# Chrysalis Quarterly

*Winter, 1992 Volume 1, No. 3*
*$9.00*

Sugar n Spice &

Everything Nice?

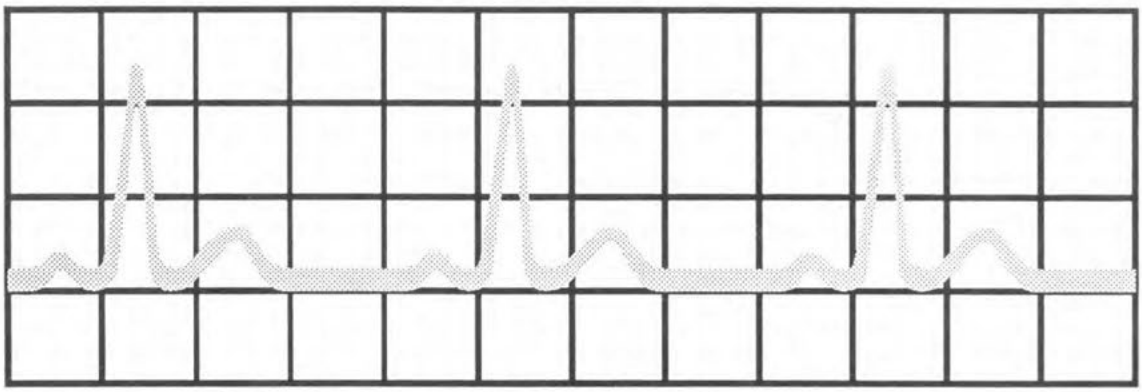
Snakes n Snails &

Puppydog Tails?


## *This issue.....*

*Politics & Sexism in Gender Confirmation*

# This is your Heart.



# This is your Heart on hormones.

# This is your Heart on too many hormones.

Hormones can change your life—for good, or for bad.

If taken under the supervision of a physician, they will, over the course of years, cause significant changes in the way you look and feel.

If taken recklessly, they can be harmful, or even fatal.

With hormones, more does not necessarily equal better. Taking excessive dosages of hormones will not feminize or masculinize you any faster than the proper dose, but will greatly increase health risks. To minimize your health risks, follow these simple guidelines.

- You should never buy hormones on the street, or take hormones meant for another person.

- You should take hormones only when prescribed by a physician, and only in the amount prescribed. Your physician should periodically monitor your blood chemistry, and if he or she does not, you should ask for blood levels to be taken.

- You should not take hormones without approval by a licensed mental health professional.

- Never withold any portion of your medical history or any adverse reactions from your physician.

Abusing your body by overusing hormones will not get you from Point A to Point B any faster—but it just might get you to the morgue.

Remember: Too much of a good thing can be a bad thing.

*A public service of*

AEGIS
American
Educational
Gender
Information
Service

*Write us at:*
*AEGIS*
*P.O. Box 33724*
*Decatur, GA 30033-0724*

# this issue...

Chrysalis Quarterly

Winter, 1992 Volume 1, No. 3

## About the Cover

*This issue's cover, "GenderMatic," was designed by Margaux Ayn Schaffer. It is, in her words, "A deconstructionist study of social engineering as it relates to society's rigid definitions of sex & gender and how they can corrupt the construction of one's 'gender persona.' In essence, the very social systems intended to validate one's gender identity inadvertently circumvent it on the most basic level, by sanctioning the sex-typed behaviors which created the problems to begin with."*

*In addition to serving as Deputy Director and Spokesperson for AEGIS, Ms. Schaffer functions as Art Director for CQ.*

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## Upcoming in CQ:

### Spring '92 Edition:

Surgeries: Sex reassignment and cosmetic procedures

### Summer '92 Edition:

Working together: Minorities within the gender community




*Chrysalis Quarterly*
Volume 1, No. 3, Winter, 1992
Dallas Denny, Publisher and Editor-in-Chief
Holly Boswell, Associate Editor
Margaux Ayn Schaffer, Art Director
Stephanie Rose, Pre-Press Production
Victoria [redacted] Production

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***Mission:*** *Chrysalis Quarterly is dedicated to the in-depth exploration of gender issues. Our focus will be on topics which have been ignored or only lightly touched upon in other forums. Our treatments will be intelligent and unbiased.*

***Submissions:*** *We welcome your stories, articles, letters, editorials, news clippings, position statements, research reports, press releases, poems, and artwork.*

*Authors should indicate whether materials have been submitted or printed elsewhere.*

*We will be happy to exchange publications and space for small ads with publishers of other magazines or newsletters. We will publish for free a description of or publicity release for your group or magazine, if you will reciprocate.*

*CQ reserves the right to reprint all submissions. All other rights revert to the individual authors after publication. Authors should indicate whether their materials may be reprinted in other newsletters and magazines.*

*Authors will receive a free issue of CQ.*

*The opinions of the various contributors do not necessarily reflect those of the editors or of AEGIS. The editors reserve the right to refuse submissions which do not meet our editorial or aesthetic standards.*

*Submissions are preferred on 3.5" or 5.25" MS-DOS, Macintosh, or Atari ST diskettes, in ASCII or WordPerfect formats. A printed version should be included. Double-spaced typewritten or legibly handwritten manuscripts are acceptable. FAX or electronic transfer can be arranged by contacting one of the editors. Media will not be returned unless accompanied by a self-addressed, stamped envelope.*

***Subscriptions:*** *Individual subscriptions are available for $30.00 per year. Institutional subscriptions and subscriptions outside the U.S. and Canada are $40.00. All mailings are in plain manilla envelopes. Subscriptions include one year (4 issues) of CQ plus three booklets from the AEGIS Transition Series and the AEGIS Abbreviated Bibliography of Gender Dysphoria, upon request only.*
***Donations:*** *AEGIS is a not-for-profit organization. We accept and encourage donations of any amount.*

***Advertising:*** *Please contact us about advertising rates and requirements. We reserve the right to refuse any advertisement which we feel does not meet our editorial or aesthetic standards.*

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# *from the publisher...*

We've been busy, moving into new and more spacious quarters; this explains why it's been a while since you saw an issue of CQ.

The new offices will allow us to have design and printing services on the same premises, giving us in-house production, from writing to editing to pre-press production to printing to distribution. There will be more people to man the phone lines and to assist with the many tasks associated with running an organization like AEGIS.

AEGIS is growing by leaps and bounds. Creative and energetic people have appeared and are continuing to appear to take on the many burdensome tasks that need doing. We have successfully launched a magazine which has drawn only raves, produced a bibliography of gender dysphoria which will be published by Garland Press, and distributed the first several of a series of booklets designed to help transgendered persons help themselves. We have started a support group (which is now independently operating, and thriving), maintained a telephone help line, and begun a speaker's bureau. We have made liaisons with service providers and with many individuals and groups in the gender community. We have been involved in the planning and running of Southern Comfort, the first-ever major gender event in the South, and are deeply involved in the planning of the second Southern Comfort.

I am amazed by the talent and energy which the AEGIS staff has shown, and by the ideas that they generate. My hat is off to each and every one of them.

## *Introductions*

After two successful issues of Chrysalis Quarterly, perhaps it is time to introduce ourselves.

I am the founder and Executive Director of AEGIS. I am a youthful and exuberant 42-year-old. I am employed at a workshop for adults with mental retardation, doing case coordination, psychological testing, and applied behavior analysis. I find the work very fulfilling. I am a licensed psychological examiner in Tennessee.

I am working hard to finish my doctoral degree in special education from Vanderbilt University.

*Stephanie Rose* is Secretary/Treasurer of AEGIS. She is in charge of pre-press production on all AEGIS publications. She singlehandedly designed and laid out the first issue of CQ and the Transition Series booklets. Stephanie was the first person to share my vision for AEGIS, and I will always love her for it. Her hard work is in a large measure responsible for our success.

Stephanie is a desktop publisher by profession. She is a member of Sigma Epsilon, the Atlanta-based chapter of Tri-Ess, and she was very active in the planning committee for Southern Comfort, designing the logo and promotional materials.

*Margaux Ayn Schaffer* is Deputy Director/Spokesperson for AEGIS and Art Director of Chrysalis Quarterly, and AEGIS representative to the Southern Comfort Convention Planning Committee. Margaux is a graphic artist who specializes in visual identity design and is in charge of the "look and feel" of all AEGIS materials.

Margaux is the model of an enlightened consumer, well-read and articulate. She and I have spent countless hours on the phone and face-to-face, discussing gender issues. Most of the things I have said and written in the past two years were first brought to light in those discussions. Many of my ideas were originally hers.

*Victoria* [redacted] is Production Director for all AEGIS publications. She is responsible for the beautiful production of CQ. A printer by trade, she has volunteered her time to help make CQ the most attractively produced magazine in the gender community. It's wonderful to watch the pages of CQ as they come out of her offset press.

*Holly Boswell,* a resident of beautiful Asheville, North Carolina, is Associate Editor of Chrysalis Quarterly. Holly is married, and has a 4-year-old son. An editor by trade, she is currently doing graphic work for several books.

Holly is founder and director of Phoenix, a transgender support group which meets in Asheville. Phoenix has been in operation for about four years, and in recent months, membership has snowballed. Holly was active at the Southern Comfort meeting, where she presented a workshop on transgender lifestyle options. She will be the editor for an upcoming issue of Chrysalis Quarterly which will examine the duality of human nature.

*Carol Miller, M.Ed.,* is a licensed professional counselor in Georgia and Mississippi, an advisor to AEGIS. She graciously allows the support group we started to meet in her offices.

There are other AEGIS personnel I would like to mention and thank: Geneva Deveraux, who came up with the idea for the Southern Comfort 1991 Cookbook, and provided the recipes; and Brenda and Tamara, who proof CQ and our other materials. And I'd like to welcome aboard Kerin Hope, who moved to Atlanta from her native Florida in order to be part of our organization.

Are any of us transgendered? Yes. No. I don't know. I'm not saying. The point is, does it matter? Each of us is participating on the basis of our education and experience. We are productive and talented and well-balanced and stable, and we have something to say. Whether all of us were born women, or whether some of us are new women is irrelevant, and should not influence what you are about to read.

### *They Infested a City*

Dr. Richard Ekins, of the Transgender Archive, graciously sent us several copies of his Archive News. A 1954 press clipping caught my eye, making me aware of just how bad things once were for transgendered persons.

*The discovery of a small black book with the names, addresses and telephone numbers of scores of men living in the Midlands led to the exposure of what was described at Birmingham Assizes as "a vicious clique who had infested the city for many years." ... The court was told that the men called themselves by names such as Tiger Lil, the Duchess, Garbo, Rita, Jezebel, and Nina. It was said also that the men held parties at which some were dressed as women... All the 28 men pleaded guilty to serious charges... At the end of the case the judge said, "I feel the police have shown considerable care and assiduity in these investigations and it is extremely fortunate that this disgusting clique has been brought to light."*

—News of the World, 1 August, 1954, p. 8

If there has been improvement in the status of transgendered persons, it has been largely due to the dedication and hard work of professionals who have chosen to work with them. Beginning with nothing, they have built a literature of gender dysphoria, created standards of care, and perfected hormonal and surgical procedures and other treatment techniques. They have helped tens of thousands of transgendered persons in their quests for personal happiness and gender consonance.

Nevertheless, there have been and continue to be problems in treatment. In some instances, transgendered persons have been ignored, maligned, mistreated, exploited, or turned away by those who have sworn to help. This has been due to ignorance on the part of a few service providers; proper training in matters of gender is unfortunately rare in education programs. Although dramatic improvements have occurred, it is still difficult for transgendered persons to find service providers who are able and willing to help them.

Ignoring treatment problems will not make them go away. They must be confronted head on, so that those who have been responsible for sexism, prejudice, and unprofessionalism can come to understand how they have wronged transgendered persons and move to remedy their mistakes.

We realize that the cover and content of this issue are controversial, and that not everyone will agree with what we have to say. But if we are able to make our readers realize the errors of the past so that they will be less likely to repeat them, we will consider that we have done our jobs.

Only after problems have been acknowledged can they be solved.

### *Public Service Advertisements*

We have begun a series of public service advertisements designed to make transgendered persons aware of some common dangers. Last issue's "Dangerous Curves" ads was the first in the series, and this issue contains the second. In hopes that they will help us to carry our message to persons both in the gender community and without, we are sending the ads to support groups and publishers around the world.This issue features "This is Your Heart on Hormones," which address the risks and dangers of over- and self-medication. Future ads will deal with other issues, including sexually transmitted diseases and adhesion to the Benjamin Standards of Care.

The ads were conceived and designed by Margaux Schaffer. ♀♂

# P.O. Box

I was shown a copy of your publication by my friend Gianna Eveling Israel, and I am impressed enough to join AEGIS. As a preoperative transsexual who is interested in matters of gender, and who hopes to someday be a gender counselor, and who wants to keep her finger on the pulse of what's happening, I found the issue that Gianna showed me (Spring '91) to be informative and useful.

One of the articles—the one about Health and SRS—especially struck me, and frankly, left me in tears. I have been HIV+ for about five years, and I have been unable to find a surgeon who will do SRS on HIV-infected individuals.

—Name & address withheld by request

*In a recent lecture at the 1991 Southern Comfort Conference, David Gilbert, M.D., of the Center for Gender Reassignment in Norfolk, Virginia, addressed the issue of HIV. To paraphrase: there are HIV+ clients in the Norfolk program. HIV infection is not a categorical contraindication for SRS. All cases are evaluated on an individual basis. We will be featuring a full length interview with Dr. Gilbert in CQ #4 (Spring '92)—Ed.*

Thank you for the speedy response to my application and the extremely useful bibliography disc. I will definitely be able to use this in my own research. I can't emphasize how impressed I am with everything I've seen from your organization to date. I'm glad to see that AEGIS is top flight.

—George R. [redacted], MD, Helotes, TX

Thank you for the copy of Chrysalis Quarterly. You are to be congratulated on putting together a very professional publication.

I should be happy to discuss the possibility of serving on your board of advisors.

—Kim Elizabeth Stuart, Oakland, CA

Thank you so much for the wealth of information about AEGIS. Your publication, Chrysalis Quarterly is terrific—timely, broad topics, superbly written. I've just started reading the materials you sent me, and they are most intriguing. Your booklet is also a fine piece. This is really a most impressive educational organization you have founded.

—Anne [redacted], Ph.D.,Elon College, NC

Thanks so much for sharing the information about the recent killings of transgendered persons in Atlanta. We here in Central Iowa read this material with a great sense of shock, grief, and anger.

Violence towards any person does a great grievance to the humanity of ALL persons. Transgendered persons are, indeed, specially vulnerable since they are often relegated to very marginal social status and granted less than the full human rights accorded to others.

The Central Iowa Gender Institute fully supports the movement towards full human rights for ALL persons, particularly transgendered ones. The day will come when we will have full human and economic rights. Keep this promise close to your heart.

—Susan McIntyre, MSW, Coordinator, Central Iowa Gender Institute

I would like to compliment you on your excellent new magazine. Wendy Parker blew into NYC last week and showed me a briefcase full of goodies, including Chrysalis Quarterly. I'd never seen or heard of it before, and was delighted by its intellectual bent. I was happy to see that Holly, a good friend of mine, was one of your contributors.

Mariette Pathy [redacted], NY, NY

*You'll be glad to know that Holly is an editor, as well as a contributor—Ed.*

*The following appeared on 25 May, 1991 in the Charlotte, NC Observer.*

# *Ex-Officer Says He Always Wanted to Be Male*

## *D'Amanda tells of Gender Transition*

*by Lolo* [redacted]

When John [redacted]'s relationship with Linda turned serious, he confessed his closest-held secret: he was born a woman.

"Give me a week to mull it over," she said. They talked again at midweek about his earlier life as Joyce Renée [redacted].

"'I don't know you as anybody but John,'" [redacted] said, quoting the woman who later became his wife. "'I fell in love with you as John. You're more sensitive, you're more caring than any man I know.'"

Somehow, he said, he'd known since he was a baby girl that his life would be different.

If not for a stolen gun, [redacted] might still be guarding his secret.

He was arrested in Florida last month on a York County conviction for stealing a gun while on police duty in 1985. Officer Renée [redacted] fled Rock Hill to avoid prison. This week, [redacted] was sentenced to two years in prison. State officials, who determined that [redacted] is still biologically female, say he will spend the time in a women's prison.

At age 2, Renée [redacted] had corrected coddling strangers who called her a cute little girl. "I'm a boy," she said. At 13, she researched sex change. At 17, she consulted a Miami sex-change doctor. By the time she was a 22-year-old Rock Hill cop, she was taking male hormones.

John [redacted], now 30, is no anomaly. He's one of about 15,000 Americans who were born one sex, psychologically lived the other, and have changed the body via medicine and surgery, reports the Harry Benjamin International Gender Dysphoria Association in Palo Alto, California. About 90 percent have spouses. And most you'll never hear about.

In an interview with the Observer this week, [redacted] talked about what his life had been like:

* He underwent a breast reduction, took monthly injections of male hormones, and plans to undergo a hysterectomy.

* He learned male mannerisms—hand gestures, the 'guy talk'—while out with male friends. He began using men's restrooms and shaving.

* He earned more money and his career accelerated faster than as a woman.

* He was more honest with his friends and family, who took the progressive change in stride.

"The hardest part for them was to call me John," [redacted] said from his isolated skylit Rock Hill jail cell. "My father would say 'Renée' or 'she' or 'her.' And I'd say, 'Dad, you have to stop that.'"

[redacted] and experts in gender dysphoria—unhappiness with gender—say sex change is as misunderstood as the reasons behind it.

Many people, including [redacted], blame it on genetics, saying the hormone level is skewed at birth in favor of the opposite sex.

A family may steer a child toward its biological gender—[redacted]'s mother used to say, "If the good Lord wanted you to be a boy, he would have made you a boy"—but the child constantly feels pulled the other way, experts say.

"Basically, the gender identification is fixed at an early age," said Dallas Denny, director of the clearinghouse AEGIS, the American Educational Gender Information Service. "That tends not to change."

Take Renée [redacted]. As her family crisscrossed the Southeast, young Renée played in boys' rough-and-tumble games. She excelled at football and starred on Virginia's teenage girls' championship softball team.

At 13, she had practiced with a boys' Little League team. Her mother didn't let her play for fear she'd get hurt.

That year, Renée began researching Christine Jorgensen, the world's first documented sex-change woman. At 17, a Miami gender-change doctor waved Renée off because she was too young. "Wait," he said.

Renée told her parents.

"They had thought this would come up one day," [redacted] said.

Then, in 1978, as many as 40 gender clinics operated across the country, performing male-to-female sex changes four times more often than female-to-male, according to AEGIS.

In a process that takes up to four years, clinics urge female patients to live as men and take injections of male hormones before they have surgery to remove breasts and the reproductive system.

That's what [redacted] started at 21. She was also patrolling a Rock Hill police beat and hanging out with the guys off duty.

For many years, she'd worn Levi's and slacks from men's stores. At men's shoe stores, she lied, telling clerks she was trying on shoes for her dad, who wore the same size. For haircuts, she went to a barbershop, not a beauty salon.

Hormones stimulated facial hair and a deeper voice.

"I thought it was exciting at first," [redacted] said. "I was trying to grow a mustache."

Three years later, while on the run from Rock Hill, Brown changed her name to John Peter [redacted].

"It was a pretty name I remembered from somewhere," [redacted] said. "It's kind of funny when my family and I talk about Renée because we talk about her like it's part of the past. Sometimes I miss Renée. Renée could get more emotional than John could. Renée could cry. If John has a bad day, he can't cry."

Another year later, in 1986, in a Virginia gender change program, doctors removed [redacted]'s breasts. His parents were hurt, but understood, he said. "They had had a daughter all their life, and suddenly they had a son. But I had to live my life to please myself."

Renée had been shy and not well-liked by some fellow Rock Hill officers. They were embarrassed when she was arrested and charged with stealing a suspect's gun while on duty. She had planned to sell it to help pay her mother's utility bills.

"It was a stupid thing to do," [redacted] said. "I left everything. I lost everything because of it."

John, who then moved to Fort Myers, Florida, was outgoing. He studied at Edison Community College and dated lots of women.

Renée had a mediocre police career. John was Phi Beta Kappa, and an officer in student government and a medical club. He worked nights at a hospital toward a goal of entering a coveted physician's assistant program.

He said he fit in better and had greater confidence. "A burden was lifted," [redacted] said, beaming. "It was wonderful. The hardest part is learning how to act. You learn to watch people."

[redacted] trained by watching men at restaurants and on sidewalks, copying their moves like an understudy.

[redacted] said sensitivity shone through his 260-pound masculine build. A hospital co-worker once said, "If I didn't know better, I'd say you were a woman in another life."

Last year, he married Linda. Her family accepted their new son-in-law, he said.

Together, they planned his hysterectomy after college graduation this summer. But last month, Florida authorities, tipped that Renée [redacted] was living in Fort Myers, arrested [redacted].

Despite the gloomy jail cell and publicity, [redacted] smiles and dubs this a "temporary thing." He says he's happier than ever. "I feel confident about who I am and what I am," [redacted] said. "It would be nice if other people understood." ♀♂

*The Xth World Congress of Sexology was held in Amsterdam, the Netherlands, 18–22 June, 1991. On 21 June, John Money, Ph.D., delivered an In Memoriam address to honor Pastor Joseph Doucé of Paris. The following was prepared by Louis Gooren, Ph.D., Professor of Medicine (Transsexology and Endocrinology) at the University of Amsterdam. We have taken the liberty of minor editing of the translation.*

*In Memoriam*

# *The Reverend Joseph Doucé*

In 1987, the Reverend Joseph Doucé (1945–1990) founded the "Centre Christ Liberateur" (Center of Christ Liberator) in Paris, France. The center provided pastoral and psychological help to persons with sexological problems. Doucé, a Baptist minister, had been granted a scholarship by the World Council of Churches to study psychology and sexology. He found his inspiration in the Bible, but his doors were open to people with any religious or political beliefs. He was a member of the Harry Benjamin International Gender Dysphoria Association. He was also a publisher, and founded a bookshop in Paris, "Autre Cultures," selling serious sexological books. Several reputable sexologists coauthored books with Doucé.

*Continued on page 8*

## *CQ's Quotations from the Literature*

This issue's politically incorrect quote:

In order for these (guidelines for sex reassignment surgery) to be effective one would have to ensure that sex reassignment surgery was done only by skilled surgeons in highly selected university-based clinics that could provide follow-up. Essentially, this would mean limiting all sex reassignment surgery to a select number of hospitals in the United States. While this raises certain ethical issues, it is clear that current abuse comes from the widespread availability of sex reassignment surgery and not the other way around.

*Leslie Lothstein (1982). Sex reassignment surgery: Historical, bioethical, and theoretical issues. American Journal of Psychiatry, 139(4), 417–426.*

## *In Memoriam: The Reverend Joseph Doucé*

*Continued from page 7*

Realizing that he lived in an anti-sexual world, Doucé was careful to avoid conflicts with the French legal public morality acts. Nevertheless, he was subject to police scrutiny for several years. The state security body, Renseignements Generaux, monitored his activities closely, tapped his telephone without authorization, barred a conference on transsexualism for the general public, and prohibited public display of his scientific publications on sadomasochism and pedophilia.

On the night of 19 June, 1990, three officers of the above-mentioned state security twice tried to force their way into Doucé's home. These officers were identified as such by the regular police, to whom Doucé had turned for help in his anguish. No corrective measures were taken against this violation of the law. The bookshop "Auture Cultures" was broken into and searched for pornography and lists of names. On 19 July, 1990, two men, one showing a police identity card, presented themselves at Doucé's office in the early evening and ordered him to accompany them to the police station. After that, nothing was heard from him.

The corpse of Joseph Doucé was found by chance in the woods near Paris on 18 October, 1990. The body was unclad and already decomposed. Autopsy did not determine the cause of death. So far, the body has not been released for burial.

A link between the activities of the French state security and the abduction and death of Doucé seems self-evident. One of the state security officers was placed in custody and found guilty of criminal acts in the performance of his duties, and of forging information on Doucé, but his involvement in the actual abduction could not be proven. He was fired when he was released.

The results of the internal state security and police investigation have been kept strictly secret on the grounds of state security interests. Even the penal court, the French Parliament, and the Senate have no access to it.

The French press and authorities have been divided on the Affaire Doucé. Mr. P. José, the former Minister of the Interior, for example, implied that Doucé was homosexual and had difficulties with the French protestant churches because of his commitment to sexology. José depicted Doucé as deviant and (semi)criminal. "There is no smoke without fire," he said. Others have defended Doucé, referring to constitutional rights.

This announcement aims to inform you what may happen to a citizen who commits himself/herself to serving people with sexological problems. Doucé did that openly and in abidance with the law. The authorities rendered his commitment to sexology disreputable in the eyes of the law.

Doucé's friends and associates strongly believe that the criminal investigation has been slow and incomplete. Alleged state security interests continue to prevail over judicial procedures. The French state security report remains, to this day, classified.

In France and the Netherlands, organizations have been formed to remind French authorities of their obligation to protect the life and well-being of their citizens and to guarantee constitutional freedom to activities within the law, "even if their field is sexology." It will be appreciated if you write to the French Ambassador in your country of origin to remind him of the above. It is important to inquire also as to the official French point of view on close monitoring of activities of sexologists, as was done for a long time in the case of Doucé. The Affaire Doucé must not go into oblivion. The legality and standing in society of sexology are at stake! ♀♂

feature...

*The author would like to thank Dr. John Money for his criticism of and suggestions for improvement in this article.*

# *The Politics of Diagnosis and a Diagnosis of Politics*

## *The University-Affiliated Gender Clinics, and How They Failed To Meet the Needs of Transsexual People*

*by Dallas Denny*

*We are presenting the following article because we feel it brings to light issues which have been long overlooked and ignored. It is not meant to be an indictment of treatment, but rather to point out areas in which we feel there is need for improvement.*

*We would like to draw a parallel here.* In the early years after Roe vs. Wade, the pro-choice movement faced little organized opposition. Abortions were available upon demand, and there came to be abuse—third trimester terminations of pregnancy, abortion used as a method of birth control, casual disposal of fetal material, abortions of minors without parental consent or in the face of active parental disapproval.*

*The pro-choice movement chose not to police itself—or was too unorganized or self-assured to do so. Consequently, it proved to be very vulnerable when opponents arose, brandishing as weapons the very things that could have been and should have been discussed and regulated by the pro-choice people.*

*A very respected sexologist wrote the author, saying that the article would "give ammunition to the opponents of transsexualism, whose policy is to criminalize and demedicalize its treatment."*

*We realize that the opponents of transsexualism would do just that. But we believe that the publication of articles which question the status quo are an opportunity to examine and regulate ourselves and our treatment of transgendered persons. It is far better to hear such arguments early, and in a friendly forum, than later, when used as swords by our enemies.*

*—Margaux Ayn Schaffer*

** We use this example only for purposes of illustration, and not as an endorsement of either pro-life or pro-choice positions.*

When the Christine Jorgensen story made headlines in 1952, she and her physicians were immediately deluged by frantic requests from hundreds of men and women, pleading for a sex change (the term sex reassignment had not yet been invented). There was little Jorgensen or her doctors could do, however, for her surgery had been one of a kind. It was considered highly experimental, and its morality and legality were being hotly debated in the pages of medical journals. Her physicians were not prepared to do further surgeries (or at least not more than one or two), and no one else was in the sex-change business.

But Pandora's Box, once opened, refused to be closed. Transsexual men and women sought and sometimes obtained hormonal sex reassignment from sympathetic physicians (the most notable of these being Dr. Harry Benjamin, in New York City). Some went abroad, to Copenhagen and Casablanca and other places, for sex reassignment surgery (SRS). A few submitted to the coat-hanger-in-the-back-room equivalent of transsexual surgery, placing themselves in the hands of inexperienced doctors and non-doctors who promised vaginas or penises and delivered death and disfigurement.

With increasing numbers of transsexual people requesting sex reassignment, and with more and more men and women with botched surgeries presenting for corrective procedures, it was inevitable that SRS would become available in this country. The circumstances of the foundation of two of the first three gender programs in the U.S. are detailed in Green & Money's 1969 text, *Transsexualism and Sex Reassignment.* At Johns Hopkins, several surgeons were curious about SRS (one had already performed two such procedures), and in fact may have seen the issue to some extent as one of professional "turf": "Among those willing to investigate the sex-reassignment procedure as a method of therapy for a specific psychopathology were surgeons for whom this represented a

unique experience and challenge to perfect techniques heretofore restricted to the treatment of congenital malformations, and traditionally the province of the urologist and gynecologist, rather than the plastic surgeon." (Money & Schwartz, 1969, p. 255).

The other two centers were at the University of Minnesota and at UCLA. The personnel at all three clinics wished to avoid publicity, but that was not to be. Even before its clinic officially opened in November, 1966, word went out that the prestigious Johns Hopkins University was doing sex reassignment surgery.

The existence of a gender clinic at Johns Hopkins served to legitimize the surgical treatment of transsexual people. In the late 1960s and early 1970s, similar clinics sprang up across the United States. Most were affiliated with universities with medical schools: Vanderbilt University in Nashville, the University of Virginia in Charlottesville, Stanford University in California, Duke University in North Carolina, and others. A few had other affiliations—for instance, there was an experimental program at Georgia Mental Health Institute in Atlanta, which apparently had ties to Emory University. Soon, there were more than 40 of these programs in the United States and Canada. Most were staffed by men and women with no special knowledge of or training in transsexualism. This is hardly surprising; the field was completely new, and there were no courses at medical schools or doctoral training pro-

# *The Price of A Ticket to Wonderland*

## *The Admission Criteria for the Case Western Reserve Gender Identity Clinic*

All of our patients went through a similar evaluation process. A typical evaluation included the following procedures.

1. The patient contacted our social worker, who screened the patient's complaint, and, if necessary, set up an appointment with the patient.
2. The patient was interviewed by the clinical social worker for a minimum of one hour. The social worker filled out a referral form on the patient (including demographic data, insurance, and psychological type questions).
3. The patient filled out the Minnesota Multiphasic Personality Inventory (MMPI) and a Self Administering Questionnaire which I devised. This included a social history questionnaire; sentence completion test; kinetic draw-a-family test; modified Bender Gestalt test; the Yale Preliminary Test of Intelligence; and selected items from the Wechsler Adult Intelligence Scale and the Wechsler Memory Scale.
4. The patient was given a brochure explaining our program: the services offered; the expenses to be incurred; and the obligations that patients were required to meet before they could be considered for surgery. For several years our evaluation costs were modest—free for indigent patients, and on a sliding fee scale for others. Eventually, we established an evaluation fee of approximately $250.00. This modest charge covered all of the above work plus a minimum of five or more hours of evaluation by opposite-sexed clinicians and the staff of his/her case.
5. The case was presented at one of the weekly meetings and assigned to a preliminary and a secondary clinician (if possible they were of opposite sexes).
6. The primary clinician interviewed the patient and his/her significant family members, friends, and spouse or partner. Usually four hours of interviewing were involved.
7. The patient was then interviewed for approximately one hour by the secondary clinician, whose main role was to provide a second opinion—usually one from the perspective of an opposite-sexed clinician.
8. The case was then presented to the clinic committee and discussed at length (usually one session was needed).
9. The results of the conferences were presented to the patient. Acceptance into the clinic meant that the patient had to become engaged in long-term psychotherapy (individual and group) with one of the therapists usually being the primary clinician. No time limit was placed on the therapy, though the patients were generally in therapy for several years.
10. During the treatment phase the therapists periodically reported on their patients and updated any changes in patient status.
11. Once the minimum time for hormonal or surgical referral was passed, it was up to the primary clinician to decide when, or if, to present his/her patient to the clinic committee for hormonal or surgical treatment.
12. Prior to presentation for hormone treatment the patient was referred for a full battery of psychological tests.
13. The clinic scheduled a time to discuss the patient's request for hormone therapy. If

grams in human sexuality—let alone gender dysphoria. In some cases, one or two workers simply decided that they were interested in providing service or doing research on transsexualism. For example, Leslie Lothstein, who has authored many articles and a textbook about transsexualism, wrote, "... My initial involvement with transsexual research began quite fortuitously. By chance a colleague, Dr. Stephen Levine, asked if I would evaluate psychologically an aging heterosexual man who wanted to change his sex." (Lothstein, 1983, pp. 86–87). Lothstein and Levine started a study group, and, subsequently, the Case Western Reserve Gender Identity Clinic was formed.

The treatment of transsexualism by hormonal and surgical means was a radical departure from ordinary therapies, for in no other "illnesses" except those requiring plastic and reconstructive surgery, was the body changed to fit the mind. In addition to being highly controversial, SRS had no track record. Although an unknown number of operations had been done overseas, it was still considered by the men and women of the clinics (and especially by the critics of the clinics) to be an experimental procedure, to be done to a small number of people under carefully controlled conditions (cf Stoller, 1973).

Consequently, the clinics were small, designed to treat low numbers of transsexual persons, with extensive follow-up. The famous clinic at Johns Hopkins, for instance, limited its evaluations to two per month. The clinics were totally

approved, the patient was referred to our internist and endocrinologist, who were advised of our decision to approve the patient for hormone therapy. It was up to the physician, however, to make the final judgement. If there were any medical contraindications for the use of hormones, it was the physician's responsibility to explain this to the patient.

14. The patient continued in psychotherapy and was periodically examined by the endocrinologist.
15. When the therapist and patient arrived at a decision that surgery was recommended, the therapist presented the case to the clinic committee. If the committee agreed that surgery might be indicated, the patient was required to meet with the entire clinic committee and to present his/her case. The interview usually lasted one hour.
16. The committee met for an unspecified amount of time to consider the patient's request for sex reassignment. In some cases it was granted directly. In other cases more tests were recommended to facilitate our decision-making.
17. The patient was appraised of the clinic's decision. If surgery was indicated the patient was referred to the surgeon for an evaluation. Once again, if the surgeon found anything that contraindicated surgery, the decision to operate rested with him/her.
18. The patient had to agree to respond to our need to have her/him available for interviewing and filling out follow-up questionnaires throughout the post-operative period, and for an indeterminate amount of time after surgery.
19. The patient was provided specific counseling around the issue of surgery; the nursing team was prepared for the patient's entry on to the general surgical ward; and the primary clinician followed the patient throughout the course of hospitalization.
20. After surgery the patient continued in psychotherapy and the primary clinician periodically reported to the clinic about the patient's condition. In addition, a schedule was set up for interviewing the patient and filling out the post-operative questionnaires.
21. Throughout the evaluation it was the responsibility of the primary clinician (who was usually the individual or group therapist) to act as liaison for the patient, helping in her/his social and environmental adjustment (e.g. with legal, family, and medical difficulties).

While this list may seem overwhelming, our clinic committee viewed it as containing the bare minimum requirements for providing a comprehensive evaluation and treatment program for the self-labeled transsexual.

Throughout the evaluation process we periodically reviewed our work with each patient and upgraded both our understanding of the patient's problems and his/her diagnosis. When feasible each of our patients was given a psychiatric diagnosis, a personality diagnosis, a psychometric diagnosis (on the MMPI), and a psychological diagnosis based on a full battery of psychological tests. Many patients had multiple diagnoses in each category. In some cases we disagreed among ourselves as to what the patient's final diagnosis should be. This variability in diagnosis reflected several different interacting procedures including: the need not to label a person prematurely as a transsexual (nor to use that as the sole diagnosis); our different levels of training; our different theoretical orientations; our various commitments to diagnostic nomenclature; and our willingness to tolerate ambiguity by entertaining multiple diagnoses which reflected changes in the patient over a period of time.

*—Lothstein, 1983, pp. 87–91.* ♀♂

unprepared to deal with the vast number of persons who presented, requesting sex reassignment.

From a treatment point-of-view, the large number of applicants was a nightmare, but from a research perspective, it allowed the clinics to be very choosy. They could afford to be—and were—very selective in whom they chose to serve. Their requirements were often excessive, as illustrated by the selection criteria of the Case Western Reserve Gender Identity Clinic, which accompany this article.

*What I have written is not true of all the clinics, or of all the workers in any clinic, but what I have written is what was experienced by thousands of American men and women. I have heard their stories again and again. To my knowledge, the clinics have never been taken to task. It is a task long overdue.*

The clinics were nonetheless a bright and shining hope for thousands of men and women who were unhappy in their assigned gender. They applied in droves, often driving or flying long distances and spending hundreds of dollars to be evaluated. But most were disappointed. They did not get sex reassignment surgery from the clinics, did not get hormones from the clinics, did not get good advice from the clinics, and in some cases, did not get (or were not told about) a diagnosis from the clinics.

The primary mistake transsexual people made was in considering the clinics as treatment centers, when they were in fact experimental in nature.

The primary mistake the clinics made was in blindly pursuing their research goals, not taking into consideration the human needs of the thousands of desperate people who came to them for help.

The remainder of this article is not meant to be a blanket condemnation of the university-affiliated gender clinics. Many were staffed by highly competent, caring professionals who delivered quality treatment, and who published scores of insightful articles in medical journals. These people, and their clinics, dealing with a phenomenon which was newly discovered, and about which next to nothing was known, built a knowledge and treatment base of transsexualism, making significant strides in all areas. When the dust had cleared, transsexual people were left with legitimization in *The Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM III), with the Standards of Care of the Harry Benjamin International Gender Dysphoria Association, Inc. (Berger, 1980), with advances in theory, surgical treatment, and hormonal therapy, with better, less biased definitions and descriptive terminology, with studies of the prevalence and etiology of transsexualism, and with studies of the outcome of sex reassignment surgery. And they did provide relief for hundreds, if not thousands, of transsexual people. But the bitter experiences of thousands of transsexual men and women are an indictment: something was wrong.

What I have written is not true of all the clinics, or of all the workers in any clinic, but what I have written is what was experienced by thousands of American men and women. I have heard their stories again and again. To my knowledge, the clinics have never been taken to task. It is a task long overdue.

### *Getting (And Being Denied) Treatment in the Gender Clinics*

The clinics viewed sex reassignment as a last-ditch effort to save those with whom other therapies and interventions had failed. Those who were accepted for treatment were often prostitutes, were profoundly depressed, and often placed clinicians under duress by threatening autocastration or suicide. They and others who were considered "hopeless"—i.e., were likely to die, anyway—were accepted. It was a classic misapplication of the triage method, with those most likely to benefit from intervention being turned away, and the terminal cases receiving treatment.

The men and women who worked in the clinics were prone to assume that anyone whose presentation was not strikingly that of the gender of choice were not good candidates for SRS (see Stoller, 1973), and probably were not transsexual. Assuming the converse resulted in the acceptance of flocks of drag queens and street hustlers, who were generally skilled at appearing as women, but who often were not transsexual.

Those whose presentation was not convincingly that of the gender of choice were especially unlikely to obtain treatment, for the general consensus was that appearance was predictive of success in reassignment, and that those who were able to achieve a convincing presentation in their original gender would be unable to pass successfully after reassignment—or were not truly transsexual. "Most who were rejected for surgery looked like men trying unsuccessfully to imitate women." (Stone, 1977). The clinics naively overlooked the fact that those who passed often did so only because of having previously (and often illegally) taken hormones. Others were labeled "fetishistic crossdressers" or "secondary transsexuals" (Person & Ovesey, 1974) and denied treatment.

The clinics' notions of "passing" were simplistic and sexist. They forced unrealistic stereotypes of femininity and masculinity on transsexual men and women (Bolin, 1985; Raymond, 1979). The drag queens were the unfortunate standards for comparison. Those who were not Marilyn Monroe burlesques of womanhood (or John Wayne parodies of manhood) were "not transsexual." Those who did

not dress seductively and sexily or otherwise subscribe to the stereotypes, or who were naive or foolish enough to show up for evaluation not looking like Jayne Mansfield were rejected. Presenting as what one actually was, rather than what one hoped to be, was a sure way to be denied services. Kessler & McKenna, as quoted in Bolin, reported "that one clinician 'said that he was more convinced of the femaleness of the male-to-female transsexual if she was particularly beautiful and was capable of evoking in him those feelings that beautiful women generally do. Another clinician told us that he uses his own sexual interest as a criterion for deciding whether a transsexual is really the gender she/he claims.'" (Kessler & McKenna, 1978, p. 118; Bolin, 1988, p. 107).

The clinics subscribed to "man trapped in a woman's body" notions of transsexualism (and vice-versa). Transsexual people were considered to be a homogenous lot. Those men who had not played with dolls in childhood, who did not report feeling like a girl from the earliest age, or who had any history of enthusiasm for or success at masculine activities were in trouble. So were women without an early history of extreme tomboyism.

Despite the heterogeneous nature of the population presenting for treatment, the clinics did not change their notions of transsexualism; instead, they diagnosed large numbers of transsexual people as nontranssexual (or withheld diagnosis), and wrote journal articles about the characteristics of nontranssexual people who presented for sex reassignment (cf Newman & Stoller, 1974).

Men and women who were reasonably normal or showed signs of being well-adjusted (apart from their transsexualism) were unlikely to be served. Being able to hold a job in the gender of original assignment, having obtained a higher degree (or even a high school diploma), having a past history which included heterosexuality

*We wanted to balance the experiences below with positive reports, but we were unable to find a single transgendered person who had had a positive experience at a gender clinic. We think this speaks volumes. If we had kept looking long enough, we could have no doubt rooted out someone who had been accepted at a gender clinic and reassigned long ago. But such folks tend to disappear into the mainstream, and are hard to find. We believe that the following is typical of the treatment of the majority of transsexual persons who asked for help at the clinics. We have disguised the names of the gender clinics.*

# *On the Front Lines in the Gender Wars*

## *True-Life Experiences at the Gender Clinics*

### *Sharon*

*Sharon, who was interviewed in the first issue of CQ, is a 41-year-old post-operative male-to-female transsexual person. She has lived full-time as a woman for nearly two years. She works in a professional capacity, and says she has never been happier. This is what she tells us about her experience with a gender clinic in a large mid-southern city in the late 1970s.*

I was in my early thirties when I finally came to terms with myself. My marriage had failed, I had left graduate school, and I was crossdressing more and more. I didn't even need to ask myself if I wanted to change my sex. I knew I did. I had always known. I just admitted it to myself.

There was a gender clinic at a university in my city. It was the only place I knew to go. I was honest and aboveboard with them. I had considering going crossdressed, but that didn't seem honest, somehow, as my body and my social role were forcing me to be a man. I had an appointment or two with the director, and then took a battery of psychological tests—it was funny; they were the same tests I had learned to give in school.

All in all, I spent about $500 before the director gave me the word. And the word was this: Word 1: "You're not so dysphoric that you aren't able to hold a job." (That just shows I'm not totally screwy, doesn't it?) Word 2: "You're heterosexual." (OK. So maybe I'll be a lesbian. I have no problem with that. Why do you?) Word 3: "You don't look very much like a woman to us." (No shit, Sherlock. Why do you think I'm here asking for help?)

The director told me the clinic would not give me hormones or surgery, or help me to feminize myself in any way, but would give me counseling to help me live as a man. Yeah, right. Make my decisions for me. I went to a half-dozen or so sessions, and then I walked in and showed my therapist some articles about self-castration and my copy of Gray's Anatomy. It didn't phase him: no hormones.

That did it. I refused to allow the gender clinic control over my gender and my life. I never went back. Instead, I went to two or three physicians in private practice, but since I had no clue as to who worked with transsexual people and who didn't, trying to find a doctor who would give me medication was like trying to find a needle in a haystack. So the last one I visited (I didn't like his attitude), I lifted the top dozen or so sheets from his prescription pad and stuck 'em in my pocket. I

went home and got out my PDR (*Physician's Desk Reference*—Ed.), found the section on estrogens, picked one, and wrote a prescription for it. It was easy, since I knew what went on the prescription; I had learned in a nursing class in a mental hospital at which I had once worked.

I hated to do something illegal, but I was at the point of desperation. I had nowhere else to go. I kept myself on hormones for years, until I finally found another source for help—and then I got a legitimate prescription. I don't regret having acted as my own physician, but I am angry for having been forced into having to take such an action.

Starting myself on hormones saved me. I had been getting more and more male by the day. I had been losing my hair big time, getting more body hair. That started to change. I softened, and most of my hair came back, and the body hair went away. After a few years on hormones, I had electrolysis, and I eventually began living full-time. I've had no major problems with transition, for I look unremarkably like a woman. But had I delayed starting hormones—

I don't like to think about it.

If I had listened to those fools, my life would have been ruined. It scares me to think about what would have happened if I had handed over the reins to my life, like the clinic wanted. And I am saddened by the thought of all the others who must have done just that.

I would like to find the man who was director of that clinic and let him know what I think of him. This is what I would like to tell him: wherever you are, you were playing God. You tried to establish dominion over me, and I didn't allow it. I refused to let you have the locus of control. You were the only source of help I could find, and you denied that help and didn't assist me to find other resources. History has proved you wrong, and me right, for I have made a successful adjustment in my new gender. You were an obstacle in my life, and not the helping force you were trained to be. You forced me into taking an action which was illegal, and which went against my nature. I resent you for making such an action necessary; I think you incompetent for it; I find you in violation of your hippocratic oath for it. I saved myself, but how many others didn't? I cry for them. Do you?

### *Carla*

*Carla is a very tall and lanky post-op male-to-female transsexual person. Her experience is with a gender clinic in New England in the early 1970s.*

They were writing a book. That's what I call it when their damned research is more important than the needs of their patients.

I had done everything right, and they just weren't being forthcoming with what I needed. It took three years to get a letter for hormones. Three years after going into real-life test, they still hadn't approved my surgery. They kept saying that I would get it soon, but "soon" never came. I guess they needed more material for that chapter. I finally said "Screw 'em," and went elsewhere.

But that's what it was. They were writing a book. They tried to keep me around until they finished it. But there's a blank page in that book, for I got wise and left.

### *Alicia*

*A combat veteran of Viet Nam, Alicia has been successfully living as a woman since the early 1980s. She works for a large newspaper, doing word processing. Her experience was at a gender clinic at a state-operated psy-*

(and especially marriage or children), having a feminist or lesbian orientation (for male-to-females), having past or present interests which were not stereotypically that of the other sex, having career goals which were not traditionally sex-typed, admitting to an adolescent genesis of feelings of gender dysphoria or a past history of sexual arousal when crossdressed—these were the kiss of death. Not subscribing to the "party line"—the expectations of caretakers—was a sure ticket to the revolving door.

Not surprisingly, transsexual men and women learned to present themselves in the ways the clinics expected. Of course, the clinics took this as corroboration that transsexual people had rigid and stereotyped notions of femininity and masculinity, had childhood onset of feelings of gender dysphoria, and did not show prior heterosexual adjustments. Reports to that effect flooded the literature, influencing workers at other clinics. Workers looked for presentations predicted by the literature, and transsexual people, who are notorious readers of medical journals, gave the clinics such presentations—and were accepted for treatment.

It was not until 1988, with the publication of Anne Bolin's book, *In Search of Eve: Transsexual Rites of Passage*, that the myths were shattered. Bolin found that the mode of dress and presentation of the group of transsexual women she studied was as varied as that of any other group of women, and she revealed the cycle of caretaker expectations/transsexual presentation for what it was:

*The preoperative individual recognizes the importance of fulfilling caretaker expectations in order to receive a favorable recommendation for surgery, and this may be the single most important factor responsible for the prevalent mental-health medical conceptions of transsexualism. Transsexuals feel that they cannot reveal information at odds with caretaker expectations without suffering adverse*

*consequences. They freely admitted to lying to their caretakers about sexual orientation and other issues.*
*Although caretakers are often aware that transsexuals will present information carefully manipulated to ensure surgery... they have only to scrutinize several of their most prominent diagnostic markers available in the literature to realize the reason for the deceit. If caretakers would divorce themselves from these widely held beliefs, they would probably receive more honest information.*
*—Bolin, 1988, p. 63.*

Bolin points out that the client-practitioner relationship was severely damaged by the manipulations of information and appearance that transsexual people felt they had to resort to in order to obtain treatment. It is tragic that her book, which so clearly points out the inequities of treatment, has been largely ignored by clinicians.

### *The Problematic Behavior of "Transsexual" People*

The middle-class values of the clinicians were rarely reflected by the street queens they served. Inappropriate behavior was the norm, as illustrated by the following:

*The severity and intensity of some patients' psychopathology and acting out were... revealed within the group, for example, two members brought loaded guns into the group (One member had to be forcibly restrained from using it!); auto- and mutual masturbation; exposure of breasts; an attempted kidnapping; several near-violent confrontations among group members which carried over outside the group (in which patients threatened each other physically and one patient drew a knife); innumerable sexual overtures to the therapists; patients bringing in pets (two dogs and a menagerie of land crabs); serious chiatric hospital in a large Southern city in the early 1980s.*

They wouldn't accept me because I hadn't played with dolls. They wanted me to be some kind of puppet, to dance on their strings, and I just couldn't bring myself to do it. They went down their little checklist, asking me all their transie questions, and I failed.

At the clinic, they weren't interested in helping transsexual people. They were interested in controlling them. They set themselves up as capable of determining who was and who was not transsexual.

They were really very arrogant. They had a preconceived notion of transsexualism. If you did not fit their template, then you were not transsexual, pure and simple. Part of their idea was that if you had lived your life up to that point as a male, then you were not suitable. They didn't understand that basically there are two kinds of transsexual people; those who go sissy at an early age, and those who fight it. If it were not for the fact that my father was raising soldiers, I probably would have been effeminate.

When I asked for hormones, they refused. When I insisted, they gave me a minimal dose, to placate me. But they were giving large amounts to the drag queens that they thought were transsexuals.

Basically, the clinic was a source of free hormones for female impersonators. The staff was totally obsessed with the idea of drag bars. Every time I had an appointment, they would ask me if I had been getting dressed up and going to drag shows. It was a big deal for them.

### *Margaux*

*Margaux is thin and pretty; she looks like a model. She has been living as a woman for two years. Margaux had an experience with the same gender clinic as did Alicia.*

Finally, it was time to hear the results of all the tests. I went into the room and sat down. The staff was making small talk. It was as if I weren't there. They were good at making you feel like you didn't exist. Finally, the head guy cleared his throat and said, "Frankly, we're worried because you've read so much on the subject of transsexualism. We have grave doubts as to whether, by seeking a sex change, you're embarking on the right course. Also, you'll have trouble passing. Because of that, and because of your age (I was eighteen), we do not feel comfortable with prescribing hormones for you.

"Our recommendation is that you be discharged—or, we will help you to work on alternative lifestyles."

This, to me, seemed ludicrous, for I was asexual at the time. If anything, I was motivated by body image and gender. I got an uneasy feeling in my stomach. "What do you mean, alternative lifestyles?"

He cleared his throat again. He was always clearing his throat. "Alternate lifestyles. Bisexuality. Homosexuality."

"I'm not homosexual. Nor do I want to be. I want to be a woman."

He banged his fist on the table. "We're not here to negotiate! You've heard our terms. Take them or leave them."

I left them. Thank God.

### *Amy*

*Amy, who is from Alberta, made several trips to a gender clinic in a large Canadian city in the late 1980's and early 1990's. She spoke to CQ in Brussels, Belgium, where she had just had sex reassignment surgery.*

My first trip to the clinic was in September, 1989. I saw a psy-

chometrist who is in charge of the program. He gave me two tests. Then I saw a psychiatrist. I had an interview with another psychiatrist, but he canceled. The next interview was with a man who was not very nice to me. We argued the whole time. He told me my hands and feet were too big, that I was too tall, that I would never pass, that everything was wrong with me. He was very hateful.

CQ: Didn't you have a name that worked in both genders?

A: Yes. My first name was Lonnie—I had started to spell it Loni—and my middle name worked, too. But the clinic told me I had to change it.

CQ: Wasn't it just a suggestion? *(In the chapter on real-life test in Blanchard and Steiner's 1990 text, Clinical Management of Gender Identity Disorders in Children and Adults, reviewed in this issue, Leonard Clemmensen writes that the Clarke Institute of Psychiatry "encourages" transsexual people to replace unisex names with more clearly sex-typed names. Was this what Anna's clinic was doing—"encouraging"?—Ed.)*

A: No, they told me I had to change it or forget about the program.

They told me to choose a surgeon, and they would write a letter for me. But I already had a letter from my doctor. The clinic didn't help at all.

### *Jenna*

*Jenna, a registered nurse, had SRS on the same day as Amy. She had an experience with the same clinic, at about the same time.*

My psychiatrist made me go through a bunch of those weird tests in his office in Edmonton. He put electrodes on my dick and showed me pictures of little naked boys being whipped, different sorts of fellatio, just to see if I passed the pervert test. He did the basic psychological profile. He suggested that I go to a certain gender clinic.

We contacted the clinic, and they sent me a big questionnaire. They wanted a profile about when I first started crossdressing, what my sexual preferences were—more pervert stuff.

About six months later, they set me up to go to the clinic, which was half a continent away. I asked if I couldn't be examined in Edmonton, since it would be expensive to travel so far. They said no, that I had to come.

I was working as an aircraft maintenance technician. I really liked it. My psychiatrist told me that I had to quit. I think he did so on advice from the gender clinic. He said it wasn't a very feminine thing to do. I said, "I'm not into flower arranging or basket weaving!" He made me quit, and I entered a continuing education program.

My first trip to the gender clinic was in the summer of '86. I remember two doctors in particular, a woman and a man. They were very obstructionistic. "You'll never be happy. You'll always be lonely. If you have a male partner, he'll be of below average intelligence, a homosexual, or a criminal."

"How can you be sure of that?"

"We just know it."

I went to the gender clinic again after I started my nursing program. I saw the male doctor I have spoken to before.

"Why do you want to be a male?"

"What?"

"Are you going from F to M?"

"No. I'm going from M to F."

"Oh. So you're a hooker. And you're on drugs."

"No."

"You're lying."

"No I'm not. I'm enrolled full-time in a nursing program."

"Bullshit. I don't believe you."

He wanted to see the documentation about the nursing program.

"We don't think you're ready." (This, after two years of cross-living.) "We want you to finish the nursing program."

"I'm not sure I want to finish. I don't like it."

He told me if I didn't finish nursing to forget it. *(No doubt this man would say he "encouraged" Jenna to stay in nursing—Ed.)*

The third time to the clinic was in May, 1990.

The same doctor again. "You look very nice. You're small. That's good. What are you doing?"

"I finished my nursing program. I'm now an registered nurse."

"I don't believe you."

Well, this time I had brought documentation.

"Oh, excellent. You're one of us."

"One of us?"

"You're in the business. You're looking good, doing well. We had a conference about you, and we've decided to recommend you for surgery. We think you'll do well, but you're going to be a lesbian."

"I don't think so."

"Oh, yes, we know that for a fact. If you liked women before, you'll be a lezzie. How do you feel about that?"

Despite his insistence that I would turn out to be a lesbian, I didn't. My work now is exciting, but you know—I really liked working as an aircraft technician.

All of the people above have made satisfactory, and even exemplary, adjustments in their new gender—although most of them were turned down by gender clinics. Their success in real-life test would seem to provide evidence that the gender clinics turned away many viable candiates for sex reassignment. We are sure that there are thousands more like them out there.—Ed. ♀♂

*psychosomatic symptoms (including ulcerative, arthritic, hyperventilative, and cardiac distress).*
*—Lothstein, 1979, p. 73.*

*Most of our surgically treated patients had a long history of arrests and convictions for minor nonviolent crimes, especially prostitution... In addition to a long history of petty criminal offenses, they dressed in dramatic seductive fashion, passed convincingly as women, had a history of passive participation in homosexual activity, and seemed to have fully adopted the feminine gender role late in adolescence. In addition they were manipulative, demanding, and therefore troublesome in their behavior... Most of the patients in our series had histories of having taken drug overdoses and some had been hospitalized psychiatrically during their turbulent years preceding and just after beginning to live fulltime in the feminine role.*
*—Stone, 1977, p. 26.*

Lothstein, Stone, and others did not consider that their naive and biased selection criteria, which were predicated on bizarreness, were a veritable recipe for erratic behavior. Consequently, the literature came to be filled with journal articles which alluded to the outlandish and grotesque behavior of "transsexual" persons and to their various additional psychopathologies. Many of these articles were little but exercises in name-calling.

### *SRS or Else*

The directors and staff of the clinics tended to view SRS as essential for satisfactory adjustment in the new gender. They did not seem to realize that it is possible to live as a woman or a man without the expected genitalia. Treatment was all-or-nothing. Those who were not accepted for SRS were generally not offered hormonal therapy, which, for many, was necessary in order to pass successfully in the gender of choice. They were given no alternative but to live in the gender of original assignment. Those who were not offered services were often told that they were not transsexual, even when they met the criteria for transsexualism that later appeared in the Standards of Care of the Harry Benjamin International Gender Dysphoria Association and in the DSM III. Some of the clinics offered to help the individual somehow manage in the gender of birth, but this was little more than a token gesture; few took them up on it.

The clinics were, in essence, condemning the individual to live in the gender of birth. They did this to thousands of men and women. Some simply went to other clinics and gave the clinicians what they wanted (c.f. Meyer & Reter, 1979), but most did not. They listened to the self-proclaimed and often untrained "experts," and remained men and women.

### *Beyond Bungling*

In a few instances, the treatment of transsexual people by the gender clinics went far beyond well-meaning ineptitude. The ignorance and desperation of transsexual people were used as tools for manipulating and controlling them. Promises of hormones and eventual reassignment surgery were used as carrots-on-sticks. Those who refused to provide whatever information the clinics demanded, who would not agree to participate in experiments, and who would not agree to unlimited follow-up (which they were often required to pay for!) were denied services. "... the probability of being able to maintain (postsurgical) contact with the patient is one of the factors assessed before sex reassignment." (Steiner, Zajac, & Mohr, 1974).

Those who did not restructure their lives in major ways according to the demands of the clinician (changing jobs, divorcing spouses) were subject to punishment by expulsion from the program. Hormonal therapy and SRS were subject to withdrawal at any time, for any reason, without explanation, and without appeal, as illustrated by the following:

*In an effort to upgrade the services, to improve the rapport between clinic physicians and these patients, and to provide the material for this report, the following prospective study was undertaken... All transsexual patients receiving hormone therapy at the clinic were asked to submit to a semi-structured interview, including a medical history, and a problem-specific physical examination. Participation in the study was mandatory if the patients wished to continue to receive hormone therapy at the clinic.*
*—Cooper, 1987, p. 142.*

Interviews conducted solely to facilitate treatment, or to improve services at a clinic, which do not specifically discriminate against transsexual people, and which do not require mandatory participation in research would not be objectionable. However, making treatment contingent upon cooperation is, in my opinion, not ethical. I contacted Dr. Cooper via the mail, and he assured me that participation in his study was not mandatory in order to receive hormonal therapy. His article argues otherwise.

### *The Gender Clinics and the Professional Literature*

Incredibly, considering their official (research) rationales, there seem to have been few publications from some of the gender clinics. But workers at many of the clinics did publish. As previously noted, many of the articles were well done, but some were instrumental in promulgating inaccurate and naive views of transsexualism. Some of the more notable inaccuracies concerned the unreliability and questionable lifestyles of transsexual people, the stereotyped notions of femininity and masculinity held by transsexual people, and the supposed homogeneity of transsexual people.

Unfortunately, the erroneous conclusions and misinformation

common in early studies continue to be taken seriously. Well-conceived and more enlightened studies are unfortunately still rare. The ignorance, and arrogance, and bias of many researchers continue to find their way into print, and exclusionary criteria for sex reassignment based on "true" (as opposed to, I suppose, "not true" transsexualism; cf Dolan, 1987) and sweeping generalizations continue to appear in the literature: "These (secondary transsexual) individuals do not pass easily in the opposite gender role without the aid of hormones and electrolysis. Their natural voice is quite masculine, numerous expensive cosmetic procedures are often necessary before they can approach the 'total femininity' they seek." (Dolan, 1987).

The psychoanalysts Robert Stoller and Leslie Lothstein, in particular, are continuing proponents of the clinics:

*The vast majority of gender dysphoric patients obtain sex reassignment surgery on a fee-for-service basis without benefit of a prolonged diagnostic evaluation. As a group they are probably more impulsive, impatient, anxious, and demanding of sex reassignment surgery than are those who enroll in university-based clinics. Many of these patients are probably secondary transsexuals who feel surgery will relieve their emotional distress. Unless these patients need additional surgery, they will be generally unavailable for follow-up. The lack of baseline data on their presurgical psychological states makes it impossible to evaluate the changes caused by sex reas-*

*Tabbas' viewpoint is one of the more radical held by transgendered people. We have included it because it is far from uncommon.*

# *Politics and Diagnosis*

*by Tabbas*

The political condition of transsexual people is distinguished by their need to appeal to one person in order to be physically changed by another. And while often, several people are involved at each step, almost never is the person approving of giving treatment to a transsexual person. This level of alienation from self-identification and self-actualization, on top of the discrimination we face, certainly makes transsexual people one of the most oppressed minority groups in the world today.

Liberation of transsexual people pivots on the question of self-diagnosis. To be transsexual, a person must have reached a decision. And while there is some marginal control, in no way is this a free choice. It's like birth (rebirth). Or, like Sylvia Plath in The Bell Jar, you can see it coming, accelerating to the point of crisis. You can deal with it, or it will deal with you.

As the penalty for transsexualism is high, too often prospective transsexual people will approach their first interview in a crisis or near-crisis situation. And they expect the service provider to recognize their problem, understand their level of need, and begin treatment. More than likely, what they receive is their first taste of politics.

Service providers, who are accustomed to dealing with the crazy and noncompetent, are horrified by a sane, articulate individual who challenges their accepted relationship between (biological) sex and (social) gender. And where passion might ordinarily be taken as a measure of commitment, a transsexual man or woman who insists on treatment generally intensifies the provider's sense of horror.

The prize in this fight between the transsexual person and the service providers is the locus of control: who establishes the criteria by which one is called transsexual; who qualifies for surgery. The fight works for personal satisfaction for service providers, who realize that locus of control is a prime index of (political) maturity. This is a matter of pride. Locus of control is a vital concern. Let's take some examples.

For years, especially during the sixties and seventies, providers screened transsexual people according to how they compared to the so-called "classic case." Apologists for this view held that sexual identity was clearly established between the ages of three and five. Therefore, if a client did not cross-dress and completely identify cross-gender by age five, the client was not transsexual. Tell someone the truth, and, baby, you were gone. It didn't matter if you grew up in a hostile environment and were resourceful enough to deflect your crisis into puberty, or even beyond. Theory said you weren't conflicted.

Today, the principal shibboleth used to separate transsexual people from crossdressers is whether one has masturbated while crossdressed. Say yes, and you can kiss your surgery goodbye. And don't expect anybody to ask what you were thinking about while you were masturbating (like how will it be when this same tissue is turned around), or suggest that maybe, just maybe, sexual stress also has a biological component.

The clown theory of competence teaches that if bozos like those above can diagnose transsexualism, then damn sure I can. Learn to lie first, and take care of business. But the day is at hand when the analysands shall analyze the analyzers. And payback is hell. ♀

*signment surgery. Moreover, neither the surgeons who perform sex reassignment surgery on demand or their patients seem to be interested in understanding the psychological roots of transsexualism.*
*—Lothstein, 1982, pp. 422–423.*

Lothstein (1982) has gone so far as to suggest that sex reassignment should be limited to university-affiliated clinics.

Heaven forbid.

### *The Decline of the Gender Clinics*

The clinic at Johns Hopkins University went out of business as the result of a press release which followed the publication of a controversial outcome study by Meyer & Reter in 1979. Just as its opening had served as a catalyst for the formation of new centers, the closing of the Johns Hopkins clinic was followed by the demise of a number of gender centers. Several clinics survived, but have become officially dissasociated from their universities. So far as I know, the last of the U.S. university-affiliated clinics, at the University of Virginia, closed in late 1989 or early 1990.

There are perhaps a dozen gender clinics in the United States today. Some operate on a for-profit basis, and some do not. It would be nice to think that those who work in these clinics have learned the characteristics of transsexual people, have begun to treat transsexual people with respect and dignity, and are functioning as true treatment centers—and to a large degree, they have—but there remains much need for improvement. Several of the present-day gender clinics, for example, include as part of their application questionnaire the question, "How often have you used prostitution as a means of supporting yourself?" Note: the question is not *have* you, but how *often* have you. This is not asked of persons seeking treatment for other conditions; it is a slur on transsexual people. The tragedy is that the authors of the questionnaire probably did not realize the offensive nature of such a question.

Some gender clinics, including the Gender Identity Clinic at Clarke Institute of Psychiatry in Toronto and the Program in Human Sexuality in Minneapolis require transsexual persons to cross-live before they will prescribe hormones. This policy, and the practice of prescribing minimally effective hormones (as Clarke does; see Jennifer Usher's review of Blanchard & Steiner, 1990, elsewhere in this issue), places transsexual persons at risk of ridicule and physical attack. This is needless gatekeeping; it must stop.

As Stoller noted in 1973, "... there is something about the person who requests sex reassignment that brings out or attracts a lower level of medical performance in all areas of evaluation and treatment."

### *The Devaluation of Transsexual Persons*

Wolf Wolfensberger (1972) has written about the devaluation of human beings with mental retardation, and of the tendency of service organizations to treat their clients with mental retardation as less than human. Transsexual people are similarly devalued. Like persons with mental retardation, men and women with transsexualism have been historically unable to defend themselves. First, they have often been insecure and frightened, and in desperate need of services. They have had (and continue to have) little protection under the law. Until recently, they had no advocacy or support organizations. Society has not been sensitive to their needs. Transsexualism was (and still is) considered a mental illness, an aberration, a curiosity, a condition to elicit fascination and amusement, but not pity and concern.

Such devaluation was inherent in the treatment of transsexual persons by the gender clinics. One need only recast the disorder to see just how outrageous much of this treatment was. Were persons with cancer denied medical treatment if they refused to participate in research studies? Was treatment of persons with heart disease terminated if they refused to restructure their lives according to the dictates of their physicians? Were children with leukemia libeled in the medical journals? Were persons with diabetes forced to conform to their physicians' notions of diabetism? Were

### *Politics in the Name of Science— The Closing of a Gender Clinic*

Meyer & Reter's 1979 study of the outcome of sex reassignment surgery at Johns Hopkins University is often quoted by people who believe that it conclusively demonstrated that sex reassignment surgery does not result in improvement in the lives of transsexual men and women. These people believe it was that the cold voice of Meyer and Reter's logic which resulted in the closing of the gender clinic at Johns Hopkins University. Not so. Leslie Lothstein, in an article published in The American Journal of Psychiatry in 1982, noted that it was political pressure associated with this paper and its attendant press release, and not Meyer & Reter's findings, which resulted in the closing of the Hopkins program. The Johns Hopkins closure was followed by the demise of the other U.S. centers, with the last center, at the University of Virginia, at Charlottesville, closing in 1989 or 1990.

Meyer & Reter (1979) has been roundly criticized in a number of forums, most recently and effectively by Blanchard and Sheridan in the textbook *Clinical Management of Gender Identity Disorders in Children and Adults.*

Unfortunately, many service providers do not realize that the majority of outcome studies indicate positive outcomes for most persons who have had surgical sex reassignment.

victims of car wrecks turned away if they were considered unlikely to agree to extensive follow-up? Were stroke victims asked how often they had resorted to prostitution?

I think not.

It is my belief that despite improvements, discriminatory treatment is still prevalent. But the treatment of transsexual persons will not reach equity with the rest of humanity until their devalued status is overcome. This means changing not only the attitudes of society, but of service providers, and of transsexual people themselves. It will mean well-designed and sensible research studies. It will mean self-advocacy, and political lobbying, and consumer awareness. It will mean organization and ongoing activism. It will perhaps mean removal of transsexualism as a mental disorder from the *DSM III-R*, as happened with homosexuality. It will mean legal reform.

Transsexualism is not a shameful condition, nor is its treatment in any way less than honorable and ethical. Transsexual people have the same right to competent and effective treatment as does anyone else. It behooves both service providers and consumers alike to be aware of consumer issues and to institute checks and balances in the treatment procedure. The transsexual person, for example, is as entitled to a second opinion as is the woman who has been told that she needs a hysterectomy.

The closing of the university-affiliated clinics was ultimately perhaps not a bad thing, for in their wake, treatment centers have arisen which place a priority on the human needs of their clients, and which have relegated research to its proper place, secondary to human suffering. In recent years, service providers have become better informed and transsexual people have begun to become better consumers. The light at the end of the tunnel is not yet in sight, but perhaps our eyes, having become adjusted to the dark, can see that the passageway ahead is not quite so dark as it is behind us. ♀♂

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# The View From The Other Side of the Treatment Fence:

## *My Experience as A Provider of Human Services*

*by Dallas Denny*

It was not transsexual people themselves but the system which arose for their treatment which caused so much human tragedy: bitter and unfulfilled transsexual men and women, disillusioned and disgusted physicians and psychologists, and a literature which unfairly stigmatizes persons with gender dysphoria. We must all of us, service providers and consumers alike, strive to understand what has happened and what continues to happen in too many instances today, for only by acknowledging the problems of the past and the present can we hope to move into the future.

It is not unusual for professionals to seek to distance themselves from their clients. Ten years ago, I worked for the Department of Human Services in Nashville, Tennessee. I was a child protective services worker. Many of the DHS clients were disadvantaged, to be sure—but that was no excuse for the terms some of my coworkers chose to give them—the word "Dirtleg" sticks in my mind. Unfortunately, many of my peers chose to view what was supposed to be a helping relationship as an adversarial one, and would needlessly erect barriers which, quite frankly, sometimes resulted in children going to bed hungry.

I have worked with persons with mental retardation for nearly twenty years. Most of my co-workers are sincere and caring, but even so, many of them find a need to distance themselves psychologically from their clientele. But the treatment system has been undergoing continual reform; the days of crying "retard" are hopefully gone forever. I have seen some instances of cruel and inhumane treatment, but the system is self-correcting. Abuse and neglect are relatively rare, and punished when they can be documented.

*. . . the relationship between transgendered persons and their caregivers has been and continues to be unnecessarily adversarial. This is understandable, because treatment systems are structured so that game-playing is almost necessary on both sides of the treatment fence. The Standards of Care make it that way. It is time for reform, for a recentering of the locus of control. It is time for consumers and service providers to work together cooperatively, and not struggle as if they were adversaries. They are, after all, working towards the same end.*

The situation was much worse twenty years ago, but was made better by advocates and lobbyists. The formation of The Association for Retarded Citizens, The Association for Persons with Severe Handicaps, and other advocacy organizations have resulted in laws to protect persons with retardation, accrediting agencies for facilities which treat them, and quality control for all phases of their treatment. Things could be better, but I'll have to say that I'm proud of the profession and the strides which have been made in recent decades.

Persons who live in poverty, meanwhile, who have fewer advocates, continue to be called "Dirtlegs" with impunity.

Persons with gender dysphoria are in the same boat as poor people. Until recently, they have had no advocacy organizations, no protection under the law, and have usually been too insecure and threatened to stand up for their rights. There has been no system of checks and balances, and, until Anne Bolin, no one to point out the deadly dance played by service providers and transsexual people in the treatment setting.

The demise of the gender clinics resulted in the rise of a new wave of treatment centers which are more responsive to the needs of their clients. However, the relationship between transgendered persons and their caregivers has been and continues to be unnecessarily adversarial. This is understandable, because treatment systems are structured so that game-playing is almost necessary on both sides of the treatment fence. The Standards of Care make it that way. It is time for reform, for a recentering of the locus of control. It is time for consumers and service providers to work together cooperatively, and not struggle as if they were adversaries. They are, after all, working towards the same end. The transgendered consumer wants help, and the service provider wants to give it.

I think that forces are coming into play which will result in treatment reform. Although transsexualism and crossdressing continue to be stigmatizing, they are not as stigmatizing as they once were in our society. Consequently, more transgendered people are able to function in positions of responsibility, and a few are willing to take a public stance in favor of fair treatment. Transgendered people are beginning to demand their rights, and to work actively toward obtaining them. This will give rise to a new wave of consumerism, and service providers will have to be responsive, just as were the mental retardation professionals before them.

Transsexual people have been characterized in the professional literature as having a great deal of psychopathology in addition to their gender dysphoria. This is because service providers have dealt for the most part with people on the ragged edge—people who have denied themselves all their lives, and who have finally sought treatment; people who are so desperate to obtain help that they will lie and deceive in hopes of getting it; people who are bitter because of a long history of abuse and misunderstanding. They see clients who have mutilated their genitalia, who make their living by prostitution, who are suspicious of the treatment program and of their own good will and competency, and who may have chemical dependency problems. Most service providers see only this; they do not look beyond the curtain to ask why their clients are the way they are, or what it is about the treatment setting which fosters the distrust and dishonesty by their clients.

What has been lacking has been a functional analysis—that is, an inquiry into the causes of this behavior. Here, too, service providers can take a cue from the field of mental retardation.

Persons with mental retardation exhibit a range of behaviors which are highly unusual, and which at first glance appear to be aberrant: Bodyrocking, head-banging, pica (the eating of nonedibles—yes, I

*Continued on page 26*

# Gender Subjectivism in the Construction of Transsexualism

*Anne Bolin, Ph.D.*

Transsexuals are a medically colonialized minority who are subject to sexism in diagnosis and treatment by medical caretakers, especially the psychiatric sector. My understanding of this phenomenon comes from two years of participant-observation and advocacy with a group of male-to-female transsexuals affiliated through a grass-roots organization, and from interview and correspondence with their medical caretakers (see Bolin 1983, 1982). Sexism emerges in two broad categories of caretaker and client interrelations: diagnosis and evaluation of the client as a bona fide transsexual and hence someone in need of treatment, and treatment itself, which includes therapy, hormonal management, and ultimately, surgery. A point of clarification is in order before proceeding. Transsexuals are defined here as genetic males who are actively pursuing or who have completed the surgery in which a physical sex change and gender reassignment will occur. Because transsexuals think of themselves as females trapped in male bodies, feminine pronouns are used in reference throughout this paper.

Transsexuals are inexorably intertwined with medical practitioners through the establishment of medical policy. Medical policy is consolidated through the Harry Benjamin International Gender Dysphoria Association, Inc. (1969–present) in the form of guidelines known as the "Standards of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons" (Berger, et al., 1980). This document outlines minimal requirements for the care of transsexuals and includes a prescribed agenda and compulsory medical surveillance.

In order for a transsexual to qualify for the coveted surgery, she must acquire two psychological evaluations stating that she is indeed a transsexual and a good surgical risk. The

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recommendations for surgery can be made only by psychiatrists or psychologists. One of the two evaluators must have known the client as a primary therapist for a minimum of six months. In addition, the transsexual must have been hormonally reassigned as a female and have lived in the female role for one year prior to the surgical conversion.

Medical policy has created a situation where the recommendation for surgery is completely dependent upon caretakers' psychological evaluations. The client is vulnerable to caretakers' conceptions about what constitutes evidence for classification as transsexual and a good risk for surgery. Ultimately, "... diagnosis remains based on the psychiatrist's subjective evaluation of patients' behavior and what patients say they are experiencing" (Torrey, 1983, p. 47). It is where evaluation and diagnosis intersect that problems of embedded sexism contribute to theoretical misconception and stereotypical expectation.

The medical profession struggles to understand a phenomenon that in its surgical resolution is only thirty-nine years old. In order to treat a client, caretakers must rely on research in the relatively recent field of gender dysphoria. This research includes alleged commonalities of transsexualism that have become elevated to the level of diagnostic criteria. These criteria, consisting of etiological correlates and behavioral characteristics, clearly reflect male preconceptions about females. Two such diagnostic attributes are the etiological correlate of dominant and over-protective mothers in association with physically or emotionally absent fathers (Stoller, 1968, p. 102, pp. 263–264; Green, 1974a, p. 216–250; Green, 1974b; pp. 47, 51) and the behavioral characteristic of heterosexual orientation (Benjamin, 1966, p. 26; Walinder, et al., 1978, pp. 16–20; Pomeroy, 1975, p. 220; Kando, 1973; pp. 13, 145; Raymond, 1979, p. 84).

I have found no support in my own research that these attributes are predictive of or invariably associated with transsexualism. Both these notions are, however, firmly entrenched in traditional notions about gender and sexuality reiterated and perpetuated by psychoanalytic theory.

For example, the dominant and over-protective mother in conjunction with the absent father is a staple of "mother blame" theories that have been popular since Freud. One is reminded of Miner's tongue-in-cheek expose of the Nacireman belief that parents (actually fathers to a lesser extent) bewitch their children (Miner, 1985, p. 13). Of course it is believed that dominant and over-protective mothers cause transsexualism; after all, earlier in the history of psychiatry, these same mothers were responsible for causing homosexuality in their sons. But dominant and over-protective mothers can really be blamed on a more basic level. Do they not violate the roles of the traditional family, whose hallmark is the dominant, controlling father? In the dominant mother-absent father model, the father, too, is seen as deviated from his role as a profound presence in the family. If the father is absent, then de facto, he has relinquished control to the mother, who will undoubtedly adversely affect the gender development of her growing boy. This type of model, so representative of mother-blame theories in general, can be seen as an idiom for expressing traditional cultural premises about sex roles in the family second only to "Father Knows Best."

Another characteristic often cited in the literature on transsexualism is heterosexuality; that is, a heterosexual object choice for a male-to-female transsexual is a male, while a lesbian object choice is female, based on the transsexual's feminine identity. A long-term and deeply abiding attraction to genetic males is viewed by caretakers as an index of true transsexualism. My data indicate that this is a dubious assertion. Of seventeen transsexuals who provided data on sexual orientation, only one was exclusively heterosexual. SIx were exclusive lesbians, nine were bisexual, and one didn't know. Underling the diagnostic criterion of homosexuality is the belief that there is only one sexual object choice for women, genetic or transsexual, and that is men. This view denies the dignity and human rights of those who choose the same gender in sex and/or love. In the case of male-to-female transsexuals, not only are they denied their dignity and human rights, but the revelation of homosexuality or bisexuality to a psychiatric evaluator could seriously jeopardize qualifying for surgery.

Without belaboring the issue one vignette illustrates this point. Tanya, a pre-operative transsexual saw a psychiatrist as part of an employment agency requirement. Because this psychiatrist was not involved with her evaluation for surgery, Tanya felt free to discuss a recent lesbian encounter and her openness to a lesbian relationship post-operatively. The psychiatrist was incredulous. He asked: "Why do you want to go through all the pain of surgery if you are going to be with a woman lover?" Such attitudes, coupled with the inequity in power relations between caretaker and client, foster a situation where transsexuals inadvertently contribute to the maintenance of these sexist conceptions by telling the psychiatrists exactly what they want to hear. Transsexuals are avid readers of the medical literature and are well-versed in caretaker expectations, augmented by the transsexual grapevine. This should not deflect, however, from the central argument that these alleged attributes are part of more general psychiatric thinking that is far older than the classification of transsexualism itself as a psychiatric syndrome.

Another recurring theme prominent in the literature is transsexual hyper-femininity, defined in a variety of ways (Kando, 1973, pp. 1[illegible] 24–25; Raymond, 1979, p. 7[illegible] Money & Tucker, 1975, p. 20[illegible] Driscoll, 1971, pp. 66, 68. Transse[illegible]

uals are described as conforming more to the feminine role than natural born women in every respect (Raymond, 1979, p. 79). Again, my research, using a variety of instruments along with the ethnographic method, questions this concomitant of transsexualism. What can account for the prevalent stereotype in the literature?

Hyper-femininity, in general terms, may be an artifact of the medical caretaker system. A number of researchers have pointed out that the medical and psychiatric communities reinforce sex role stereotypes in sundry ways (e.g., Raymond, 1979; Chesler, 1973). In regard to transsexuals, this is undoubtedly a product of the psychological evaluation procedures in which the male-dominated medical, especially psychiatric sectors, employ their own stereotypes of women in judging how well transsexuals' appearances, presentation, and sex role performance fit into their conceptions of womanhood. In this regard, Kessler and McKenna report that one clinician:

*said that he was more convinced of the femaleness of a male-to-female transsexual if she was particularly beautiful and was capable of evoking in him those feelings that beautiful women generally do. Another clinician... [revealed] that he uses his own sexual interest as a criterion for deciding whether a transsexual is really the gender she claims (1978, p. 118).*

One transsexual in my research population, an ardent feminist who preferred wearing t-shirts and jeans, stated: "Shrinks have the idea that to be a transsexual you must be a traditionally feminine women: skirts, stockings, the whole nine yards." A number of transsexual confirmed this view of their male psychiatrists.

Transsexuals, through their knowledge of caretaker expectations, knew that hyper-femininity was anticipated by many psychiatrists. They were aware that many male caretakers were relying on their own male versions of females, utilizing cultural stereotypes of women. Rather than re-educating their male caretakers, many chose to superficially conform to caretaker expectations, realizing this would facilitate the desperately desired surgery.

Other factors contributed to the stereotype of the hyper-feminine transsexual. Space does not permit an in-depth discussion of these. Suffice it to say that the process whereby transsexuals are chosen for complete gender identity programs of sex reversal selects for those individuals who are either more hyper-feminine or who know how to play the game. The result is the same: male psychological evaluators employing stereotypes of women in selecting transsexuals for gender clinics, will undoubtedly find what they expect to see. Thus, transsexual hyperfemininity may be a result of a system in which "transsexual candidates [for surgery] are judged on the basis of what a man's view of a real women is" (Raymond, 1979, p. 92).

One might reasonably ask: "Where are the women practitioners who might mediate the sexism in the diagnosis and treatment of transsexuals?"

There are, in fact, a number of women who are the therapists of transsexuals. They, however, dominate the helping mental health professions such as social work, guidance and counseling, and master's level clinical psychology. The helping mental health professionals are not eligible to act as psychological evaluators of the transsexual's request for surgery. The "Standards of Care" explicitly state that: "The analysis or evaluation of reasons, motives, attitudes, purposes, etc., requires skills not usually associated with the professional training of persons other than psychiatrists and psychologists." Furthermore, of the two recommendations for surgery which must be made by psychologists and psychiatrists, one of the two must be a psychiatrist (Berger, et al., 1980). *(The current [1989] Standards of Care do not require that one of the two therapists be a psychiatrist, but do require that one of the two hold a doctoral degree—Ed.)* The apparent medical and psychological (in many states a psychologist is legal only with a Ph.D.) imperialism is discriminatory towards not only the helping mental health professions, but towards women as well, since psychiatry and psychology (in terms of Ph.D. psychologists) are dominated by males (Chesler, 1972, pp. 62–63; Syverson, 1982, p. 1204; Raymond, 1979).

This medical policy is a sore point to many of the women mental health professionals who are members of the Harry Benjamin International Gender Dysphoria Association, and who are actively involved as therapists with transsexual clients. While overtly an issue of medical control, it is covertly an issue of male control in medical policy relating to transsexuals. This policy adversely affects not only women mental health professionals, but their transsexual clients as well.

Transsexuals prefer the helping mental health professions for two reasons: first, they are dominated by women, and secondly, their fees are lower. The latter is an important consideration for a financially burdened population preparing for surgery. Transsexuals with whom I worked distrusted male therapists, who they felt imposed their male view of womanhood on them. They stated they could be more honest with women therapists and at the same time develop a rapport in the all-important arena of woman-to-woman interaction. It was believed that women therapists had fewer preconceived notions about transsexualism because women themselves were aware of their own heterogeneity and were inherently more tolerant of variation. Basically, women therapists were favored simply because they were women. They had something to offer in addition to the therapy. They were role models for their transsexual clients, and by virtue of their own history as women, knew

secret information about women's lives, something highly valued by transsexuals.

Finally, transsexuals are subject to sexism in hormonal treatment programs. Transsexuals are required by medical policy to participate in a program of hormonal management prior to surgery. They welcome the hormone therapy, which consists of the administration of female hormones orally and/or intramuscularly. A hormonal therapy program will result in physical changes in the direction of the female somatotype, e.g., breasts develop, fat is redistributed, and muscle diminution occurs. The primary female hormones is estrogen. A secondary source of female hormones is progesterone, which is used as a supplement to the estrogen (Meyer, Finkelstein, et al., no date, p. 3). "A typical regimen would be 2.4–5 mg daily of conjugated estrogen before surgery and slightly less after, usually in combination with a progestational agent (Meyer, Finkelstein, et al., p. 4).

There is actually a great deal of variation and diversity in hormonal management regimens available to transsexuals. There are, however, only two primary hormonal strategies employed. The first, as mentioned above, involved daily and/or regular intake of a hormonal dosage that is consistent over time. I would like to take issue with the other strategy; that of cycling the transsexual on female hormones. This approach is one in which the transsexual is cycled on estrogen with or without progesterone, in order to emulate the fluctuations in estrogen in the reproductive female's menstrual cycle. Cycling regimens vary in terms of the hormonal agents used, alone or in combination, and in continuity of dosage over time. For example, in a study of twenty gender clinics by Meyer, Walker, and Suplee ( date, pp. 3–4), five were found subscribe to a cycling program three weeks of daily intake estrogen, followed by a week w out hormonal therapy.

One endocrinologist in the a of my research endorsed a progr of two weeks of oral estrog daily, followed by seven to days of a progestational agent conjunction with estrogen, a concluded with a week free of h mones. Because there is some dence, although it is controvers that fluctuations in female h mones may contribute to Pre-m strual Tension Syndrome in gen women, I asked the endocrin gists if there might be some sim side effects for transsexuals. endocrinologist acknowledged possibility of fluid retention mood fluctuations, but sugges

*Continued on pag*

## *The View From the Other Side of the Treatment Fence*

*Continued from page 22*

know that it sounds like a malapropism), rumination (the continual regurgitation and subsequent reswallowing of food)—get the idea? For more than twenty years, applied behavior analysts concentrated on reducing the frequency and severity of these behaviors, and they were moderately successful. But in the last decade, more attention has been placed on the analysis of the functionality of these behaviors—and, surprisingly, it can often be demonstrated that these "aberrant" behaviors very effectively serve a purpose—or even more than one. Head-banging, for example, can serve the dual function of attracting the attention of caregivers and of reducing the demands caregivers make on the individual. The behavior seems less unusual when the institutional environment is considered, for it is clearly demonstrable that appropriate behavior is largely ignored.

Transgendered persons deserve this same kind of analysis.

The ways in which transgender feelings affect one's life are global—many transsexual men and women are good liars, for instance, because until they achieve gender congruity, they are necessarily living a lie. They are often suspicious, because of a history of being betrayed and laughed at. They may turn to prostitution because of societal rejection due to their appearance. They may deal with the depression and pain caused by their gender dysphoria by turning to alcohol or other drugs, or by punishing themselves in other ways—for instance, by developing eating disorders.

It is not difficult to see how a service provider who has been burned by a number of transgendered clients might come to be wary of them, especially when the clinical literature warns of the unreliability of transgendered persons, reinforcing their personal experience. And as there are no protections for transgendered persons, it is easy to laugh at them and stereotype them. But it is not right. Department of Human Services clients are not "Dirtle And few transgendered person the stereotypes, and those whc may have their reasons. The fa that most are sane and whole sons who are trying to improve t lives.

"The Politics of Diagnosis" not meant to slam ser providers, but it was meant to i trate what I consider the check past of the treatment of trans dered persons. I wrote it becau want service providers to rea that despite all the good that been done, harm has been d and to prepare themselves for treatment reform which the will bring. We need the partie both sides of the treatment fenc realize that their behavior c have been and can be better only then can we achieve the logue that will be needed in c to bring reform.

In future issues of CQ, we' further defining the problem proposing a definitive solution. plan is to build a gate in the t ment fence. ♀♂

# Gender Boxes

*by Susan Edwards*

Almost every speaking engagement that I have been on, I get a question that more or less asks what the difference is in "feeling" between transsexual people and crossdressers. They are in a sense asking, "How do you 'know'—that is know with certainty—that you want to do this? It is a question that I have heard asked by many of my friends and acquaintances in the gender community, and not a few of the clients that I have counseled have come to therapy asking that self-same question of themselves. I heard it asked at the very first support group meeting I attended. It would seem that for many, the release of the "feminine" part of their identity through crossdressing begins to lead to a logic something like, "If some is good, and more is better, than a lot more is better still; ergo, I must be transsexual."

A friend of mine (I'll use the name Anne) came out a couple of years ago. Being out, dressed in public, was a thrill, and having the opportunity of both time and money, she spent a good deal of her time perfecting her feminine persona. The elation that she was feeling was not only about the clothes, but about freedom: the freedom to feel beyond the bounds of the narrow range of emotions that bind the masculine role in this culture. Anne was learning that she had great capacity for the more tender, nurturing, "feminine" feelings and to express them felt good. It opened for her a whole new world of caring not only about others, but about herself. Never before, as a man, had she stopped to take care of herself. She had felt that taking to time to do nice things for oneself wasn't manly, but, rather, that as a male she was bound to a role of stoic endurance. She found what real joy there was in the simple pleasures of taking care of one's own needs—even to simple things like a concern for appearance or making the time for a relaxing bath. Her own need to like herself was finally getting met. But it was only getting met while in the feminine role. So, because it felt good, both physically and psychically, Anne wanted to stay in the role and the persona that she had allowed and created for herself, wherein it was allowed to experience these "feminine" feelings.

It was then that she began to talk about being transsexual and wondering about whether she could go through with transition and all the anxieties associated with such a fateful decision. Talking to her one day, she was going on about how "Bob" could never do this and "Bob" was such a jerk because he never would do that. I had to ask her who the hell she was talking about. "Well, me, of course," she answered.

Well, if that was so, I asked, why didn't she just say "me" instead of "Bob?" For it was she that didn't do those things. Wasn't she trying to disown and evade responsibility for her own actions by ascribing them to this other person, "Bob?"

If, as we profess, we are facing our individual gender issues openly to feel better about ourselves, then it would seem to me that we would want to feel that way all of the time, regardless of how we're dressed or what gender role we happen to be fulfilling at any particular moment. In a rap group that I was in, one of the subjects being discussed one night was "feeling feminine." The talk centered around how you felt when all decked out in some frock, with the stockings, and the killer "come fuck me" pumps. The facilitator listened to all of this for a while and then finally spoke, posing this situation: It's eleven at night. You are almost ready for bed when you remember that you are out of razor blades. So, you pull on a pair of jeans and thrown on a t-shirt and hoof it on down to the 7-11. Now, the question is, do you feel any less feminine? Does who you consider yourself to be and how you feel about yourself depend that greatly upon what you're wearing? Does your mode of dress dictate what you may allow yourself to feel and how you act upon those feelings?

As our culture has defined different modes of dress for the sexes, the culturally defined gender roles can also be seen as limiting the allowed modes of emotional expression. Our socialization teaches us that, "big boys don't cry," and that for males to show empathy and sensitivity towards the feelings of others is somehow to be "sissy." Men should be hard and cold and unfeeling, the strong and silent John Wayne type of guy. But having those feelings and those emotions is not a matter of gender; rather, they are natural and normal human expressions. For many of us, the reaction to having the need to express those facets of our personalities that are culturally defined as feminine is made all right by assuming the culturally appropriate role (i.e., to dress in women's clothes). We then put ourselves into a psychic closet. Rather than have anyone suspect that we would have such "unnatural" feelings, we disallow them. We hide in a role that is hyper-masculine. It is only in the privacy of the closet, where we dress in the outward symbols of those repressed feelings, that we allow ourselves to open up to those emotions that society has labeled as feminine.

Like Anne, many of us have divided our emotional life into gender roles. We jump from one gender box to another. When dressed, there is the constant worry of passing—not just in terms of looks, but of behavior. On the one hand, we rail about the limitations of the masculine role, and on the other, we gladly take on the restrictions of role that would have made Queen Victoria seem a fellow traveler of Gloria Steinem. In looking at my own issues, I began to understand that for me, it was necessary to be emotionally a whole person. Defining myself was not about sex, or gender per se; it was about integrating all parts of myself into someone I liked. I am not a different person emotionally if I am wearing hose and heels, or if I am wearing jeans and tennis shoes.

There is in the gender community a popular rationale for cross-dressing behavior—that by so indulging, it "allows" men to feel those emotions that are outside the cultural and social boundaries of the male role. Perhaps. But I think it offers more a gateway, a means and a mode of becoming a fully feeling person unrestricted by the sociocultural definitions of what is or is not gender-appropriate. It is a stage to a whole that is greater than the sum of the individual parts. Emotion has no gender. Feeling has no sex. Permission to feel soft or vulnerable or nurturing, much less strong, aggressive or protecting, is not granted by the clothes we wear, but by the quality of person we are. In this respect, the issues are not those of gender, but rather of "simply Human-being," to quote e.e. cummings.

So, to answer the question of how you know if you are or are not transsexual, you must look for the answer beyond the trappings and restrictions of both gender roles—to see yourself as being the best person that you can.

For Anne, she found that when "Bob" started to put away his macho attitude and started to loosen up, and to acknowledge and allow the full range of his emotional pallet, he found himself beyond the self-imposed limitations of how he had perceived the way men and women should act. Anne/Bob was no longer leading separate emotional lives defined by culturally dictated gender roles. It gave him/her the space to decide and really know how he/she felt—not as a man or as a woman, but as a person. Bob decided that on the whole, he was more comfortable with his genitals the way they were. The need to define him/her self as being one gender or another had lost the urgency it had once held. Bob is much happier now, and so is Anne.

If we do this right, our transgendered experience can be a great opportunity to grow into the people whom we wish to be. In the Play "Hidden, A Gender," by Kate Bornstein, she has written the line: "Gender, it can either be a battleground or a playground." Decide what you are after you have thought about who you are. ♀♂

# *Notes From the Yellow Brick Road*

*by Lea* [redacted]

To be a good consumer of gender services, it is vitally important to keep your end goal in mind. This sounds like a simple statement, very silly to mention, but the goal of the whole effort is often lost in the struggles and triumphs of individual segments.

What is the actual goal? You were born a woman or man with a physical handicap. The goal is simply to live your life as a normal woman or man after physical therapy and necessary reassignment surgery.

The progressive steps to the goal are to recognize the need for treatment, to begin in earnest, then to suffer the "ugly duckling" phases of physical transition, and finally to escape from the nest of transition assistance and take your place with the other people of the world, believing that you belong and knowing you have a right to be the person you are.

The fuel that keeps this whole process running is personal courage. In finding enough and using it to overcome all the hurdles that lay ahead of you, you will also set patterns and find the strength to face all of the other elements in life that will require courage when you are just a common citizen again.

Wherever you are right now, the reason you are not at the next step is an unwillingness to face the consequences of the decision to progress and to pay the price necessary to gain admission to that level. Some of these levels are scary and may cost a lifetime of friendships and roots. Some are so comfortable, soft, and warm that it is very easy to sell yourself on the idea of "just staying here." But in the quiet of the night, facing yourself in the mirror, you know that without progression, you are lying to yourself. You know what wholeness is instinctively and in actuality, as you watch the fifty percent of the population that you want to be a member of walk past you every day, longingly looking at them as if you were peering through a plexiglass window.

Somewhere else in collected literature are all the technical details of transition. My purpose here is only to relate what I found worked best to create growth and wholeness throughout my whole process.

I learned the most important thing for me was to keep as close to reality as possible by having the courage to find needed service suppliers in the local "normal" markets: to explain the situation to people who could help, to have the perseverance to carry through the changes they helped me to effect so that they could see my conviction, and to learn to be comfortable in dealing with people who will be my friends and suppliers of services for the balance of my normal post-transition life.

To get results and avoid disappointments, you must be straightforward and honest with people. You will of course be refused help by some folks, but there are enough good people out there who will believe in your seriousness of purpose and lend assistance. Without honesty, you are forced to settle for shysters, grey market scammers, and unsatisfactory results. Don't accept something second rate just because someone is "doing you a favor." All that points out to them is that you think of yourself as some sort of willing victim and less than a real person.

Get a good electrologist. Get a good hairdresser you can talk to who can follow you all through your transition. Go to a professional makeup counselor. You don't need special introductions or help. Get out the yellow pages and shop. Go into clothing stores and explain exactly what you are doing and that you haven't the vaguest idea of how to put this together. People will help if for no other reason than for the money from the sales. You are, after all, the customer. You are spending money, and you deserve for your purchases of services and goods to be up to the standard you want. You are not buying pornography—you are purchasing the normal apparel and accouterments of the gender you know you belong to. As you get more experienced and discerning and develop your own style, you will have the courage to express your likes and dislikes. If you are the customer, act like one. Be prepared to pay the price. Expect the service you desire.

Get away from "transsexual specialists," and stores that cater to drag queens and crossdressers. You are not a pariah who needs to sneak-order second-rate cosmetics at triple price out of the back of some magazine that is "helping you find your femme self through styrene prostheses, natural hormones, and lifelike body forms." You are an otherwise normal woman or man with a problem of physical appearance that needs to be overcome.

At one point, when I was in an androgynous part of my transition, I went into Wal-Mart to buy shorts. I was completely changing my wardrobe for the future, and so I selected three pairs of women's shorts. When I got up to the counter, there was a young fellow at the register. He said to me, "Do you know these are women's shorts?" I said, "Yes." He then said, "I guess you are buying them for your wife." I said, "Either that, or I'm having a sex change." He thought about this for a minute, then said, "Naw. You're buying them for your wife." I smiled sweetly and said, "I'm not married," picked up my purchases, and walked out.

In another instance, I was purchasing makeup in a department store. The clerk, a young woman, was almost totally unwilling to wait on me. In the end, she did sell me what I was trying to obtain. I turned to her manager and said, "Apparently, your clerk has a bit of difficulty in waiting on transsexual people." The manager, without blinking, said, "I'm very sorry. If you want to come back later this afternoon, I will wait on you personally and give you a full makeover."

I relate these incidents because in the whole process of organizing the transition, they were the only times I met any overt questioning. This is not to say that I probably didn't produce quite a bit of amusement and chatter in my wake after shopping, but the simple fact is that I was never impeded from obtaining what I wanted or needed by the fear of what someone else thought about what I was doing.

Once set in motion, if you allow changes to happen and aren't held down, delayed, or sabotaged by your own fears, the physical aspects of the transition are rather rapid—at least to the practical phase where you can function in the world as a normal person with a high degree of anonymity. When you put on a dress or cut your hair and don men's clothing, your life and what you have to learn culturally about the role you have been denied since birth is just beginning. To so many people, this is such a "goal" that they forget what the real goal is—to function as a normal person. After a few months of really trying, things that seemed almost an impossibility will become second nature. An hour of applying makeup becomes five minutes, with you being one of those women who, to save time, is still putting on her mascara on the drive to work. At work, the question won't be how everyone likes your skirt; it will be what sort of job you are doing. If they hired you as a woman in the first place, they won't be in the least impressed if your shoes match. They expect that—but how much have you gotten done on that contract?

I know that this is a little hard to believe for those of you sitting out there reading this with a dream, a five o'clock beard shadow, a crew-cut, and the couch potato sags. And I know that a lot of you will never get beyond the stage of reading about the subject and wishing that it could be you. I know this because I used to be you. But the pain was worse than the fear, and at each step, as it got scarier, I remembered what life was like when I wasn't me. I remembered

*Continued on page 33*

# Making Plans for Emergencies

*by Michael* [redacted]

Edward left Atlanta on the 3:15 PM flight to New Orleans. At 5:45, he was checked into his room in the famous French Quarter. An hour-and-a-half later, Evelyn walked out of Edward/Evelyn's room and entered the elevator.

On his frequent business trips, Edward always carried two suitcases. One contained Edward's business suits, starched button-down shirts, wing-tip shoes, and power ties. The other was a little different. In a sense, it contained Evelyn.

Edward/Evelyn had been playing this game for years. He often left Atlanta on Tuesday and returned on Thursday or Friday morning. To his friends and business associates, he was a successful businessman. To his neighbors in suburban Atlanta, he was an ideal homeowner.

When Edward was in Atlanta, the second suitcase stayed in the trunk of his car. No one knew about the second suitcase. His wife, Marilyn, knew her husband crossdressed, but she had always been uncomfortable with the idea and never encouraged her husband's hobby. She and Edward had agreed years earlier that if he would keep his crossdressing out of her life, she would not tell anyone about it. Edward agreed, and by luck, his traveling helped him to keep his promise.

Evelyn was a beautiful person. She had spent twenty years crossdressing, and was able to pass perfectly. She went everywhere with Edward. Today, she had noticed a tightness in her chest during the flight. As she dressed, the tightness had become somewhat more intense. While she was bending over to put on her pantyhose, the tightness was stronger than ever, and there was some tingling in her left arm.

She had dismissed the pain. She thought it would go away during dinner. But Edward/Evelyn was wrong. Edward died as Evelyn, on the floor of a French Quarter restaurant. A massive heart attack killed the Atlanta businessman on the spot.

The paramedics responding to the call hardly lifted an eyebrow. In New Orleans, in the French Quarter, life is never as it seems. Evelyn wasn't the first crossdressed person they had found sprawled on the floor. To them, the gender of the person didn't matter. Their job was to keep the patient alive. But it was too late for this one.

As Edward-Evelyn was being transported to the city morgue, the New Orleans police started using the telephone. They had to notify the next of kin.

Imagine the pain and heartbreak Edward's wife felt when she flew to New Orleans, identified the body, and picked up Edward's belongings. The police also gave her all of Evelyn's things.

Can you picture something like what I've just described happening to a friend of yours, or to yourself?

I've discussed with other crossdressers the absolute possibility of being found out after an accident or tragedy. This is one real fear that I have. I spend a lot of time in women's clothing. Sometimes I am completely dressed. Other times, I wear only undergarments. I think of myself as another Cinderella. I plan to get home before midnight. But even Cinderella missed her ride.

I drive a lot. My working territory covers one-third of the state where I live. I am a careful driver, and have logged over 100,000 miles during the past three years. I've been involved in two minor accidents. One was the other guy's fault, and the second was due to weather (my vehicle hydroplaned). In either case, had I been dressed, I would have been in a very embarrassing situation. But luck was with me both times.

Think about all the times we go about our daily business wearing a bra and panties under a camp shirt and jeans. When was the last time you wore a pair of pantyhose under your slacks while you were at work?

Now, don't get me wrong. I am a very optimistic person. I think nothing will ever happen to me. It always happens to the other person. I'm addressing this to you, the other person.

Maybe you can't bear to tell your wife about your crossdressing. Maybe she can't stand the idea of you crossdressing. Maybe you have promised to never crossdress again. But keep in mind—there's a good chance she will eventually find out Then you won't be able to say a thing to defend yourself. It will be too late, and it will be blunt and dirty. You may be in an accident or you may be stricken with a sudden illness. You may be alive or dead. She will have to jump in and take command.

Suddenly, in the trunk of your car, in the attic, in a storage box that no one knows about but you, somewhere, some place, she will find your clothes. What will go through her mind as she holds up a size 16 or 18 dress—especially if she's a size 8? You may be able to think of something to tell her. You may come up with some sort of excuse for owning a dress. But what about the panties, the bra, the stockings, the makeup, the earrings and jewelry? Who is going to tell her about the breast forms and wig and size 11 high heels?

Maybe your son or daughter will find your wardrobe. That's no better, is it?

I've had a lot of correspondence with transsexual people and with other crossdressers. I can't bear to throw the letters away, for they contain a lot of information I may refer to later on. I'd hate for anyone to read any of those letters. How do you store such material, if you are a heterosexual male with a family?

I thought about making some provision in my will for disposing of my wardrobe. That's real smart. Then some lawyer gets to read it out loud and the will is recorded in the courthouse. I thought about giving my attorney or CPA a letter to be opened immediately in the event of my death, asking him to take care of such loose odds and ends. But I keep my wardrobe in a couple of different places. There's no way I could keep the letter updated. (Maybe I could send him a new letter every month or so). I'm sure he'd charge me or my estate for that kind of work, and I would turn over in my grave, knowing someone local had to unravel my secret life.

Besides, what is he going to say to my wife? "Sorry, Mrs. Williams. Your late husband gave me this

note. As you can see in his letter, I'm supposed to remove a few things from the basement, his office closet, and the attic. Read on, and you will note that under no circumstances are you to know or find out what it is I'm removing.

"That's right, I can't show you what I'm taking out of your house. I can't even tell you about it. No, Mrs. Williams, I don't know what it is. I expect I'll be just as surprised as anyone.

"Now if you don't mind, I'd really like to hurry so I can get out to the golf course. Ed, Harry, and I are going to try to play nine holes before dark. Yes, we're sure going to miss Michael's Wednesday afternoon golf games. He was a great guy to be with."

If you're looking for the answer here on this page, I apologize. I don't have the answer. I don't even have a recommendation.

Some crossdressers have had heart-to-heart talks with their wives. Some have tried to tell their family as a group. But many have done absolutely nothing, hoping for the best.

I know I haven't done enough to solve the problem. My wife knows I crossdress. We've had long, long talks about it, but we've never discussed what she's to do if something happens to me. The closest we've come is to have frank discussions about keeping my secret away from the children. That's the first harsh step towards reality.

I am allowing my wife to know more and more about my crossdressing. Hopefully, we will have one another until we both grow old. Maybe the dresses and slips will eventually end up in a garage sale or in a bundle left for the Salvation Army. That's a lot to hope for. I can't envision a time in my life when I won't have the desire to dress up. I'd like to be 80 years old and able to dress the part I want to be. I can't imagine deciding on my 65th birthday—or any other—not to crossdress anymore.

And one of these days, I'm going to go, and someone is going to have to deal with my wardrobe. ♀♂

*Notes From the Yellow Brick Road*
*Continued from page 30*

the pain, and that gave me the propulsion.

And it got easier. The horror and worry leading up to the dreaded ear piercing was far more of an event than the procedure of the orchidectomy *(Note: castration—Ed.)*. By then, I just needed to know how soon I would heal enough to get back to work.

If I could suggest one gender service you could find that will be the most valuable, I would urge you to find a good friend who is a member of the gender you identify with. Find someone removed from the gender community; someone who knows her way around K-Mart, or a guy who knows his way around the sports bar and the barber shop. These people lead a normal life, taking for granted their right to obtain the goods and services of their gender. Follow their example. Don't make a big deal out of everything. No trumpets will sound when you get your ears pierced or walk through a store in a skirt. People that you encounter will just expect you to act like a normal, predictable person—a member of the gender in which you are presenting yourself.

They supposedly don't serve any wine before its time. Don't expect good results if you shortcut necessities like electrolysis, dieting, or letting your hair grow. But when you are ready, get out there and live, because only in the real world will you learn to live in the real world. Get away from support groups when you've found that you've outgrown them. Don't hang around in gaggles and go on guided tours at specially staged gender events and expect that they are going to be like real life. Never take makeup tips from a transgendered person.

Remember: on the yellow brick road, Dorothy could get anywhere, if she only believed that she could. Once she knew that fact, she was home, and so will you be. ♀♂

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Now, don't get me wrong. I am a very optimistic person. I think nothing will ever happen to me. It always happens to the other person. I'm addressing this to you, the other person.

Maybe you can't bear to tell your wife about your crossdressing. Maybe she can't stand the idea of you crossdressing. Maybe you have promised to never crossdress again. But keep in mind—there's a good chance she will eventually find out Then you won't be able to say a thing to defend yourself. It will be too late, and it will be blunt and dirty. You may be in an accident or you may be stricken with a sudden illness. You may be alive or dead. She will have to jump in and take command.

Suddenly, in the trunk of your car, in the attic, in a storage box that no one knows about but you, somewhere, some place, she will find your clothes. What will go through her mind as she holds up a size 16 or 18 dress—especially if she's a size 8? You may be able to think of something to tell her. You may come up with some sort of excuse for owning a dress. But what about the panties, the bra, the stockings, the makeup, the earrings and jewelry? Who is going to tell her about the breast forms and wig and size 11 high heels?

Maybe your son or daughter will find your wardrobe. That's no better, is it?

I've had a lot of correspondence with transsexual people and with other crossdressers. I can't bear to throw the letters away, for they contain a lot of information I may refer to later on. I'd hate for anyone to read any of those letters. How do you store such material, if you are a heterosexual male with a family?

I thought about making some provision in my will for disposing of my wardrobe. That's real smart. Then some lawyer gets to read it out loud and the will is recorded in the courthouse. I thought about giving my attorney or CPA a letter to be opened immediately in the event of my death, asking him to take care of such loose odds and ends. But I keep my wardrobe in a couple of different places. There's no way I could keep the letter updated. (Maybe I could send him a new letter every month or so). I"m sure he'd charge me or my estate for that kind of work, and I would turn over in my grave, knowing someone local had to unravel my secret life.

Besides, what is he going to say to my wife? "Sorry, Mrs. Williams. Your late husband gave me this

note. As you can see in his letter, I'm supposed to remove a few things from the basement, his office closet, and the attic. Read on, and you will note that under no circumstances are you to know or find out what it is I'm removing.

"That's right, I can't show you what I'm taking out of your house. I can't even tell you about it. No, Mrs. Williams, I don't know what it is. I expect I'll be just as surprised as anyone.

"Now if you don't mind, I'd really like to hurry so I can get out to the golf course. Ed, Harry, and I are going to try to play nine holes before dark. Yes, we're sure going to miss Michael's Wednesday afternoon golf games. He was a great guy to be with."

If you're looking for the answer here on this page, I apologize. I don't have the answer. I don't even have a recommendation.

Some crossdressers have had heart-to-heart talks with their wives. Some have tried to tell their family as a group. But many have done absolutely nothing, hoping for the best.

I know I haven't done enough to solve the problem. My wife knows I crossdress. We've had long, long talks about it, but we've never discussed what she's to do if something happens to me. The closest we've come is to have frank discussions about keeping my secret away from the children. That's the first harsh step towards reality.

I am allowing my wife to know more and more about my crossdressing. Hopefully, we will have one another until we both grow old. Maybe the dresses and slips will eventually end up in a garage sale or in a bundle left for the Salvation Army. That's a lot to hope for. I can't envision a time in my life when I won't have the desire to dress up. I'd like to be 80 years old and able to dress the part I want to be. I can't imagine deciding on my 65th birthday—or any other—not to crossdress anymore.

And one of these days, I'm going to go, and someone is going to have to deal with my wardrobe. ♀♂

*Notes From the Yellow Brick Road*
*Continued from page 30*

the pain, and that gave me the propulsion.

And it got easier. The horror and worry leading up to the dreaded ear piercing was far more of an event than the procedure of the orchidectomy *(Note: castration—Ed.)*. By then, I just needed to know how soon I would heal enough to get back to work.

If I could suggest one gender service you could find that will be the most valuable, I would urge you to find a good friend who is a member of the gender you identify with. Find someone removed from the gender community; someone who knows her way around K-Mart, or a guy who knows his way around the sports bar and the barber shop. These people lead a normal life, taking for granted their right to obtain the goods and services of their gender. Follow their example. Don't make a big deal out of everything. No trumpets will sound when you get your ears pierced or walk through a store in a skirt. People that you encounter will just expect you to act like a normal, predictable person—a member of the gender in which you are presenting yourself.

They supposedly don't serve any wine before its time. Don't expect good results if you shortcut necessities like electrolysis, dieting, or letting your hair grow. But when you are ready, get out there and live, because only in the real world will you learn to live in the real world. Get away from support groups when you've found that you've outgrown them. Don't hang around in gaggles and go on guided tours at specially staged gender events and expect that they are going to be like real life. Never take makeup tips from a transgendered person.

Remember: on the yellow brick road, Dorothy could get anywhere, if she only believed that she could. Once she knew that fact, she was home, and so will you be. ♀♂

# Reviews

*Rating System*

Don't Bother.
Only if the price is right
Definitely worthwhile
Most Excellent.

## *Clinical Management of Gender Identity Disorders in Children and Adults:*

## *A Consumer's Viewpoint*

*Review by Jennifer S. Usher*

Edited by Ray Blanchard, Ph.D., & Betty Steiner, M.B., F.R.C.P.(C)
199 pages, hardbound
Available for $32.00, postpaid from
American Psychiatric Press, Inc.
1400 K. Street, NW., Ste. 1101
Washington, DC 20005
Rating:

This book from the Gender Identity Clinic of the Clarke Institute of Psychiatry in Ontario, is the most recent text aimed at health care professionals who wish to learn more about transsexualism, transvestism, and other gender identity disorders. While in many respects it is an excellent book, it has some serious problems. It would be hard to totally recommend their approach in every case.

The book consists of a preface and ten chapters written by various professionals, all of whom are affiliated with the Clarke Institute. One of the book's shortcomings is that it provides only one clinic's approach. It would be better if other approaches were discussed in more detail.

The preface, by Ray Blanchard, is excellent. It provides a reasoned and sympathetic overview of the field. It acknowledges that patients are not all the same, that the problem may be found even in early childhood, and that there are those who are in their sixties when they first present for treatment. Further, it acknowledges the lack of knowledge as to causes, while chiding those who claim to have all the answers. Finally, it points out that even if the cause is discovered, that does not ensure a "cure."

The first two chapters, by Kenneth Zucker, deal with the gender identity disorders of childhood and their treatment. An interesting point raised is that many, if not most, children resolve such problems by adulthood. A child who expresses a desire to be the opposite sex will not always grow up transsexual. Zucker raises this issue in relation to the claims by certain practitioners of cures for childhood gender identity disorders. He points out that the cure might have happened anyway.

Next, Ray Blanchard offers up a basic description of the types of gender identity disorders. Like most in the field, he engages in the offensive practice of classifying transsexual people according to sexual orientation. Also, like most authors, he bases the classifications on biological rather than gender criteria. Perhaps this is required by the norms of the field, but it seems to deny the veracity of the patient's gender identity while emphasizing the sex of birth. A male-to-female transsexual person does not see a relationship with a male as homosexual, nor does she see a relationship with a woman as heterosexual. This attitude contributes to the public's perception of those seeking sex reassignment as homosexuals. Further, it causes many in the gay and lesbian community to view transsexual people as copping out. One interesting point: while he does acknowledge that some female-to-male transsexual people choose to live as gay men, Blanchard does not make allowances for bisexuality among female-to-males. This is an improvement over other authors, most of whom insist that there have never been any "heterosexual" female-to-male transsexual people, but still falls a little short of the mark. I have a friend who is a post-operative female-to-male who does not fit into either of Blanchard's categories.

Having established the various types of gender identity disorders, the next chapter, by Betty Steiner, deals with the issues of clinical intake and diagnosis. This is another excellent chapter, discussing differential diagnosis and the need to establish the truthfulness of the patient's statements. In the section on assessing the patient's ability to pass, the author makes a mildly humorous remark about "Strange esoteric hairdos and immensely long artificial nails like talons—usually

painted a bright scarlet..." Further, she makes a slightly disturbing observation that "homosexual" males are somewhat more successful in passing than "heterosexual" men.

The next chapter, by Lana Stermac, deals extensively with the treatment of those who are judged not to be transsexual. This group includes ego-dystonic homosexuals and crossdressers. For these patients, they suggest a variety of approaches, including psychotherapy, group therapy and marital counseling. Stermac also suggests the possibility that low dosages of estrogen may help alleviate cross-gender desires in some marginal crossdressers who are uncomfortable with crossdressing.

Now we come to the section where the book has its worst faults. In a chapter on the real-life test, Leonard Clemmensen advises that patients not be given hormones until they have cross-lived for one year. This is far more strict than the Standards of Care require, and strikes me as not only overly conservative, but extremely harmful. The rationale that Clemmensen gives seems mistaken, at best. He argues that patients should not rush into cross-living. However, the Clarke program requires a year of cross-living before hormones. This is strange, since one of the functions of hormones is diagnostic. As pointed out before, hormones may cause some crossdressers to lose interest in changing sex; however they will often intensify those feelings in transsexual people. It seems to me that any possible side effects of proper dosages of hormones would be much less severe than the disruption of one's life that full-time cross-living would cause. This is especially true if after a few months on hormones the patient loses interest in cross-living. Imagine the possible problems resulting from breaking ties with family and friends—not to mention employment. If the patient has simply changed jobs, that would be bad enough, but what about a patient who has approached their employer and received permission to begin transition on the job and then has to go back and explain that it was all a mistake. This could have far worse effects than those caused by a few months on hormones. Also, the hormones can help one as they prepare for transition.Clemmensen writes that those who want it badly enough will find a way to pass without hormones. What this is supposed to prove, I am not sure.

In fairness to Mr. Clemmensen, I should point out that the above comments apply to male-to-female situations. In the case of female-to-males, changes such as deepening of voice and beard growth would present more serious problems if the choice was made to return to the female role. While beard growth can be eliminated with electrolysis, voices changes can be very difficult and expensive to remedy.

One other area where I disagree with Clarke's approach concerns hormone dosages. Robert Dickey and Betty Steiner recommend no more than .1 mg of ethinyl estradiol or 2.5 mg of conjugated estrogen (i.e. Premarin). From other articles I have read, these dosages seem rather low. Dickey and Steiner base their conclusions on a 1973 study of cardiac disease by the Coronary Drug Project Research Group. In fact, the authors suggest a regimen using a drug providing .05 mg of ethinyl estradiol and .25 mg of d-norgestral. This might explain their statement that patients have only mild feminization. In my own case, after a year of being on a combination of .5 mg of ethinyl estradiol with bi-weekly shots of estradiol, I developed significant body fat redistribution and breast development. The only negative side effect I have noticed is some facial pigmentation. This condition, know as "mask of pregnancy," is also found in genetic females who take oral contraceptives and can be eliminated with over-the-counter products. I should also note that the authors do mention the use of cyproterone acetate and spironolactone as adjuncts to hormone therapy. These drugs can lower the needed doses of estrogen; however, .05 mg of ethinyl estradiol still seems too low.

Next, Dickey and Steiner consider the question of surgery. The surgical procedures described seem to be among the better approaches I have seen. Details are given for both male and female patients, with alternative procedures discussed. I was particulary impressed with the male-to-female procedure that was discussed here. It seems to provide a good compromise between the simple penile inversion and the more complicated use of tissue from the lower intestine.

The last two chapters in the book, by Ray Blanchard and Peter Sheridan, and Robert Dickey, respectively deal with the results of surgery and some of the anti-social problems some transsexual people seem to have. In the chapter on surgical results, considerable space is given to refuting the infamous Meyer & Reter study. For those not familiar with Meyer & Reter, it was a very poorly researched paper claiming that sex reassignment surgery had no beneficial effects. It led to the end of the Johns Hopkins program. While others have refuted the findings of this study since its publication in 1979, it is still used by some practitioners to deny transsexual people adequate care. This section of the book truly serves to make up for other shortcomings.

Finally, the book looks at subjects such as criminal behavior, prostitution, and how transsexual people should be handled by the penal system.

For the most part, this is a very good book which provides a good basic view of the treatment of transsexual people. Except for the problems mentioned, it provides fairly good advice. I was both surprised and disappointed that little was said concerning the Standards of Care. While for the most part, the program described in the book meets or in many case exceeds these standards, they receive very little mention.

Overall, this is a very good book for those who want a introduction to the treatment of gender disorders, provided that they also look at what others have suggested in the way of hormonal treatments. ♀♂

# Bits n Pieces

*Gianna Eveling Israel is a peer counselor and the founder of the Gender and Self Acceptance Program, P.O. Box 424447, San Francisco, CA 94142.*

## *Victims of Silence*

*by Gianna Eveling Israel*

"SILENCE = DEATH" is a catchphrase created by San Francisco's gay community in the late 80's to publicize governmental disacknowledgement of the AIDS epidemic. Almost eight years later, silence continues to permeate the gender community, setting such a scenario that the catchphrase "SILENCE = DEATH" is destined to become a reality. At present, few gender-related publications print AIDS-related materials. Currently, no services are oriented towards assisting gender-conflicted individuals facing the AIDS crisis. Programs basically designed to serve gay individuals find difficulty assisting gender clients. While providing counseling for transsexuals and crossdressers, I commonly come across new clients who are caught in a web of misinformation, internalized homophobia, and practicing unsafe sex. It is truly unfortunate when an individual discovers that s/he is HIV-positive, in addition to already existent gender and self-acceptance issues.

Only through education will the gender community be able to prevent the silent death of its members. As the AIDS epidemic continues on its deadly path, hopefully individuals will acknowledge its presence and take responsibility for protecting their lives and the lives of others.

AIDS = Acquired Immune Deficiency Syndrome. Thus, AIDS is an impairment of the body's ability to fight diseases, leaving an individual susceptible to "opportunistic infections" that a healthy immune system could protect against. These infections come from the environment, or may be caught from non-HIV-infected individuals.

HIV (Human Immunodeficiency Virus) is the virus which causes the AIDS condition. This virus is identifiable only through blood testing. An individual who is HIV-positive is at risk for developing AIDS. The HIV virus may lie dormant for up to ten years. For this reason alone, responsible sex and health practices are mandatory.

Commonly, while exploring gender, individuals may find themselves examining their sexuality. For some, this may mean experiencing the same/opposite sex for the first time. For others, their newfound gender role may be an avenue of escape. AIDS is primarily transmittable through blood and semen. Thus, AIDS CANNOT BE SPREAD BY CASUAL CONTACT. Sexually, this means practicing "safe-sex" with emphasis on not exchanging body fluids by using a condom or dental dam. At present, no known cases have been passed through saliva or tears. Intimacy outside of body fluid exchanges is permissible. Equally encouraged is your love, compassion and support for the individual dealing with AIDS or an HIV diagnosis.

Individuals eligible for sex reassignment surgery (SRS) will appreciate the protective option of storing their own blood prior to surgery. SRS is not usually available to HIV-positive individuals; this protects the surgeon from large quantities of virus-exposed blood and the patient from the likelihood of serious infectious complications. Although not being able to have SRS may be disenchanting, hormone therapy can be continued under medical care. Some HIV-positive individuals have found surgeons willing to provide orchiectomies and breast implants.

With electrolysis, regardless of one's HIV status, it would be wise to seek the services of an electrologist who provides proper sterilization and labelling and storage of individual needles, or a new needle at the beginning of each session. No complications have been reported where proper electrolysis guidelines were followed.

At present no "cure" or "vaccination" exists for the HIV virus. However, there are various drugs available to treat the different infections

accompanying the AIDS virus, in addition to a variety of immune-boosting therapies. Because AIDS DOES NOT MEAN A DEATH SENTENCE, medical professionals are encouraging testing for anyone who has engaged in high-risk sexual practices during the past ten years, or who suspects they may carry the HIV virus. Testing is available confidentially through your physician or through anonymous testing facilities located in most metropolitan areas.

In working with various gender clients, it has been my observation that both individuals who are and are not dealing with HIV issues have found excellent health benefits by integrating healing arts into their personal growth work. These arts include meditation, self-acceptance training, Eastern and Western herbs, massage, reflexology, acupuncture, and acupressure.

In respect to the AIDS epidemic, it is my hope that each individual will choose to take responsibility in educating and protecting themselves and others, keeping in mind that continued silence will result in unnecessary death. Obtain information through your physician, or personal therapist, or by anonymously calling the National AIDS Hotline (1-800-342-AIDS). ⚥

## *A Proposal for A National Review Board for Research Using Transgendered Subjects*

Every year, dozens of articles about transsexualism and cross-dressing appear in scientific publications. Many of these articles are reports of research or case studies using transgendered subjects. While many studies are well-run, a surprising number are poorly conceived and conducted. The transgender literature is replete with papers which engage in useless namecalling of transgendered subjects, and which needlessly subject transgendered persons to extremely aversive procedures. While this situation does not seem to be as dismal as it once was, the problem is not solved, and will never be solved unless positive action is taken.

Universities and other organizations maintain review committees for the use of human subjects. Peer Review Committees, consisting of persons with special training in the field in question, ensure that research asks scientifically valid questions, using a design that is likely to provide an answer to that question. Human Rights Committees, consisting of persons both from the institution and from the community-at-large, ensure that the civil and human rights of subjects are not violated (some organizations have only one committee, which serves both purposes).

It is the opinion of AEGIS that for transgendered subjects, the existing literature shows that the usual safeguards are not enough. In most cases, the members of neither Peer Review nor Human Rights Committees are aware of the special circumstances and needs of transgendered subjects, and the members have little or no experience or training in the gender area.

AEGIS is therefore calling for the formation of a National Review Board for Research Using Transgendered Subjects. This Board will consist of researchers, community leaders, and others. A significant proportion of the Board will consist of transgendered persons.

The Board would meet annually in association with a national gender or sexological conference, and would there hear proposals for research using transgendered subjects. The Board would approve a proposal, reject it, or suggest revisions. The Board would additionally review published studies to determine whether the rights and welfare of transgendered subjects had been violated, and whether research which had been previously approved by the Board followed the proposal.

The National Review Board would supplement, but not replace, existing review committees. Those who plan to conduct research using transgendered subjects would be asked to submit a proposal to the National Review Board as well as to the usual committees. Sanction of the Board would result in approval of the research by AEGIS and other sponsoring organizations.

For the National Review Board for Research Using Transgendered Subjects to be effective, it will need the approval of both professional organizations and of consumer groups.

AEGIS invites the participation of the Harry Benjamin International Gender Dysphoria Association, Inc., the International Foundation for Gender Education, and other organizations, as well as interested individuals. If sufficient interest is shown, a planning committee will be formed.

Until the time of the formation of the planning committee, correspondence regarding the proposed National Review Board for Research Using Transgendered Subjects should be directed to:

AEGIS
P.O. Box 33724
Decatur, GA 30033
(404) 987-8312 ⚥

## *Message to All Transgendered Physicians*

*By Sarah Seton, M.D.*

Several physicians in various specialties are currently interested in founding a National Ad-Hoc Medical Committee on Gender Identitiy (NAHMCOGI). I am soliciting all transgendered physicians interested in becoming founding members. All specialties are welcome.

### *Prospectus*

The purposes of this committee would include but are not limited to:

**Physician Peer Review** of unethical and unprofessional treatment of transgendered people by other physicians.

**Liaison with State Boards of Medical Quality Assurance** to enforce sanctions upon physicians who provide substandard care.

**Publishing** anonymously, under the Committee, position papers regarding stigmatization of gender-

## *This Poem is for Darius Barney*

*by Denise Noe*

*This poem is for Darius Barney*
*Nose dripping red*
*Tongue tasting blood*
*Hands and knees on the street*
*A man in a skirt*
*Like a giant crawl-baby*
*Cops look at him*
*Darius Barney*
*On his hands and knees*
*They see that he's hurt*
*This cocksucker for cash*
*The man in a skirt*
*"I don't look like a woman,"*
*he says.*
*So there's no mistake*
*No mistake*
*A man who pays him, pays*
*Darius Barney,*
*Knows he is renting the time*
*And the services of*
*A man in a skirt*
*A man who will open his mouth*
*To another man*
*For money*
*This poem is for Darius Barney*
*A Navajo*
*An Indian*
*A Native American*
*A man who*
*Works in a skirt*
*This poem is for Darius Barney*
*Who has seen a gun*
*Felt a knife*
*Been raped by two men*
*Who knew they were not raping*
*A woman*
*"I don't look like a woman."*
*The men who raped him, raped*
*Darius Barney*
*A man in a skirt*
*This poem is for Darius Barney*
*A faggot, a fairy,*
*Transvestite*
*Ho-Mo-Sex-U-Allll*
*A gay man always gay*
*Always a man*
*Always a gay*
*Always a Navajo*
*This poem is for Darius Barney*
*Who is always a man*
*And sometimes*
*Only sometimes*
*Wears a skirt*

conflicted physicians by fellow-physicians, which prevents them from obtaining referral patients or hospital privileges, or isolates them from their peers.

**Application for grants** from NIMH and other agencies for the scientific study of gender dysphoria syndrome and publishing of results in mainstream scientific journals. Some areas include PET, MRI, SPECT, and BEAM studies of transsexual brain function and structure, RFLP and genetic probes of the TDF genetic cascade, pulsatile GnRH studies, search for metabolic errors in psychoneuroendocrinology (e.g., is there an aromatase deficiency in transsexual brains?), use of psychopharmacology in treating gender dysphoria (e.g., serotonergic uptake inhibitors), infant psychiatric intervention alternatives, etc.

**Union of mutual support** by all transgendered physicians as a collective bargaining agent to prevent any members from being discriminated against.

**Outreach to future physicians** in medical schools across the nation in the form of a speaker's bureau of transgendered physicians willing to teach the medicine of gender dysphoria, preparation of course material for use in medical student Human Sexuality courses, etc.

**Creation of a self-help book** similar to "Our Bodies, Our Selves," and a textbook on gender dysphoria by transgendered specialists, edited and published by the Committee.

**Lobbying** the Health Care Financing Administration/HHS and Congress to help approve SRS as a non-experimental medically necessary expense for insurance company underwriting.

**Revision** of the HBIGDA Standards of Care.

**Liaison with HBIGDA, AMA, AMWA, APA, APSA,** and other mainstream groups.

These are only a few suggestions. Constructive criticism is welcome, as are suggestions for further ways the committee may help transgendered people less fortunate than ourselves. We can further provide a model for other gender-conflicted professionals such as lawyers, media professionals, etc. to pool their own talents to serve others similarly afflicted.

A word about anonymity. Yes, we must have it. Initially, I suspect you all will use pseudonyms to protect your professional identities, as I have done. As we get to know each other better, we will need to address this problem of the closet further.

I am taking the initiative as interim coordinator because a committee representing ourselves vis-a-vis the non-transgendered medical community needs to exist and nobody has wanted to step forward.

Perhaps such a committee is unnecessary, but I find any objection on that score hard to believe in view of the need we all have to protect our careers by remaining silent while transgendered people are persecuted by this society and by the medical profession within its own ranks. Perhaps it's premature; someone else inevitably will come forward later and try again—maybe too late. Our paranoia has got to stop by confronting our fears and the aggressive ignorance and bigotry of this society. We must turn our personal experiences into political action.

I hope you will put forth your ideas so that the Committee may form from the grass-roots up. It is not my intention to be a leader and I hope we will not become vertically integrated, but rather we will be guided by principles rather than personalities for the betterment of the transgendered everywhere.

Please contact me by writing:

Sarah Seton, M.D.
Coordinator, NAHMCOGI
P.O. Box 1060
Kamuela, HI 96743-1060

Thank you for your interest and Best Wishes! ♀♂

*Continued from page 26*

these could be treated with the same methods used to treat Premenstrual Tension Syndrome in genetic women patients.

Apart from the ethical question of a treatment plan that possibly spawns further medical programs that then require a subject treatment plan, and the obvious experimental nature of the cycling regimen, I question the underlying assumptions of such a therapeutic program. The model upon which this management program is based is the reproductive woman. Transsexuals, despite the sophistication of the surgical conversion procedure, are and always will be infertile females, not unlike post-menopausal women. This practice can only be based on the medical and cultural premise that, in fact, a normal woman is a reproductive one. And if transsexuals wish to be women, albeit infertile ones, they should at the very minimum approximate the hormonal tides of reproductive women who serve as the "true" models of womankind, not the post-menopausal woman. The cycling therapeutic program reflects broader cultural values that women's worth lies in the reproductive potential and if that can't be fulfilled, as in the case of the transsexual, an approximation legitimizing the reproductive model will be employed.

Male-to-female transsexuals provide a glimpse of overt and covert sexism in medico-psychiatric beliefs and practices through the back door, as it were. Sometimes it is the extraordinary and the unusual that points the way to the mundane, those little-questioned cultural suppositions that lie hidden behind the voices of the medical experts. For the male-to-female transsexual, her exercise in sexism vis-a-vis the medical profession is unfortunately only a beginning. ♀♂

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# International TranScript

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