Chrysalis Quarterly

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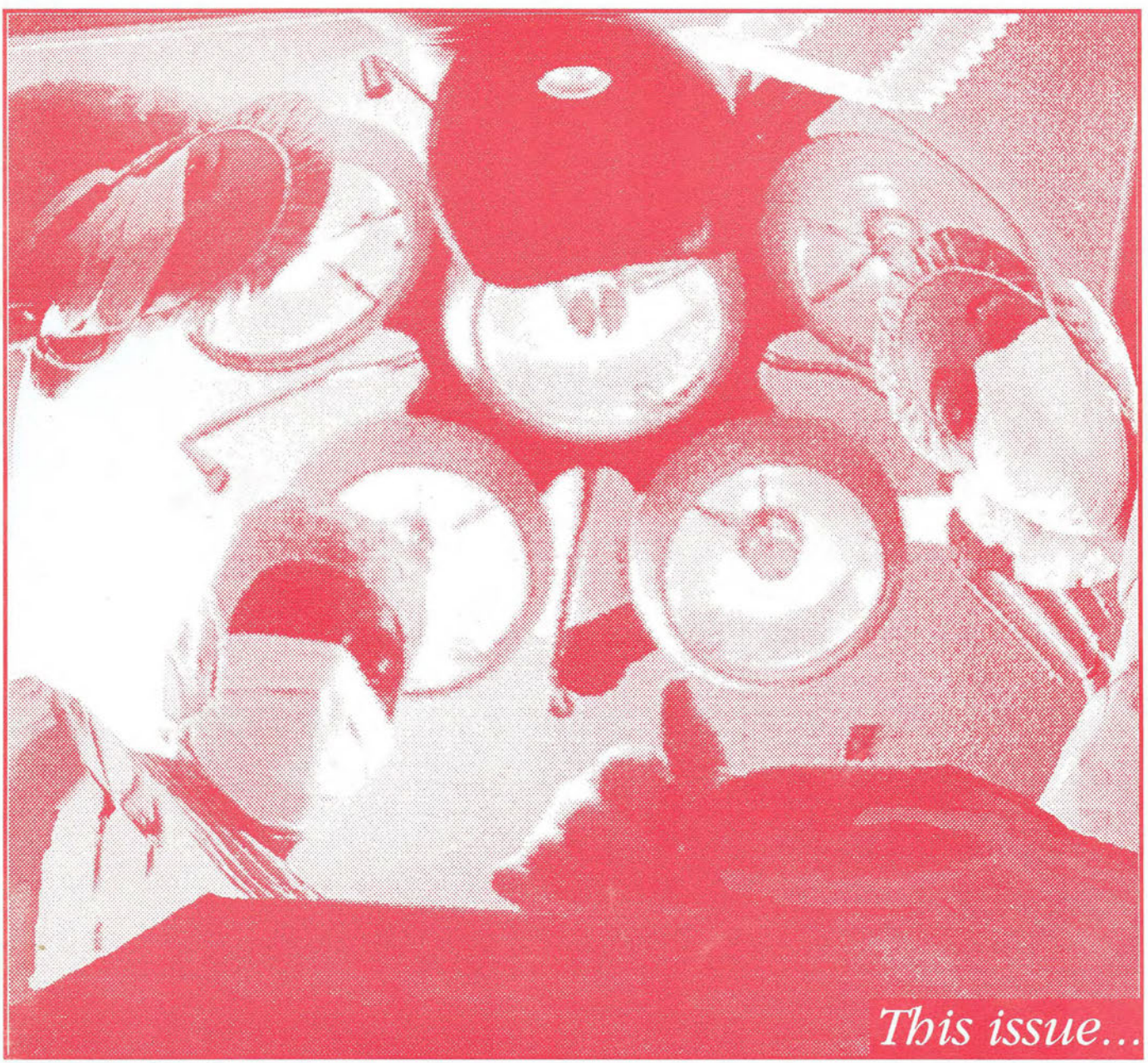

This issue.....

The realities of transsexual surgery

Before trading in your old equipment go for a test drive first.

You wouldn't buy an expensive car without looking under the hood, would you? Without starting the engine? Without taking it out on the road? Without having it checked by a mechanic? Of course not. Well, neither should you rush into an irreversible procedure like sex reassignment surgery without a period of at least one year in which you will work and live 24 hours a day in your chosen gender.

This period of crossliving (called the real-life test) is part of the Standards of Care of the Harry Benjamin International Gender Dysphoria Association, and is required by all reputable surgeons and gender clinics, for it has been found that a period of crossliving minimizes the chance of surgical regrets.

Sex reassignment surgery does not turn men into women, or women into men; it merely confirms what already is. Few people see your genitalia, but your gender is evident to everyone. Rushing into surgery before establishing yourself in your new role is taking a needless risk.

The period of crossliving is like a test drive. It enables you to establish yourself in your new role, to experience your new life before making permanent changes to your body.

Think about it: would you rather pay for that new car before you take the test drive or after you have taken it around the block?

Don't be sorry... Be sure.

A public service of

AEGIS
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Service

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

this issue...

Chrysalis Quarterly

Volume 1, No. 4 1992

About this Issue:

In this issue, we take a look at the social and medical realities of transsexual surgery.

The cover was designed by Margaux Ayn Schaffer, who also did the public service ad on the inside front cover.

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of the Goddess

AEGIS Interdisciplinary Advisory Board

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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.

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from the publisher . . .

I am hardly the first to call for increased cooperation between consumers and service providers. Dr. Anne Bolin kindly sent me a position paper prepared in 1981 by the Colorado Gender Identity Center, in which it was written, "As the principle consumers of hormonal and surgical sex reassignment, we have a legitimate vested interest in efforts to standardize and improve the level of medical care provided gender dysphoric persons... there should be more and more opportunity for transsexuals to share in the process of defining the standards of their own treatment. Just as other areas of medical specialization have profited in the recent past from the increased input provided by educated and aware patients and consumers, the treatment of gender dysphoric individuals can be enhanced by the creation of a full partnership between patients and professionals in the field."

Few things on the planet generate as much heat and as little light as the controversy surrounding sex reassignment surgery (SRS). The effectiveness, morality, and legality of this procedure have been debated in the pages of scientific journals, religious tracts, and daily newspapers, as well as on the television screen. Few people are neutral on a subject that has been called at various times humane, lifesaving, mutilating, noneffective, and sacrilegious; which some feel to be psychosurgery, changing the body to match a diseased mind; which has been said to turn men into "constructed" women and women into "constructed" men; which has been called cosmetic and unnecessary in some theaters, and medically and psychologically essential in others.

Few would argue for SRS; its proponents campaign for freedom of choice of genitals, much as the pro-choice movement is hardly a pro-abortion movement, but instead campaigns for the freedom of women's bodies. As Dr. John Money has noted, the opponents of SRS would demedicalize and criminalize it. They would give it the back-alley status abortion suffered in the 1940s and 1950s, and turn transsexual people and the surgeons who treat them into outlaws. Others, not enemies, perhaps, of transsexualism, but certainly not friends, would have SRS performed only as an experimental procedure, in limited numbers at government-selected centers.

In these pages, I have likened surgical treatment of transsexualism to Pandora's box. Those who demand SRS will not be gainsaid. A population that was undreamed of before 1952 is manifesting itself in growing numbers. We can expect more men and women to request SRS in the nineties, and even larger numbers in the 21st century. More and more transsexual people will come forth, playing havoc with incidence rates. They will declare themselves, form alliances, demand their place under the sun. They will be hungry; they will be vocal; they will be restless; they will want.

And what will they want, these men, and increasingly, these women? They will want SRS, most of them.

For some, surgery will be appropriate; for others, it will not. But the demand— the large number of people determined to have this procedure— will ensure that it remains available. The supply will grow to meet the demand. This has already been happening, and it will continue to happen. Wendi Kaiser, of The Human Outreach and Achievement Institute, told me over the telephone that 43 postoperative pre-registrants for Outreach's New Woman Symposium in September, 1991 reported 42 different surgeons. Wendi said that The Outreach Institute had over 200 sources for reassignment surgery in its files. She estimates that in the U.S. alone, there may be more than 500 surgeons doing SRS.

It is unfortunate that we live in a society with a strongly bipolar view of gender, a culture which defines sex primarily on the basis of one's genitalia. It is unfortunate because many transsexual people subscribe to this view, believing that they will not be women or men until they have the correct genital equipment.

Yes, it is too late to slam the SRS door shut.

For many people, reassignment surgery is the culmination of a long journey toward congruity. It enables them to have normal sexual relations; it removes those last traces of insecurity about their physical selves, and it gives them genitalia which are more appropriate for their appearance and their social role. For them, it is, to use Donald Laub's term, gender confirmation surgery, and they accept it, with all its limitations.

But for every legitimate candidate, there are scores of others who want surgery: often unrealistically, often with no notion of passing in the gender which matches their desired genitalia, often without the necessary persistence or stability of purpose, often without funds— they want SRS. They declare their transsexualism, and set their surgery date, some of them, on the same day.

It is unfortunate that we live in a society with a strongly bipolar view of gender, a culture which defines sex primarily on the basis of one's genitalia. It is unfortunate because many transsexual people subscribe to this view, believing that they will not be women or men until they have the correct genital equipment. Often, this segment of the transsexual population desires and values surgical change over the more important and realistic goals of coming to look and act like a member of the gender of choice and establishing a viable life in that gender. These people forget, or do not care, that their genitalia are tucked away, hidden by clothing, unseen by the masses. They know they don't have what they want. They want what they want, and pursue it monomaniacally, like Ahab after the White Whale. They never think about the social and financial difficulties involved, the medical risks, the fact that their money and energy would be better spent on facial plastic surgery or psychotherapy or electrolysis, that they are sacrificing perfectly functional equipment for something from the surgeon's trick-bag. They want SRS, and too often, they get what they thought they wanted.

But in too many cases, it is not what they expected, for they had unrealistic and perhaps fetishistic notions of what it would mean to have the new equipment. They find that it does not help them to pass, that their level of sexual pleasure is diminished, that they still have trouble attracting sexual partners, that the new equipment requires upkeep that they are unable or unwilling to carry out, that life is no better, that it was not worth the pain and the money and the bother, that all things considered, they would rather be in Philadelphia with their original genitalia. They grow despondent, and sometimes suicidal; they (if male-to-female) lose vaginal depth because they will not dilate (sometimes dreaming of further surgery to increase vaginal depth!); they begin to regret having the surgery. They discover that life is not magically different because they have changed plumbing. They have lived their fantasy, and they find it wanting.

I am not saying here that SRS is a bad thing. It is a miracle of modern science, and I would not have it done away with. But for transsexual people, and sometimes for people who merely think they are transsexual, blind pursuit of SRS can be a bad thing. It is one thing for someone with a viable appearance, living and working in the gender of choice, to seek SRS as a sort of closure to a process they began years earlier; it is quite another for someone who has

(Continued on page 49)

P.O. Box

I must have been napping, for I missed the second issue of *Chrysalis Quarterly*. Otherwise, I would have written and congratulated you and your staff on a truly marvelous publication. The third issue blew me away! Every element— from the smallest graphic nuance to the major articles— combine talent, wit, and professionalism of the highest caliber. You all have established a standard that others in the community can only hope to reach. I am steadying my nerves in anticipation of number four.

— Paula Jordan Sinclair
Senior Editor, *Renaissance News*

A good friend of mine recently lent me her copy of *Chrysalis Quarterly*. Wow! Intriguing, professional, intelligent, gutsy! You moved me, you won my subscription. Now keep it up!

Indeed, an examination of the policies of Gender Clinics is well overdue and your article in the Winter 1992 issue was on target. I have seen over a score of therapists and been to four gender clinics in the last 25 years of my 45-year life. Based on these in general horrendous experiences, may I contribute briefly?

I attended the *(omitted— Ed.)* Gender Clinic from February, 1988 through March, 1990. I fulfilled all requirements for hormonal reassignment in January, 1989, received "conditional approval" by their Gender Review Board in March, 1989, satisfied the final conditions in April (redid the MMPI and another physical exam) and they changed the rules in May!

They decided not to give me a prescription because my divorce wasn't finalized. This was a new, unwritten rule, a complete surprise to me. I reasoned and then argued, to no avail. Finally, in January, 1990, I acquired a prescription through the black market in North Chicago but two months prior to living full time as "me."

Foolishly, I continued my honest approach with the clinic and told them of my prescription. During my last session in March, 1990, my therapist put me "on trial" and attempted to have my transsexual brothers and sisters rebuke me. They didn't. They unanimously supported me for "what I did"! Nevertheless, the Clinic tossed me out of their program. Teaches me for being honest and controlling my life!

This "trial" occurred but nine hours after I had to say good-bye to my three children (court order), one day prior to having six hours of cosmetic surgery, and two weeks before moving 1200 miles away to start a new life. This was the "support" provided by the *(omitted— Ed.)* Gender Clinic.

(I had a) similar experience two years earlier, with the infamous Dr. _____ *(a name you might know— Ed.)*. After two sessions, he concluded that I was "stressed out at work" and recommended that I "think only of positive things and cope." He refused to recommend any reading materials on transsexualism. "None exists," he told me.

My fortune changed after my move. Found a knowledgeable and empathetic psychologist, Dr. Leah Schaefer, and in April, 1991, I had my SRS conducted by Dr. David Gilbert. Very successful! I am wonderfully well-accepted at work as quality assurance manager for a major corporation and am touching, feeling life. It is a marvel!

— Christina Hollis, Ph.D.

As a transsexual who is a former sex worker, I often bristle at comments made by other cross-gendered people about those of us who are prostitutes. Though I occasionally hear accurate observations, too often I notice very judgmental, intolerant things being said. As a community, we need to focus on unity. Can we not learn from the bickering that divides parts of the gay community? We comprise less than one percent of society. Can we learn to support each other in our diversity, rather than insisting on homogeneity and judging those who behave in ways of which some of us disapprove?

It is galling to hear stigmatizing comments come from other transsexuals, especially from peer counselors. All of us have ideas about what is appropriate behavior, and we are entitled to live as we deem fit. We do NOT, however, have the right to judge those whose views differ from ours. Many "normal" people judge us all to be immoral or mentally ill

because we don't conform to their expectations. Do we want to be guilty of the same thing in our minority?

To be sure, public attention often focuses on the most obvious and colorful aspect of ANY subculture. That is a fact of life. It is NOT an excuse for our group to censure and judge those who we think give us a bad reputation. For years I was intolerant of cross-gendered people whose public presentation of gender was less than skilled. In fact, most of the people I sneered at were not prostitutes who over-painted. Quite the opposite; they were mostly genetic males who had very few feminine traits and who insisted on going out crossdressed in public anyway. Further, some of the most vocal critics of transsexual prostitutes are not very passable themselves. This suggests that some of their judgmental attitudes are caused by envy. To bolster their egos, these envious ones name-call the others, saying "drag queen."

The customers of most prostitutes prefer they wear lots of makeup and revealing clothes. A prostitute who doesn't is disadvantaging herself in a highly competitive market. Consider the plight of the many transsexuals whose lives were interrupted at an early age and had no chance to acquire job skills. Most of them have little choice but prostitution as a means to afford the high cost of gender transition. You can't pay for a "sex-change" by working at a fast food joint or collecting disability checks.

I am grateful that circumstances allowed me to eventually overcome my handicaps and pursue my career. My heart goes out to my sisters who don't have a background that gives them an advantage to break out of their current existence. It is not surprising that many of them do not. The life they lead often includes drug abuse and a low self-esteem caused by outsiders telling them they are sick or criminal. Imagine how it must feel to be judged by other transsexuals. Wouldn't you tend to reject all outsiders, including "respectable" transsexuals? Do you think that you would listen to someone who is putting you down for surviving as best you know how?

I am glad to be beyond the point where I have to be a prostitute to meet my needs. I hope to be able to support my sisters (and female-to-male brothers) in any way I am able. One way I hope to help is to educate members of all facets of our community, and hopefully to reduce the incidence of finger-pointing. I am lucky to be connected with so many different parts of our community, and I am grateful for the expanded viewpoint that my associations provide me. I hope that knowledge will open many eyes within and outside of the gender community. We're all in this together, so let's act like it!

— Christine Beatty
San Francisco, CA

We can't agree with you more that transgendered persons should pull together, and not ostracize segments of our community. We are indeed all in this together. Too many of us are so busy looking out for our own needs that we do nothing to help others.

It would seem to be to the advantage of those in the gender community who are not prostitutes to offer help to whose who are. But many people do not understand the forces that lead people to become prostitutes, and to stay prostitutes. They turn an intolerant eye on those who are different, often while complaining about those who have turned an intolerant eye on them.

At AEGIS, we strive to educate all facets of the transgender community, including, and maybe even especially, prostitutes (witness our "Dangerous Curves" advertisement in the second issue of CQ). We will be devoting the next issue of the magazine to the diversity of the community. — Ed.

I have a hint, a technique, regarding pre-op, full-time living. I starting living as a woman nine months before I started electrolysis, without being comprised by a five o'clock shadow. The way I did it was to purchase a product called Zoalla, a resin in a tube that I used to strip my facial hair. One can use the waxing method, but it is, I hear, more painful and damaging to the skin. I came upon Zoalla in the pages of a glamour magazine, where it was offered for sale with other beauty products. It cost only $10, but saved me a fortune and provided peace of mind.

After using Zoalla, it takes about two months for the hair to start growing back in, and it doesn't all return at the same time. I maintained by plucking. I do not recommend waiting past the time that the hair grows back in because one will spend all their time plucking, and continual plucking causes ingrown hairs. I've passed this on to some others, and they claim that it works great.

I have discussed all of this with my electrologist, and she quite agrees that a one-time stripping of the facial hair should not cause any significant problems with ingrown hair, and gives the transsexual a jump on living full-time. One problem does exist for some— the subcutaneous hair, as it grows out and before it reaches the surface, will leave a telltale blue shadow. For a while I had the "mask of pregnancy" on the upper lip, until electrolysis finally zapped enough hairs.

At first I was doing electrolysis twice a week for an hour at a time. Now I am down to 30 minutes once a month, and this includes eyebrow shaping and miscellaneous hairs elsewhere.

Most of the hair attacked by electrologists is dead hair which is at the end of its life cycle, and the electrolysis procedure does not kill that particular follicle; thus money is spent for nothing. The stripping process yanks out these dead or dying hairs, and the subsequent electrolysis attacks the new hair.

Hope this helps.

— Jennifer Lee Farrar
Santa Cruz, CA

Electrologists say plucking is a no-no, for it distorts the follicle and causes ingrown hairs. But then again, electrologists will tell you treatment is more effective for hair in the anagen, or early growing stage.

Use your judgement on this one, folks— Ed.

Letters should be sent to:
Chrysalis Quarterly P.O. Box
P.O. Box 33724, Decatur, GA 30033

in reaction . . .

George R. Brown, M.D is a board certified psychiatrist and Clinical Assistant Professor of Psychiatry at the University of Texas Health Science Center in San Antonio, Texas. He has actively worked with gender dysphoric persons since 1980, when he was a medical student in Rochester, NY. He volunteers his time as psychiatric consultant to Boulton and Park Society in San Antonio, offers free support groups for spouses of transgendered men, and serves as a volunteer educator of medical students and psychiatric residents (both military and civilian). Since leaving the Air Force in 1991, he has established a part-time practice dedicated to the evaluation and treatment of transgendered persons and their families. Dr. Brown is an ardent supporter of hormonal and surgical treatment of severe gender dysphoria following the Standards of Care as established by the HBIGDA. He continues to conduct clinical research and has published numerous papers in the medical literature. Dr. Brown is a member of the AEGIS Interdisciplinary Advisory Board.

Anne Bolin, Ph.D., is an Associate Professor of Anthropology at Elon College and the author of In Search of Eve: Transsexual Rites of Passage *(1988, Bergin & Garvey), an ethnomethodological look at a group of male-to-female transsexual persons in an undisclosed Midwest City.* In Search of Eve *was a groundbreaking book, because of its nonclinical perspective and its view of transsexual people as essentially normal. Dr. Bolin is a member of the Society for the Scientific Study of Sex, and has published in a variety of scientific journals. She is currently studying female bodybuilders. She is a member of the AEGIS Interdisciplinary Advisory Board.*

I recently received the Winter, 1992 issue of *Chrysalis Quarterly* and found it to be of the same high quality as the preceding two issues. Both you and your contributors are to be commended for producing the most thought-provoking publication of its type that I have seen to date. I would like to comment on the provocative article by Anne Bolin, Ph.D. entitled "Gender Subjectivism in the Construction of Transsexualism."

While I will not attempt a detailed criticism of the paper in this forum, I do feel compelled (as a male psychiatrist, researcher, and educator of health care professionals in the evaluation and treatment of gender dysphoric persons) to respond to some of the statements and generalizations made by Dr. Bolin.

I have no quarrel with some of Dr. Bolin's basic tenets, including: 1) sexism is rampant; and 2) accurate information about transsexualism and transsexuals is difficult to come by. I do object to her characterization (by statement or implication) of all male psychiatrists as discriminatory, ill-informed, controlling medical mercenaries unworthy of caring for gender dysphoric persons and unable to render competent, objective evaluations. This is a dangerous set of generalizations that can only serve to keep persons with gender concerns away from some of the professionals who are in the best position to comprehensively address these issues.

Having stated my major opposition to this destructive generalization (in an otherwise thought-provoking and useful article), let me address specifics. Dr. Bolin cites early work of psychiatric theorists and references from 1966-1979 and presents it as current thinking in the field. In this relatively new subspeciality area, that is tantamount to criticizing Henry Ford's choice of wood-spoked wheels instead of using aluminum alloys. Dr. Bolin further states that "psychiatry and psychology are dominated by males," citing 1972, 1979, and 1982 references. The current facts indicate that between 35% and 45% of residency graduates in psychiatry and psychology are female, hardly a situation that can be accurately described as "dominated."

Dr. Bolin goes on to describe fee structures, stating flatly that non-psychiatrist "helping mental health professionals'" fees are lower. While this is generally true, (compliments of exorbitant malpractice insurance premiums and other components of medical office overhead expenses), there are those of us who charge less than non-physician professionals. I offer my own practice (largely limited to gender and sexuality concerns) as a case in point: because I have worked with transsexuals for over a decade, I know they are frequently financially disadvantaged. My fees are lower than professionals with many years less training and experience in addressing gender concerns.

Dr. Bolin's tenet regarding the lack of adequate information on transsexualism, in particular research-based criteria for SRS, is accurate. I do not agree that this situation exists because of sexism by male psychiatrists. Part of the responsibility for this dearth of longitudinal follow-up research data rests with postoperative transsexuals themselves. A minority of persons receiving surgery and subsequently blending into the fabric of society have participated in follow-up studies, as if avoiding a confidential research interview (or telephone call) would somehow jeopardize their "new" life. Those of us who conduct research are therefore left with a biased sample self-selected for poor, or suboptimal, surgical outcomes. The talk-show circuit is further biased by the rare, "sensational" cases of those who have been multiply "reassigned," or by the surgeon-bashing patient who changed his/her mind postoperatively and jumped on the antiphysician bandwagon with stops at Geraldo's, Sally's, and Phil's houses.

To be sure, there are sexist men and women practicing in all mental health fields. Poor understanding of gender issues is ubiquitous. Abuses occur. Money changes hands. But some of us (even some of us in the "suspect" class of male psychiatrists) are truly dedicated to providing sensitive, high-quality medical and mental health care services to gender dysphoric persons without discriminating based on gender of assignment at birth or sexual orientation. It is unfortunate if Dr. Bolin has never met any of these professionals. It is a tragedy if your readers never try.

— George R. Brown, M.D.

(See Dr. Bolin's reply on page 43)

A Kinder and Gentler Festival

by Nancy Burkholder

I was expelled from the 16th Michigan Womyn's Music Festival by two festival security guards while waiting at the main gate for a friend arriving on the chartered bus. I was approached by the security women, who questioned me about whether I was a man. I answered that I was a woman, and I showed them my picture ID driver's license. Then one of the women asked if I was transsexual. I asked her the point of her questioning. She replied that transsexuals were not permitted at the festival, that the festival was for "natural, women-born women" only. I replied that nowhere in the festival literature was that policy stated, and I asked her to verify the policy. She contacted the festival producers, Lisa Vogel and Barbara Price, and she told me that she had verified that transsexuals were not permitted by festival policy. When I asked to speak to the producers directly, she said that they would not speak to me, that she was their designated contact person. Then she asked me if I had had a sex change operation. I replied that my medical history was none of her business, but that I was willing to submit to genital examination if that would satisfy her concerns regarding my sex. She declined, saying that she would not feel comfortable doing that. I asked her to produce proof to substantiate her insinuations that I was transsexual. Then she quoted more festival policy, saying, "We are empowered to expel any woman from the land for any reason that we feel appropriate." She said that I had to leave the festival at once and that I would not even be allowed to return to my campsite to retrieve my equipment. Once I was outside the front gate, I was on my own to find transportation home.

I believe the festival producers are disseminating misleading information regarding the nature of their festival. The festival is portrayed as a "woman-only" event, but in fact, they mean something else. Apparently, there is a covert policy to exclude transsexuals. That policy is not in any festival literature, advertisement, or the program guide.

The security women refused to take into account the irrefutable fact that I am a woman, and they acted to implement their own version of a "woman-only" policy. During the course of our conversation, one of the women acknowledged that there were transsexuals present at the festival, but only because "we haven't caught them yet." Since there is no conclusive way to determine if a woman is transsexual, I suspect that she targeted me because she perceived me as presenting an ambiguous gender appearance. Transsexuals who "pass" as born-female are safe, so long as they stay in the closet about their transsexualism.

The festival producers' unwillingness to put their policy in writing, while at the same time reserving their options to enforce their secret policy on innocent and unsuspecting festival participants, is unethical. The producers, in condoning the actions of the festival security women, have tarnished the image of women's values and the community they glowingly depict in their literature.

The festival expulsion process is an example of how absolute power corrupts absolutely. The festival security women played prosecutor, judge, and executioner in their process of implicating me, rendering their summary judgement, and executing their judgement. I had no access to due process. There is no "Festi-goers Bill of Rights." One could search back in history, say 50 years on the European continent, to find archetypes for their style of security enforcement. I feel troubled that the security women have duplicated at the festival some of the most repressive structures from the dominant culture.

The festival security women told me the reason for their secret policy is "for the protection of the transsexuals and women on the land." When I hear this explanation, I think back to when I attended my first festival in August, 1990. During the

five-day festival, I met hundreds of women while performing two work shifts at the Sober Support Tent, going to concerts, standing in food lines at the kitchen, line dancing in the nude to the music of Two Nice Girls, bathing at the community showers, participating in workshops, and walking on the trails. At the 1991 festival, I met dozens of women in the 16-hour period before I was expelled from the land, and, like last year, I encountered no hostility or negative reactions from any women.

Who is the covert policy really designed to protect? Judging from my experience with the women I've met, I have a hard time imagining that very many of them would want the kind of protection the policy purports to offer. In my opinion, the women who want the protection are some women in the self-defined, comfortable "mainstream," who prefer not to look at their own attitudes toward women different from themselves. In the context of a dominant culture, such people often play the role of oppressors. Inside or outside the festival, so-called "protection policies" serve and benefit the oppressors at the expense of the oppressed. The policy protects oppressors from experiencing and owning their discomfort, and the policy is used to justify their actions against the oppressed. Women who are probably oppressed in their daily lives became the oppressors at a festival that portrays itself as a "...precious time when we see ourselves reflected in a cultural mirror where femaleness is honored. It's one week when it is safe to walk alone under a star-filled sky, where we create a piece of the world defined by female values and love for life."

Although this episode has left me feeling hurt, offended, betrayed, outraged, and a bit cynical, I am also trying to accept the actions that the festival producers and personnel have perpetrated against me with as much understanding, compassion, and humor as I can find. My highest hope would be to meet with the women in a nonthreatening, mutually respecting, and safe space— free from any vestiges of the "power-over" dynamics that prevailed at Michigan— where each woman could share her experience, perhaps further our individual process of growth and awareness, and maybe begin to heal the pain between us.

Sisterhood, good will, and tolerance for our diversity are qualities that a woman may or may not bring to the festival. Until the festival producers and personnel step forward to address the issues of gender diversity and oppression with open-mindedness, I have one parting piece of advice for women who are transsexual or who present ambiguous gender appearances. Be careful that you don't walk too near the main gate late at night, for you might meet the "Gender Police"—security women who are empowered to expel you from the land if you do not fit their definition of "woman." Be aware that their definition does not have to take into consideration the anatomy between your legs, nor any form of legal identification you may possess.

If you have an opinion about this incident, I would urge you to write the festival producers and tell them how you feel. They can be reached at:

WWTMC
P.O. Box 22,
Walhalla, MI 49458.

This letter originally appeared in Southern Voice, *5 March, 1992.*

Lisa Vogel and Barbara Price
Michigan Womyn's Music Festival
Box 7430
Berkeley, CA 94707

Dear Sisters:

I am writing to you in regard to a statement you made in the January '92 issue of Lesbian Connection regarding your policy toward transsexuals at the Michigan Womyn's Music Festival.

In response to a letter from a womon named Janis (a friend of the transsexual you ejected from the festival), you stated that the festival was for womyn. You went on to refer to the person in question as a transsexual man. You did not give any reasons for this, but Janis proposed two possible ones, namely that transsexuals are not socialized as womyn, and that they have not suffered the same oppression as womyn. I would like share with you my personal experience in these matters. (Yes, I am transsexual).

Regarding socialization— no, I was not socialized as a womon. Society tried to encourage me to exhibit stereotypical male behaviors, but I was unable to do so because this behavior was completely foreign to me. (Imagine a bunch of adolescent males sitting around bragging about their conquests and one of them angrily rebuffing the others for treating womyn as objects! Did someone say social suicide?) My male counterparts wrote me off as a lost cause and the girls had no patience for me because I was always saying things like, "What do you see in them, anyway? Why don't you get yourself a nice girlfriend?

... Which leads me to the oppression part.

Yes, perhaps I did temporarily enjoy the privilege of higher pay, but I, like my feminist sisters before me, had to play by the rules of the patriarchy to survive. I, like them, had to swallow my very identity just to pay the rent. I, like them, was forced to conform to stereotypes with which I did not identify. If that's not oppression, I don't know what is.

The point I am trying to make here is that while the jury is still out regarding the specific causes of transsexuality, and while there are obvious differences between transsexuals and genetic womyn, one thing is certain: we are womyn. We are not men. We are not genetic womyn, but we are womyn nonetheless.

There is much more at stake here than a single festival. Your attitude is symptomatic of our (patriarchal) society's overwhelmingly negative attitude toward transsexuals, which has serious social and legal ramifications for us, from loss of employment to prosecution. Today we are barred from your festival. Tomorrow?...

Lisa and Barbara, I beg you, as my sisters and as champions of the rights of all womyn, to reconsider your views.

— Respectfully,
Susan M. Hanlon

poetry . . .

Silence of the Lambs?

by Jessica M. Xavier

Yes, you won their hearts and minds
You found the perfect villain this time
A freak so foul they won't forget
Evil personified and yet...

You went so far as to offend
A group like us that can't defend
Ourselves: T people, who can't fight
We who only come out at night.

The gays and lesbians, up in arms
Hollywood dared to do them harm
They organized and did protest
But it's not our Basic Instinct yet

Yes, one of us was in Psycho
Hitchcock used us first, you know
Then De Palma's slasher made us ill
When we get dressed,
we're Dressed to Kill

Maybe it's useless to complain
Maybe it's pointless to explain
This lonely life, this world of pain
When they use us just to entertain
I wish that they would understand
But I can't make them give a damn
And that's because of who I am
That's the true Silence of the Lambs

Incantation Against Adversity

by Holly Boswell

Sweet muse,
fairy-goddess of my soul,
refresh my joy and wonderment
with original innocence,
instill the purity
of what I mean and do, and
hold my heart true
to my deepest, highest, path.

Why Me?

by Traci [redacted]

Why was I placed here; what was the plan?
To be a woman, instead of a man?
To some, this process
seems weird or offensive
But for me, it's both painful and very expensive
This journey may seem like a lot to pay,
But weighing my options,
I'd rather die than stay this way.
We're actually modern-day pioneers of sorts
Only it's our lives we rebuild, instead of forts.

Illusion

by Alexis [redacted]

To divine and define
The who and what of me
Should take an inward sight.
Heritage, experience,
And choices past too
Should together show how
"To thine own self be true."

But it's others' as much—
What they'd like me to be,
Their vision somehow
That forms what should
Not just reflections be.
I sometimes seem simply them
Masquerading as me.

The truth
(On occasion)
Of what
I am not
Flows
Painfully through
What I am.

At 8 am on Thursday, 27 September, 1990, my lawyer telephoned to tell me that the European Court had made its decision. By ten votes to eight it had found against my right to change my birth certificate. By fourteen votes to four it had found against my right to marry.

"I'm so sorry," Said Henri.

Numb with shock, I replaced the receiver. On the television the newscaster was just telling early-morning Britain the same news that I had just heard. To most viewers the decision was a matter of small interest, but for me and other transsexuals it was a shattering blow. Legally it left us at a dead end. There was no higher court or authority who could review the case. Any transsexual wishing to marry would find their case thrown out by the European Court and their lawyer referred to Cossey versus the United Kingdom.

What, I wondered, were the other implications of the ruling? Does it mean that I will not receive a pension until I am sixty-five— the retirement age for men— even though male-to-female transsexuals pay a female insurance stamp? Perhaps I should get myself arrested to see how the courts deal with my being sent to a penitentiary crammed with men detained at Her Majesty's pleasure.

Perhaps a change of government, or else the Europeanization of the UK, will bring this backward-looking country into line with its more progressive neighbours. I believe that one day governments all over the world will recognize the rights that transsexuals should possess in their new sex. And I shall not give up the struggle, however long it takes. However long.

— Caroline Cossey, My Story, *Epilogue*

An Interview With Caroline Cossey

by Dallas Denny & Margaux Schaffer

Caroline Cossey, also known as "Tula," is an international model and celebrity who happens to be transsexual. You may have seen her in the September 1992 issue of *Playboy* magazine, or on Entertainment Tonight, or on Donahue, or on The Joan Rivers Show, or on the cover of a tabloid in the supermarket, or maybe briefly in the James Bond film, For Your Eyes Only. But chances are that you've seen her, whether you know it or not.

Caroline had no choice about her public status. She had worked undiscovered for six years as a showgirl and dancer before being brutally exposed by the British tabloid *News of the World*. The article turned her life into a circus. In response, she hastily wrote her first autobiography, a paperback called *Tula: I Am A Woman*.

Caroline has written a new book, a good seller. It's called *My Story*, and it tells of her painful childhood and her painful relationships with men. *My Story* also tells of Caroline's unsuccessful struggle with a government which offered her free reassignment surgery, but which has consistently denied personhood to her and thousands of other English transsexual men and women. It is this fight that makes Caroline significant for the gender community, for her battle is everyone's battle. She has vowed to make things better for everyone. And she is likely to, for she is in the public's eye, and so has an unmatched ability to reach the masses.

For someone who is basically an innocent, Caroline has certainly had her share of hard knocks and detractors. Because she makes her living with her beauty, she has been criticized by feminists, who accuse her (and all models) of perpetuating sexist and stereotyped notions of womanhood. Some of them seem to think it's somehow worse because Caroline was once a boy named Barry.

In September, 1991, Caroline was insulted by Atlanta Mayor Maynard Jackson, who made a public statement denouncing (but not renouncing) the honorary citizenship his office had just given her. He claimed that he had had no knowledge that she was to be given the award, and made the statement that he did not think that anyone whose "main claim to fame was having had a sex change operation" deserved the honor.

Mayor Jackson was far out of line. Unlike Christine Jorgensen, Caroline was well-known and successful before the facts of her gender reassignment were made public— besides, she had made a point of informing his office of her transsexual status.

Caroline has dealt maturely and wisely with a burden that generally only those who do not pass well have to face— identity as a "known transsexual." To show our support, we hosted a reception for her at Atlanta's Petrus night club (the same place where she was given Mayor Jackson's award) in September. We presented her with a nonrescindable award for service to the gender community and welcomed her to our advisory board.

We interviewed Caroline in October, 1991, in the lobby of the Wyndham Hotel in the fashionable Buckhead section of Atlanta. The first thing she told us was that the hotel had thrown away all of her messages and tried to charge her a hundred dollars for a bottle of vodka. "I called Petrus and had them send over some Stoli."

CQ: Do you consider yourself a feminist? What would you define as a woman of the '90s?

Tula: A good strong woman who could stand up for her rights, but at the same time, I like women to be feminine, and I hate to feel that women must become so manly and aggressive that we lose the respect of a man. You feel vulnerable with a man. I mean, they're stronger than women— although they're not smarter, in most cases.

CQ: Some individuals in what we call the gender community might think you you are a mannikin for the male sexist establishment. Would you comment on that?

Tula: I've been interviewed by a few feminists, and I always say, "Maybe you take for granted things I wasn't able to— that I hadn't been able to— that I wasn't born with." I was lucky enough to be given a chance to travel the world, to be paid good money for someone to take pictures of my body, which— I felt very insecure about going through gender reassignment. For someone to actually want to pay you money and take your picture, that's the biggest ego boost that you can have. And we know what being transsexual is all about, so, you know, people, say, are you trying to prove your femininity by being a model? No, it's a job, and it's nice to have had a choice of what job.

CQ: Please explain for us the laws of Britain as they pertain to transsexual people, and how these rulings came to be.

Tula: Well, we have no rights at all. In the last few years, we got our passports changed, and they actually have "Miss" on it, now. It used to be plain Caroline Cossey; now it's Miss Caroline Cossey. Driver's license is female. We pay a female insurance stamp and get a pension at age 65, the male age, as opposed to getting it at 60, as for females. You know, if we get in trouble with the law, we're thrown in men's prisons, which is appalling. We can't marry— well, we could marry a female legally, but we couldn't consummate it, and can't marry a man, although we can consummate it. We have no legal rights.

Mark Rees, a female-to-male transsexual, tried to change things and failed because he didn't have a partner. I won before the Commission, but the British government appealed, and I lost. So after a long six year battle to get to the Commission, and getting so close with ten votes to six, and then losing on appeal with ten votes to eight, it was pretty close. That's what kept me going. Next year, when we join Europe, I'm going to lobby the Home Office and put the idea of getting a pressure group in a couple of magazines. You know, a pressure group, as opposed to one individual taking a case to Strasbourg. It's costly. It cost me twelve thousand pounds, which is about thirty thousand dollars.

CQ: You've spend a great deal of time and money on this.

Tula: Sure. It would have been great to have had an organization. We would have had a fund to do it. Having a pressure group is easier, as opposed to just one individual.

So that is the legal situation, which I think is quite pathetic, considering the state allows the operation to be done for free.

CQ: The same state that subsidizes the surgery makes it impossible to live as a female.

Tula: There are actually four good hospitals. Charing Cross has a good gender clinic. You see the psychiatrist for a year— I think it's two now— then you live and work as a woman, and then you get on a waiting list. Just at the moment there is a problem with the National Health Service. The waiting list is much longer than before for any operation— not just the transsexual surgery. They used to do 25 a year. Now because of the cuts, our National Health is up the creek. I don't know how many they're doing. The fact is, though, that they actually do them on the state, and then we're stuck in legal limbo.

CQ: Is the treatment on the National Health Plan as good as what you can get privately?

Tula: They're the same surgery. I was working, and because I was on tour as a dancer, I didn't go back to my psychiatrist regularly. Once I had got the money, which I got by working for three years, I went back to see the psychiatrist and said, "Look, if you don't think this is okay, I'm going to go to Casablanca." There you didn't have to go through all the red tape. I saw him twice, and he gave me the letter of referral, and I didn't have to wait for the two years.

Once you get to the surgeon, you then get to wait, which can be up to two years on a list. I had the money, so I had it done within a month of seeing him. So to answer your question, the same surgeon.

The surgery is very simple now. In my day it was a five-hour operation. Now it's two hours. Mark would be able to help me with this. Mark is a female to male. Their surgery is not that wonderful. I don't know how it is here.

CQ: How can the government justify making you legally a man, and yet give you medical treatment to make you physically a woman?

I won't be silent. I won't be humble. I won't be grateful. I did not choose to be born the way I was, and I refuse to be punished for something over which I had no control. And so I have written this book not only for transsexuals but also for the many men and women who have no understanding of what it means to be trapped in the wrong gender, who have no idea of the persecution that transsexuals suffer. I hope that it will teach them to show a little compassion, tolerance and understanding. For, in the words of barrister David Pannick, "The way in which our society deals with minorities is a guide to our civilization." (My Story, *page xiii)*

Talking Transie With Tula

Snatches of Post-Interview Conversation

On Family

Dallas: Your mother is marvelous, by the way.

Tula: She's a darling. She's very nervous on shows that have an audience, but she's done an awful lot of documentaries in England. She had quite a few letters from one organization, the Beaumont Society, which is transvestites. She was talking on different shows about being a mum, and the last thing you should ever do is, you know, kick them out. You've got to love and support your child and stand by them, whatever.

Dallas: I was telling her that I admired her the more, because I lost my parents when I told them. And yet they knew, because they caught me crossdressing when I was young.

Tula: And you've not spoken to them since?

Dallas: No. I told my mother about two years ago. Actually, she guessed. I told her I was coming to Atlanta to work with transsexual people. She asked me point-blank, and I told her. She said "I didn't have a little girl; I had a little boy." And then my sister called and said that my parents didn't want any contact. I wrote letters for a year and a half, and then I stopped because I knew it was painful for them to hear from me. So you're very lucky.

Tula: That's what I say on shows, that what has kept me more balanced than anything is the fact that I— I think it's bad having to fight society, let alone your own flesh and blood, your family, so— that's why I'm stronger about everything, because I don't care what Joe Blow is saying. I mean I do, but as long as my family and friends love and support me—

On "Outing"

Margaux: I've been in situations where I've have some friends, because they've known me before, feel inclined to tell people about me because they think they can get away with it. Everyone was called together by one of my clients and told what I was, and one day I was taken aside and told, "You know, you've really got to watch Bob." I said "What?" and she goes, "God, he's really spreading some shit about you. He said you used to be a man, and no way! He actually said that about you. Can you believe that?"

Dallas: I work a civil service job, being like a staff psychologist in a workshop for adults with mental retardation. I've been there for nearly three years, ever since I went full time, and at any time it takes only one person, and suddenly the word is out. I've been just another woman for a year and a half, and it's wonderful, but I'm afraid that my AEGIS activities will cause me to be recognized. I don't want that to happen, but I'm prepared to deal with it if it does.

Tula: I've got nothing that I'm worried about. There's not one newspaper that can write anything about me that is going to bother me now. I just figure, if people don't like my gate, they don't have to swing on it. I get invites to premieres, parties. I know half the time I'm treated like a party piece, because they find me intriguing, but at least I'm not paranoid that Oh my God, they're going to find out.

On Unwanted Hair

Margaux: When I used to wait in the waiting room at the electrologist, I saw some women that looked more scary than me.

Tula: There was one woman that used to come into my room for room service and she had this beard, and I thought Luv, and I wanted to say something.

Margaux: Sounds like a hormone problem.

Tula: And we all have those.

On Growing Up Transsexual

Margaux: I feel it's better to be called transsexual than faggot, and that's what I used to have to go through when I was growing up.

Tula: Me too. Sissy. Mommie's boy. Faggot. Oh, God!

Margaux: They used to call me Michael/Michelle all the time.

Tula: I used to get beaten up, and now they're all coming on to me.

Margaux: I actually had a specific person who once beat me up try to pick me up not that long ago. It was real vindication. I thought, "I could really wreck this man's world by telling him who I used to be."

Tula: You could have gone home with him, and then afterwards, told him, "Oh, by the way..."

On Silicone

Dallas: We're very concerned about the injection of liquid silicone to shape body contours. Can we talk about that?

Tula: It freaks me out, the loose silicone injections. I'm doing two television shows tonight. I don't know how the conversation will go, but if they can get onto— sometimes people say, what advice do you have for transsexuals, and I normally say, make sure you go to the right specialist, 'cause there's so many back street guys that are willing to cut it off, and then you're stuck with nothing that functions. So if I can cover that, I can bring in the silicone. I should say I keep meeting these people. It's bothering me, freaking me, 'cause they're having all this loose silicone injected in, which is very unsafe.

Margaux: That would be wonderful, because we recently had a conference here in Atlanta, and we were distributing our public service ad, the Dangerous Curves Ahead ad, and it met with a lot of dissent. A lot of people are making money from silicone. There's a lot of blood money attached to it, and we feel a lot of transsexual people are being victimized. Unfortunately, no one cares if a she-male dies of a globule of silicone in the lung.

Tula: Exactly. I think this thing they do with fat now is quite safe. They can take your fat out and inject small areas, but as far as having silicone, and the type of silicone that is used—

Margaux: Industrial grade silicone. Not medical grade. Industrial grade.

Tula: Appalling.

Dallas: A lot of people are looking for the quick-and-easy way.

Margaux: They want it yesterday.

Dallas: And it ends up costing them more just for the silicone than they would have spent at a plastic surgeon.

On Prostitution

Tula: And I get questions like, why do the majority of transsexuals turn to prostitution? That's been one that comes across an awful lot. I think it exists more in the countries where transsexuality is not as legitimate as it is here. That's why I like the idea of getting a fund together for the ones who are very desperate. And you can check them out and they should be able to have the surgery done, and the fund can pay for that.

There's so many of them in Singapore and Bangkok. Because surgery is so expensive, and the state doesn't do it, it's a quick way of making the money for it.

On Atlanta Mayor Maynard Jackson

Tula: Well, the next time I'm over, we're gonna have a little drag party, and I hope we'll have him an invite.

Margaux: I think when your club opens, we'll definitely need to.

Dallas: You can ask him to show up for the club's opening.

Tula: He can be there on the opening night, but he's gotta come in drag.

Tula: That's my argument. I mean, that's what is stuck in my blood. I mean, why help me? If this is a psychological condition only, why not say, "Go abroad, because we don't recognize you people here." Then I would accept it and say, "Well, I'll take my choice of giving up my citizenship and taking it up elsewhere in Europe, because all of Europe is much better." Italy changed eight years ago, and with the Pope and all, you would have thought it would have been one of the last countries to change. In Denmark, two men can marry. But not in England. It's crazy to have this double standard, where you can be helped medically, but not in any legal situation. My husband was allowed to walk away from the marriage, and me not have a penny of compensation because I didn't have the law on my side.

CQ: You've spent a lot of time in America lately. What is your appraisal of the legal situation here, as compared to England? And what of the other countries you've visited?

Tula: I've met a lot of transsexuals on my last two visits, because I've gone places like the Limelight, a club in New York, and they turn out to meet me. Generally, I write whoever writes to me, and I pick up the phone and what have you, but I've not been here for any length of time. I know that there are states here where things are bad, legally, but maybe it's been because no one has challenged the law.

CQ: In Italy, they have more rights?

Tula: In Italy, they have total rights as a female to marry, sue— what have you.

CQ: But then Belgium is a different matter, and Holland is a different matter. Have you found that there is a transsexual Mecca, where it seems to be easiest?

Tula: If you mean anyplace in the world, then I should imagine Denmark and San Francisco. They are liberated places.

CQ: Are there places that you think might be worse than England?

Tula: Someone who goes over to Turkey and India was telling me that they have what they call eunuchs. They literally tie the things up for a couple of days and then snip it off and then get married, and what have you.

CQ: They're like a third sex. They call them Hijras. You've been to the European Court of Human Rights and lost.

Tula: It was the Commission first. It's like a filter for the cases that go to the High Court of Human Rights. I won at the Commission. In England, if you have a grievance with the law, you have to exhaust all domestic remedies So I was referred first to my local M.P. *(Member of Parliament— Ed.)*, then to the registrar of births, deaths, and marriages, and then to the local court, but my case was rejected because of the situation not being accepted. I had to exhaust all that before I could take up with the High Court of Human Rights, which is the place that can change laws. So that's what I had to go through with.

So I went to the registrar of births, deaths, and marriages, and then to my local M.P., and then got to the Commission of Human Rights. Then, winning that, 10 votes to 6, the British government appealed. I won on the 9th of May, and I got married on the 21st of May. And then the appeal came. So then the ruling wasn't through, so we had to go to the High Court. And then because I lost, the marriage was annulled.

CQ: Do you plan to go back to court?

Tula: I couldn't appeal against the High Court. What I hope to do when we join Europe next year, is to push the home office into letting me slide through. But with a pressure group, we're going to have a go, and get a petition, and make as much noise as possible, and film documentaries. This is reinforcing. It's happening now. They're making a film about April Ashley, who is the one that screwed it up. Before April Ashley, all transsexuals had their birth certificates changed, and had full rights in their new gender. After April Ashley— the ruling was in 1960— it's all been changed. The criteria for determining sex in Britain is the genitalia, gonads, and chromosomes. Did I mention the book Brain Sex? Ten years of research has just come out to the effect that the brain is sexed within six weeks of the embryonic formation. That's the sort of thing I could have used in my case with the Commission. It would have helped. The judges that I lost with— there was a Canadian, an Irish, and two English, which was very unfair. Obviously, the ones that would have gone in my favor were the ones that were from a country that treated transsexuals fairly— I sat there flashing my eyelashes, at you know, the Italians and Portuguese. It was a heavy day. There were like eighteen judges, and the court was full. Have you seen any footage? It was very impressive on film. It was a full courtroom, and they— what was so stupid, all these judges walked in. Half of them looked like they were in drag, anyway. There's me trying to get recognition— and there's them, in gowns, and everything, floating around.

CQ: When you visited Atlanta recently, you were given an honorary citizenship by the major's office. Mayor Maynard Jackson later made a statement saying that anyone whose primary claim to fame was having had a sex change operation didn't deserve the award. Do you have anything to say to Mayor Jackson?

Tula: That offended me terribly, because my claim to fame— I mean, I don't have any one claim to fame. I was a model before I was forced into the open, and I just dealt with it. I deal with rights and issues, and that's all I've been dealing with since I was exposed. How would he say what he did without obviously looking into my situation? I was very offended and hurt by that.

But I did phone the office and ask them if they wanted me to send the award back, and they said no, and so it's on my bedroom wall. I've been here now for three days, and I was hoping he would phone me and ask me for tea and apologize, but he hasn't.

CQ: We'll be sure he gets a copy of the magazine this interview is in.

When you were on the Joan Rivers Show, you mentioned that you were considering moving to the U.S. Do you still think that might come about?

Tula: Yes. I'm coming over in the spring, and I've been spending a lot more time here. I'm rounding up my affairs financially. I'm going to open up a club here in Atlanta.

CQ: How much contact have you had with the American gender community?

Tula: Well, you're the closest I've had with any of them. I mean, in New York, I had quite a few turn up say hello. In Australia a magazine wrote, and the ones in Britain, Germans. But nothing in America. But yours is the classiest magazine I've ever seen on the subject. So I just felt that I wanted to take part in it, and that your hopes of getting it all international will be great.

Since the interview, Caroline has moved to Atlanta and become involved with the American transgender community—and a British "Pressure Group" has been formed.— Ed. ♀♂

I Fly East; You Fly West

Two Stories of the Quest for SRS

Dr. Stanley Biber in Trinidad, Colorado, and Dr. Michel Seghers in Brussels, Belgium, are two popular sex reassignment surgeons. Both have been performing the surgeries for more than 15 years. Hundreds of transsexual women (and, increasingly, with Dr. Biber, transsexual men) have made journeys and had experiences similar to those we give you here.

What strikes me about the stories of Wendi and Veronica, and why I chose to present them side-by-side, is not that their journeys were so different, Wendi going west, over the mountains, and Veronica going east, over the ocean, but that they were so similar. The signs and symbols along the way—the beautiful Pakistani woman standing at a Belgian crossroads with blood streaming down her face, the burning car glowing eerily in the Colorado rain, the men, Charlie, and "Smokin' Joe," from which the secret of transsexualism must be kept, and even the ubiquitous golden arches of McDonalds emphasize that the journeys of these two women are in tandem, sharing everything but geography —Editor.

This article is abridged from a longer article in The TV-TS Tapestry. Wendi notes, "The following is a recollection of events that I experienced immediately preceding and during a period in my life in the spring of 1989. My purpose in writing this piece is to give others some insight into the events that transpired during an event such as I experienced. In retrospect, I would not want to go through an experience such as this again, but if I had not yet done it, I would surely go through it again in order to be the complete person I feel that I now am."

This article previously appeared in the GGA Phoenix Monthly-International, and in the March, 1991 edition of XX Minutes, the former newsletter of the XX Club. And yes, Veronica says, it is a true story.

There and Back Again: The Trinidad Experience

by Wendi Danielle Pierce

The last few weeks before leaving for Colorado are a blur. I know I was busy, with work, my social life, and a newsletter I published, but now little seems to stand out. I do recall telling a few friends at work that I was going to travel to Colorado for some surgery and mentioned that I was going to Trinidad, probably by train via Albuquerque. One person said, "Why not fly right into Pueblo? They've got an airport and it's only about an hour or so drive down to Trinidad from there." I checked and they were right. Now, at least, I knew how I was going to get there; another thing to check off my mental list of things I had to do before leaving.

Finally, the trip started. It was on a Sunday, and I flew to Pueblo where I was to catch a bus to Trinidad. I made the assumption, which turned out to be a poor one, that I could just take a taxi from the airport to the bus station and be on my way in an hour or so.

Sorry, Charlie: The Brussels Experience

by Veronica Brown

Nestled on the Senne River is Brussels, the largest city and capital of Belgium.With tree-lined boulevards, charming old Flemish architecture, and beautiful parks, it is one of the most beautiful cities in Europe, as well as the headquarters of the European Economic Community. The country lives by foreign trade, exporting half of what it produces. As the per capita income is nearly $10,000, Belgium has one of the highest standards of living, and some consumer items are expensive.

My housemate, Becky, and I arrived in Brussels on December 6th. We were scheduled for sex reassignment surgery the following Tuesday. Michelle Hunt, RN, the organizer of the Brussels Gender Congruity Service, had met us at the airport. After checking into the American-style hotel on the Chausee

There and Back Again

Part I: A Bus Ride to Hell?

As I soon found out, there were several busses that traveled south from Pueblo, but if I wanted to get off in Trinidad, I would have to wait till about 9:00 pm that evening. Here it was, four in the afternoon. I waited.

There was a light sprinkle of showers that afternoon in Pueblo, and I had not brought an umbrella. Since Pueblo is about six thousand feet above sea level, it was also quite chilly. I had not brought much in the way of clothes, and my denim jacket was barely enough to keep me warm. I did, however, venture across the street from the bus terminal for a bite to eat in a little bar/restaurant called "The Do Drop Inn." It turned out to be a friendly neighborhood bar which served pizza and sandwiches. The locals were a little curious about my lingering for a few hours, but when I told the waitress I was waiting for a bus, she obviously spread the word and the glances slowed to an occasional quick look by a few of the guys at the bar. Later, it was back to the bus terminal to await my transportation to Trinidad.

Bus stations are interesting places if you're into peoplewatching, as I am, and this one was no exception. There were the bums looking to get out of the rain, the obviously low income and down-on-their-luck families with two or three small children and grocery bags as luggage, the students traveling back to college after a weekend home, the elderly men and women traveling alone, all sitting on benches, staring into space and at one another. Once in a while a conversation would spring up between strangers, and everyone would tune in to what was being said. It was apparent that the air was filled with anticipation. Someone would break the silence—or rather, the background noise— and query someone about something, and then the telling of each others' stories would unfold. It went something like this.... "I'm going to see my sister in Albuquerque. She's been ill, and I got some time off to see her." "We're going to El Paso to look for work. They told me that carpenters are doing real good down there right now." "I've got this travel pass and it's good for three more months." "I've never been out of Colorado, and since I'm retired now, I'm going to go to Florida and visit my grandchildren." No one asked me for my story, but I bet they would probably have raised an eyebrow if I had told them of the purpose of my trip.

Busses came and went every half-hour or so, and the cast of characters was always changing.

Everyone seemed to know when it was their bus. There were announcements on an almost intelligible PA system, and then a group of passengers would scurry off. Another group would begin to slowly congregate. This went on for over four hours. Finally, a bus pulled in at about the time mine was scheduled. I waited a few minutes, but no announcements came over the PA system. Was this one mine? I went over to the door and looked at it and it did not say Greyhound. The name on the side was Greenville Bus Lines. I then walked over to the ticket counter and asked the agent if this was the bus to Trinidad. He said, "Oh, yeah. It'll be leaving soon."

In a few minutes, I was boarding. This was a milk run bus that stopped at every little burg along the way, and it was fairly full. I started looking for a seat and asked a passenger in the front if smoking was allowed on the bus. His reply was "Yeah, in the back." On my way to the back of the bus, I started to peoplewatch again. What a strange and varied group we were! There were old men sleeping, mothers with small babies crying, two old women staring at me and whispering to one another, and a pair of obviously gay women necking. At any moment, I was expecting to see a farmer with a few chickens under an arm.

Near the back I spotted a pair of empty seats and laid claim. I wanted to stretch out and try and nap a little, so I didn't want to sit next to anyone. The seats seemed ideal. Actually they were about the only choice.

Within a few minutes we started rolling— and I mean rolling. The rain had started in earnest and was coming down quite heavily. In no time we were on the interstate, passing other vehicles at a regular rate. I couldn't understand how the driver could even see the road ahead.

I started to investigate my immediate travel companions. It was pitch black outside and a blinding rain was obscuring any views out the front of the bus, so the only thing left besides sleep, which I couldn't do at the time, was a little more people-watching and listening. Behind me were two little old ladies chain-smoking and gossiping about their relatives. A very heavy older gentleman snored loudly on the seat across from them. The lesbians were still going at it hot and heavy in front of me. A young mother dangled a cigarette in her mouth while rocking her newborn across from me. A solitary young man was in front of her. It seemed such a strange congregation of souls, all wanting to be somewhere, and all kind of bunched together for the trip. Then I started to hear the people in the front of the bus all saying to each other, "Look at that!" There was a bright orange glow through the front window of the bus and as we passed, I could see an older station wagon pointing in the opposite direction, pulled over, with flames blazing out of all its windows. There were no people outside and I could only wonder if they had made it out in time. We shot by, and in a moment it was no longer in sight.

As I have noted, this was a "milk run." We stopped at every little town along the way. We'd leave the interstate, wind through a few country roads and enter the little towns. Since it was almost ten and pouring rain, they all appeared like ghost towns: no one in sight. Empty bus stops, with not even a stray dog in sight. I thought it a little strange that no one got off or on at any of the stops. We were all headed somewhere down the line.

When the bus pulled into Trinidad, I wasn't sure quite what to expect. Was this town going to be like all the rest of the stops along the way, or would it at least seem inhabited? Would I get off the bus and be in another ghost town, with Rod Serling standing there, saying, "You have now entered the Twilight Zone?" Then I began to see familiar sights out the bus window: a Pizza Hut, drug stores, supermarkets, and even a McDonalds. People were also visible. The rain had subsided. I began to feel a little more secure. The bus then pulled up on a side street next to a laundromat I looked out, and there was a glass door at the side of the building with a Greyhound emblem over it. This was my stop. I shuffled out to see what was in store in the next segment of this trek.

der Vleurgat, we set out to see the sights of this charming city.

As part of the services, Michelle took us to lunch and dinner several times during the weekend. When back at the hotel, we would go upstairs to visit "Lori" and "Monique," two American post-ops who had had their surgeries done the week before.

On Sunday morning, Becky walked to a nearby Catholic church, while Monique and I made our way to Rick's American Restaurant on the Avenue Louise, just around the corner from the hotel.

Rick's is one of the few restaurants in Brussels where familiar American food is available and English is spoken. The atmosphere is definitely European, but posters of old Hollywood films decorate the walls. Monique and I were shown to one of the small tables in the back by the large window. A movie poster of the Bogart film Casablanca covered the small patch of wall to my right. Seated next to us were two American businessmen who discussed plans and read from documents during breakfast. To my right was a man, obviously American, dining alone.

Monique ordered the breakfast special, and I a tomato and mushroom omelet. After several days of dining in French restaurants, it was enjoyable to hear the waiter speaking English. Our food arrived and we started to eat.

Monique is ten years younger than I, good looking. Like myself, she was dressed in the usual low-key transsexual manner, wearing a casual sweater and jeans. We wore little makeup, depending on many hours of electrolysis and hormonal body changes to project our feminine selves.

After observing us for a while, the gentleman to my right spoke to Monique. "Hi. You girls look like Americans. My name is Joseph Charles Taylor. Everyone calls me Charlie. My work takes me to Brussels and all over the West Coast. You here on holiday?"

I played the shy type and let Monique do the talking. I wanted to see how all this would develop. He was indeed an American. I watched as a hearty American breakfast slowly vanished from his plate.

Charlie was a pleasant middle-aged type with dark hair, a neat moustache, a cute smile, and a little pot. Beer, I thought. He had a copy of a science fiction magazine, one I considered juvenile and stopped reading years ago. I saw my chance, and we discussed science fiction. I found my confidence and the three of us engaged in a lively, Sunday morning late breakfast chat.

"I'm not doing anything today. Would you two ladies like a tour of Brussles? I've lived here for a few years, and I know the city like my home town."

Monique looked at me. I read the message in her eyes. I nodded, and she said, "Sure, why not? We'd love to."

I said, "I did have plans, but nothing important. Yes."

Charlie was full of questions, and we didn't have answers prepared. We told him about Lori being "sick" in bed back at the hotel— something she ate the night before, we thought. And we mentioned Becky going to church and how we American girls were on holiday in Brussels, visiting our friend, Michelle. He seemed to accept our jerry-rigged story. Neither of us had expected to be picked up by an American at Rick's American.

Part of the real life test for any transsexual person is to blend with society and learn to pass with a minimum of props like wigs, high heels, and gobs of makeup, if the individual is so inclined. In one sense, Monique had done better than me. She was living and working as a female, and no one knew her secret. I had cheated, making my gender transition on the job. I was a known transsexual. What amazed me about Monique was, though she was only nine days post-op, she acted so lively and mobile. She was even wearing jeans. I knew she had some discomfort, but she hid it well.

We left Rick's in Charlie's Mercedes and headed down Avenue Louise. Michelle had no need for a car, since all of Brussels is easily accessible through the public trams, the underground Metro, and the many taxis. A chance to see the city from a private car was a treat.

Charlie knew Brussels well. He casually pointed out places of interest through the eyes of a long-time resident. We saw the Royal Palace, the U.S. Embassy, the Tomb of the Unknown Soldier, Saint Michel Cathedral, and the Palace of Justice. And then we entered the Grand Place, that splendid open space surrounded by tall old guild houses, each adorned with gold leaf. Some of the buildings date back to 1698. I stood in the center of the square, imagining the untold numbers of people who had stood there before. Brussels has been occupied by Spanish and French forces, and in this century, by Nazi troops. I thought of booted Nazi feet in this peaceful place.

Charlie had parked the Mercedes on a side street. We walked a short distance from the Grand Place down a narrow cobblestone street to the Manneken Pis, the famous statue of a little boy urinating.

The Manneken Pis is well-known throughout the world. The original stands behind an iron fence in a small triangular area cut out of the corner of a building. It isn't a fancy statue, or a large one, and doesn't lie on a modern thoroughfare, but in an alley. If you aren't observant, you'll walk right by and not notice it. Around midnight, a dozen hours earlier, Michelle, Becky, and I had stood before the statue, after leaving an enjoyable gourmet dinner and spectacular female impersonator show at Chez Flo.

Monique, Charlie, and I returned to the car and drove northwest on Boulevard Anspach. As we approached North Station, I saw one of the entrances to City 2, the mall where Michelle had turned us loose on Saturday.

Near North Station lay seemingly forgotten old buildings. Charlie turned down one street and said, "Look in the windows, ladies. This is the area where the local prostitutes advertise their wares."

Monique said, "Have you ever done business here, Charlie? I mean, we know how you men are— there are so many women here to choose from."

"No," Charlie said. "These women aren't my type. I don't think my wife would allow it."

"You're married?" I asked, with exaggerated mock surprise. Charlie's pleasant, easygoing manner put me at complete ease. The three of us had been trading jokes for the past hour.

"Oh, yes. The wife moved stateside last year. She missed the American way of life and her friends. I'll be going back next week."

Charlie headed the Mercedes to the south, away from the city. We passed a spacious, beautiful park with a small lake, green grass, and many people strolling,

There and Back Again

Part II: There at Last

With some difficulty, I managed to get my suitcase, which was on a two-wheeled carrier, up the steps and through the door of the tiny bus station. When I got inside, I realized that this same business was also the laundromat, a video arcade, a variety store, a lunch counter, and even had rooms to rent. I later found out that the rooms were only $10 a night, but didn't have phones, TV or a private bath— but they were rooms! I waited at one end of this "bus station" counter while the girl behind the counter made some small talk with the bus driver. She seemed to know him fairly well, for they talked and joked for a few minutes. Then he said that he was running late due to the rain and had to be going. Now her attention turned to me, a stranger in town who obviously needed some information. I'm not sure, but I'd say that she didn't know why I had come to Trinidad. I told her that I'd need a place to stay for a couple of days, and she recommended the Trinidad Motor Inn. She said it was a nice place, close to the center of town, and that they usually had vacancies. I asked her to call a cab, and she looked at me a little strangely and said that it wouldn't be any real bother to take me over there herself. I sensed a friendly undertone to her voice. Since I had just heard her telling the bus driver that she and her boyfriend were on the rocks, I felt that she wanted to talk to someone, and I seemed a likely candidate. I asked her how she could leave the bus station unattended (actually it was only a counter in the laundromat). She replied that it was no problem; there wouldn't be another bus until ten the next morning and, "It's a real dead night with the rain and all." So off we went.

I waited outside while she went to get her car, "a rickety old station wagon," as she called it. She was about my age, of medium build, with curly, shoulder-length hair, and she spoke with a decidedly Southwestern drawl. When she arrived with the car, I started to unfasten my suitcase from its carrier, and she interrupted, saying, "That's OK. We'll just keep it all together and toss it back here," and she picked up the forty pounds of suitcase, travel carrier, and duffel bag and placed them in the back of the wagon like it was a small bag of groceries. She was a strong woman!

On the way over to the motel, we began to talk, and she asked me why I was in town. I didn't want to be evasive, but I also didn't want to get into a long explanation, so I just said that I was here to see some people for a few days over at the hospital. That satisfied her, and she changed the topic to herself. She said that she was a pipe-fitter for oil drilling companies and had worked all over Texas, Oklahoma, Colorado, and even Alaska. She did not go into any detail about the circumstances that brought her to Trinidad, but she did say that she had only been here for a few months, was getting tired of the sleepy little town, and probably would be moving on soon. I could tell she was a free spirit and probably liked to party. Later I would confirm these observations.

As we approached the motel, she mentioned that they had a lounge and that she might just stop in and have a nightcap. This I thought I could use too, as it had been a trying day of travel and unfamiliar surroundings. I said that I'd like to join her if she didn't mind, that as a matter-of-fact I would like to buy her a drink for being so friendly and helping me to get over to the motel. She accepted my offer, and after I checked in, before I even stopped off at the room, I met her in the bar.

It was a cozy little place, with a dozen or so tables, a jukebox playing country tunes, a small dance floor, and a barmaid looking a little bored. There was a single guy at the other end of the bar conversing with the barmaid as I came in and sat down at the bar next to Barbara. I offered to pay for her drink and she said that the barmaid had bought this one. Then, to my surprise, the barmaid asked me if I'd like a complimentary one too. I accepted, ordering scotch on the rocks. What I got was a triple, with more scotch than rocks. While I was starting to sip my drink and get acclimated to my surroundings, I listened to the conversation already in progress. My friend Barbara had introduced herself and me to the guy at the other end of the bar, and he was telling her and the barmaid what he did for a living. He was a "high voltage" repairman and worked on live high tension lines all over the country. He traveled and worked with another guy who was his associate and assistant. Barbara then asked where his friend was, and he replied, "Up in the room." She asked whether he could get his friend to come down and join us, but he replied, "Why don't you just go up and get him!" In a flash, she had his room key and was off, returning in about 15 minutes with Tim.

While she was gone, I started a conversation with the guy. He said his name was Joe, but everybody called him "Smokin' Joe." He immediately got up and moved over next to me. After a short while, I was sitting there talking to him, with his arm around me. I sure hadn't expected to be partying with a couple of cowboys and a "local" in Trinidad, the night before entering the hospital for SRS, but here it was happening!

The four of us had a lively time talking and dancing, and there was even a little necking. About 1:00 am, I explained that I had an appointment to see someone at 9:00 that morning and would have to call it a night. Smokin' Joe was not too happy, but he was a gentleman, and after a little discussion and a goodnight kiss, I was off to my room, which I had yet to enter.

Part III: Hurry Up and Wait!

The morning came quickly. I awoke about 7:00 am. I was a little unsure about the time I was supposed to appear at Dr. Biber's office, but seemed to recall the time 10:00 am from the many times I had read the information sheets provided by his office. So I was in no big hurry showering, getting dressed, applying my make-up, and packing the few things I'd spread about. I had brought along a companion, a soft cuddly bear that had become a kind of night-time companion during the past few months, and I was beginning to talk to this stuffed animal as if it was alive. I had named the little guy "Dinner Bear," since he originally was perched on a chair at my kitchen table, and therefore was always present at dinner. I was living alone at the time, and the bear was always willing and eager to "hear" my stories of the day's happenings (humor me on this one). Anyway, "Bear" and my few other belongings were soon packed away, and I was off to the restaurant in the motel for breakfast. It was 8:35 am, and I felt I was

taking advantage of the warm sun. Along the road we saw two wrecked cars. Both drivers had tried to occupy the same space at the intersection at the same time. The driver of one car was a Indian or Pakistani woman. There was blood on one side of her beautiful face.

We rounded a curve, and I saw a sign for Waterloo. "Want to see Waterloo? Do you girls have the time?" asked Charlie.

Monique wanted to go, since her roommate, Lori, would be in bed all day. Not every post-op could recover as quickly as Monique. I had plans with Becky and Michelle to see the Grand Place and a Christmas bazaar.

I said, "I'd love to see Waterloo. I didn't realize it was in Belgium. Could we go back to the hotel first? I must leave a note for Michelle and Becky."

"OK. Tell you what. I'll drop you two at the hotel and meet you back there at 1:00 P.M. I've got to go back to my hotel and call my office."

Monique turned to me in the back seat and gave me a big grin.

Back in the hotel lobby, we tittered like schoolgirls. I pressed the elevator button. "Do you think we're passing?"

Monique leaned against the wall. "I don't see any problem. The guy is absolutely interested, or he wouldn't be spending so much time with us."

"You think he's looking for sex?"

"Well, not from me, dearie. I still have some stitches and the packing down there. This body is going to heal a lot more before I let any guy get near me."

"Monique, dear, I've messed around with bisexual crossdressers a few times, just to get a little experience, but never with a straight guy. I couldn't take the risk. I'm scared. I've never been in such a predicament before."

"Don't worry, Veronica. You're doing all right."

"Well, thanks... but I worry about my voice."

"Trust me. You're doing fine. Who knows— maybe Charlie is gay. But I doubt it. He is a lonesome American far from home."

I signed my name to the note just as Becky and Michelle arrived. "Hi, guys. I won't be going out with you. Monique and I have a date with Charlie. He wants to show us Waterloo, in his Mercedes."

Michelle's eyes widened. "Where did you find him?"

"At Rick's. Everybody goes to Rick's place. We got picked up during breakfast. Do you believe it?"

Becky said, "Got room for two more?" She looked at me, and then at Michelle.

"Well... it isn't a big car and we don't want to share. We found him. Go find your own guy."

"Go for it, girl," Michelle said. "You realize, of course, this is all part of my program here. I arranged to have Charlie meet you two at Rick's. There is no extra charge for this."

"Sure you did, Michelle, just like I'll change my mind about the surgery on Tuesday."

Becky was hurt that she wouldn't be joining in on our fun.

Charlie showed up promptly at one o'clock. Monique again took the front seat. She needed all the comfort possible, and I needed the back seat for my camera gear. Charlie headed south out of the city. We passed the Waterloo sign we'd seen earlier and entered the countryside. The scenery was like nothing I was used to in Massachusetts.

After a short ride, I saw the city limits sign for Waterloo, the site of Napoleon's defeat. The main street of the town was quiet, with little Sunday traffic. Tidy shops lined the sidewalks on both sides of a wide road. I saw a familiar McDonalds' sign ahead. When we reached it, Charlie turned right. Moments later, he turned left into a small gravel parking lot.

"This is it? I expected something fancy."

"This is it, ladies. Waterloo is not a fancy town," said Charlie, opening his door.

Monique got out of the Mercedes carefully. I hoped she wasn't overdoing it and that Charlie hadn't noticed anything wrong. We walked past a restaurant and turned left into a narrow path. A guardhouse stood by the gate. No one was there.

I saw a huge grassy mound beyond the fence, roughly triangular in shape. We began the trek up the stairs. Monique stopped to rest at the halfway point. She told Charlie of a temporary back problem, and he waited by her side. Being the forty-year-old kid I am, I ran up the remaining stairs and nearly collapsed at the top.

A large statue of Napoleon astride a horse overlooked the peaceful, surrounding farmland. Low clouds, fog, and brief moments of sun lent an eerie atmosphere to this grand monument. I shot photos with my old Minolta, stopping only when the sun vanished and snow began to pelt my face.

At the bottom of the monument, we passed a museum. "We'll leave guns to you men," I told Charlie. "My boyfriend is a wargamer, and I get enough war and guns at home."

I did have a male friend back home who was into wargaming. This was my reason for knowing a bit about Napoleon. I didn't know how much of this stuff a woman should know.

The visit to Waterloo was over. We expected Charlie to return to Brussels, but we continued through Braine L'Allude and into the province of Hainaut and the town of Charleroi. We were ten miles from the French border. Headed north, Charlie drove through several Belgian towns. I had forgotten my nervousness of hours ago. Charlie was a polite dear, and took such pains to show us around the south of Belgium. Abruptly, we turned into another gravel parking lot.

"Ever see a 14th century castle?" he asked, turning to the back seat to look at me. "This is the Castile de Beersel. I think you girls will enjoy it."

Charlie paid the man at the gate, and we crossed the drawbridge and moat. Good: the dragon was not in sight. We explored the castle for almost an hour. The brochure gave the points of interest; we found the dungeon and torture chamber. Monique took my picture while I lay on the torture table. I saw tiedowns for limbs, and rested my head in the appropriate hollow spot. How many humans had lost their lives in this room?

The exploration proved fascinating, but Monique showed a little discomfort, and seemed grateful for the rest at the Castile de Beersel Restaurant. We each had a Stella Artois beer, sitting at a rough wooden table near the fireplace. I didn't know how old the restaurant was, but the interior was dimly lit and reflected a long time ago. Maybe it, like the castle, dated back to the 14th century. The decor resembled Early American.

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running a little ahead of schedule.

As I approached the lobby, I wondered if I would see "Smokin' Joe" or his friend and possibly have breakfast with them. But as I entered the lobby, there were no signs of life at all. I shuffled into the restaurant, my baggage in tow on the folding airline tote cart. With the exception of a group of about four or five "Good Old Boys" spread out at a table on one side on the room, the place was deserted. As I passed, they gave me a close look, and all started mumbling to each other. I assumed they had put the inevitable "two and two" together and knew why I was there. They had probably seen hundreds of unaccompanied young-to-middle-aged women, looking a little uneasy and unfamiliar on many a Monday morning. Dr. Biber's work was no secret in the community, and after thousands of others had been here before, I assumed that my presence needed no explanation. Anyway, I proceeded to shuffle past them, smiling as I passed. They returned the smiles and I felt a little more comfortable.

Service in the restaurant was quick; after all, the "Good Old Boys" and I were the only customers in the place. I was soon presented with a bacon omelet, a side of home fries, and hot coffee. Before I started to eat, I decided to get the blow-by-blow description of what was going to happen during the next few days out of my purse and review it one more time as I was eating. As I started to munch, I again (probably for the 100th time) read the first section: "A Visit to the Doctor's Office." Well, there it was in black and white, right before my eyes, "BE AT THE DOCTOR'S OFFICE AT 9:00 AM THE MORNING BEFORE SURGERY." I had read this sheet many times before, and I could swear it had said l0:00 am. "Oh, Damn!" I looked at the clock and it was 10 minutes to nine. Down went the whole breakfast in 18 seconds flat. I flew past the cashier, money in hand, and she grabbed it as if it was a mail bag dangling out the window of a steam train, as in old times. I checked out of the room at the front desk, had them call a cab, and was standing outside at the curb in about 90 seconds.

It was a very brisk morning. I later saw the temperature at the Trinidad National Bank, which read 7° Centigrade (about 45° Fahrenheit). Several minutes passed and the cab pulled up. It was being driven by a middle-aged woman, probably an American Indian She was a real talkative soul. The back seat was filled with what looked like laundry and a teenage girl, possibly her daughter. She said, "Going to the bank?" I replied, "Yes. How did you know?" She then said, "Most of you girls do." I was thus assured that she knew why I was in town. She looked me in the eyes, smiled, and said, 'I've taken hundreds of you girls over there." Out of the blue, she started to talk about Dr. Biber. She said how most of the people in town were very grateful to him for his efforts to keep the hospital afloat, largely due to his "sex-change ah-pray-shins," as she put it.

She was a real leadfoot. We were soon at the bank building where Dr. Biber's office was located. Actually, it was only five short blocks down the street, and I could have walked it in about 10 minutes. Oh well! The fare was five dollars, which was a bit steep, but she was the only game in town and knew it. I had enjoyed her conversation, and as I got out she said, "See ya in a little while." She knew I'd probably be getting another ride, this time from the motel to the hospital, since I'd left my bags with the desk clerk in the lobby.

The bank building is in the center of Trinidad, which is a typical mid-west or western town. It had a main street lined with shops, and was crowded with pick-up trucks and cars carrying farmers and town people about to do their shopping after the weekend. Dr. Biber's office was accessible via a side street entrance and a ride up an ancient elevator. The entrance to the building was a bit tired and run-down. The once-elegant marble directory had tenants' names crossed out and taped over with new ones. The doctor's office, "The Trinidad Medical Clinic," had a place of prominence as the sole occupant of the fourth floor. I rode up the battle-scarred elevator, listening to it creak and groan. Finally the graffiti-scarred door opened at the fourth floor.

After a wait of several hours, the whole visit/interview lasted about 15 minutes. I was down in the street at about 12:30, walking back to the motel to get my bags and have lunch. About a block-and-a-half up the street, I realized that I had passed my final test and was heading for the goal line. I was beaming! The walk to the motel was like floating on a cloud. I could see a light, a bright shining light at the end of the tunnel.

Part IV: Mt. San Rafael Hospital

I recall walking up the slight hill toward the motel and looking casually in the store windows as I passed, but I wasn't seeing anything inside. I was too preoccupied with what had just happened in Dr. Biber's office. I was thrilled that the final approval, his, had been given for me to complete my long desired goal, that of becoming the complete woman I had always felt I was inside.

As I reached the motel, I realized that it had warmed up a little, although a brisk breeze was blowing, and I was rather windblown in appearance. I attempted to tame my hairdo a little as I entered the lobby, but I didn't really care what I looked like. All I was concerned with was collecting my things and getting over to the hospital. As I walked in, I noticed that lunch was being served and decided to grab a quick bite. After all, I would be eating hospital food for several days and did not know what to expect. After retrieving my bags, I shuffled into the restaurant for lunch. I know I ate, but the meal itself and the activities in the restaurant were clouded and overshadowed by my preoccupation of what was going to happen shortly.

The next thing I remember, I was standing in the lobby waiting for my ride, via Trinidad Cab, to Mt. San Rafael Hospital. When the cab arrived, I was greeted by the same woman that had picked me up before. She commented that everything must have gone all right at the doctor's office. In a few moments, we were traveling across town to the hospital. She again made the comment that she had taken hundreds of girls over to the hospital, adding that she was sure that I'd do fine. She apparently noticed my nervousness and my now more serious nature. Actually, I was just deep in thought, recalling all the steps I had made in the past three or four years that had brought me to this place, this point, in preparation for the coming event. Thoughtfully, I watched the small town pass by.

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The Care and Feeding of the Neovagina

by Dallas Denny

Find the word vagina in your Webster's Dictionary. Point to it. Now lower your finger about a half inch. What do you see? Vaginitis. Now look up the word penis. What is the next word? Penisitis? No, (perhaps appropriately), penitence.

Why do you suppose that the word vaginitis (inflammation of the vagina) is in the dictionary, and a corresponding word for inflammation of the penis is not? Ask any adult who was born with a vagina, and she will tell you: female genital equipment requires a great deal of maintenance.

Problems with Vaginas

Males have the advantage of having a urethra at the end of a long tube, far from the anal opening, and of having genitalia which are exposed to the air and easy to keep clean. In females, the proximity of the urethra and vaginal canal to the anus make contamination by fecal matter more likely, and the vagina, which is in essence a dark, warm, wet (and some would say wonderful) cavity, is difficult to keep clean and odor-free.

Vaginas are particularly susceptible to bacterial and yeast infections, which can be persistent and difficult to control. Such infections cause unpleasant odors and itching, and can make sexual intercourse uncomfortable. Additionally, vaginal disturbances can spread into the uterus, fallopian tubes, and ovaries (with resulting risk of sterility), or to the bladder and kidneys. Because they have a shorter urethra than do males, females are more subject to bladder infections— and kidney infections often arise from bladder infections.

The vagina is lined with mucous tissue, with the result that females are at high risk for acquiring sexually transmitted diseases (STDs) during sexual intercourse. Lesions caused by diseases like Chlamydia, herpes, syphilis, and gonorrhea may be less readily apparent in the recesses of female genitalia than on the external equipment of males, and symptoms of infection may be mistakenly attributed to bacterial or yeast infection. Females seem to be at relatively high risk for acquiring the HIV virus during sexual intercourse.

Vaginas can be a nuisance in another way. From the early teen years until menopause, the female genital tract cleanses itself once a month, sloughing off a layer of skin which is discharged with a bloody fluid. Discharge can be copious. This menstrual process lasts several days. It is triggered by hormonal changes, which also cause emotional stress. Tampons and pads are necessary

"Especially pleasant and pretty I feel is the build of the female genitals in contrast to the male's, particularly their position as inner organs; with women it is discreet, in opposition to the protruding of the male organ."

— "Case 17," p. 116, in Magnus Hirschfeld's Transvestites: The Erotic Drive to Cross Dress, *Michael A. Lombardi-Nash, translator*

in order to control the menstrual flow, and must be changed often, to prevent odors and staining of clothing. As was discovered a decade or so ago, blocking the vagina with a tampon can result in the accumulation of bacterial toxins which can result in illness, or even death. This is known as toxic shock syndrome.

Problems with Neovaginas

A minority of male-to-female transsexual people eventually have sex reassignment surgery (SRS), in which the testicles and penis are removed and an artificial vaginal cavity is built. In most cases, the skin from the scrotum and penis is utilized; this is called penile inversion, and may be supplemented with a variety of other techniques. Some surgeons incorporate a section of bowel into the neovagina, and some use skin flaps or skin grafts.

No surgical procedure is risk-free. There are dangers from anesthesia, from the surgeon (who is only human, and can make mistakes), and from blood (if transfusion is required). Problems can arise afterward: infection, internal bleeding, rejection of transplanted tissue, persistent pain, formation of excess scar tissue— you name it. Negative outcomes are possible under the best conditions, and with the best treatment (something the American legal system does not seem to realize).

SRS risks can be minimized by careful selection of surgeon and hospital. Skills of reassignment surgeons vary widely. A surgeon who has years of experience, who has done scores or hundreds of sex reassignments, who has a good working relationship with an anesthesiologist, and who uses the latest techniques and equipment is much more likely to create a functional, sensate, aesthetically pleasing neovagina, and to have much lower complication rates than is someone who has done only one or two surgeries. Unfortunately, many transsexual people, especially those who have found rejection in their quests for gender consonance, do not comparison shop, but accept the first source for surgery.

A surgeon with limited skill or experience can really wreak genital havoc. It is not uncommon for the result of surgery to be a "pocket" which bears little resemblance to a vagina; for labia to be nonexistent, or unaesthetic; for there to be little or no potential for erotic sensation; for neovaginal depth to be insufficient for intercourse; for the urinary opening to point in the wrong direction. I will repeat: selection of a competent surgeon is critical.

It would behoove the transsexual person to learn not only about the skill and experience and reputation of the surgeon, but about the technique the surgeon will use, for advantages and risks vary with the procedures used. When a bowel segment is used, for example, there are sometimes strictures (partial or total closures) at the place where the penile and bowel tissue meet. When skin grafts are used, there is promise of greater vaginal depth, but also risk of rejection. Even after healing is complete, there may be repercussions. For example, bowel segments are composed of mucous tissue, placing the individual at higher risk for STDs, and at jeopardy for developing gastrointestinal diseases of the neovagina— Crohn's Disease, for instance, or gastroenteritis. These risks are counterbalanced by an equal number of advantages, including greater vaginal depth than is possible with simple penile inversion surgery, and without the unsightly scars caused by skin grafts. Another advantage of this "Cadillac of vaginas" is that it is self-lubricating, freeing its owner from the necessity of using K-Y jelly or other lubricants.

Even the best SRS surgeon will have occasional complications— but they will almost all be what I would call routine complications; that is, their nature will be foreseeable, as will their method of treatment. Routine complications include urethral stricture and vaginal stenosis (closing of the neovagina), and are easily remedied (by dilation, in both instances). Urethral stricture is due to formation of scar tissue at the neo-urethral opening, and can be taken care of on an outpatient basis by a urologist. Vaginal stenosis is caused by the natural tendency of the vaginal dissection to heal, and is the reason why frequent dilation (stretching with a mechanical device) is necessary for some months after surgery. Such dilation is done at home by the individual. Some surgeons favor a mechanical device, much like a vibrator; others provide a stent which is worn in place for several months following surgery.

Some complications are very serious. An example is rectovaginal fistula, in which the vaginal pocket intrudes into the rectum. R-V fistula occurs because there is but a limited space for the vaginal cavity. It is of necessity close to the rectum. Overenthusiastic dilation can cause a fistula, but they are more frequent when SRS is done by inexperienced surgeons, who may tend to dissect too close to the rectum. R-V fistulas often require temporary colostomies (redirection of the bowel to a suitable location on the side, and wearing of a bag to catch feces).

Other serious complications can include infection, incontinence, prolapse of the neovagina (with the neovagina actually becoming everted), and necrosis of the vaginal lining, with the resulting need for a skin transplant. Necrosis can occur because of inadequate blood supply, rejection of transplanted skin, infection, or allergic reaction to vaginal stents.

If sex reassignment surgery is done outside the immediate area of residence (one can always return to the surgeon for aftercare), it can be difficult to find treatment for complications— whether they arise shortly after surgery, or years later. Selection of someone who will give quality postoperative care is as important as selection of a good surgeon, and should occur before surgery, for many gynecologists and urologists are unfamiliar with transsexual patients, and may refuse to treat them. There may be little time or patience for a search when complications arise during the recuperative period. Even in medical emergencies, it is not uncommon for transsexual person to be turned away by private physicians, and even by hospital emergency rooms.

Most practitioners show a great deal of caution in dealing with the unknown, and may order tests and procedures which are unnecessary. This safeguards the patient, and minimizes the risk of a successful lawsuit for malpractice. Most physicians correctly feel 'tis better to err in the direction of caution— but many transsexual people, who have spent their life savings for SRS, are financially depleted and unable to afford expensive aftercare tests and procedures which essentially serve educative and self-protective

(Concluded on page 52)

special feature . . .

The bulk of this interview took place at the Southern Comfort Convention in Atlanta, Georgia, on 6 October, 1991, and was later transcribed from tape. Dr. Gilbert was also furnished with a subset of written questions, to which he responded after some thought. His written answers have been integrated with his spoken answers.

An Interview With David Gilbert, M.D.

by Dallas Denny & Margaux Schaffer

Dr. David Gilbert is a plastic surgeon and microsurgeon who is co-founder of The Center for Gender Reassignment in Norfolk, Virginia. His wife, Deborah, is a registered nurse, and Coordinator of the Center. Plans were to interview both Dr. and Mrs. Gilbert at Southern Comfort, but Mrs. Gilbert became ill shortly after arrival, and was still under the weather on Sunday afternoon, the last possible time for the interview. Dr. Gilbert, who was obviously worried about his wife, nevertheless gave us what we believe to be the finest interview on sex reassignment surgery which has ever appeared outside, and perhaps inside, the pages of a medical journal.

Lisa Richard, the Assistant Coordinator of The Center for Gender Reassignment, was present and participated in the interview, which took place in the empty room in which Dr. Gilbert had earlier given a presentation, complete with slides of his surgical results.

CQ: How did you get involved in working with transgendered men and women?

Dr. Gilbert: The Norfolk experience in genital and urinary reconstruction dates back twenty-five years. When I moved to Norfolk to start my plastic surgery practice, one of the interests I had was in genitourinary reconstruction. My initial experience was with congenital and traumatic genital deformities. As we developed the techniques to reconstruct the male and female genitalia, we began to apply our reconstructive philosophy and techniques to the gender patients. Many of our techniques were developed in Norfolk.

At that particular time, several things were coming together. One was advancements in genitourinary reconstruction. We were constantly developing and evolving techniques. At the same time, the concept of microsurgery was coming into play. We combined those two things, pioneering the use of microsurgical techniques with genitourinary techniques. We had been doing penile reconstructions on little boys who had been born without a penis, and on men who had lost their penises. I had always felt that the gender patients were part of the group that could benefit from this particular type of surgery, and from our expertise. What we learned about the genitourinary patients we sort of transposed to the transgendered population. Soon we were doing a lot more of the gender patients.

For the past five of six years, the mainstay of our practice has been the female-to-male patients, but lately we've seen a lot more male-to-female patients, to the

point that we now see them in equal numbers.

CQ: When and how was the clinic established?

Dr. Gilbert: We'd been doing the surgery since the late seventies, but the program and the committee were, quite frankly, sporadic. When I got my wife, Deborah, involved in my practice, she came to a couple of these gender committee meetings. She said it was a date— one of our first dates was going to a committee meeting. It was after we had worked in the operating room together. She became so enthused about the gender reassignment and so interested in it that when the person who had held the position previously was retiring, giving up coordinating the gender program, he handed over all his charts to her, and she really jumped in and bit off a big chunk. She was the one who developed the concept of and named The Center for Gender Reassignment. That was back in 1984.

CQ: So the Center has been in operation for seven or eight years?

Dr. Gilbert: Yes. We began to get a lot of enthusiasm from a group of professionals there, urologists who had worked with us on genitourinary reconstruction, and the psychologist Jerry Ramsey, who had been there for a long time. We got involved with the gynecologists and endocrinologists. Mrs. Gilbert and Lisa, her assistant, really began to coordinate things and get interested in transgendered patients.

I'm very pleased that this enthusiasm has remained, and that all of the professionals involved have steadfastly supported the committee.

CQ: John Money is very concerned with what he calls the antisexual forces. Has your work with transgendered men and women drawn any criticism?

Dr. Gilbert: No, it hasn't. We don't seek to draw any flak, but we feel we wave the flag pretty strongly, and we have not drawn a lot of negative criticism, directly, or overtly.

CQ: The literature is filled with descriptions of transgendered persons as having a lot of psychopathology in addition to their gender dysphoria. Has that been your experience?

Dr. Gilbert: It hasn't. My personal experience— and I'm not a psychologist, and I don't test people— my own personal experience is that transgendered patients are no different from people out in the street.

Lisa Richard: Because they've had to look so inward, they seem to be more in tune with life. Most people don't have to look so inward as transsexuals do. That's our experience.

Dr. Gilbert: That's true. I agree with what Lisa said. I think that the transgendered patients are the most honest people, because they've had to face a lie of nature. They've had to face the fact that they are not what they seem. They are not what they look at when they see themselves in the mirror. And to be able to answer that in their own mind, I think, requires a lot of strength.

CQ: One of the problems in treatment has been that many transgendered people, being desperate, have been, as Anne Bolin pointed out, sometimes less than honest when they present for treatment. Do you have that problem with people perhaps trying to cover up medical disorders that they might have because they think it might negatively effect their chances for surgery?

So You're Thinking About Taking the Big Step...

What the Prospective Patient Needs to Know About The Center for Gender Reassignment

CQ: Tell us about your services.

Dr. Gilbert: The Center is a loose association of medical professionals from several different specialties. The Center includes a gender coordinator, an assistant coordinator, a plastic surgeon, urologists, a gynecologist-and-endocrinologist, and psychologists. The Center is committed to the goal of successfully, surgically converting transgender patients to their desired gender.

CQ: What is the best way to contact you?

Dr. Gilbert: Just write or call us.

CQ: What are the initial requirements?

Dr. Gilbert: The initial requirements include establishing a chart and filling out the standard transgender questionnaire. In addition, there is a fee for printing, publishing, and processing this questionnaire.

CQ: What information do you need?

Dr. Gilbert: Information that is important to anyone inquiring about the Center includes:

— the patient's name
— the patient's chromosomal gender
— the gender of choice
— how long has the patient cross-lived?
— is the patient on hormones?
— is the patient in psychotherapy, and if so, for how long?
— has the patient had any previous surgery or therapy?
— what are the goals of the patient?

CQ: What should prospective clients not do?

Dr. Gilbert: Anyone who is interested in transgender surgery must not smoke or use illicit drugs. The patient must be in two years of ongoing crossliving and cross-occupation in the gender of choice. If patients have a history of thought disorder, they are ruled out as being a credible candidate for surgery.

CQ: Sex reassignment is an expensive proposition. I understand that you have made a provision for a medical line of credit for your patients.

Dr. Gilbert: Associated Management Services, a subsidiary of The American Society of Plastic and Reconstructive Surgeons, and Household Retail Services, Inc., was developed exclusively for members of the Society and their patients. This Associated Management Services Personal Equity Service was developed to aid patients in receiving financing for proposed surgery. Although these financial services were designed with potential surgical patients in mind, it is organized along the same lines as any other financial institution.

The Center for Gender Reassignment
142 West York Street, Suite 915
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FAX 622-7026

Dr. Gilbert: The way we're set up, and the way that we interview patients is such that I don't think we've been deceived by many people for too long. How I would embellish that is to say that our gender day is a very aggressive free-for-all, where there is a lot of give-and-take between the physicians and the patients. I think the patients pretty much have to come clean by being interviewed by a large battery of professionals over a short period of time. Anybody can keep a lie together for an hour or two. It's really dependent upon a patient's local psychologist and local physicians being able to evaluate the patient. We do not profess to be able to know what a patient is like within the hour we see them, although we feel that we get a pretty good idea. I do know patients who have deceived some other physicians, and they quite frankly admitted to us, "Well, I told the doctor that I just had some gynecomastia. He never examined my genitals." "I told the doctor I had heavy bleeding; that's how I got my hysterectomy." But as a rule, I think that the patients, over time, have been pretty honest with us.

CQ: I've read in the literature that at one point diabetes was considered an absolute contraindication for surgery. Would you talk about a couple of diseases— diabetes, perhaps, and HIV disease, and how that impacts the decision about surgery?

Dr. Gilbert: I think that all of these have to be taken on an individual case basis. The fact that you have a patient who is HIV-positive versus their transgenderism— basically, you have to decide, along with the patient, along with all the input you can get, where is this patient vis-a-vis both of these life problems. It has to be individualized from that point of view. Which is going to be more important? Which is going to impact the patient initially? Long-term? I think you have to take it on that basis. The same with any illness— diabetes, or chronic heart disease. If a patient basically is healthy other than having this particular disease process, and has the disease process well-controlled over a long period of time, then conceivably they would be candidates for the surgery. If they are uncontrolled— if they have a disease process that is only going to get worse, or if they aren't taking care of themselves— then that might mitigate against the surgery.

CQ: Is there something that the treatment team can do, aside from taking even more precautions than normal, to protect against transmission of HIV during surgery?

Dr. Gilbert: I am a general plastic surgeon. I treat patients on an emergency basis. I take calls at the hospital. I treat patients on an urgent basis, and on an elective basis. All of those have an input about whether I will treat a patient who is HIV-positive. It's my ethical duty to take care of patients on an emergency basis. If it's a more elective situation, then I have a choice. But in fact, any type of precautions that would be used for any patient need to be carried out. In this day and age, you have to assume the worst about any situation. We take a lot of precautions with every patient.

CQ: How many male-to-female genital surgeries have you done? And would you please describe the relative advantages and disadvantages of the use of bowel segments in vaginoplasty? What technical improvements do you see in store for vaginoplasty?

Dr. Gilbert: We have done several male-to-female genital surgeries within the past five years. Within the past two years, we've begun to utilize the sigmoid colon as donor source for our vaginoplasties. The sigmoid colon is vascularly predictable and provides an excellent replicate for the vagina. Colon segments do not require the continuous stenting that split thickness and full thickness skin grafts have required in the past. They do, however, require daily dilation, at least initially, in order to prevent any introital stenosis.

The sigmoid vaginoplasty is something that we think has made a contribution. We are favoring it more and more. We pretty much discuss this with all of the patients who are ready for the definitive male-to-female surgery. That's not to say that the other techniques for vaginoplasty— skin grafting and so on, don't have a place— they do. It's nice to have another option.

CQ: How about some of the complications that are indigenous to that particular method— colitis, Crohn's disease, and HIV transmission?

Dr. Gilbert: There are things that would mitigate against the surgery, and in fact, one patient asked me yesterday about colitis. I think you would have to consider very carefully whether a patient with colitis would be a good candidate. The HIV may be a factor. And the fact that we are taking a piece of bowel out and then rejoining the bowel is a potential complication. But overall, we've been pleased with the results in the time that we've been doing it. It's not a new procedure. Using bowel to make the vagina has been used since the turn of the century by some Europeans surgeons. So this is not a new procedure; it's a reintroduction of an old principle. The bowel has its place, and there are some technical drawbacks which sometimes make it more difficult.

I think that the transgendered patients are the most honest people, because they've had to face a lie of nature. They've had to face the fact that they are not what they seem. They are not what they look at when they see themselves in the mirror. And to be able to answer that in their own mind, I think, requires a lot of strength.

CQ: Do you construct a clitoris?

Dr. Gilbert: At the present time, we are working on developing construction of the clitoris from the penectomy segment. These clitoral reconstructions include preservation of the dorsal neurovascular bundle so that the resultant clitoris has some of the erotic sensitivity that the penis previously had. In addition, we are continuing to work on improving the aesthetic of the reconstructed female perineum.

CQ: Would you speak about undesirable results of both male-to-female and female-to-male surgeries? What are the complication rates?

Dr. Gilbert: Both female-to-male and male-to-female genital surgery should be considered as major surgery in every sense of the word. One of the problems that gender patients and their physicians get into is trying to cut corners, particularly if the patient is paying for all of the surgery and hospitalization. Gender surgery should be considered as a major surgery with all of the complications that are attendant in any surgery: hemorrhage, infection, scarring, poor results,

urethral cutaneous fistulae, urethral stenosis, pulmonary emboli, urinary infections, and bowel infections are all potential complications. Fortunately, our major complication rates are minimal and I directly attribute this to the professionalism of the surgeons involved. All of the surgeons at The Center for Gender Reassignment have had long experience with transgendered patients. This accounts for our low complication rate. However, I do warn all of my patients prior to surgery that there is a possibility that they will require some kind of "touch-up" surgery in order to maximize the functional aesthetic result.

CQ: How often do you confer with other professionals, like Donald Laub, or Stanley Biber?

Dr. Gilbert: As you know, the Harry Benjamin meeting is every other year, and it is usually very well represented by surgeons doing a lot of this work. The Genitourinary Reconstructive Surgeons meeting is every year, and it is held in association with the American College of Surgeons, so I get a lot of exposure there to some of the other gender surgeons. We also share our experiences at the American Urologic Association meeting and the American Society of Plastic and Reconstructive Surgeons. So there are several meetings where I come into contact with professionals who are doing this same type of surgery.

CQ: On that same note, how much exchange is there of screening data? When you hold clinics, you're collecting a lot of data about people's histories, their physical characteristics. Do you get to exchange that kind of information with other clinics who are screening people, in order to get some insights into common correlations and secondary symptoms that manifest along with transsexualism?

Lisa: Most of the information we get is kept in the patient's file, and is used only for the patient and the doctor. If we were to share information, it would only be under the patient's consent.

Dr. Gilbert: That's true. Individual patients' files are the property of the physician and the patient. We have generated some papers out of our experience. We have begun to distill some of this information and impart it to others.

CQ: Is the individual's presentation— the ability to look viable in the gender of choice— a factor in acceptance for surgery, and if so, how much?

Dr. Gilbert: You're asking a subjective question.

CQ: I guess I'm thinking of an extreme case— someone who is obviously going to have problems— or maybe they have neglected some things they could do, like plastic surgery or electrolysis. Would that seem to be a relative contraindication? Yesterday, Lisa and I were talking, and she said that the answer at the Center was either yes, or not yet. Never no. Would that be a not yet?

Dr. Gilbert: Not yet, certainly. If a patient feels in their own heart that everything is squared away, then perhaps yes. To take an example— I don't mean to be glib— but to take the ugliest man and make him into the second ugliest woman in the world, I still think it would be worthwhile, everything else being equal. This patient is transgendered, and physical appearance may not be as important as feeling like a woman. When we interview patients, we question them. In fact, for a large percentage of patients, the first priority is that they want to "feel like a female." And that means completing the surgery.

The metadoioplasty converts a testosterone-enlarged clitoris into a small penis.

CQ: You are known for your female-to-male genital surgeries. How many have you done? Do you see female-to-male persons coming forth in increasing numbers?

Dr. Gilbert: At present, we have carried out more than fifty microsurgical phalloplasty reconstructions in the gender patients. This series is one of the largest in the world. We anticipate an increased number of female-to-male transgender patients coming forth in the future. In addition, we also anticipate an increase in our congenital and traumatic patient population coming forth and requesting phallic reconstruction.

CQ: Please tell us the advantages of the medial forearm flap in phalloplasty.

Dr. Gilbert: The forearm flap has been the best flap so far designed for phallic reconstruction. The flap is based on either the radial or ulnar artery and its vascular territory. The flap is usually thin, relatively hairless, well-vascularized, and has the potential to be molded from a flat swatch of tissue on the forearm to a phallus when it is transferred into the perineal area. In addition, the nerve supply to these flaps is usually anatomically and physiologically predictable.

The tissues that are borrowed from the forearm include the skin, subcutaneous tissues, arteries, veins, and superficial nerves. The muscles of the forearm and hand, the nerves to the hand, and the major blood supply to the hand are not interrupted, and therefore the risk of compromising hand function in minimal.

CQ: What is metadoioplasty, and what are its advantages and disadvantages?

Dr. Gilbert: Metadoioplasty, or genital plasty, was originally designed for patients who were unable or unwilling to go through a staged phallic construction or a microsurgical phallic construction. The metadoioplasty converts a testosterone-enlarged clitoris into a small penis. In this situation, the ventral chordee, or bend, of the clitoris is released in order to give it more length. At the same time, the short female urethra is turned forward and constructed out of the tip of the clitoris. The labia majora are then transposed posteriorly and joined in the midline as a scrotum.

This procedure has the advantages of not requiring the length of time, or the number of stages, or the microsurgical expertise required in order to construct a phallus by other means. The female genitalia are converted to their male analogues with a minimal amount of surgical maneuvering.

The disadvantages of this operation are in the final function of the clitoris-penis. The penis remains short and is likened to "a man just getting out of a cold shower." These patients may or may not be able to stand to void, and may or may not be able to have sexual intromission with their clitoris-penis.

The operative procedure may be recommended for elderly patients, or those who are unwilling or cannot undergo the more lengthy phalloplasty procedure. However, most of our patient population would prefer to have a larger and more dramatic phallic construction.

Metadoioplasty is, I think, a useful adjunct to the other surgical procedures. I think it's indicated in a certain percentage of patients, where a microsurgical

phalloplasty procedure may be contraindicated. Let me make a couple of explanations here. We believe that the surgery of choice— the optimum surgery of choice, the postmodern phalloplasty, consists of a microsurgical procedure carried out by skilled surgical technicians, usually two or three surgeons together, who work long hours to transpose tissues from one part of the body to the scrotum to make a phallus. It's never a God-given penis, but a phallus. However, not all patients are optimum candidates for this particular surgery. Although they may fulfill all of the Harry Benjamin Standards of Care, they are obviously not going to be good candidates for this particular surgery. At that point, we need a surgeon to decide if we can give these patients some kind of viable alternative. The alternatives are to transpose local tissues— skin and muscle flaps from the thighs, and the perineum, and the lower abdomen— areas around the groin, which will help to give a phallus, or to convert the clitoris into a small phallus— and that is known as a metadoioplasty. The term was introduced by Dr. Donald Laub. It's Greek, and I believe that his explanation was "conversion to male of the female parts." The metadoioplasty depends upon a tremendous amount of influence of depo-testosterone on the clitoris, so that it makes the clitoris grow to a point that it has the potential of becoming a small penis. It's been our feeling that if we're going to try to make a short penis that will be, say, three inches long, if we can get enough clitoris, then there would be potential to do the surgery.

This metadoioplasty will never replace a true phalloplasty as the optimum procedure. It is indicated in patients who are middle-aged or older, patients who are in poor health and could not tolerate a long and lengthy procedure, and perhaps patients who have little or no interest in using the genitalia sexually. In these cases, I think metadoioplasty has a place.

CQ: What about revision procedures that would enhance metadoioplasty? Has much work been done in terms of utilizing implants, or utilizing implants to improve upon it?

Dr. Gilbert: Yes and no. We have used scrotal implants in order to create a scrotum out of the labia. We have not yet used a penile stiffener to place in a clitoris. I don't think it is going to be possible, or worthwhile. I think that in order to enhance the metadoioplasty, there are limited things that can be done. Trying to lengthen it as much as possible is the best that can be done. Next step is to move other tissues from the thighs, such as the gracilis muscle flaps— and we have done that on several patients in order to elongate and make a neophallus on top of the metadoioplasty.

CQ: The past decade has brought considerable improvement in phalloplasty techniques. What are these advancements? What are the remaining difficulties, and what do you see happening in the next twenty years?

Dr. Gilbert: The two greatest advancements of the decade in phalloplasty construction are the utilization of microsurgical tissue transfers and neurolization— that is, the return to the flap of erogenous and tactile feeling. These advancements have allowed our patients to masturbate to orgasm, as well as to regain good sensory feeling to the phallus.

At the present time, we are modifying our urethral reconstructions, and our recent results have had many fewer urethral cutaneous fistulae and urethral stenoses. Over the next decade, I would like to see some development by the biomedical companies for a stiffener for the phallic patient population. At the present time, the penile stiffeners that are available have been designed for anatomic penises and are difficult to adapt to our reconstructed phalluses. Within the next twenty years, it is possible that we may be transplanting penises, much like we are now transplanting hearts, kidneys, and livers.

CQ: Do you see advanced imaging techniques as providing better preoperative planning and surgical management— such as utilizing scans to assess the exact anatomy of an individual? To help, for instance in the male-to-female, to minimize the chance of rectovaginal fistulae.

Dr. Gilbert: I think that in certain cases, imaging is important. I'm not sure imaging the pelvis, for example, is going to make a difference in how we decide to do our bowel or in the actual creation of a vaginal cavity. There are certain cases in which imaging procedures do help. And I'll give you an example. There are a certain number of patients who are not good candidates for microsurgical transfer of tissues because the blood supply of the forearm simply is not good enough to remove this piece of skin from the arm and risk hurting the hand. These are patients who we examine preoperatively with what we call an Allen's test. If the Allen's test is positive— if there is a concern or question about whether they have enough blood supply to the arm, we have to stop right there. Sometimes we'll do an angiogram to actually study the blood vessels. If the blood vessels are not good— are not normal types of blood vessels— if there is some kind of anomalous flow, that tells us that microsurgery is not indicated. It wouldn't help, and therefore, we have to go to some other kind of surgical procedure.

CQ: As a footnote, what exactly is the Allen's test?

Dr. Gilbert: The Allen's test is measuring the blood supply by pressing on the radial artery and ulnar artery to study whether there is enough blood flow into the hand.

CQ: To shift gears a bit here, a proverbial problem has been that people are lost to follow up postsurgically. Do you think that is improving? Do you think that people are more willing to be followed-up than has been common in the past?

Dr. Gilbert: I'll let Lisa start with that, and then I'll respond.

Lisa: As far as the patients that we have, they usually stay in the area after their surgery. We keep in fairly close contact. The patients who come and have surgery are part of our center, so we usually keep in very close contact. We have patients who write us five or six years postoperatively and tell us they just got married, and so on. And they do come back annually for their checkup, and if problems do occur, the first place they do call is us, and we get them taken care of right away. I think they've gone through it with us, and feel that we are part of us, and so they do come back and let us know how their life is going.

Dr. Gilbert: I would answer that question two ways. First of all, we always tell the patient that they are going to need follow-up surgery, because quite frankly, they are. Our goal is to do as much surgery in one sitting as is possible, but we often need to do some touch-up or cosmetic surgery following

the initial, or big surgery. And for that reason, we get to follow them fairly far out. Secondly, as you may understand, we run a fairly conservative program, and we are very conservative about who we select to operate on, so that we are very confident before we start to operate that these patients are going to be happy with their new genitalia. We know they're happy in their new lifestyle, because we follow them closely. We know that they're happy, having made the adjustment. All that needs to be done is the genital surgery. And when it comes down to that, yes, it makes it easy to predict that patients are going to be happy after surgery and follow-up. I've never had a patient say to me, "Boy, did I make a mistake. I wish I had never started this." And this comes from being very careful about who we select.

CQ: How many people do require revision surgery?

Dr. Gilbert: I've looked at that. I would say that of the patients who require revision, approximately 80% are fixed up with one revision surgery.

CQ: Are the insurance companies loosening up? Is it getting any better? Are they willing to not claim that reassignment surgery is cosmetic, to not claim that it is experimental? Lisa pointed out yesterday that insurance companies are always on the move. Are they on the move in the right direction, or the wrong direction?

Lisa: Any time they can get out of paying money, I feel that they will. We've had some insurance companies that have been wonderful and have not fought us tooth and nail. They've been very supportive of the person carrying the plan. I don't know enough about insurance companies to tell how they feel politically. I guess it would just depend on the individual insurance company. Those who are out to make money are not going to be supportive.

Dr. Gilbert: I would substantiate what Lisa has just said. I think that the insurance companies will try to hold onto their money for as long as they can, particularly in these tight-fisted times. It seems to me that every time we hear of a patient who has been approved for surgery by some insurance company, we get another patient that has been denied. It's a constant battle, a constant tug-of-war.

CQ: One peripheral issue we wanted to question you about is in regard to illicit silicone injections. We feel that it is a very serious issue. We are aware that a number of patients withhold information from doctors. What would you have to say to patients who are contemplating silicone injections, as far as to the fact that they think that they can fool you? What would you like to say to them?

Dr. Gilbert: I'm strongly against silicone injections. I think it's bad medicine, and I think it's terrible for patients to go through this. I have seen disastrous results from breast injections of silicone, with extensive operations required to correct the problem. They were very deformed after the surgery. I would actively dissuade patients from getting silicone.

CQ: You're a board-certified plastic surgeon. Would you like to elaborate on the ancillary procedures that you perform in relation to gender dysphoria?

Dr. Gilbert: I'd be happy to. We do a lot of aesthetic surgery on the gender patients, as well. You asked me earlier about imaging, and it brought to mind that we are using much more imaging with the facial cosmetic surgery— facial feminization, reducing the brow bone, reducing the chin, reducing the size of the jaw in the male-to-females. Those are things that we're doing now. We do a lot of rhinoplasty and tracheal shaves, otoplasty, which is ear-pinning, and even face lifts, and blepharoplasties, of course. These are all areas our program is particularly interested in. We do a lot of chest wall reconstructions on the female-to-male patients— breast reductions, chest wall reconstructions— and we do a lot of breast augmentation on the male-to-female patients.

CQ: What about the newer pectoral implants and the gluteal implants and the calf implants? Implants for men. Are these procedures you've had much experience with?

Dr. Gilbert: We've had experience with the calf implants and the pectoral implants. Particularly, I think, the pectoral implants have a place in some of the patients who are having their breasts reduced and getting chest wall reconstruction, either at the time of the breast reduction, or because they have some kind of complication or deformity from a prior chest wall surgery. I've stated that I have a particular interest in this area. I see a lot of patients who are scarred by surgery— mastectomy and chest wall reconstruction. I think that pectoral implants have a particular role in this area.

CQ: How about surgery for the male voice?

Dr. Gilbert: I don't do any voice surgery, per se. I work with an otolaryngologist who does some voice training, and he does do some voice surgery. Of course, it's much easier to deepen the voice than it is to elevate it. There are some surgeons who claim that they can elevate the voice, but they are very secretive about their methods.

CQ: Sex reassignment surgery has been called experimental in nature. In your opinion, is it experimental in a medical sense? In a social sense? Does it differ for male-to-female and female-to-male patients?

Dr. Gilbert: I do not believe that sex reassignment surgery is experimental in any way, shape, or form. The surgical procedures that have been developed and that are carried out for sex reassignment surgeries have undergone a long developmental process. The improvements in our techniques occur one stage at a time and are based on scientific hypotheses and facts. Most sex reassignment surgery is merely an adaptation of surgery that has already been developed for other medical problems.

In a social sense, I do not believe that sex reassignment surgery is experimental, either. Because of our high standards, we believe that all of our patients who are approved for surgery will be successful in their new gender role, no matter how the surgery turns out. In fact, it is very important to operate only on people who have totally adapted their lives to their new gender, rather than on those who hope that the surgery will convert their lives to the new gender.

There are some differences in male-to-female and female-to-male patients in a social sense. It appears to our committee that the male-to-female patients initially have a much more difficult time in adapting themselves to their new persona in society. However, postoperatively, we have found the same satisfaction in both groups of patients. ♀♂

commentary . . .

Kim Stuart is a journalist and the author of The Uninvited Dilemma. *Please contact her via AEGIS for permission to reprint.*

Transsexuals and Civil Rights

by Kim Elizabeth Stuart

The question of genetic gender with respect to transsexuals is one that does not seem to go away. The question is raised on all of the talk shows about transsexualism, it is the watermark for participation in Olympic sporting events, and it is the argument most often used to deny transsexuals civil rights.

Many states do not allow for changes of gender designation, even when transsexuals have had their genitals surgically altered so that they can function sexually as well as socially in gender roles opposite to those they were assigned at birth. Transsexuals born in those states are prevented from participating in society in their gender roles of choice.

Marriage is a prime and fundamental example of the denial of civil and human rights to those transsexuals. No state in this country allows persons of the same gender to become legally married. If a transsexual who has not had his or her birth certificate altered after surgery gets married, he or she could have any normally legal inheritance denied, or could have protections disallowed that laws usually grant to spouses.

Transsexuals who have completed sex reassignment surgery and cannot get their birth records legally changed run grave risks if they become entangled in the criminal justice system. They may well be put in jails or prisons with men if they have become females, or female prisons if they have become males. Many legal jurisdictions have the foresight to recognize the problems which would arise, but some do not care. It is hard to believe, but there are people who are so sadistic that they enjoy knowing about or seeing the suffering imposed on transsexuals by other prisoners— and guards as well, in some instances.

These two legal examples lead to the wider issue of social attitudes towards transsexuals. Most people do not understand transsexuality— nor, in most cases, do they want to understand it. The same curious questions have been asked on talk shows for more than a decade: "Is sex different as a woman than as a man?" "What does your family think" "Did you enjoy sex at all before..." "Why did you have children when you knew you would make them suffer?" "Were you gay?" "How can you be a woman if you can't have children?" or "How can you be a man if you can't father children?" "Are you a hermorphadite (sic)?" "God made you the way you are. You can't change that." On and on. These are probably legitimate questions born of curiosity, but they mostly reflect social attitudes about transsexuality.

I once saw a talk show where a very beautiful transsexual model from England was a guest. She had had sex reassignment surgery, but England does not allow changes in birth records. She was as beautiful as any woman I have ever seen.

Governments exist to protect the rights of minorities.

— Wendell Phillips

CQ's Quotations from the Literature

How have we in the medical profession responded to Hamburger's legitimate plea? Empathically, with compassion and understanding? Hardly. Instead, we have driven these individuals into the hands of unscrupulous men because we hate them and have treated them accordingly, with contempt and disdain.

— Baker, H.J. (Lt.). (1969). Transsexualism: Problems in Treatment. American Journal of Psychiatry, *125(10), 118-124.*

A peculiar wet feeling was gathering around my legs. I pressed the button again and again to scream for help. Thinking about detaching myself from the bed, I propped myself up on one arm, but then fainted and fell back. When I woke up, some ten or fifteen minutes later, the blood had made its way down the side of the bed to the floor. I was weaker, now, and the pain didn't matter. I was bleeding to death... Bending my head, I looked once more at the side of the bed, half-covered with my life's liquid. I couldn't help thinking now how ironic it was that I had worked and saved all this time to pay for my own death. I would be my own executioner.

— Canary Conn. (1974). Canary. *Los Angeles, CA: Nash Publishing Co., pp. 314-315.*

One young man stood up and said she was very attractive, but he wouldn't go in the same room with her because she had been a man. What he meant was: "I'm afraid of being near her because I might become sexually aroused by her, and I could never forgive myself if I had sexual relations with her because she was born a man." Psychologists call it the—Oh my God, Pa, I disgraced myself and was tricked into having sex with a homo—syndrome.

This young man's attitude needs to be taken seriously by transsexuals. It can't be written off by saying he's just another homophobic. This is reality in terms of most of society, and certainly with respect to those in power who make, judge, and enforce the laws of our country. The truth is that transsexuals have not been included in most of the civil rights legislation which grants rights and protections to homosexuals and other minorities. Transsexuals have lost case after case in the lower courts and in the appeals courts with respect to such matters as parental rights and job discrimination. Many of the official court opinions from appeals courts are in my files. I paint a rather grim picture, I'm afraid, but the reality is rather harsh.

Most transsexuals, long before they have surgery usually, realize that being a man or being a woman requires having a mind and a body that are compatible with each other. When they are not synchronized, nothing is ever quite right. Transsexuals are caught in between, with very little room to maneuver without creating pain and anxiety for themselves and for those they care about.

The fact that transsexuals want to renounce their genetic gender assignments is what seems to bother most people. This is primarily due to the fact that when transsexuals come forward, they are usually adults. They are making conscious decisions, as adults, with respect not only to their gender, but to their sexuality. This startling combination stirs the mud at the bottom, creating a direct challenge of society's perception of bipolar gender expectations and behavior. The desires and needs of transsexuals make these waters rather murky very quickly.

Religion and reality both contribute to and reinforce the confusion. The three major religions of the world, Judaism, Islam, and Christianity, encompass a large share of the world's population, and all of these religions have strong concepts and beliefs of bipolar gender roles and sexual behavior. While it is true that there are societies on this planet that have expanded definitions of gender roles, they constitute a very small portion of the world's population.

The reality is that it does require the egg of a female and the sperm of a male to create human life, and human beings have always placed a high value on fecundity to perpetuate the human race. It is probably instinctive; however, unlike other forms of life, our human minds have the ability to conceptualize and verbalize our feelings, even though the feelings may arise from instinct. As civilization took root, it was certainly a logical step for societies to form rather rigid rules concerning gender role behavior and sexual behavior within the context of gender roles. The obvious reality of the need for an egg to be joined by a seed to perpetuate life, reinforced by spiritual beliefs that this was manifest destiny determined by a higher order, led societies to lay out strict modes of gender role and sexual behavior.

Although homosexual behavior violates a longstanding taboo of culture, it has been tolerated in varying degrees by many societies throughout history. Recently, our culture has provided a modicum of civil and human rights to homosexuals. The homosexual community deserves most of the credit for these changes, for they have banded together and applied political pressure on government to demand their rights. Although our society is still not very accepting of homosexuality, it has grudgingly given ground as the pressures have increased. Homosexuals have been willing to stand up and stand together to achieve their goals.

Transsexuals are faced with a somewhat different situation. They do not necessarily desire to be different from the rest of society. They want, for the most part, to conform to long-standing gender role patterns. Although some transsexuals may be homosexual in their chosen gender roles, transsexuality revolves around the issue of being accepted as men and women in society.

(Continued on page 51)

There are no guarantees in this life. Surgeries commonly undergone by transsexual persons are certainly no exception. While careful selection of a surgeon minimizes the chance of negative outcome, there is always some risk involved.

We present for your amusement (as Rod Serling used to say) articles from two women, both of whom happen to be named Sarah. Both tell of what one (Seton) calls "polysurgical adventures." Sarah Shaker writes of her own experiences, which were uniformly positive, while Sarah Seton, who is a physician, gives us the story of Miriam, one of her patients, who truly wound up in "The Twilight Zone."

You shouldn't be overly worried by Sarah Seton's article, but by the same token, you also shouldn't be overly enthusiastic about Sarah Shaker's. The articles counterbalance each other by proving two extremes. The reality for most of us lies somewhere in the middle.

Dr. Sheila Kirk has been good enough to read both articles and to comment on them.

Tales From Two Sarahs

The Favorable and Unfavorable Result in Plastic Surgery

Sarah writes, "Please note that all names in this article have been changed to protect the guilty."

The Adventures of Miriam: A Gothic Tale of Horror

by Sarah Seton, M.D.

Introduction

The following case presentation concerns Miriam, a transsexual patient who saw me professionally last year. With her generous permission, I am writing this clinical letter under no pretense of general applicability. Miriam's story is anecdotal, but my experience suggests that her story, far from being unique, represents a composite of the average circumstances the transsexual patient faces when traversing the surgical gauntlet.

My focus here is not to discuss transsexualism per se, but rather to portray a cautionary tale to those contemplating surgery to reverse their primary and secondary sex characteristics. Furthermore, I want to send to my physician colleagues a message that the currently-accepted practice of transsexual diagnosis and treatment is at best inadequate, and at worst life-threatening.

Miriam's outcome is not inevitable, and I encourage transsexual persons to persevere in their quests for self-actualization. There are some good people out there on the horizon, so

On the Cutting Edge: Surgical Horizons

by Sarah Shaker

At the suggestion of friends and members of the AEGIS family, and having consulted with the surgeon and his staff, I am writing to share with you my experience with two surgical techniques that have assisted me in acquiring feminine aesthetics in "trouble areas" common for the transsexual— the voice and the hairline.

The story of my background perhaps reads similar to chapters of many of your own lives. I had placed my transition on hold until my early thirties, having undermined this vision from earliest childhood in favor of a staid, unchallenging lifestyle in the Midwest. My departure for California in 1983 broke this mold, a decision that enabled me to sever ties with my morally conservative background (another Catholic in search of her true self), and to follow the dictates of my conscience. By this time, having begun with cyclic female hormones, it became apparent to me that a natural, realistic overall female aesthetic would not be achieved merely by altering the endocrine system. The human body matures to its optimum by the mid-thirties, which is to say, my

keep looking for them, but beware that there are also people who do not wish you well, and could be looking out for you. To be forewarned is to be forearmed.

Clinical Background

Miriam is a 42-year-old male-to-female transsexual who is twelve years removed from surgical sex reassignment. She presents as an attractive, middle-aged woman, tall and slender, with auburn hair which complements her hazel eyes. Her husky voice is appropriately feminine, as is her dress and demeanor. She is alert, oriented, and very bright; her IQ on the Wechsler Adult Intelligence Scale—Revised tested at 150. Her affect is sad, with depressed mood and no lability. The mental status exam revealed no cognitive impairment or thought disorder.

Miriam had requested that the surgeon provide her with an innervated clitoris. She had also requested that he use the glans penis as a cervix. Both issues were discussed prior to surgery, and the surgeon agreed to include these reconstructions. As Miriam emerged from the euphoria of morphine, she discovered she had no clitoris, and in fact, the dorsal nerves had been cut...

Miriam endorsed mild paranoid ideation which was devoid of systematic delusions and clinically appropriate to her particular life circumstances. She reported longstanding anxiety concerning being discovered as transsexual, as well as a few persecutory thoughts that people would destroy her life if they found out. She lived a very private life, revealing her past to no one, until she was exposed recently by malicious persons at work. Stressors included being sexually harassed for six months in her work place (sexual slurs, innuendos, and malicious rumors on a large scale), as a result of which her personal and professional reputation in her community were destroyed. The slanders forced her to resign voluntarily when she found there was no managerial or legal recourse to the harassment. "Sadomasochism was not in my job description," she remarked. She thinks she is usually "read" by others as a transsexual when they hear her voice, and sometimes otherwise.

Miriam's biography revealed longstanding, intense gender cross-coding, and denial of her male genitalia from preschool onwards. In the face of her protestations, she was raised as a boy and not permitted to crossdress in public. Her upbringing was traumatic, with many episodes of rejection by her family, and abuse from peers and society, related to her cross-gender behavior. Although a gifted child, her talent was never recognized, due to emerging hopelessness about anyone helping her with the conflict between her gender identity and gender role. She had repeated bouts of childhood depression, resulting in cognitive and associative blunting or pseudo-dementia (Stanford-Binet IQ was 105 at age twelve). Along with frequent attempts at emasculating herself, there were two suicidal gestures in adolescence.

As Miriam got older, she emancipated herself from her family and sought out definitive medical help at age 23. Two major gender clinics evaluated and diagnosed her as a "classic" primary transsexual (verified by correspondence). Miriam was placed on chemically castrating doses of estrogens with good response, and consequently was disowned by her family as she proceeded with the "real-life test." In therapy, she was helped to understand that she could no longer live by other people's expectations, but rather, must save her own life. The longer she was on hormones, the less her gender dysphoria was a problem, and the happier she became, feeling that she was finally living in her correct gender role.

It is beyond the scope of this paper to review all the interesting psychosocial aspects of Miriam's life. Her ability to survive a lifetime of severe stressors is impressive, and speaks to her innate ego strength, for certainly lesser people would have decompensated. When asked to describe herself in one sentence, she replied, "I'm a survivor."

My clinical impression of Miriam is one of an intellectually gifted, emotionally honest, and direct woman who continues to recover from primary transsexuality with a possible underlying genetic component (see Miriam's Test Results). Her life has been complicated by prevailing traumatic stressors, with which she tried to cope adaptively to the best of her ability.

Clinical Vignette

Miriam had sex reassignment in 1980 under Dr. Waulon, a plastic surgeon who learned sex reassignment surgery as a former chief resident of the famous surgeon, Dr. Sanders. The standard penile-inversion technique with split-thickness skin graft was performed, without complication.

Miriam was ecstatic over this final confirmation of her female sex and gender, which she had bitterly fought for all of her life. She still celebrates the day of her surgery as her true birthday. However, it was to be the beginning of a twelve-year struggle with the surgical complications of sex reassignment.

Miriam had requested that the surgeon provide her with an innervated clitoris. She had also requested that he use the glans penis as a cervix. Both issues were discussed prior to surgery, and the surgeon agreed to include these reconstructions. As Miriam emerged from the euphoria of morphine, she discovered she had no clitoris, and in fact, the dorsal nerves had been cut; the glans also had not been used. When she asked, "Why didn't you give me a clitoris as you agreed, Dr. Waulon?" he pointed to her right labia and said, "See that little bump here? That is your clitoris."

Miriam was shocked that he would think she was so stupid. However, she thought so little of herself (being a stigmatized transsexual) that she felt she had no right to complain, and in fact, should be grateful to him for saving her life. She needed his medical support, and, after all, "Doctors know better than their patients; he probably had some complication that he couldn't avoid," she said to herself. Thinking discretion the better part of valor, she gave him the benefit of the doubt, meekly accepting her fate.

Dr. Waulon performed a rhinoplasty and thyroplasty during the same insurance hospitalization; both turned out very well.

Miriam pushed her luck further because her insurance agreed to pay for everything required in the reassignment as

medically necessary. Her receding hairline was the last obstacle to correct. Dr. Waulon performed a bilateral Juri scalp flap. This consists of mobilizing two pedicles of scalp from the temporal regions and swinging them into place above the forehead at the receding hairline. Although the blood supply is still attached proximally, each pedicle must be delayed in order to vascularize at the new transplant site; otherwise, the graft will not take.

Miriam's surgeon did not do this; he committed malpractice instead. The surgery did not turn out well at all; in fact, it was a disaster. When the bandages were removed, there was a strip of necrotic flesh extending from temple to temple about two inches wide. The wound was debrided, but did not heal, remaining as granulation tissue or "proud flesh," as the quaint old saying goes. She was discharged from the hospital for follow-up.

Miriam was furious: on that blunder, she could no longer give the surgeon the benefit of the doubt. She heard from a nurse at the hospital that shortly after he had performed the Juri flap procedure on Miriam, Dr. Waulon had had an epileptic seizure in the doctor's parking lot; he was diagnosed with a brain tumor and underwent brain surgery after she was discharged.

Astonished, Miriam went to a plastic surgeon at Harvard who gave her a concentrated solution of mercurochrome to apply thrice daily to her ""proud flesh," and six months later, it finally scarred down. She now wore a wig because of the ugly two-by-ten-inch scar across her forehead.

Miriam went to other plastic surgeons in town to get their opinion of what had happened toher. They all agreed, off the record, that it was clearly malpractice, but, "Hey! I still have to practice in this town!" No one would testify against her surgeon in court, so Miriam had to pay for correcting his mistake herself. While recovering from his brain surgery, Dr. Waulon offered to correct the error himself, but Miriam had had enough from his corner.

For the next three years, Miriam went far away to specialists in scalp reconstruction, Drs. Maynard and Johnson. She had a scar reduction, then a Z-plasty to move the scar to the top of her head,

For Clinicians Only

Miriam's Test Results

Miriam complained of sadness over the many issues she endured in her life. She met DSM III-R criteria for dysthymia Beck Depression Scale, however, was moderately severe at 29/63, and a valid MMPI-2 displayed the signature of post-traumatic stress disorder (T-Scores: D72, Hy58, Pd76, Pa100, Pt57, Sc72, Si61, and all others less than one standard deviation). In other words, Miriam endorsed significant (T > 2SD) depression, social alienation, persecutory ideas, and social avoidance on sub-scales (T-Scores PTSD-Keane = 64, PTSD-Schlenger = 60). Comparison with her valid MMPI recorded eight years earlier revealed dramatic increases in six of these variables from baseline over the intervening years (T-Scores: D59, Hy50, Pd55, Pa70, Pt48, Sc49, Si61). Note that a moderately high level of social introversion remained constant.

All other variables (T-Scores: Hs46, Mf39, Ma45) remained identical over the eight-year period and were less than one SD from the median. Miriam consistently endorsed more feminine items, with both tests reflecting no significant sex-role conflicts as a female over the eight-year period. Turning to the Mf sub-scales, Miriam's stereotypic feminine interests, denial of stereotypic masculine interests, and heterosexual discomfort-passivity were all less than one SD (T-Scores: Mf2(42), Mf3(49), Mf4(38)). Interestingly, she appeared to be significantly (T > 2SD) introspective and self-critical about her femininity, while being moderately (SD < T < 2SD) narcissistic, hypersensitive, and socially retiring (T-Scores: Mf1(64), Mf5(73), Mf6(58)).

The MCMI-2 was also consulted to clarify characterologic factors on Axis II. A valid profile revealed significant avoidant and self-defeating personality traits (BR-Scale 110 and 86, respectively). Surprisingly, Miriam did not endorse significant paranoid, borderline, narcissistic, dependent, passive-aggressive, or other traits (BR-Scores < 75). Although the MMPI and MCMI have somewhat different norms than DSM III-R diagnostic categories, one can look at the MMPI as a state description and the MCMI as a trait description. Thus, a state-trait profile indicates prominent situationally-driven, stressor-induced paranoia overlying a long-standing avoidance character disorder, perhaps from childhood.

Physical exam revealed Klinefelter's stigmata, but otherwise, Miriam was very healthy. Her arm span was 14.7 centimeters greater than her height, she had slight cubitus valgus, and eunuchoid body habitus. Her family physician reported hypogonadism and gynecomastia in adolescence.There was no evidence of Marfan's syndrome. I asked her whether she had ever had her chromosomes studied, and she said, "I asked them to do that at the gender clinic, but they responded with, 'What's the point'." Nevertheless, I ordered a cytogenetic analysis, which discovered a low-level 46,XY/47,XXY mosaicism; molecular Y probes revealed a weak signal for the TDF gene, close to normal females. The occurrence of both conditions seems unlikely in the same person and may be due to lab error; it is an intriguing finding. The last time I spoke with the genetic pathologist, her group was planning to submit an abstract on the finding at the next International Conference on Human Genetics. What became of that, I do not know.

After six months of intensive supportive psychotherapy, Miriam's depression subsided (Beck Score 10), and MMPI-2 depression, paranoia, and hysteria sub-scales were significantly reduced (T-Scores: D53, Hy47, Pa78).

As a result of her growing up within a society essentially antipathetical to her existence, Miriam suffers today from symptoms of post-traumatic stress disorder, and Axis II avoidant and self-defeating personality traits. Borderline/narcissistic or other character pathology, however, is not clinically impressive. ♀♂

then a further scar reduction. She lost even more of her scalp in these procedures, and as a result, the scar could not be removed completely because developing new scar tissue caused further scalp retraction. Next, extensive hair transplantation into the affected areas was resorted to, but in the end, Miriam ran out of donor sites. Where she once had had a full head of hair, Miriam's scalp now had a sparse piebald appearance. This was a blow to her self-esteem, and she became very depressed.

Today, Miriam's scalp looks like one of the moons orbiting Jupiter, and she will have to wear a hair prosthesis for the remainder of her days.

There were some good experiences during this early period. Miriam sought out Dr. Sanders, the famous reassignment surgeon who had trained her original surgeon, Dr. Waulon. He was very kind and understanding. Dr. Sanders reconstructed her labia and created a functionless clitoris. Miriam was very satisfied, and regained confidence enough to enter into a significant relationship with a man; this relationship lasted several years. However, because her nerves had been cut during reassignment surgery, she was never able to have an orgasm. She was grateful that she could at least give some satisfaction to her partner.

Many years passed, and Miriam grew into a well-adjusted woman within society. She had a bittersweet outlook on life, derived from sadness over the many poor surgical outcomes of her reassignment. But fate had even more suffering in store.

Miriam received a year of speech therapy as part of her transition process. She learned to modulate her habitual pitch into the upper registers of her melodic (baritone) range. She already had the phonation and intonation of a female. However, without visual cues, she was continuously confused as a man on the telephone. She always had to explain herself to the caller, sometimes without success.

After years of misidentification, she researched the medical journals for someone who could augment her vocal pitch. She found Dr. Parker, an otolaryngologist, who had developed an anterior commissurotomy and anastomosis procedure which artificially creates a laryngeal web on the vocal cords. The procedure raised the vocal pitch by shortening the cord's length, but since it involved surgery on the muscularis vocalis, the risk of permanent hoarseness was high. Wisely, Miriam canceled the day before the surgery, hoping that something more reliable would come along. She monitored the medical databases with her computer for years, waiting for someone to develop a better procedure.

As sometimes happens in a person's life, there occurred a coincidence of circumstance which provided, on the one hand, a window of opportunity, and, on the other hand, a pressing need for the opportunity. Miriam's voice problem became severe enough to cause her to be sexually harassed at work. Simultaneously, reports popped up on her computer of revolutionary laryngeal-framework phonosurgical techniques developed by Dr. Ishiki, which were being touted as voice-lift surgery. Miriam read avidly the original papers and was impressed by the fact that there was no risk of hoarseness because the surgery did not touch the vocal cords themselves, but rather relied on the cartilage supports to raise vocal pitch.

The procedures had a good track record, and Miriam was desperate. She flew to Holland, where Drs. Manning and Malisi performed a cricothyroid approximation under local anaesthesia. It worked— raising her pitch an octave! Miriam was ecstatic with her new mezzosoprano voice. She noticed an immediate change in the way strangers regarded her. No longer did their smiles turn into uncomfortable stares when she opened her mouth. Shopkeepers addressed her politely with "May I help you, ma'am?" instead of the usual "And what do you want?" She flew back to the States, confident that the crisis at work was over.

A month passed without people addressing her as "sir" on the telephone, and Miriam felt she had beaten the odds. The gods were watching, however; Miriam contracted a viral, then a bacterial, laryngitis, and her local ear, nose, and throat man, Dr. Copper, put her on voice rest and antibiotics for several weeks. For inexplicable reasons, her vocal pitch dropped to presurgical levels virtually overnight.

Panic-stricken, Miriam flew back to Holland. Dr. Manning evaluated her and could not explain the reversion. "We have had wonderful success with twelve patients prior to you," he said in his German accent. "This is the first time we have seen this happen." It was true, Miriam knew, since she had heard the before-and-after tapes of those voices prior to being operated on; she also knew that her surgeons were regarded as the leading experts besides Ishiki himself.

Drs. Manning and Malisi re-operated on Miriam free of charge. They failed to reverse the cricothyroid approximation, and, while Miriam was still on the table, they asked her if she would let them try one last procedure that just might work— an anterior commissural advancement. Miriam, lying there under local anaesthesia with her throat cut open, was desperate for a glimmer of hope. If she refused, she would have to face the lack of acceptance from society that had grown so intolerable to her— a lack of acceptance that would last for the rest of her life. If she accepted, might there be a merciful God who would look on her suffering with charity...?

Back in the U.S., Miriam looked at Dr. Copper with tears in her eyes." It didn't work," she said plaintively. "I'm going to be saddled with this albatross around my neck for as long as I live. I'm never going to get free of this stigma. After spending thousands of dollars of my own savings, all I've succeeded in doing is to create a nice big scar on my throat: I'm lucky I still can talk!" Dr. Copper, feeling a bit uncomfortable at the sight of any emotion, didn't quite know what to say to Miriam. He cleared his throat; for some reason, it had suddenly become awfully dry. "You know, I told you from the beginning that you should have gone to Dr. Bross; he was the chief I trained under while at the Carson Clinic. The clinic is very prestigious, and he is the best ENT surgeon in the country. He is quite familiar with laryngeal framework surgery, and I'm sure he could help you."

Praying silently for mercy, Miriam called the Carson Clinic and spoke with Dr. Bross. "You have had two previous surgeries that failed, but there is an outside chance that I can help you," he said over the line. "Dr. Manning is a highly respected surgeon, but I have a different technique that just might work. The most you could expect is a three-tone rise in pitch, however."

Miriam agonized over the decision, and talked it over with her psychiatrist

and friends. They all agreed that a three-tone rise was better than nothing, and if it didn't work, she would at least know she had done all that was humanly possible to help herself.

Hoping against hope, she flew to the Carson clinic for re-evaluation. Dr. Bross's speech team could find no reason why her voice had dropped, and by exclusion suggested multiple sclerosis or amyotrophic lateral sclerosis in the differential. The team decided to surgically examine the larynx and perform whatever adjustments they could.

When Miriam's thyroid cartilage was exposed, they discovered that the tantalum shims which Dr. Manning had used to advance the anterior flap and place tension on Miriam's vocal cords had embedded themselves in the cartilage itself. This plasticity effectively reversed the effect of the previous surgery.

Dr. Bross tried his approach, making a lever flap, but the tantalum shims were so well-incorporated in the cartilage that he could not finish the job without destroying the entire thyroid cartilage. The team closed, and Dr. Bross told Miriam that nothing more could be done.

Miriam's melodic range by that time was reduced from two-and-a-half octaves to less than one. Her habitual pitch remains in the upper baritone, and is almost an obligate monotone in modulation. Consequently, she continues to be "read" as a transsexual, with all the lack of rights and privileges applying thereto.

The past ten years had seemed to Miriam to involve more suffering than any one person could bear in a lifetime, and her heart was near breaking. She developed panic attacks with ischemic chest pains. Yet, life was not through destroying her dreams.

Miriam dutifully wore her stent dilator for many years. At about nine years post-op, her vagina became stenotic in spite of the dilator. Vaginal stenosis is the inevitable outcome of the penile-inversion technique using split-thickness skin grafts. The operative words are "skin graft." Many transsexual persons use estrogen for years prior to conversion surgery, and this reduces the size of the male genitals employed as donor tissue; consequently, in order to establish adequate vaginal depth, skin grafts from the thigh are taken for the neovagina. Unfortunately, the body looks at this tissue as a scar which must contract to the smallest possible area. Because Miriam had small male genitals to begin with, she was especially liable to this complication.

Contraction started within the fundus of the vagina. She began to get severe abdominal cramps when dilating; when the stent was out, she found blood spotting her pads. Her gynecologist, Dr. Scarponi, examined her pelvis and found granulation tissue. The stent was creating pressure sores similar to the decubitus ulcers bed-ridden patients get. Furthermore, the infrequent coitus Miriam engaged in became very painful and dyspareunia forced her to give up on sex altogether.

Once again, Miriam appealed to the famous surgeon, Dr. Sanders, who had helped her many years earlier. After eleven years, she was fed up with wearing the stent and wanted the "Rolls-Royce of vaginas," the rectosigmoid transfer. Dr. Sanders assured her that after six weeks of post-surgical stent dilation, she would be stent-free for the rest of her life. What he didn't tell her was that the squamo-columnar junction at the anastomosis of the rectosigmoid pedicle and the introitus was prone to stricture.

Miriam's surgery went well, and she was up and about after eight hospital days and two weeks of convalescence. She was very happy with the results. Depth was excellent, and secretions trickled off to zero. After six weeks of dilation, Miriam tapered off, but found her introitus growing tight pari passu. Dr. Sanders told her it was just vaginismus— involuntary spasm of the pelvic muscles. She went to Dr. Scarponi, who tested her for vaginismus and concluded she had a stricture on the pubo-coccygeus muscle. Dr. Sanders was skeptical, but told her she would have to dilate three times per week, indefinitely. In the meantime, dilation had become so painful to Miriam that she was unable to comply. Dr. Sanders nevertheless said he would evaluate her in six months and determine whether she would need yet another operation to widen the introitus. He planned on using a Huang Z-plasty flap on her remaining labia (the right labia was used up in the rectosigmoid operation).

If a physician has not dealt with his own subconscious insecurity and agendas regarding his own sex and gender, there is a risk of unprofessional conduct, even malpractice. For example, just as there are Freudian slips of the tongue, Freudian slips of the scalpel are not unheard of amongst surgeons, as Miriam's "clitorectomy" attests.

Miriam is a font of patience and tolerance for abuse, but this was beyond belief. Unsatisfied, she currently is negotiating with a female gynecologist/plastic surgeon, an expert in vulval reconstruction, outside the "transsexual empire."

As if all of this horror were not enough, Miriam's latest routine mammogram showed a 3-centimeter dysplastic mass in her right breast (upper-outer quadrant). Coned-down views confirmed the mass, and Miriam was recently sent for a lumpectomy. The surgical pathologist reported fibrocystic disease, a benign dysplasia which does not usually lead to carcinoma. Miriam is at risk for breast cancer because her mother died of metastatic breast cancer several years ago. Also, she quite possibly has Klinefelter's mosaicism. Finally, over nineteen years, she has been exposed to approximately 1100 milligram-months of estrogen and 395 milligram-months of progesterone. These are all risks. Miriam's most devout wish has always been to be a complete woman and to be free of the curse of transsexualism. Her final triumph may be to die eventually of a female disease.

Commentary

I think we can all agree that Miriam's is a tragic story of a gifted person of essentially sound body and mind entrapped in a life-long struggle for wholeness. My colleagues may point out an element of self-punishment in her polysurgical adventures. Yet by what criteria do we judge this? Does a patient who requires repeated coronary artery bypass surgeries seek self-punishment? What about a horribly burned child who must endure interminable— sometimes

heroic— reconstructive plastic surgeries before he is able to live some semblance of a normal life? Or the victim of genetic error who needs extensive skeletal reconstruction? Are these patients seeking self-punishment? Clearly not. They all have our sympathy and compassion because they are not whole people like ourselves, and we wish to make them whole. In Judeo-Christian medicine, we have a mission to make people whole. And yet, how is Miriam different? Her wholeness involves having a female body which corresponds to the female brain with which she was gifted. She is not narcissistic in demanding this. There is no difference between Miriam's desire for wholeness and somebody else's, except that one is socially sanctioned and the other is not. There is clearly a double standard here: Miriam is somehow "different" from the rest of us "normals" and so is deserving of much less consideration.

Miriam illustrates the extremes that an intelligent transsexual will go to become whole— to make it right. The reassignment was liberating and fulfilling to her; her IQ went up 45 points, and she achieved more in work and love than she ever had before the reassignment. Yet as a result of her odyssey, Miriam suffers from post-traumatic stress disorder today.

Considering her behavior in the context of professionally unrecognized gender-identity disorder of childhood, adult transsexualism, and intercurrent situationally-driven affective disorder, Miriam did what anyone would have done in order to survive. As a marginalized citizen, she was misunderstood, neglected, and even persecuted for being different. Instead of asking why she is punishing herself (which seems to assume there must be something wrong with her), it is more apropos to ask the question, "Why is all this suffering necessary in the first place?"without putting blame or guilt on anybody.

How do we minimize this needless suffering? There are no simple answers to this question, and no one person has the answer themselves. The answer lies within yourself and between ourselves.

Discussion: The State Of the Art of Transsexual Care

Although transsexualism has been long recognized by a handful of researchers, if it wasn't for caring physicians like Harry Benjamin and others, transsexuals would never have been treated, let alone taken seriously, by organized medicine. Nevertheless, physicians who have promoted the welfare of transsexual men and women have always been in the minority.

Amongst the more "legitimate" subspecialities, the professionals constituting the Harry Benjamin International Gender Dysphoria Association (HBIGDA) have always worried about their respectability. Their conferences frequently have had a paranoid flavor about them, especially when the press was involved (see note). By their emphasis on careful documentation, HBIGDA's Standards of Care mainly serve to protect the provider from litigation from the consumer. Until the 1990 revision, the Standards permitted providers to charge the consumer whatever the traffic would bear for reasonable and customary services (Standards of Care, 1990). The patient is not the center of attention for HBIGDA, but rather, defensive medicine is. A patient-centered customer service model needs incorporation into the HBIGDA Standards of Care.

Beyond its Standards, HBIGDA has done very little to advance the quality of life for transsexuals. Its attitude is reminiscent of the defunct gender clinics, which presented as research projects under the guise (i.e., with the appearance) of treatment centers. Without sensitivity to its patients, HBIGDA will be a dead organization. It will eventually be replaced by other professional organizations more responsive to patient concerns.

I have a high index of suspicion that my colleagues are not only ignorant about transsexualism, but replace their ignorance with a Biblical version of sex and gender. "God said it, I believe it, and the issue is closed." Physicians do not always make good scientists. In medical school, I was introduced to transsexualism in Human Sexuality and Psychiatry— generally considered a couple of filler courses to rest your brain on while gearing up to tackle the real medical subjects like pharmacology or surgery. In Human Sexuality, the lecturer presented three films about "transsexualism," which saved him the embarrassment of lecturing on the subject. The first was of a gynecomimic changing gender roles as he-she danced around on stage in a spotlight (catcalls). Next, a sensitive film about a Canadian male-to-female transsexual as she went through the transition (more catcalls, hisses and boos, gestures of disgust). Finally, they ran out of time and said they would show the last film during lunch. It was an "up-close and personal" depiction of an actual sex-reassignment surgery. Female medical students, such as myself, found it very interesting, but it became a macho thing for the males, who chomped on their sandwiches and cavalierly made a carnival out of the scene, as if to say, "We don't have castration anxiety!"

In the Psychiatry class, a prominent psychoanalyst lectured us that transsexuals were "sick," that their mothers were "sick," and that their whole families should be in interminable psychanalysis.

With all the hostile labeling, off-color jokes, and outright moral condemnation, it seemed to me sad that my fellow medical students would one day go forth into practice with this impression of transsexuals. How would they behave when the inevitable severely needy transsexual patient stopped at their doorstep to make a final appeal for medical help before the grave? With compassion and understanding, as our Hippocratic oath dictates? Or with scorn for human dignity and intolerance for human diversity?

Physicians are rapidly losing their professional status and becoming managers in corporate iatro-businesses. Medicine in the latter part of this century has made the gerund "to care" into a four-letter word, as in "managed care." In the case of providers of transsexual "care," one commits an error when the Will transcends the Understanding. If a physician has not dealt with his own subconscious insecurity and agendas regarding his own sex and gender, there is a risk of unprofessional conduct, even malpractice. For example, just as there are Freudian slips of the tongue, Freudian slips of the scalpel are not unheard of amongst surgeons, as Miriam's "clitorectomy" attests.

Transsexualism is a challenge to medical science, the understanding of which has helped to motivate the advancement of sexual neuroscience in general. Quality care for the transsexual will not improve until physicians educate themselves in compassionate diagnosis and treatment and deal with their own gender insecurities so as not to inflict their hidden agendas on their patients. If they cannot do this, they should get out of the field before they hurt someone.

The latest outcome studies of sex reassignment indicate that in properly screened candidates, the adequacy of surgery itself plays a critical role in the postsurgical adjustment of the transsexual (Blanchard & Steiner, 1990). Miriam's lack of surgical success has been the major factor frustrating her successful rehabilitation. One of the most important predictors of success is the ability to match targeted male or female sex stereotypes. Being gifted by birth with such a body is simply a matter of luck. Cosmetic surgery to feminize a masculine body habitus becomes a near necessity for many male-to-female transsexuals. They have not asked to be born in a male body, nor have they wanted to be poisoned by pubertal testosterone. The same applies to female-to-male patients mutadis mutandis. Since society does not legitimize their intersexed condition, the most transsexuals can do for themselves is damage control. It should not seem surprising that transsexuals would want to change physical stigmata which decrease their fitness to survive in the jungles of society. With that said, nevertheless, there are important points that must be made clear to transsexuals when embarking upon surgical damage control.

First, surgery is a Faustian bargain. There never is a case where you don't give up something in exchange for what you seek. You must give up something to get something, and, in both the giving and the getting, there are inevitable risk-versus-benefit trade-offs. In assessing a future surgery, make two columns and label them, "What I want," and "What I am giving up." Split these columns into two columns each and label them, respectively, "risks" and "benefits." If you have done your research well, you are ready to list the facts under the four columns. To help you weigh the factors, add an index to each risk and benefit, rating their likelihood of occurrence on a scale from one to ten. If you have trouble, you have not broken down each factor far enough; continue to analyze the factor into its simple components until you arrive at a set that can clearly be ranked. Sum up the rankings and divide by the total number of factors in each column to give the probability of risks and benefits. Subtract the risk from the benefits, and you will have the weights of what you are giving up balancing what you are gaining.

First, surgery is a Faustian bargain. There never is a case where you don't give up something in exchange for what you seek. You must give up something to get something, and, in both the giving and the getting, there are inevitable risk-versus-benefit trade-offs.

With sex reassignment, no amount of plastic surgery will make up for the fact that you were born in the wrong body. The most that can be hoped for is an approximation to gender norms. Where you draw the line depends upon how desperate you are, what you are willing to give up, and how extensive the defects you want to correct. There are inevitable compromises and complications. Miriam, an example of a desperate transsexual, is an object lesson in how bad complications can get. But she, like most transsexuals, wanted her body and gender role to reflect as much as possible the inner sense of her own femininity and female gender identity (cf Money's 1988 global-model of Gender-Identity/Role).

In one recent series of 65 patients (Ross & Walters, 1986), rectal perforation, rectovaginal fistulae, hemorrhagic diathesis, neovaginal prolapse, and neovaginal necrosis had an incidence rate between one and nine percent each. Other complications included urethral and vaginal stricture, vesicovaginal fistulae, prominent urethral bulb erectile tissue around the meatus, lack of a functioning clitoris (or none at all), vaginal stenosis, atrophy and scarring, vaginismus, and dyspareunia. The number of secondary surgical procedures (n=23), including vaginal lengthening, urethral repositioning, urethral bulb reduction, labial reduction, and posterior skin fold revision, ranged between four and twenty-one percent. When you add into the mix nosocomial and iatrogenic causes, the statistics are probably much higher.

The complications of taking sex steroids have been sufficiently addressed elsewhere (Kirk, 1991). For male-to-female transsexuals, thrombo-phlebitis and prolactinemia are the main concerns, along with risks of pulmonary embolism, lower extremity vein disease, and pituitary tumor. Amongst female-to-male transsexuals, androgens elevate the lipid profile, with resultant risk of atherosclerosis, stroke, and heart attack.

Breast cancer is a long-term complication of taking hormones; there are three cases of breast cancer in 30-to-35-year-old male-to-female transsexuals reported in the literature (Pritchard, et al., 1988). Family history of breast cancer, Klinefelter's syndrome, and prolonged high doses of estrogen (all of which Miriam had) are inconclusively linked as risk factors. Doses in the range of 150 milligram-months (as little as 1.25 mg/day of Premarin over five to ten years) have been implicated in the three cases cited above. Contrary to what is generally believed, the transsexual's breast is not clinical gynecomastia; in the three cases cited, their tissues were histopathologically identical to "genetic" female breast tissue. Hence, transsexuals should regard their breasts as normal female breasts with estrogen and progesterone receptors which, when overstimulated, can transform breast tissue into cancer.

Many transsexuals eat hormones like candy; you should know that more is not better with regard to sex hormones. High serum levels of sex hormones saturate sex hormone binding globulins and cellular receptor proteins so that after a certain level, they not only contribute nothing to feminization, but create a chemical hepatitis as the liver strains to metabolize the excess. In other words, small doses of estrogens over longer periods of time are more effective than mega-dose boluses, which your body simply deactivates and you flush down the toilet. I urge all male-to-female transsexuals to

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secondary male characteristics at age 33 were more pronounced than they were while in my teens and early twenties. Realizing that I had quite a lot to accomplish, and with limited financial resources, I promised myself to budget and sacrifice in order to achieve one important surgery a year (all the while fighting a robust beard line of Mediterranean lineage with electrolysis) until, in my mind's eye, my female self would be reflecting back at me by the end of the decade. (As I suddenly recall, it was a similar instant in time when, at age 4 1/2, I was standing with my next youngest sister, age 2, in front of my mother's full-length mirror, reflecting back her image as my own.)

By doing without car, insurance, extensive wardrobe, and other trappings of a yuppie lifestyle, I was able to finance, by 1983, annual surgeries that altered my nose, eyes, forehead/browbone, jaw, and chin. By 1985, I was planning to have a hairline surgery the following year. How I chose my surgeon is discussed below.

It had always been my style to research surgical procedures in medical libraries such as those of the University of California at San Francisco and the University of Cincinnati Medical Center. Over the years, I had followed the professional writings of Toby Mayer, M.D. and Richard Fleming, M.D., concerning their work with restoring hairlines using advanced surgical techniques. I favored them in this specialized area because their literature was the most thorough on the subject, their practice the most prolific, they critiqued journal offerings by other surgeons, and because up until the time I visited them in 1986, theirs were the only up-close, resolute photographs of successfully restored hairlines offered in the journals.

When I first met Dr. Mayer in his office in Beverly Hills in the Fall of 1985, I was still planning the hairline procedure for 1986; however, we soon broached the subject of voice pitch. I had told him that I was one of the unfortunate ones— even with speech therapy and my most vigilant efforts, I could not bring my baritone voice up to a reasonable female pitch. At best, I ended up with a falsetto, at times quite unearthly to the ears. It was to my complete surprise that Dr. Mayer said he could remedy it surgically. He explained to me that the vocal surgery he performed was an experimental procedure, not yet discussed in the medical journals, but the vocal chords themselves were not tampered with. (I had remembered years earlier that Dr. Paul at UC Davis Medical Center in the Sacramento area had attempted to raise the pitch of several transsexuals by shortening their vocal chords surgically. The patients did not benefit from the procedure. Actually, some were the worse for it, according to the discussion portion of Dr. Paul's journal writings.) At my request, Dr. Mayer presented me with an example of one of the results of his work. He brought in a cassette tape player and played back the voice of one of his patients who had recently undergone the procedure. I was truly amazed, because the quality of her voice seemed to be more natural than even the most successful of my T.S. friends who were able to produce a female pitch with or without speech therapy.

I traveled back to Beverly Hills in 1986 to have the vocal surgery performed. The operation was to be performed under local anaesthesia. was placed on an operating table, fully relaxed and aware of the proceedings. Since the small incision was to be made at the position of the thyroid cartilage (Adam's Apple), we had agreed that he would remedy that protrusion with a surgical shave before entering behind the cartilage to perform the actual vocal surgery. After that procedure, he began working with other cartilage and minute tissues. He then requested that I use my natural male voice and count down from 100 so that he could begin the pitching of my voice. (Utilizing the natural pitch prior to surgical intervention produces the best results.) I felt a sensation in my neck similar to what one feels when tugging at shoe laces before they are tied. For lack of precise medical terminology, I believe he was adjusting the structure through which vibrations from the vocal chords pass. (Again, I stress that Dr. Mayer does not tamper with the vocal chords themselves, as such has been shown to produce unfavorable results.) As he was handily manipulating sutures, he was also simultaneously setting temporary female vocal pitches for me to listen to. By the time I had counted down to 95, Voila!— the first pitch. Could this be me? I hadn't even remotely approached this pitch before, even on my best practice days. It sounded very good to me. Continuing the countdown, he tugged once again and the results— another pitch. The second offering did not please me as much; the voice sounded too high for my 5'9", 150 lb. frame. That was it for my vocal ranges. (Dr. Mayer explained to me later that one has perhaps two or three quality vocal pitches to choose from.) We played with both pitches again, this time relying on the doctor and attending nurse to give their own opinions. We reached agreement that the first (and lower) of the two sounded more natural for me. He "sutured the pitch in place."

By the time I had counted down to 95, Voila!— the first pitch. Could this be me? I hadn't even remotely approached this pitch before, even on my best practice days.

I was escorted off the operating room table after little more than an hour of surgery. There were no problems with imbalance or nausea, because the surgery had been done with local anaesthesia. With a wrapping around my throat, I was advised to limit rotation and other movements of the neck, and to try and maintain a stationary position. The voice sounded wonderful; I couldn't believe the sound was coming from me. Dr. Mayer then advised me that some minor swelling of the neck tissues would begin and therefore not to worry should a hoarseness develop in my voice— it would only be temporary. He went on to tell me that swelling occurs naturally after surgery and, depending on the patient, will subside with time. (This I could relate to; I remember all too well the swelling that set in after my rhinoplasty.) A hoarseness and "lump""in my throat did set in shortly after the surgery, but gradually, after a few weeks, the swelling disappeared and I was left with a clear, unmistakable female voice. Moreover, the hairline incision, placed in a natural crease in the neck, was virtually undetectable. (For some patients having this procedure, the incision line completely disappears.)

With time, inflection in the voice continued to improve, and within a year I was able to naturally sing in a female range. My female pitch has not changed in five years, and the range remains at a fine level. The complete cost of the surgery, at the time, was $2,200.00. I'm sure that it is more than double that now, five years later. However, at the time it was identified as an experimental surgery and I was one of Dr. Mayer's first patients. For what it has given me, a lifetime release from the worry of being "read" because of my voice, I would gladly pay today's price for the procedure if I needed it.

Both Dr. Mayer and Dr. Fleming perform the vocal surgery procedure. Although they have had a high success rate with it, in all fairness to this discussion, individuals in poor physical health or advanced age do not produce the best results. Heavy smokers seem to be particularly at risk of poor results; some may not experience a change at all in their pitch. I think I recall Dr. Mayer saying that heavy smoking produces a structural change in the cartilage throughout the neck area which compromises the intended effect of this procedure.

In 1987, I obtained my sex reassignment surgery at Stanford. The following year was devoted to cosmetic follow-ups of the operation. It was then, in 1989, that the hairline procedure I had planned for several years ago finally became a reality. That summer, in his office, Dr. Mayer studied my head and scalp, took measurements, and concluded that my high forehead and receded hairline at the temples could best be remedied using a new technique. Tissue expanders placed under the scalp, he said, would gradually expand the hair-bearing scalp adjacent to the bald area. Once the measured expansion was complete, then, in the second part of a two-step operation, the expander (or expanders) would be removed and the slack in the hair-bearing tissue brought down and over to fill over the bald area.

The use of tissue expanders had been developed and used originally to aid surgeons in repairing tissue lost from severe burns, while producing a much better match of skin texture and coloring. Healthy tissue, adjacent to the burn, would be expanded and then, with the resulting slack, brought over to cover the burned area. This is vastly superior to the previous method of harvesting tissue from another area of the body (which did not allow for a perfect match) while producing a "donor scar" in the area where it had been excised.

A month later, I flew down from San Francisco to Beverly Hills to have the operation. We decided upon expanding the crown of the head to bring down the frontal hairline this year (1989), with closing in the temple regions with bilateral expanders scheduled for the following year. Dr. Mayer reasoned that too many surgical incisions and expansions in one operation could subject the scalp to possible trauma and the interruption of adequate blood supply. The loss or sloughing of scalp and hair for the sake of saving a little time and money would be asking the surgeon to abandon safe and responsible surgical procedures— a severe price to pay.

Under local anesthesia, Dr. Mayer inserted the tissue expander.

I can best describe a tissue expander as a very thick-membraned type of balloon— a device that is custom-built and shaped for the surgeon and the nature of his operative technique. The expander is fitted with a valve and tube through which bacteriostatic saline solution is injected with needle and syringe. The fluid flows through the tube and into the expander, in order to fill it to a desired level. Depending on the desired expansion of the scalp (100-250 cc is a common range), saline solution is injected in amounts of about 30-40 cc a week over the course of four to six weeks.

I was on the operating table for less than an hour, and the expander with its valve/tube assembly was placed under my scalp. I was assisted off the table and, once again, as with the voice surgery, I was able to walk unassisted. I was given oral medication to prevent infection and suppress swelling and, per the doctor's instructions, stayed overnight at a motel nearby. (It is the policy of the offices of Drs. Fleming and Mayer that when a patient is required to stay over in the area, a call is placed to the patient that evening to check to see if everything is O.K.)

The next day, I visited Dr. Mayer's office for a medical follow-up. Everything was fine at this point, so I was given permission to return to San Francisco.

With instructions in hand; I contacted medical personnel here in San Francisco to assist me in gradually filling up and thus expanding the tissue expander underneath my scalp. After five weeks, I had had about 180 cc of saline solution injected into the expander. Certainly, it made for a rather funny-looking appearance on my part, sort of a "junior conehead" look, but I prevailed over my mixed emotions, realizing that this temporary, "swelled head" appearance, which I covered successfully by wearing turbans of different colors, would lead to a natural-looking, feminine hairline.

I returned to Beverly Hills after five weeks for the scheduled removal of the tissue expander and the surgical replacement of my hairline. Under general anaesthesia, Dr. Mayer operated for perhaps two or three hours to remove the tissue expander and perform the replacement of my frontal hairline, which he was easily able to bring down about an inch-and-a-half, while leaving me with adequate looseness in the scalp (it having been too tight to begin with). I stayed overnight in the same motel. Dr. Mayer checked me over the next day, removed the bandaging around the head, prescribed medication, and I was on my way back to San Francisco later the same day.

Surgical placement of tissue expanders has become the technique of choice in producing the most cosmetically acceptable hairlines. As with the reconstruction of tissue lost by burn victims, the tissue match using this technique is far superior to previous techniques. There is an added benefit, though. Tissue expanders stretch the already-existing hairline, maintaining the texture and growth pattern, without sacrificing any appreciable loss of the density of hair growth in the region. Another method widely used, rotating flaps of hair-bearing scalp from the sides and back of the head, produces a hairline too thick and abrupt (without

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Reviews

Transvestites: The Erotic Urge to Cross-Dress

By Magnus Hirschfeld

Review by Jennifer [redacted]

 Translated from the German by Michael A. Lombardi-Nash. Preface by Vern Bullough, Ph.D. Available for $40.45 postpaid from IFGE, Box 367, Wayland, MA 01778.

Rating:

For many years, *Die Transvestiten* by Magnus Hirschfeld stood as one of the leading texts in the field of gender identity disorders. Unfortunately, the lack of an English translation left it accessible only to those with a knowledge of German. This is no longer a problem, for this important work is now available to all.

Transvestites: The Erotic Drive to Cross-Dress, translated by Michael A. Lombardi-Nash, and published by Prometheus Books, provides both professional and lay readers access to a book that has been cited by many writers since it was originally written in 1910. Since the book covers a very broad range of topics, the translation is a very important event for the gender community as a whole, not just those commonly labeled transvestites.

Magnus Hirschfeld led an interesting life— one which had a profound impact on the social sciences' view of gender and sexual orientation. He was born in 1868 in Kolberg, Germany. Even though his father and grandfather had both been respected physicians, Hirschfeld first chose to study philosophy. Later, family pressure led to his pursuing a medical degree at the University of Strasbourg. Upon graduation, he went into research. Hirschfeld is believed to have been gay, and perhaps a cross-dresser.

In 1865, Hirschfeld published his first book on sexuality, *Socrates and Sappho*, using a pseudonym. *Socrates and Sappho* was a sympathetic look at homosexuality. Hirschfeld chose to study sexual orientation following the suicide of a young military officer on his wedding night. The officer had left Hirschfeld his confession.

In *Socrates and Sappho*, Hirschfeld proposed that sexual orientation was congenital, and therefore immutable. This was a bold step at the time. Even today, this question is still debated by the medical profession, although there is increasing evidence to prove Hirschfeld right.

After he developed this new theory, Hirschfeld went on to found the Humanitarian Scientific Society, which helped people who had come into conflict with certain scientific and social prejudices of the day. This was perhaps the first support group of its kind in modern history. Eventually, the society evolved into the Institute of Sexual Science, which studied anything pertaining to sexual activity. The Institute carried out its research until 1933. While Hirschfeld was abroad on a lecture tour, a Nazi mob descended on the Institute and searched the building. They carried away numerous volumes from its library, as well as research and patient records, some of which may have involved high-ranking Nazi officials. These were destroyed. It was a truly great loss to humanity, as well as to history.

Transvestites is a very thorough book which looks at the phenomenon of cross-dressing from a number of viewpoints. Not only does it examine the diagnosis and etiology of crossdressing; it deals with its historical and social significance as well. Few authors have taken as close a look at this subject as Hirschfeld.

It is important to remember that Hirschfeld wrote at a time when the knowledge of human biology was far less than we have today. In his day, nothing could be done for the true transsexual. Many were permanently committed to asylums for the insane, since they could not be dissuaded from their convictions that their bodies were in error.

The book is divided into three main sections. The first presents 17 cases that range from classic crossdressers to obvious transsexuals. There is no logical order to the cases, so it is left to the reader to draw his or her own conclusions as to the significance of each case. The next section deals with the differential diagnosis of transvestism. Again, it must be remembered that Hirschfeld wrote at a time when transsexualism had not been recognized as a distinct condition– a state that would continue until the 1950s. The first article written in a medical journal about Christine Jorgensen described her condition as transvestism.

The final section of the book deals with the ethnology and history of transvestism. In this section, one finds an interesting collection of chapters ranging from transvestism of children to women as soldiers. The subject is looked at both from a historical perspective, and from a social one. Both the tragic and humorous are seen here. In one chapter, Hirschfeld looks at suicides of cross-dressers. Another chapter is titled "Comedy and Transvestism." There is a wealth of information for those who wish to know more about the history of crossdressing and transsexualism.

Overall, this is a fascinating book. I wish to emphasize that the title is misleading. Many of the people whose stories are told here were transsexuals or transgenderists. Perhaps the book's most important contribution is that it lays to rest the idea that transsexualism is a relatively new condition. I once read an article in which a doctor claimed that transsexualism was a cure in search of a disease— i.e., that there were no transsexuals before there was sex reassignment surgery. He went on to say that before Christine Jorgensen's case became public, no one wanted to change sex. This book proves that idea wrong.

The book is not without some faults. Because it is a translation and because it was written in a time that few of us have intimate knowledge of, it can be difficult to read. Some of the terms (e.g. succubus, uranian) are archaic and have lost their meaning for contemporary readers. The translator Michael Lombardi-Nash, has included footnotes that define terms the average reader might not be familiar with, but more would be welcome.

Of course, as the book was written more than 80 years ago, some of the chapters are completely out of date if you are looking for current information. For example, I would not advise looking to the chapter on "Transvestism and the Law" except for historical purposes.

I would highly recommend *Trans-vestites* to all serious students of transsexualism, transvestism, and other gender disorders, for it is often cited by others, and provides an interesting insight into the history of those who have these conditions. I find it comforting to know that transsexualism has been around throughout history, even if it is only in recent years that medicine has learned to deal with it. ♀♂

Magnus Hirschfeld
Gay Emancipation and Nazi Persecution in Germany
by Walter [redacted]

"I believe in Science, and I am convinced that Science, and above all the Natural Sciences, must bring to mankind not only truth, but with truth, justice, liberty, and peace for all. That that day may come soon... is my hope and desire."

These words were written in 1933 by the renowned sexologist Dr. Magnus Hirschfeld, exiled in southern France from his native Germany. The Nazis had imposed his exile for the crimes of being Jewish, gay, and an early advocate of gay and lesbian rights. In 1935, Hirschfeld died, but much of his research on sexual behavior and ideas on human rights have survived. To his honor, modern studies by Kinsey and Masters and Johnson are reflections of his pioneering work. The examination of divergent sexual behavior in a non-judgmental, scientific manner was an effort of enlightenment.

Hirschfeld was born in Kilberg, Germany, in 1868. Both his father and grandfather had been respected medical doctors. Naturally, when the time came for Hirschfeld to go to University, he chose to study philosophy. Family pressure later persuaded him to complete a medical degree at the University of Strasberg.

Upon completing medical school, research beckoned. Again the traditional path was followed, and a paper on "Influenza and its Pathological Effects on the Nervous System" was published. However, as early as 1895, Hirschfeld's first book on sexuality appeared. It was written under a pseudonym and entitled *Socrates and Sappho*. Why the change in research direction? Hirschfeld explains that not only were the well-publicized homosexual exploits of Oscar Wilde circulating in the German press, but on a personal level, tragedy struck. "I was moved to write *Socrates and Sappho* by the suicide of a young officer, one of my patients, who shot himself on the night he married, and left me his confession." We all know what the young officer confessed.

Deeply troubled, Magnus Hirschfeld proceeded to go beyond the tragedy and investigate sexual orientation, or The Love That Dared Not Speak Its Name. Also, the research must have sprung from a well of personal introspection: Hirschfeld himself was gay.

The pamphlet *Socrates and Sappho* concluded that objects exerting erotic attraction upon humans are determined by the specific sexual constitution of the individual, and that this is congenital and immutable. In other words, lust is not demonic possession or premeditated sin; attraction is due to some combination of internal forces that individuals develop from the beginning, and is unchangeable. What do you think? That is one question still being debated by sex researchers today. However, one consequence of such a theory back in 1895— yes, 1895— was to give human beings an equal standing in sexual orientation. Hirschfeld essentially said, you want what you want because you want it; what can you do?

The new theory had implications for sexual people, period: straight, gay, lesbians— whomever.

The next step for an impetuous, inquisitive young German doctor with a new theory was to form an institute. In 1887, Hirschfeld established the Humanitarian Scientific Society, the object of which was to help people who had come into conflict with certain social and scientific prejudices of the day. This was the first attempt at helping people adjust to their sexuality in a positive, supportive way. The society evolved over 25 years into the respected Institute of Sexual Science in Berlin.

The intervening years saw not only significant sexual research being done by Hirschfeld. Due to research findings, social and political pressure was brought to decriminalize homosexuality in Germany.

At the Institute, anything pertaining to sexual activity was open to study. Findings were published in the Annals of Sexual Intermediacy. One can still obtain copies of this journal in libraries today and read about what Germans were up to in the bedrooms

and other places during the early 1900s. The surprise in reading these materials is not the range of sexual diversity. After all, *Socrates and Sappho* could have told us that. It took Magnus Hirschfeld to verify diversity through detailed records and statistics.

The early years saw amazing growth in the Institute. Symposiums were sponsored for medical doctors from all over the world. The library contained over 6,000 books related to case studies. Politicians cited the Institute's work to support legislation.

The Institute's focus of political action in the 1920s was directed against the German sodomy law, known simply as Paragraph 175. Paragraph 175 originally forbade male intercourse with other males.

Because of Hirschfeld's scientifically based research, many of the myths and misconceptions about homosexuality were destroyed. Liberal politicians and social advocates presented legislation to decriminalize consensual sexual acts between males in an effort to remove the German government from the privacy of the bedroom. Does this sound familiar? What happened? The Nazis.

With the arrival of the Nazis to power, Paragraph 175 became more than an exclusionary law; it became another means of oppression. Under the Nazis, the law was expanded to cover lesbians and all "inappropriate sexual behavior between same sex partners." The law went further. Expression of sexuality was broadened to include "suggestive" touching and staring. People were actually being arrested for being in a known "homosexual" area and staring at the wrong person in a suggestive manner.

Arrests were made. Confessions and names of the offenders were coerced. Pink triangles were sewn on prison clothes, and thousands of people died for being different.

The distinguished Institute created by Magnus Hirschfeld came under siege, for the Nazis could not tolerate opinions other than their own hate-filled ideas. Individuality and diversity are always a threat to totalitarian doctrines. Nazis declared that German homosexuals polluted the race. They viewed the Institute of Sexual Science as a source of polluted ideas. Also, Hirschfeld was a Jew.

In 1931, Nazi thugs bodily attacked Dr. Hirschfeld on the streets of Munich and beat him senseless. Undeterred by these irrational acts, he returned to Berlin after recovering from his wounds and resumed work in spite of the worsening political climate.

The turning point came in 1933. While abroad on a scientific lecture tour, Hirschfeld received a letter from an English colleague, Norman Haire, describing the destruction of the Institute of Sexual Sciences:

"On the morning of May 6th, the Berliner Lokalanzeiger reported that the cleansing of Berlin libraries of books of un-German spirit would be begun that morning, and that the students of the Gymnastic Academy would make a start with the Institute of Sexual Science. On the publication of the press notice, an attempt was made to remove for safekeeping some of the most valuable private books and manuscripts; but this proved to be impossible, as the person removing the books was arrested. At 9:30 am, some trucks drew up in front of the Institute with some one hundred students and a brass band. They marched into the building and proceeded to make a careful search through every room, taking down to the trucks baskets of books and manuscripts— two truckloads. Authors such as Sigmund Freud, Havelock Ellis, Oscar Wilde, Edward Carpenter, Judge Lindsay, Margaret Sanger, Andre Gide, Marcel Proust, and Zola were confiscated, along with the thousand volumes of research studies. Three days after the confiscation, the students carried your (Dr. Hirschfeld's) stone bust in a torchlight procession to the Opera square where it was tossed into a fire made from the burning books..."

The Nazi press described only a brief reports of a "deed of culture" successfully carried to completion.

Dr. Hirschfeld decided not to return to Germany to face certain trial and death. Instead, he settled in the South of France. In his last remaining two years of life, he tried to recreate the Institute. Fortunately, copies of most of the research materials existed in other countries. With Hirschfeld's death, however, the Institute, with its focus on scientific and social reform, lost its driving force. The world was soon plunged into war. It would be many years before interest was revived in sexual research.

The Nazis may have burned the books, but the ideas escaped obliteration. Many medical and social reformers of today look back to Dr. Magnus Hirschfeld's studies as a foundation stone. Why people love the way they love is a question yet unresolved, but Magnus Hirschfeld spoke openly, clearly, and scientifically of the unspoken love. He may not have given us justice, liberty, and peace, but he did give us hope. ♀♀

In Reaction (Continued from page 7)

Anne Bolin's Reply to George Brown

I would like to thank George Brown, M.D. for reading and responding to my article "Gender Subjectivism in the Construction of Transsexualism" in the Winter 1992 issue of *CQ*. Dr. Brown, like so many professionals in his field, is obviously a person of great compassion and concern, both for his profession and the transgendered community. I would, however, like to address the criticism leveled by Dr. Brown and offer clarification on several issues.

1) Dr. Brown states that I have characterized all male psychiatrists as discriminatory, ill-informed, and medical mercenaries among other things– which he considers a dangerous act of generalization. I am saddened that Dr. Brown misinterpreted my cautions concerning the medicalization of transsexualism. This was a very short paper that summarized the findings from my book, *In Search of Eve: Transsexual Rites of Passage* (1988, Bergin & Garvey). The book documents in greater detail my findings concerning medical discourse on the subject of gender dysphoria. I state on p. 36, "It is important to remember that the small sample size responding to the questionnaires [in my research] is probably subject to regional variation and other factors which make it unique in some respects (such as their affiliation through the Berdache Society) and hence unrepresentative of the total transsexual population." In regard to my stereotyping of psychiatrists, I report the following as it specifically relates to the transsexual consultants in my research: "The imbalance of power relations germane to transsexual-caretaker interaction along with transsexual resentment of psychiatric classification as a mental illness has culminated in transsexual hostility and distrust towards caretakers, particularly psychiatrists. Such feelings unfortunately override, and in many ways offset the great concern and advocacy efforts of many psychiatrists and psychiatrist." (p. 55). Finally, I have received numerous letters from transsexuals who have given my book to their therapists, who report that it has been very helpful in the therapeutic encounter for both caregiver and client.

2) Dr. Brown critiques my references as antiquated. At the beginning of the article, it is clearly stated that it was a reprint of a 1985 article, which makes my references current at that time, including my reports of androcentric biases in graduates with Ph.D's in psychology. That 35 to 45% of the degrees in psychiatry and psychology are awarded to women does not mean that women are not in male-dominated fields.

3) I am heartened to hear Dr. Brown charges lower fees for counseling than his peers. However, I was discussing what I found to be true in my area of research. Dr. Brown does concur with my statement that it is generally true that the helping mental health professionals' fees are lower.

4) Finally, Dr. Brown takes issues that sexism in psychiatry is not the reason behind inaccurate information on sex reassignment surgery. I did not say sexism was the only reason, but that it is a salient factor in transsexual interaction with caregivers and researchers. Follow-up questionnaires I have seen utilize heterosexist and gender-biased questions to assess adjustment postsurgically as well as presurgically, as documented in my book. I would like to point out that there is a vast scientific literature that exposes Western medicine as both patriarchal and hierarchical. Unfortunately, at the time of my research, Foucalt's critique of Western medicine as power knowledge had not come into its own in anthropology, although I feel my perspective anticipated it. A short quote summarizes this viewpoint: "Health-care systems continue to monopolize 'scientific' knowledge and exercise control over individual bodies, families, and the social body...they are producing and reproducing as well as transforming the relations that are imminent and essential to their knowledges in society" (Biddy Martin, 1990, "Feminism, Criticism, and Foucalt," pp. 3-20, in *Feminism and Foucalt*, Northeastern University Press). Basically, this perspective acknowledges all of our bodies as the locus of patriarchal and hierarchical domination facilitated by Western medicine (among many other institutions) both historically and in the present. This is an argument that focuses on the institution of Western medicine in culture, not in individuals such as Dr. Brown, who challenges masculinist constructs in his practice.

I am delighted to make Dr. Brown's acquaintance through AEGIS. He is truly what is meant by a caregiver. His concern is clearly evident. However, I might have chosen another vehicle for our initial encounter... maybe the weight room.

Sincerely,

— Anne Bolin

A Word on Terminology

The Editor-In-Chief has worked in the field of mental retardation for nearly twenty years, and has become sensitized to the application of stigmatizing labels to individuals.

Current thinking by many in her field is that persons have mental retardation. They are not "retarded," not "the retarded," but "persons with mental retardation" or "persons who have mental retardation."

Like mental retardation, transsexualism is a stigmatizing label. Those with transsexualism are not "transsexuals." Rather, they are persons who have transsexualism.

Consequently, rather than conceptually turn people into something less than human beings– "transsexuals"– we at AEGIS will strive to use, both in our publications and in our speech, the terms "transsexual people" and "persons with transsexualism."

Transsexualism will refer to a characteristic of the individual and not the individual himself or herself.

The bulk of those in the crossdressing community have chosen the terms crossdresser and CD to replace the pejorative term "transvestite." Rather than use the term "person who crossdresses," we will adhere to this apparent preferred usage.

– Dallas Denny

Bits n Pieces

This article was printed in shorter form in FTM, April 1992.

How Much Does It Cost to Become a Man?

by James Green

When I became serious about following through with my gender alignment (reshaping my body to correspond with my psyche), I spent some time gathering information about the types of surgery available, the providers, and the costs. In a nutshell, two types of surgery are required for female-to-males (FTMs); top and bottom, or bilateral mastectomy and genital reconstruction. And there are two types of genital procedures. I opted for the genitoplasty (metadoioplasty) over phalloplasty, partly because the aesthetic result appealed more to me, and partly because it seemed more affordable. Costs quoted to me by providers and consumers alike hovered at less than $4500 for top surgery (performed on an outpatient basis), and roughly $6000 for the lower procedure. In the excitement of my newfound conviction to follow through on my self-realization as a man, I figured I could easily afford to pay $10,000 to $12,000 over a period of two or three years. Hell, it's just like buying a car, right? Wrong!

I didn't realize it as it was happening, but the true costs of the sex reassignment process can be astronomical. As an example, I've totalled most of my costs so readers who are just starting out can get a realistic picture, and so that others can compare what they spent. Keep in mind that phalloplasty costs much more (the range I've seen quoted most often is $10,000 to $50,000). Advance payment is almost always required for any procedure not covered by insurance. Also keep in mind that every procedure is not successful: revisions are often required; if these can be handled in a clinic environment, the costs are usually less than $2000.

Not everybody will require or desire a hysterectomy; my general physician suggested I have it done after I had complained of severe uterine cramping immediately following orgasm. The pathology lab found several good-sized uterine fibroids, and significant deterioration of the uterine wall such as that which precedes cancer, so I was ultimately glad to have had the hysterectomy/oophorectomy in conjunction with the genitoplasty. The less general anaesthesia I experience, the more alive I feel.

Time off work is also a consideration. People tend to neglect bed-rest and reconditioning time as cost factors. This may amount to quite bit of lost income, which you need to anticipate and provide for in advance. Guys who do physically demanding work may want to take more time off to ensure good healing with minimal scarring. In my case, the original estimate of time off for top surgery was two weeks. I needed three weeks. And the original estimate for recovery from genitoplasty was two weeks. Add in the hysterectomy, and you have four more weeks, for a total of six weeks— but I required eight weeks. And when the tissue expanders in the scrotum were replaced with the actual testicular implants in a separate procedure several months after the original surgery, I was told at first that I could be mobile in four days, when the proper bed-rest healing time was ten days.

Above all, when considering sex reassignment surgery, it's important to remember that your path is a solitary one. Your body is not the same as anyone else's. Your aesthetic is yours alone, and your choice of therapy or clothing may be more or less than what I've listed here. In fact, what I've listed for clothing is extremely conservative. As your body changes, your self-image changes. You may need or want to experiment with different styles, or you may make "fashion errors." Clothing is expensive, even if you buy at discount or second-hand stores. I had to replace all my business shirts (any shirts I wanted to button at the collar and wear a tie with) three times when I went from a 14" neck / 30" sleeve to a 14 1/2 / 30", to a 15 /31".

The figures in my summary may seem daunting, but keep in mind that the process unfolds slowly. I was fortunate enough to have a good job and high salary, so I was able to accomplish my transition rather quickly, without long periods of building cash reserves. I know not everyone on this path can more as rapidly. The time it takes to accomplish transition is not so important as the quality of the services you receive. Gather as much information as possible, consider all your options, and don't make snap decisions about any treatment.

While I was surprised to realize how much money I had spent, I've got to say that for me it was definitely worth it.

Summary of Costs for Female-to-Male Sex Reassignment Surgery

$ 400 initial evaluation by Gender Dysphoria Program
34 binder for breasts (pre-surgical cross-living)
312 annual cost of Delatestryl (depotestosterone or generics may cost less)
200 annual cost estimate for physician visits and blood tests
100 prosthetic penis to wear under clothing (not for sex!)
4242 "top" surgery: O.R., surgeon, anesthesiologist
4250 annual cost estimate for psychotherapy (50 sessions)
500 estimated cost to augment wardrobe (size changes— neck and shoulders bigger; hips smaller)

$10,038 expenses during first year (3 weeks on disability)

$ 200 annual cost estimate for physician visits and blood tests
312 annual cost for Delatestryl
4700 plastic surgeon's fee for genitoplasty (metadoioplasty)
1385 anesthesiologist's fee for 5.5 hours surgery (combined genitoplasty /total abdominal hysterectomy)
3000 OB/GYN surgeon's fee for hysterectomy
500 plastic surgeon's fee for mastectomy scar revision
11000 operating room and hospitalization (4 day stay because of hysterectomy; not required for genitoplasty alone)
300 pre-op lab work and post-op pathology lab work
4250 annual cost estimate for psychotherapy (50 sessions)

$26,147 expenses during second year (8 weeks on disability)

$ n/c series of office visits over 3 or 4 months required to fill expanders in scrotum to stretch skin for testicles
1150 surgeon's fee to remove expanders and implant testicular prostheses
725 O.R. fee
200 annual cost estimate for physician visits and blood tests
312 annual cost for Delatestryl
136 Superior Court filing fee: name change and birth certificate
80 required publication of Order to Show Cause
25 fees for copies of judge's decree and new birth certificate
4250 annual cost estimate for psychotherapy (50 sessions)

$ 6878 expenses during third year (2 weeks on disability)

$43,063 total cost of transformation (summary reflects costs incurred 1988-1990)

$ 2700 annual maintenance visits post-transformation: includes physician visits and blood tests, testosterone, and psychotherapy (25 sessions)

A Brief Glossary of Medical and Terms
(Definitions from Taber's Cyclopedic Medical Dictionary)

anastomosis [*G. opening*]. 3. an end-to-end union.

blepharoplasty [*G. blepharon, eyelid, + plassein, to form*]. Plastic operation upon the eyelid.

cricothyroid [*G. krikos, ring, + eidos, form*]. Pertinent to the thyroid and cricoid cartilages.

debridement [*Fr.*] 1. Enlargement of a wound in operating. 2. Slitting a constricting band of tissue.

diathesis [*G. diathenai, to dispose*]. Constitutional predisposition to disease.

dyspareunia [*G. dyspareunos, unhappily mated as bedfellows*]. Painful coitus.

fistula [*L. a pipe*], Abnormal tubelike passage from a normal cavity or an abscess to a free surface or to another cavity or abscess. Rectovaginal: opening between rectum and vagina.

fundus (pl. fundi). *[L. base]* The body of the uterus from the internal os of the cervix upward above the fallopian tubes.

granulation [*L. granulum, little grain*]. 1. Formation of granules, or state or condition of being granular. 2. Fleshy projections formed on the surface of a gaping wound that is not healing by first intention or indirect union.

innervation [L. *in, in, + nervus, nerve*]. 3. The nerve supply of a part.

introitus [*L. intro, intro, + ire, to go*]. Any aperture in the body.

ischemia [*G. ischein, to hold back, + aima, blood*]. Local or temporary anemia due to obstruction of the circulation to a part.

lability [*g. labi, to glide*]. State of being unstable or changeable.

muscularis [*L. muscular*]. Muscular coat of a hollow organ or tubule.

nosocomial [*G. nosos, disease, + komien, to care for*]. Of a hospital or infirmary.

otoplasty [G. *ous, ot-, ear, + plassein, to form*]. Plastic surgery of the ear to correct defects.

perineum [*G. perinaion, perineum*]. The space lying between the vulva and the anus in the female; between scrotum and anus in male.

prolapse [*L. pro, before, + lapsus, from labi, to fall*]. 1. A dropping of an internal part of the body, as of the uterus or rectum. 2. To drop down, noted of an organ. Synonym: ptosis.

stenosis [*G. stenosis, a narrowing*]. Constriction or narrowing of a passage or orifice. Synonym: stricture.

vaginismus [*L.*]. Painful spasm of vagina from contraction of the vaginal walls preventing coitus.

Estrogen Cream
Some Basics
by T.J. Stockus

At some time or another, questions arise about the effects of the estrogen cream that is advertised in magazines. This is a basic description of "mail-order" estrogen cream and an attempt to present some facts to help in decision making. Unfortunately, there is chemistry involved, but it's not too difficult to understand if you read slowly and learn a few simple terms. The first is "milligrams," often abbreviated as "mg." It is a metric unit of weight, used for very small quantities of substances. For example, 2 or 3 grains of sand would weigh about 1 mg. The second term is "International Units," abbreviated "IU," which also has a slang abbreviation of "units." An IU is a quantity of bio-active substance that produces a particular effect agreed upon as an international standard. The confusion arises because it is not normally weight-related (but it can be converted into weight units). An example of the use of IUs is in vitamins. A, D, and E are usually dispensed in IUs. Vitamin C was dispensed in IUs in the past, but is now more commonly dispensed by weight, in milligrams. A simple comparison can be used. For Vitamin C, 1000 IU = 1000 mg. For Vitamin A, 1000 IU = 0.3 mg. Vitamin E is variable, depending on the blend of Vitamin E isomers.

Now, let's look at the cream. Just as Vitamin E can have isomers, estrogen also has many isomers, depending upon whether it comes from a natural source or is manufactured. Natural estrogen is a combination of isomers which are obtained from sow (pig) ovaries or equine (horse) urine. Natural estrogens are inexpensive, and may not be regulated by the Food and Drug Administration. An average value for the quantity used in a cream I saw advertised was 20,000 IU. This would probably be about 2 mg (based on 17b estradiol as 10,000 IU = 1 mg)— not much! Looking at the dose and quantity supplied, there was a 60-day supply. This means that only 2 mg of estrogen is applied to the skin over a 60-day period. By division, one gets a daily dose of 0.03 mg applied to the breasts (if used there).

Surprisingly, most of the estrogen in the cream does enter the surface tissue, and small amounts go deeper. By comparison, some individuals are prescribed estrogen orally at typical daily doses of 2-5 mg (20,000-50,000 IU). Either way, estrogen enters the body and can increase breast size. The comparison here is method of administration—transdermally, with cream into a specific area, versus orally, for distribution throughout the body. The effects are going to vary from person to person, and will depend upon the sex of the individual.

Variable results due to sex are dependent upon different types of tissues present around the breast and chest areas. Estrogens are steroids and their activity is tissue selective; they target muscles, fat, and skin. Mammary tissue is often considered a specific target, and growth is common when certain estrogen isomers are offered to the cells.

In 1988, a letter was published in The Lancet, describing breast growth in a man as a result of the use of an estrogen cream his wife used for postmenopausal symptoms. She had been using the cream (in unspecified areas) at night, and he apparently picked it up by body contact with her. A physician advised her to use the cream in the morning, and the husband's symptoms eventually subsided. It is probable that the cream formulation used was stronger than that which could be obtained by mail-order, but the effects of epidermal application and time of use cannot be ignored.

With new concerns being raised about implants and silicone injections, it would seem that the most natural approach should be considered for one's body. Estrogen creams can represent one way of introducing a natural bioactive material into the body; prescribed estrogens are another. The cost and effect comparisons are up to the consumer, who can make a choice between use of a low-dose item advertised in a magazine, or obtaining the care of a medical professional.

A Letter to The Lancet

Sir:

For certain drug side-effects, the responsible drug is not easily found, even when the victim was the person who took the drug. Finding the culprit can be even harder when the victim did not take the drug.

An attractive young woman doctor complained of excessive facial hair growth, with a distinctively male pattern. She was extensively treated for endocrine abnormalities. She was taking no drugs other than an oral contraceptive, and stopped even that, with little effect. She knew that her husband was using a testosterone cream for hypogonadism, but the pharmaceutical company had assured her that the hair growth could not be due to the cream. Everything else being negative, she asked her husband to stop using the cream, and the hair growth stopped worsening within days. After epilation, it did not relapse, as it had done before.

A middle-aged man in perfect health and not taking any medication complained of unilateral breast enlargement. A clinical check-up was negative apart from gynecomastia. Investigations were normal and the physician was completely baffled until he learned that the patient's wife was using a cream containing estrogen for menopausal symptoms. He asked the wife to use the cream in the morning rather than in the evening, and the husband's breast enlargement rapidly subsided.

Other instances of transdermal heterologous drug penetration are known, especially with nitroglycerin ointments. Physicians should be aware of this possibility in the presence of unexplained findings in a patient not taking any drugs.

N. Moore
G. Paux
C. Noblet
M. Andrejak

The Lancet, 27 February, 1988, *1*(8583), p. 468.

A Recent Study of Transgender Causation

Critiqued by Holly Boswell

Humphrey, G.W. (1989). ***Men who cross-dress: The attempt to retain the comforting object.*** Dissertation. California School of Professional Psychology, San Diego. University Microfilms, Inc., 300 North Zeeb Road, Ann Arbor, MI 48106.

The findings presented by Glenn W. Humphrey in his doctoral dissertation in psychology, entitled "Cross-dressing in Males: The Attempt to Retain the Comforting Object," are worth examining. This study, for which I volunteered as a subject, seems rather typical of the psychology establishment's attempt— however sincere— to "understand" the transgender phenomenon on its own pre-established, theoretical terms.

I will not attempt to critique Dr. Humphrey's research methods, which seem reasonably defensible within the accepted guidelines, except to question the appropriateness of generalizing this (or any) study's conclusions across a population which is exceedingly diverse. I will, however, respond to the key points of his conclusions from the perspective of a transgendered person who is also a student of psychology.

Humphrey's study supports the theory that both crossdressers and transsexual persons use female clothing as a "transitional object" to achieve calm and soothing, rather than as a fetish for sexual arousal. He explains this as resulting from unresolved childhood separation anxiety with a mother who was inadequate. Anxious attachment to the mother as provider of security was even more intense with pre- and post-op transsexual persons than with crossdressers. Pre-op transsexual persons reported that crossdressing had less of a soothing effect. Humphrey interprets this as a failure of the transitional object, resulting in a "merger fantasy" of sex reassignment surgery to resolve the elusive search for security. However, post-op transsexual persons reported as frequently as crossdressers that crossdressing was effectively soothing. Humphrey concludes from this that SRS may serve only as a temporary solution to achieve a lasting sense of security.

Humphrey claims that his clothing-to-sooth vs. fetishism findings seriously call into question the DSM III-R classification of transvestism as a paraphilia. He also recognizes that, like a baby taking its mother's breast (or pacifier), there is a sense of excitement that precedes the calm and relaxation. I have observed that most of us who are transgendered go through an initial phase of being aroused by crossdressing, but usually discover broader aspects that progress toward deeper fulfillment and a new sense of identity. We replaced the term "transvestite" with crossdresser because of its association with fetishism, yet the DSM III-R classification remains appropriate for many.

Concerning the issue of crossdressing as "use of transitional object to overcome anxious attachment to the mother": can it really be that simple? My experience (encompassing a population far bigger than Humphrey's test sample) does not support any such preponderance of inadequate mothering, nor limited use of "dressing" as a pacifier. In fact, the very notion of "crossdressing" seems based on a faulty premise. If one comes to identify oneself as transgendered in any way, or even androgynous by nature, hence beyond their biologically-imposed stereotype, then the clothes one chooses to wear are not their mother's, or any one else's but their own. We adapt our wardrobe to suit our evolving sense of self.

It's no wonder to me why post-op transsexual persons report "crossdressing" as soothing. Besides being a welcome confirmation of establishing their rightful gender, it is perfectly natural and enjoyable (hence soothing), and not necessarily any indication that SRS was "a momentary palliative," as Humphrey contents. And perhaps pre-op transsexual persons are not experiencing a failed transitional object, but rather a range of discomforts due to the newness of dressing full-time, heightened anxiety over passing and assimilating, and the shift of focus away from mere "dressing up" to the priorities of corrective surgery and major changes in lifestyle.

But what is more troubling in Humphrey's conclusions is his reinforcement of previous suggestions (Lothstein, 1984; Murray, 1985; Ovesey & Person, 1976) that transvestism and transsexualism are manifestations of "borderline personality disorder." Borderline personality is a category used to describe individuals who have a rather shaky sense of who they are (identity), and whose ambivalence and uncertainty causes exaggerated emotional fluctuations, erratic reactions, disjointed relationships, and other dysfunctions. The lack of a sense of self separate from mother and capable of autonomous ego functioning (i.e. being able to soothe and comfort oneself without external assistance) is proposed by Humphrey as a predisposing factor. These unresolved issues of separation and individuation (becoming autonomous, differentiated, and whole) lead to the borderline level of personality functioning which is especially pronounced in transsexual persons, says Humphrey.

I don't doubt that this sort of diagnosis may be an accurate assessment of some transgendered people. Even so, how does it explain the fact that so many of us who may struggle with and even resolve this and other disorders, still feel the undeniable need to redefine our gender in some way? Borderline personality may be one of any number of causal links for some transgendered people, but why should all of us be seen as dysfunctional? Not only may a personal redefinition of gender be a healthy coping mechanism, I would strongly content that expanding one's awareness and range of gender options past stereotypes and rigid cultural expectations is an evolutionary imperative worthy of voluntary initiation. New trends toward androgyny and egalitarian relationships are hopeful signs that future social structures will reflect human realities and aspirations— not abstract constructs that demand conformity.

Aside from a minority of "borderline" transgendered people, I further contend that most of us have experienced a lifelong trial-by-fire concerning who we are. We've been thoroughly tested— sometimes brutally so— and we have come to know exactly who we are in spite of cultural dictates and familial rejection. Far from a "shaky sense of self," we have achieved far more self-knowledge and security than most "normal" people who remain undifferentiated from their culture,

accepting the roles assigned to them without question.

Humphrey advocates that a developmental approach based on "clinical understanding" be used for early identification and appropriate intervention where crossdressing occurs in young people. We can only speculate on what would be deemed "appropriate" by Humphrey and the psychological establishment. Yet all of us who "wish we knew then what we know now" ought to consider how we would advise all these young people struggling with gender issues. Part of their future is in our hands.

Psychology as Art; Psychology as Science; Psychology (Unfortunately) as Pseudoscience

Commentary by Dallas Denny

I was initially reluctant to publish Holly's critique of Glenn Humphrey's dissertation because I knew that if I did so I would feel compelled to write this comment, and I feared what I might say. It was, after all, not a major study, and hardly worth the risk of offending Dr. Humphry or anyone else. But no moral coward am I; here it is, and damn the torpedoes.

Despite what its critics think, psychology can be as much of a science as any other field with complex, subtle variables. I am trained in applied behavioral analysis, a discipline often maligned and certainly misunderstood. Applied behavior analysts use known characteristics of organisms to modify their behavior in an applied setting. It is useful in a variety of settings, including prisons, amusement parks, and banks, but its most dramatic and obvious effectiveness has been in the training of persons with severe mental retardation. Through the use of single-subject, repeated-measure experiments replicated across behaviors, settings, and subjects, applied behavior analysts have, in the past 35 or so years, built a small but effective armamentarium of techniques which increase and decrease behavior. There is no disputing the effectiveness of these techniques, for they have been demonstrated and replicated, and replicated again. Times may change, but data do not. This is the essence of science.

Psychology can also be an art. The Freudian psychoanalyst inhabits a world in which behavior is explained in terms of theoretical constructs like transitional objects and castration anxiety and Oedipal conflicts, which give way to measurable symptoms like denial, sublimation, and repression. The clinical psychologist deals with real-life problems of real-life people, using a skill called clinical judgement to deal with complexities which our science is as yet too crude to quantify and qualify. This work is critically important, for it helps the substance abuser, the juvenile delinquent, the exhibitionist, the agoraphobe in ways in which applied behavior analysis and its less scientific cousin behavior therapy sometimes can't. It is an art, a healing gift that requires empathy and that can be learned only with difficulty, and only from an expert.

My problem begins when this art is disguised as a science, as it is in Glenn Humphry's dissertation, for doing so misleads and blinds (yes, with science) the onlooker to the intellectual sleight-of-hand that is being pulled, and leaves even sophisticated observers breathless and impressed. And it is in this way that much evil is done.

Witness parent-blame theories of autism, homosexuality, and transsexualism. How many mothers and fathers have castigated and punished themselves because they were judged and found guilty by the Bruno Bettelheims and Robert Stollers of this world? And how many transsexual people have believed themselves to be seriously and hopelessly flawed because of Leslie Lothstein, Ethel Person, Lionel Ovesey, and their followers? How much suffering have they caused to people who were already suffering? (And, the behavior analyst in me cries, "Where are their *data*?")

And now Glenn Humphry adds another howling voice to that of the wolf pack. He categorizes transgendered people as having borderline personality disorder. How can this be? Do people with borderline personality disorders fly airplanes, command armies, deliver babies, write plays, climb Mount Everest? What is borderline about such endeavors? How does one distinguish between a borderline personality graduate student and a non-borderline personality graduate student? By doing a panty check? Is borderline personality disorder a synonym for transgenderism? Let us hope not, or else all those people out there washing the windshield of your car at mid-city traffic lights may be surprised to learn that they should be dressing up or on hormones.

Humphrey would have done better to have spent more time on his experimental design and less on searching the DSM III-R for an additional stigmatizing label to place on transgendered people. Why did he not compare postoperative transsexual male-to-female people to genetic women? Why did he compare them instead to crossdressers (men, the other gender)? Are other women not the appropriate group against which to measure people who have become in every sense women? Is it any wonder that someone would find clothing which is appropriate for their social role and anatomy soothing? Would any woman not find appropriate clothing soothing? And in the absence of an appropriate control group, what the hell has Humphrey's study done except to place another stone (borderline personality disorder) on the shoulders of transgendered people?

I'm not meaning to be overly critical of Dr. (now Doctor, because he has libeled us!) Humphrey; he was undoubtedly just trying to get out of graduate school. He was required to play an intellectual game, and he did it only too well. He's not morally culpable or a bad psychologist simply because he perpetuated, doubtless with help from his doctoral committee, a fallacy. My complaint is about what his dissertation is symptomatic of and what the "scientific" literature is full of: character assassination of an entire class of people by those sworn to "do no harm."

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From the Publisher
(Continued from page 4)

not yet begun to live in the gender of choice, or even to alter their appearance, to be consumed with fantasies or thoughts of surgery. Such fascination is not healthy. It is counterproductive; it is fruitless; it is a waste of time and effort that could be better applied elsewhere.

If a walk-in SRS clinic were to open its doors, there would be long lines of people, most of whom would be asking for genitals which contrasted with their social role and outward appearance. Most of these people, if given surgery, would later regret it.

It is for this reason that there needs to be quality control— that it is important that there be standards and guidelines which will minimize the chance of any individual undergoing irreversible surgery which he or she will later regret, and yet minimize the chance of the truly deserving being turned away. We have achieved the first part of this equation; I would argue that we have a long way to go before we can say the equation is balanced.

The tightrope walk of transition should not be negotiated blindly, but with illumination provided by the helping professional. The object should not be to knock the individual off the rope, but to help him or her to maintain balance. And if the individual falls, there should always be another chance to walk the tightrope. Unfortunately, this does not always happen.

Given that SRS is occurring and will continue to occur, and that it is decidedly inappropriate for a considerable percentage of the people who desire it, some sort of regulation is needed. We need to move now to ensure not only that those for whom surgery would be inadvisable at that time are required to wait, but that those who need and desire surgery get it. We need to switch from what is essentially an exclusionary model to a criterion-based model.

The Harry Benjamin International Gender Dysphoria Association, Inc., publishes the only commonly accepted guidelines for hormonal and surgical treatment of transsexual persons. Their Standards of Care provide minimal requirements for both service providers and transsexual people.

The brilliance of the Standards of Care lies in the placement of SRS at the end of a period of real-life rest, in which the individual must live successfully in the gender which will match the new genitals. Because many find this impossible, and opt to return to their gender of original assignment, they are spared irreversible and potentially humiliating change. Those who persevere can expect to find SRS at the end of the tunnel.

Unfortunately, the Standards of Care are minimal guidelines, and as such are subject to overenthusiastic excesses by service providers. As Dr. Anne Bolin has pointed out in her book, *In Search of Eve*, the Standards of Care turn service providers into gatekeepers, giving them inordinate control over something that perhaps can be best viewed as the business of the individual. Worse, sexist and inappropriate notions of the gatekeeper can keep deserving persons from surgery.

What is needed is a balance.

The problem is one of locus of control, and it is a sticky one. Because surgical treatment is a medical procedure which can be done only by licensed physicians, the individual must give up some autonomy, just as is done with zoning laws and traffic regulations. But control should not be placed entirely in the hands of service providers, who are subject to failure and bias, and who are, as I have mentioned, making a determination of gender that is more the business of the individual than it is theirs.

Where is the balance? I'm not sure, but I suspect that the answer may lie partially in supply-side economics. If individuals are free to choose among service providers, then they can avoid those who are unnecessarily strict or unsympathetic. The risk here is that by shopping around it may be possible to find a service provider ignorant enough or unscrupulous enough to recklessly give the green light to irreversible procedures like SRS. But it does give the individual some semblance of control— unlike the case when staying with a single service provider, who has final and absolute say-so about hormones and surgery— and hence, the fate of the individual. I think the advantages of this a la carte method outweigh the risks. By comparison shopping for service providers— or even for gender clinics— the individual maintains some control over his or her life and destiny.

Another point of balance may lie in reification of the real-life test as a prerequisite for surgery. Unfortunately, there are sometimes disagreements between transsexual people and service providers as to what constitutes success in real-life test. Here, too, I think the locus of control must shift a bit. Currently, the service provider is in the driver's seat. Criteria for success should be arbitrated and contracted, with both the service provider and the transsexual consumer coming to a clear understanding of what "success" is. It is important that success not be limited to the service provider's notion of what is feminine or what is masculine, or what constitutes "success." If necessary, a third party should be invited to facilitate agreement. A binding written contract should be produced, clearly stating what the transsexual person must do in order to receive the go-ahead for surgery. It is imperative that both parties understand clearly what is expected, and follow through with the written plan.

To this end, it is critical that the consumer be provided with a copy of the Standards of Care. It is morally indefensible and medically unethical to keep a consumer ignorant of these rules. And yet, this sometimes happens, even in the most prestigious treatment settings.

A third point of balance might be for service providers to rethink the business of counter-sex hormones. Certainly, they are not without risk, but they are frequently withheld for social and psychological, rather than medical reasons, turning the physician into a social worker/psychologist— something he or she is probably not trained to do (and besides, for what other conditions is necessary medical treatment withheld for social and psychological reasons— besides plastic surgery, that is?)

Some service providers, and even some gender clinics, like the Clarke Institute of Psychiatry in Toronto and the Program in Human Sexuality in Minneapolis, require long periods of cross-living before hormones are prescribed. For a variety of reasons, this causes problems: 1) the physical effects of hormones, which are largely reversible simply by stopping their use, are less

damaging, especially in the short term, than the global effects of terminating marriages, telling family and friends, and dealing with employers, all of which are necessary in order to even start to live in the other gender; 2) cross-living before hormones have changed the habitus to approximate the other sex is discriminative, giving unfair advantage to those who are lucky enough to be young, to those who have physical characteristics which help them to pass, and to those who have (often illegally) had previous hormonal therapy; and 3) requiring crossliving before hormones places the individual in a situation in which verbal abuse and ridicule is highly likely—and at risk for physical abuse, in this era of minority-bashing. I would add that hormonal therapy and SRS are separate and distinct, with SRS being much more intrusive, and that hormonal therapy does need not necessarily lead to the desire for surgical reassignment. An increasing number of people who identify as nontranssexual are coming forward, requesting hormones. What are we to do with these people, who call themselves transgenderists?

Finally, failure in real-life test is extremely traumatic, and can do lasting psychological harm— and failure in real-life test leaves the person not only without a viable life in the new gender, but with the original life thoroughly dismantled. The service provider should support the individual in real-life test in every way, rather than throwing up needless and harmful obstacles like the real-life-test-before-hormones requirement.

We are coming to an era in which transsexual persons are becoming comparison shoppers, are starting to stand up for their rights, and are proud of who they are, refusing to slink back into the closet after SRS. They are beginning to question methods of treatment, and are already demanding reform. They are demanding a shift in the locus of control. This is a mark of social and political maturity.

Transsexualism is coming of age, and service providers should be glad of it. ♀♂

Sorry, Charlie (Cont. from p. 19)

Charlie took a sip of his beer. "I'll be out of town Monday and Tuesday, but I'm free Wednesday and Thursday night. I'd like to take you two to dinner. I know some good places around Brussels. Whatever your preferences are, I know you will be pleased."

"I'd love to," said Monique. She looked at me, and before I could speak, she said, "... but Veronica can't make it."

Charlie smiled from across the table. "And why not? Do you have another date?"

"Well, no, it's just that..."

Monique said, "She'll be out of town for a week or so."

"There's nothing wrong, is there, Veronica? I've enjoyed your company today and..."

"There's nothing wrong, Charlie. It's a long story, and I can't go into it. I think I'll be available next week. How about then?"

"I'm going back to the 'States on Friday. I'll won't be back until March."

I smiled at Monique. "I guess you'll just have to carry on without me."

In twenty-four hours, I would be entering the hospital with Becky. In forty hours, I would be on the operating table, having reassignment surgery.

Michelle had promised us a Brussels vacation, but I hadn't expected anything like this.

Refreshed from the beer and the stop at the restaurant, we went with Charlie to the zoo. Children played among the flowers near the aviary, and we roamed the spacious grounds in the late afternoon sun. The three of us walked arm-in-arm along the shrub and flow-lined paths. "Is this what being a woman is all about?" I thought I had never enjoyed an experience like this before. Why had I had to come three thousand miles to Europe to have such a good time?

It was getting late, and Charlie chose a modern highway back to Brussels. He stayed in the passing lane. Soon we were doing ninety-five miles an hour. The Mercedes slipped along the road without a bump, sway, or strain.

Back in the city, Charlie glided the Mercedes to a smooth stop in front of the hotel. Monique leaned over and gave him a kiss on the cheek. I leaned over the front seat and did the same.

"Sorry, Charlie. I wish I could have dinner with you on Wednesday. Thank you very much for a wonderful time today. I really enjoyed it."

"Oh, yes, thank you, Charlie. And I'll see you Wednesday night," Monique said.

"Is eight OK?"

"Oh, that's fine."

"See you then. Goodbye, Veronica. Goodbye, Monique."

We got out and the Mercedes nosed out into the traffic, reached the corner, and turned left on the Avenue Louise. We went into the hotel to fill Becky, Michelle, and Lori in on our adventure.

On Tuesday morning, I had my surgery and was returned to my room at the clinic at 10:45 am. Then it was Becky's turn. On Thursday, Michelle appeared for her usual morning visit and brought Lori and Monique along. Becky and I were two days post-op and had some pain and discomfort. But my mind was on Charlie, and Wednesday night.

"Monique! Get over here and tell me all about Charlie," I demanded.

"Oh, let me tell you, Veronica," said Lori, grinning. "This little girl didn't get back to the room until 7:00 am this morning. I think she had fun last night."

"What? Come on, tell me more."

Monique came over to my bed. "Charlie took me to a fine restaurant and winded and dined me."

"Oh yes he did," said Michelle "Charlie spent $85 on a dinner for two."

"Monique, tell me what happened!"

"We went back to his hotel, had some wine. We listened to some music and then we went to bed." Monique had an evil look in her eyes.

"And around 3 am, I told him."

"You told him you were post-op?"

"Yes. I wanted to knock his socks off. And I did, too."

"Did he ask about me? And why I couldn't come to dinner?"

"Oh, yes. I told him the whole story. I told him we American girls had come to Brussels to have our sex reassignment surgeries. He said, 'You mean when I took you two out on Sunday, Veronica was still a guy?' You should have seen his face, Veronica. It was priceless."

"You did this on purpose?"

"That's right," Monique said, smugly.

"But why? Charlie was a nice guy," I said.

"Charlie was a nice guy, but he was out for a good time. And I wanted to give him the time of his life. I thought he needed to have his balloon pricked."

I dropped my head into the pillow and laughed. We all laughed. Poor Charlie.

Somewhere in California, or perhaps in Europe, is an American businessman. He used to think he knew the city of Brussels. And maybe he did. But one thing is for sure: the next time he's having Sunday morning breakfast at Rick's and sees one or two American women dining alone, he may think twice or even three times before picking them up.

Sorry, Charlie. ♀♂

Transsexuals and Civil Rights (Continued from page 20)

Sexual preference is a peripheral issue with respect to the core of transsexuality. The problem is that their desires to be accepted as men and women begin at a point where that acceptance is based on participating in society in gender roles different from those they were assigned at birth. This creates the real dilemma for transsexuals and for society.

Some forms of hermaphroditism are surgically corrected shortly after birth. Parents usually do not advertise these types of surgeries for fear of stigmatizing children as they grow up. But, generally speaking, society is fairly tolerant of various operations on babies to correct physical and sexual abnormalities. Babies don't have track records in specific gender roles long enough for society to make harsh judgements.

Transsexuality is not a condition that can be observed or tested for in babies. It is a self-awareness on the part of children that there is something askew concerning their gender roles and how they feel. They usually hide their feelings, because rules for gender role behavior are laid down very early in life. Only when children become adults do they make intelligent decisions about the course of their lives, because the decision to have gender reassignment requires mature judgement.

Society is faced with mature adults with extensive track records in specific gender roles announcing that the gender roles in which they have track records are not the gender roles with which they are comfortable. People are rather inclined to jerk back their heads and say something like, "Come on, now, who do you think you are kidding?" while their minds turn to thoughts of homosexuality; and that is something they can more or less understand, whether or not they approve of it. It is often very visible to them, and they are frequently repulsed by seeing demonstrations of affection between persons who are of the same gender.

It is interesting that it matters in what context physical affection between persons of the same gender takes place. I have seen more rear ends patted and more men hugging each other during and after sporting events than I have seen in the Castro district of San Francisco. I suppose it is rationalized as happening in the heat of competition. But it has a very negative implication when it happens in the heat of genuine physical attraction.

Since transsexuality occurs in the psyche of a person instead of the visible body, and is only fully understood as adulthood holds sway, society casts a very wary eye on the condition.

Transsexuals face two very different problems when confronting society. Unlike homosexuals, they do not necessarily want to live different lifestyles than the heterosexual population. Quite the contrary, as a rule. Some transsexuals are heterosexual and some, like the general population, are homosexual in their gender roles of preference. The glue that binds the gay community together is absent for transsexuals. The other problem is that they are very few in number compared to homosexuals. Even if they were able to band together as a political force, their numbers would be minuscule compared to the gay population.

"Money is the mother's milk of politics." Political action is the mother's milk of progress with respect to civil and human rights. Political action requires both money and personal energy.

Faced with these two onerous problems, one has to ask what transsexuals can do to become more legally, if not socially, accepted members of society and enjoy civil rights like their fellow citizens do.

Political action is the energy that makes the wheels of this constitutional republic turn. Let me construct another metaphor based on something one of California's most famous politicians said: "Money is the mother's milk of politics." Political action is the mother's milk of progress with respect to civil and human rights. Political action requires both money and personal energy.

One transsexual, because of her knowledge of politics and how the system works, was able to convince the California Department of Motor Vehicles to allow transsexuals to obtain new driver's licenses with new names and new gender identities. She did this by involving members of the medical and mental health communities, lawyers, politicians, and by dogged persistence on her part. Her efforts met with much resistance in the beginning, but she was relentless. In 1978, her persistence paid off and the rules were changed.

I can only point out that California is the largest state in the Union in terms of population. Yet this woman, through political action, brought about sweeping changes which have benefitted transsexuals in this state ever since.

I doubt that many transsexuals who have since applied for new driver's licenses with different gender designations on them even wonder how this may have come about. It didn't happen because California has a beneficent state government. It happened because one transsexual was determined to change things. She used the system through political action for the benefit of all transsexuals in the state.

The example I have just discussed is a lesson to be learned. If transsexuals are content to keep quiet and continue to be denied their rights, that is their choice. It is not easy for transsexuals to stand up for their rights publicly. It isn't easy for people under the best of circumstances. Individuals usually make sacrifices when they publicly demand rights that have been denied to them. Martin Luther King, and others, paid a very high price. But that's the way things get done under our system of government. The founders of this country had to fight for rights and liberty, and, until recently, we have treasured and honored those rights because people stood up and fought and died for them.

At one time, I felt that transsexuals were too diverse and too few in numbers to carry out political action. And they are indeed diverse and few in numbers, on a relative scale. I have come to realize, however, that there is no real alternative. Rights are never granted willingly by those who govern. They always have to be fought for.

Wit and perspicacity combined with determination form a much stronger weapon, and an easier one to wield than the sword, when it comes to securing rights. ♀♂

Care and Feeding
(Continued from page 22)

functions for the physician who is unfamiliar with gender reassignment surgery and curious to find out about it. Choosing an experienced urologist or gynecologist will reduce such unnecessary medical expenses.

Care and Feeding

Those who are lucky, and who have chosen wisely, will end up with neovaginas which are virtually indistinguishable from natural vaginas. And guess what? They will have most of the disadvantages of natural vaginas: susceptibility to infection, sanitation problems, increased vulnerability to STDs— everything but menstruation (and pregnancy, which is only a disadvantage under certain conditions).

In addition to these problems, the neovagina will have difficulties of its own, including the aforementioned tendency to close up. The new plumbing may not pass aesthetic muster. Inadequate lubrication during intercourse is common. Despite frequent dilation, vaginal depth may be insufficient to accommodate large penises. The urinary stream may be directed forward, rather than downward. If lined with scrotal skin, it may have a tendency to become clogged with hair. And sometimes, even with the best surgery, orgasm is not possible.

Anyone with a neovagina needs to have a gynecologist who they see twice yearly. Vaginal inspection should be done annually, for the medical literature includes a number of reports of cancer of neovaginas created with skin grafts (both in genetic females and in post-operative transsexual people). Although the gynecologist may not be able to tell that the vagina has not been present from birth, it is wise to reveal the facts of the surgery; it will help him or her to make good medical decisions.

Dilation is essential to maintain (and increase) vaginal depth. For the first six months to a year, it must be done several times daily. Occasional dilation will be necessary for the rest of the individual's life.

One form of dilation requires manual insertion of a vibrator-like device into the vaginal cavity. Moderate pressure is placed on the form, which is kept in place for about 20 to 30 minutes. Some individuals simulate the in-our movements of intercourse with their dilators. As previously mentioned, overenthusiastic dilation can lead to rectovaginal fistula. A good rule of thumb, according to an Atlanta gynecologist with a number of transsexual patients, is that dilation should be uncomfortable, but not painful. With the passage of time, progressively longer and thicker dilators are used.

Another form of dilation requires the wearing of an internal stent. Some are solid, and others pneumatic. Stents are sometimes covered with latex, in the form of condoms. Prolonged contact of skin to latex can lead to an allergic reaction; great pain or discomfort caused by an internal stent is not normal. Those who experience it should check with their physician.

Regular dilation can result in considerable increases in vaginal depth and diameter. Conversely, lack of dilation can result in a vagina of fingernail width and depth. Surprisingly, many, and perhaps most post-operative transsexual women do not dilate sufficiently, and lose vaginal depth.

Sexual intercourse is possible as early as six weeks following SRS, and— good news, here, neoladies— serves as a dilation. Sex is, in fact, the best way to dilate. But remember the old adage that if a couple puts a penny in a jar every time they have intercourse during their first year of marriage, and take a penny out every time thereafter, the jar will never be emptied. Our Atlanta gynecologist tells a similar story, about a transsexual woman who married soon after surgery. She lost half of her vaginal depth during the second year of marriage. Sex should be supplemented with dilation.

Although some lubrication occurs naturally (perhaps due to discharge from the prostate gland), artificial lubrication is usually necessary for sexual intercourse, in order to protect the delicate vaginal tissues. Water-based lubricants like K-Y jelly are preferred, as they will not harm latex. Petroleum-based products like Vaseline are death to latex condoms.

When the neovagina incorporates a segment of bowel, lubrication is not necessary. However, overlubrication may sometimes be a problem, necessitating the constant wearing and changing of pads or sanitary napkins.

Keeping the genital area clean is important. Care must be taken after defecation, to keep from wiping fecal matter into the vagina, which lies dangerously close. One postoperative woman remarked at a support group meeting, "Do you know how difficult it is to learn to wipe in a backward direction after 34 years of wiping forwards?"

Douching flushes warm water, usually containing vinegar, Betadine, or other cleansing substances, through the vagina, killing bacteria and eliminating odors. It is accomplished by use of a rubber bag with a long tube— and now you know about that alien looking apparatus that your mother kept hanging on the wall in the bathroom. Genetic females should avoid douching too frequently, as it tends to dry out the mucous tissues which line the vagina, but neovaginas can be douched four or five times a week without harm.

As neovaginas are susceptible to various STDs, it is important that safe sex techniques be practiced. Use of condoms, dental dams, and antiviral lubricants significantly reduce risk of infection.

Properly cared for, a vagina is unlikely to cause significant problems. Certainly, proper sanitation and frequent inspection will minimize risks. If infection or side effects of surgery are ignored, serious problems can result. Painful or slow urination, itching, lesions, or presence of a discharge are a sign to immediately see a physician. Over-the-counter products are no substitute for good medical care. ♀♂

decrease administration of estrogen to the lowest possible level as feminization is achieved. They should also be involved in routine screening, which includes monthly breast self-examination and, after age 35, yearly mammograms in high-risk cases.

Those seeking sex reassignment must look at their own beliefs, motives, fantasies, and expectations. Furthermore, these must be tested against reality, usually with the aid of a psychotherapist who hopefully has no hidden agendas. Clearly, requesting sex reassignment for kicks, sex, or out of curiosity are not legitimate reasons for embarking on this path, regardless of whether you have passed some "real life test."

Transsexualism is a gender disorder, and not a sexual disorder; sex and gender are quite different phenomena. Sex is between the legs; gender is between the ears (Seton, 1991). If you are considering this path because you want a new "sex toy" between your legs, for your own sake, please look elsewhere. Reassignment can only be embarked upon as an existential commitment to life when all other options have been exhausted and death seems the only option. Only at that point can you be certain that heroism is called for. If you have not reached this point, then you haven't hit bottom yet and you lack the motivation and strength to make the life changes required in the reassignment path. As I noted earlier, to be forewarned is to be forearmed.

Concluding Remarks

As with many transsexuals who cannot pass in society without detection, Miriam has cured her internal problem of gender dysphoria, while unknowingly inducing an external problem of societal unacceptance. She is well-adjusted as a female within herself, while, in spite of her legal status as a female, society continues de facto discrimination against her and others like her, with so-called "genetic" women being somehow considered more legitimate. This is happening while medical research is destroying any such distinction between "genetic' women and other women, a case of the proverbial pot calling the kettle black (Seton, 1991). According to John Money, genetic sex, gonads, and internal genitalia do not innately preordain gender identity, gender role, sexual orientation, or erotic status in adulthood (Money, 1988).

One recalls how African-Americans were freed from slavery while, as society resisted change, they simultaneously became subject to a subtler, more insidious kind of discrimination in Jim Crow and sharecropping, leading eventually to the civil rights confrontations of the 1960s. Stonewall has not yet happened for transsexuals.

Sex reassignment is much more than having some cosmetic and "sex change" surgery. More than anything, it is a total life change. If you cannot rehabilitate your life, then how can you hope to do the same for your new sex and gender? You will not find a simple solution to any problem in life, despite popular psychology's promotion of panaceas and canned answers. Do not be misled by book-transsexuals. Success stories very often sound too good to be true because they are too good to be true. Most autobiographies are edited, incomplete, and above all, self-serving. The gender community, like so many other areas of life, has been little more than show business: keep up the song and dance, and no one will notice that you are crying on the inside while smiling on the outside. Contrary to what Hollywood and Madison Avenue would like you to believe, all that glitters is not gold. Life is not simple— nor is it fair. As Jacques Brel exclaimed in one of his songs, "Stand up and cry like men!"

When one becomes mature enough to realize the existential conditions of human life— such as transsexualism imposes on a person— one sees that compassion, love, and understanding for one another are all we have to hold onto in our lives. Physicians and transsexual patients will learn these elements of true wisdom in time, and towards this purpose, I have presented Miriam's story.

Postscript

Miriam was placed on Prozac-40 mg daily and Desyrel 150 mg daily with good results. After six months of intensive supportive psychotherapy, she reported being able to put her life back together again and make decisions necessary to reduce the stressors in her life. She decided to leave her current profession, where she experienced harassment, and go into business for herself, where the boundaries between herself and others were more clear. She also decided to move far away and start over where people were less sophisticated at reading her as transsexual. I wish her well, wondering whether she will ever be free of her torment and whether our society will ever stop persecuting transsexuals.

Miriam, like other primary transsexuals, was the victim of a childhood developmental disaster rivaling autism and schizophrenia in its devastating consequences. She has suffered enough. Why do we find the need to punish her further?

Note

When a respected transsexual professional was admitted into membership, he showed up at an HBIGDA conference and no one would talk to him until at the dinner table the president came over and whispered, "He's all right," to the other members. Once given this imprimatur, the transsexual was then recognized as existing. (Personal communication, J2CP Information Services, 1990.)

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Commentary

by Sheila Kirk, M.D.

This paper is too long and too laden with medical terms and concept for this readership. While it deals very much with Miriam's very deplorable problem, it is too diverse, and while the author stated that she did not want to discuss transsexualism, in fact, she does in great detail.

The Adventures of Miriam could be made into several papers, for there is a great deal of material in it. I don't want in any way to discredit Dr. Seton, for she is highly intelligent and has a large fund of information and experience to share with us. I wish, however, that she had less negativity and had taken the initiative to inform our readers rather than to frighten them. She makes some wonderfully important points, and her message that there are not enough caring, knowledgeable, and honest physicians out there is what I know to be the case. I think, however, that she missed a fine opportunity to inform her audience.

A very important point to be made is that most transsexual individuals have a normal karyotype— that is, their chromosomal count is 46 XY or 46 XX. They are not to be placed in the relatively uncommon group of intersexuals to which Miriam, as reported by Dr. Seton, belongs as a Klinefelter patient. There are scattered reports of Klinefelter's syndrome individuals who are 47 XXY and have no physical stigmata of the disorder. Whether or not Miriam is one of these persons is not quite clear, but if she did represent a Klinefelter patient to Dr. Seton, she would have as well to others, had she been correctly evaluated early in her transition. The fact that she wasn't has important implications and considerations for her future; she evidently was not informed as she should have been. This is a fact that Dr. Seton does not emphasize.

Dr. Seton mentions that transsexuals taking hormones are at risk for breast cancer, stating that there are three reported cases in the medical literature. I don't agree with her assessment of risk. What she doesn't report is this:

a) Only three reported cases out of many thousands of transgendered male-to-female individuals taking hormones indicates very little reason for concern. This incidence would be expected, as it is the same as for males not using estrogen. The incidence of breast cancer in the male population (not using hormones) is exceedingly low, constituting 1.5% of all malignant tumors in men.

b) There is concern, however, for individuals who have Klinefelter's syndrome. They have a lifelong alteration of estrogen-testosterone ratio. Their state of hyperestrogenism does make them more at risk for breast cancer. Gynecomastia (breast enlargement), which is part of the Klinefelter's syndrome, is not a precursor to breast cancer or in any way a sign of the development of breast cancer in any male; the medical literature substantiates this statement. There is, however, a 3% projected incidence of breast cancer in all Klinefelter individuals not on estrogen. Some authors believe the incidence parallels that of genetic women. Is there, then, any more risk with estrogen use in a Klinefelter transsexual? I don't know— but quite possibly.

Dr. Seton did not ask that question, but rather, confused the issue by suggesting that all transsexuals carry an increased risk by using hormones. I suggest strongly that she might have said that transsexual individuals with no hint of Klinefelter's are at low risk of breast cancer. However, Klinefelter individuals who follow a transsexual pathway should be warned that there is risk. Was Miriam warned? Probably not! She should have been!

While counseling as Miriam experienced it was most likely correct in selecting her for a transsexual path, putting her on a hormone regimen of low estrogen and moderate-to-high anti-androgen would have been far more to her advantage. She must examine her breasts monthly and be instructed how to do this properly. She should have yearly mammography as well— a bit frightening, but still necessary to her well-being.

c) There is a suggestion in the literature that Klinefelter's syndrome, in addition to being a genetic alteration (which, again, most transsexual individuals do not exhibit), is also an autoimmune disease. There are several reports in the medical literature wherein some of the observed Klinefelter patients (although not all) showed decreased lymphocyte count and were not responsive to photohemagglutinin stimulation, suggesting failure of immunologic tolerance. There are reports also of Klinefelter patients exhibiting immunologic disorders and malignant neoplasia more often than would be expected in the ordinary male population. What could this mean? Could it possibly reflect a poor healing response such as Miriam displayed? Her surgical outcome in the instances discussed by Dr. Seton could reflect this lowered immunologic status. Hence, her surgeons are not all to blame; rather, the most important point to be made is that Miriam had a special genetic disorder which is not found in the greatest number of male-to-female transsexuals. Dr. Seton should have emphasized that much of what Miriam experienced, or has to look forward to, is not a probability for most male-to-female transsexuals, provided that other factors are controlled.

Certainly, if they fall into the hands of inexperienced and uncaring professionals, transsexuals will follow in Miriam's footsteps. Dr. Seton should have emphasized that difficult as it is, this meddlesome surgical approach to a "new person" can be very successful, in the right hands. Those "right" hands are out there to be found. I can find them, and I would hope that Dr. Seton, with her knowledge and skill, will begin to locate them with me.

One last thought: even though they do their best, we must remember that even the best physicians with the best techniques can be frustrated greatly when selection for surgery is poor, when counseling falls short, and when thoroughness and competence is lacking.

Dr. Seton Replies

I congratulate Sarah [redacted] on her storybook success. I clearly point out in my introductory comments that some transsexuals do find effective treatment. She probably realizes, however, that her

success was not so much her own doing as a lucky "hit" at the Transsexual Lottery. Miriam did everything Ms. Shaker did, yet the two outcomes were vastly different.

Dr. Kirk makes cogent points about Miriam's intersexuality. Klinefelter's syndrome has fairly well-known associations with Lupus, Sjogren's syndrome, Hashimoto's Thyroiditis, Diabetes Mellites, and other autoimmune disorders. I could find no evidence in Miriam for these diseases, either on physical exam or routine lab testing (ESR, RPR, Thyroid, Differential CBC, or Glucose Tolerance). Miriam did have a face-lift after I treated her and, in the hands of a caring and competent plastic surgeon, she did very well. If Miriam does have an occult collagen vascular disease, it might explain the puzzlingly unsuccessful voice augmentations surgeries— one of which was identical to Sarah Shaker's procedure. Be that as it may, Miriam was evaluated at two major gender clinics and neither thought to do a karyotyping— "What's the point?" they told her. So, we should probably add these further negligences to the tally.

I would like to know where Dr. Kirk gets her data on the "thousands" of transsexuals who have been karyotyped and found to have "normal" male or femalechromosomal complements. There has been no cohort study or even the slightest interest by medical research in the genetics of transsexuals since the ill-fated H-Y antigen controversy. Transsexuals are hardly ever karyotyped prior to treatment. I am inclined to suspect that the only difference between transsexuals and the intersexed is the resolving power of our instruments to detect genetic variations (cf. Seton, S., "Is There a Genetic Case for Transsexualism," and "Open Letter to Physicians.")

With regard to breast cancer, Dr. Kirk is confusing my comments about Miriam's susceptibility versus that of transsexuals in general. The research I quoted concerned male-to-female transsexuals who were not intersexed at all. Concerning them, Pritchard et alia state: "Lobules and ancini, usually found in normal female breasts, were clearly documented in our patient. This feature is distinctly different from gynecomastia, in which lobules and acini are not present. Slides of tissue samples taken from our patients that were reviewed by pathologists unaware of the clinical history confirmed the presence of normal-appearing female breast tissue in areas uninvolved by tumor." One index of breast cancer risk is exogenous versus endogenous estrogen exposure. Endogenous hyperestrogen states such as Klinefelter's or early and prolonged reproductive years in the female are correlated with increased risk. Exogenous risk seems to be correlated with dose exposure as the number of milligram-months. Currently, estrogen replacement therapy for women is considered safein regard to breast cancer risk. However, these issues are far from closed. We do not yet know the long term consequences of exogenous estrogen in the transsexual. When such cases do happen, they seem to be related to the number of milligram-months on estrogen. I think under the circumstances, I am not being alarmist in urging transsexuals to exercise breast hygiene taken for granted by most women.

Lastly, as retired professor of obstetrics/gynecology, Dr. Kirk's apologetics for the medical profession speak for themselves. I wish to point out that transsexuals vote with their feet when it comes to medical care. They go to Seghers in Belgium and Biber in Colorado to the exclusion of organized medicine elsewhere in the U.S. This is because transsexuals trust their feelings in selecting a doctor. They sense, I think correctly, a primal sadistic hatred towards them (e.g. the writings of Dr. Leslie Lothstein). This hatred of human diversity is fostered in the medical schools (as I have witnessed) and then via the "Ole Boy's Club" of physicians in practice. There used to be a saying at my school that it didn't matter whether you were a male or female going into medical training, you always come out as a "male"physician.

Frankly, I think there is entirely too much fluff bantered about by socioeconomically priviliged transvestites who casually take the transgender path as a lark late in life. For primary transsexuals like Miriam, they are afflicted early in life— it hits them hard— and there is no choice in the matter. Door close on them. There is little chance of reaching the status of those who make it as men in their professions because they are men. Many primary transsexuals, through no fault other than being born with a devastating genetic condition in a culture which thrives on hate and violence, downwardly drift into the sociologic sewers of the world. Stonewall has not yet happened for the transsexual. I doubt that it ever will with so many Polyannas living in a fool's paradise. In such company, I am proud to play the role of Cassandra.

Commentary

by Dallas Denny

The Importance of Informed Consent

Recently, when I was in Belgium, I had the opportunity to speak with Dr. Michel Seghers, who has been doing quality male-to-female reassignment surgery and other plastic procedures for more than fifteen years. He told me, "In the United States, it is not generally understood that poor outcome does not always equal malpractice."

I think it is safe to say that few transsexual people who give the amount of planning and forethought to their transition that Miriam obviously did will have her uniformly bad experiences. Certainly, poor practitioners are out there, using poor techniques, or inappropriately using good techniques, but rarely are they the ones who are defining the frontiers of treatment, as are many of Miriam's surgeons. And yet results like Miriam's certainly do occur.

Transsexual people (and others) need to realize that treatment is constrained by the frontiers of medical knowledge. State-of-the-art phalloplasty techniques, performed by the best phalloplastician (did I just invent a word?) will have all the problems inherent in this difficult and demanding procedure. The person who compares the result to a "naturally grown" penis will find the artificial product less aesthetically pleasing and less functional. That does not mean that the surgeon was incompetent or did not do a good job. It means that the best phalloplasty leaves much to be desired.

It is critical that those who undergo transsexual-related plastic surgeries— or any other medical procedure, for that matter— be told the strengths and weaknesses of the procedures to be used (and of the care providers) so that they

can make their treatment decisions from a position of knowledge, rather than ignorance.

Miriam, certainly, seems to have been missing critical data, in that because critical genetic tests were not done, she was unaware of her unusual genetic makeup. Since, as Dr. Kirk has pointed out in her commentary, Klinefelter's syndrome is believed to manifest itself in irregularities in the autoimmune system, the fact that Miriam has Klinefelter's would have been critical information in making decisions about hormonal and surgical procedures. If malpractice was done, perhaps it was done by the physicians who did not order genetic tests when she was first evaluated. ♀♂

On the Cutting Edge
(Continued from page 37)

the natural feathering of a normal hairline), while often producing hair growth angles that are diametrically opposed to the natural hair growth angle of the frontal region of the scalp.

The following year, I went back to Dr. Mayer to surgically modify my recessed hairline at the temples. This time, he placed two smaller tissue expanders bilaterally– beneath the tissue at each temple. The same procedures were followed, and the surgery was again successful. I now had a surgically modified hairline that resembled the female hairline.

Dr. Mayer's artistry was truly excellent, for the incisions at the hairline became very faint to the point of being almost imperceptible. But in addition to this, and unlike the other so-called specialists in this field, Dr. Mayer uses the technique of "de-epithiliation" at the hairline. What this means is that he performs the hairline incisions at an angle so that several rows of hair shafts, undamaged at the root base of their follicles, actually grow through the tissue in front of the hairline incision. This hides or camouflages the incision and actually will permit the patient to wear his or her hair back, exposing the new hairline. This is a wonderful added benefit and it is why Drs. Fleming and Mayer can provide close-up photographs of their work, showing the hairlines, where other "specialists" would not dare to do so.

Unfortunately, few plastic surgeons perform the state-of-the-art techniques described throughout this article, and even fewer perform them well. I believe I have selected the two best doctors in both the disciplines I have discussed throughout this article. I hope you will consider using my approach of researching and thereby finding the finest of plastic surgeons for the surgeries you may be considering. Researching articles at the medical library, and obtaining professional references from other reputable physicians and surgeons would be the best approaches. Ask for photographs and consult with actual subjects who have had the surgeries you are considering.

Thank you for your time, and good luck!

Commentary

by Sheila Kirk, M.D.

This is an excellent article, presented with wonderful clarity and style. Actually, Ms. Sarah [redacted] experienced three surgical techniques, and all three are very important and complimentary to the "new woman." How delightful that she had such wonderful results in the hands of such an expert as Dr. Toby Mayer. I know of his great skill and great desire to accomplish the very best for "our people." In his hands, the techniques are certainly not experimental any longer. But herein lies the concern: while there are countless cosmetic surgeons throughout the country, very few are doing the techniques Sarah described, and many who offer these services (and they are very expensive and most often not covered by insurance) are not as experienced as is Dr. Mayer, even though they are apt to be very responsible to the individual coming to them. It will be some time before a great number of surgeons with this expertise will be available country-wide.

The hairline tissue expansion technique requires relatively close distance for completion. That poses a real expense and problem for many. However, keep faith! What Dr. Mayer and his partner, Dr. Richard Fleming, report in the literature is read by other skilled and innovative plastic surgeons. As they adopt the procedures, they will become more and more available and our ability to find them in other cities will increase steadily.

Plastic procedures are all important. These three: hairline modification, tracheal shave, and voice pitch technique, are particularly so.

Those interested in contacting Toby Mayer, M.D., or his partner, Richard Fleming, M.D., may do so by writing the Beverly Hills Institute of Aesthetic and Reconstructive Surgery, 416 Bedford Drive, Ste. 200, Beverly Hills, CA 90210, or by calling (213) 278-8823– Ed. ♀♂

There and Back Again
(Continued from page 20)

Mt. San Rafael Hospital is roughly across town from the Trinidad Motor Inn, about a 15-minute ride through the noontime traffic. It is located part way up a small hill. I was expecting an older building, similar to the buildings I had seen on Main Street, so I was surprised to see a fairly modern one-story brown concrete structure with a large lawn and trees. It looked much like a contemporary junior college. We pulled up to the front entrance, unloaded my bags, and after paying her, the driver was off to pick up another fare.

There I stood, at the curb, looking at the doorway about sixty feet away, knowing that I would be confined within those doors for the better part of two weeks. The sun was warm on my back, the air brisk and cool. I turned around to watch the cab disappear down the road, and thought for a moment. Would everything be OK? Would I come through with flying colors, or would this be the ordeal of my life? Mentally, I was ready. Physically I was ready. I walked in.

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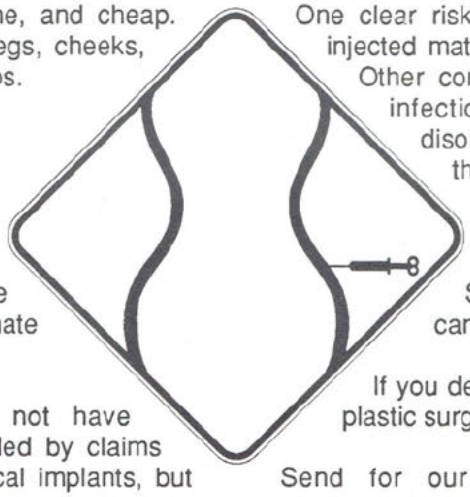

Freely injected silicone does not have USFDA approval. Don't be fooled by claims such as "Just as good as surgical implants, but without the price." The truth of the matter is that non-medical, non-sterile grade silicone is often used, and is frequently adulturated with other non-medical grade substances. It is injected by people not trained in medical techniques or human anatomy, who frequently reuse needles.

One clear risk is migration or slippage of the injected material into other parts of the body. Other complications include inflammation, infection, and connective tissue disorders, as well as extrusion from the body. AIDS (from contaminated syringes) and other dangers may not become apparent for some years.

Sometimes the price of beauty can be too high.

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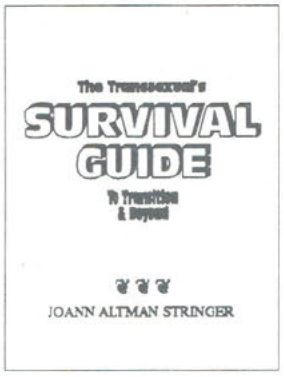

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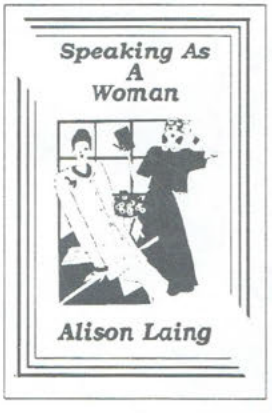

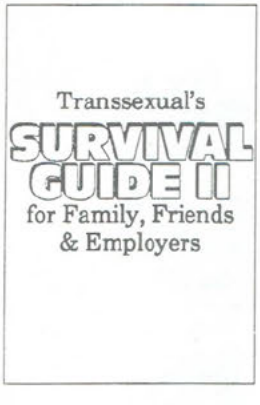

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