THE TRANSSEXUAL VOICE

DECEMBER 1991 $3.00

SHALL WE GO FOR TEN MORE YEARS?

I never dreamed I would be in contact with so many people when I started this newsletter ten years ago. There has been much change in our lives since that time. I lost my brother in 1985 and my father in 1989 and I know about changes in many of your lives. I still live with my semi-invalid mother and work for the State of Georgia. I began my 22nd year November 1st - seven months after completing my sex-reassignment surgery (SRS).

There are many more avenues of communication today than when TSV was first published. I don't think anyone seeking SRS today would have a real problem finding good doctors to work with; you may have to search, but they are out there.

Ten years ago, most people were not aware that they knew a transsexual. Today most everyone knows at least one person who has had SRS or is planning to have it; that's not to say that everything is hunkey-dory; it's still a long way from it, but there are many, many successful post-op transsexuals (Sandra, please let me slide this time) out there who are happy with their lives and whose history is unknown to anyone.

There is one big difference today than when TSV was first started - there was much more participation then. Hopefully, this will change. I know it's up to me to interest you enough to get involved; that's one of my goals for 1992. Now that I have a good computer I hope to produce a more professional looking newslettter; help me put it to good use.

I sincerely hope you have a happy holiday season and a great 1992.

PHOEBE

Dear Doctor Wollman:

I saw your name in the TRANSSEXUAL VOICE and thought you would be the propr person to write to. I am a pre-op transsexual in Fresno, California and I am having trouble locating surgeons. I specifically need a coctor that can perform a tracheal shave. My adam's apple is rather large and I would like to have it taken care of as soon as possible. If you know of any doctors that have experience with this, I would greatly appreciate it. I have come to the conclusion that I will probably have to do some traveling in order to get this done; but that's okay. Please respond as soon as you can. I have school break coming in January and would like to do it then. Thank you very much. Jamie.

P.S. I was wondering if you knew of anyone that could perform voice "softening" or altering of any kind. Any names of doctors that you could provide me with from anywhere would be okay; even if they're on the east coast or in Canada.

Dear Jamie;

You could consult these two sources: MMPI in Georgia - [redacted] or J2CP, P. O. Box 184, San Juan Capistrano, CA. 924693-0184; they maybe able to provide you with names and addresses of surgeons who perform tracheal shaves.

Voice "softening" is within the province of the speech therapist. Leo Wollman, M.D.

(DOCTOR WOLLMAN IS AN INTERNATIONALLY KNOWN AUTHORITY (PSYCHIATRIST/ENDOCRINOLOGIST) ON THE SUBJECT OF TRANSSEXUALISM. HE WILL PROVIDE ANSWERS TO YOUR QUESTIONS IN THIS NEWSLETTER. PLACE YOUR QUESTION(S) IN A STAMPED, SEALED ENVELOPE WITH DR. WOLLMAN'S NAME ON THE ENVELOPE AND ENCLOSE IT IN AN ENVELOPE ADDRESSED TO ME. I WILL FORWARD (UNOPENED) TO DR. WOLLMAN.)

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Earlier this year, I requested names of any surgeons you know of who does sex-reassingment surgery. I received only one letter - with no names of surgeons - but informing me that there are only two surgeons in the U.S. that are currently doing this surgery.

Dr. Wollman enclosed a list of surgeons to be sent to Jamie (above). I am going to contact them and ask them if they are doing this surgery now and if they will permit me to list their names and address in TSV. In the meantime, if you know of anyone, I'd still like to have their name and address. Thanks. Phoebe.

Dear Phoebe;

Congratulations upon reaching the milestone of your tenth anniversary issue of THE TRANSSEXUAL VOICE.

Over the five or so years that I have been a subscriber, I have witnessed its continued growth in maturing and quality. Your dedication has attracted more and more people to send you some excellent articles. It has become one of the prime publications available to transsexuals, professionals and any others of interest ... may you continue to have many future additional tenth anniversaries.

The October Anniversary issue had two very good articles.

First of all, Kim Elizabeth Stuart's "Guilt On the Road Less Traveled" dealt so well with the guilt that can be put on us transsexuals. She gives excellent advice regarding how transsexuals can try to deal with this undeserved victomization by society! This past summer I spend a short while in the San Francisco area for medical treatment. Fortunately, I was able to spend quite a bit of time with Kim and thoroughly enjoyed getting to know her on a face-to-face basis. Ever since reading the "UNIVITED DILEMMA: A QUESTION OF GENDER" years ago, I felt that Kim had described the transsexual condition much more accurately and realistic than any other book I have read on the subject - before or since that time (which is quite a number over my 62 years). I couldn't recommend it more highly for any transsexual who has not already read it. By the way it is excellent to use in helping family and loved ones better understand our condition. I have recently seen it advertised by Facts & Fiction, Inc., [redacted] Miami, Fla. 33139 and IFGE>, P. O. Box 37, Wayland, MA. 11778.

Also, the article, "An Open Letter To Physicians" by Sarah Seton, M.D. was extremely informative, as was her previous article. Dr. Seton's efforts in attempting to educate other physicians about transsexualism and understanding our needs is a wonderful crusade. I highly commend her efforts and hope that she is very successful in spreading the word within the medical community. I gave Dr. Seton's article to my own physician and he said that he was anxious to read it and he also planned on sending a copy to an understanding neurologist that I have been seeing.

I feel privileged to have been counted as one of the past authors of articles in the TRANSSEXUAL VOICE. Sincere regards. Jane Nance

CONNECTIONS

THE CONNECTION SECTION WILL BE USED TO LOCATE PEOPLE (OTHER THAN FOR PERSONAL RELATIONSHIPS) SUCH AS ROOMMATES, BIG SISTER/BIG BROTHER, JOBS WANTED; ETC. ALSO, IF YOU WOULD LIKE TO BE A BIG SISTER OR BROTHER(I'M GOING TO FIND A BETTER WORD FOR THIS ONE), THIS IS THE PLACE TO OFFER YOUR FRIENDSHIP. IF YOU ARE IN A POSITION TO HIRE A TRANSSEXUAL POST-OP OR PRE-OP, PLEASE, PLEASE LET IT BE KNOWN.

THERE IS NO CHARGE FOR THIS COMMUNICATION, BUT PLEASE DO INCLUDE S.A.S.E. FOR MAIL THAT IS TO BE FORWARDED.

ROOMMATE WANTED - ONE BEDROOM APARTMENT, CAN CONVERT LIVING ROOM INTO BEDROOM. WALL-TO-WALL CARPET, AIR CONDITIONED, FULLY EQUIPPED KITCHEN AND POOL. CALL SHELBY [redacted]

NEED ROOMMATE IN ORDER TO RELOCATE AND GO FULLTIME. CONTACT: KIM, P. O. BOX 564, LAKE CITY, S.C. 29560.

SOUTHERN TRANSSEXUAL PRE-OP SEEKING FINANCIAL HELP AND SUPPORT. HELP RELEASE THIS WOMAN WITHIN ME. CONTACT LINDSEY [redacted], ROUTE 1, BOX 50, MIDVILLE, GA. 30441.

MERRY CHRISTMAS

AND BEST WISHES FOR THE NEW YEAR

"THE WAR STORIES": #1 The White Christmas

by Phyllis Randolph Frye, Attorney, Houston, Texas

(Recently, I went back into my many boxes of diaries, letters and other records to retrieve something from the past. In so doing, I met a flood of memories of episodes in my life, what some might call my "War Stories". If you are willing to read them, I will make the effort to produce them on a regular basis for publication.)

December of 1977 was a bleak month for my spouse and me. I had been unemployed for nineteen months since I was last fired for being "a dress wearing freak". Her job wasn't generating what we needed because during the time that we were both employed, we had accumulated much debt. (Several years later, her profession enjoyed a substantial pay raise, but that was later.) We had used all of the savings while trying to learn how to downgrade our standard of living.

To make it worse, I had been unable to get unemployment compensation. My last employer did not fight it, but I had a homophobic Texas Employment Commission referee who chose to write up my interview in such a way that I was blocked from benefits. (We eventually won and got the benefits, but that was later.)

We felt very alone because neither of our families would have anything to do with us. (Her mom eventually came around and became a great ally, but that was later.)

The fight to change the ordinance was not making much headway. At the time Houston had a crossdressing ordinance. I'd already been lobbying against it for about a year. Every day, I never knew if I'd be arrested. Every day, my spouse never knew when she left for work if I'd make it home from job hunting, lobbying and such. (The ordinance was overturned in 1980, but that was later.)

Christmas was going to be meager. We had shoes, but they were not winter shoes. We had some warm clothes, but they were a bit tattered. It was depressing as hell. Actually, it was all around shitty.

About the only things we did have were each other, our faith in God and our church family. Even though she and I loved each other (and still do) and were best friends (and still are) those years of hardship bonded us together. We felt that our faith was being tested, much as in the story of Job, but no matter how bad it got we always tithed (and still do) 10% of our gross. Our church family helped to keep the loneliness and the isolation at bay. We were with the Metropolitan Community Church of the Resurrection and we sang in the choir. (Today when I sing the Hallelujah Chorus, I get it all mixed up. In junior high, I memorized it as a tenor and in college I learned the bass line. There at MCCR I sang soprano and in later years I did the alto line. Now when I hear it I just kind of sing it all.)

Each year at MCCR, as in most other churches, they have a White Christmas offering where people bring canned and non-perishable goods each Sunday in December, wrapped in white paper, and place them at the altar. The poor families are given this the day before Christmas.

As I sit here keypunching this out, I am starting to cry again, because they brought the food to us. We were the White Christmas family that year. It was really quite wonderful. We separated the eight boxes of food into category and took out ten percent. We then went to another transgendered person who had been living on the street because she'd also lost her job and gave it to her. We three cried a lot. With the money we saved from not having to buy food for several weeks, we bought some warm shoes and each a warmer coat.

*As you all know, my spouse and I did survive and now are prosperous. The other transgendered person I referred to was an engineering graphics designer. She got a job several months later washing cars. Eventually, she made it back and got rehired in her previous profession.

I shall never forget.

This is being sent to the following organizations for their newsletters or magazines:

Gulf Coast Transgender Community, P.O. Box 90335, Houston, TX 77090
Boulton and Park, P.O. Box 700042, San Antonio, TX 78270
Gender Alternatives League, P.O. Box 3392, Napa, CA 94558
I.F.G.E., P.O. Box 367, Wayland, MA 01778
H.T.G.A. San Angelo, P.O. Box 30413, San Angelo, TX 76903
Creative Design Services, P.O. Box 1263, King of Prussia, PA 19406
Cross-Talk, P.O. Box 944, Woodland Hills, CA 91365
J2CP Info Services, P.O. Box 184, San Juan Capistrano, CA 92693
The Transsexual Voice, P.O. Box 16314, Atlanta, GA 30321

* Actually, Phyllis, we don't know much about you. Please send a short bio for next issue so we can know more about you and your work.

Phoebe

Dawn [redacted] C/O
The Transsexual Voice
P.O. Box 16314
Atlanta, GA 30321

Dear Ms. [redacted]:

Thank you for publishing your column in the Transsexual Voice, I hope it will be a helpful place for people under going electrolysis to go for answers to their questions. I have been having electrolysis for approximately 9 months and am starting to see some results, however, less than I had hoped for. I go twice per week for one hour sessions using the blend method. My goal when I started was to have most of my facial hair removed in a one year time period, I have quickly come to learn my expectations were a little high.

In your column you stated that it takes "approximately 300 to 500 hours of treatment to eradicate the facial hair problem". This statement was disappointing to me in that I had heard 200 hours from others. At two hours per week, 400 hours of treatment would take approximately 4 years. My goal was to start living full time as a female within one year after starting electrolysis. My question is, if 300 to 500 hours of treatment is required to completely treat the facial area, how many hours is needed before one can begin to pass in public with out having to use heavy makeup?

Selecting an electrolysis and knowing if they are doing a good job is a difficult task, especially if you have limited experience. Certain traits such as being friendly, having a clean work area, etc. are easy to identify. It is more difficult to know if their procedure is the best. A column on evaluating your electrolysis would be helpful.

An example of one question I have is how long should a hair be treated using the blend method before it is pulled out. In Julius Shapiro's book "Electrolysis", he states that with the blend method the hair is treated for approximately eight to ten seconds. My electrolysis treats the hairs for four to six seconds, and at times when in a hurry for only

three to four seconds. She has told me that time of treatment is based on the settings of her machine and type of skin being treated using a formula. I have fair skin and always have red spots following the treatment indicating that some degree action has taken place, but how can I be sure the hair root is destroyed? There is always some degree of re-growth but how much is acceptable? How does one know if they are receiving the maximum return from the treatments they are receiving.

Some areas of the face including the upper lip and lower neck are very sensitive to pain, is there anything that I as a patient can do to reduce the discomfort when these areas are treated?

In your column could you talk about the effect hormone treatments have on electrolysis. I have been told that estrogen improves the treatment by thinning the hair making it more susceptible to the electrolysis. A question I have is if the estrogen does reduce hair growth somewhat, how long does one have to let the hair grow before an electrolysis session. Without hormones I have to go with out shaving at least 36 hours to assure the hairs are long enough to be grabbed by a tweezers. As I begin hormones and begin to live part time as a female this issue becomes more important.

I hope this letter gives you some ideas for your next column. Again thank you for taking your time to prepare this helpful source of information.

Sincerely,

Nancy

Nancy

DEAR NANCY;

I'm sorry, Dawn [redacted] apparently has decided not to continue with a column on electrolysis.

She was very eager to do the column. I have been surprised that she has not responded to the mail I forwarded to her.

If anyone knows of an electrologist who might be interested in providing a column for TSV, ask them to contact me.

Phoebe

An Open Letter to Physicians

Thus errors in fetal hormones produce errors in genital dimorphism which can be misread by the doctor at birth. A girl may be read as a boy and a boy may be read as a girl. The odds of this happening are roughly 1: 2000 births -- fairly common. This innocent guessing affects how society will influence the child from that point on. The infant's perceived or assigned sex from birth will constitute the person in the eyes of society. For example, pink or blue clothing, choice of name, pronouns used, legal status, social conventions and a myriad of other distinctions relentlessly remind and reinforce in the child's mind that he is a boy or she is a girl.

These pervasive and barely conscious cultural forces mutually reinforce the biologic forces in normal children. What happens if the child's gender identity is contrary to the sex of rearing? There is an anecdote a colleague told me about a boy who grew up telling his parents he felt like a girl. The parents thought he was crazy and sent him to a psychiatrist who for years tried to cure the child of his gender identity conflict. When the boy entered puberty, one day he came screaming to his parents with blood all over his underpants. The parents took him to the emergency room where a doctor examined the child and announced that their boy had just had his first menses: she was intersexed but nobody ever thought to listen to her.

All evidence so far points to the fact that the fundamental direction toward masculine or feminine behavior is laid down before birth. It is true however that, like language acquisition, the prenatal thrust towards gender identity is a state of functional preparedness that will be unable to mature unless it finds and is found by the social environment. To refute this prenatal thesis, the only case that social learning theorists can point to is the one in which a male twin had his penis ablated during electrocautery while being circumcised. It was decided to reassign the boy surgically and raise him as his brother's sister. His brother was brought up normally. This girl in adolescence was given estrogens to feminize her as in normal puberty. Long term follow-up by Diamond clearly indicates the girl is having severe gender identity conflict adjusting as a girl and recent information indicates she has already been reassigned surgically as a male.

In the transsexual, the individual's inner sense of who they are as males or females is constantly in conflict with the contradictory messages given them based on the superficial regard for the body habitus in which these children mature. The tension or gender dysphoria produced by these contradictory messages creates many psychological adjustment problems, needless suffering, and wasted lives.

Body Image

Our physical self is the way we visualize our bodies, and sexuality is an important component of this. It is the most concrete expression of gender. Body image is co-determined by genital and brain dimorphism in our psychosexual decision tree. With the genitals in agreement with the brain's gender, the person's genitals appear to determine what the person's body image will be . However, this is only an apparent distinction. When the genitals do not conform to the brain's gender, the primacy of the brain in forming body image comes to the fore. For example, some genetic females with adreno-genital syndrome who had been subjected to fetal androgen, discussed earlier, were discovered at birth and surgically corrected as girls. They looked and were reared as girls but still behaved as tom-boys -- more assertive, func-

tional in dress, athletic, interested in boys games rather than doll-play, achievement--oriented rather than romance-oriented. The boys with 5-α reductase deficiency syndrome revealed the opposite picture -- they were raised completely as girls but sensed themselves as males and became masculine. With transsexuals, body-image is opposed to genital sex because the brain has differentiated somehow as female in male-to-females and as male in female-to-males. Why this is, brings us to a discussion of brain dimorphism, the next stop on the decision tree.

Brain Dimorphism

In animal ethology, the work of Lorenz, Tinbergen and others have discovered critical periods in learning behavior. With Greylag geese, shortly after hatching, the goslings will follow their mother. If the gosling is taken into human care immediately, it will follow the initial object presented to it, rather than its own species, whether the object is human or wooden. This phenomenon is called imprinting.

Evidence from matched control studies of gender reassignment in infants who had ambiguous genitalia indicates that the destiny of gender in early childhood is locked at a critical period similar to imprinting in lower animals; this period is partially determined by thyroid hormone levels. The window of opportunity closes between 18 and 36 months; the same period in which language acquisition occurs. Both windows are probably effects of myelination, dendritification, and vascularization of the central nervous system completed at about 18 months. In children brought up contrary to their biologic sex due to the presence of ambiguous genitalia at birth, the further away from this critical period, the more difficult is the attempt to reassign gender.

Furthermore, in lower animals it has been shown that a critical level of testosterone will produce imprinting on a neuro-physiological level resulting in cross-gender behavior. For example, barbiturates increase the breakdown of testosterone in the liver of the fetal male animal. When developed without testosterone, the male will exhibit lordosis and other female sexual behavior. A testosterone pellet placed surgically in the fetal ewe causes it to grow up behaving as a ram with mounting behavior towards other ewes. Similar trans--sexing phenomena have been discovered in bird-song, fish, frogs and other vertebrate species, even as a natural phenomenon in the wild. The target sites for this cross-gender behavior have been mapped using radioactive hormones in the hypothalamus.

Gorski at UCLA, Dorner in East Germany, and others have demonstrated that male and female brains are anatomically different. The medial preoptic area, ventromedial nucleus, suprachiasmatic nucleus, anteroventral periventricular area, tubero-hypothalamus, amygdaloid nucleus, stria terminalis, corpus callosum, limbic cortex and the lumbar spinal cord differ in size between the male and female in virtually all mammalian species including humans.

The amygdala, part of the limbic system, is involved in male aggression in response to testosterone. The medial preoptic area is five times bigger in males than females. Conversely, the ventromedial nucleus is larger in females than males. Testosterone actually increases the size of the preoptic area in female rats and castration of males causes regression of this structure. Testosterone enlarges the lumbar spinal cord so that it can control penile erection in the male.

Changes in size of these sexually dimorphic structures correlate with changes in sexual behavior. Grafting of female ventromedian tissue into the corresponding male's site results in female behavior in the male rat. Similarly, grafting of the male preoptic area onto a corresponding female's site causes the emergence of male behavior. In females, exogenous testosterone stimulates the preoptic area to suppress the growth of the normally enlarged ventromedial and suprachiasmatic nuclei. The stimulus in turn eliminates the pulsatile Gonadotropin Releasing Hormone (GnRH) necessary for cyclic estrous, and establishes male tonic GnRH. Further, the suprachiasmatic nucleus is implicated in female sexual behavior by stimulating the pituitary's pulsatile secretion of Luteinizing Hormone. Lesions in this nucleus cause tonic secretion of LH and lack of ovulation.

A congenital absence of GnRH in Prader-Willi syndrome is characterized by mental retardation, obesity and hypogonadism. In the hypogonadic state, sex hormones are poorly secreted. Lack of male sex hormone causes the suprachiasmatic nucleus to enlarge severely during fetal sexual maturity. Study of post-mortem transsexual brains reveals an extremely large suprachiasmatic nucleus (twice the age-matched controls) just like Prader-Willi; this lends support that the male transsexual's brain may be formed in the absence of male sex hormones during development and is structurally like the larger suprachiasmatic nucleus of the normal female brain.

The Dorner hypothesis proposed that transsexualism is the result of this imprinting in utero. Contrary variation in the testosterone-estrogen ratio causes contrary differentiation of the hypothalamus and related structures in the brain. This results in gender identity and later body-image opposite to gonadal sex. As the sex hormone ratio influences errors of genital dimorphism, transsexualism appears to be a sex error at the level of brain dimorphism. A transsexual's neurological pathways have been laid down opposite to the vector of gonadal differentiation. Once the neuro-endocrine critical period is closed, the pathways reify and it is impossible to change them. Many professionals have noted that transsexuals are notoriously refractory to psycho-therapy. They pursue their cross-gender drives in snow-ball fashion to the point of sex reassignment with a motivation and determination that is hard to explain as other than a biological imperative.

To summarize so far, transsexualism probably is a sex error of the body at the level of brain dimorphism. It is not a matter of choice. It is probably caused by previous stages of neurosexual differentiation; at the level of fetal hormones, testosterone-estrogen ratio is imbalanced due to a defect in fetal gonadal development at the molecular level. This may be determined by the absence or presence of certain genes in the TDF cascade. Each gene produces an enzyme responsible for correct genetic transcription of instructions for gonadal, hormonal, and neurosexual pathways. When these are disturbed, a small change at the level of the genes can have devastating consequences at the level of the person in society. Correct understanding of this phenomenon will probably be at the molecular genetic level.

Differential Diagnosis

In making the diagnosis of transsexualism, the physician has to exclude several mental disorders that may present this way. Obvious thought disorders such as the schizophrenias must be ruled out as well as organic disorders. (There is an association of transsexual-

ism with temporal lobe epilepsy.) Occasionally, self-defeating, schizoid, borderline, or obsessive-compulsive personality traits can be ruled out on the basis of history. Primary transsexual patients are not delusional or body dysmorphic. What the patient invariably means when they say they are of the opposite sex is that they feel like it. They do not believe that they are already the opposite sex. As reported above, medicine is investigating to what extent transsexuals can be truly considered as the opposite sex; it is a useful heuristic. From the transsexual's viewpoint however they are treated in society without regard to this distinction.

Transsexualism is an identity disorder that happens to involve gender concomitantly. It has nothing whatever to do with sexual preference or life-style as with homosexuality. Most transsexuals are asexual (analloerotic) but hetero- and homosexual transsexuals can frequently be found just as in the general population. It has nothing to do with transvestic fetishism, sexual masochism, or other paraphilias. Transvestites -- exclusively heterosexual men -- gain sexual arousal from wearing woman's clothes as an adjunct to masturbation or coitus. Cross-dressing in transsexuals is never erotic, rather it serves to ameliorate gender dysphoria. Neither the transvestite nor the homosexual has a gender identity conflict. At times they may appear to have one as a defense against being conscience-ridden (e.g., ego-dystonic homosexuality and self-stigmatized transvestism). Less easily differentiated is the Gender Identity Disorder Non-Transsexual Type (DSM-III-R: GIDAANT). Here the patient does not have any history of denial of his genitals and is comfortable as a transgenderist living quietly in the gender role opposite to his gonadal sex without any desire to reassign sex. The transgenderist is an extreme form of transvestism where the former male identity over a lifetime gradually recedes into the background as the female self (anima) is discovered and consciously cultivated. Some researchers like Docter think there are secondary transsexuals who evolve from transvestism through transgenderism to finally request sex reassignment surgery. Experience has show that the etiology of secondary transsexuals is quite different from primary transsexuals who have life-long cross-gender identity and denial of their biologic sex. Secondary transsexuals do less well in follow-ups of sex reassignment than primary. Most professionals prefer to keep the designation "marginal transvestite" instead of using "secondary transsexual" in referring to these patients.

Pubertal Factors

There are further contributors to adult gender identity in the decision tree such as pubertal hormonal levels, pubertal eroticism, and pubertal morphology. However, in transsexuals, because of the primacy of brain organization, these pubertal factors have little affect on the transsexual's cross-gender identification. In fact, transsexuals persist to the point of trying to reverse these pubertal factors. Some, by gaining access to sex steroids illicitly, prevent the pubertal effects on body habitus and others physically deny their developing genitals in the form of binding, "gaffing", auto-castration and asexual behavior. In some cases, denial of assigned sex occurs as early as three years. However, most cannot gain access to hormones and at puberty they grow into bodies which they loathe; they further succumb to loneliness and peer pressure to behave according to the societal expectation of heterosexual norms and sex-stereotypes. While their minds become more and more alienated from their bodies, a severe cognitive dissonance develops which

leads to dysphoria, dysthymia, major depression and suicide. It is reasonable to expect these patients to recount a history of mood disorders. In a society less polarized with regard to sexual diversity, transsexuals would have much less psychopathology (observe the Berdache of indigenous peoples who allow transsexuals a third sex).

Appeal for Compassion

Human nature steeped in the shame of original sin has always required a scapegoat. As the ancient ritual recounts, the Jews collected the blood of unclean animals and ritually imbued the blood with the sins of their tribes. They took a goat and pored the blood over it so that it may carry their sins. Then they took the goat out far into the desert and tied it to a stake without food or water and left it to die thereby expiating their sins.

Today we are little more conscious than this -- we persist in projecting our own shame on others, attacking, hating and even destroying that which we do not understand. Jesus was the apotheosis of the scapegoat -- the spring lamb. Transsexuals and other sexual minorities are made to wear the shame of our society's insecurity about gender identity and sexual preference; they are sent out into emotional deserts to die of alienation and loneliness to expiate society's loathing of itself.

For, in truth, no one is without stigma -- "let those who are without blame cast the first stone." Some people's stigma are hidden or not obvious and so these people become the normals within society. Those whose stigma is clear for all to see are the ones who are set apart. The normals stigmatize them so as not to call attention to their own hidden stigmata. Normals fear being discovered by others and being set apart themselves so they require scapegoats. And so fear, ignorance and hatred persist.

Transsexuals are the new dispossessed, the invisible. While medical science continues to seek answers to the problems at hand, what do we -- as physicians -- do? Will we game play? Or will we, in faith, struggle together in the reality of the present world depending on a gracious and loving God to minister to and through all persons seeking grace and fulfillment?

God has shown by His actions and nature that His love and concern extend to every area of human life. The dominant theme of the Gospels is a Divine Person actively engaged in healing physical and emotional anguish ... bringing wholeness. How then can we -- as healers -- continue to turn our backs?

Our Hippocratic Oath, not to mention the Gospels, enjoin us to be compassionate, to strive for justice and to respect the dignity of every human being. History has also shown us that it is human nature to hate, attack and destroy that which we do not understand. Are we not, therefore, compelled to stand between the dehumanizing forces within society and people, to strive for compassion born of understanding, coupled with the knowledge of what we can accomplish, with God's infinite love?

(The author wishes to thank the J2CP Information Services and its director Sr. Mary Elizabeth, SSE, for the opening scenario.)

An Open Letter to Physicians

CONT'D FROM OCT 1991 ISSUE

The ***Coming Together - Working Together*** Convention exists to help build a better world in which to live. Our intention is to bring our people and our friends together so we can learn how to better understand each other's needs and issues, learn how to respect each other's differences, to care about each other, and to work together for the benefit of all. The convention also exists to reach out to the general public, to help them better understand our issues, and to respect us as positive, constructive, and contributing members of society, and as human beings.

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Houston, Texas
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P.O. Box 1105, Alief, TX 77411-1105

Boulton & Park Society
P.O. Box 169652, San Antonio, TX 78280-3252

Delta Omega Chapter - Tri Ess
P.O. Box 1021, Arlington, TX 76004-1021

Woman Associated With Crossdressers (WACS)
c/o C. Philips, P.O. Box 17, Bulverde, TX 78163

Heart of Texas Gender Alliance (HTGA)
P.O. Box 17, Bulverde, TX 78163

WHITE MALE, 32 YEARS OLD, 5'8"; BRUNETTE WITH HAZEL EYES. COMPLETELY DISEASE FREE AND IN EXCELLENT HEALTH DESIRES TO TRULY BECOME, LIVE AS A TOTAL FEMALE WOMAN. I AM DESPERATELY SEEKING A PERMANENT RELATIONSHIP WITH ANY INTERESTED SINCERE, CARING PATIENT MALE WHO WILL PROVIDE TENDER LOVING CARE, AND SUPPORT ME AS A FEMALE LADY. I WILL TREAT YOU AS A MAN. MICHELLE [redacted], P. O. BOX 7746, CLEARWATER FLORIDA 34618

I'M IN SEARCH OF A VERY SPECIAL LADY THAT HAS COMPLETED HER METAMORPHOSIS FROM MAN TO WOMAN AND WISHES TO SETTLE DOWN WITH A NICE SINGLE WHITE MALE, 29 YEARS OLD, 5'11" - SAID TO GREATLY RESEMBLE BURT REYNOLDS IN APPEARANCE, 195 LBS. EDUCATED, EMPLOYED PROFESSIONALLY AND POSSESSOR OF A KEEN WIT. I'M FOR REAL AND CAN OFFER MUCH FOR THE RIGHT GAL. LETS GIVE EACH OTHER THE CHANCE TO FULFIL OUR DREAMS! PLEASE SEND PHOTO AND LETTER TO: JOHN, 6126 CORAL PINK CIRCLE, WOODLAND HILLS, CALIFORNIA 91367

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PERSONAL LISTINGS/ADS ARE FREE (MUST RELATE TO TRANSSEXUALS). IF YOU HAVE SUBMITTED A LISTING PREVIOUSLY THAT APPEARED IN THE FEBRUARY 1991 ISSUE OF TSV OR ANY TIME DURING THIS YEAR, NOW IS THE TIME TO UPDATE YOUR LISTING FOR THE FEBRUARY 1992 ISSUE; OR YOU MAY WISH TO DELETE YOUR LISTING. PLEASE ADVISE BY FEBRUARY 1, 1991.

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I HAVE AT LONG LAST PURCHASED THE COMPUTER I MENTIONED A YEAR AGO. I COULD HAVE GOTTEN ONE SOONER BUT I WAITED TO GET THE ONE I WANTED. I HAVE ALSO PURCHASED COMPUSERVE AND PRODIGY AND WILL BE SEARCHING FOR ITEMS THAT I THINK WILL BE OF INTEREST TO YOU; BUT I STILL WANT YOUR INPUT SUCH AS ARTICLES, LETTERS, ETC.

INITIALLY, I WILL BE ENTERING INFORMATION FOR THE STATE LISTINGS OF PROFESSIONALS WHO WORK WITH THOSE WHO HAVE PROBLEMS THAT ARE GENDER-RELATED. THERE IS NO CHARGE FOR THIS INFORMATION. IF YOU WOULD LIKE AN INFORMATION SHEET FOR YOUR STATE OR ANY OTHER STATE IN PARTICULAR, PLEASE SEND S.A.S.E.; AND PLEASE, IF YOUR PHYSICIAN WILL ALLOW US TO ADD HIS OR HER NAME TO OUR LIST, IT WILL SURELY HELP SOMEONE ELSE IN YOUR AREA WHO MIGHT REQUEST YOUR STATE LIST. **Phoebe.**

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