to their sense of their past. That is why it is of high importance to position myself towards my interviewees. It is impossible to fill in the feelings, and experiences of another human being. There will always be some sort of own interpretation. Importantly, the fact that oral history also explores emotional subjective experiences creates an opportunity to break out of the very common, highly medicalised way of writing about transgender

people.

My research explores something that has not been explored yet, at least in The Netherlands, and, instead of adding up on existing facts, I aim at offering new insights into the gender reassignment procedure in The Netherlands, namely the personal stories of the transgender children and adolescents themselves.

The collection of stories

To be able to collect these oral histories I decided to find three to five transgender people between the age of twenty and thirty who were willing to tell me about the experiences they had as youngsters.

In my search to find these people I reached out to several trans organisations and networks, and I emailed several trans activists. I deliberately chose to use these channels instead of reaching out to the VU Medical centre. The reason for this is that I did not want the VU Medical Centre to influence or determine my research in any sense.

After an extensive search I finally made a selection by choosing a small group of people that was as diverse as possible. In the end, I interviewed four people from between the age of twenty and twenty-nine. Of these people, one person identified as agender, and three identified as male. Only one person of the people I interviewed had a "full transition"[15], two people deliberately chose not to proceed with the sex reassignment surgery, and one person only did a mastectomy and a hysterectomy but deliberately chose not to take hormones. There was also great diversity in their experiences with the VU Medical Centre. Even though more than half of the people I interviewed had negative experiences with the gender team, it was not all bad. Several positive memories came to the surface that will also be mentioned in the next chapters.

With each one of them I had several meetings. It always started with an introductory meeting in which we had a cup of coffee, and got to know each other a little bit better. In this first meeting, I explained the aims of my research, and I explained how I wanted to incorporate their stories into my research. After that first meeting we had the main interview, in a place of choice for the interviewee. The reason I let the interviewee choose the place is that I wanted them to feel as comfortable as possible while talking to me. The interviews, of which the shortest one

[15] When I say "full transition" I mean a transition that includes sex reassignment surgery

lasted for one hour, and the longest one for over three hours, were recorded on my phone. After the interviews I corresponded with one of the interviewees through email, to get some more information. Since the interviews were held in Dutch I had to translate all the quotes I wanted to use for the research. For verification I have sent each interviewee the translated quotes via email.

To collect the personal stories of the interviewees, I have decided to use an 'unstructured' form of interviewing. Doing an unstructured interview entails that you have a basic interview plan in mind, but minimum of control over how the participant should answer the question (Hesse-Biber 186). I asked the questions as open as possible and mainly supported the interviewees in their narratives, and let them tell their story. This way I hope I have prevented steering the interview in a certain direction to get the answers I expected or wanted.

With unstructured interviewing, one needs to be very aware of the nature of the relationship between interviewer and interviewee, and be careful to understand the particular personal and researcher standpoints (Hesse-Biber 184). This is important because the research will always, in a sense, be an interpretation of the researcher. The researcher is still the one who makes the final choices on how the voices of the interviewees are being heard. To act accordingly regarding to this relationship, one could ask questions like: "What am I feeling about this narrator? What similarities and what differences impinge on this interpersonal relationship? How does my own ideology affect this process" (Yow 67)? Preparing for the interviews I asked myself these questions. During the interviews I tried to address topics and ask questions as open as I could.

In sum, oral history is a particularly useful methodology to reveal hidden realities, and to let underrepresented groups speak for themselves. Even though oral history is widely criticised for being unreliable, and subjective, these so-called weaknesses can also be turned into strengths. Oral history is subjective, but by being subjective it offers a new insight into what is known, and reveals unknown aspects to know events. For my research oral history offered a great chance to show the gender reassignment procedure in The Netherlands, as practiced by the VU Medical Centre, from another perspective, namely the perspective of transgender children and adolescents. By using unstructured interviews as a method, in which I was very aware of my relationship towards the interviewees, I hope to have contributed to new narratives and stories from this usually unheard perspective.

Chapter 3: The VU Medical Centre as regulatory power (and the need to convince them)

There are several issues that reoccurred during the interviews. To structure these issues I made a division in the following two chapters. First I will go more in depth on the relationship between the gender team, and the people I interviewed. During the interviews I noticed that, even though I did not ask for it explicitly, all interviewees felt the need to convince the gender team of the fact that their transgender identities were real, and that they needed to go into transition. Also the sense that there was a power relation between the gender team and the interviewee came back in almost every interview. Secondly I will, in chapter four, go more in depth on the visible gender binary, and the medicalisation of the gender reassignment procedure. Here, issues like stereotypes on femininity and masculinity, and the pathologisation of trans people are discussed. The reason I made this specific division is because in the topics discussed in chapter three, the ambivalent relationship between the VU Medical Centre and the interviewees became very clear. In the narratives discussed in chapter four, this relationship was not of importance; they pinpointed much more the vision, and the protocol of the VU Medical Centre.

But before diving in to these interviews, I must give an overview of the existing research that is done regarding transgender children and adolescents in The Netherlands. I have chosen to focus on a selection of the studies that are done instead of on all existing research. The reason for this is that I merely want to indicate the different types of research that are currently done. This way I can show to what extent the stories of the interviewees differ from, or add up to, the existing research that is done on the gender reassignment procedure in The Netherlands.

Existing research

There are several articles that give insight in the gender reassignment procedure of transgender children and adolescents in The Netherlands. In "Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study", Annelou de Vries compared 'psychological functioning and gender dysphoria before

and after puberty suppression in gender dysphoric adolescents' in The Netherlands[16]. This research showed that suppressing puberty with the use of puberty blockers, which prevents adolescents from developing secondary sex characteristics, is indeed a valuable contribution when it comes to clinical management of transgender adolescents. Even though symptoms like anxiety and anger did not change with the use of puberty suppression, behavioural and emotional problems and depressive symptoms did decrease, and general functioning improved (de Vries, et al. 2276).

'Adolescents With Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-up Study' is a research project, done in The Netherlands, that evaluated the outcome of early sex-reassignment surgery, and the decision not to allow them to start sex reassignment at all or at an early age. The transgender adolescents were tested on their psychological, social and sexual functioning. This research showed that careful diagnoses and strict criteria are necessary to justify hormone treatment for transgender adolescents. It also showed the sufficiency of allowing transgender adolescents to go into the procedure. None of the operated trans people had regrets concerning their surgery, and they were psychologically and socially functioning well (Smith, et al. 472).

'Sexual and Physical Health After Sex Reassignment Surgery ' is a long-term follow-up study that evaluated the sexual and physical health of transgender people who had sex reassignment surgery in The Netherlands. Research showed that in general the sexual health and physical health was all right, and that the sexual organs were functioning like they should. Health problems that did occur were directed to age and bad habits. The problem that was reported most regarding the sexual health was pain during intercourse (de Cuypere, et al. 679).

Joost a Campo, Henk Nijman, H. Merckelbach, and Catharine Evers questioned the early treatment of transgender children and adolescents in The Netherlands by looking to what extent gender identity disorder could be distinguished from a cross-gender identification that is secondary to other psychiatric disorders (Campo, et al. 1332). In their article, 'Psychiatric Comorbidity of Gender Identity Disorders: A Survey Among Dutch Psychiatrist', they explain that, to get results, they sent out a survey to 382 Dutch psychiatrists. According to this research the data suggested that there was little consensus among Dutch psychiatrists, about diagnostic

[16] In this part of the chapter I will use words like gender dysphoria, treatment, and surgery more often, to indicate what kind of terminology is used by these researchers

features of gender identity disorder or about the minimum age at which gender reassignment procedure is a safe option (Campo, et al. 1332). According to them more specific diagnostic rules were necessary.

There is a significant amount of research on the gender reassignment procedure in The Netherlands. Nonetheless the focus of these articles is mostly on the procedures themselves. Articles about the experiences of transgender people are rare. And if they exist, they are still written from a medical point of view, with measurable entities and quantities as the most important aspects of the research.

The biggest gap in the existing research is that currently the focus is almost solely on male-to-female and female-to-male transgender people. Especially with the follow-up studies of the medical procedure, the main focus is on transgender people who desire sex reassignment surgery. Research (from a medical point of view) about transgender people who prefer to be genderqueer, and want to live without sex reassignment surgery, is very rare.

Now I have set out what research, and especially what type of research is done on the gender reassignment procedure of transgender children and adolescents in The Netherlands, I can show to what extent the stories of the interviewees differ from this research, or add up to it.

Interviewees: an overview

Before going in depth on the personal stories of the interviewees it is important to start with some basic information. This is necessary to understand the following analysis.

Cecil is a twenty-year-old transgender person who identifies as agender[17]. Cecil had their[18] first meeting at the VU Medical Centre when they were sixteen years old. Cecil had a mastectomy[19], and hysterectomy[20] but deliberately chose not to take hormones. The reason they chose not to take hormones is because it changes your body in a way that Cecil did not want it to change. The total length of the period that Cecil was seeing the gender team was almost four years.

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17 When someone identifies as agender this means that the person does not feel comfortable with being called male nor being called female

18 Cecil prefers the gender pronoun them/they, that is why I will address Cecil with them/they throughout this research

19 'Mastectomy' is the medical term used for the surgical removal of one or both breasts

20 'Hystectomy' is the medical term used for the surgical removal of the uterus

Nick is a twenty-nine-year-old transgender man who identifies as male. Nick had his first meeting at the VU Medical Centre when he was seventeen years old. Nick underwent hormone treatment, a mastectomy, and a hysterectomy, but deliberately chose not to do sex reassignment surgery. The total length of the period that Nick was seeing the gender team was 3,5 years.

Stephen is twenty-seven years old, and he also identifies as male. Stephen had his first meeting with the gender team when he was nine years old. Stephen is the only one I interviewed who did the “full transition” which means that Stephen also did the sex reassignment surgery. The total length of the period that Stephen was seeing the gender team was twelve years.

Danny is twenty-one years old, and identifies as male. Danny had his first meeting at the VU Medical Centre when he was seventeen. Danny had hormone treatment, a mastectomy, and a hysterectomy, but no sex reassignment surgery. The reason for this is because Danny thinks the operation techniques are not developed enough yet. The total length of the period that Danny was seeing the gender team was four years.

The analysis

In the following part of this chapter I will go more in depth on the actual analysis, and I will do so according to the following topics. First I will go more in depth on how all interviewees felt that they had to convince the gender team. Then I will touch upon some of the positive memories that were told during the interviews, followed by some memories that showed the great laxity of the VU Medical Centre. I will end with explaining how there was a visible power structure between the VU Medical Centre and the interviewees, and how the VU Medical Centre functioned as a regulatory power in their narratives.

3.1 The need to convince

Throughout the interviews I found out that the relationship between the gender team and the transgender people I interviewed was very ambivalent.

First of all, everyone I interviewed felt the need that they had to convince the gender team, to get what they wanted. But there were big differences in how this manifested itself though.

Take Cecil for example. Because Cecil had such a specific wish for their procedure, namely a mastectomy and hysterectomy but no hormone treatment, it was unsure if they were going to get the green light for the operations. Cecil strongly felt the need to get something out of the gender team, namely the diagnose for gender dysphoria, to be able to move on. According to Cecil this definitely led to a tenser atmosphere during their conversations with the gender team:

Especially in the beginning I really felt that I had to wear manly clothes, and had to wear my hair short, because I thought that suited me best. I did that for a few months, but I'm never doing that again. It doesn't suit me at all! So after I went to the psychologist with my hair short, new clothes, and a new name, at one point I decided that this also wasn't really it for me. But then you have to make sure that your psychologist doesn't get the idea that you are not transgender at all. I was still transgender, I just was not as manly as I thought I would be. But how do you tell this to your psychologist without risking that she gets a wrong image of you? Every time when I had a meeting I was struggling, and I was constantly doubting if I could say certain things or not. There wasn't really a relationship built on trust. (Cecil)[21]

Cecil knew what they wanted, but was aware of the fact that there were certain things that were better not to say, to be able to get where they wanted to be.

Stephen was only nine years old when he had his first meeting with the gender team. Because he was so young, he did not feel that he had to withhold any information. He said everything that came to mind, without fearing that the gender team would judge him on that. But he also indicated that, even though he was so young, he was already aware of the fact that he needed to convince the gender team.

For example they had an observation room with a one-way mirror. This room was filled with toys. On the one side you saw Barbies and that kind of stuff. On the other side there was Lego, and toy guns. By looking at all those toys I thought, 'I don't give a shit about either!' I had to pick a toy to play with, but the toys didn't do anything for me at all. At one point I just wanted to pick something to please them, to get it

[21] Every quote in this analysis is translated in English by me, since all the interviews were done in Dutch. If requested, the original interviews can be listened to in Dutch

over with. As young as I was, I still saw that this was such a failed experiment. In the end I really picked up the gun to please them, that is how it felt for me. (Stephen)

Later on in the procedure, the need to convince started to get stronger. During his appointments with the gender team he was pretending that he was feeling better than he actually did, in the hope that this would speed up the process.

What is in it for me? To tell people that it's a fucked up situation? A situation that I cannot deal with? It will not help me to speed up the procedure. Even worse, I was afraid it would set me back. Of course I did mention from time to time if things were not going so well. But mainly I tried to stay positive, just to show the gender team that I was ready, that I was strong enough, and that I knew what I was doing. (Stephen)

The need that Stephen felt to convince the gender team was twofold. At the one hand he felt the need to convince them of the fact that he had "masculine interests", and on the other hand he felt the need to convince them of the fact that he was strong enough to start the gender reassignment procedure. Danny also mentioned that he had the feeling that he had to convince the gender team. But for Danny this did not have a negative connotation. When Danny told about the first time he set foot in the VU Medical Centre for an appointment, it did not take long before he started talking about the need to convince:

During the intake you immediately get appointed to a psychologist. It feels like you have to convince them, to show them that what you want is real. In my case, this meant that you have to show that you really feel like a man. (Danny)

When I asked Danny where he thought that this feeling came from, he answered in a very practical manner:

Well they see so many different people, and they all want help. Some people just seem to doubt more than others, and some people might regret it. So yes, of course they want to make sure that this is really what you want. I totally get that. (Danny)

And Nick, even though he did not literally mention that he felt the need to convince, was very aware of the fact that it was better not to mention certain things. For example that he used to play with dolls as a kid, that he practiced ballroom dancing, or that he liked shopping. He was aware that he did not fit the stereotypical conception of masculinity, and he felt like the gender team did expect him to fit in this stereotype.

The way that all the interviewees feel the need to convince the gender team, and are inclined to withhold certain information from the gender team, resonates very well with what I discussed earlier on about the research of Dean Spade. According to Spade, medical professionals reinforce the gender binary because only a small group of transgender people, namely the people who desire a full transition from female to male (or the other way around) are "allowed" to go into transition. To work around this, transgender people feel the need to lie about themselves, or exaggerate certain characteristics, to get the procedure they want.[22] This is exactly what happened with Cecil, Stephen, Danny and Nick. All four of them were aware of the fact that there was a certain narrative that they had to fit into. This manifested itself in a sense that they would withhold certain information that did not fit into this narrative, to get the procedure they want. Also according to Spade, there is a big difference between how transgender people construct their idea of gender identity and how the medical professionals see it (Spade 315). This was also very evident in the interviews. Cecil, Danny and Stephen felt that there was a certain rigid view on what it entails to be a man, and this view was something that they did not share. This eventually led to that they exaggerated their stories, and hid certain aspects of their identity.

The gender team's vision on who can get surgery and who can not also naturalises gender, and functions as a regulatory power. With Stephen's case for example, there was a power relation that defined what was the truth, already before he stepped into the observation room. There was no room for him to show who he was, there was only room for what is deemed as "typically feminine" and "typically masculine"[23]. Or with Cecil, who so clearly knew their own identity, but was constrained by what was expected from them. Cecil's story shows that when the "truth" on gender is already so clear beforehand, it leaves no room for genderqueer

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[22] This theory was discussed more extensively in chapter one, on page eleven and twelve

[23] When I say "typically feminine" and "typically masculine" the traits that are assigned to males and females in the social construct of the Western culture

people to express their own identity. The problem here is not "fundamentally lying in the project of gender change or body alteration, but in how the medical regime permits only the production of gender-normative altered bodies, and seeks to screen out alterations that are resistant to a dichotomized, naturalized view of gender" (Spade 319). A regime like this unfortunately excludes people like Cecil.

3.2 Positive memories

Several positive memories came to the surface as well, and those deserve to be mentioned. The most recurring positive memory was the feeling of being acknowledged, after receiving the phone call in which was said that the interviewees got their green light for the hormone treatment or operations.

When I asked Nick which memory made the biggest impression on him he told me:

The most important thing for me was the phone call in which they said, for us it's clear, you have green light for everything. It really made me feel acknowledged. Because, you know, you've been working on it for a year. What if they just say, we are sorry, you can go home? In a sense, they decide on your life. (Nick)

Stephen also affirmed this feeling during the interview. For him, because he was one of the first transgender children who started the procedure, the protocol was still very strict. Even though he started seeing people from the gender team from age nine, the protocol said he had to wait until he was fourteen before he could start the puberty blockers.

Back then, when I was eleven, the gender team told me that it was clear for them, once I would reach the age of fourteen I could start with puberty blockers. This piece of acknowledgement was extremely important for me. The diagnostic phase lasted for a very long period in my case, and I had a lot of conversations with psychologists. Every conversation leads to new questions, new doubts, and just puts your world upside down again. The more people ask about your identity, the more insecure you can get. So yes, the moment that I got the acknowledgement that they thought that what I had was real, was of great importance for me. (Stephen)

The fact that the gender team already told him that he had green light for the gender reassignment procedure made a huge impact on him. For Stephen it was very important to get this acknowledgement.

For Danny, this acknowledgement even came earlier than he had expected. Danny, who had a very good relationship with his psychologist, had been using hormones for not even a year. Normally, you have to live as your desired gender, and use hormones, for at least one year. After that year, the gender team makes the decision if you can move on to the next phase, namely the operations. Danny got the relieving call from his psychologist earlier than expected:

The fourteenth of May I would be on hormones for precisely a year. I was very curious to know when the gender team would discuss my case. My psychologist said this would be in the beginning of May. Totally unexpected I got a phone call in April, that I had the green light for the operations. This made a major impact on me. I think he did it because he was so sure that this was what I really wanted, he had no reason to wait any longer. (Danny)

The cooperativeness of the gender team also reoccurred in several interviews. Firstly there was Danny, who, even though he wanted to transition, and identified as male, still had a desire to have children:

Because I had a desire to have children I had a hard time deciding if I wanted to start with hormones. My psychologist really made an effort to look at possible solutions, for example starting the real-life phase without hormones, then do a mastectomy, but leave the womb in. He really supported me in making my decision. (Danny)

During the conversations with his psychologist Danny felt heard, and he felt like his psychologist was very cooperative in finding solutions in which Danny could transition, and still bear children.

Cecil also felt that the gender team was cooperative, in the sense that they really did an effort to understand the situation that Cecil was in, and the specific wishes that they had. Even though their psychologist failed to understand it for a long time, the fact that she kept trying did make an impact on them. When I asked Cecil about what memory stuck the most:

Well it's not really one specific moment, but what I really appreciated is that at one point I noticed that the gender team was really working with me to find a solution in which my specific wishes could be realised. It still had to go according to protocol, but they really fought hard to find a way in which I could participate in it. Eventually they really were open to it, and that made a big impact on me. (Cecil)

3.3 Disconnected and uncaring: the laxity of the VU

Besides the ability to be compassionate, and to think of solutions for the specific wishes of the interviewees, there are also several stories in which the gender team seemed less empathetic.

Take Cecil's case for example. Cecil really looked forward to getting the call from the gender team, in which they would say if Cecil got the green light to go further in the procedure.

After one and a half years of appointments, you are pretty much dying for these results. Especially because, considering my wishes, I really was not sure if I would get the green light or not. (Cecil)

By the time Cecil was supposed to get the call, they were at a music festival in Germany. Regardless of the fact that they had raging loud heavy metal music all around them, when Cecil did not receive a call, they decided to call themselves:

I just had to know, so I called. First I spoke with someone who said to have no idea, but who did confirm that the gender team had their meeting already. She said she would call me back, but of course, she didn't. Eventually, after waiting for a couple of hours, I decided to call again. Finally I reached the head of the gender team, who told me, in the most nonchalant manner: 'oh yes of course, you have the green light.' My whole life depended on that diagnose, and they said it to me with a sort of 'Oh? Didn't you know this already?' The VU just really isn't very considerate with issues that are of major importance for patients. (Cecil)

The fact that the gender team treated something that was of such vital importance for Cecil with such indifference really made an impact on Cecil. Besides Cecil, Stephen

also felt like there were issues that were treated with great laxity. When Stephen turned sixteen he could finally start hormones, something that he had been looking forward to for many years:

On the day of the appointment, when I arrived in the hospital, the endocrinologist[24] *told me I should have had made a bone scan. Without that bone scan, she could not do anything for me, and I could come back in 2 to 3 months. At that point I felt completely lost. I waited so eagerly for this moment. Luckily, in the end there was a nurse who did understand how extremely important this moment was for me, and she pulled some strings to schedule an appointment for me the next week. The others just simply said: well, according to the computer we can only make an appointment in 2 months. The worst part is that my endocrinologist wanted to make very clear that this was my responsibility, which is complete nonsense.* (Stephen)

Also for Stephen, this experience is something that should not be taken lightly. This narrative exemplifies really well how devastating it was for him, especially after having to wait for such a long time for his gender reassignment procedure.

As it has become clear from the stories of Nick, Cecil, Danny, and Stephen, the gender team has a very big impact on the lives of transgender children and adolescents. They can decide on your life. If handled with care, this can leave a positive memory. It can give transgender people the acknowledgement they deserve. But the stories of both Cecil and Stephen show that there can also be a lack in empathy regarding certain milestones that are of great importance for the interviewees.

By comparing these positive memories with the examples in which the gender team showed a lack in empathy, it shows what a huge difference it makes if the medical staff expresses that they care. The extent to which they do seems to be crucial to the experience of the interviewees. According to Sally Hines, who expands in her book 'Transforming gender: Transgender practices of identity, intimacy and care' about the importance of good quality of care for transgender people, "the need for greater education about transgender issues is a major theme within narratives of care" (Hines 168). Not only with regard to carers in home settings, but also general

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[24] Endocrinologist is the medical term for 'hormone doctor', and is the person you have to see when you want hormone treatment

practitioners and the medical staff in a hospital should be educated in the care of transgender people (Hines 168). This is evident in the interviews as well. Cecil and Stephen both mentioned that certain aspects that were of such vital importance to them were treated with such laxity. The gender team seems to be unaware of the importance of these issues. But at the other hand, as the stories of Danny, Stephen, and also Cecil tell us, when the gender team understands the importance of certain milestones within the procedure, and treats each case with good care, this can have a major positive impact on the transgender people involved.
To really show the importance of the relationship between the gender team and the transgender person, and a good quality of care in The Netherlands, more research is necessary.

3.4 The VU as regulatory power

During the interviews I noticed that the VU Medical Centre was seen as a regulatory power by several of my interviewees. Danny was the only one who felt that there was a completely equal relationship between him and his psychologist. He told me that he had a very pleasant relationship with his psychologist. He felt like his psychologist was simply there to help him, and did not feel like he pretended to be something more than Danny.

The other interviewees had different experiences though. They experienced their relationship with the gender team as very difficult. Cecil as well as Stephen both felt very dependent on the VU medical centre, and felt that the gender team had complete authority over them.

For Cecil, this was extra evident because their specific wish for their transition was something from which they did not know if anyone else had ever done it before.

It felt like I had to overcome a huge obstacle, namely the whole system and protocol of the VU. You really have to follow their steps, and you have to do this based on their requirements. And even then it is still uncertain if you fulfil these requirements. At one point I started to think: what on earth can I do to convince the big bad VU to give me what I want? This really gave me a lot of stress; I had a hard time with this. (Cecil)

When looking at Cecil's situation it can be said that Cecil wanted something that did not fit the concept of "gender dysphoria" the way that the VU Medical Centre envisioned it.

As mentioned earlier in chapter one, the VU Medical Centre can be described as a regulatory power. They are the ones who decide if a transgender person can go into the gender reassignment procedure or not. Besides that, the VU Medical Centre also makes up the protocol in which the whole procedure is described, and which requirements one must meet before being able to go into the procedure. This protocol can be seen as the knowledge that is produced by the regulatory power, namely the VU Medical Centre. This is really evident when looking at Cecil's quote, and at how Cecil experienced their relationship with the gender team. For Cecil it felt like the VU Medical Centre functioned as a regulatory power, and that the knowledge that this regulatory power produced, was not the type of knowledge that applied to Cecil. As a result, Cecil had the feeling that they had to work around this, and this was not easy for them.

It is kind of an abstract feeling. There is this system, made up by a certain group of people, which is really standing in the way. The longer you are waiting for your diagnose, the more insecure it gets, and the more stressed out you feel. This really gives an enormous amount of pressure. At a certain point it starts to feel it is Me Vs. Them, I even felt oppressed in a way. (Cecil)

Following Foucaultian scholarship, one must recognise that power creates knowledge, and that these two are always intertwined. Not only must we be aware of the fact that the VU Medical Centre functions as a regulatory power, we must also be aware of the fact that a product of their power is also the knowledge that transgender children and adolescents come to acknowledge as the truth.[25] Even though it did not make Cecil doubt their own identity, the VU's vision on what it meant to be gender dysphoric had a huge impact on them since it is this vision that decides what the norm is. If one does not fit this norm, one can feel the need to fulfil requirements that they do not feel comfortable with, which was clearly the case with Cecil.

[25] This theory is discussed earlier on in chapter one of this research, on page 9

Nick also had his problems with the authority of the gender team. He told me that the VU Medical Centre can decide not to operate on someone who is overweight, or someone who smokes, because of the increased risk on complications. He himself had several unpleasant experiences regarding this measure.

I used to smoke. During one of the meetings at the VU I had a pack of cigarettes in the front pocket of my shirt. At one point she pointed at my chest and said: 'that's a pack of cigarettes you have in your pocket, am I right? You know that I can stop your operations if I don't approve that you're smoking, right? (Nick)

Nick explained that, even though he agrees that you should be made aware of the dangers, he thinks that it is your own responsibility, and that the VU Medical Centre should not decide on your body.

The fact that Nick was overweight never was a problem, since it was solely due to the hormone treatment that he gained so much weight. When he had a mastectomy that was very poorly executed, this changed. Besides the fact that his nipples were very uneven, his breasts were not reduced enough in size. After the surgeon who did this refused to correct it, and gave as reason that 'fat guys simply have breasts', Nick was desperate.[26]

I waited a few years, lost a few kilos, and eventually I went to the VU. The surgeon there looked at it, and did agree that the other surgeon did a very bad job. But, this surgeon also told me that he was not going to operate me, because I was overweight. When I told him that I was not a medical risk what so ever, he answered me that he does not operate overweight people, because the result is not so beautiful. I had to lose 12 kilos before he would operate on me. (Nick)

Finally, after having to walk around with this for more than seven years, he found a surgeon at Slotervaart Hospital who agreed to operate on him.

Nick's situation is a striking example of what Susan Stryker explained about how, for the medical staff, the naturalness of a trans body is more important than the functionality of the body. According to Stryker, the agenda that produced hormonal

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[26] The first operation was done by a surgeon of het OLVG hospital, not by someone from the VU

and surgical gender reassignment techniques is pretentious, and has little to do with the personal wellbeing of transgender people ("My Words To Victor Frankenstein" 248). The main goal to be achieved by the medical staff is an endeavour to triumph over nature, to pursuit immortality through the perfection of the body (Stryker, "My Words To Victor Frankenstein" 248). In Nick's case, the cultural politics on what is deemed as "beautiful" are leading in the decision not to operate on him, while instead the wellbeing of Nick should be leading. It is very troubling that arguments on what is deemed as beautiful by the surgeon are even taken into account in this procedure.

To conclude

Hopefully with this chapter I have shown the ambivalent relationship between the gender team at the VU Medical Centre, and the transgender children and adolescents that come to see them because they want to transition. Even though there are definitely positive aspects - it has shown that when the gender team acknowledges the importance of their issues the procedure is experienced as something positive and pleasant - there is a lot of room for improvement. It is evident that there is a very visible power relation at play here, and that the interviewees really felt the need that they had to convince the gender team. Hopefully I have shown that strict protocols, and power relations have a negative impact on the experience of the transgender children and adolescents, and a negative impact on the prosperity of the procedure. When the VU Medical Centre agrees to look beyond their protocol to seek for solutions, as we have seen with Cecil's wish to transition without hormone therapy, and Danny's wish to transition but with the possibility to still be able to bear children, a fruitful and cooperative process is eventually possible.

Chapter 4: Gender norms at the VU Medical Centre: is there enough room for everyone?

In the previous chapter I gave more insight in how the relationship between The VU Medical Centre and the interviewees was experienced as very ambivalent. This next chapter will be structured as follows: first I will explain how the VU Medical Centre has a very strict vision on what is considered masculine, and what is considered feminine. This shows in a way that, even though three out of four interviewees identified as male, they still all had the feeling that they could not fulfil the expectations of the gender team regarding masculinity. After that I will go more in depth on how the importance to "pass" as a natural gender was felt during the gender reassignment procedure, and on the negative influence this had on the interviewees. Finally I will explain how the term "gender dysphoria" is extremely medicalised, and how this pathologises the interviewees by making them believe that they have a disorder.

4.1 Thinking in binaries

One of the recurring topics during the interviews was the binary thinking of the VU Medical Centre. Even though three out of the four people I interviewed identified as male, they still had their issues with the gender team's vision of masculinity and femininity.

Take Nick for example. Even though Nick identified as male, he still felt that he did not meet the requirements. According to Nick, the VU Medical Centre had a very stereotypical view on masculinity, in which there was only room for characteristics and interests that were deemed "masculine" by Western society. He felt that his sense of masculinity was not masculine enough for the gender team. During the interview Nick told a striking story about the day he decided to wear a pink shirt to an appointment:

When I arrived I immediately got comments on the fact that I was wearing pink. They said 'hey! You're wearing pink! Pink is for girls, and for gays.' My reaction was 'yes, so what? What if I am gay?' I immediately regretted it, because my comment led to an

excessive amount of questions about my sexuality. But I really did not feel like talking about that. For me it had nothing to do with why I was there. (Nick)

The gender team saw the fact that Nick was wearing pink, and the fact that he could possibly be gay, as a sign that he was not masculine enough. To be legitimised as a "real man" (or woman) apparently one must be heterosexual. According to Judith Butler, the 'natural' attraction to the opposing sex/gender is also socially constructed, and serves reproductive interests ("Performative Acts" 524). According to Butler, this compulsory heterosexuality is "reproduced and concealed through the cultivation of bodies into discrete sexes with 'natural' appearances and 'natural' heterosexual dispositions" ("Performative Acts" 524). Nick did not fit in this social construct, and therefore he challenged the norm. By not fitting in this discrete gender with 'natural' heterosexual dispositions he was deemed as not masculine enough by his psychologist.

Nick felt like the gender team was really trying to categorise him, and push him in a certain direction, regarding his interests. For example, when he mentioned that he liked reading, his psychologist responded:

Okay, but there are way more women than men who read. Or do you mean you read comic books? (Nick)

And the fact that he did not practice a ball sport was also something that was doubted by his psychologist.

I told her that I did fitness, squashing and that I cycled a lot. But she kept on asking: and what about soccer? Are you not practicing soccer? Or some other ball sport? Don't you like ball sport? I thought by myself: should I necessary do some kind of ball sport? Is soccer the only sport that men can do? (Nick)

Even though Nick proclaimed that his interests are mainly interests that are seen as masculine, he still felt that everything he said was labelled as feminine or masculine. During the time that Nick was transitioning, a "full transition" was the norm. When he decided to stop after his mastectomy and hysterectomy, he experienced a lot of incomprehension from the side of the gender team. They never said it directly, but in

comments like ‘but if you decide to, just like the others, finish the whole process’ and ‘don’t you want to be a full man then?’ Nick really felt that they did not understand. This example shows very well how, according to Dean Spade, the medical professionals who have the power to say “no” or “yes” to a request for transition, only reinforce the gender binary (Spade 315). By not understanding that some people perhaps do not want the “full transition” they keep a very strict vision on gender.

Nick was not the only one who felt that the gender team had certain expectations regarding his transition. Stephen, who was one of the first participants in the procedure for children and adolescents, said that once the gender team had diagnosed him with gender dysphoria, they assumed that he wanted to take all the steps, and do a full transition.

There was no middle ground back then. In my case this was not really a problem. But if I look back at it now, I must admit that it was assumed quite easily. (Stephen)

In the previous chapter I mentioned the anecdote in which Stephen had to go into an observation room filled with toys, and he had to pick a toy to play with. Stephen felt that these toys were a very stereotypical representation of masculinity and femininity. This had as a result that he did not want to play with any of the items, and it even made him doubt his own identity.

It is not that I felt genderqueer or anything, but it just felt like they put me on the spot. Because I did feel like a man, just not like the type of “man” they reduced it to. (Stephen)

Both quotes show how a stereotypical masculine identity was projected upon Stephen. He did acknowledge in his stories that he was one of the first participants, and that a lot has changed since he started his transition. But still it felt like in the time of his transition a full transition was the norm, and he did not really had a choice.

Cecil also struggled with the VU’s perception of the gender binary, but for different reasons. Cecil experienced a lot of difficulties with their psychologist who was trying, but failed to understand that Cecil identified as agender.

She couldn't understand how I experienced my gender, and the fact that I felt neither male nor female. I kept explaining time after time, but it didn't connect with her. Eventually she had to call upon a second psychologist, who helped her in understanding my situation. (Cecil)

When I asked Cecil how this was expressed, they answered:

She kept on asking the same questions over and over again. And she really did not understand why I would want to transition, if I didn't identify as a man either. But for me it was simple: I feel better when I have an 'M' on my passport instead of an 'F', that suits me a bit better.[27] *Preferably I wouldn't have either of those on my passport, but unfortunately that is not possible. She really couldn't grasp that, I could explain it to her hundreds of times but it did not connect. It is funny how easily I can recite this now, I had to tell it to her so many times.* (Cecil)

Cecil struggled because they wanted something that was not in line with the protocol of the VU Medical Centre. Cecil's explanation about the 'M' on their passport is a very striking example of how hard it can be for a genderqueer person to function within the existing social system. But even though Cecil's psychologist kept failing to understand Cecil's situation, for Cecil this is a memory that also has a positive connotation.

But the fact that she was trying really hard to understand me already helped a lot. It made me feel heard. (Cecil)

For Danny the dichotomised thinking of the VU Medical Centre was never an issue. As I mentioned before in the previous chapter, his psychologist was very considerate, and really made an effort to find a solution for Danny's wish to bear children. For Danny this was very important. This example shows a different perspective, namely

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[27] Up until 2014 one of the requirements to be able to change the sex on your passport from female to male was that you have had a hysterectomy.

that even though Danny wanted to transition, and identified as male, the gender team was still open to look at options in which he could still bear children.[28]

When I asked Nick if there was anything that he wanted to say to the VU Medical Centre about the gender reassignment procedure, he responded with something that really exemplifies well how the gender team thinks in binaries:

It is not a matter of one size fits all. You can't assume that all transgender people fit the same outfit. Even though the VU is getting less strict with it, their basic principle is still: if you are a man, you have short hair, you're tough, strong, you have a big mouth, you show no emotions, and you have masculine interests. They really have to let go of this, and look at people at a more individual level. (Nick)

Three out of four interviewees felt the need to comply to the idea of a gender binary. They felt that the VU Medical Centre had certain ideas on what masculinity and femininity is, and they did not comply to this vision. Besides that, there was not enough room for them to choose to not go for a full transition. They stumbled against a lot of incomprehension.

According to Judith Butler, but also many other scholars from the gender studies and transgender studies field[29], this is because there is a social construct that heavily influences us. It influences us in how we envision femininity and masculinity, and it causes gender binary thinking. It does not give enough choice to freely be who we want to be. According to Butler "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" (Butler, "Undoing Gender" 7). These social norms were very evident in the interviews. Almost all interviewees felt like there were social norms that were putting pressure on them. Their choice of identity was limited due to these norms. If one cannot fulfil these norms, these expectations, it has punitive consequences. "Discrete genders are part of what 'humanizes' individuals within

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[28] Because for Danny this was such an important memory I shall not go into further detail about why it is remarkable that the only way that the VU Medical Centre deviates from their strict gender norms is to serve the normative patriarchal ideas about the sancity of life, and the need to (almost) always support those who want to have children. It would be interesting to conduct furhter research on this remarkable fact though.

[29] Simone de Beauvoir was one of the founding scholars with her famous "one is not born ; but rather becomes, a woman" quote, but scholars like Judith Butler, and also Kate Millett who wrote the, in the 70s very infuential book, "Sexual Politics", stated pretty early on that that gender differences are culturally- and not biologically based.

contemporary culture; indeed, those who fail to do their gender right are regularly punished" (Butler, "Performative Acts" 522). The interviewees were punished in the sense that their decisions to not go for a full transition, or to not solely have "male interests" were heavily frowned upon.

But it is too short sighted to say that narratives around femininity and masculinity, and transgender narratives, are solely limiting. Henry Rubin claims that these narratives can also function as tools that are used by trans people in a very welcoming way to describe, and make sense, of their own identity (Rubin 498). It can provide tools to describe their own transgender identity to others, and to themselves for that matter.[30] With Danny for instance, who never felt the need to comply to a gender binary, and who experienced his meetings with the gender team as very pleasant, it was nice to get more insight into his own identity, and it provided him with tools to talk about his situation.

4.2 The Politics of Passing

By acknowledging that there is a gender binary, one agrees that there are only two options; you are either male or female. By doing so, one starts taking it for granted, because 'that is just how it is'. A sense of gender as being something natural that you are born with is created, and in this sense gender gets naturalised. Unfortunately in this naturalisation of gender there is no room for people who feel genderqueer. When looking at this naturalisation of gender, something that is deemed by many as important is the politics of passing.[31] The importance to pass as a "natural gender" came to the surface in several of the interviews. But the gender team mainly initiated this importance, not the interviewees themselves.

Nick mentioned that the first time he noticed that passability was something that was deemed important by the VU Medical Centre was when he read their brochures about gender dypshoria.

I have read terrible things in the folders that were distributed by the VU. Not alone did they contain warnings for increased chance in depression and unemployment. It also contained stuff like if you are 1.50m or smaller and you identify as male, or

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[30] This theory was discussed earlier in chapter one of this research, on page thirteen

[31] This theory was discussed more extensively in chapter one of this research, on page ten and eleven

1.80m or taller and you identify as female, the chance in passing is very small. Since I am only 1.60m myself, I got extremely discouraged by these folders. (Nick)

Besides the folders, Nick's endocrinologist also gave him a hard time about his height. When Nick was finally ready to start hormone treatment, she commented on his length and said that, because he was so small, it was weird that he was starting hormone treatment. For her it was almost impossible to understand, since he was even smaller than she was. She very much laid the focus on his passability.

This desire to pass, which can be explained as the desire to pass as a cisgender person,[32] is in itself already problematic because it supports a naturalisation of the gender binary. And especially if this desire to pass is something that is not felt by one self, but is implied by others, it can be very hurtful. But besides that, the comments of the endocrinologist about Nick's height, and the comments that Nick read in the brochures of the gender team, are also very problematic because of the ethnocentric, and racist connotation that it has. In both cases the Dutch heights for men and women are considered to be the universal norm. It is not considered that Dutch people are, on a universal scale, very tall people. In other ethnic, and geographical contexts a man who is 1.60m high is not considered unusual at all.

Cecil never cared about passing, and had their own identity very clear from the start. But Cecil's psychologist kept on hammering on the practical issues of their appearance and identity.

She questioned really practical things, why I did not want to wear my hair short, and why I liked certain clothing. Also she kept asking things like how I thought that this would work later on in life, how I would ever have a romantic relationship with someone. At that point I really thought, that is not my problem! We will see what happens when the time comes, but that is not my concern right now. She was extremely focussed on how this would work in practice. (Cecil)

It becomes clear from the quote that Cecil's psychologist was really focused on how Cecil could pass as a "normal" human being. She expressed her worries about how the outside world would react to the genderqueer identity of Cecil. Luckily for Cecil

[32] Cisgender people are people that have a gender identity that matches the sex that they were assigned at birth.

this was not important, they were more focused on how it would work for themselves. For Stephen it was important to pass though. He was just a little kid when he started seeing the gender team. It had a huge impact on him when he started to develop certain characteristics during his puberty that he did not want to develop. But because the protocol of the VU did not allow him to start using puberty blockers before the age of fourteen, there was nothing he could do about it.

I saw that it was going in the wrong direction. My own puberty was starting, and I was changing. But still they wanted to wait until I was fourteen years old. I really developed issues with my own body, I felt removed from my own body more and more, and at one point I was only living in my head. That was the only thing that still felt right. I saw my body developing into the body of a woman, and I knew that was not right. And I thought that the people in my surroundings were seeing this too. Looking back at it, if we hadn't waited that long, things would have been a lot easier. (Stephen)

This quote exemplifies that we must also be careful in the claims that we make about the importance of passing. Even though the idea of passing should not be important, for a lot of people it still is. In Stephen case it can be said that, in retrospective, when he thinks back at the entire procedure he does acknowledge the stigmatising effect of constantly laying the problem with the transgender people, instead of with the system itself:

I think we can feel a lot more pride for who we are, instead of having the idea that we have a problem that needs to be fixed. That we have an identity that counts. (Stephen)

Sandy Stone shares this opinion. According to Stone, the desire to "pass" as a cisgender person has a negative influence on the acceptance and understanding of transgender people. By wanting to "pass" one neglects a substantial part of ones history, because a 'plausible' history has to be created (Stone 230).

Dean Spade, who partly draws from personal experience in his article 'Mutilating Gender', also speaks of the downfalls of this desire to pass. According to Spade, "perhaps the most overt requirement for transsexual diagnosis is the ability to inhabit and perform "successfully" the new gender category" (Spade 322), and that

the favoured indication of this "success" does not come from within the trans people, but from the gender attribution of cisgender people (Spade 322). This is very hurtful, and is something that becomes clear in the interviews.

And why should it even be important to pass? This desire mainly reinforces the naturalised gender binary. Instead we should, as the research of transgender theorists Kate Bornstein exemplifies so well, recognise that the word gender has scores of meaning built into it. Gender is a mixture of bodies, identities, experiences, and behaviours[33] There is so much more than only male, and female, and by pretending there is not, this idea only gets reinforced.

4.3 The medicalisation of trans people

"Gender dysphoria" is seen as a mental disorder. I personally oppose this, and think the pathologisation of trans people needs to stop. Several of my interviewees felt that they were pathologised, and gave very interesting insights in how their transition is being medicalised.

One of the things that came to the surface regarding this topic is how the information of the VU Medical Centre is distributed. As mentioned before, the politics of passing is deemed as very important in these brochures. But Cecil also explained that in the information that is distributed, the social transition[34] is often not mentioned at all.

They lay complete focus on the medical transition, which is weird actually. Especially in the brochures for transgender children and adolescents. It's nice that you describe how the operation precisely works, but this has no relevance for these young people in the first couple of years. The social transition is much more important for them at the beginning. (Cecil)

By only focusing on the medical transition, and not on the social transition, a very medicalised image is offered. The focus is mainly on all the medical procedures and surgeries, one can undertake. This gives of a wrong idea of what it means to

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[33] This theory was discussed earlier on in chapter one of this research, on page eleven

[34] With the social transition is meant: that a person starts to live openly as the gender identity that they desire. This is expressed in the way that a person acts, and dresses on a daily basis. http://www.transvisie.nl/transvisie.nl/index.php/transgenders-transitieproces

transition. During the gender reassignment procedure, some of the interviewees also experienced the feeling that they were pathologised. Stephen for example thinks that, now when he looks back at the procedure, the VU Medical Centre was very stigmatising towards transgender people:

It is so stigmatising to have the feeling that you are the one with the problem. But then when you have done the whole transition, then what? The problem is solved? Well no, it is not. You are still the same person. The problem does not lie with you, it lies with the society that does not know how to deal with trans people. (Stephen)

Through the claim that nothing is solved by saying that trans people have a disorder; a problem that needs to be fixed, Stephen expresses his concern with the pathologising of transgender people. Stephen's quote corresponds very well with what scholars from the transgender studies field are currently saying, namely that it are the structures within our social system that have to change instead of the transgender people themselves.[35] Stephen also mentioned that he felt ambivalent towards the fact that he needed to be diagnosed before he was able to go into the procedure.

I did not want to be diagnosed, because I find it nonsense. Psychiatrically speaking there is nothing wrong with me. But at the same time, being diagnosed is the only way in which the gender team thinks they can know for sure that what you feel is real, and that you can go into transition. You stand with your back against the wall. Saying you don't want to be diagnosed is barely even an option. If you do that, there is a very big chance you won't get "treated." (Stephen)

Stephen really expresses his issues with the medicalisation of transgender people. He knew that he was not ill, and did not have a disorder, but he had to go play along to get what he wanted. This is a concern that is researched extensively by scholars like Dean Spade, and Susan Stryker for instance, as I mentioned earlier in these chapters. Even though I already incorporated Dean Spade's theory from his research "Mutilating Gender" into this research several times, it is again important to mention some of his arguments here. Stephen's story exemplifies really well how the way that

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[35] This was discussed more extensively earlier in chapter one of this research, page eleven and twelve

transgender people envision their identity is different from the way that the medical staff sees it, and that to work around this transgender people have to lie about their identity (Spade 315). If it was up to Stephen he would not be diagnosed at all, but he understands that it is necessary to be able to go into transition. So he decides to just go along with it.

Gender dysphoria was not the only thing that my interviewees got tested on during their many visits with the gender team. Cecil explained to me really well how it felt to be tested for numerous disorders, among which autism was one.

At one point the gender team suspected that I had autism. I already knew that, even if I indeed had autism, it was not affecting my daily life in a way that I needed help for it. But they kept on hammering on that diagnose for autism. At the beginning I went along with them, but at a certain point I realised that was not even mandatory, so I decided to stop cooperating. I did that because I knew, if they suspect autism, they might wait even longer to see if your transgender feelings remain constant. People with autism tend to develop obsessions that last for a couple of months, in which they focus on something very intensively. (Cecil)

These tests had a negative impact on Cecil. Later on in the interview Cecil explained that, because the diagnostic fase took such a long time, and because of the fact that the gender team kept on hammering on the diagnose for autism, Cecil started to doubt their own identity.

Besides the fact that transgender children and adolescents get tested for numerous other disorders, these disorders are often taken out of context. Cecil told me that someone at the VU Medical Centre once said, "I never met a transgender person without mental issues."

Sure, in certain cases transgender people have a mental problem that is completely disconnected from their gender dysphoria. But sometimes it is required that these problems get treated, before paying any attention to the gender dysphoria. This is something that can't be asked, because that's not what the gender team is there for. And on the other hand, there is the possibility that a mental disorder, like depression for instance, comes forth out of gender dysphoria! In that case, treating the mental disorder before getting to the gender dysphoria makes no sense at all. If you are

depressed because you can't live as the sex that you want, you can keep on treating until eternity. (Cecil)

If you have the feeling that your body does not correspond with how you feel on the inside, it is not strange that you might feel depressed, or anxious. But to say that all transgender people have other mental issues is too simplistic, and does not take into account enough the different reasons one can have for being depressed, or anxious.

Danny also mentioned the many questionnaires he had to fill in, about his sexuality, about how he felt, and many other things. Even though Danny thought it was annoying he had to fill it in every single month, he did understand the relevance of it. According to Stephen, all these tests, and questions about his mental health, his relation to others, and so on, had a negative impact on him. When Stephen spoke about the test he had to do in the observation room filled with toys, he mentioned:

The stupid thing is that a test like that can make you doubt your own identity. You start to think: am I supposed to like this? Is this what is expected from me? (Stephen)

Also during the conversations with the gender team, this feeling of doubt occurred.

During the conversations with the gender team the focus was mainly on how I was doing. If I had many friends, how I was doing in school, if I ever felt depressed. I understand that they had to ask those questions to get to the diagnose of gender dysphoria, and to exclude that it was something else. But if you constantly have to answer those kind of questions, if constantly everything is put up for discussion, you really start to get insecure. You start to think things like: what does it mean that I don't have many friends? Am I depressed? Am I suicidal? It can really make you doubt everything. (Stephen)

With both Stephen and Cecil it became very clear that all the tests they had to do, and questions they had to answer, made them doubt their own identity as a trans person. Both of them experienced this as very unpleasant. They were pathologised in the sense that Cecil's identity was linked to autism, and Stephen was constantly questioned about his mental health even though he did not feel that there was psychiatrically something wrong with him.

The way that the VU medical Centre pathologises transgender people and uses the term "gender dysphoria" as a disorder brings into being a certain discourse that can have a negative influence on transgender people.

Sally Hines researches this medicalised thinking through the term "trapped in the wrong body", but her explanation is very well applicable to how the interviewees felt pathologised. According to Hines, the idea of being "trapped in the wrong body" follows medical discourse and reinforces the notion of a naturalised gender.[36] But even though this medicalised term has had critiques, for many transgender people it supports the idea that they have a core gender (Hines 60). As Hines mentioned in her book, we also need to keep in mind "the representations of fixed identities articulated in many transgender autobiographies" (Hines 60). These autobiographies show that the idea of having a fixed identity, or an "authentic gender" which can be brought to the forefront through a gender reassignment procedure, can also function as a very welcoming one.

A naturalised gender is seen as the norm, and the VU Medical Centre imposes this norm in their procedure. But it must be said that this can be very helpful for transgender people as well. When looking at Danny for example, it can be noticed that for Danny there were no issues with being pathologised. For Danny it was a very welcoming way of understanding what was happening with his identity.

To conclude

With this chapter I have shown the way that the VU Medical Centre has a very strict view on masculinity and femininity. All interviewees felt pressured, and felt that they did not live up to the stereotypical notion of masculinity that the VU Medical Centre has. Also I have shown that the protocol of the VU Medical Centre is based too much on a gender binary, and that their focus on the importance of "passing" can have a negative influence on transgender children and adolescents. Passing should not be the highest achievable goal, since this desire mainly reinforces the naturalised gender binary. Besides that, the diagnosis of "gender dysphoria" works very stigmatising, and it pathologises transgender children and adolescents.

But it must be said that the gender binary system of the VU Medical Centre, and their transgender narrative, can also have a positive effect, and can help

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[36] This theory was discussed more extensively in chapter one of this research, on page thirteen

transgender children and adolescents to make sense of their own identity, and to construct their own narrative.

Chapter 5: Conclusions

By conducting interviews with four transgender people between the age of twenty and twenty-nine, and by putting these interviews in a theoretical context, I hope to have shown to what extent the oral history of the personal experiences of transgender children and adolescents in The Netherlands, offers new insights in the gender reassignment procedure at the VU Medical Centre, as practiced until 2014.

These personal experiences have led to several new insights. First and foremost it can be said that the vision of the VU Medical Centre on what is masculinity and what is femininity is too strict. Because of their gender binary thinking, there is not enough room for genderqueer people to express their identity, and even transgender children and adolescents who identify as male or female can have the feeling that they do not live up to the gender norms that are imposed on them by the VU Medical Centre. This results in the need for transgender children and adolescents to convince the gender team of the fact that they really have a transgender identity. They often choose not to mention certain interests, and they even feel the need to lie about themselves from time to time.

Besides that, there is a very ambivalent relationship between the gender team at the VU Medical Centre, and the transgender children and adolescents who come to see them. This ambivalent relationship manifests itself in the fact hat there is a very clear power structure at play, in which the VU Medical Centre is the regulatory power that decides, through a very strict protocol, what the possibilities are within the gender reassignment procedure. Also the diagnosis of "gender dysphoria" works very stigmatising, and it pathologises transgender children and adolescents. Especially for those who do not fit the strict protocol that works from an idea that there is a gender binary, it is very hard.

I hope to have shown that when the personal experiences of transgender children and adolescents are taken into account enough, and when it is taken into account that transgender children and adolescent might not want the "full transition", or might feel genderqueer, it can provide very interesting and valuable outcomes.

Even though a lot of negativity regarding the functioning of the VU Medical Centre came to the forefront in the narratives, there were also some positive accounts. When the VU Medical Centre agrees to look beyond their protocol to seek for solutions, as we have seen with Cecil's wish to transition without hormone therapy for instance, a fruitful and cooperative process is eventually possible

The aim of this research was to contribute to the existing medical transgender discourse, and to approach that discourse from another perspective, namely from the perspective of the trans youth themselves. Besides that, I wanted to show that, even though the existing research focuses solely on male-to-female and female-to-male transgender people, there needs to be room for genderqueer people as well. Through the narratives in this research, I hope to have filled these gaps, by showing the perspective of transgender children, and adolescents themselves, and by showing that there is a considerate amount of transgender children and adolescent who do not want to fully transition from female to male, or the other way around.

This research can provide valuable qualitative data for medical professionals seeking to understand the impact of the past gender reassignment procedure on the lives of people who underwent it. For further research I would suggest that it is necessary to even go more in depth on the personal experiences of transgender children and adolescents in The Netherlands. I have made a start in collecting these oral histories, but to make sure that none of them are forgotten, we must collect more.

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