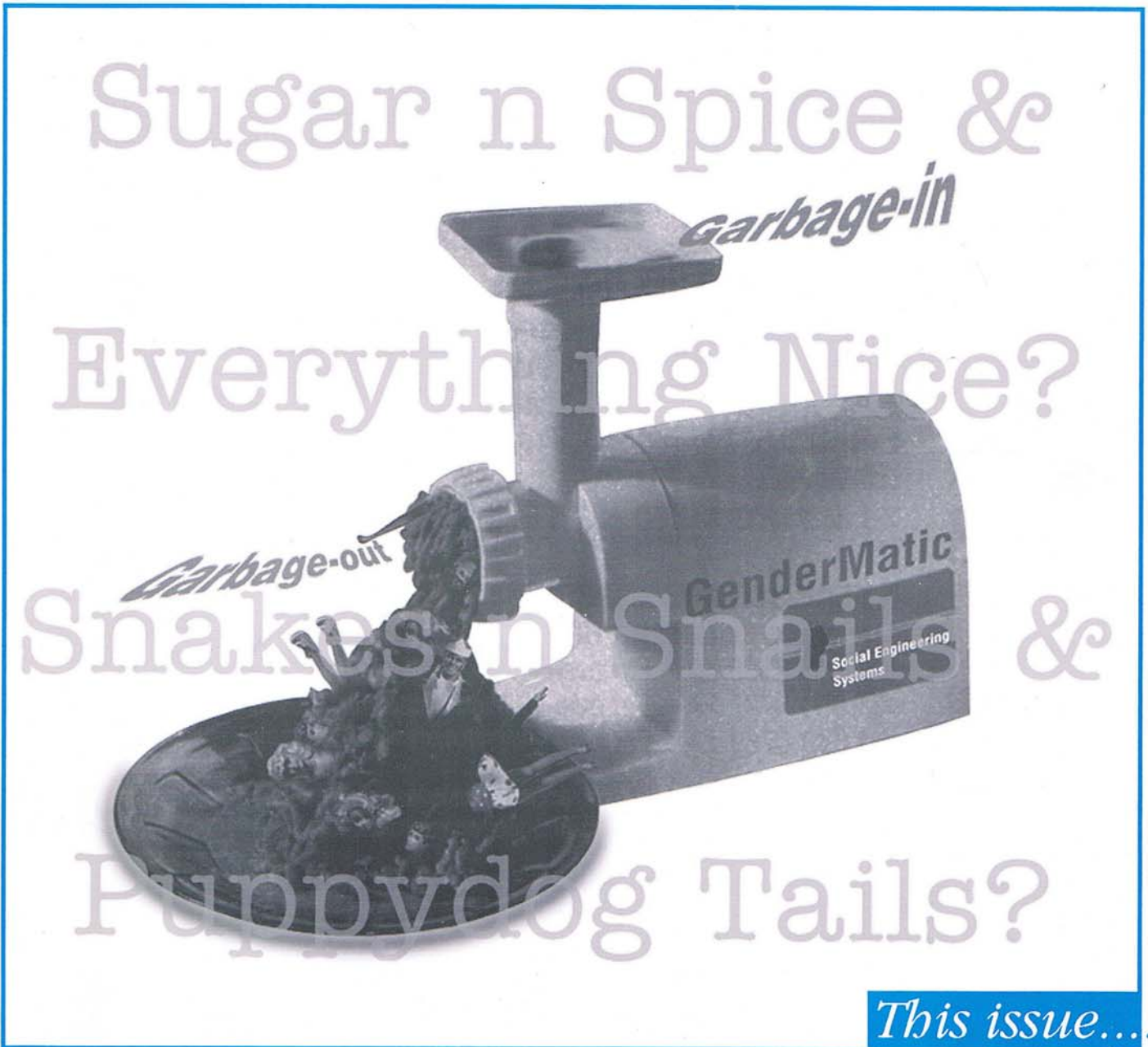


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This issue.....

*Politics & Sexism
in Gender
Confirmation*

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

The Politics of Diagnosis and a Diagnosis of Politics

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

by Dallas Denny

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

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

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

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

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

—Margaux Ayn Schaffer

W

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

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

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

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

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

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

that the prestigious Johns Hopkins University was doing sex reassignment surgery.

The existence of a gender clinic at Johns Hopkins served to legitimize the surgical treatment of transsexual people. In the late 1960s and early 1970s, similar clinics sprang up across the United States. Most were affiliated with universities with medical schools: Vanderbilt University in Nashville, the University of Virginia in Charlottesville, Stanford University in California, Duke University in North

Carolina, and others. A few had other affiliations—for instance, there was an experimental program at Georgia Mental Health Institute in Atlanta, which apparently had ties to Emory University. Soon, there were more than 40 of these programs in the United States and Canada. Most were staffed by men and women with no special knowledge of or training in transsexualism. This is hardly surprising; the field was completely new, and there were no courses at medical schools or doctoral training pro-

The Price of A Ticket to Wonderland

The Admission Criteria for the Case Western Reserve Gender Identity Clinic

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

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

grams in human sexuality—let alone gender dysphoria. In some cases, one or two workers simply decided that they were interested in providing service or doing research on transsexualism. For example, Leslie Lothstein, who has authored many articles and a textbook about transsexualism, wrote, "... My initial involvement with transsexual research began quite fortuitously. By chance a colleague, Dr. Stephen Levine, asked if I would evaluate psychologically an aging heterosexual man who wanted to change his

sex." (Lothstein, 1983, pp. 86–87). Lothstein and Levine started a study group, and, subsequently, the Case Western Reserve Gender Identity Clinic was formed.

The treatment of transsexualism by hormonal and surgical means was a radical departure from ordinary therapies, for in no other "illnesses" except those requiring plastic and reconstructive surgery, was the body changed to fit the mind. In addition to being highly controversial, SRS had no track record. Although an unknown number of

operations had been done overseas, it was still considered by the men and women of the clinics (and especially by the critics of the clinics) to be an experimental procedure, to be done to a small number of people under carefully controlled conditions (cf Stoller, 1973).

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

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

14. The patient continued in psychotherapy and was periodically examined by the endocrinologist.
15. When the therapist and patient arrived at a decision that surgery was recommended, the therapist presented the case to the clinic committee. If the committee agreed that surgery might be indicated, the patient was required to meet with the entire clinic committee and to present his/her case. The interview usually lasted one hour.
16. The committee met for an unspecified amount of time to consider the patient's request for sex reassignment. In some cases it was granted directly. In other cases more tests were recommended to facilitate our decision-making.
17. The patient was appraised of the clinic's decision. If surgery was indicated the patient was referred to the surgeon for an

evaluation. Once again, if the surgeon found anything that contraindicated surgery, the decision to operate rested with him/her.

18. The patient had to agree to respond to our need to have her/him available for interviewing and filling out follow-up questionnaires throughout the post-operative period, and for an indeterminate amount of time after surgery.
19. The patient was provided specific counseling around the issue of surgery; the nursing team was prepared for the patient's entry on to the general surgical ward; and the primary clinician followed the patient throughout the course of hospitalization.
20. After surgery the patient continued in psychotherapy and the primary clinician periodically reported to the clinic about the patient's condition. In addition, a schedule was set up for interviewing the patient and filling out the post-operative questionnaires.
21. Throughout the evaluation it was the responsibility of the primary clinician (who was usually the individual or group therapist) to act as liaison for the patient, helping in her/his social and environmental adjustment (e.g. with legal, family, and medical difficulties).

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

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

—Lothstein, 1983, pp. 87–91. ♀♀

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

From a treatment point-of-view, the large number of applicants was a nightmare, but from a research

nals. These people, and their clinics, dealing with a phenomenon which was newly discovered, and about which next to nothing was known, built a knowledge and treatment base of transsexualism,

placed clinicians under duress by threatening autocastration or suicide. They and others who were considered "hopeless"—i.e., were likely to die, anyway—were accepted. It was a classic misapplication of the triage method, with those most likely to benefit from intervention being turned away, and the terminal cases receiving treatment.

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

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

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

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

perspective, it allowed the clinics to be very choosy. They could afford to be—and were—very selective in whom they chose to serve. Their requirements were often excessive, as illustrated by the selection criteria of the Case Western Reserve Gender Identity Clinic, which accompany this article.

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

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

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

The remainder of this article is not meant to be a blanket condemnation of the university-affiliated gender clinics. Many were staffed by highly competent, caring professionals who delivered quality treatment, and who published scores of insightful articles in medical jour-

making significant strides in all areas. When the dust had cleared, transsexual people were left with legitimization in *The Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM III), with the Standards of Care of the Harry Benjamin International Gender Dysphoria Association, Inc. (Berger, 1980), with advances in theory, surgical treatment, and hormonal therapy, with better, less biased definitions and descriptive terminology, with studies of the prevalence and etiology of transsexualism, and with studies of the outcome of sex reassignment surgery. And they did provide relief for hundreds, if not thousands, of transsexual people. But the bitter experiences of thousands of transsexual men and women are an indictment: something was wrong.

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

Getting (And Being Denied) Treatment in the Gender Clinics

The clinics viewed sex reassignment as a last-ditch effort to save those with whom other therapies and interventions had failed. Those who were accepted for treatment were often prostitutes, were profoundly depressed, and often

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

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

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

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

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

On the Front Lines in the Gender Wars

True-Life Experiences at the Gender Clinics

Sharon

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

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

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

All in all, I spent about \$500 before the director gave me the

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

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

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

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

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

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

I don't like to think about it.

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

I would like to find the man who was director of that clinic and let him know what I think of him. This is what I would like to tell him: wherever you are, you were playing God. You tried to establish dominion over me, and I didn't allow it. I refused to let you have the locus of control. You were the only source of help I could find, and you denied that help and didn't assist me to find

other resources. History has proved you wrong, and me right, for I have made a successful adjustment in my new gender. You were an obstacle in my life, and not the helping force you were trained to be. You forced me into taking an action which was illegal, and which went against my nature. I resent you for making such an action necessary; I think you incompetent for it; I find you in violation of your hippocratic oath for it. I saved myself, but how many others didn't? I cry for them. Do you?

Carla

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

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

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

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

Alicia

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

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

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

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

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

consequences. They freely admitted to lying to their caretakers about sexual orientation and other issues.

Although caretakers are often aware that transsexuals will present information carefully manipulated to ensure surgery... they have only to scrutinize several of their most prominent diagnostic markers available in the literature to realize the reason for the deceit. If caretakers would divorce themselves from these widely held beliefs, they would probably receive more honest information.

—Bolin, 1988, p. 63.

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

The Problematic Behavior of "Transsexual" People

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

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

chiatric hospital in a large Southern city in the early 1980s.

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

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

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

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

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

Margaux

Margaux is thin and pretty; she looks like a model. She has been living as a woman for two years.

Margaux had an experience with the same gender clinic as did Alicia.

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

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

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

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

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

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

I left them. Thank God.

Amy

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

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

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

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

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

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

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

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

Jenna

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

My psychiatrist made me go through a bunch of those weird tests in his office in Edmonton. He put electrodes on my dick and showed me pictures of little naked boys being whipped, different sorts of fellatio, just to see if I

passed the pervert test. He did the basic psychological profile. He suggested that I go to a certain gender clinic.

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

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

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

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

"How can you be sure of that?"

"We just know it."

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

"Why do you want to be a male?"

"What?"

"Are you going from F to M?"

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

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

"No."

"You're lying."

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

"Bullshit. I don't believe you."

He wanted to see the documentation about the nursing program.

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

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

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

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

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

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

"I don't believe you."

Well, this time I had brought documentation.

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

"One of us?"

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

"I don't think so."

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

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

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

psychosomatic symptoms (including ulcerative, arthritic, hyper-ventilative, and cardiac distress).
—Lothstein, 1979, p. 73.

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

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

SRS or Else

The directors and staff of the clinics tended to view SRS as essential for satisfactory adjustment in the new gender. They did not seem to realize that it is possible to live as a woman or a man without the expected genitalia. Treatment was all-or-nothing. Those who were not accepted for SRS were generally not offered hormonal therapy, which, for many, was necessary in order to pass successfully in the gender of choice. They were given no alterna-

tive but to live in the gender of original assignment. Those who were not offered services were often told that they were not transsexual, even when they met the criteria for transsexualism that later appeared in the Standards of Care of the Harry Benjamin International Gender Dysphoria Association and in the DSM III. Some of the clinics offered to help the individual somehow manage in the gender of birth, but this was little more than a token gesture; few took them up on it.

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

Beyond Bungling

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

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

and without appeal, as illustrated by the following:

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

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

The Gender Clinics and the Professional Literature

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

Unfortunately, the erroneous conclusions and misinformation

common in early studies continue to be taken seriously. Well-conceived and more enlightened studies are unfortunately still rare. The ignorance, and arrogance, and bias of many researchers continue to find their way into print, and exclusionary criteria for sex reassignment based on "true" (as opposed to, I suppose, "not true" transsexualism; cf Dolan, 1987) and sweeping generalizations continue to appear in the literature: "These (secondary transsexual) individuals do not pass easily in the opposite gender role without the aid of hormones and

electrolysis. Their natural voice is quite masculine, numerous expensive cosmetic procedures are often necessary before they can approach the 'total femininity' they seek." (Dolan, 1987).

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

The vast majority of gender dysphoric patients obtain sex reassignment surgery on a fee-for-service basis without benefit of a prolonged diagnostic evaluation.

As a group they are probably more impulsive, impatient, anxious, and demanding of sex reassignment surgery than are those who enroll in university-based clinics. Many of these patients are probably secondary transsexuals who feel surgery will relieve their emotional distress. Unless these patients need additional surgery, they will be generally unavailable for follow-up. The lack of baseline data on their presurgical psychological states makes it impossible to evaluate the changes caused by sex reas-

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

Politics and Diagnosis

by Tabbas

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

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

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

treatment. More than likely, what they receive is their first taste of politics.

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

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

For years, especially during the sixties and seventies, providers screened transsexual people according to how they compared to the so-called "classic case." Apologists for this view held that

sexual identity was clearly established between the ages of three and five. Therefore, if a client did not cross-dress and completely identify cross-gender by age five, the client was not transsexual. Tell someone the truth, and, baby, you were gone. It didn't matter if you grew up in a hostile environment and were resourceful enough to deflect your crisis into puberty, or even beyond. Theory said you weren't conflicted.

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

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

signment surgery. Moreover, neither the surgeons who perform sex reassignment surgery on demand or their patients seem to be interested in understanding the psychological roots of transsexualism.

—Lothstein, 1982, pp. 422–423.

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

Heaven forbid.

The Decline of the Gender Clinics

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

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

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

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

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

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

naire probably did not realize the offensive nature of such a question.

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

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

The Devaluation of Transsexual Persons

Wolf Wolfensberger (1972) has written about the devaluation of human beings with mental retardation, and of the tendency of service organizations to treat their clients with mental retardation as less than human. Transsexual people are

similarly devalued. Like persons with mental retardation, men and women with transsexualism have been historically unable to defend themselves. First, they have often been insecure and frightened, and in desperate need of services. They have had (and continue to have) little protection under the law. Until recently, they had no advocacy or support organizations. Society has not been sensitive to their needs. Transsexualism was (and still is) considered a mental illness, an aberration, a curiosity, a condition to elicit fascination and amusement, but not pity and concern.

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

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

I think not.

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

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

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

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The View From The Other Side of the Treatment Fence:

My Experience as A Provider of Human Services

by Dallas Denny

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

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

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

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

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

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

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

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

I think that forces are coming into play which will result in treatment reform. Although transsexual-

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

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

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

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

Continued on page 26

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

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

slightly less after, usually in combination with a progestational agent (Meyer, Finkelstein, et al., p. 4).

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

Meyer, Walker, and Suplee (no date, pp. 3–4), five were found to subscribe to a cycling program of three weeks of daily intake of estrogen, followed by a week without hormonal therapy.

One endocrinologist in the area of my research endorsed a program of two weeks of oral estrogens daily, followed by seven to ten days of a progestational agent in conjunction with estrogen, and concluded with a week free of hormones. Because there is some evidence, although it is controversial, that fluctuations in female hormones may contribute to Pre-menstrual Tension Syndrome in genetic women, I asked the endocrinologists if there might be some similar side effects for transsexuals. The endocrinologist acknowledged the possibility of fluid retention and mood fluctuations, but suggested

Continued on page 39

The View From the Other Side of the Treatment Fence

Continued from page 22

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

Transgendered persons deserve this same kind of analysis.

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

It is not difficult to see how a service provider who has been burned by a number of transgendered clients might come to be wary of them, especially when the clinical literature warns of the unreliability of transgendered persons, reinforcing their personal experience. And as there are no protections for transgendered persons, it is easy to laugh at them and stereotype them. But it is not right. Department of Human

Services clients are not "Dirtlegs." And few transgendered persons fit the stereotypes, and those who do may have their reasons. The fact is that most are sane and whole persons who are trying to improve their lives.

"The Politics of Diagnosis" was not meant to slam service providers, but it was meant to illustrate what I consider the checkered past of the treatment of transgendered persons. I wrote it because I want service providers to realize that despite all the good that has been done, harm has been done, and to prepare themselves for the treatment reform which the '90s will bring. We need the parties on both sides of the treatment fence to realize that their behavior could have been and can be better, for only then can we achieve the dialogue that will be needed in order to bring reform.

In future issues of CQ, we'll be further defining the problem and proposing a definitive solution. Our plan is to build a gate in the treatment fence. ♀♂