ENDAblog

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For Those Who Think A Dressed-Up, Toned-Down, Academic-y, Touchy-Feely Paper From a Crackpot Trans-Eliminationist Should Just Be Ignored…

…we have the one thing that trans-eliminationists hate most of all: history (don't let the reference to "historical sex" fool you.)

- "Is there any such enduring reality as biological maleness or femaleness?"
- "Transsexualism as disease raises many deeper issues about the medical model in general and the ways in which transsexualism has come to the defined as legitimate medical territory."
- "Historical sex is a term that I would add to this already lengthy list of distinctions. History is important, in this context, because there is a certain constellation of events that attend the sex into which one is born. For example, menstruation for a girl is a biological happening, but it is also a historical event around which cluster a certain set of very different yet also very similar collective female experiences. Men do not have a history of menstruation nor the experiences which surround its onset, its monthly occurrence, or its demise."
- "[I]n the name of dealing with an individual crisis, itis important to note that this kind of therapy does not foster genuine individualism. Current transsexual therapy and surgery promote an individualism that serves a role-defined society. Thus, it is more accurate to say that these are solutions that promote the values of social conformity. To use another example: Many oppressed people use heroin to make life tolerable in intolerable conditions."

The context:

Paper Prepared for the National Center for Health Care
Technology on the Social and Ethical Aspects
of Transsexual Surgery
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The subject of transsexualism, whether raised in the public forum or in the academic or medical communities, has been viewed generally as a medical issue that requires hormonal and surgical intervention. Several assumptions accompany this profile of transsexualism.

1) That the transsexual is a person who is trapped in the body of the wrong sex. Thus we have the popular definition of a transsexual as a "female mind in a male body."[1] This results in the perception of transsexualism as a disease or as disease-like and thus a medical problem. In many cases, a "cure" can only be effected through radical intervention such as specialized hormonal treatments and sex conversion surgery.

2. That it is possible to transsex, i.e., to change one's sex through such medical intervention.

3. That it is a therapeutic necessity and a reasonable and humane treatment to perform surgery on those individuals who have undergone rigorous preoperative psychological evaluations and who can truly "pass" as members of the opposite sex. Furthermore, proof of the surgery's efficacy is that over 90% of those who have undergone transsexual operations report that their lives are healthier and happier.

The aim of this paper is to analyze these assumptions and, in so doing, to address the much-neglected social and ethical issues surrounding transsexual surgery. Transsexualism is an important medical ethical issue that raises questions that go far beyond the transsexual context -- questions of bodily mutilation and integrity, medical priorities, unnecessary surgery, the inevitable issue of the medical model in general, as well as definitions of maleness and femaleness, and the boundaries of such. Scholars will also find that transsexualism touches the parameters of many of the academic disciplines in such a way as to raise fundamental questions about the territorial imperatives of biology, psychology, medicine, and the law, to name but a few. Questions about the causes of transsexualism and the proper methods of treatment have been hitherto restricted to the domains of psychology and medicine. But as an ethicist, I would maintain that these issues of causation and treatment are often embedded with social values and philosophical beliefs -- values and beliefs about the so-called natures of women and men, for example.

Historically, one could say that some people have always felt "trapped" in the wrong body, in the wrong skin, and in the wrong period of time. But this feeling never certified them as members of the "right" body, skin, or period of time. For example, persons who felt "trapped" in black skin were never encouraged to undergo a pigmentation change. Ultimately, it was recognized that such "trapped" feelings were encouraged by a society that oppressed and discriminated against black people, and that it was the society that needed changing, not the individual black. In the same way, to acknowledge that a man who feels trapped in his native-born body is a transsexual (and ultimately, through hormonal and surgical intervention, a woman), is to ignore the social causes and ramifications that surround the issue. Indeed, one must ask why it is possible in this society that persons could even talk about a "female mind in a male body."

If transsexualism is a disease, then does desire qualify as disease? As Thomas Szasz has asked, does the old person who wants to be young suffer from the "disease" of being a "trans- chronological" or does the poor person who wants to be rich suffer from the "disease" of being a "transeconomical?"[2]

Transsexualism as disease raises many deeper issues about the medical model in general and the ways in which transsexualism has come to the defined as legitimate medical territory. Within the last century, more and more areas of life have come to be defined as medical and technical problems. This is most evident, of course, in the mental health realm where all sorts of behaviors have been categorized as diseases, and then treated by drugs, surgery, and other medical-technical means. My point here is to affirm that more and more personal, moral, and now social problems are defined as medical problems when they are actually human and social conflicts. Approaching these conflicts from a diagnostic and disease perspective prevents the person who is dissatisfied with his sex from seeing the issue in an alternative framework. Specifically, persons who think they are transsexuals are not encouraged presently to see this desire as arising from the social constraints of masculine and feminine role-defined behavior. Thus a man who wishes to be emotional or non-aggressive is encouraged to think of himself as a woman instead of as a man who is trying to break out of the masculine role.

The ultimate effect of defining transsexualism as a disease, and as a medical problem, is to encourage persons to view other persons (especially children) who do not live out proper and appropriate sex role behavior as potential transsexuals. Thus, for example, for the boy who likes to play with dolls or the girl who wants to be a truck driver, these behaviors can be interpreted as transsexual behavior instead of as non-stereotypical behavior that helps to break down sex roles. Thus the classification of transsexualism as a disease or as a therapeutic category relegates non-stereotypical sex-role behavior to the medical realm.

It is important to understand that doctors here are not curing a disease. They are actually engaged in the political and social shaping of masculine and feminine behavior. Several facts bear out this contention. Here especially, I note the role of the so-called gender identity clinics and private therapists who foster and reinforce stereotyped behavior. Persons wishing to change sex come to these clinics or go to individual therapists to receive counseling and ultimately to be referred for treatment and surgery. It is a primary requirement of these centers that men who wish to be transsexed must prove that they can "pass" as "true women" in order to qualify for treatment and surgery. "Passing" requirements evaluate everything from an individual's feminine dress, to

feminine body language, to so-called feminine positions in intercourse. Most clinics require candidates for surgery to live out opposite sex-roles and rigidly defined stereotypical behavior for periods of six months to two years. Thus the role of these clinics and clinicians in reinforcing sex-role stereotypes is significant and, as I have tried to show above, one that has consequences that reach far beyond the transsexual issue. I would suggest that what we are witnessing here is a "benevolent" form of behavior control and modification. It is not inconceivable that gender clinics, in the name of therapy, could become potential centers of sex-role control for non-transsexuals--e.g. children whose parents have strong ideas about the kind of masculine or feminine children they want their offspring to be.

The ultimate effect of viewing the desire to live as a member of the opposite sex as a disease or as a medical category is that a social and ethical issue becomes transformed into a therapeutic and medical-technical problem to be solved by "passing" requirements, hormone therapy, and sex conversion surgery. Medicine focuses on the surgical construction of desired genitalia. Artifacts of silicone breasts, artificial vaginas, and the like come to incarnate the essence of femaleness which the transsexual so desperately desires.[3] Since the general result of sex conversion surgery is that the transsexual becomes an agreeable participant in a society which encourages conformity to rigid sex role behavior, then ultimately the medical solution becomes a "social tranquilizer." Sexism, and its foundation of sex-role stereotyping, is reinforced.

Transsexual surgery also enables doctors to gain medical knowledge about the manipulation of human sexuality that probably could not be acquired by any other medical procedures. In what other medical situation could a penectomy be done upon a healthy penis and an artificial vagina inserted into a chromosomal male? What we also witness in the transsexual context is a number of medical specialties combining to create transsexuals -- urologists, gynecologists, endocrinologists, plastic surgeons, and the like. The proliferation of treatments that has been generated to take care of the "disease" is remarkable. These range from the initial and basic operative procedures undergone by all transsexuals to highly specialized forms of secondary cosmetic surgery such as eye, nose, and chin operations.[4] Not coincidentally, hormone therapy and surgery are expensive.[5]

The terminology of transsexualism becomes an issue in this context. For by its very existence, the word perpetuates the notion that transsexualism is a state of being, and that there is a group of people who will continue to need the surgery because they are "born" transsexuals. Until the surgery was popularized, in the aftermath of the Christine Jorgensen case, the specific need of surgery for a group of persons known as transsexuals was not evident (although, of course, some people may have felt that they wished to change sex). The extent to which the popularization and availability of surgery has generated a wider need for it is obscured by the terminology of transsexualism itself.

Finally, treating transsexualism as a disease and making it medical territory have also masked the fact that a unique group of medical consumers has been created by medicine itself. The terminology of transsexualism disguises the reality that transsexuals prove they are "real" transsexuals by conforming to the canons of a medical institution that evaluates them on the basis of their being able to pass as stereotypically masculine or feminine, and that ultimately grants surgery on this basis. Once sex-role dissatisfaction is given the name of transsexualism, institutionalized in gender identity clinics, and treated

by hormone therapy and surgery, the category of transsexualism functions to explain and order very valid dissatisfactions with sex-role stereotypes.

The terminology of transsexualism raises the inevitable question of is it possible to change sex, i.e., to transsex? To answer this, it is necessary to discuss various meanings of the word SEX, a word that has both a dismaying multiplicity and ambiguity of meanings. John Money has distinguished various definitional levels of the word SEX that are helpful in assessing whether it is biologically possible to cross sex.[6] Chromosomal sex determines biological maleness or femaleness, contrary to popular opinion that anatomical sex is determinative. Normal males have a chromosomal pattern of XY with normal females being XX. There are some individuals who are born with chromosomal anomalies in which surgery is often used to bring the anomalous person in line with the anatomical characteristics that become most dominant, or else the developing anatomical characteristics are altered in line with the sex in which the child has been reared. The pattern of sex chromosomes is present and unchangeable in every body cell, including blood cells. Chromosomal sex can, however, conflict with anatomical sex.

Anatomical sex refers to primary and secondary sex characteristics. Primary characteristics include the testes in the male and the ovaries in the female. Secondary anatomical sex characters include the penis, scrotum, prostate, hair distribution, and a deeper voice in the male; and the clitoris, vulva, uterus, vagina, breasts, a wide pelvis, female voice, and hair distribution in the female. Transsexual surgery alters anatomical sex through hormonal and operative procedures.

Genital or Gonadal sex is the collective term for the tests in the male or the ovaries in the female.

Legal sex is designated most often by genital sex, although this is not actually defined in the codes. It is in this area that errors of sex do occur, since the obstetrician or mid-wife may be deceived by the apparent genital sex. Endocrine or Hormonal sex is determined by androgen in the male and estrogen in the female, supplied by not only the sex glands, but also by the pituitary or adrenal glands. Endocrine sex is mixed to certain extents since, for example, the testes as well as male adrenals, produce certain amounts of estrogen.

Psychological sex or the word gender are terms used in much of the literature to designate attitudes, traits, characteristics, and behavior that are said to accompany biological maleness or femaleness. I would prefer the term psychosocial sex to indicate the all-important factor that such attitudes, traits, characteristics, and behavior are socially influence and orchestrated.

Historical sex is a term that I would add to this already lengthy list of distinctions. History is important, in this context, because there is a certain constellation of events that attend the sex into which one is born. For example, menstruation for a girl is a biological happening, but it is also a historical event around which cluster a certain set of very different yet also very similar collective female experiences. Men do not have a history of menstruation nor the experiences which surround its onset, its monthly occurrence, or its demise.

What significance does this delineation of the various terminologies of sex have in answering the question of is it possible to change sex? Beginning in order with the list of sex distinctions, the most important reality is that it is biologically impossible to change

chromosomal sex. If chromosomal sex is taken as the bottom line of maleness or femaleness, the male who undergoes sex conversion surgery is NOT female.

Anatomically, transsexualism does take place, but anatomical changes also happen in what is commonly termed plastic surgery. Transsexual surgery alters genital or gonadal sex most intrinsically. For example, it is possible to remove a woman's ovaries or a man's testes through this surgery, and it is also possible to construct an artificial vagina in a man whose penis and testes have been removed. The question then becomes how much value one would give to this kind of alteration in terms of changing the totality of a person's sex. George Burou, a Casablancan physician who has operated on over 700 American men who wanted to become women, expressed the superficiality of changing genital sex in this way: "I don't change men into women. I transform male genitals into genitals that have a female aspect. All the rest is in the patient's mind."[7] Furthermore, a change in genital sex does not make reproduction possible.

Endocrine or hormonal sex is the most susceptible to alteration, but this is done without surgical intervention. Hormonal intake of opposite-sex hormones have certain anatomical effects resulting in, for example, breast for men or a redistribution of body hair for both women and men. Hormonal treatments must be lifelong, however, for most of the anatomical effects to be prolonged.

In law, it is possible to transsex; that is, it is possible to change one's legal sex. However, the whole area of legal sex has been one of contention for the transsexual who wishes to have sex conversion surgery validated by a corresponding change of sex on official papers such as birth certificates, social security, drivers' licenses, and the like.

If it is impossible to change basic chromosomal structure, then it is necessary to take a more in-depth look at not only the terminology but also the reality of transsexualism? Can we call a person a transsexual, biologically speaking, whose anatomical structure and hormonal balance have changed, but who is still genetically XY and XX? If chromosomal sex is not the bottom line, what are we really talking about when we say that a person is a biological male or female?

Is there any such enduring reality as biological maleness or femaleness?

Obviously, there is more to maleness or femaleness than chromosomal make-up. Feminists have been arguing this for years, and I am not re-affirming the biology is destiny argument. In fact, it is transsexuals and defenders of the surgery who are asserting a new form of biology is destiny. For what they are ultimately saying is that it is impossible to change male or female behavior, traits, characteristics, and the like UNLESS one also changes one's body. Transsexuals define themselves by exclusive reference to the body of the sex they want to be. This is a new variation on the theme of biology is destiny. What transsexuals and those who support the surgery affirm is that persons are irrevocably determined by what body they are born with. In the transsexual context, persons desiring the surgery become enfettered by both the unwanted body of their chromosomal sex (which they reject) and the body of the opposite sex for which they are willing to undergo painful and mutilating surgery. Ultimately, the transsexual and the medical community which supports surgery give the message that the body is all-important, that it does guide one's destiny, and that all else is body-bound.

Chromosomal sex is the enduring reality which determines biological maleness or femaleness. This can never change. What is more significant in determining the totality of maleness or femaleness, however, is what I have called historical sex. No man can have the history of being born and located in any culture as a woman. He can have the history of wishing to be a woman and of acting like a woman, but this is the history of one who DESIRES to be a woman, not of one who is a woman. Surgery may confer the artifacts of outer and inner female organs, but it cannot confer the history of being born a woman in this society.[8]

History, of course, is not static. All of us make changes in both our personal and social history. I am not advocating that history should determine the boundaries, life, and location of the self. However, there are aspects of anyone's personal and social history that cannot be changed. For example, a person who is born into a particular class cannot change that history. He can change his class attitudes, habits, and complex of behaviors that accompany a certain class typology. Likewise, in the transsexual context, a man cannot change his history of having grown up male. Men who want to change masculine attitudes, habits, and complex of behaviors should not take on the bodies of women but rather should try to change their unwanted history in their own bodies.

To summarize, it is impossible to change sex, i.e., to transsex, because it is impossible to change not only the chromosomes of one's native-born sex but also much of the personal and social history that accompanies biological maleness and femaleness.

Proponents of transsexual surgery claim that the only way of treating those individuals who find themselves to be born into "the wrong sex," and who have undergone rigorous preoperative screening procedures, is ultimately through sex conversion surgery. It is emphasized that many persons who think they might be candidates for surgery are weeded out through these stringent evaluations, and only those who can truly "pass" as women (or men) are referred for surgery. For this small number of individuals, transsexual surgery is not only a therapeutic necessity but a reasonable and humane treatment. Furthermore, the majority of postoperative reports of transsexuals testify that the surgery has been proven effective and efficacious and is therefore no longer experimental. They cite the fact that 90% of those persons who have undergone surgery report that their lives are happier and healthier.[9]

These reports, however, do not explore the deeper social issues, nor do they question a satisfaction that is achieved at the expense of never investigating the underlying social and ethical issues. They do not state that after surgery the transsexual fits into a role-defined world better than most native-born women who live out their feminine roles.

Critics of this position maintain that it would be an overwhelming burden on both the transsexual and the therapist to attack so large a problem as sex-role socialization in the therapeutic, never mind social, context. Therefore, it is easier, to confront the problem within role limits, making use of a ready-made social structure that created transsexualism initially. While proponents of transsexual surgery may admit that it would be preferable to modify society's attitudes toward masculine and feminine behavior, they emphasize that in the immediacy of the therapeutic moment, the task of social change is impossible. Faced with the personal crisis of a gender-disturbed individual, they opt for ignoring or relegating the social effects to a secondary place.

However, in the name of dealing with an individual crisis, it is important to note that this kind of therapy does not foster genuine individualism. Current transsexual therapy and surgery promote an individualism that serves a role-defined society. Thus, it is more accurate to say that these are solutions that promote the values of social conformity.

To use another example: Many oppressed people use heroin to make life tolerable in intolerable conditions. Heroin usage is a highly effective yet dangerous treatment for dissatisfaction and despair. Recently, black leaders have drawn attention to heroin as a pacifier of black people. The contentment and euphoria produced by the drug diffuses the critical consciousness of the users.

Although there are many real differences between the users of heroin and the recipients of transsexual surgery, the analogy is appropriate in at least one significant way. Transsexual surgery produces satisfaction and relief for the transsexual at the expense of muting his or her critical consciousness of the ways in which such surgery reinforces sex role behavior. Thus transsexuals are not encouraged to ask how their own socialization conditioned not only their choice of surgery, but also their motivation to choose.

It is in this sense that transsexual surgery can be said to be experimental surgery. Transsexuals are seeking surgery to relieve gender discomfort and dissatisfaction. Within the context of a role-defined society, the surgery is narrowly successful at doing this for some transsexuals. But there is no evidence to prove that the surgery "cures" the deeper problems which lead many persons to seek the surgery. In other words, sex conversion surgery cannot bestow upon the transsexual the sense of self that he or she lacks. Furthermore, there is evidence, at least in some postoperative cases, that transsexuals themselves have come to realize this, but too late. Meyer and Hoopes, as early as 1974, noted that a group of their patients had reacted self-destructively after surgery. These reactions included multiple and serious suicide attempts, drug abuse, and serious physical complications.[10] Randall in an earlier study, reported on four cases (out of 29) in which postoperative adjustment was worse than before the operation. The behavior included suicide, suicidal impulse, moral depravity, and a wish to reverse the effects of the operation.[11]

One of the first well-known physicians to work in the areas was Charles Ihlenfeld, an endocrinologist, who was a co-worker and protégé of Harry Benjamin. Ihlenfeld left the field after helping one hundred or more transsexuals change sex because as he reported to have said: "Whatever surgery did, it did not fulfill a basic yearning for something that is difficult to define. This goes along with the idea that we are trying to treat superficially something that is much deeper."[12]

Finally, Johns Hopkins terminated transsexual surgery in 1979 after conducting a study of fifty transsexuals which showed that there was no significant difference in successful life adjustment between those who underwent transsexual surgery and those who did not. The study was the first to compare postoperative transsexuals with an unoperated group of persons who wanted the surgery. The study, initially reported in the ARCHIVES OF GENERAL PSYCHIATRY and in the press release issued by Johns Hopkins which appeared in newspapers across the country said, among other things: "Physicians have to ask themselves if transsexual surgery is medically necessary. To say that this type of surgery cures psychiatric disturbance is incorrect. We now have

objective evidence that there is no real difference in the transsexual's adjustment to life in terms of jobs, educational attainment, marital adjustment, and social stability."

On physical grounds alone, there is a substantial amount of evidence to confirm that sex conversion surgery is experimental. Transsexual treatment is far from established as a safe medical procedure. In some instances, it has been known to cause cancer. In 1968, W. Symmers reported two cases of carcinoma of the breast in which the transsexuals died. He suggested that the malignance was entirely due to the hormonal imbalance created by castration plus the massive does of estrogen received.[13] There are several other studies that have investigated the correlation between male-to=constructed female transsexualism and cancer.[14]

This paper has argued that the issue of transsexualism is an ethical one that has profound social and moral ramifications. Transsexualism itself is a deeply moral question rather than a medical-technical answer. In concluding, I would list some suggestions for change that address the more social and ethical arguments I have raised in the preceding pages.

While there are many who feel that morality must be built into law, I believe that the elimination of transsexualism is not best achieved by legislation prohibiting transsexual treatment and surgery but rather by legislation that limits it and by other legislation that lessens the support given to sex-role stereotyping, which generated the problem to begin with. Any legislation should be aimed at the social conditions that initiate and promote the surgery as well as the growth of the medical-institutional complex that translates these stereotypes into flesh and blood. More generally, the education of children is one case in point here. Images of sex roles continue to be reinforced, at public expense, in school textbooks. Children learn to role play at an early age.

Nonsexist counseling is another direction for change that should be explored. The kind of counseling to "pass" successfully as masculine or feminine that now reigns in gender identity clinics only reinforces the problem of transsexualism. It does nothing to develop critical awareness, and makes transsexuals dependent upon medical-technical solutions. What I am advocating is a counseling that explores the social origins of the transsexual problem and the consequences of the medical-technical solution. It would raise questions such as the following: is individual gender suffering relieved at the price of role conformity and the perpetuation of role stereotypes on a social level? In changing sex, does the transsexual encourage a sexist society whose continued existence depends upon the perpetuation of these roles and stereotypes? These and similar questions are seldom raised in transsexual therapy at present.

I am not so naive as to think that these measures would make transsexualism disappear overnight, but they would at least pose the existence of a real alternative to be explored and tried. Given encouragement to cultural definitions of both masculinity and femininity, persons considering transsexual surgery might not find it as necessary to resort to sex conversion surgery.

Public education must also be emphasized. Up to this point, the transsexual and the transsexual professionals have been the sources of information for the general public. The mere existence of the postoperative transsexual, moreover, and the fact of the surgery's availability permit people to restrict their thinking about sex role dissatisfaction to these medical-surgical boundaries.

One way in which education about transsexualism has reached the general public is through the media. Famous transsexual personages such as Jan Morris or Renee Richards appear in widely circulated magazines and on television talk shows. Thus transsexualism becomes "media-ized" in certain prejudicial ways, which contribute to public opinion that surgery is indeed the solution to gender dissatisfaction. Different perspectives on the issues of transsexualism need to receive more attention and publicity. We need to hear more from those men and women who, at one time, thought they might be transsexuals but decided differently -- persons who successfully overcame their gender crises without resorting to medicine and surgery.

We need to hear more also from professionals such as endocrinologist Charles Ihlenfeld who, after helping many to change sex, left the field. Finally, we need to listen to persons, such as feminists, who have experienced sex role dissatisfaction but did not become transsexuals.

In the final analysis, it is important to remember that transsexualism is merely one of the most obvious forms of gender dissatisfaction and sex-role playing in a role-defined society. It is one of the most obvious because, in the transsexual situation, we have the stereotypes on stage, so to speak, for all to see and examine in an alien context. What can be overlooked, however, is that these same stereotypical behaviors are lived out every day in "native" bodies. The issues that this paper has highlighted should by no means be confined to the transsexual context. Rather they should be confronted in the "normal" society that spawned the problem of transsexualism to begin with.

Footnotes

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1. Since the preponderance of those seeking the surgery and those undergoing it are men, my consistent references throughout this paper are male pronouns and examples. According to international medical literature, only one out of four persons who requests and obtains surgery is female. I also use male references, because I do not want to contribute to a false affirmative action mentality which represents transsexualism as a human problem. It is very clearly a male phenomenon.
2. See Thomas Szasz, review of THE TRANSSEXUAL EMPIRE: THE MAKING OF THE SHE-MALE by Janice G. Raymond, New York Times Book Review, June 10, 1979, p. 11.
3. The medical literature on transsexualism is a good example of the way in which the medical model has confined the questions raised by this issue to a narrow and fetishized field of inquiry. Such literature is replete with photographs, plates, and anatomical drawings of sexual organs. Interestingly, these photographs seldom show the whole person. They center on the genitalia. The narrow area of the chemical and surgical specialties commands attention here in such a way that the primary problem often is represented as how to construct a vagina, for example, in an aesthetic a way as possible.

4. A "salvation by surgery" ethic is created by the initial transsexual procedures. Secondary operations are often sought by the transsexual, usually for esthetic reasons and/or to correct real or psychologically felt complications. This cosmetic surgery frequently has nothing to do with refashioning the genitalia. Rather such surgery is undertaken in the hope of conforming the postoperative body more to fashionable and stereotypical feminine body images. Many transsexuals resort to an immense amount of polysurgery to fit themselves to the prescribed body measurements and gestalt of a curvaceous feminine figure.

5. 1978 figures estimated that, on the average, the male-to-constructed female operation and hospital stay alone can cost from $3,000 to $6,000. The female-to constructed male operation involves a series of several operations before the results are achieved and costs up to $12,000. There are, of course, many other expenses besides the surgery and hospital bills.
6. See John Money, "Sex Reassignment as Related to Hermaphroditism and Transsexualism," in Richard Green and John Money, eds., Transsexualism and Sex Reassignment (Baltimore: Johns Hopkins University Press, pp. 91-93 (1969).
7. For this reason, I use the term "male-to-constructed female" to indicate that only a superficial change does take place, that while transsexuals are stereotypically feminine, they are not fundamentally female, and that it is impossible to change sex. Thus transsexuals do not convert from male to female but from male-to-constructed female.
8. What of persons born with ambiguous sex organs or chromosomal anomalies that place them in a biologically intersexual situation? It must be noted that practically all of them are altered shortly after birth to become anatomically male or female and are reared in accordance with the societal gender identity and role that accompanies their bodies. Persons whose sexual ambiguity is discovered later are altered in the direction of what their gender rearing has been (masculine or feminine) up to that point. Thus those who are altered shortly after birth have the history of being practically born as male or female and those who are altered later in life have their body surgically conformed to their history. When and if they do undergo surgical change, they do not become the opposite sex after a long history of functioning and being treated differently.
9. Percentages vary slightly but most authors doing postoperative follow-up report that "the majority of" or "most of" the transsexuals they surveyed are satisfied, both with the results of the surgery and with their own state of being after the

operation.

10. Jon K. Meyer and John H. Hoopes, "The Gender Dysphoria Syndromes: A Position Statement on So-Called Transsexualism," Plastic and Reconstructive Surgery, 54 (October 1977): 455ff.
11. John Randall, "Preoperative and Postoperative Status of Male and Female Transsexuals," in Richard Green and John Money, Transsexualism and Sex Reassignment (Baltimore: Johns Hopkins University Press, 1969), p. 373.
12. "A Doctor Tells Why He'll No Longer Treat Transsexuals," The National Observer, October 16, 1976, p.14.
13. W. Symmers, "Carcinoma of the Breast in Transsexual Individuals after Surgical and Hormonal Interference with Primary and Secondary Sex Characteristics," British Medical Journal, 2 (1968):83. Symmers reported on two cases of transsexuals who came to autopsy with carcinoma of the breast.
14. J. Hoenig et al., in their article, "The Surgical Treatment for Transsexuals" (Acta Psychiatra Scandinavia, 47 [May 1974]:106-36), state that surgical treatment to increase breasts in male transsexuals should not be undertaken, especially if such treatment is followed up with estrogen therapy, since there is a risk of malignancy. Other studies that have investigated the correlation between male-to-constructed-female transsexualism and cancer are:
    The Veteran's Administration Cooperative Urological Research Group "Treatment and Survival of Patients with Carcinoma of the Prostate, Surgery, Gynecology, and Obstetrics, 124 (1967):1011.
    K. A. Hanash, et. al., "Relationships of Estrogen Therapy for Carcinoma of the Prostate to Atherosclerotic Cardiovascular Disease: A Clinicopathologic Study," Journal of Urology, 103 (1970):467.
    J. D. Bailar and D. P. Byar, "The Veteran's Administration Co-operative Urological Research Group: Estrogen Treatment for Cancer of the Prostate: Early Results with Three Doses of Diethylstilbestrol and Placebo," Cancer, 26 (1970):257.

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Compiled from a series of 9 messages from the TRANSITION Echo of TGnet - HLJ

11

What is important to remember when considering *this* scrubbed-of-blatant-lesbian-separatism document – as well as openly trans-exterminationistic versions that appeared in Chrysalis in 1977:

Finally, and I think most important, there are more male-to-constructed-female transsexuals because men are socialized to fetishize and objectify. The same socialization that enables men to objectify women in rape, pornography, and "drag" is also that which enables them to take distance from their own bodies. In the case of the male-to-constructed-female transsexual, the penis is seen as a "thing" to be gotten rid of. The female body parts, specifically the female genitalia, are seen as "things" to be acquired. Men have always fetishized women's genitals. Male-to-constructed-female transsexualism is only one more relatively recent variation on this theme, where the female genitalia are not only viewed as fetishized *parts* of the female body. In this case, they are completely *separated* from the biological woman and, at the surgical point, come to be totally dominated by incorporation into the biological man. Transsexualism is thus the ultimate and, we might even say, the logical conclusion of the male possession of women in a patriarchal society.

...

Language and classification are extremely significant in this context. By categorizing the disordered

experiences of the gender-dissatisfied individual under the heading of "transsexualism," and by giving it the force of "statehood," so to speak, the therapists and technicians are able to order and control that reality. Once gender dissatisfaction is given the name of transsexualism, and institutionalized in the gender-identity clinics, and realized by hormonal and surgical treatment, the "condition" of transsexualism itself explains *why* one would have "the wrong mind in the wrong body." Why? Because one *is* a transsexual, of course. Thus the medical classification system and its ordering power confront transsexuals as meaningful realities that comprehend them and all their experiences. This classification and its ordering power bestow sense on all the disparate and fragmented experiences that once seemed so unfathomable. It enables someone like Jan Morris, for example, to order by hindsight and in chronological fashion the steps in his transsexual odyssey from the age of three, when he first "realized he was a woman" as he sat under his mother's piano listening to Sibelius, to his conquest of Mt. Everest, his last fling with masculinity. The various stages of his biography suddenly fit together

suddenly fit together.

… and in *The Transsexual Empire* in 1979 – is that all of this is just the ejaculation. The foreplay was the 1970s trans-exterminationists' championing of – and demand for – employment discrimination *against* a transsexual woman.

And it had nothing to do with any bathroom.

Bear all of that in mind when you see one of the authors of the latest *de facto* call for trans-exterminationism claim:

> I do not want anyone to face **irrational** discrimination…

Because, of course, the unintentionally illuminating caveat which follows it tells you that, like all exterminationists, she has her own lexicon and she's not letting you see how she definies what her meanings and intentions are.

> …that includes females **as well as trans folx**.

Janice Raymond's fluffy 1980 version of her radical lesbian separatist, anti-heterosexuality, anti-society excretions of 1977-79 did not, of course, have its *full* intended effect: the full force and majesty of the United States did not exterminate transsexuals and eliminate all transition-related healthcare.

However, it did permanently poison politico-legal discourse.

The *menage a transphobique* (Raymond's insanity together with the fraudulent 'study' perpetrated by Jon Meyer and Donna Reter and legitimized in the Archives of General Psychiatry) gave governmental organs thereafter the ability to say that there was a 'debate' about what was acceptable treatment for transsexuals (sound familiar?) - which almost always resulted in the strangely-on-all-fours-with-Raymond, anti-treatment views of christianism-addled bean-counters being inflicted on transsexuals who found themselves in a position of trying either to get aid directly from the government or to get courts to rationally interpret insurance contracts.

There is no denying it: at least some transsexuals died as a result of what Janice Raymond spewed during the late 70s and early 80s.

You know it.

I know it.

Cathy Brennan and Elizabeth Hungerford know it.

The (anti-)civil rights vermin - straight and gay - who, in and out of the halls of government, have influenced policy from 1980 onward know it.

At the time of Raymond-Meyer-Reter *menage*, the largest jurisdiction in the United States with a gay rights law – the city of Los Angeles – was tran-inclusive with its scope.

L.A. Passes Gay Bill

Los Angeles has become the largest city in the country to enact gay rights legislation. On June 1 Mayor Tom Bradley signed into law an ordinance prohibiting discrimination based on sexual orientation in employment, housing, business, credit, and public accommodations, facilities and services. Religious organizations are exempt. The law which became effective July 1, made L.A. the 44th city in America with similar legislation, and provides for actual damages, court cost, attorneys' fees, and $200 minimum fine.

The unpublicized move took gay activists, as well as some City Council members, by surprise. During the 40 minute debate a few Bible-toters voiced the usual un-Christian concerns, but as Councilman Robert Farrell said, "The battle has already been waged over this issue." He was referring to the defeat of the Briggs Initiative of last year. The Council approved 13-2.

Although the surprise legislation was drafted by pro-gay City Attorney Burt Pines, activist Morris Kight noted "the state had been set for this (passage)" by many years of gay activism. The Stonewall Democratic Club, the Municipal Elections Committee of L.A. (MECLA), and the Gay Rights Chapter of the ACLU had literally "had dinner over this issue" with Council people for years.

Although activists are happy that the long fight has paid off, and understand the Council wanted to avoid the controversy publicity has brought other cities, many are less than pleased with the legislation itself. "Our input into the drafting and final passage was zilch" explained Kight, who says corporations will have little trouble with a "light" $200 fine. Kight believes the lack of publicity means many of that city's estimated half million gays will not know they can now save their jobs and apartments. Kight and lesbians are also upset because the bill defines homosexuals in part as, "an individual having a self image not associated with one's biological maleness or. . .femaleness." Calling this definition sexist, activist Jeanne Cordova said, "I don't recognize my self image in that definition."

The measure was sponsored by Council President Joel Wachs and Councilwoman Peggy Stevenson. Voting against were Robert Wilkinson (San Fernando Valley) and John Gibson (San Pedro).

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Ah yes…

> Calling this definition sexist, activist Jeanne Cordova said, "I don't recognize my self-image in that definition."

And then when California enacted a gay rights law twenty years later, transexuals and all trans people were absent from its definition (as had been the case with Wisconsin, Massachusetts, Connecticut, Vermont, New Hampshire, New Jersey, Rhode Island and Hawaii – and as would thereafter be the case with Nevada, Maryland, New York and Delaware.)

> Even where law has evolved to formally prohibit sex-stereotyping; women continue to suffer from the lingering effects of sexist ideologies about female inferiority. So although we support every individual's right to freely express their *gender identity*, it is absolutely critical that law not confuse "feminine expression" with female reproductive capacity or female genital presentation.

In case you missed it, I'll mention Maryland again.

Every turd that's old gets smelly again.

This entry was posted on Friday, August 5th, 2011 at 5:37 pm and is filed under History, Random nutty fundies. You can follow any responses to this entry through the RSS 2.0 feed. You can leave a response, or trackback from your own site.

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