In Search of the "True" Transsexual

by Dallas Denny

Although transsexualism and crossdressing have been widely viewed as mental disorders in contemporary Western society, transgendered (i.e., transgressively gendered, what we might today call transsexual or cross-dressing) people in any number of cultures other than our own have filled established social roles in which they were viewed sometimes with scorn, sometimes with awe and respect, and sometimes with a mixture of emotions—but not as mentally ill or perverted. Evidence of this can be found in sources as scattered as a seventeenth-century sketch by Theodor de Vrie (reproduced in Williams, 1986), which shows transgendered Tinemuca Indians serving as stretcher bearers; a historical study by Roscoe (1994), in which he shows that emasculated gallae served as priestesses of the goddess Magna Mater throughout the Middle East and Eastern Europe; a Paleolithic cave drawing of a transgendered shaman (Dragoin, 1995); and cross-cultural Nanda, 1989, 1994) and historical (Roscoe, 1990; Williams, 1986) studies.

In Western societies, transgendered persons have not fared well since their socially accepted roles were repressed by early Christians and others (Bullough & Bullough, 1993; Roscoe, 1994). For two thousand years, crossdressing has frequently resulted in prosecution, persecution, and even execution (Bullough & Bullough, 1993). With a few notable public exceptions such as the Chevalier d'Eon (Kates, 1995), those with transgender natures either lived quietly and probably unhappily in the gender and clothing of original assignment or as "passing men and women" (Dekker & van de Pol, 1989). Only in the past several decades have transgendered persons felt free to crossdress or crosslive openly, but even in the 1990s, it can be dangerous and even fatal to do so (cf Minkowitz, 1994; Bowles, 1996).

In the nineteenth century, transgendered persons began to come under the scrutiny of Western science; they and homosexuals were...
initially characterized as "sexual invert" (Uhlrichs, 1994). As Richard Ekins points out (Ekins, 1993), transgendered persons were not adequately differentiated from homosexuals until early in this century (Hirschfeld, 1910), and it was not until 1953, when details of Christine Jorgensen's case were published in The Journal of the American Medical Association, that transsexualism was defined as a clinically diagnosable "syndrome" (Hamburger, Stürup, & Dahl-Iversen, 1953).

The publication of Benjamin's book The Transsexual Phenomenon in 1966 legitimized the mid-twentieth century category and identity of transsexualism, in which individuals with a presumed mental disorder called (at least initially) transsexualism or wish to use medical technologies in order to change their bodies to resemble those of the other sex. [1] Within this framework, sex reassignment came to be seen not as an option that a reasonable individual might choose in order to have a body and gender role more to his or her liking, but rather as a medical treatment, a way to give relief to the suffering of the individual by altering the body because he or she had a mental condition which could not be "cured" by psychotherapy or other traditional means. Even those who dissented did not argue that transsexuals did not have a mental disorder. Their disagreement was in regard to the use of medical technology to modify the body. They contended that the proper way to treat a mental illness was by altering the mind, and not the body; they considered sex reassignment "collusion with delusion" or "collaboration with psychosis," and argued against it (cf Ostow, 1953; Socarides, 1976; and Wiedeman, 1953).

Considering that the initial center of academic interest in the United States was Johns Hopkins Hospital, where John Money had been working with intersexed persons since the 1950's (Money, 1991), it is not surprising that the treatment system which arose to describe them followed this medical model. Under the medical model, transsexual people became not merely presumably competent individuals who sought medical intervention to change aspects of their bodies and social roles which displeased them, but, because of the clinical and general societal zeitgeists of the time, patients with a mental disorder; it was incumbent upon medical and psychological caregivers to determine who would and would not benefit from sex reassignment, in which the individual's body, behavior, and social role were modified as much as was feasible to mimic that of the other sex.

In Transsexualism and Sex Reassignment (1969), Richard Green and John Money of Johns Hopkins presented a variety of clinical perspectives on the phenomenon of sex reassignment. A number of viewpoints were represented in their book, but later clinicians and researchers narrowed rather than expanded Green & Money's focus, with the result that the literature came to consist almost solely of papers based on the medical model; other viewpoints rarely if ever made it into print.

During the 1960's and 1970's, the process of sex reassignment was viewed as fraught with peril, and was considered best done in a highly restrictive setting under the guidance of an interdisciplinary team which made treatment decisions in the supposed best interest of the patient (Lothstein, 1979a). In actuality, these teams usually actively dissuaded individuals— and especially those who did not fit the characteristics of transsexual people as depicted in the emerging literature— from pursuing sex reassignment; only those most persistent and who most closely fit the clinics' models of what a transsexual was were offered sex reassignment (Denny, 1992). To this day, many gender clinics continue to place needless and often sexist (Bolin, 1984) requirements on their patients. In a survey of gender programs, Petersen & Dickey (1995) found that some clinics still withhold hormonal and surgical procedures for such things as the "wrong" (i.e. post-transition gay or lesbian) sexual orientation; for inability or unwillingness to pass as a nontranssexual member of the natal sex; and for refusal to adopt a stereotypical cross-gender role and mode of dress (i.e., those who fail the "Barbie" and "Ken" tests). Not uncommonly, all treatment is withheld if the individual does not desire (or profess to desire) surgical sex reassignment (SRS) (cf Dickey, 1990)— this despite the commonly acknowledged fact that most transsexual people who transition (i.e., permanently cross gender roles) never, for one reason or another, have surgery.

In 1979, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) put into place minimal Standards of Care for hormonal and surgical sex reassignment (Walker, et al., 1984). Standardization of treatment was in fact badly needed, but the Standards of Care placed mental health professionals in the unenviable position of having the ultimate say-so about whether the applicant for sex reassignment procedures actually obtained them. A number of writers (Bolin, 1988; Denny, 1992; Kessler & McKenna, 1978; Stone, 1991) have commented on the unfortunate effect this "gatekeeping" function has had on the therapeutic relationship. The power dynamics inherent when one party (the transsexual) is dependent upon "permission" from another (the therapist) for a highly desired commodity (medical treatment) is hardly conducive to honest communication. The therapist may use this access as a tool for motivating the transsexual client to deal with other issues, or to entice the client into continuing with therapy. The client, on the other hand, will say or do whatever he or she thinks will maximize the chance of obtaining permission for hormonal therapy and surgery.

In my earlier examination of the literature (Denny, 1994), I was struck by the fact that it reflected a curious tunnel-blindness. Despite the fact that as early as 1978, studies by sociologists and anthropologists clearly indicated problems with the medical model (Kessler & McKenna, 1978), the model itself has never been never seriously questioned by clinicians. Nor have clinicians, before this decade at least, seemed to really listen to the things transsexual people have been telling them about their lives— their sexuality, their developmental histories, their views of masculinity and femininity (see Devor, 1994, for some interesting data on transgender sexuality which arose
from a sociological study). No one seriously questioned a literature which depicted transsexual people in various unflattering ways which were in actuality reflections of the power struggle which centered around access to medical technology: as untrustworthy and manipulative (Stone, 1977), as inventing their early histories (Knoor, Wolf, & Meyer, 1968), as having highly stereotyped notions of masculinity and femininity (Althof & Keller, 1980; Kando, 1973), as having various characterological and personality disorders (Levine & Lothstein, 1981; Lothstein, 1983), and even as having a propensity for violence (Lothstein, 1979b) and murder (Milliken, 1982). Baker (1969) characterized much of what was said in the literature about transsexual people as "psychiatric name-calling." I myself have noted that the literature is "full of countertransference, which surfaces as name-calling, inaccuracy, misperceptions, opinion posing as fact, humor at the expense of transsexual people, and perhaps even some lies" (Denny, 1993).

Not surprisingly, it was not until someone not directly involved in the patient/caregiver cycle took a careful look at transsexualism that this clinical microcosm was put into perspective. Anne Bolin, a cultural anthropologist, building upon the theories and observations of Kessler & McKenna (1978), studied a group of transsexual women outside the clinical setting. Her doctoral thesis, which was published in 1988 with the title In Search of Eve: Transsexual Rites of Passage, was a participant-observation study of a small group of transsexual women in a city in the Midwest.

Bolin found that many of the clinical truisms did not apply to her subjects. They did not, for instance, have highly stereotyped and exaggerated feminine appearance, as had been widely reported (cf Althof & Keller, 1980; Kando, 1973). Instead, Bolin found a diversity of personal styles and sexual orientations which paralleled those of a group of nontranssexual women.

But Bolin's most important contribution was her analysis of the client-caregiver interaction. She confirmed the findings of Kessler & McKenna (1978) that the cultural assumptions of caregivers affected the way they viewed and reacted toward their transsexual clients. Bolin charged that:

... inherent in the Standards of Care and in the policy relations of caretaker to client is an inequality in power relations such that the recommendation for surgery is completely dependent on the caretaker's evaluation. This results in a situation in which the psychological evaluation may be, and often is, wielded like a club over the head of the transsexual who so desperately wants the surgery. Such power dynamics often breed hostility on the part of transsexual clients. (p. 51).

The imbalance of power germane to transsexual-caretaker interaction along with transsexual resentment of psychiatric classification as a mental illness has culminated in transsexual hostility and distrust towards caretakers, particularly psychiatrists. Such feelings unfortunately override, and in some ways offset, the great concern and advocacy efforts of many psychiatrists and psychologists. (p. 55).

Bolin's work has had little direct impact on the clinical literature, which continues to rely heavily upon a pathology model. However, by placing the clinical literature in context, she has had an immense impact by pointing out that there are alternative ways to view it. Consequently, to many clinicians, researchers, and transsexual people themselves, much of the clinical literature of the sixties, seventies, and eighties is colored by unfair and untrue assumptions about the nature of transsexual people; by power dynamics in the treatment settings which generated the literature; and by selection criteria which washed out all subjects except the ones who filled the expectations of the authors (Denny, 1992).

It is time to re-examine the basic tenets of the medical model of transsexualism. Should medical technologies continue to be available only to a narrowly defined class of persons called transsexuals, with mental health professionals having the responsibility and privilege of deciding who does and does not qualify to receive it? Should the technology continue to be available only in an all-or-none fashion, with the invariable goal being to produce picture-perfect males with neophalluses and females with neovaginas? Or should it be available, as are other body-sculpting medical technologies, in piecemeal fashion to those who can give informed consent?
The Medical Model

Clinicians from Benjamin onward have noticed that transsexual people are a diverse lot and have looked for ways to distinguish between types. Most commonly, they have differentiated between primary and secondary transsexualism. The fictitious transsexual at the start of this article would meet the criteria for what has been called in the clinical literature primary transsexualism (Person & Ovesey, 1979a). Secondary transsexuals were considered to be those who gradually develop a transsexual identity in adulthood, after a period of fetishistic crossdressing” (Person & Ovesey, 1979b). Primary transsexuals were attracted to males as sexual partners; secondary transsexuals had a heterosexual history and had often been married and had children. Clinical wisdom held that primary transsexuals were more “naturally feminine” than secondary transsexuals, and made better candidates for sex reassignment (Stoller, 1975). Consequently, those who presented with histories suggestive of primary transsexualism were more likely to be accepted by gender programs than others, as they were considered to be more likely to have successful postsurgical adjustment.

Although men and women had been slipping “across the sex border” (Turtle, 1963) since time immemorial, transsexualism as we know it began only in the 1950’s, after the news of Christine Jorgensen’s sex reassignment rocked the world. Suddenly, people realized, it was possible to “change sex.” Large numbers of men and women began to approach medical professionals, requesting medical treatment to do just that. Before, most had known only that something was going on within themselves, but they had no name for their problem; now, there was a new script to follow, and many auditioned for the part.

The publication, in 1966, of Harry Benjamin’s The Transsexual Phenomenon formally codified the “syndrome” and its method of treatment:

There is hardly a person so constantly unhappy (before sex change) as the transsexual. Only for short periods of his (or her) life, such as those rare moments of hope when a conversion operation seems attainable or when, successfully assuming the identity of a woman in name, dress and social acceptance, is he able to forget his misery (Benjamin, 1966, p. 66).

Benjamin saw relief for this unhappiness in medical intervention:

Now, it is possible for this desperate human being to be helped. Through surgery and hormonal techniques, transsexuals can be transformed into normally functioning members of the opposite sex. Dr. Harry Benjamin, long-recognized as an expert on sexology and a leader in transsexual treatment, tells you how it can be done (Benjamin, 1966, endplate).

But sex reassignment, as it came to be called, was only for those patients who had been appropriately evaluated, who were mentally stable, and who could pass in the new gender— and, most importantly, for those who were terribly unhappy (pp. 136-137). After surgery, the presumption was one “was” a woman or man, and life would be fabulously improved:

I have found happiness that I never dreamed possible. I adore being a girl and I would go thru 10 operations, if I had to, to be what I am now. A girl’s life is so wonderful. The whole world looks so beautifully different (“H,” in Benjamin, 1966, p. 85).

For transsexual people, this process had come to represent the only possible way of achieving happiness. One had but one real choice: to make an 180° change from man to woman, or from woman to man. If one did, if one was “really” transsexual, then everything was fine forever after, as one had “become” a woman or a man. Otherwise, the script called for a miserable life in the original gender, and possibly suicide. And the more the process was popularized, the more transsexuals there were to read for a part in the play.

Very seldom did the transsexuals we interviewed refer to themselves as “transsexual”... in other words, although they may at one time have been seen as one gender and were not seen as the other, they were never outside one of the two gender categories... they are not changing gender, only correcting a mistake ... (Kessler & McKenna, 1978, pp. 121-122).

This is the medical model of transsexualism, as formalized by Benjamin. One has a birth defect and grows up feeling trapped in the wrong body. The recognition that one is “really” a girl or “really” a boy comes at a very early age. Childhood is unhappy, adolescence is miserable, and adulthood is a travesty. Eventually, there comes a time when the individual must either transition or die. He or she then seeks help from the medical profession, which recognizes his or her misery and grants relief in the form of hormonal therapy and eventual sex reassignment surgery. The results are marvelously successful, unless the individual is not “really” a transsexual, in which case
Transsexuals quickly learned to give histories which maximized their chance of acceptance (Bolin, 1988; Denny, 1992; Kessler & McKenna, 1978; Stone, 1991): It took a surprisingly long time — several years — for the researchers to realize that the reason the candidates' behavioral profiles matched Benjamin's so well was the candidates, too, had read Benjamin's book, which was passed from hand to hand within the transsexual community, and they were only too happy to provide the behavior that led to acceptance for surgery (Stone, 1991, p. 281).

Thus, every transsexual was a primary or "true" transsexual. This created an undefined category of wannabees, who were presumably "not-true" transsexuals, unable to benefit from the dramatic life change made possible by the surgery. A number of professional papers were written to help clinicians to screen out these "unsuitable" patients (cf Abel, 1979). Occasionally a transsexual said something that suggested that he/she was not concerned with displaying some aspect of the natural attitude toward gender. We then found ourselves questioning the "reality" of that person's gender. In other words, we found ourselves wondering whether that person was "really" a transsexual, and "really" a member of the gender to which he/she claimed to belong. (Kessler & McKenna, 1978, p. 124).

This construction of transsexualism enabled some transsexual people to obtain medical treatment, but at a terrible price to their peers; for every applicant accepted for sex reassignment, many more were rejected, turned away from their only source of help with instructions to live their life in the original gender. And the ones who were most often accepted were those most willing to falsify their histories to conform to the script provided by Harry Benjamin and his disciples. Those who said they "wanted to be a woman" or "wanted to be a man" were suspect; those who said they were women, or were men, were acceptable. The thinking was that the former did not have gender identities which were sufficiently feminine; in actuality, it had much more to do with following the medical model script. Those who were passable because of fortuitous biology, who were skilled with makeup application and hair, who happened to have sparse beard growth, who acted in a highly camp manner, who were attracted exclusively to the same biological sex, who were unable or unwilling to function in the assigned gender role, were much more likely to receive treatment than those who did not look like women or men to the clinicians. Those who were accepted tended to play out, in dress and demeanor, the stereotyped roles of men and women. Internal feelings took a back seat to skill with makeup and other artifice.

It is this "Biff and Buffy" or, as Wendy Parker puts it, "Rambo/Bimbo" dichotomy to which feminists like Mary Daly (1966) and Janice Raymond (1979, 1994) objected. They noted, and rightly, that the medical model of transsexualism perpetuated the binary gender norms they were working so hard to destroy.

The truth is, there are many ways of being transsexual. Transsexualism is not about adherence to stereotyped notions of masculinity of femininity, or sexual orientation. It is not about passing, and it is not about being dysfunctional, whether that dysfunction manifests as suicidal thoughts, hatred of one's genitalia, or withdrawal from life in general. It is not about going into the woodwork.
ualism, and in working with hundreds of other transsexual people, it has become clear to me that transsexualism, as conceptualized by Benjamin (1966), is an invented way of looking at a much larger transgender phenomenon, and that the process of sex reassignment, as outlined in Green & Money's 1969 *Transsexualism and Sex Reassignment*, is but one way of dealing with that phenomenon. Transsexualism has a set of convenient diagnostic characteristics and its treatment (sex reassignment) gives only two choices: remaining in the sex of original assignment or doing everything possible to "change one's sex." There is no middle ground.

Raymond (1979, 1994) and others have criticized transsexual people for perpetuating what she sees as an inherently evil bipolar man/woman-male/female gender system, but her criticism would more appropriately have been directed at the treatment system which insisted that they move from a social role as a man to a narrowly defined role as a woman, rather than taking whatever steps they found necessary to feel comfortable in their own skins.

During the 1990's, and even before, transgendered people have begun to claim this middle ground. Prince (1978) was the first to ask just why it is important for transgendered people to have or claim to want SRS in order to live productively in the desired gender role. Her 1978 talk, given at The Fourth International Conference on Gender Identity, went virtually unremarked. When Boswell (1991) raised the question again, Prince had been living successfully as a woman for more than 15 years, without surgery.

While many transgendered people identify as "men trapped in women's" and "women trapped in men's" bodies and seek sex reassignment, as classically defined, others claim an essential transgender nature, and seek a level of comfort and personal satisfaction which may or may not involve genital surgery or hormonal therapy, and in which they may or may not attempt to "pass" as members of the other sex. For the first time, post-operative transsexual men and women are not disappearing into the closet of assimilation, but being open about their transsexual status, and adopting appearances and identities which are far from the stereotypes the clinical literature has claimed that they inevitably portray.

It is time to re-examine the basic tenets of the medical model of transsexualism. Should medical technologies continue to be available only to a narrowly defined class of persons called transsexuals, with mental health professionals having the responsibility and privilege of deciding who does and does not qualify to receive it? Should the technology continue to be available only in an all-or-none fashion, with the invariable goal being to produce picture-perfect males with neophalluses and females with neovaginas? Or should it be available, as are other body-sculpting medical technologies, in piecemeal fashion to those who can give informed consent? Must the inevitable result of masculinizing or feminizing surgical and hormonal procedures be to produce a member of the "other" sex with "appropriate" genitalia who will disappear into the greater society, or is it acceptable to produce persons who identify as either or both sexes, or as a third or fourth sex, or who function in society as men with vaginas or women with penises? Is it necessary or desirable or accurate to continue to depict those who desire the application of such technologies, or who wish to change their social roles from male to female or vice-versa as dysfunctional, pathetic, and unfortunate?

Neither I nor anyone else has definitive answers to these questions, as data have not yet begun to accumulate. But my belief is the Benjamin model of transsexualism has had its day as the sole way to view persons with gender identity issues, and sex reassignment will in the future be but one of many options for them. CQ

**Note**

[1] Today, transsexualism is lumped with similar "conditions" and classified in DSM-IV as "Gender Identity Disorder" (see Pauly, in press).

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**Respecting Choice**

Feelings can run high (and often do) when identities are built on ideologies. Those for whom the medical model seems appropriate view themselves as women or men with an unfortunate birth defect; sex reassignment offers an opportunity to live a normal life. Those who have undergone a life full of self-doubt and persecution from others—a common lot for transsexual people—cannot be faulted for wanting to find happiness by disappearing into the larger society. Neither should those who acknowledge or are proud of their transsexual status be faulted, or those who desire sex reassignment but make the difficult choice not to seek it. No one has legitimate claim to being more authentic, more "real," more appropriate, more transsexual, than anyone else. What separates the people who make these choices is the way they construct their transsexualism; the force that drives them to change their sex is the same.

It's permissible and appropriate to undergo sex reassignment and put one's past behind oneself. But it's entirely as appropriate to be visible and out. Both are valid choices which can lead to productive lives. Neither choice is "better," except as it affects the individual. Every individual has the right to make one of these choices, or the choice not to seek sex reassignment, or any of an increasing palette of choices which include non-operative status, androgyny, or gender blending.

Those who are undercover will inevitably become frustrated with those who are politically active, for fear that their own security may be compromised. Those who are out will doubtless become frustrated with those who do not help them in their struggle for political change. Those who choose not to have surgery may be frustrated by those who do, and those who have surgery may not understand those who don't. But we all can, and should, respect each other and the choices we make.
What is a gender support group?

Does a support group require its members to adhere to a particular political or ideological agenda?

Does a support group require its members to follow a particular timeline, or move in a predetermined direction?

Does a support group require its members to adopt a particular label?

Does a support group rigidly police its membership, casting out those who are politically or ideologically “incorrect”?

Does a support group define itself according to what its members are not? (i.e., “We are not gay,” or “We are not crossdressers”)

Does a support group stand by its members when they are making difficult decisions? Does it support them in the decisions that are right for them, rather than in the best interest of the support group?

Does a support group stand by its members who are having hard luck or difficult times?

Does the support group make no effort to increase its diversity, refusing to reach out to racial minorities, the poor, the disabled, women, men, straights, gays?

If the answers to any of the above are “YES,” then I would assert the group is not a support group, but something else— a place for the sharing of mutual delusions; or a place for the reinforcement of mutual prejudices and dislikes; or a gathering place for the rich, beautiful, social advantaged, and/or passing. IT IS NOT A SUPPORT GROUP.

Support groups help individuals make sense of their lives. They are not places which require particular life decisions.

Exclusions like Sarah’s happen every day in “support groups” around the country. Those with sexuality or gender issues are cast out of heterosexual-only groups, those who are not “transsexual enough” are cast out of TS groups.

It is a crying, bleeding shame.

I never knew anyone who got fucked up by going through their transition too slowly.

— Sean Marvel, on hearing of what happened to Sarah Wade Smith

A Cup of Bitter Yaupon
by Sarah Wade Smith

Once upon a time, the Creek Nation would prepare a ceremonial “black drink” from the leaves of the Yaupon plant. The purpose of this drink was to purge and purify the tribes’ warriors by causing them to empty their stomachs and bowels.

At the moment, I feel like I have had such a drink, for I, too, have been purged.

You see, I recently received a darling note from the president of the transsexual support group I used to belong to, informing me that the group’s new membership committee had voted to expel me because I was not, in their opinion, committed enough to my gender change.

In other words, I was not woman enough to associate with them.

I can’t say I am alone or unique. At least three other members were expelled at the same time. I also can’t say I wasn’t expecting it.

Three months ago, I went by the house of a friend I had introduced to the group. To my shock, she greeted me by informing me I was longer welcome to visit her because she considered me not transsexual, but a transvestite. Though she insisted she still loved me as a sister, she could now see me only as an obstacle on her own path to complete womanhood.

Ironically, she was one of the others expelled from the group. In her case, since she was living full time, her purging had more to do with the loss of her job and imminent loss of her house; she did not have “stable housing.”

On a rational level, when I am being the East Tennessean from Vulcan, I can say that this is laughable. On the emotional level, I am
February 29, 1996

Dear Sarah Wade,

At the last meeting of TSG those members present voted to elect a Membership Committee. The purpose of this committee is to set the standards and requirements for membership, as well as evaluate persons applying for new membership. Further discussion on the standards and requirements led to a vote on the appropriateness of several members. It is felt that some members may not be ready for, or may not be at the appropriate level in their transition to fit TSG's mission criteria of, "providing the specialized emotional support needed when a transsexual commits to transitioning to their appropriate gender role."

Those members who are voted to be inappropriate or not ready at this time are now being asked to withdraw from TSG for a period of at least three months. After that time they may apply to the Membership Committee for reinstatement as a member. It is hoped that this action will serve to improve TSG's part in the overall process of transition by encouraging progress and growth, and discouraging excuses and inappropriate levels of change and transition.

It is my unpleasant task to inform you that you are one of the members affected by this vote, and your membership is being suspended until such time as you demonstrate to the Membership Committee that you are ready to rejoin TSG. Your reinstatement will not be considered for a minimum of three months, and we ask that when you do reapply you provide some evidence of renewed commitment to achieving your personal goals in your gender change. Examples of this may be; stable housing; a job or a volunteer position in your new gender; hormone approval; etc. What we are asking is for is you to demonstrate a firmer commitment toward your target gender.

This is a BIG commitment, but one which we all must make in order to be a part of TSG meetings and functions. We want people to explore their transgendered feelings, but a setting must be maintained where members may progress, and their progress is not diminished by those not yet having a strong commitment. Progress for all depends on all members being committed to making progress and solving problems for ourselves and each other.

We all wish you success in meeting these minimum criteria for TSG membership.

Sincerely,

46 Chrysalis
not laughing at all. This hurts. Down in the pit of my stomach, it hurts.

There is a scene in Leslie Feinberg’s *Stone Butch Blues* in which her hero, Jess, makes her first visit to a gay bar and prays, “Please, God, let me fit in here, because it’s the only place left I can fit.” Right now, I feel like I am Jess and I’ve just been told, “No, you can’t fit here, either.” My family feels they don’t deserve to have to deal with my gender issue, my ex-lover feels that I am an embarrassment because of my “weirdness,” which, she never fails to remind me, will condemn me to a life of loneliness. And now even my fellow transsexuals are telling me they can’t stand me, either.

Maybe more shocking than the purge is the remembrance that we formed this group on the wake of a community tragedy. Lauren had had her surgery. Everyone thought that she was all settled into her new life as a woman. However, she had suffered a heart condition, I had taken their medical insurance for my then-wife, and so I am afraid of not getting so good medical care, I would have sold my soul, let alone my hair. I have no regrets. But, to my friend, the retreat was not going gung-ho for SRS, then I was telling her back, and that was worth casting me out over.

Of course, by this standard, Virginia Prince, who has lived full-time as a woman for over 30 years, yet has never sought or desired SRS, is the enemy of transsexuals. So is *Cross-Talk* publisher Kymberleigh Richards, and so is Andy Warhol’s former superstar, Holly Woodlawn, who once backed out of having surgery. So is Lee Brewster of Rainbow Service, and so are Alison Laing and Paula Jordan Sinclair of Renaissance, and so is any poor man or woman who does not have the money to pay for surgery or therapy or hormones.

Suddenly, being transgendered becomes a competitive event. If you are not rich enough or pretty enough or passable enough; if you are making it through transition with your marriage intact; or if you are hesitating because of your love for your girlfriend or boyfriend, then you are not worthy of belonging to our community.

This scares me, and I am not alone in my fear. On page 36 of *Lesbians Talk Transgender*, author Pat Cali notes she is “afraid that the visibility of FTMs will change the definition of what’s butch until women will feel that they have to take male hormones to make them masculine enough to be butch... Labels are important to us and we stigmatize women who don’t meet our expectations of the roles we have assigned them... I am afraid of not qualifying, not counting, being second rate.”

So am I. One of the women kicked out with me had been living in a halfway house where she was not allowed to crossdress. Another had been criticized because she is balding and could afford only a wig, and not hair transplants. All three either lost work or were having trouble locating jobs because of their gender. Now, I cannot recall anyone in the group suggesting where they might apply for work or finding inexpensive ways for them to get their electrolysis. They were judged as second rate because of their failures to solve their problems by themselves.

Frankly, the concept of setting up some litmus test for who is or is not a “real transsexual” strikes me as a tremendously male way of thinking. This is setting up a hierarchy based on who has the most TS points. “Nyah, nyah, I’ve got more TS points than you do, so I’m more of a woman (or man) and a better person than you are!” Oh, really!

The result of this attitude is that members whose spouses have stuck with them through their gender change do not participate in the group because their lovers are not welcome, while they themselves are pressured to “behave appropriately” by divorcing those they love. Another result is that those members who are most in need of support are cast out in their time of despair, while those who remain find themselves compelled to play out a role or risk rejection themselves.

In her *Transsexual Survival Guide*, JoAnn Altman Stringer notes that only a minority of those who seek surgery will actually have it. Of those who do not, some will live full time as women (or men), but will either not feel the need for sex reassignment surgery or will never have the money to pay for it. Others will discover that as much as they may celebrate their femininity or masculinity, a full-time transition is not really what they need or want in their lives. This is why there is a one-year real-life test before we can get surgery—not to compel us to prove our dedication to being women or men, but to give us the time and experience to be sure that this is not an impulse, and to be sure of what we truly want to do with our lives.
When transsexuals must prove themselves by getting surgery within a specified time, then we create a situation in which it is not possible to voice any doubts. To express doubt is, in effect, to exile oneself from the group. If the group is the only supportive force in our lives, then it becomes 'way too dangerous to openly acknowledge any feelings that are “inappropriate.” And so we feel pushed into making decisions that may be wrong for us in order to be Transsexually Correct.

Aside from the I hope obvious inhumanity of such rigidity, does it not also seem politically fatuous? We are at best a small minority in a world which seeks to marginalize and even destroy us. What profit is there in taking what little strength we have as a community and splintering it into ideologically pure shards consumed with internal squabbles instead of using it to build coalitions with other oppressed and marginalized communities such as women, gays, Blacks, Hispanics, and Native Americans? Together, we might have enough strength to actually stop our real enemies.

The Song “The Yew Tree” notes that “When the poor hunt the poor across mountain and moor, the rich man can keep them in chains.” When a national transvestite group refuses after thirty years to admit gay crossdressers or transsexuals, no one benefits but Jesse Helms. When gay liberation groups dump the drag queens who have raised so much money for gay causes in order to protect their image, the only image that gets burned is Pat Buchanan's. When a lesbian event expels a lesbian woman simply because ten years ago she was a man, only Rush Limbaugh benefits. And when transsexuals hold themselves superior to and do not deign to mingle with mere crossdressers, it's another vote for Pat Robertson.

A well-known Talmudic proverb asks, “If I am not for myself who will be for me? But if I am for myself alone, what good am I?” Now, I am a feminist and I believe fervently in the sisterhood of womanhood and of MTF transsexuals. How can I call myself a woman and not be for the rights of women? How can I call myself a transsexual and not support the rights of all my brothers and sisters?

We do not build a community by casting out the weak and homely among us. We do not earn respect by sacrificing the outrageous upon the altar of public opinion. We do not strengthen ourselves by walling ourselves off from other minority communities, or by balkanizing our own community into a dozen mutually exclusive ghettos. Of course, we are a community of very diverse individuals. Many of us have little in common beyond the fact of our gender issue. It is not to be expected that we will all get along well, or even like each other very much. I do not hold myself guiltless in this. On the other hand, I acknowledge that my dislike for certain factions in the community is my problem. My not liking someone else's sense of fashion does not give me the right to expel them from a group, nor to define who they are. Everyone is entitled the respect for their personal dignity and their individual needs and tastes.

I believe in trying to help my brothers and sisters in any way I am able. I do not believe it helps anyone when a transsexual who hasn't completed electrolysis or started hormones, who has a great deal of difficulty in passing, is told to prove her transsexuality by going full-time right now and loses her employment and family as a result. Yes, there are transsexuals who have done exactly that and are living fulfilled, happy lives. There are a lot more who have tried doing it that way and are not living happily. Some of them aren't even living at all.

It may be that you feel that those who expelled me are right: that I am a crossdresser, and not transsexual. I don't agree, but you certainly have the right to hold that opinion. Whether you do or don't, remember this: What we struggle for is the right to be who WE say we are, to be who WE feel we are. That is not a license to be indifferent to other people—it is the right to define yourself. When you give anyone, even your transsexual brothers and sisters, the right to define who you are, you give up the right to be true to yourself.

Whatever else, I will be my own woman. CQ

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Gail Sondegaard is the publisher and editor of Transsexual News Telegraph. The following is excerpted from her Voices of Childhood, another transsexual autobiography.

Q: What's the difference between a crossdresser and a transsexual?
A: About five years.

— Transgender Community Joke

Transsexuals and homosexuals frighten crossdressers. Transsexuals frighten transgenderists. Crossdressers frighten transsexuals. And so it goes.

Do these groups pose a danger to one another? No, they do not. It is, however, human nature to overlook the many ways in which we are similar to others in favor of the small ways in which we differ. We magnify these differences until they seem huge. I think it is a primate thing, a mammal thing, something rooted deep within our DNA.

When someone has an irrational and unreasonable fear of others, there is only one reason— insecurity in their identity. When heterosexual crossdresser groups police their applicants to keep out suspected gays or transsexuals, it is because those in charge have issues in those areas. When transsexuals loudly proclaim that they are different from crossdressers, it is because at a deep level, they know they aren't. When transgenderists who choose not to have surgery argue loudly against those who do have it, it is because at their deepest level, they desire it. When transsexuals insist that only "real" transsexuals have surgery, it is because way down deep, they fear having it or regret having had it — Ed.

Dream last night: I am in my apartment at night with Martin. Outside my door I hear Skyler barking. I also hear Lynn, my downstairs neighbor. "Well, I have to do it eventually," I think to myself. "Lynn," I call out, and open the door. I introduce myself and tell her my name is Gail. We talk for a few minutes. An old woman is walking a small dog in the hallway. She passes us by. Lynn says that the old woman needs a push in the noosh (meaning butt). We laugh like two women sharing a joke. end of dream. (3/29/86)

Dream last night: I am in an apartment at night with Martin. I am dressed the way I am at work now, hair pulled back and wearing green sweater vest. I am happily telling Martin how I am going to change my sex. end of dream. (4/1/86)

Dream two days ago: I am a woman, driving a car down a country road at night. Another woman, who is in shadows and has the same hairstyle as me, sits in the back, silent. We drive up to a farmhouse with tall trees. It is deathly silent, no wind, still. end of dream. (4/2/86)

By spring, 1986, I lived as a woman all the time except for work. I needed to talk with others about this experience. I wanted the insights that could come only from other transsexuals. I wanted to hear how they coped with living in the world as transsexual women, how they dealt with the problems and harassments, as well as the good times.

There was only one support group in San Francisco at this time. It met once a week at a new age storefront church in the outer Richmond district, eight blocks from the ocean. There was a core group of five people with 10-12 people usually attending each meeting. Some of the people in the group I already knew. Some were post-op. But mainly the group was made up of people like me: young and not-so-young MTFs just starting their transition to living full time as women.
I had not had good experiences in other support groups. No one ever spoke about the troubles we faced, the way the medical establishment jerked us around, the pros and cons of surgery, the problems of passing and the problems of not passing. I was hoping this one would be different.

I was soon disappointed. Everyone tried to paint the sunniest picture possible of their lives, but there was a jarring dissonance between the events described and the way each person said they felt about them. People spoke of families who no longer talked to them or friends who now pointedly ignored them, but invariably described such painful occurrences as insignificant, even laughable. When a woman named Janice cheerfully told how a once-friendly co-worker had turned her desk around so she wouldn't look at her, I had to say something.

"That sounds awful," I timidly said.

"Oh no, it's really funny," Janice replied. She had a happy grin frozen on her face and looked like she was about to cry. "Really, it is." Everyone else in the group smiled at her in support. I said nothing more, but I didn't believe her.

There was a widely held viewpoint at this time that any complaints, criticisms or acknowledgement of bad times meant one shouldn't be cross-living or, at the extreme edge of opinion, that one wasn't transsexual. This pernicious belief was held not only by transsexuals but by many "helping professionals" as well. I knew the world could be quite cruel from the hatred that many people carried for transsexuals. Everyone else knew it, too. But no one talked about this. It left me experiencing emotional pain in isolation, with cold comfort coming only from the ridiculous notion that talking about the difficulties of being transsexual was something to be ashamed of. It made the honest expression of emotional experience so necessary for mental health impossible.

And I was no better than anyone else in the group. I might vent my frustration about this state of affairs in my diary, but never spoke about these feelings when I had the chance. I didn't want to alienate myself from everyone, as contact with other transsexuals was too important to me.

Most of the talk was about surgery— how soon a person was going to have it, who their surgeon would be, and how, after surgery, each person would no longer need to come to the group. Anyone who still came to the group after surgery was seen as a failure.

My own feelings about surgery were sharply divided. My dreams were alternately filled with positive hermaphroditic images and feelings of anguish about my genitals. I didn't try to reconcile these disparate feelings in waking life. It was easy not to think of them. The long-stifled feelings about my family forced every other thought out of my mind.

I knew enough post-ops to know that the outcome of surgery wasn't always successful. While many of the pre-ops spoke enthusiastically about The Big Surgery Date on their one year anniversary of cross-living full time, almost all of the post-ops knew, even the ones who had been gung-ho for the surgery as pre-ops, were now subdued when the subject came up. None of my post-op friends actively discouraged me from having surgery, but no one pushed it with their former fervor, either.

I had been lovers with a post-op transsexual woman for about a year. One night, while we lay in bed, Colleen spoke frankly about her surgery.

"I'm lucky," she said. "I can have orgasms, but it just as easily could have gone the other way. The odds of getting a good result are no better than flipping a coin — just 50%. It's a dooryway you go through only once, and you can't know what's on the other side until you get there."

"Then why did you do it, if it's that risky?" I asked.

Colleen reached out and put her hand on my cheek. "When you're like us," she said, "it's almost inevitable."

The uncertainty of the outcome of surgery didn't bother me. There were so many variables to consider — how good was the surgeon, for one, or which method one chose, or the differences in each individual's post-surgical care and healing capacities. What did bother me was that no one talked about the uncertainties of surgery or even acknowledged that there was a risk. The surgery was regularly spoken of as if it was no more complicated than setting a broken arm. Whenever the reality of bad surgery came up, it was always someone else's, and dismissed with the remark, "So-and-so just wasn't transsexual."

Some of my feelings about surgery surfaced at one meeting when one lady said she wouldn't be living as a woman if she couldn't have surgery.

"I would," I said. Everyone turned and looked at me. I nervously continued, "If I couldn't have surgery, I'd still live as a woman." This was greeted with shrugs. I have always wondered if I was written off as someone who wasn't "real" in her transsexuality.

But I believed that being a transsexual was more than having your dick cut off. Being a woman sprang from one's nerve endings and muscles. It was a way of being, thinking, and feeling in the world. Being TS was what you were inside, not what surgical procedures you had done to your body. I would always be transsexual and live as a woman until I died, whether I had surgery or not. Hearing someone say they wouldn't live as a woman if they couldn't have surgery made me wonder: if you could live as a man and have your genitals removed, would you still want to live as a woman? What was more important—having your genitals removed, or being a woman?

Achieving surgery as fast as possible was openly encouraged by other transsexuals and, in a more subtle way, by gender therapists and helping professionals. Getting on the surgery treadmill, we called it, because the desire for surgery defined a person as transsexual, and any ambivalence meant you weren't. If you didn't tell the shrink you had a surgery date already scheduled when you started cross-living, you were liable to get your hormones yanked, something I personally could not have lived with. The shrinks had a great racket going: if you wanted a surgery approval letter, you had to see the shrink for a year. At a minimum of $75 a session for 52 weeks, it amounted to a $4000 bribe, paid on the installment plan.

I was bothered that many people in the group approached being a
woman as something to be accomplished through money and technology. "Once I've had the surgery, there'll be no going back and I'll have to make this work!" was a common statement, as though being a woman was accomplished by making it impossible to back out. More frequently, surgery was seen as magical transformation: "After the surgery, then I'll feel like a woman, then I'll be feminine, then I'll pass." But if you weren't like a woman before the surgery, you wouldn't be like one afterwards. All the hormones and surgery in the world wouldn't give you an identity you didn't already have.

Transsexuals approached surgery from many different perspectives. Some approached surgery as though it was the ultimate macho trip. Their attitude seemed to say, "I'm so macho I'll even cut my balls off," while others seemed to encourage surgery out of a spirit of malice, as if they regretted their choice and wanted others to make the same mistake.

Surgery could also be an act of repression. After the surgery, it became irrelevant how you felt about your genitals. The only approach that resonated for me was Colleen's expression of the inevitability of surgery.

A story made the rounds once of a woman who passed quite convincingly to her psychiatrist. At the end of a year he wrote a letter approving her for surgery. What he didn't know was that she only lived as a woman when she went to see him. The other 167 hours of the week she lived male. She apparently believed that after the surgery she would automatically adapt to living as a woman full-time. Cross-living full-time for the very first time was a big shock to her, and rumor had it that she almost checked out. I later heard that she had been sincere in her woman-feelings, but way off on her execution.

But I wasn't even living full-time as a woman yet, and had nothing even close to the amount of money needed for surgery. Most of my thoughts now were of how to break the news of what I was to my mother, and what I was going to do.

two dreams last night: In the first I am fighting with my mom and dad. It ends when I tell them they are only a dream. In the second, I am in my apartment and every possible opening is blocked—windows, doors are shut, blocked with chairs and tables. There is even a stepladder shoved up a chimney! end of dream. (4/14/86)
dream last night: I am Gail, but feeling lousy-male, trying to get a job in a restaurant. The owner hires me, straight cash, but I can't take the job because I can't put myself out there as Gail. Then the dream shifted. People from work are involved—Agnes, Ed, Malcolm. I am trying to tell Agnes about myself when Ed and Malcolm somehow "know" I'm TS. I freak, become angry, walk out. Ed and Malcolm both call for me to come back but I keep walking. Then I realize I have no place to go, or hide. end of dream. (6/14/86) CQ

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