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OTHERS OF MY KIND: Transatlantic Transgender Histories

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In the Shadows of Society: Trans People in the Netherlands in the 1950s

Alex Bakker

When Christine Jorgensen's 1952 transition gave hope to hundreds of trans people around the world seeking a similar way to become their true selves, it seemed that the near future for trans persons looked bright, especially in the Western European countries of Denmark and the Netherlands. Harry Benjamin thought of the Netherlands as a country with "more enlightened attitudes in matters of sex" and hoped that gender-affirmation surgery could take place there.[1]

In reality, Dutch society at that time offered transgender people very little space, as I explain below. Trans men remained invisible, as they were in other Western societies, because they were hidden or not distinguishable. Indeed there are hardly any sources on trans men in the Netherlands dating before 1959. As a result, the unfolding of transgender history in this time frame largely focuses on the lives of trans women. Trans women did have some sort of recognized existence, though they often worked under precarious economic

Figure 4.1: Aaïcha Bergamin, Dutch trans woman, around 1960 [private collection].

conditions in nightclubs and on the streets of red-light districts. Adult entertainment was often the only way of making a living for trans women who expressed their identity – and by becoming part of the night life, a trans individual was ostracized from the larger society and categorized as morally depraved and/or psychiatrically disturbed. Trans women who did not feel they were up for this life stayed in the closet. Some of them looked for help, talking about their feelings with a family doctor or a psychiatrist. Almost all medical doctors lacked understanding of and knowledge about transgender identities and interpreted the cry for help as a sign of a specific mental disorder – that is, the delusion of being of the opposite sex.

This description of the social situation for trans people will sound familiar to readers of the works of trans historians such as Susan Stryker, Joanne Meyerowitz, Aaron Devor, and Christine Burns about the realities of North America and the United Kingdom. So in which ways did the Netherlands stand out? Was Harry Benjamin right in his optimistic assessment?

Through archival research in the collections of Harry Benjamin and the Dutch psychiatrist Coen van Emde Boas, I traced a network that was formed between these two key figures – the latter in cooperation with Frederik Hartsuiker, who was the first Dutch psychiatrist involved. In the mid-1950s, for a year and a half, the Netherlands replaced Denmark as the place of refuge for trans women (mostly American) seeking gender-affirmation surgery. My guess is that around ten foreign trans women had operations in Holland. How did these pioneering trans women experience their medical treatments; how were they treated by the doctors? What medical and personal views did these Dutch doctors develop? How did they understand or even explain the "transsexual phenomenon," and how did they diagnose and screen trans persons seeking gender-affirmation surgery? Later in this chapter I will explore the archival evidence about surgical options available to trans women in the 1950s.

Due to a lack of support from medical authorities, the route to the Netherlands stopped in 1955, to be followed by Casablanca as the new destination for trans women who wanted surgery. In the penultimate section of this chapter I describe the service Dr. Burou provided there, as well as the possibilities, limitations, and significance of this treatment for trans people around the world. Did Burou's clinic for gender-affirmation surgery, which lasted until the mid-1970s, qualify as an ideal solution? The last section deals with the first case of trans surgery performed within general, public health care in 1959 in the Netherlands. Remarkably, this surgery was openly presented to the public. How did this come about, and what was the response to it?

Transgender People in the Twilight

We know far less about transgender men from the 1950s and 1960s than we do of trans women. Possibly this is because trans men did not stand out, or possibly

it is because they remained in the closet.[2] Transgender women could escape to society's shadows. Joining this subculture was not an option for transgender men, whose freedom of movement was limited by the gender designation on their official identification. People assigned female at birth were dependent on men in all sorts of ways. Until 1956, Dutch married women were prohibited from buying a car or a house, opening a bank account, or undertaking any other legal action without written permission from their husbands. Breaking out of this coercive mould required enormous fortitude. How far could one go? One common assumption is that trans men tried to establish their gender identity by behaving in the most masculine ways possible. Perhaps even some of those who – openly or not – identified as lesbians were in fact transgender men. This could include someone like the Dutch novelist Andreas Burnier, who wrote about androgyny and the struggle with gender identity, for instance in the 1969 novel *Het Jongensuur* (The boys' hour).[3]

Testosterone was identified as the crucial male sex hormone in 1935. Its use as a medical drug only became available in the 1950s, in particular for intersex patients and cisgender men who lacked male hormones. Unlike the female sex hormone estrogen, which was available in tablets and therefore relatively easy for trans women to acquire and consume, testosterone had to be injected intramuscularly. This is not something easy to do by yourself – another factor making it harder for trans men to self-medicate than it was for trans women. A similar difficulty faced trans men seeking surgery. After having performed defeminizing surgeries in Berlin in 1912, Richard Mühsam noted that trans men were also more likely to seek surgery than trans women in the early twentieth century. Unlike trans women, who could surgically self-castrate with a reasonable chance of survival, trans men required a doctor's assistance to remove breasts or the uterus.[4] Despite these complications, it is certain that there were transgender men in the 1950s and 1960s who underwent a physical transition. In 1956, Van Emde Boas asked the pharmaceutical company Organon to please send him a supply of the new medicine "sustanon," a brand name for testosterone: "In connection with the specific make-up of my practice, I deal with patients who require treatment with an androgen relatively frequently."[5] We know that the trans man who was operated on in 1959 in Arnhem (see the final section of this chapter) had been on hormonal treatment for some years. Another source quotes the memory of a student who witnessed Van Emde Boas presenting a trans man with a full beard as an example of one of his transgender clients during a university class in the 1960s.[6]

A Trans Subculture

Fringe venues like nightclubs with transvestite shows and red-light districts were always part of big city life in Europe – particularly in cities like Amsterdam, Paris, Antwerp, or Berlin. Finding work within this subculture, which often meant resorting to prostitution, was a survival strategy and therefore an entirely rational

Hirschfeld's "Female Transvestites"

Medical sources devote comparatively little attention to people who at the time were called "female transvestites" (trans men), and many women who cross-dressed wanted to be recognized not as transvestites but as men. This is reflected in many of the life stories that accompany these images. For instance, in 1930 Hirschfeld reprinted the following two photos from Hans Abraham's 1921 dissertation *Der weibliche Transvestitismus* (Female transvestitism), the first publication dedicated to this topic.

Abraham tells the story of an aunt and niece. His main intention was to show that there were also what he called heterosexual female transvestites, i.e., women who liked to dress as men but who were sexually attracted to men. Today, we would speak of trans men who love men. But just as with Hirschfeld's earlier work *Die Transvestiten*, this attempt failed. What the book depicts is, to use its own terms, female transvestites who desired other women. When Hirschfeld retells this story of this "aunt and niece," he describes both of them as homosexuals and transvestites: as women (as he genders them) dressing as men who were attracted to other women (even if those women dressed as men or in masculine styles).

Hirschfeld reprints the image to underscore his theories that sexual traits or dispositions such as

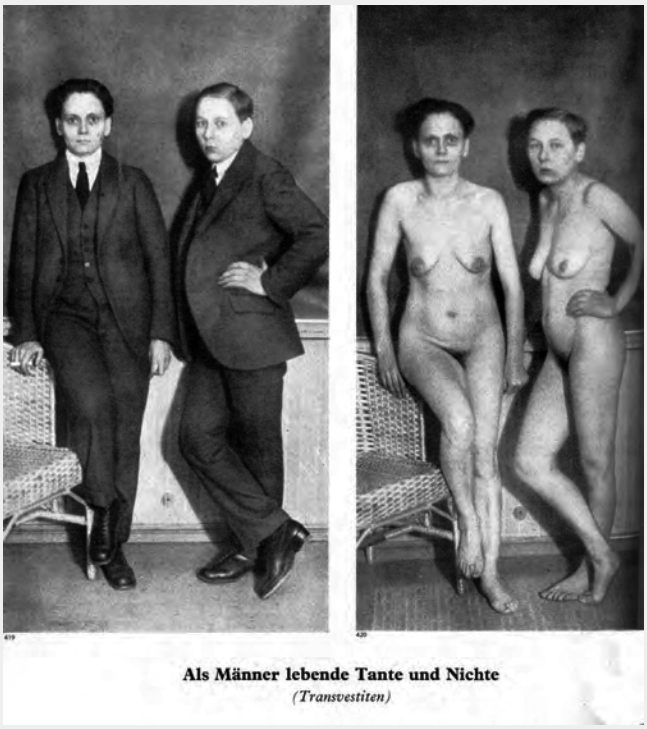
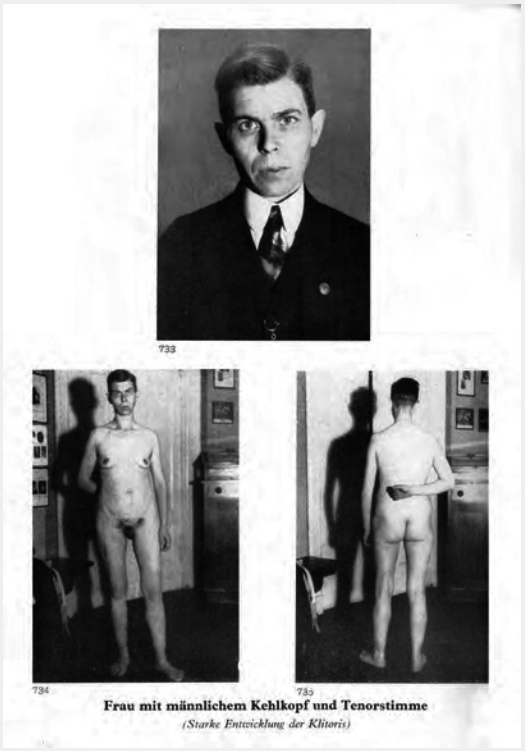


Figure 4.2: "Aunt and niece living as men (transvestites)," Hirschfeld, *Geschlechtskunde*, 1930.

transvestitism or homosexuality are genetically heritable. The key point for this argument is that "aunt" and "niece" are related. Yet the story does not fit so easily within this framing. In noting that it was the niece who convinced her older relative to cut her hair and dress and live as a man, Hirschfeld was likely pushing back against common charges that homosexuals seduced the young. And in any case, the niece's act of social reproduction, as well as the obvious way in which both these individuals copy recognizable styles of dress and comportment (see the gallery on trans men), are plainly



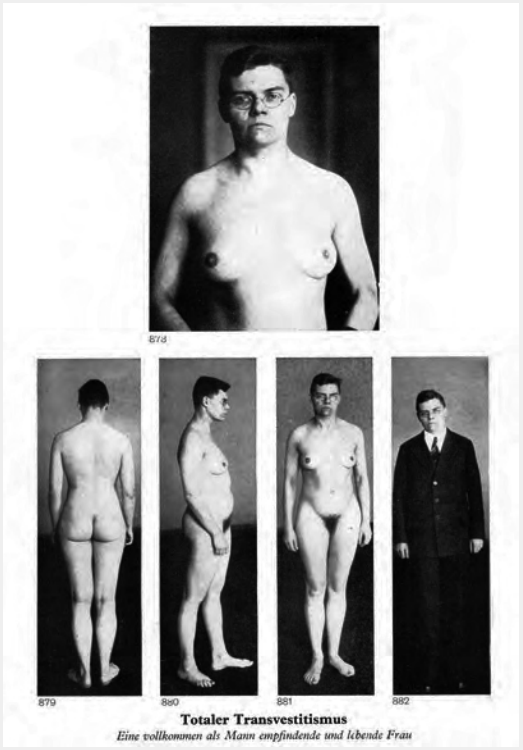


Figure 4.3 and 4.4: "Woman with male Adam's apple and tenor voice (strong development of the clitoris)" / "Total transvestitism, a woman living and experiencing himself completely as a man." Hirschfeld, *Geschlechtskunde*, 1930.

visible as irritants – if not counterevidence – to this biological discourse. Looking at these two women who want to be men (as Abraham would put it), Hirschfeld explicitly tries to exclude social reproduction and focus on heredity. One might even say he willfully ignores the photographic evidence to define these "female transvestites" in terms of their bodies and to explicitly counter the idea that they might reproduce their kind socially, not biologically. Social reproduction can also be read here as a disruption or threat to the biological definition of females as tied to sexual reproduction.

Hirschfeld's attempt to focus attention in such cases away from cross-dressing and onto the body is evident in other images from *Geschlechtskunde* that repeat this visual gesture. These two sets of photos above (figures 4.3 and 4.4), captioned "total transvestism," were most likely taken in Hirschfeld's Institute for Sexual Science. Produced in the mode of clinical demonstration, they are difficult to view today because of the unequal power relations they reproduce and the way that they expose their subjects to our gaze.

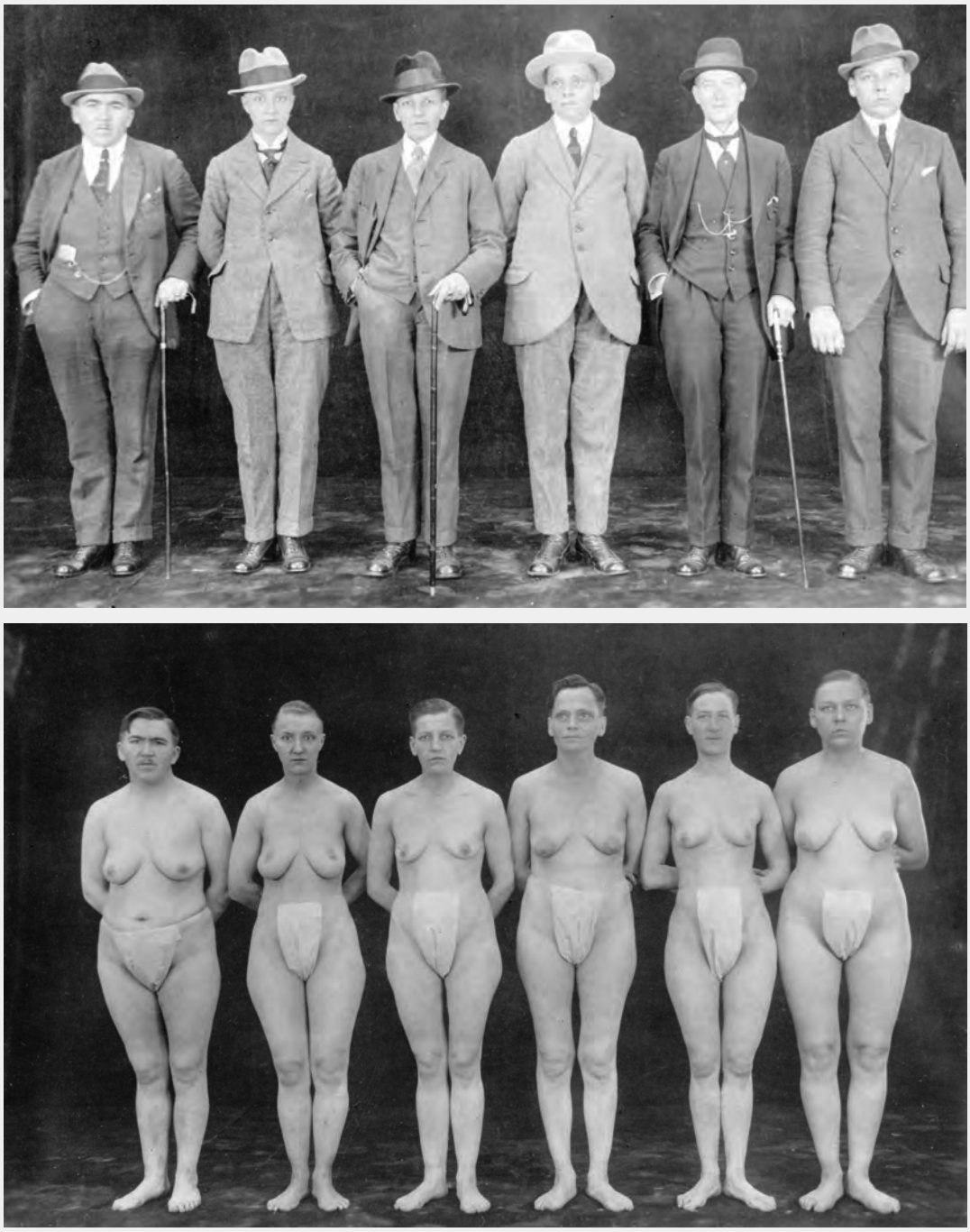


FIGURE 4.5 and 4.6: Two photographs categorized under "Nudism, German" in KILSC photo collection, KIDC56621 and KIDC56622. Copyright © 2017, The Trustees of Indiana University on behalf of the Kinsey Institute. All rights reserved."

They were meant to demonstrate that these individuals should be allowed to dress in men's clothing because their bodies supposedly display mixed-sex characteristics. Hirschfeld is attempting here to anchor an ethical and political argument about social norms in an understanding of the body as objective and natural, meaning that this truth should be immediately visible to the eye of the natural scientist and his readers. Hirschfeld's label "total transvestite" corresponds to what Benjamin later described as "transsexuals" – individuals who are "deeply unhappy as a member of the sex (or gender) to which [they were] assigned by the anatomical structure of the body." Benjamin's focus, however, was on individuals assigned a male sex at birth who wanted to live as women.

Figures 4.5 and 4.6 offer another juxtaposition of two photographs, so clearly similar in staging and style, found in Kinsey's archive. Their provenance is unknown, but they were donated by Harry Benjamin in 1958.

The photos were catalogued under the heading of "Nudist Photographs, German" – a decidedly odd categorization given that they are obviously meant to draw a contrast based specifically on how the figures are dressed. This might be taken as further evidence of the difficulty with which women who dressed in men's clothing fit into scientific-medical theories of transvestitism. Yet if read against the background of Hirschfeld's category of "total transvestite" and his use of similar images, it also suggests that whoever catalogued these photos – and perhaps the medical gaze of the camera itself – was in fact not concerned with clothing or cross-dressing at all, but rather with a notion of gender taken to be legible on the body itself.

This same scene appears in a very popular 1922 film about the work of Eugen Steinach (1861–1944), an Austrian endocrinologist whom Benjamin also revered and personally visited.[1] Steinach, who worked first in Prague and later in Vienna, believed that he had found the means to therapeutically manipulate aging and gender. He experimented on animals, transplanting testes into juvenile female rats and ovaries into juvenile male rats. He believed that he had found the causes of homosexuality and gender deviance – that there would be cells in the testes of homosexual men producing female hormones, and cells in the ovaries of women producing male hormones. His aim was to cure homosexuality and other "abnormal" variations of sexuality and gender through tissue implants from normal heterosexual men and women. His name even became a popular verb; having yourself "steinached" referred to a rejuvenation procedure meant to increase libido by either pinching off or severing the vas deferens of men or implanting foreign testes under the abdominal wall. The discourse of rejuvenation that grew out of this research was chiefly concerned with re-establishing male vitality.[2]

Figure 4.7: Benjamin's copy of the Steinach Film brochure in his files, KILSC-HB KILSC-HB HB 15-II B-58a.

In 1922, the German film studio Ufa produced a film, *Steinachs Forschung* (Steinach's research), as part of its new mission to distribute "educational films based exclusively on scientific knowledge." This earlier version was aimed exclusively at an expert audience, but a popular version was produced against Steinach's will and was released in 1923. The film was screened to enthusiastic audiences across German-speaking Europe and was spoken of elsewhere. The use of Steinach's research to treat transgender individuals was not its original purpose, nor was it the primary application of its results. The film nevertheless motivated many individuals, such as Otto Spengler, to seek hormonal and surgical procedures. As Annette reveals, in 1921 Benjamin lectured on the procedure at the New York Academy of Medicine and arranged for the film's screening there in 1923. But Benjamin's attempt to bring the film to mainstream American theatres was unsuccessful. His papers, however, include a – decidedly phallic – brochure for the film. The motif is evidence of the deeply masculinist, sexual shape of this rejuvenation discourse, its marketing and public perception, and its visual representation.

It was only when we hung these two photos (figures 4.5 and 4.6) in our exhibition next to a projection of an excerpt from the Steinach Film, however, that we discovered their appearance there. Archival research is always a combination of serendipity and diligence.

choice. As long as one's official papers did not match the gender in which one was living, it was not possible to live openly as a woman and get a "regular" job. Getting an income was crucial: legally, trans women were still men – men who had to provide for themselves. The nightlife of theatre and prostitution offered various ways of making a living and provided enough cash to pay for an attractive appearance, hormones, and perhaps surgery. Nevertheless, it required a fearless, daring character to survive in these surroundings, and it helped if trans women had some talent in singing, dancing, or at least entertaining. Bourgeois trans people who had the same transgender feelings but often lacked the required audacity or even willingness to enter this world, which so many considered "depraved," therefore often stayed in the closet. Hence the imagery and stereotype of trans women as sexual deviants – exciting and seductive or immoral and vile – was perpetuated.

Figure 4.8: Bambi in the dressing room of Le Carrousel, Paris, 1960s [public domain].

Drag clubs were particularly common in Paris. Le Carrousel and Madame Arthur were well-established clubs with high-quality shows in the red-light district Pigalle. Some of the performing artists became true jet-set stars in the late 1950s, such as Coccinelle, Cappucine, Bambi, and April Ashley. It was widely known that the artists had been born as men – that was indeed the attraction for many of the men who came to see the performances. Cross-dressing had the reputation of being a form of theatre with a tantalizing amount of stylish nudity. After the show was over, some of the girls offered their services to the customers. That is how they made their money, and how the customers received the pleasure they were seeking. Other big cities in Europe, such as Amsterdam, Antwerp, Hamburg, and Berlin had similar clubs. In the 1950s and 1960s, Dutch transgender women travelled to these cities, hoping to become stars themselves and to make lots of money, but mainly to be able to live as women. As Jill Pattiradjawane (a Dutch trans woman born in 1939), told me:

> I was born as a boy in Jakarta, Indonesia. The news about Christine Jorgensen reached there as well. It immediately gave me a future. When I had seen Le Carrousel's cabaret, I was sure: I wanted to be part of that. I needed to get to

> Europe, to Paris, Berlin, Amsterdam!
>
> I've worked at Le Carrousel for years. It had to be perfect, and exactly the same every single night. Lower your left arm now, raise your right arm now, stand like this now, like that now. You couldn't afford to let go, even a little a bit. So, rehearsals every day, be present at eleven every morning. We were the mannequins and stood at the back of the stage. The lead characters were at the front and had their own acts. They were the stars. But we didn't look bad either, if I say so myself.[7]

There were also travesty clubs on the fringes of society, but these lacked the glamour of the more famous Pigalle clubs. In the red-light districts of the major cities, transgender people often combined their performances as artists with a life of prostitution. In Amsterdam "the life" largely happened around the Zeedijk. Good citizens did not visit this narrow street full of bars between Central Station and the Nieuwmarkt; here you would find all that was considered perverse and corrupt: sex workers (women, boys, transgender people), opium, so-called "Negro" music in jazz clubs, and a wide selection of seedy bars.

Life was often hard and grueling for transgender prostitutes, yet it also offered the freedom to live somewhat publicly as a woman. Within this subculture, transgender women were able to realize their identity; simply put: they could be themselves. By the mid-1950s, it was known to trans people in this scene that taking female hormones yielded the desired results: breast development, softer skin, and a feminization of body fat. In Amsterdam, a progressive family doctor with an office in the middle of the red-light district had no objections to prescribing hormones for transgender women. In other cities, women were able to source them on the black market.[8] The standing of these women in the world of pimps, police, and cisgender prostitutes was usually very low. Often, transgender women were limited to hustling, as it was difficult to obtain a "love room," i.e., a rented room to perform sex work. The madams knew that these women were vulnerable to the police and to the law, and demanded rents much higher than the market rate.[9] In Amsterdam, the infamous APV 105 (Algemene Plaatselijke Verordening, a local regulation with the force of law), otherwise known as the cross-dressing law, stated that it was forbidden to dress in the clothes of the opposite sex. The Netherlands was one of the very few countries to have such a law, and in the rest of Europe, particularly in Germany, cross-dressing was generally punished with laws against creating a public nuisance.[10] The police used this ruling as a means to bully transgender prostitutes they knew, to arrest them and bring them in to the station, where they were forced to undress and were humiliated, laughed at, and had their clothes taken away.[11] The police did this for fun on quiet nights, making clear that they considered transgender women fair game for their amusement. If your official gender did not match your looks, you had reason to fear the authorities.

Transatlantic Connections

"EX-GI BECOMES BLONDE BEAUTY" was the big headline on the front page of the *New York Daily News* on December 1, 1952. The sensational news spread far and wide, as far as the Far East. As Aaïcha Bergamin (1932–2014), a Dutch trans woman told me:

> You didn't even know it had a name. But then something appeared in the news. About a Christine Jorgensen, an ex-soldier of the American army who'd had an operation in Scandinavia to become a woman. All newspapers covered it and we went absolutely crazy, in those dressing rooms of our Paris nightclub. So, there were more options besides illegal hormones, besides hiding your penis between your legs. We immediately went to find out how we could get those operations as well.[12]

Jorgensen became a beacon of hope for transgender people in the 1950s after she had sex reassignment surgery in Copenhagen, Denmark. She received hundreds of letters from all over the world – from fans, from admirers, but mostly from other transgender people who had up until then believed that they were the only ones in the world with such "deranged feelings."[13] Jorgensen was the first transgender woman to receive such elaborate attention from the press.

Jorgensen's transition in the early 1950s had a profound impact on transgender people. In her book *How Sex Changed: A History of Transsexuality in the United States*, Joanne Meyerowitz showed in detail the positive impact that this visible transition had on American trans people. After interviewing several older Dutch trans pioneers, I can confirm that this effect was not confined to the United States. As Aaïcha Bergamin and Jill Pattiradjawane make clear in the quotes above, the news stories about Christine had the same impact in the Netherlands that they had in the United States and other countries.[14]

Figure 4.9: Christine Jorgensen in Copenhagen, Denmark, December 11, 1952. Copyright © The Danish Royal Library.

But what did doctors in the Netherlands think of "the Jorgensen case"? It took a while before the medical field came up with

Sensationalism

Many of the images and stories from the sources we used in *TransTrans* are marked by sensationalism, which drew its power from a combination of sex, scandal, tragedy, and gender transgression. For instance, here is a story published by Hirschfeld in 1930 in *Geschlechtskunde* (figure 4.10). It tells of a woman who was impregnated by a sailor who threatened to report her as a cross-dresser unless she had intercourse with him.

Hirschfeld was both an advocate for marginalized communities and a scientist, and he constantly drew attention to the violence that sexual minorities faced. His decision to include the story of the sailor underscores the double vulnerability of this person as a biological woman and a cross-dresser.[1] Yet it is also significant that sailors were a social class perceived as being at the limits of respectability: even more rowdy, less socially disciplined or respectable than other workers, they were considered unrooted to any one place or family and had a reputation for sexual licentiousness. The scandal exists on so many levels: not only of a hidden pregnancy (an old trope and fact of social reality), or of a man proving to be a woman, but of a woman proving to be a sailor and the conflict of all of these scandalous facts with the bourgeois ideals of motherhood.

Friedrich Radszuweit's popular publications quite often openly exploited this sensationalism. These magazines include many examples of boulevard-style tales of sexual scandals and what were called *Lustmorde*, or murders of passion. One of his publications, *Das dritte Geschlecht* (1928–30) – which carried the same name as *Das 3. Geschlecht* (1930–32) but was written out – entirely consisted of sexual scandals. Yet the following example, at least, from *Die Freundin*, also uses personal tragedy and sensational

Figure 4.10: "Women as men from the working class. Woman who was impregnated as a sailor (a comrade who had discovered her sex threatened to report her if she did offer herself sexually)." Hirschfeld, *Geschlechtskunde*, 1930.

Figure 4.11: *Die Freundin*, 1928. Headline: "Killed her husband out of love for her girlfriend." Caption: "Vilma West, who murdered her husband out of love for her girlfriend (see the longer report inside)."

rhetoric to argue for social reform. The scandal is announced on the cover, and the report follows inside.

The full story:

She killed her husband out of love for her girlfriend!

Report from Brooklyn:

Velma West, an 18-year old girl from a good family, was forced by her family to marry a respectable young man. She lived with him for three months before her husband tried to separate her from her girlfriend, to whom she was bound by a great love. To prove to her girlfriend how great her love was, and because it was impossible for her to live at her husband's side, Velma murdered her young spouse with a hammer.

Had the case been reversed – had Velma murdered the young man because he had had an affair with another woman – then the sentence would likely have come to five years prison with possibility of parole. "Cherchez le femme" is what the judge would have said! But since this love was something unnatural, something dirty, hardly to be mentioned, Velma West had to pay for this misdeed with her life. This American way of thinking! Would it have not been more just to punish the parents (who forced the girl against her will into marriage, supposedly to make her "normal")?

When will America learn that same-sex love is not a vice but an appearance of nature? According to all appearances, never!

Die Freundin (1928)

Figure 4.12: "American female transvestite," *Das 3. Geschlecht*, May 1930.

This same drawing also appeared in *Das 3. Geschlecht*, where the figure is described as a woman dressed as a man – an "American female transvestite" – rather than as a lesbian:

> The need to reuse the probably limited stock of photos that Radzuweit had, and of course to sell magazines, undercuts the authenticity of the story and any agenda of social reform we might glean from it. In short, it probably did more harm than good.

This fine line that *Die Freundin* is toeing here between emancipation, visibility, and pandering to the prejudices of its day is brought home by a comparison with these tabloids from the 1960s that Harry Benjamin collected (figures 4.13, 4.14, and 4.15).

Here, the intentions of connecting a community or giving it visibility are completely absent, replaced by nothing but prurient sex(ual) scandal. This comparison reminds us, however, that these later tabloids did not invent such tropes of sensationalism and scandal. Indeed, the tenor of shocking sexual revelation is almost constant in the histories we are looking at here precisely because it reflected social reality.

Figure 4.13, 4.14, and 4.15: Tabloids from the 1960s collected by Harry Benjamin. The National Insider, 19 July 1964, Volume 5, Number 3, cover, KILSC-HB 14-15 / The National Insider, 19 July 1964, Volume 5, Number 3, p. 4, KILSC-HB 14-15 / Midnight, 24 June 1963, cover, KILSC-HB 14-15.

a serious response. Only in 1954 did the authoritative medical journal *Nederlandse Tijdschrift voor Geneeskunde* (NTvG) review an article by Christian Hamburger, the endocrinologist from Copenhagen who had directed Jorgensen's treatment.[15] Hamburger's article reveals his excited fascination and his compassion for his patient. In his review of Hamburger's article, gynecologist Willem Paul Plate mirrors this perspective and literally copies Hamburger's closing sentence: "Doctors should regard it as their duty to do their utmost to make the lives of these men and women, who are deprived of a harmonious and happy life due to no fault of their own, as comfortable and easy as possible."[16] But Plate was one of very few doctors with this perspective. The prominent psychiatrist and university professor Eugene Carp called Jorgensen's transition a peculiar perversion of erotic feelings, and he labelled the people affected with these feelings "sufferers of the delusion of sex change." His conclusion was crystal clear: one should not use surgical intervention to "deform" the patients "into beings who, on the surface, show the characteristics of a female physicality."[17] Carp had published earlier about the so-called delusion of sex change in his 1951 textbook *Psychopathologische opsporingen* (Psycho-pathological investigations).[18] He explained the disorder as stemming from strongly suppressed homoerotic feelings, but he also found that the delusion occurred in "many sufferers of other perversions, in neurotics and some types of schizoid psychopathology."

Given guidelines for medical privacy, we cannot determine whether professor Carp's patients were indeed psychiatric patients or not. But these are not mutually exclusive concepts: these individuals could have been psychiatric patients *and* transgender. This may have starkly coloured Carp's perception and may perhaps explain in part his opinion that trans identities were "delusions." However, his texts do provide insights into the way an influential psychiatrist in the Netherlands of the mid-1950s would view this phenomenon – or at least, how he would write about it, as we will see below.

From the United States to Holland

Transgender people all over the world, especially from the United States, wanted doctor Hamburger's clinic in Copenhagen to also operate on them. The hospital in Copenhagen was unable to cope with all the requests and soon the Danish authorities decided that transgender people from abroad were no longer welcome. Harry Benjamin had by this time treated many trans people in his clinics in New York and San Francisco. When Denmark became inaccessible, Benjamin contacted his network and found psychiatrist Frederik Hartsuiker in Haarlem, who was known for his expertise in prescribing castration for sex offenders. (There is a striking parallel to the role of Hartsuiker with that of Karl Bowman in the United States, a psychiatrist who specialized in the castration of male sex offenders and ultimately came into contact with trans women and medical practitioners such as Harry Benjamin.)[19] Christian Hamburger,

the Danish doctor who was responsible for Jorgensen's treatment, was already referring transgender women to him: there was, in other words, a direct line from Hamburger to Hartsuiker.[20]

The Dutch psychiatrist Hartsuiker and the American endocrinologist Benjamin first established contact over the case of Dixie MacLane early in 1954.[21] Hartsuiker had received a letter from MacLane, asking to be castrated by him. Hartsuiker responded by asking MacLane not to come to Holland before sending more information, such as the results of tests carried out by a psychiatrist or psychologist and a written life history, including a description of MacLane's sex life. Thinking that Harry Benjamin was MacLane's psychiatrist, Hartsuiker wrote to Benjamin asking for his advice in this case. It is not clear whether the doctors had previously met or known about each other, but the tone of the correspondence suggests some level of acquaintance. The Dutch doctor wrote to his colleague overseas: "Would there be good purpose to operate [on] this man? Is it possible that, for instance, we perform the castration here and that the further demasculinization is done in his own country?"[22] Benjamin responded by making it clear that he was not MacLane's psychiatrist, and he agreed with Hartsuiker's impression of MacLane as being very unstable and unrealistic in their demands. Benjamin was perhaps also influenced by Carla Erskine's analysis of Dixie and by the conflict between the two women that Annette describes. His belief that Dixie might become even more unstable if denied surgery certainly echoes Carla's description of Dixie "blowing a cork all over the place" and threatening suicide.[23]

> It would be entirely up to psychiatrists like yourself to decide whether Dixie is a suitable subject for a de-masculinization operation. I am afraid however that a blunt refusal may precipitate an acute psychotic state. The recommendation of "chemical castration" with large doses of estrogen and accompanying psycho-therapy may be the next best way to help him. I think Dixie is a more serious problem than many other transsexualists and it is really often difficult to decide which is the lesser of the two evils: to operate or to refuse operation.[24]

Hartsuiker decided not to proceed with providing care for MacLane;[25] however, this interaction with Benjamin led to their collaboration in helping other transgender women from the United States in the Netherlands. In response to a request from Violet C. to come to the Netherlands for surgery, Hartsuiker wrote to Benjamin in March 1954, asking that Benjamin arrange for a psychiatric evaluation, which should include a life story written by the patient and the results of Rorschach and Szondi tests.[26] His request was meant to save Violet C. from incurring additional costs for testing in the Netherlands. Hartsuiker gave a price estimate of 200 to 300 Dutch guilders for the procedure and twelve to fifteen guilders a day for the hospital stay (an amount equivalent to approximately 200 US dollars).[27] After receiving this

information, Benjamin answered transgender women seeking his help, such as Shelly W., by explaining: "If you are interested in an operation, I must explain to you that such would not be feasible in this country because it is illegal. The operation can and has been done repeatedly in Holland and I have the necessary contacts there."[28] Benjamin also gave Shelly W. information about how he prepared patients for the trip to the Netherlands: he placed them under observation and treatment for at least three months; he gave them hormone injections at least once a week; and some possibly also received hormone pills, a consultation with a psychiatrist, and several psychological tests. Patients were to visit Benjamin once or twice a week and would be charged ten to fifteen dollars for each visit.[29]

Dr. Hartsuiker, however, had in the meantime developed some doubts about transgender surgery. He was skeptical of the idea that men could really become women, which was how he was conceptualizing such surgical interventions. With this specific group of patients, he simply recognized an extreme desire for castration, and he had been willing to assist with that in an expert manner. But after the exchange with Benjamin, he started backtracking, writing:

> In recent months so many transvestites have come to Holland, especially from England and America (and several without announcing their arrival), seeking demasculinization. Among them were so many unbalanced and hysterical figures, that the surgeons refuse to carry out operative treatment any longer. I believe that from a psychiatric point of view there are indeed some objections to this treatment for these mentally so very much disturbed patients.[30]

Harry Benjamin responded immediately, afraid that the Holland connection was falling away. He tried to convince Hartsuiker that the four people he wanted to send overseas were completely balanced psychologically and that a "sex change" operation was the only appropriate option for them – it was the right thing to do. He also objected that they had already made all the preparations for their trip to the Netherlands. Benjamin agreed with Hartsuiker that there was no indication for surgery, as traditionally understood, for the majority of the transvestites, but for some "we must consider surgery as a calculated risk and perhaps as the lesser evil." He referred to an article he was about to publish in the *American Journal of Psychotherapy*.[31]

The debate between the two doctors continued in an elaborate correspondence. Hartsuiker suggested an alternative: send the candidates to surgeon Daniel Lopez Ferrer in Mexico, which would be a more appropriate place for them than the Netherlands. Once again, the source of Hartsuiker's resistance reveals the paradox that characterized notions of transgender identity at the time. The patients were blamed for being too effeminate and for showing homosexual tendencies. It is clear that they were still being seen as men – men who wanted to undergo castration.

This conflation of homosexuality and transsexuality, both of which Hartsuiker viewed negatively, was quite common in the 1950s, as Meyerowitz has argued.[32] Hartsuiker told Benjamin that

> In the hospitals here there have been some rumour [sic] about the operative treatment of transvestites. People do not feel it ethically justified. The patients-transvestites themselves caused this opinion. Some of them behaved themselves very hysterically, showed unpleasant homosexual tendencies and acted at the men's ward in such an effeminate way that the other patients protested against their being there. The result is that the surgical department will not take them up for the time being.[33]

Despite his skepticism, Hartsuiker wrote a letter to Coen van Emde Boas, a well-known progressive psychiatrist and sexologist from Amsterdam, the same day, asking if Van Emde Boas would be willing to treat a few English and American "transvestites." Coen van Emde Boas was the embodiment of sexology in the Netherlands in the 1950s, often occupying himself with sensitive issues, such as homosexuality, birth control, and abortion. In his home-based practice he saw people with what were then called paraphilias or sexual disorders, including transvestites. Van Emde Boas answered Hartsuiker positively: "I've been interested in the transvestites' issue for many years now, but my material base is still very small and I also believe that we should help these tragic figures as much as we possibly can."[34]

Figure 4.16: Coen van Emde Boas, famous Dutch psychiatrist and sexologist

Demasculinization and Feminization Procedures

Backed up by Van Emde Boas and the arguments Benjamin continuously supplied, Hartsuiker eventually agreed to admit more American transgender women for treatment, though he now mostly served as an intermediary for Van Emde Boas and only saw patients once or twice, for diagnostic support. Van Emde Boas became the attending physician for these cases. It proved very hard to find

a replacement for the surgeon who had been doing the operations up to then, Dr. Nauta of the Diaconessenhuis in Haarlem. Hardly anyone wanted to step in. Only the Amsterdam-based general surgeon H. C. Koch Jr. was willing to help. Koch performed the surgeries at the Boerhaavekliniek, a small hospital in the heart of Amsterdam with a capacity of only sixty patients. Hartsuiker made one final exception for patient F., who had already been to see him and Nauta in 1953 and who had been promised that the duo of doctors would continue the treatment.

What did the procedure entail? The candidates for operation had already been using female hormones, which generated a somewhat castrating effect. The wish these transgender women shared was to get rid of their male genitalia, and preferably then undergo vaginoplasty, though this was a secondary consideration. The immediate goal was demasculinization by castration. As already mentioned, in the United States this procedure was viewed as mutilation and was legally prohibited on those grounds ("mayhem"). This judicial status, which had come about after the decision in a 1949 legal case of a trans woman seeking medical care, blocked further gender-affirmation surgery in the United States for years to come. According to Susan Stryker, only a few dozen operations were secretly performed by urologist Elmer Belt in Los Angeles.[35]

The legal reasoning of mayhem in regard to gender-affirmation surgery did not apply in the Netherlands. Basically, there were four possible surgical phases for transgender women: 1) castration of the testes; 2) penectomy (penis amputation); 3) plastic reconstruction of the empty scrotum into a female exterior and 4) vaginoplasty.

The first two procedures were available in the Netherlands during this period, with the surgical techniques that had been developed after ample experience with castration of sex offenders. However, procedures number three and four were not available in the Netherlands. To further femininize their genitalia, transgender women tried their luck in Denmark. Although Christine Jorgensen's doctors had officially announced that they were no longer taking on foreign patients, they made some exceptions if patients had already been castrated. This was the case for J., for example, who went to Copenhagen a few weeks after her castration and penectomy in Amsterdam in order to convince the doctors to perform the next procedure. She succeeded, and shortly after she was admitted to the local hospital for procedures to lower the urethra and remove part of the scrotum; the remainder was fashioned into a likeness of the labia majora, but no vaginoplasty was performed.

Many American women went back to the United States for vaginoplasty, even though this technique was still in its infancy. Benjamin knew a number of plastic surgeons, such as Elmer Belt in Los Angeles, who were willing and able to do this. Because the procedure did not qualify as mayhem it was not illegal, which cleared away the legal hurdles that had prevented doctors from operating. It is interesting to note that in terms of eligibility for transformational procedures the situation in Europe and the United States was completely inverse: the main

obstacle, demasculinization, was possible in the Netherlands, but further steps towards femininization were not, whereas feminization procedures were much more available in the United States.

In early 1955, Van Emde Boas wrote to J. about the option of a vaginoplasty: "that such surgery as this hadn't proved effective, to his knowledge. He said that the opening had a tendency to grow together and lose its depth. However, he said he based his opinion on a couple of cases in Germany about twenty-four years ago."[36] But phase three, the plastic reconstruction of the empty scrotum into a female exterior, also turned out not to be an option in the Netherlands – to the bitter disappointment of F., who had stayed on for a long time, waiting for the promised operation. This made Benjamin furious. As he wrote to the prospective patient Rosa F.:

> I don't know whether I feel more sorry or more bitter about this utterly indefensible attitude of those Holland clinics. Are they trying to outdo us in hypocrisy, puritanism, cowardice or whatever you may call it? All you can do at the present is to wait for further word from Dr. Hartsuiker and be patient. After all, nothing is lost. The operation can and will be performed, if not abroad, then here. The annoying part is merely the uncertainty of time and place.[37]

The Dutch doctors presumably reasoned that further care for these foreigners was not their responsibility, given that they had already provided access to castration with great difficulty. After all, feminization treatment was available (both legally and in practice) in the patients' home countries. The Dutch doctors only wanted to heed the most urgent requests. What might also have played a role here is that the treating physicians were focused on keeping the transgender women in the Netherlands for the shortest possible time. They always feared publicity or problems with the police. Van Emde Boas later wrote that the police told him that "if we continued treating these people we could end up coming into conflict with the law ourselves for intentional infliction of grievous bodily harm."[38] Writing to Benjamin in April 1955, J. explained the atmosphere in the following terms:

> It seems that Dr. Emde Boas is reluctant to approve more than the orchidectomy and peotomy[39] for foreign patients and has made a sort of "gentlemen's agreement" with his colleagues and with the police that no plastic surgery will be approved for foreign patients after the aforesaid castration and peotomy. Dr. Emde Boas apparently feels that the patient's own country, should grant him the extra surgery. Moreover, if there should be any publicity, the entire blame for the feminizing operations won't fall on Holland if the plastic work is done elsewhere.[40]

The stance of the treating physicians in the Netherlands with regard to secrecy was

Figure 4.17: News clipping from United Press, 1954

related to what had happened in the case of Tamara Rees. Rees is considered to be the third American transgender woman after Christine Jorgensen to have received gender confirmation surgery, the second being Charlotte McLeod.[41] Rees contacted Dr. Hartsuiker in Haarlem through Hamburger in Copenhagen, and she received the notification in the fall of 1953 that she was welcome to come to the Netherlands for treatment. In her memoirs, which are certainly not factually reliable,[42] Rees describes Hartsuiker as very likable. She remembered his continuous warning that the choice was irreversible and that positive outcomes were not guaranteed. Hartsuiker undertook psychiatric analysis, which spanned several hours of examination. After receiving a green light, Rees was operated on by surgeon Nauta in the Diaconessenhuis in Haarlem on January 5, 1954, where she underwent castration and possibly penectomy (amputation of the penis).

Tamara Rees stayed in Amsterdam for almost a year. The exact circumstances

surrounding this stay are unclear, but while there she came to the attention of the (immigration) police. According to Rees, she was followed by the police, who thought she must be a prostitute. In September 1954, she was arrested and put in jail, possibly because she went out dressed in women's clothes. Hartsuiker had advised the police in Amsterdam and the American consulate to allow Rees to dress as a woman, which they did for several months before inexplicably changing their policy. Rees was deported back to the United States in November 1954, escorted by the police. Her story got some publicity in the American press,[43] very much to Dr. Hartsuiker's annoyance, as he was quoted as Rees's psychiatrist without having spoken to the press himself – and despite his agreement with Rees to stay clear of any publicity. He uttered his frustration in a letter to Benjamin, saying: "Up to now I have had only unfavourable experiences with these patients concerning their reliability in many respects,"[44] and he once again expressed his wish not to continue these treatments. Benjamin replied: "You are quite right that many of these patients are utterly unreliable. After all, nature has made them misfits. The tragedy is that some of the reliable and reasonably balanced patients (like F. and J.) have to suffer for the sins of the others."[45]

Following the problems surrounding Tamara Rees, Van Emde Boas was strict: the candidates had to be absolutely willing to remain under the radar of the press while they were undergoing the entire procedure. Transgender women had to arrive in the Netherlands with their masculine appearances and had to stay that way until they left the country again. They were not allowed to dress in female attire in public, since this was against the local law and might lead to trouble with the police – something that the women were already very much familiar with in their home countries.

So these transgender women were by no means out of the closet – in fact, they were invisible. The feminizing effects of the use of hormones were there, in varying degrees, but these remained unnoticed against a background of male clothing and male voices. They were addressed with "he" and "him" by the doctors, and, as we know from their letters, they used male pronouns when referring to each other. The concept of the "real life test": a certain period of time, mostly a year, to prove to the medical caregivers that one was ready for gender affirming surgery, was definitely not yet part of medical practice. This would only become protocol from the 1970s on. For now, the order of the steps was the opposite: first (castration) surgery, then at a chosen moment, coming out and starting life as a woman. Describing this need to stay undercover, F. wrote to Benjamin that "Under the circumstances it was not an easy task for Dr. Nauta to make arrangements to maintain the secrecy of the operation to be performed, which was done in a Catholic Hospital and I was accommodated with two other patients. Helpful, was my not understanding the Dutch language – so they could not ask me any questions."[46] Only when someone had had the "conversion" and presented herself as a woman to the outside world did these women and the doctors introduce and use the female


Figure 4.18 and 4.19: Pictures (possibly self-taken) of Catherine J. KILSC, Harry Benjamin Collection, KILSC-HB 5.

name and the pronouns "she" and "her." Some trans women tried to obtain a female identity document by showing a letter from the doctor and psychiatrist that they should be considered a female to the American embassy in the Netherlands. In some cases they succeeded and were able to safely travel back to the United States as women, but others were forced to wait until they were home to take this step.

In the first months of 1955, Violet C., Rosa F., Catherine J., and Daphne P. came to the Netherlands in the hopes of obtaining surgery. C., J., and P. already knew each other very well and they looked after each other after their operations. The trans women stayed together in the little hotel Hegra on Herengracht 269 in Amsterdam, "so they would not become lonely, at least not emotionally," as Van Emde Boas described it years later.[47] The hotel was affordable, simple but comfortable. The owners of the hotel were aware of their guests' situation and were very discreet and helpful during their unusual stay. Apart from the doctors and other medical staff, they were probably the only people who knew that these surgeries had taken place. As J. wrote to Benjamin in one of her many letters: "My family still doesn't know

about me. They think I've gotten a leave of absence from my job in order to enjoy an extended vacation in Europe. I've sent them post cards regularly, and also an occasional letter, all telling of the marvelous time I'm having sightseeing. During those times I was hospitalized I had [Daphne] or the nurses mail the cards for me."[48]

It was an intense trajectory: for the actual operation, the transgender women were dependent on Van Emde Boas for permission. Unlike Hartsuiker, Van Emde Boas wanted to reexamine everything himself. They were expected to appear in his practice almost every day. He did extensive psychological and physical examinations assisted by endocrinologist Grad Hellinga, a prominent expert in the field of andrology, among others. The psychological and sexological examinations investigated how patients viewed homosexuality or masturbation, whether they had suicidal thoughts, and whether they would be able to sustain themselves financially after transition.

Van Emde Boas also demanded that they present themselves once in female attire at his office, and he expected them to appear at an educational seminar that he organized for students at his home. C. and J. spoke to a group of about fifteen students and a few college professors about their transgender feelings. During the first part of the evening they were dressed in a masculine manner, during the second part, in a feminine. Much like Carla Erskine, they were happy to answer the many questions in the interests of contributing to the development of knowledge and understanding.[49] The four transgender women wrote to Harry Benjamin throughout their entire stay in the Netherlands; Benjamin very much wanted to stay abreast of how they were doing. Van Emde Boas also corresponded with Benjamin during this period, repeatedly telling him that he had to ease up on sending new people over and that these people had to be stable, inconspicuous, and able to dispose of sufficient resources. Benjamin asked more questions about concrete details, so he could sufficiently inform future patients before they left for the Netherlands – for example, about the costs. The total costs minus travel added up to about a thousand dollars (which would be about 10,000 dollars today): 500 dollars for medical expenses and 500 for transportation costs and room and board.[50]

Patients arrived in the Netherlands approximately five to six weeks before surgery. The reason for their admission to hospital was kept a secret; the other patients and the nursing staff who were not directly involved in their care were not informed. Hospital staff not directly engaged with the medical care viewed the patients as just ordinary men who had the bad luck to be suffering from a hernia or appendicitis while on holiday. As J. described things to Benjamin:

> The average Dutchman apparently knows nothing of the demasculinization operations that are performed in his country. Certainly, the procedure is not generally known. When I was lying in bed

Figure 4.20 and 4.21: Pictures of Daphne P., taken at Hotel Hegra, Amsterdam, 1955. KILSC-HB 5. Copyright © 2017, The Trustees of Indiana University on behalf of the Kinsey Institute. All rights reserved.

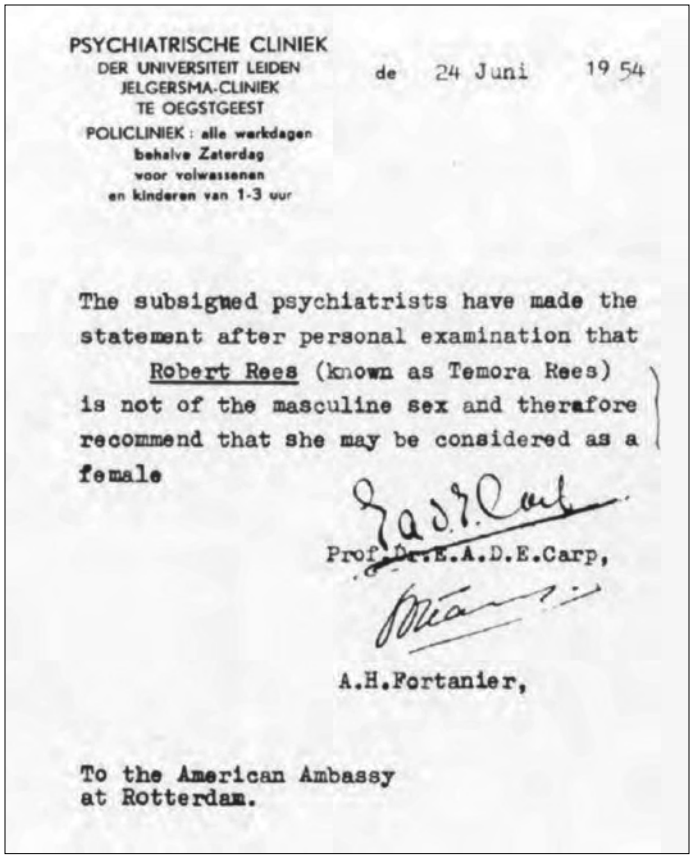
the night before my operation a nurse asked me if it was my appendix that troubled me. I told her I had a growth in the joint that had to be removed. Other nurses during the past ten days have sympathized with me because my "holiday" was spoiled by my sudden illness while in Holland.

One of my night nurses asked me if I suffered much pain before the operation. I told her not very much. Generally speaking, the nurses are not curious at all. Their observations about my "sudden illness" were apparently prompted merely by sympathy. Still, I can't help but feel that some of them might be a bit suspicious, but all this is of relatively small moment. For the most part, I myself am "playing dumb."[51]

Disconnection of the Dutch Route

This organized transatlantic route for trans women wanting sex reassignment surgery would not last long. When Van Emde Boas was organizing these procedures, it had been possible for surgeons to perform surgeries under their own authority in private clinics. The surgeon was hardly accountable to anybody – not to the anaesthesiologist, not to the assistant, not to the nurse, but only to the hospital director. The surgeon Koch performed a number of operations under these conditions in the Boerhaavekliniek in Amsterdam, until the hospital director found out and prohibited the procedures in April 1955. According to Van Emde Boas the last patient was literally removed from the operation room.[52] Van Emde Boas's assistant wrote to him while he was on holiday in April 1955, noting that since no other clinic was willing to conduct surgery of this kind, Koch had decided to perform the operation on this last patient under local anesthesia in his home office.[53] "Everything went well," the assistant continued:

> He/she is now being nursed at Huize Ardina, Keizersgracht 280, the owner is a friend of Hotel Hegra, the daughter of the family is a nurse …Do we have to write to Benjamin that the arrival of the next patient will have to be postponed for a while, in view of the stance of the hospital boards? I don't think it's very useful to have them come here for examinations and then be sent back without surgery. And Koch didn't seem willing to help every next patient the same way he helped P. To the contrary. This was an emergency solution.[54]



PSYCHIATRISCHE CLINIEK
DER UNIVERSITEIT LEIDEN
JELGERSMA-CLINIEK
TE OEGSTGEEST
POLICLINIEK : alle werkdagen
behalve Zaterdag
voor volwassenen
en kinderen van 1-3 uur

de 24 Juni 19 54

The subsigned psychiatrists have made the statement after personal examination that Robert Rees (known as Temora Rees) is not of the masculine sex and therefore recommend that she may be considered as a female

Prof. Dr. E.A.D.E.Carp,

A.H.Fortanier,

To the American Ambassy
at Rotterdam.

FIGURE 4.22: *Psychiatrische Cliniek* on Robert Rees. Copyright © Tamara Rees, Reborn (1955).

Benjamin was consequently informed that he should not send new patients for the time being. This provisional decision became permanent, ending the official route from the United States to the Netherlands for transgender patients.

Small Circles

The small circle of trans women who sought surgery in the Netherlands sent frequent letters back and forth, and they were also in constant contact with Benjamin, who kept them informed about the shifts in medical policy. As the other chapters of this book have demonstrated, his relationship with trans women seems to have been close, intense, and sincere. It is evident that these women put their trust in him and felt support from both him and his wife, to whom they kept sending their best wishes. The image of Benjamin as a compassionate doctor has been noted before, for instance by Pat Califia in her analysis of Harry Benjamin as one of the first "Gender Scientists."[55]

Even with Benjamin's warm support and extensive involvement, however, the transgender women had to convince the Dutch doctors of their wishes. They were thoroughly questioned, examined, and tested physically and psychologically. In practice, the standard protocol involved transgender people moving heaven and earth to convince the treating physician. By pushing back strongly, the treating physicians tested the urgency of the desires of the patient in question. Nevertheless, the transgender women who kept Benjamin informed mainly wrote very positively about the Dutch treating physicians. They describe these doctors as sympathetic, caring, and highly interested. F. was even taken by Hartsuiker on tourist trips in his car, and they went out to dine. It is possible that the reports back to Benjamin tended to be positive because the women were dependent on the doctors. But their drive to supply Benjamin with accurate information seems authentic. Only C. was angry that she was not allowed to wear female attire in public, and she blamed the treating physicians for this. In contrast, J. wrote: "The whole procedure in Holland is hardly a cut and dried one … As it is, enlightened men like Drs. Emde Boas, Hartsuiker, Kijzer and Koch are in the minority in Holland … Once again, however, I'd like to emphasize that I for one am more than grateful to Holland for what has been done in my case up to now."[56]

It is hard to evaluate the level of compassion that Hartsuiker and Van Emde Boas had as doctors. Based on their writing, it seems to me that they were more authoritarian figures and more professionally distant than Benjamin. Their opinions demonstrated a limited medical-psychiatric perspective that framed trans women only as interesting cases. They did want to be kept informed about the well-being of the women when they returned home and exchanged letters. But their interest was not so much personal or humane; rather, the transgender phenomenon was a fascinating new field of study for them, and they needed the information that only trans people themselves could provide.

Moreover, there seems to be some contradiction in the way doctors behaved on a personal level versus how they wrote about trans people in general. Public writing was often less caring. A prime example comes from professor Carp of

Leiden University, whose official statement on the validity of transgender identities was very negative. He condemned transgender people as having a psychiatric disorder that should not be physically treated.[57] In practice, however, Carp backed Hartsuiker's decision to perform a castration on Tamara Rees and wrote her a note to hand to the American embassy, stating that he "recommend[ed] that she may be considered a female."[58] Carp was also consulted for the surgical treatment for F. and granted his support.[59] We can conclude that Carp, as a leading psychiatrist in the Netherlands, conformed and even contributed to professional peer pressure to authoritatively reject medical treatment for trans people even as he acted differently in the privacy of his own clinic.

Van Emde Boas as a Sexologist

It was not only trans women from the United States whom Van Emde Boas helped; others came to him from England, Germany, and of course the Netherlands. In 1955 he examined at least thirteen people.[60] Because Coen van Emde Boas played such a large role in the care of transgender people in the 1950s, it is essential to focus on the criteria he used.

To Van Emde Boas, the feminine or masculine look of transgender people, based on extensive observations, was very important. His assistant at the time, Margreet Groot, remembers him explicitly asking her opinion: did the patient, upon entering the waiting room, come across as predominantly male or female?[61] He wanted to hear her views as a woman, and he regarded it like a second opinion.

The value Van Emde Boas placed on the appearance of transgender people went beyond makeup and dresses. If a transgender woman was unlucky enough to be unable to physically conform to common standards of feminine presentation due to her height or heavy build, for instance, Van Emde Boas would refuse to recommend treatment. Van Emde Boas also imposed a number of conditions before he would recommend surgery. Psychotherapeutic solutions had to be exhausted, and the candidate had to be mentally stable and free of any "exhibitionistic tendencies à la Jorgensen."[62] Relying on a report of the Dutch Health Council from 1966, which I will discuss in more detail below, we can glean an understanding of the treatment norms that were prevalent at the time Van Emde Boas was practicing. The report describes the criteria that the small international network of psychiatrists-sexologists, including Van Emde Boas, relied on in the 1950s:

> Pro-indications: The existence of constitutional transsexism that brings subjective intolerable suffering to the patient, resulting in the danger that he or she will slide into suicide, automutilation or a social psychiatric untenable situation. Contra-indications: Insufficient intelligence; insufficient ego-strength; malign progression in demands; insufficient insight into the fact that plastic surgery does not mean a change of sex; exhibitionistic

> tendencies; absence of willingness to live a virtually asexual and partnerless life; looks, voice and demeanor unsuitable for the desired sex; familial and other social complications.[63]

Van Emde Boas himself never mentioned demanding asexuality from his patients, but he was concerned about "malign progression in demands," meaning that patients would desire more and more far-reaching and unrealistic transformative procedures. He only agreed to treat transgender people when he felt that the diagnosis was beyond doubt. In a letter to his colleague, Professor Urban of the University Clinic of Innsbruck, Austria, Van Emde Boas formulated it like this: "Je ernster der Wahn, desto besser die Prognose" (the more serious the delusion, the better the prognosis).[64] He did use the term "delusion," but he meant it in the psychiatric sense current at the time, not in the sense of a misguided illusion.

The discussion was never about hormonal treatment; the doctors only spoke about surgical interventions. Its irreversible aspect instilled so much fear that chances of success had to be 100 per cent. Van Emde Boas basically delinked his diagnosis of transsexuality from his recommendation for an operation. It was not about being trans or not: what mattered was being suitable to undergo the transition.

Besides diagnostic criteria, Van Emde Boas developed his theories about the foundation of the transgender phenomenon as a psychiatrist and sexologist. He initially distinguished between constitutional and neurotic transsexists, even using the term transvestites. He had introduced the term "transsexists" to counter the increasingly commonly used term "transsexuals." He stated that the treatment for these individuals involved evaluations of people's sex, not of their sexuality. Harry Benjamin recognized the reasoning but did not adopt this term, because he found it "a bit of a twister for the American tongue."[65] As we mention in our "Note on Transgender Terminology," Benjamin did come close to Van Emde Boas's usage by briefly employing the word "transexualist."

Constitutional transsexists, according to Van Emde Boas, were born with a condition that left their brain insensitive to their own sex hormones. Recent animal testing with rats served as preliminary proof of his theory. The logical consequence of this condition, he averred, was that the child was destined to develop the identity of the other sex. But because this was not visible on the outside, the child would still be recognized by others as the sex that had been designated at birth. Neurotic transsexists did not suffer from the same innate condition. In their case, psychological development was the villain. But if psychotherapy proved to be unsuccessful, Van Emde Boas believed that the "therapeutically resistant neurotic transsexist" nevertheless deserved gender-affirmation surgery. He made a further distinction between different versions of the neurotic transsexist: there were real ones and fake ones. Real neurotic transsexists could be suffering from a primary condition, acquired in early childhood, or a secondary one, acquired after an initial

masculine development. The fake neurotic transsexists were to be found in show business and prostitution, and they only wanted to transition in order to garner professional benefit.

That Van Emde Boas referred only to the initial masculine development in his description of neurotic transsexists was no accident. He did not ascribe a biological foundation to transgender men at all and believed that their condition was the result of "disastrous environmental influences in early childhood," such as a family setting in which the child had been given a masculine role.[66] With both types, the constitutional and the neurotic transsexists, he believed that psychiatric testing was of the utmost importance. He considered extensive diagnostics, based on psychiatric and clinical psychological research and a long trial period of functioning successfully in the role of the other sex, to be necessary.

Casablanca and Georges Burou

After surgical procedures became impossible in Copenhagen and Amsterdam, a new location coincidentally emerged: Casablanca, where the French gynecologist Georges Burou had his Clinique du Parc. A front door with gold-plated handles and wrought-iron ornamentation contrasted with the somewhat less classy back door. Women who came for regular gynecological appointments entered through the front door; those who did not want to be seen went in through the back. Burou was known as a doctor for "secret procedures." He did abortions, he helped women deliver babies to be put up for adoption, and he likely also reconstructed hymens for unmarried women whose desire to appear to be living by Islamic moral standards caused them to seek help in having their virginity "restored" before marriage.[67]

In 1956, someone called on him with a desperate cry for help to change male genitalia into female. Burou, who had a passion for inventions and was totally unaware of previous such work in the world,[68] developed the technique of the penis inversion: turning the skin of the penis inside out to create a hole and make a vagina. This turned the procedure into a one-stage operation – a big step forward from the four stages that were used up until then: castration, penectomy, reconstruction, and creation of an artificial, shallow vagina.[69] Burou's technique turned out to be the gold standard for vaginoplasty and is still used today.

Unlike Hamburger, Benjamin, Hartsuiker, and Van Emde Boas, Georges Burou was not part of any medical network and, like colleagues in Mexico and a few other parts of the world, he worked in relative obscurity and isolation.[70] In 1970, Burou made first contact with Benjamin, and only in 1973, towards the end of his career, did he present his knowledge at the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome at Stanford University Medical Center in Palo Alto, California. For trans people, the crucial distinction between accessing care from one of the doctors in the network of the Danes, Americans, and Dutchmen and coming to Burou's practice was that with Burou they could get immediate surgery.

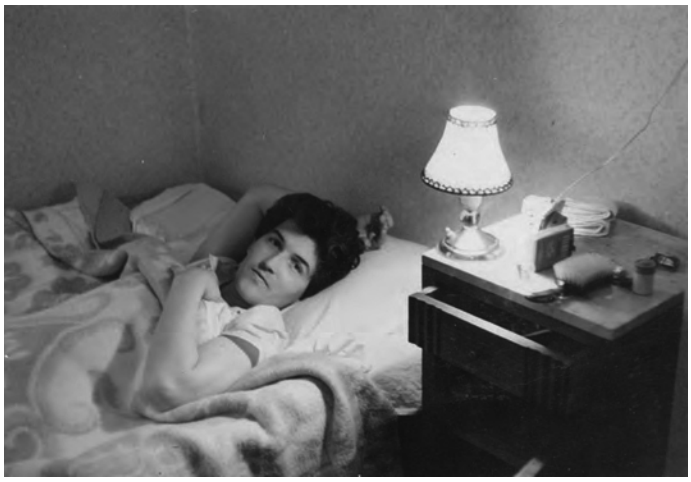


Figure 4.23: Daphne P., possibly recovering in Hotel Hegra, Amsterdam, 1955. KILSC-HB 5. Copyright © 2017, The Trustees of Indiana University on behalf of the Kinsey Institute. All rights reserved.

No screenings, no diagnoses, no talks with psychiatrists to try to convince them of the urgency. Burou did show a humane understanding of the needs of trans people, and he respected their identity, as he himself stated in a newspaper interview.[71] But he was not committed to understanding the psychological background of the transgender phenomenon, nor did he care about social standards regarding trans men and women being able to pass. He gave trans women full autonomy over their own decisions, including the financial, psychological, emotional, and medical risks that came along with surgery.

Trans women knew how to find Burou; news travelled fast in the right circles. One of his first patients was Coccinelle, the famous star of the French drag clubs. Soon, patients started to arrive from all over the world, including possibly a few dozen from the Netherlands. They handed a note with the clinic's name to a taxi driver – that was enough information. Payment was due upon arrival at the clinic: an amount ranging from 2000 to 5000 dollars,[72] preferably in French francs, American dollars, or travellers' cheques. A few basic medical tests followed to determine whether the patient could safely be operated upon. The operation was then scheduled for the next day. Burou's clinic had eight to ten beds, half of which were reserved for transgender women. The Dutch trans woman Colette Berends (1934–2012) remembered:

> For me, having the operation in Casablanca was a huge and scary step to take. Positive as well as negative stories about Doctor Burou were circulating in our circles. One day you'd hear he was a butcher, the next that he was a good surgeon. That's why I decided to accept a two-month contract with a cabaret over there, so I had the time to properly find out what kind of man this Burou actually was and assess the clinic for myself. I had a conversation with him and got a favorable impression. I had also asked him: "Does it hurt badly when you come around?" He said: "No, don't worry, we'll make sure it doesn't." That positive impression turned out to be correct as I had a good operation and received good care.
>
> One Sunday evening I had myself admitted. The nurse noticed that I was very nervous and sedated me. I only woke up the next morning to undergo the surgery. After

> the operation, I came around and found myself, arms tied, in the bed. No pain at all. I asked: "When will it start?" "Madame, it's already happened." I then cried and cried, and the next day again. All the tension was released. And I was overcome with joy.[73]

Burou stopped working around 1975, when he was sixty-five years old. In the meantime, gender surgeons had opened offices in other places in the world, so the options for gender-affirmation surgery remained available for transgender women,[74] that is to say, for those who could afford it. A sum of 2,000 to 5,000 US dollars was a lot of money in the mid-1970s, comparable to 20,000 to 50,000 today. And this only covered the surgery part of the trip; travel and possible extra accommodation costs (after or before the time in the clinic) had to be added. Such costs thus excluded trans women who had no means to obtain such a large amount of money. In a recent book on the subject of transsexual surgery, Aren Aizura argues that this was a privilege of white middle-class trans women.[75] I would instead say that this kind of surgery was a privilege of people with money, full stop, since I know that a number of Burou's patients were part of the subculture of drag shows and prostitution, and some were people of colour, such as Jill Pattiradjawane, who remembered that she had to work and even had to go without food to be able to save the money for her trip to Casablanca.[76]

In the space of twenty years, Burou performed an estimated 1,000 vaginoplasties. He focused almost solely on transgender women; it was very rare that a transgender man turned to him for help. One of those exceptions was from the Netherlands. After reading about Burou's practice in a magazine in 1972, a Dutch trans man (who wishes to remain anonymous) took the train and boat to Casablanca to ask for surgical help. Burou said he did not have the expertise to create a penis, but was willing to surgically remove the uterus and breasts.[77] One or two years later, Burou performed three phalloplasties but then stopped, because he was not content with the results, despite the fact that, according to *Paris Match*, the trans men themselves were.[78]

The generally good results of Burou's vaginoplasties did not mean that there were no complications. The downside of Burou's clinic, besides the exclusionary effect of the high price, was the total lack of aftercare. Patients came flying in and usually left straight after their hospital stay – which normally lasted seven to fourteen days – flying back to Paris, Amsterdam, Antwerp, Berlin, New York, or wherever they came from. They had to deal with any problems that developed afterwards themselves, at home, or hope that the local hospital would understand their situation and offer medical care.

One of the people who developed post-operative complications was Ms. B. from the Netherlands. When she arrived back home, she noticed she was losing a lot of blood, and the surgical site had become infected. She was urgently admitted to the Wilhelminagasthuis in Amsterdam, where the doctors treated her with some disdain.

She stayed in the hospital for months – in the psychiatric ward. This could be because she was indeed not quite herself after all that had happened, but it might also have been because at the time, transgender people were generally treated as being psychologically disturbed by definition.[79]

1959: Operation in Arnhem

On April 7, 1959, at the Municipal Hospital (Gemeenteziekenhuis) in Arnhem, plastic surgeon Siebren Woudstra operated on a thirty-four-year-old transgender man. This was likely the first female-to-male operation in the Netherlands. It was certainly the first transgender operation in the Netherlands that happened openly, in a general hospital.

The trans man who would play such an historic role was the thirty-four-year-old German Gert M. Gert M. was an instrument manufacturer by profession who had been living as a man for quite some time. A couple of years earlier, he had been tested by an international team of sexologists and psychiatrists at the university clinic in Hamburg. Apparently, his gender dysphoria had been so obvious and compelling that the doctors recommended plastic surgery. He had undergone a mastectomy in South Africa,[80] but he also wanted to have his uterus removed and a phalloplasty performed. To obtain these procedures, Van Emde Boas, who was part of the international team, required him to submit to an intense four-month observation in 1958. Van Emde Boas's assistant Margreet Groot remembers him very well:

> Gert was the first woman-to-man transsexual we had. A gentle boy, he looked a bit boyish for his age, short, with stubble. He hated not being able to pee standing up and was very scared that people would notice that his pants were empty when he was playing sports. A nice, very modest man, with a steady girlfriend, a nurse whom he later married. He managed very well in daily life. Coen did his thorough analysis, and in all the sessions Gert's story remained solid. So, in the end it was a straight-forward case.[81]

Van Emde Boas arrived at the conclusion that people like Gert could benefit from medical assistance, and he referred Gert to a plastic surgeon, Woudstra. Woudstra was one of the first plastic surgeons in the Netherlands, and he enjoyed an excellent reputation. It is unclear what his motivation was to perform this daring procedure. It could not have been about the money, as the operation did not take place in a private clinic. It is likely that Woudstra was guided by the diagnosis of the psychiatrists in question and that he subsequently honoured the patient's request on ethical grounds. On the other hand, he may have been professionally excited by the new and technically challenging elements of the surgery. Woudstra had been asked to remove the uterus and vagina and to construct a penis that Gert could urinate with – an even more complex surgical challenge. Woudstra was able to fall back on existing techniques developed for cismen who needed penis reconstruction

after some kind of trauma. He also studied the case of the English transgender man Michael Dillon, who underwent a series of phalloplasty surgeries performed by Harold Gillies between 1946 and 1949.[82] Gillies had constructed a penis with a big tubular piece, in which a smaller tubular piece was attached to serve as a urinary tract, forming a tube within a tube.[83]

The team meeting discussing the surgery at the Gemeenteziekenhuis Arnhem was published almost in its entirety in the *Nederlands Tijdschrift voor Geneeskunde* (Dutch journal of medicine),[84] but the gynecologist refused to cooperate. Plastic surgeon Woudstra was disappointed: "Who are we – nonexperts – to refuse to help." He meant "nonexperts" in comparison to the expertise of the two psychiatric institutions that made the initial diagnosis. The diagnoses indicated that it was best to continue on the path of transformation as far as possible. The reasoning was pragmatic: a process of transformation had already begun, so now it would have to continue to "complete" the person as much as possible.

Despite the fact that the German patient had been living as a man for years, the doctors consistently used the word "woman" and the pronouns "she/her." Obviously, they perceived the transgender man to still be a woman, albeit a woman wanting to live as a man. Almost all attending doctors said they could not understand the woman's wishes, but they could see that the patient was seriously ill and needed help. They trusted the psychiatrists' assessment that medical treatment was indicated. The treatment consisted of several operations and encountered some complications. When asked if he still would have done it knowing how hard it was going to be, the German transgender man answered wholeheartedly: yes.[85]

The extensive report in the *NTvG* did not receive a warm welcome from readers. A barrage of heated letters to the editor ensued. Very few spoke in favor of the Arnhem team and the individual with the wish to change their sex. Responses included the following:

> I therefore want to only say one word: Insane!
>
> … deliberate infliction of serious bodily harm … bizarre operations, mental aberrations …
>
> If the procedure would have the desired results, do we then not need to consider the possibility that this "man" may develop masculine feelings for our daughter? Then I am glad that I don't live in Arnhem, because I have two daughters.

A plastic surgeon called it indefensible that a psychosis was being treated with a dummy treatment and found the entire idea downright ludicrous. "Surely, there won't have been anyone suggesting to her that she could become a 'real' man!"[86] And another: "All mutilating operations raise aversion, and to mutilate a normal female body in this way is so disgusting that it almost makes one sick to the stomach … We therefore have to hope or pray (depending on one's religion) that psychiatry will find

Figure 4.24: Trans women backstage at Bar Oporto, Warmoesstraat, Amsterdam, 1967. Aaïcha Bergamin (not in this picture) performed at it and later managed the bar. Copyright © Cor Jaring/Amsterdam City Archive.

an adequate therapy for these kinds of horrible 'freaks of nature.'"[87]

Plastic surgeon Woudstra also had to go before the medical disciplinary council. All those involved made statements except the patient.[88] Woudstra was cleared of neglect and medically unethical behaviour because he had performed his operations under the authority of renowned psychiatrists and sexologists. The medical uproar did not go unnoticed and led to parliamentary questions being posed to the Minister of Justice. According to a national newspaper the operation even created "widespread" turmoil.[89] Meanwhile, the Minister of Social Affairs and Public Health requested a formal opinion from the Health Council on this medical-ethical problem. The question was: "Can it, in all fairness, be stated that in some cases we may expect a transformation to yield (psycho) therapeutic results?"[90] A committee was appointed, consisting of professors of psychiatry, psychology, a professor of criminal law, the chief inspector for Public Health, and a few doctors. It took the committee five years to formulate an opinion. In January 1966, its report was made public, ironically in the same year that Benjamin's more sympathetic *The Transsexual Phenomenon* was published.[91]

The committee's opinion was adamantly negative. The committee took it for granted that transsexuality stemmed from a mental disorder and its assessment of psychotherapy as a solution (albeit a limited one) followed from this predisposition. The argument that you should not cut into a healthy body carried a lot of weight. Between the lines, the committee also painted transgender people as unpleasant – freaks, even – who did not behave as good patients and were out to manipulate doctors. Examples of the positive effects of operations were simply rejected. The committee drily mentioned that it had rejected the idea of consulting any transgender people at all, simply conducting a literature review and interviewing two psychiatrist-sexologists: Coen Van Emde Boas and Herman Musaph. The final decision followed Musaph's psychoanalytical vision. This formal government statement effectively banned the provision of medical assistance to transgender people, making it all but illegal.[92] No doctor dared to touch this field anymore. Transgender people were once again confined to psychoanalytical sessions on the couch. In some cases, electroshocks were even applied.[93]

Waiting for Better Times to Come

And that is what life looked like for transgender people in the Netherlands in the mid-1960s. Out-of-the-closet transgender women were largely sent into the shadows of society, into a subculture of prostitution and nightlife – a hard and unsafe life. The outside world – be it the police, landlords, or municipal services – had the power to intimidate trans people, particularly because their identification and official registration generally failed to match their self-presentation. No physical change was possible other than the effects of taking hormones, unless one was brave and wealthy enough to go to Casablanca.

What about those who remained in the closet? Their transgender feelings must have left them in a state of confusion and frustration. Christine Jorgensen and other celebrity transgender women may have been role models, but not for everyone. Many transgender people in the Netherlands believed themselves to be crazy, sick, or sinners. Some transgender men believed that a transformation was only possible from man to woman and did not know it could also happen the other way around. The lack of future perspective kept people in chains. Many transgender people had internalized the stigma that they were dirty and vile, and they felt that they had to fight their desire to transition. They all had to wait for better times to come. As Aaïcha Bergamin put it:

> When they say to me: "Well, you'll understand that to normal people you …" et cetera, then I immediately think: Right, normal people, and I'm opposite as abnormal. You'll always be marked, abnormal, perverse, sick, mentally ill. Especially psychiatrists give you that feeling. They're mostly brief visits. I don't have the impression that they begin to understand us. They're staring

at you like you're a miracle of God, and you can sense that they think you're some sort of idiot, a mad person.[94]

Conclusion

The Netherlands made a start in offering medical care to trans people as early as 1954. Within an international network that was largely constructed by liberal psychiatrist Van Emde Boas, doctors started treating transgender women from abroad who were seeking gender-affirmation surgery. The surgical treatment for American trans women focused solely on castration, this being the critical intervention they were not allowed to undergo in the United States. This early form of transgender care reflects normative social and medical views of the era that now feel quite narrow minded. As Susan Stryker writes: "medical science has always been a double-edged sword – its representatives' willingness to intervene has gone hand in hand with their power to define and judge."[95] The goal was to integrate trans people back into society, to have them lead a normal, inconspicuous, invisible life without anybody knowing about their history, not even potential partners. The Dutch approach was in sync with that of Harry Benjamin, about whom Pat Califia noted critically: "He seems completely unaware of any damage it might do a reassigned transsexual woman to hide her past from intimate partners … But Benjamin was not in the business of critiquing social sex roles or revolutionizing society's concept of womanhood. He was in the business of helping disturbed and upset people fit into society as much as possible, to lead lives that were as contented as possible."[96] In my opinion this concept of transgender medical care can best be characterized by the word "detranssexualization" – a word commonly used by trans health care providers in the Netherlands in the 1970s and 1980s. It formed the core of the doctors' involvement: if a post-operative trans woman would have gone on living a life in the subculture of queer circles, my guess is that most of these doctors would have been quite disappointed.

Trans surgery was anything but easily accessible: the accessibility relied heavily on psychiatric concepts and on the psychiatrists' assessment of how well the individual passed, with an underlying assumption that the ultimate goal was to prevent desperate people from committing suicide. One of Van Emde Boas's criteria was that the candidate should no longer be susceptible to psychotherapy. Again, Califa's analysis points out the similarity to Benjamin: "Benjamin claims that in the absence of surgery, transsexuals will engage in self-mutilation or suicide. This makes it sound as if the surgeon is morally compelled, almost blackmailed, into operating, lest he contribute to self-destruction. In order to justify removal of male sex organs, the doctor must be seen to be as helpless in the face of this 'disorder' as the transsexual."[97]

Although Van Emde Boas and Benjamin shared many views towards the transgender phenomenon, there were also significant differences between them,

possibly stemming from the fact that the Dutchman was a psychiatrist and the American was an endocrinologist. Benjamin located the etiology of "transsexualism" (as did the Danish doctors) as hidden in the body, not in the mind.[98] Van Emde Boas did not agree, and his disagreement is evident in his psychoanalytic theories. Nevertheless, such psychoanalytic interpretations did not stop Van Emde Boas from offering help and medical care.

In a way, the start of gender-affirmation surgery in the Netherlands was linked to a quite specific and body-negative form of health care: surgical castration as a form of relief for people suffering from what was considered a problematically high sex drive. Trans women contacted those with medical expertise in the castration (voluntary or nonvoluntary) of sex offenders. Removing the testes as a source of unwanted sex drive meant demasculinization, and that was the first step to becoming female. In general, one could argue that pioneering efforts to gain access to transgender care succeeded only by relying on very negative views about trans peoples' states of mind. In my interpretation of the Dutch case, these pioneers managed to persuade the few doctors willing to help not by achieving truly empathetic understanding but only because the doctors viewed gender-affirmation surgery as the lesser of two evils. But even this option remained closed to most: the accessibility of this medical care was restricted, because it relied primarily on the ability to pass. It was based on the concept of gender normativity and required integration into society. Some trans women had no problem with this, because it was exactly what they wanted for themselves.[99] We have to realize, however, that the heteronormative and cisgendered norms excluded others from any consideration.

A number of Dutch trans women also went to Casablanca. The absence of gatekeeping in Dr. Burou's clinic empowered trans people to make autonomous decisions. The surgery itself was a big improvement for trans women, The option of having gender-affirmation surgery in the Netherlands through Van Emde Boas was not available anymore – had they even heard of it. The milestone male gender-affirmation surgery for Gert M. in Arnhem sadly backfired, in that it led to a storm of upheaval among medical peers and in society, which resulted in the Dutch commission's decision that no therapeutic success could be expected from transgender care and doctors should stay clear of these ostensibly severely disturbed patients. With this public statement of official government policy, the recognition of transgender people and their rights came to a full stop. Despite the fact that the door had been opened a crack, trans people in the Netherlands continued to be defined by limitations and exclusions. This would last until around 1970 before the first new attempt at trans health care came about. In line with the Arnhem case, trans health care was to be part of general health care, ultimately leading up to one of the biggest centres for trans care in the world, the Gender Team of the VU Medisch Centrum, Amsterdam (1975–present, total number of patients around 10,000).

GALLERY NOTES: Hirschfeld's "Female Transvestites"

1 On the Steinach Film, see Rainer Herrn and Christine N. Brinckmann, "Of Rats and Men: Rejuvenation and the Steinach Film," in *Not Straight from Germany: Sexual Publics and Sexual Citizenship Since Magnus Hirschfeld*, edited by Michael Thomas Taylor, Rainer Herrn, and Annette F. Timm, 212–34 (Ann Arbor: University of Michigan Press, 2017). Four major recent work on Steinach are Sonja Walch, *Triebe, Reize und Signale: Eugen Steinachs Physiologie der Sexualhormone; vom biologischen Konzept zum Pharmapräparat, 1894–1938* (Vienna: Böhlau Verlag, 2016); Michaele Lindinger, *Sonderlinge, Aussenseiter, Femmes fatales: Das "andere" Wien um 1900* (Vienna: Amalthea, 2015); Cheryl A. Logan, *Hormones, Heredity, and Race: Spectacular Failure in Interwar Vienna* (New Brunswick, NJ: Rutgers University Press, 2013); and Heiko Stoff, *Ewige Jugend: Konzepte der Verjüngung vom späten 19. Jahrhundert bis ins Dritte Reich* (Cologne: Böhlau, 2004). On the notion of the "glandular self" as it developed in the United States, see Michael Pettit, "Becoming Glandular: Endocrinology, Mass Culture, and Experimental Lives in the Interwar Age," *American Historical Review* 118, no. 4 (2013): 1052–76.

2 Michaela Lindinger argues that Harry Benjamin was the only doctor specialized in the rejuvenation of women, and that this work was "centered on (re-)establishing femininity as such": "Im Zentrum stand die '(Wieder-) Herstellung der Weiblichkeit an sich'"; *Sonderlinge, Aussenseiter, Femmes fatales*, 148.

GALLERY NOTES: Sensationalism

1 This photo likely depicts the person whose story was told in Case 15 in Hirschfeld's *Die Transvestiten* (116–27).

NOTES TO CHAPTER 4

1 Harry Benjamin, *The Transsexual Phenomenon: A Scientific Report on Transsexualism and Sex Conversion in the Human Male and Female* (New York: The Julian Press, 1966), 147.

2 For more about the invisibility of trans men and their separation from LGBT communities during earlier periods in the United States, see Emily Skidmore, *True Sex: The Lives of Trans Men at the Turn of the Twentieth Century* (New York: New York University Press, 2017). Susan Stryker has written that "'Transgender women who survive by participating in sexual street subcultures have long bonded together for mutual support, whereas transgender men often lived without being part of a larger transgender community." *Transgender History* (Berkeley, CA: Seal Press, 2008), 79.

3 For more background, see Elisabeth Lockhorn, *Andreas Burnier, metselaar van de wereld* (Amsterdam: Atlas Contact, 2015).

4 Richard Mühsam, "Chirurgische Eingriffe bei Anomalien des Sexuallebens," *Therapie der Gegenwart* 67 (1926): 451–5.

5 Coen van Emde Boas, translation from a letter in personal archives, 8 Nov 1956.

6 Dick Swaab, *Wij zijn ons brein: Van baarmoeder tot Alzheimer* (Amsterdam: Olympus, 2010), 96.

7 Interview with Jill Pattiradjawane, 2017.

8 Alex Bakker, *Transgender in Nederland: Een buitengewone geschiedenis* (Amsterdam: Boom Uitgevers, 2018), 43.

9 Otto de Vaal, *Man of Vrouw? Dilemma van de Transseksuele Mens* (Amsterdam: Wetenschappelijke Uitgeverij, 1971), 83.

10 There was not even a law against cross-dressing in the Third Reich. Another exception was the United States. As Clare Sears has documented, in the period between 1848 and the First World War, laws against cross-dressing were passed in forty-four American cities. She focuses particularly on San Francisco, which passed such a law in 1863. Clare Sears, *Arresting Dress: Cross-Dressing, Law, and Fascination in Nineteenth-Century San Francisco* (Durham: Duke University Press, 2014).

11 Local laws like these existed in many cities around the world. Susan Stryker describes the possible origins of these laws in the United States, dating back to the 1850s, in *Transgender History*, 32–5.

12 Interview with Aaïcha Bergamin, 2013.

13 Christine Jorgensen Collection, Archives Royal Danish Library, Copenhagen.

14 I have written about this in my book *Transgender in Nederland: Een buitengewone geschiedenis* (Amsterdam: Boom Uitgevers, 2018).

15 Christian Hamburger, "The Desire for Change of Sex as Shown by Personal Letters from 465 Men and Women," *Acta Endrologica* 14 (1953): 361–72.

16 W. P. Plate, "Het verlangen om van geslacht te veranderen," *Nederlands Tijdschrift voor Geneeskunde*, 13 Mar 1954, 726–7.

17 E. A. D. E. Carp, "Transvestitisme," *Nederlands Tijdschrift voor Geneeskunde*, 29 May 1954, 1474–7.

18 E. A. D. E. Carp, *Psychopathologische opsporingen* (Amsterdam: Strengholt, 1951) "Over het psychisme van de waan van de verandering van geslacht," 118.

19 Susan Stryker, *Transgender History* (Berkeley, CA: Seal Press, 2008), 43, 44.

20 It is likely that Hamburger knew Hartsuiker as a fellow medical expert on the impact of sex hormones.

21 I am providing MacLane's full name here because she sought fame as a burlesque performer under this name.

22 Letter from Frederik Hartsuiker to Harry Benjamin, 9 Feb 1954, Kinsey Institute Library and Special Collections, Harry Benjamin Collection (hereafter KILSC-HB), Box 5, Ser. II C – Hartsuiker, Dr. F.

23 Carla Erskine to Harry Benjamin, 28 Feb 1954, 10 Feb 1954, and 8 Mar 1953, KILSC-HB, Box 4, Ser. II C.

24 Benjamin to Hartsuiker, 15 Feb 1954, KILSC-HB, Box 5, Ser. II C – Hartsuiker, Dr. F.

25 We know from Benjamin's statistical lists and tables, compiled for *The Transsexual Phenomenon*, that Dixie MacLane ended up getting surgery with Dr. Ferrer in Mexico. See KILSC.

26 The Rorschach and Szondi tests are both so-called projective personality tests, designed to let a person respond to ambiguous stimuli, presumably revealing hidden emotions and internal conflicts projected by the person into the test. The Szondi test had images of gender variant people in it from the Hirschfeld's collection.

27 Hartsuiker to Benjamin, 10 Mar 1954, KILSC-HB, Box 5, Ser. II C – Hartsuiker, Dr. F. With the 1954 rate of 1 guilder for 3.8 American dollars, this seems to be quite low. In 1955, the price mentioned by Catherine J. to Harry Benjamin was around twice as high.

28 Harry Benjamin to Shelly W., May 3, 1954, KILSC-HB, Box 8, Ser. II C – W., Shelly.

29 Benjamin to W., 7 May 1954, KILSC-HB, Box 8, Ser. II C – W., Shelly.

30 Hartsuiker to Benjamin, 12 May 1954, KILSC-HB, Box 5, Ser. II C – Hartsuiker, Dr. F.

31 Benjamin to Hartsuiker, 18 May 1954, KILSC-HB, Box 5, Ser. II C – Hartsuiker, Dr. F. "Transsexualism and Transvestism as Psycho-Somatic and Somato-Psychic Syndromes," *American Journal of Psychotherapy* 8, no. 2 (1954): 219–30.

32 Meyerowitz, *How Sex Changed*, 82.

33 Hartsuiker to Benjamin, 12 June 1954, KILSC-HB, Box 5, Ser. II C – Hartsuiker, Dr. F.

34 Personal records of Van Emde Boas, correspondence with F. Hartsuiker, 24 June 1954.

35 Stryker, *Transgender History*, 45.

36 Catherine J. to Harry Benjamin, 30 Jan 1955, KILSC-HB, Box 5, Ser. II C – J.

37 Harry Benjamin to Rosa F., 31 Oct 1955, KILSC-HB, Box 4, Ser. II C – F., Rosa.

38 C. van Emde Boas, "De behandeling van transseksisten in Nederland 1953–1973: Een les van 20 jaar attitudeschommelingen," *Medisch Contact* 29 (1974): 475–8, here 475.

39 Peotomy is synonym for penectomy.

40 Catherine J. to Benjamin, 1 Apr 1955, KILSC-HB, Box 5, Ser. II C – J.

41 Meyerowitz, *How Sex Changed*, 82.

42 Tamara Rees, *Reborn: A Factual Life Story of a Transition from Male to Female*, n.p., 1955. Correspondence between Benjamin and Hartsuiker shows that Rees's story about having had a second and third genital operation in the Netherlands is not true.

43 "Boston Traveler," 8 Nov 1954, 15 and "Omaha World Herald," 8 Nov 1954, 7.

44 Hartsuiker to Benjamin, 19 Nov 1954, KILSC-HB, Box 5, Ser. II C – Hartsuiker, Dr. F.

45 Benjamin to Hartsuiker, 24 Nov 1954, KILSC-HB, Box 5, Ser. II C – Hartsuiker, Dr. F.

46 F. to Benjamin, 5 May 1955, KILSC-HB, Box 4, Ser. II C – F., Rosa.

47 Van Emde Boas, "De behandeling van transseksisten in Nederland," 475.

48 J. to Benjamin, 27 Apr 1955, KILSC-HB, Box 5, Ser. II C – J., Catherine.

49 J. to Benjamin, 11 Mar 1955, KILSC-HB, Box 5, Ser. II C – J., Catherine.

50 J. to Benjamin, 3 Mar 1955, KILSC-HB, Box 5, Ser. II C – J., Catherine.

51 J. to Benjamin, 11 Mar 1955, KILSC-HB, Box 5, Ser. II C – J., Catherine.

52 Van Emde Boas, "De behandeling van transseksisten in Nederland," 475.

53 In the Netherlands, it is quite common for doctors to have a home office as a practice.

54 The letter is stored in the personal records of Van Emde Boas.

55 Pat Califia, *Sex Changes: The Politics of Transgenderism* (San Francisco, CA: Cleis Press, 1997), 53.

56 J. to Benjamin, 1 Apr 1955, KILSC-HB, Box 5, Ser. II C – J., Catherine.

57 E. A. D. E. Carp, "Transvestitisme," 1474–7.

58 Rees, *Reborn*, 37.

59 F. to Benjamin, 6 May 1955, KILSC-HB, Box 4, Ser. II C – F., Rosa.

60 Note in personal archive Van Emde Boas.

61 Interview with Margreet Groot, by Alex Bakker, 2017.

62 Personal archives of Van Emde Boas, correspondence with Prof. Dr. Urban, Innsbruck, 14 June 1956.

63 Gezondheidsraad, "Rapport betreffende plastisch-chirurgische geslachtstransformatie: Verslagen en Mededelingen betreffende de Volksgezondheid," January 1966, 28.

64 Personal archives of Van Emde Boas, correspondence with Prof. Dr. Urban, Innsbruck, 14 June 1956.

65 Benjamin, *The Transsexual Phenomenon*, 30.

66 C. van Emde Boas, "Transseksisme: wat is dat eigenlijk?" *Medisch Contact*, 5 Apr 1974, 443–5. The article stems from 1974, but Van Emde Boas stated that he had developed this concept already in the 1950s.

67 Interview with Dutch plastic surgeon and Burou specialist Joris Hage, by Alex Bakker in 2017.

68 Donald R. Laub and Patrick Gandy, *Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome* (Stanford, CA: Stanford University Medical Center, 1973), 247 (see https://catalog.hathitrust.org/Record/003521724 and http://ai.eecs.umich.edu/people/conway/TS/Burou/Burou.html, accessed 28 June 2019).

69 It should be noted that Burou's procedure remained unknown to doctors practicing elsewhere in the world as late as 1972, the year that Canary Conn (who later wrote an autobiography and appeared on various television interview shows in the United States) was operated on by Jesus Maria Barbosa (whom she anonymizes as Dr. Lopez) in Tijuana, Mexico. Her surgery, which she describes as having taken place in horrendously unsanitary conditions, was in two stages: castration and labiaplasty followed by penectomy and vaginoplasty. See Canary Conn, *Canary: The Story of a Transsexual* (Los Angeles: Nash Publishing, 1974). On "Lewis's" real name, see Sandy Stone, "The Empire Strikes Back: A Posttranssexual Manifesto," in *The Transgender Studies Reader*, ed. Susan Stryker and Stephen Whittle (New York and London: Routledge, 2006), 233n22. A fascinating interview that Conn gave to *Psychology Today* in 1977 has recently been made publicly available in a

podcast by Gillian Frank Lauren Gutterman. "Canary." Sexing History. Accessed 1 July 2019. https://www.sexinghistory.com/episode-24.

70 A discussion of gender-affirming surgery in Mexico awaits future research. Barbosa's name first appears in Benjamin's table of surgeries in 1966, while Burou (initially misspelled "Bureaud") first appears for a 1962 surgery. A later version of the table (clear because the spelling has been corrected), lists a Burou-performed surgery in 1957. See KILSC-HB 28.

71 "De gynaecoloog die vrouwen maakt," *Nieuwsblad van het Noorden*, 15 June 1974, 37.

72 Interview with Dutch plastic surgeon and Burou specialist Joris Hage, by Alex Bakker in 2017.

73 Interview with Colette Berends, by Alex Bakker, 2010.

74 J.Joris Hage, Refaat M. Karim and Donald R. Laub, "On the Origin of Pedicled Skin Inversion Vaginoplasty. Life and work of Dr Georges Burou of Casablanca," *Annals of Plastic Surgery*, (Dec 2007), 723-9.

75 Aren Z. Aizura, *Mobile Subjects: Transnational Imaginaries of Gender Reassignment* (Durham, NC: Duke University Press, 2018).

76 Interview with Jill Pattiradjawane, Dutch trans woman (born 1939), by Alex Bakker, 2017.

77 Interview with anonymous trans man, by Alex Bakker, 2015. See: Bakker, *Transgender in Nederland*, 48.

78 V. Merlin, "L'homme qui change le sex," *Paris Match* (1974): 37–9.

79 Interview with Ms. B. by Alex Bakker, 2010.

80 B. Haeseker and J-P. A. Nicolai, "De eerste geslachtsveranderende operatie van vrouw naar man in Nederland, 1959/'60," *Nederlands Tijdschrift voor Geneeskunde* (3 Mar 2007): 548–52.

81 Interview with Margreet Groot by Alex Bakker, 2017.

82 Gillies and D. Ralph Millard Jr., *The Principles and Art of Plastic Surgery*, vol. 2 (London: Butterworth & Co., 1957), 368–84.

83 Haeseker and Nicolai, "De eerste geslachtsveranderende operatie," 550.

84 "Nuttige notities No. 9 Verslag van een bespreking op een stafvergadering van het Gemeente-Ziekenhuis te Arnhem," *Nederlands Tijdschrift voor Geneeskunde* 103 (26 Dec 1959): 2647–9.

85 H. R. Bax, "Letter to the Editor," *Nederlands Tijdschrift Voor Geneeskunde*, 6 Feb 1960, 303. Bax was a surgeon at the *Gemeenteziekenhuis Arnhem*.

86 W. H. Beekhuis, "Letter to the Editor," *Nederlands Tijdschrift Voor Geneeskunde*, 12 Mar 1960, 536.

87 A. E. Nordholt, "Letter to the Editor," *Nederlands Tijdschrift Voor Geneeskunde*, 9 Apr 1960, 742.

88 Haeseker and Nicolai, "De eerste geslachtsveranderende operatie."

89 "Commissie zegt 'neen' tegen geslachtstransformatie," *Het Vrije Volk*, 1 Oct 1966.

90 Gezondheidsraad, "Rapport betreffende plastisch-chirurgische geslachtstransformatie," 3.

91 Gezondheidsraad, "Rapport," 4.

92 Archives Foundation Netherlands Gender Centrum (NGC): Frans van der Reijt, "De bejegening van transsexuele mensen in Nederland in de jaren 1960 tot 1990," 1993.

93 Interview with Henk Asscheman, endocrinologist at the Vrije Universiteit Medical Centre, Amsterdam, 2016.

94 De Vaal, *Man of Vrouw?*, 88.

95 Stryker, *Transgender History*, 36.

96 Califia, *Sex Changes*, 59.

97 Ibid.

98 Meyerowitz, *How Sex Changed*, 103.

99 See Meyerowitz, *How Sex Changed*, 12, on the risk of misinterpreting trans pioneers as activists against traditional norms.