

The Transsexual Phenomenon: A Counter-History

Abstract

*Within a relatively short period in US history, transsexuality, a category that had once not existed, became a widely recognized term. It was named and described in the 1960s in influential publications, including Harry Benjamin's *The Transsexual Phenomenon* (1969). The national picture changed from one of no significant institutional support for transsexual therapy and surgery in 1965 to a situation in 1975 where about twenty major medical centers were offering treatment and some thousand transsexuals had been provided with surgery. Historians of transsexuality have been somewhat dazzled by this demonstration of the making of sex. One of the most perceptive observers of the twentieth-century historical sociology of sex has written of transsexualism's "widespread public and professional acceptance" by the 1970s, "an accepted syndrome, buttressed by a vast medical armamentarium of research, publications, and treatment programs." The result is not exactly a case of hidden history but rather inattention to an important period of critique, and the implied success of systems of technology and therapy that I am going to suggest were far more tentative, contested, and fragmentary. This neglected story both rethinks the early history of a new medical diagnosis and entity and sheds rather negative light on US psychiatric and surgical practices in the 1960s and 1970s.*

Introduction

This passing fad for what is miscalled "transsexualism" has led to the most tragic betrayal of human expectation in which medicine and modern endocrinology and surgery have ever engaged. In the name of gender transmutation they have led people to believe that alchemy was possible, thus fostering in individuals and in our whole culture conscious and unconscious neurotogenic fantasies whose only possible outcome is an intensification of the neurotic fantasies which underlie their expectation and ultimate psychosis. (Lawrence Kubie, 1974.)¹

Historians of transsexuality in the US have been somewhat dazzled by this demonstration of the making of sex. Janice Irvine, one of the most perceptive observers of the twentieth-century historical sociology of sex, wrote of transsexualism's "widespread public and professional acceptance" by the 1970s, "an accepted

syndrome, buttressed by a vast medical armamentarium of research, publications, and treatment programs.”² Joanne Meyerowitz, transsexuality’s skillful historian, is aware of what she terms “years of unresolved tensions,” yet devotes relatively little space to such strains.³ Susan Stryker, transgender’s best-known chronicler, does not deal with the issue at all.⁴ The result is not exactly a case of hidden history but rather inattention to an important period of critique, and the implied success of systems of technology and therapy that I am going to suggest were far more tentative, contested, and fragmentary—hence the counter-history of my title.

Although there were individual instances of surgery and experimental sex modifications in Europe and (even more rarely) in the US from the early twentieth century, we should locate the effective beginnings of this history in the 1950s. Indeed Meyerowitz begins her story with the publicity surrounding the sex change of Christine Jorgensen, “Ex-GI becomes Blonde Beauty,” a media event of epic proportions—similar to the impact of Alfred Kinsey’s research on sex in the 1940s and 1950s—that brought the possibility of sex change firmly into the public sphere.⁵ Jorgensen’s Danish specialist received hundreds of letters from men and women—from Algiers to New Zealand—who wanted to transform their sex.⁶ Meyerowitz writes of a demand, a “fierce and demanding drive,” for bodily modification during that decade.⁷ American transsexuals, predominantly male-to-female in these earlier days, sought hormonal treatment from Harry Benjamin in New York and surgery from sympathetic practitioners such as Dr Elmer Belt in Los Angeles and the Langley Porter Medical Clinic at the University of California School of Medicine in San Francisco, or they traveled to Casablanca for help from Dr Georges Burou, pioneer in pedicled skin inversion vaginoplasty (the conversion of the penis into a vagina).⁸

Yet it was the 1960s and 1970s that saw the main expansion of treatment facilities. In 1965 Ira Pauly, Professor of Psychiatry at the University of Oregon Medical School, summarized the state of play regarding what he termed “a dramatic psychiatric syndrome,” male transsexualism, “the male’s intense desire for sexual transformation by surgical and/or hormonal means, based on his complete identification with the feminine gender role.”⁹ Pauly counted a total of 603 reported male and 162 female transsexuals, whom, he argued, were but the tip of an iceberg.¹⁰ In 1968 the same author reported on the postoperative adjustment, socially and emotionally, of 121 male-to-female transsexuals, concluding that it was overwhelmingly successful. Hence, he reasoned, and given the relative failure of psychotherapy to revert rather than facilitate the process, “the apparent success of sex reassignment surgery . . . compels one to accept the surgical treatment of transsexualism on an experimental basis until the initial results can be verified or contradicted or until alternative treatment procedures prove successful.”¹¹ It was, in other words, cautious psychiatric support for transsexual surgery.

The history of transsexual surgery is closely linked with treatment of the intersexed—the chronologies are identical—where, from the 1950s, a protocol was established for clinicians to determine the sex of infants born with a “gender-atypical anatomy” (of doubtful sex) so that their bodies could be modified to correspond to the assigned sex.¹² Though the intersex patients (infants and children) were younger than transsexuals (always adult when cutting was involved), surgical procedures overlapped. Genital surgery for the transsexed did not involve clitoral reduction as it did for the intersexed, but penectomies (removal of the penis) and

vaginoplasty (construction or modification of the vagina) were performed on both types of patient. Robert Stoller, Professor of Psychiatry at the School of Medicine, University of California at Los Angeles, and a well-known transsexual expert by the 1970s, was reporting on intersex surgery in the 1960s, outlining cases of created vaginas and (badly) constructed penises.¹³ The Johns Hopkins Hospital in Baltimore was “a primary center for the diagnosis and treatment of intersexuality” and, as we will see, played a similar role in the therapeutic history of transsexuality. The name of John Money recurs in both stories.¹⁴ So the list of possibilities for transsexual treatment during this period is a long one.

Within a relatively short time, then, a category that had once not existed had become a widely recognized term. Transsexuality was named and described in the 1960s in Benjamin’s influential publication *The Transsexual Phenomenon* (1969) and Richard Green and John Money’s edited collection *Transsexualism and Sex Reassignment* (1969), and in the 1970s in Stoller’s *The Transsexual Experiment* (1975).¹⁵ As the French psychoanalyst Catherine Millot once put it, there is a sense in which there was no transsexuality before experts like Benjamin and Stoller “invented it”.¹⁶ The national picture changed from one of no significant institutional support in 1965 to a situation in 1975 where about twenty major medical centers were offering treatment and some thousand transsexuals had been provided with surgery.¹⁷ By the time they presented to the annual meeting of the American Psychiatric Association in 1977, Jon K. Meyer and Donna J. Reter were able to assume the “normalization” of sex reassignment.¹⁸

Yet when Meyer and Reter assumed the “normalization” of sex reassignment, they simultaneously cast considerable doubt on the outcome of its “almost routine acceptance.”¹⁹ This neglected story, the subject of this article, both rethinks the early history of a new medical diagnosis and entity (Benjamin’s Transsexual Phenomenon) and sheds rather negative light on US psychiatric and surgical practices in the 1960s and 1970s.

Early Critiques

Transsexuality’s counter-history can be traced back to the very beginnings of the emergence of the term and its earliest treatments. The psychoanalysts seemed always to be wary. A New York therapist wrote in the letters section of the *American Journal of Psychiatry* that with many transsexuals physicians were unwittingly treating fantasies rather than diseases: “Those patients seen by me who wanted to change their genital status were all borderline psychotics who also wanted other parts of their body altered.”²⁰ The same issue of *The Journal of Nervous and Mental Disease* that contained Pauly’s earlier-mentioned 1968 summary, “The Current Status of the Change of Sex Operation,” also featured a piece co-authored by the prominent New York psychoanalyst Lawrence S. Kubie, writer of the epigraph to this article, that was highly critical of the ready acceptance of the term transsexual and advocated “eschewing” the word altogether. Kubie thought that “gender transmutation” better described the processes involved, whether endocrinological or surgical.²¹ The simplicity of the term transsexual, he argued, masked the complexity of the problem and implied “that unsolved problems have been solved.”²²

The article was perceptive in its list of the issues glossed over through a simple clinical diagnosis of transsexualism. There were men who wished to

achieve the *appearance* of being women, but wish to think of themselves and be known as men who “simulate women.” Such men often slant their descriptions because they soon become aware that in most medical centers, in the United States at least, they must present themselves as textbook examples of “transsexuals,” if they are to persuade any team of physicians to change them.²³

Hence the transvestite became the transsexual. The simplicity of the diagnostic model—what the authors termed the “premature solidification of the concept of ‘trans-sexualism’”—forced conscious or unconscious conformity.²⁴ Personal histories were reformulated. Patients were tutored by friends, or their histories formulated by their own, targeted research.

Even with the limited information currently available it is clear that *not all* patients who have undergone surgical changes were unalterably convinced of their membership in the opposite sex. Moreover, abundant clinical and some empirical data show that retrospective self-justification can play a role in distorting the developmental histories given by individuals who petition for sex reassignment.²⁵

Kubie and his co-author James B. Mackie concluded that the concept of transsexualism provided the unique combination of false diagnosis and lack of conceptual clarity with “emotionally charged” and “dramatic” medical intervention.²⁶

In a short article originally written for the *American Journal of Psychiatry* in 1973 Stoller also outlined his “uneasiness” about what he described as the “carnival atmosphere that prevails in the management of male transsexualism.”²⁷ The medical climate had changed rapidly in a matter of years from a situation where opinion was divided over diagnosis and surgery to one of widespread acceptance based almost solely on the patient’s mere request for “sex transformation”—though the existence of his piece indicated another, less endorsing shift, the one that we are discussing here.²⁸ Diagnosis was also complicated by the supposed transsexuals’ familiarity with the medical literature. It was hard for therapists to determine “how firm is the patient’s conviction he really is a woman trapped in a male body” when those treated “are in complete command of the literature and know the answers before the questions are asked.”²⁹ He thought that people with slender links to transsexuality and with ill-defined claims of femininity were being treated surgically and irrevocably as transsexual. “We all know of surgeons willing to operate as long as the price is right; they seem scarcely concerned even when inexperienced.”³⁰ Furthermore, there was little or no concern with follow-up research. He concluded:

Since 1953, when “sex change” procedures were first publicized, an unknown number of males has received hormonal and surgical treatment on request. That we have no notion how many have been treated, when the procedures are experimental and potentially dangerous, is astonishing. That we do not know, almost 20 years later, how the patients fared, is scandalous.³¹

There was patient criticism of doctors too. Jane Fry’s autobiography implies a discontent with medical expertise that slipped into contempt.

By this time I was getting very down on doctors. I am still very turned off by them. For one of the most educated professions they have some of the biggest

assholes I have ever seen in my whole life. I went to see Dr. Moore. I sat down and went on with my normal spiel. By this time I had like a sales pitch. He said, "so you're a transsexual, huh? Well, that's good. I was just reading some articles on that." It just freaked me out. I didn't know what to say. He said that he was just reading Dr. Benjamin's book. . . . At least he had read something and knew a little bit about what he was doing. . . . Actually, he didn't know that much about hormones and their effects. It is very tricky. . . . I knew more about hormone and therapy treatment than he did. I kept an eye out that he didn't give me too much or too little.³²

This transsexual claimed to know more than her therapists ("he didn't know that much about hormones and their effects"); and was cynical in her interactions ("I had like a sales pitch").³³ As Fry's collaborator and editor stressed, her version was profoundly at odds with the perspective of the professionals. She was acutely aware of the centrality of the doctor in the lives of transsexuals, more important sometimes than the closest of kin. They prescribed the hormones and recommended surgery: "You've got to keep him happy."³⁴ "One thing that I did learn in meeting all the doctors is that you have to give a little—pretend a little. Any one of them can kill you physically or emotionally."³⁵ At the same time, she was scathing about psychiatric explanations for transsexualism. "Every doctor you see gives you a different explanation, and you just come to the point of knowing that they just don't know the hell they are talking about."³⁶ One therapist told John Fry that his desire to be Jane was because his father was so violent: "in rejecting him I rejected masculinity and violence, so I had to be a female. I think that's bullshit."³⁷ In and out of psychiatric care after leaving the Navy, and suicidal, Fry submitted to therapy as a means to an end (surgery), with little conviction as to its efficacy. "I don't think my transsexualism is the direct cause of my emotional problems, but I have to let psychiatrists keep saying it or else they won't treat me. I have to get back on the road to getting my operation, so I have to see one."³⁸

These snippets of early patient and therapist comment are consistent in their critical themes, locating problems of what might be broadly categorized as attitude to patients, surgery, therapy, definition/diagnosis, and assessment. Let us examine these in more detail.

Attitude to Patients

One clear problem was doctor–patient interaction. A mid-1960s survey of the opinions of surgeons, urologists, gynecologists, general medical practitioners, and psychiatrists—the very people whom a transsexual might approach for help—found a general conservatism when it came to sex reassignment. Even when the most responsible of treatment regimes was proposed in a hypothetical scenario involving prolonged psychiatric consultation as a preliminary to bodily remodeling, only 37 percent of surgeons, 45 percent of psychiatrists, and 41 percent of GPs would approve a request for sex transformation. The majority of practitioners were not exactly sympathetic.³⁹

Some experts were simply hostile to the whole notion of transsexuality. The psychiatrist Charles Socarides thought that transsexuals were delusional and included homosexuals in denial who thought that changing sex would render their same-sex desires acceptable as heterosexuality: "In this author's opinion . . .

surgical intervention constitutes a sanctioning of the transsexual's pathological view of reality and cannot resolve the underlying conflict."⁴⁰ The homosexual sociologist Edward Sagarin (author, as Donald Webster Corey, of the pioneering 1951 homophile work *The Homosexual in America*) was similarly skeptical about transsexualism, writing in 1969 in a book on "deviants" that male-to-female transsexuals suffered from "doubly unacceptable" self-imagery, that of being both homosexual and effeminate.⁴¹ The obvious solution for such victims, Sagarin posited, was for them to convince themselves that they were really women not men: "Thus, having sex with a man is not an abnormal act for the transsexual because he is, in his self-view, a woman."⁴² In reality, Sagarin wrote, "normalcy" in any relationship between transsexual and a male was "impossible . . . the partner is and must be a homosexual, and . . . even with conversion surgery, a transsexual can at most become a castrated male with an artificial vagina."⁴³ One has only to read Benjamin's case studies "to note how disturbed are the patients." Transsexuals were "deviates" to be discussed alongside necrophiliacs.⁴⁴

Socarides was notoriously anti-homosexual and Sagarin/Corey was conflicted about his sexuality. Yet even those engaged in pioneering transsexual research and treatment could not avoid a battle-weary negativity in their assessments of their patients. Hence the notorious case of Agnes, one of Stoller's patients, written up in a classic study by the sociologist Harold Garfinkel in 1967.⁴⁵ Agnes, who first presented in 1958 as a nineteen-year-old woman, a typist, was treated as an intersexed patient. From the outset, the team from the Departments of Psychiatry, Urology, and Endocrinology in the Medical Center of the University of California, Los Angeles, accepted her as female, "convincingly female":

She was tall, slim, with a very female shape. Her measurements were 38–25–38. She had long, fine dark-blonde hair, a young face with pretty features, a peaches-and-cream complexion, no facial hair, subtly plucked eyebrows, and no makeup except for lipstick. At the time of her first appearance she was dressed in a tight sweater which marked off her thin shoulders, ample breasts, and narrow waist.⁴⁶

But along with her large breasts (and highly-stereotyped 1950s femininity) she had the "normal external genitalia of a male." She was a "female with a penis."⁴⁷ They carried out the kind of tests used for the intersexed—which revealed no internal female organs but "moderately high estrogenic (female hormone) activity"—and in retrospect relying rather too much on the patient's testimony, concluded that this was an individual born as one sex but developing the sexual characteristic of the other at puberty when the testes started to produce estrogen, "a unique type of a most rare disorder."⁴⁸ The team wrote a learned paper, "Pubertal Feminization in a Genetic Male."⁴⁹ They arranged for Agnes (as intersexed rather than transvestite, homosexual, or transsexual) to have the surgery in 1959 that removed her penis and testicles and used them to construct her vagina and labia. (Agnes had a boyfriend, Bill, who had been eager for her to gain a vagina so that they could have intercourse.) Then, in 1966, Agnes admitted to Stoller that she had been taking estrogen from the age of twelve (stolen from her mother) and had lied to her doctors when they had specifically considered that possibility all those years ago. The psychiatrist wrote, "My chagrin at learning this was matched by my amusement that she could have pulled off this coup with such skill."⁵⁰

The point about this case, however, is that it reinforced notions of patient duplicity. Even before the hoax had been revealed, Garfinkel's long account of their interaction indicated a certain amount of fraudulence on the part of Agnes: "how practiced and effective Agnes was in dissembling . . . she was a highly accomplished liar."⁵¹ Of course Garfinkel was oblivious to the big lie and was treating her deception as an integral part of her passing in order to attain the femininity that she claimed was natural; "In contrast to homosexuals and transvestites, it was Agnes's conviction that she was naturally, originally, really, after all female."⁵² But the parade of deceptions outlined by the sociologist were those that would become the alleged tricks of transsexualism.

Because Garfinkel was so alert to what he termed "management devices" he was able to list off those employed by Agnes: "shrewdness, deliberateness, skill, learning, rehearsal, reflectiveness, test, review, feedback."⁵³ She was adept in patient-therapist encounter:

When I read over the transcripts, and listened again to the taped interviews while preparing this paper, I was appalled by the number of occasions on which I was unable to decide whether Agnes was answering my questions or whether she had learned from my questions, and more importantly from more subtle cues both prior to and after the questions, what answers would do.⁵⁴

She presented a "remarkably idealized biography" in which her femininity was exaggerated and her masculinity suppressed.⁵⁵ She refashioned her personal history, "reading and rereading the past for evidences to bolster and unify her present worth and aspirations . . . she was engaged in historicizing practices that were skilled, unrelieved, and biased."⁵⁶ She also knew when to remain silent and how to deflect. Garfinkel said that after seventy hours of communication with various therapists, and despite specific questioning on these issues, there were areas—mainly about Agnes's sexual interaction, including what she did with her penis—"in which we obtained nothing."⁵⁷

So distrust of patients was there almost from the start. Witness too Elmer Belt's discouraging appraisal in 1969: "I found that these patients in general were so unsuited to handle the problems of life itself that changing their sex organs was not a satisfactory solution of their troubles with society." They were rarely satisfied with the results of their treatment. They craved publicity of the kind that was anathema to their doctors and medical centers. Many were oblivious to the codes of public behavior. Belt claimed that his transsexual patients so troubled his non-transsexual clients that he had to establish separate premises for their consultation. And—in what we have already noted would become a familiar refrain—their reported patient histories were unreliable: "In the case of the transsexual . . . who has become accustomed to live a life of deception the history is apt to be a figment of lies. Virtually every transsexual does not tell the truth in answer to the doctor's questions." He cited the famous Stoller case, just discussed, where his patient privately took estrogen and faked his/her hormonal levels.⁵⁸

Stoller himself could be equally scathing. In one short published piece, "The Psychopath Quality in Male Transsexuals," he fulminated over their unreliability (he said that his team could almost diagnose a patient's transsexuality unsighted if "she" failed to turn up on time for the first appointment), their lying, and the superficiality of their relationships.⁵⁹

So even those who might be assumed to be the most empathetic, given their expertise and case-loads, could still betray a sense of disdain. Indicating his attitudes both to women and male-to-female transsexuals, John Money and one of his (numerous) co-authors claimed that not only were “male transsexuals . . . devious, demanding and manipulative” but that they were possibly also incapable of love.

Though there is no definite proof at the present time, it is quite likely that one of the characteristics of the transsexual condition in males is impairment of the neuropsychologic mechanism that mediates the experience of falling in love. If such be the case, then the full-blown experience of being in love is replaced, in the male transsexual, by what, at the outset at least, is a more perfunctory, instrumental and opportunistic relationship. It may well be that the transsexual male, when first reassigned as a female, is erotically “turned on” more by the subjective imagery of having a functional role as a coital female than by the erotic stimulus-image of the partner or prospective partner.⁶⁰

They wrote of the inadequacies of the surgically constructed vagina, the sexually anaesthetizing effects of encountering a penile stump, and, most disconcertingly, drew comparison with a study of a male turkey attempting to copulate with a head that had been separated from its body. “Like incomplete bird models, the human transsexual male, though an incomplete and impersonating female, obviously projects at least the minimum number of feminine cues to attract the erotic attention of a normal male.”⁶¹ The article was about the male partners of these “incomplete” women.

L. M. Lothstein, the author of a pioneering study of female-to-male transsexuality that drew on data on over fifty such patients at the Case Western Reserve Gender Identity Clinic in the 1970s and early 1980s, diagnosed female-to-male transsexuality as “a profound psychological disorder.”⁶²

Most female transsexuals . . . have serious personality disorders and while not psychotic, they have subtle thought disorders which affect their sense of reality and their ability to relate to others. In addition to their personality disturbances many female transsexuals exhibit a wide range of other psychiatric symptoms: including depression, anxiety, panic attacks, and severe psychosomatic complaints.⁶³

Lothstein saw the solution to transsexuality as lying with psychotherapy rather than surgery and when advocating the latter did so reluctantly in service of the former. Some female transsexuals, he thought, were only amenable to psychotherapy after surgery had “disrupted their rigid defensive structure”!⁶⁴ His key words for female transsexuality were “failure,” “self pathology,” “impairment,” “disturbance,” “defect,” and “developmental arrest.”⁶⁵ The woman who wanted to be a man, he wrote in his 24-point strategic guide to therapy, had “failed to develop a core female identity . . . her ultimate defect is a psychological one related to her lack of a nuclear female self and a cohesive gender-self system.”⁶⁶

Moral judgment continually crept into diagnostic classification. The Gender Identity Clinic of The Johns Hopkins Hospital divided its 1960s patients into two—morally classified—groups: the first, clearly less-favored, flamboyant, effeminate, homosexually-oriented, “antisocial,” petty criminal (a description hinting at the transvestite prostitutes and drag artists who sometimes transitioned

to transsexuality); and the more morally acceptable, better-behaved, more socially integrated, second group that “usually has tried, unsuccessfully, to make a heterosexual adjustment.” The practitioners argued that this classification had ramifications for treatment: “The patients in the second group give more reliable histories and are much less manipulative, hysterical and demanding than the first group.”⁶⁷ Whether, in practice, it was always easy to separate the groups is another issue. Interestingly, James Driscoll, who wrote a sociology of transsexual prostitution, claimed in 1971 that two of his subjects were former patients of Money at Johns Hopkins and had provided their specialist with very select histories: “In telling him their life story, they left out much and presented themselves as a combination of Alice in Wonderland and Rebecca of Sunnybrook Farm,” while supporting themselves by prostitution in Baltimore during their treatment.⁶⁸

Surgery

One of the great puzzles for non-transsexuals is why, knowing the trauma involved in reconstructive surgery (and transsexual patients were often very well-read), anyone would embark upon such a shattering experience. The earlier transsexual memoirs were graphic. Female-to-male Mario Martino wrote of the death of his new penis, “black and foul-smelling,” and recalled sitting in his bath cutting away dead tissue—“Talk about castration complex!”⁶⁹ Male-to-female Aleshia Brevard was “in agony” after her surgery in the early 1960s; her new vagina, when she saw it for the first time, looked “like something you’d hang in your smokehouse . . . after a hog killing.”⁷⁰ She was equally blunt in her summary of her surgeon’s technique: “In creating vaginal depth, Dr. Elmer Belt skinned the penis, took a skin graft from the bottom of each foot, and removed a six-inch square from the back of my left thigh.”⁷¹ Henry Glavovich consulted the same surgeon at much the same time when he became Patricia Morgan and recalled almost identical experience of extreme pain. “I was a woman at last. But at the moment, I was just a gob of aching flesh.”⁷² Renee Richards, another male-to-female transsexual, who, as an ophthalmologist, had medical knowledge, referred to a “bath of suffering.”⁷³ Understandably, she resorted to less than clinical similes: “It was as if someone was relatedly poking a firebrand into my groin. Mixed with this was a tearing sensation; it was like someone was ripping at my organs with a pair of pliers.”⁷⁴ She also outlined some distressing details of a specialist’s shaving of her Adam’s apple to modify it to her desired femininity, when he “dug too deep and broke through into the interior . . . I was choked by the disintegrating larynx.”⁷⁵

Bernice Hausman has argued that these surgical details disrupt the seamlessness of the other narrative in the same texts: “The tension between the two stories—the story of the subject as the other sex and the story of the methods used to make the subject represent the other sex—constitutes one central disjunction in transsexual autobiographical narratives.”⁷⁶ Why is the transition to what is seen as a true state so traumatic to achieve?

The writer Jan Morris spared her readers the details of her surgery but the descriptions of hormone ingestion are not unswervingly positive:

Hasty calculation suggests to me that between 1964 and 1972 I swallowed at least 12,000 pills, and absorbed into my system anything up to 50,000 milligrams

of female matter. Much of this doubtless went to waste, the body automatically discharging what it cannot absorb; the rest took its effect, and turned me gradually from a person who looked like a healthy male of orthodox sexual tendencies, approaching middle age, into something perilously close to a hermaphrodite, apparently neither of one sex nor the other, and more or less ageless.⁷⁷

Although, overall, these are stories of successful transitions, they were not trouble-free journeys.

The learned papers also contain explicit illustrations of flesh cutting and bodily separation and descriptions of the surgical aftermath. Garfinkel's study of Agnes contains a subtextual horror story of vaginal closing, painful dilations, urethral contracture, cystitis, "uncontrolled seepage of urine and feces," pelvic pain, and "sudden uncontrollable spells of crying" and depression.⁷⁸ The state-of-the-art, early summaries of transsexual research of the late 1960s and early 1970s provided male-to-female transsexuals with details of the process that reconstructed their genitalia, with a vaginal space cut and the penis turned inside out and then severed to make a "functioning" vaginal cavity (strangely reminiscent of the sixteenth-century medical drawings of the vagina as an inverted penis), the urethra separated and repositioned, and the testes removed.⁷⁹ They were warned of the possibility of urethral stenosis (that is, narrowing), of the dangers of neo-vaginal closing, and the importance of the painful vaginal form or stent (balsa wood, lucite, or silastic) worn to prevent closure and held in place by an unglamorous girdle and a variety of plastic brackets, hooks, and elastic reinforcement—all pictured in black-and-white photographs.⁸⁰ "Above all," wrote the Professor of Gynecology and Obstetrics at Johns Hopkins, "transsexuals need to understand that the reconstructed genitalia may not appear to them as perfect as they had envisioned. Many patients desire a perfect body form. They must clearly understand, prior to operation, that the postoperative appearance of their genitalia may fail to be quite up to their expectations."⁸¹ The illustrations in the published proceedings of a 1973 symposium tended to reinforce such warnings.⁸²

The equivalent surgical summary relating to female-to-male transsexuals referred dramatically to "obliteration of the vagina, breast amputation, and hysterectomy" but also made it clear that those with, it should be pointed out, rather limited clinical experience with female transsexuals (six female-to-male patients in twelve years at Johns Hopkins) thought them less eager for the complete surgery demanded by male-to-female patients and more willing to agree to a "gradual transition" and ready to "accept imperfections."⁸³ "Selection of breast amputation as the primary procedure is in keeping with the patient's major quest and, in addition, seems less of a surgical assault than combined one-stage hysterectomy and beginning construction of a phallus."⁸⁴ That "surgical assault" is an appropriate description is reinforced by both text and illustration. "Breast amputation" involved the grafted relocation of the nipples, and, in one case when the graft did not take, replacement of the areolae with sections of the labia minora. As for the construction of male genitalia, even the surgeons were skeptical:

The patients fully understand that the phallus will serve little, if any, role in sexual activities; and it is hard to comprehend that they insist on undergoing the multiple hospitalizations and relatively extensive operative procedures when

they are aware of the severe limitation of this technique. . . . Creation of male external genitalia is not to be undertaken without deliberate planning and a substantial background of plastic surgical experience. One must be prepared fully to deal with the complications attendant upon loss of free grafts and pedicle flaps, and one must be conversant with the management of urinary problems in the form of fistulae, urinary tract infections, and incontinence. A considerable volume of experience is reported in the literature on the management of traumatic avulsions [tearing] of the penis and scrotum.⁸⁵

The full sacrificial horror of constructing a non-functioning penis from an abdominal flap, and the resultant bodily scarring to achieve this early form of phalloplasty can only be conveyed visually.⁸⁶ “The bottom line with ‘bottom’ surgery,” an informed patient wrote more than thirty years later, “is that no surgeon can give a transman the penis that he should have had at birth.”⁸⁷

Therapy

Jane Fry’s version of her case conference is unquestionably disheartening. One doctor summed up his opposition to transsexual surgery as “If someone wanted to be an umbrella, would you try to make him an umbrella?” Others recommended aversion therapy.⁸⁸ This was her account, but her editor obtained Fry’s medical files (in itself an indication of attitudes towards patients) and they showed that the professionals who dealt with her thought that they were treating someone who was psychologically disturbed:

It is obvious that Jane has problems with sexual identity. It seemed to many of the staff that one of the core conflicts was around excessive dependency needs. She has been able to see that her creating crisis situations—taking overdoses—are often attempts on her part to have others express love and concern for her. In addition the role of “poor Jane trapped in a man’s body” is part of her repertoire. Underneath this, one might suggest that being a woman means being passive, being taken care of and not being active in satisfying one’s need but getting that need satisfied indirectly.⁸⁹

John was suppressing his masculine identity “as a defense against castration anxiety.” The patient exhibited “immature verbalizations around the topic of a new sexual identity. . . . a pattern of character disorder of a very primitive nature.”⁹⁰ Her suicide attempts reflected the bad he at war with—attempting to destroy—the worthless she.⁹¹ These various recorded diagnoses do little to inspire confidence in American psychiatry during the late 1960s and early 1970s.

At its worst, the literature of transsexual treatment at that time makes for disturbing reading, with the psychiatrist’s overreliance on the patient’s outline of their early life, and the construction of shaky interpretations on these unreliable memoirs: “at age 7 he plunged a knife into his father’s prize cabbage. . . . ‘I liked defiling the cabbage. . . . I must have hated my father.’”⁹² There were blanket condemnations of parental roles, again based on the flimsiest of actual evidence: “There was constant and excessive physical contact between the mother and child which the patient describes as, ‘I was like a monkey clinging to its mother.’”⁹³ These quotes are from research from New York’s Payne Whitney Psychiatric Clinic that presented case material open to pretty much any

interpretation but which was read as leading inexorably to the making of a “sissy” destined to male-to-female transsexuality:

His mother, an embittered, empty woman, kept her child in constant and excessive physical contact with her. She sabotaged all of his efforts at separating from her and achieving a sense of masculinity. His father, effeminized by his own mother, was unconcerned with his son's rearing except for infrequent rages at the mother-child closeness. The patient became an effeminized boy, perpetuating early forms of identification with his mother and unable to effect the normal identification with the father.⁹⁴

Literature from the Gender Dysphoria Clinic at the Case Western Reserve University School of Medicine in the 1970s, which employed psychotherapy in the treatment of transsexuality, makes it difficult to understand how its program could have been at all successful—though perhaps explains the large number of reported patients who left before the completion of the study.⁹⁵ Lothstein's discussion of the varieties of countertransference at work in the (multiple) gendered interactions between patient and therapist are interesting in their recognition of the complexities of such treatment, yet are notable more for the revealed attitudes towards the treated (“severe character pathology and bizarre self presentation”) and the perceived insecurities of the supposed experts (“disgust, jealousy, rage, terror and pleasure”).⁹⁶ We read of male-to-female transsexuals depressed when they are confronted by a “*real* woman” in the form of their female therapist, and of female-to-male transsexuals who feel more masculine than their male doctors.⁹⁷ We are informed that the gender dysphoric patient is a “guarded, secretive individual who uses massive denial, fails appointments, blocks, is superficial, narcissistic, employs primitive and morbid psychological defenses and bizarre self-presentation.”⁹⁸

But even more unsettling is the perceived state of their therapists. Here we learn of the “politically active gay female therapist” who may “unconsciously” support the castration of the male-to-female transsexual “for non-clinical reasons,” or, alternatively, the female therapist jealous because her male-to-female patient is a more attractive woman than she is.⁹⁹ A male therapist may become uncomfortable in the presence of a female-to-male transsexual who seems more of a man than he is, or, may be condescending if she fails to present the proper masculinity.¹⁰⁰ As for those who advised female-to-male transsexuals, Lothstein writes that the “construction of a phallus in the anatomical female stirs up the [male] therapist's own wishes and fantasies for a bigger and better penis,” and, if the psychiatrist is a woman, that the patient's “wish for a penis may stir up the female therapist's own pre-oedipal wishes for a penis and reactivate formerly resolved conflicts.”¹⁰¹ These poor therapists must have required constant therapy.

We will see shortly that Lothstein's work raised questions about the fragility of some initial diagnoses, however he (unintentionally) also demonstrated the potentially deleterious effects of over-analysis. When he wrote of the “importance of intensive psychological testing and psychotherapy in the overall evaluation and treatment plan for the female transsexual,” he really did mean intensive.¹⁰² His cases were subjected to a barrage of tests, what he termed the “full battery of psychological tests”: the Minnesota Multiphasic Personality Inventory (MMPI),

the Weschler Adult Intelligence Scale (WAIS), the Thematic Apperception Test (TAT), and the Rorschach.¹⁰³ Testing occurred both before and after sex reassignment surgery—a year after surgery if that surgery was approved—and references to the patient's "façade" and "defensive structure" imply that the therapist assumed an eventual cracking of this surface to reveal deeper anxieties: "she had erected a bland façade to control her inner excitement and confusion."¹⁰⁴ It is little wonder then that the therapist's relentless testing eventually found this assumed disorder:

In summary, the findings suggested a bi-modal clinical picture. On clinical interviewing and objective psychological testing Tina appeared "stable" and free of serious psychopathology. Intensive psychological testing, however, suggested that she had a subtle but non-intrusive thought disorder and the capacity to regress under stress. The overall clinical picture suggested a mild borderline personality disorder.¹⁰⁵

Little wonder too that Tina became "depressed" and that a friend commented that she "seemed more disturbed than ever."¹⁰⁶

Another case, Donna/Douglas, an African-American who took male hormones, bound her breasts, sported a goatee, and successfully passed as a man (known on the streets as "Frenchy," "a nickname which identified her [his] special talents for oral sex") was considered to be troubled rather than transsexual and therefore not a suitable candidate for surgical reassignment.¹⁰⁷ Lothstein used this case as an example of someone who might have been carelessly misdiagnosed without the intensive evaluation that he provided. However, his formulation was influenced by Donna/Douglas's deteriorating performance after prolonged testing as initially good results declined in later tests. "Under stress Donna's thinking became confused, illogical, and derailed, marked by tangentiality, symbolic meanings, and autistic logic."¹⁰⁸ While the therapist interpreted this as evidence that "most female transsexuals, who appeared 'healthier' on the initial clinical interview, might have severe character pathology," it is conceivable that the pressure of testing produced the detected psychosis.¹⁰⁹

Then there was the team from the Department of Psychiatry and the Gender Identity Research Treatment Program, UCLA School of Medicine, Los Angeles, who treated "pretranssexuals" in the late 1960s and early 1970s.¹¹⁰ The notion of the "pretranssexual" was based not only on the retrospective evidence of adult transsexuals who always interpreted what was seen as the excessive feminine behavior of their own childhoods as an inexorable marker of their gender disjunction and eventual adult transsexuality, but also on the earlier work of Money, Green, and others who used Konrad Lorenz's classic research on imprinting in ducklings to explain very early gender role learning in infants.¹¹¹ Green and Money had, in the late 1950s and early 1960s, claimed that early indulgence of effeminacy in boys could lead to transvestism and homosexuality.¹¹² (Note both the absence of transsexuality in this early work and the equation of effeminacy and homosexuality.)

A decade later, with Green now in the UCLA team, such children were seen as "pretranssexuals." Hence the "very feminine young boys" who were in treatment from the age of five-years-old because of perceived "feminine interests."¹¹³ It was reported of one "transsexual", eight-year-old boy that his clinical history

Paralleled the retrospective reports of adult transsexuals, including (1) feminine voice inflection and predominantly feminine content in speech, (2) verbal self-reference as “sissy” and “fag” and statements about his preference to be a girl, (3) feminine hand and arm gestures and “swishy” gait, (4) an aversion to masculine play activities, (5) a strong preference for girl playmates and taking a feminine role in play and role-playing, and (6) improvised cross-dressing.¹¹⁴

Therapy in such cases consisted of: “Developing a close relationship between the male therapist and the boy, stopping parental encouragement of feminine behavior, interrupting the excessively close relationship between mother and son, enhancing the role of father and son, and generally promoting the father’s role within the family.” Drs Green, Newman, and Stoller claimed success: “Results indicate the capacity for gender role preference in the preadolescent male to undergo considerable modification toward masculinity.”¹¹⁵ Carl, the transsexually-threatened eight-year-old, was dissuaded away from modeling himself on the cross-dressing (and very funny) early 1970s African-American comedian Flip Wilson and encouraged to talk about masculine things (“e.g., firemen” and “camping with the Boy Scouts”)—did these therapists have no cultural awareness, no sense of humor?¹¹⁶ A hapless research assistant became Carl’s “buddy” in the absence of the obligatory father figure. “Interactions between Carl and the assistant included informal athletic sessions, tumbling lessons [sic], trips to the park, regular treats (e.g., sodas, ice cream), and occasional trips to the beach.” Apart from providing an exemplar of “appropriate masculine behavior,” the poor assistant also became “a sounding board for Carl’s many and bitter complaints about his past treatment by family members, school mates, and authority figures.”¹¹⁷

The therapists made dubious claims of success. When interviewed at the age of twelve, Carl proclaimed that he “used to be a queer, but not anymore.”¹¹⁸ But Carl seemed to adapt his speech and gesture mannerisms to the environment in which he operated and the feminine proved rather resilient.¹¹⁹ Another patient, a (ventriloquized) seven-year-old, said of his earlier cross-dressing, “Oh, that was baby stuff. I was just mixed up. I must have thought I was a girl or something. Now I don’t.” Then in his *third* year of treatment, this young subject talked of becoming an actor, and was described by the team as “remaining somewhat feminine in gesture and mannerisms.” Nonetheless, two years later—and at the tender age of nine—the boy was deemed to have “repressed the active, conscious transsexual yearnings,” although he still did not like physical sports.¹²⁰

The historian will be horrified by a therapy that defined masculinity in terms of fantasies of beating, torturing, and raping women and which viewed the cultivation of such imaginings as progress: “Lance wants to play murder with Barbie.”¹²¹ We could question the wisdom of the four-times-a-week psychoanalysis of a five-year-old by someone for whom “this is the first child I have ever attempted to treat psycho-analytically.”¹²² We should be skeptical of eight-year-olds who see themselves as sissies or fags, or cured queers, and of therapy that identifies early interest in “artistic things,” dressing up in girls’ clothing, parental hostility to boyish aggression, motherly closeness, and female decision-making in the home as evidence of an incubating male-to-female transsexualism, an incubation that could occur very early: “This mother had been extremely close to her infant son during the first year of life. She carried him

around with her, pressed against her body almost constantly during the first 12 months—behavior described by Stoller as etiologic for male transsexualism.”¹²³

The gender logic behind such interventions now appears both misguided and dangerous, especially when it involved the very young. The therapists were not unaware of their highly gendered assumptions: “While privately, one might prefer to modify society’s attitudes toward crossgender behavior, in the consultation room with an unhappy youngster, one feels far more optimistic about modifying the behavior of that one child than the entire of society.”¹²⁴ Yet clearly they were reinforcing the problem rather than challenging it.

The reader may have detected a predisposition to blame women, especially mothers, in the making of a male-to-female transsexual. It was a bizarre form of Freudianism: “I wish to expand on how the transsexual’s mother, with her feelings of deprivation and worthlessness as a female, uses this son as the penis—her perfect phallus—she always wanted.”¹²⁵ Stoller encapsulated this tendency in an article called “Transvestites’ Women” that claimed that the females in the lives of male transvestites played “an essential role . . . in the cause and maintenance of transvestism.”¹²⁶ This was achieved, Stoller argued with *Catch-22*-like logic, either by a mother’s conscious man-hating (Stoller refers to “malicious male-haters”), deliberately dressing her son as a female and demonstrating hostility to all things male, or by her suffocating inability to separate herself from her child (what he termed the “symbiote”) with the result that he became “feminized” by his inability to separate his ego boundaries from his mother’s body.”¹²⁷ Generations of women were culpable:

Because of the unconscious needs generated in this mother’s past, this infant son is fated to serve as the treasured phallus for which she has yearned. So he is to be the cure of the lonely, hopeless sadness instilled in her by her cold and powerful mother and rejecting father, and he is also to be the penis that will equalize the feeling she has had of being inferior by not being male.¹²⁸

The substitute penis would grow up to be a man who wanted a vagina! The other enabling women in a transsexual’s life were the sisters, girlfriends and wives (the “succorers”) who encouraged his transvestities.¹²⁹

This does not mean that fathers were blameless. “Transvestites’ Women” finished by reminding its readers of the role of fathers in male feminization:

the failure of his father to be an adequate model of masculinity with whom the child can identify when he needs to turn to a man, and even earlier in the boy’s existence, the failure of his father to act as a shield protecting the boy against the urges to feminize him that his mother or sisters may have.¹³⁰

Money was later to reject what he called Stoller’s Neo-Freudian focus on mother and son in favor of a seduction of the father theory.¹³¹ “This is the formula: the father covertly courts his son’s allegiance, in place of what he finds missing in his wife, and casts him in the role of a wife substitute, if not for the present, then for the future.”¹³² Money went on to explain the collusion of the son in this scenario:

The son, for his part, may solicit his father’s allegiance as a formula for keeping him in the household, and for preventing a parental separation. If the father has

already gone, or even if he had died, the son's gender transposition may serve to solicit his dad's miraculous return. His life becomes a living fable of the boy who will become daddy's bride, for the evidence is plentiful that a daddy can be counted on to return to the home that his wife keeps ready for him.¹³³

While Stoller and his colleagues devoted most attention to the male-to-female transsexual, they also treated and reported on girls who identified as male:

In the present series of cases, the mother is almost always psychologically removed from the family, usually by depression, early in the girl's development. The father, while a substantial person in most regards, does not support his wife in her suffering but instead sends a substitute into the breach. This surrogate husband is the transsexual-to-be, also chosen perhaps because she strikes her parents as unfeminine in appearance from birth on. Since the family needs the child to function thus, any behavior construed as masculine is encouraged, and feminine behavior discouraged, until the islands of masculine qualities coalesce into a cohesive identity.¹³⁴

The logic was similar. However, whether posited as daddy's bride or mummy's husband, these theories of the parental nurturing of postnatal gender-crossing are unlikely to have resulted in any meaningful therapy.

Another approach, explored by Money and others from the late 1960s onwards, was the use of the synthetic steroid Depo-Provera[®] that was later to acquire some notoriety as an injected hormonal contraceptive for women. Though it was used for treatment of more extreme forms of male-to-female transvestism involving inappropriate public display, pedophilia, or self-harming activity, its advocates held out the promise of wider application.¹³⁵ Treatment, in this early usage of the drug, was to inhibit desire: the injected hormone reduced a male's testosterone to prepubescent levels.¹³⁶ The risk, Money explained, was that this hormonal tuning could increase the transvestite's femininity (the opposite of the desired outcome) rather than inhibiting the sexual impulse to cross-dress.¹³⁷ Richards claimed that Money treated her with this method and with no discernible result: "By this time I was frantic, and even the most farfetched scheme seemed preferable to no action at all."¹³⁸

Definition/Diagnosis

Another issue in the early years of transsexuality was the question of its actual identification. "Although some clinicians . . . still maintain the idea that a group of pure transsexuals exist for whom SRS [sex reassignment surgery] ought to be prescribed," Lothstein wrote in 1977 with Benjamin and Stoller in mind, "the fact is that patients requesting such surgery constitute a diverse group of individuals suffering from a broad range of gender disorders."¹³⁹ In *Female-to-Male Transsexualism* he took the case of Tina/Tim, an archetypal female-to-male transsexual, a textbook exemplar, "I have no doubt that Tina would have been judged as a 'true' or 'primary' transsexual, if not as a good candidate for surgery at most gender clinics."¹⁴⁰ And yet Lothstein was able to dissect the case, casting considerable doubt on the certainty of the initial diagnosis. The power of his example lay with the fact that he was able to demonstrate a weakness of diagnosis and appraisal of treatment despite the involvement of therapists with psychiatric and

psychological training—indeed their testing facilitated his revisiting of the treatment process. The point was that many transsexuals were being treated by those with no such expertise and where the potential for error was far greater.¹⁴¹

Meyer, a psychoanalyst at Johns Hopkins, argued that the term transsexualism had become a victim of its own rapid diagnostic acceptance. Its “reification” disguised huge clinical variation: transvestism, masochism, conflicted homosexuality, polymorphous perversity, schizophrenia, and true transsexualism (also known as eonism).¹⁴² The “self-designated transsexuals” that he had treated fell into one or more of those numerous categories.¹⁴³ They included “aging transvestites,” most of whom were taking hormones, but only one of whom was granted surgery because he considered them “poor candidates for sex reassignment.”¹⁴⁴ They included those he designated homosexual—both male and female—who were denied surgery because “sex reassignment surgery is sought by these patients seemingly to lend quasi-biological and medical rationalization to what is viewed otherwise—by the patient—as a perversion.”¹⁴⁵ And they included the polymorphously perverse whose “erotic behavior is dependent on opportunity and convenience, rather than internal preference.” “It seems unreasonable to view them as having made a commitment to any one social or sexual role.”¹⁴⁶ Accordingly, Meyer suggested a more comprehensive term, “gender dysphoria syndrome,” for such cases and urged that transsexual and its derivatives be reserved for those who had actually undergone surgical reconstruction (“It could be used much as the term ‘amputee’ to describe a postoperative fact”).¹⁴⁷ He also questioned whether transsexualism represented “a true reversal of core gender identity” given that the cases that he dealt with “indicate more ambivalence and ambiguity of gender than fixed reversal.”¹⁴⁸ This was an interesting anticipation of the later transgender turn.

It is evident from a close reading of Meyer’s 1974 report that Johns Hopkins was overseeing the reassignments of patients whom he classified as other than archetypically transsexual. While none of the five so-defined schizoid or six homosexual patients received genital surgery, one of the ten fetishistic transvestites, one of the four masochists, and two of the three polymorphously perverse underwent sex reassignment.¹⁴⁹

A report in the same year from the Department of Surgery at the Stanford University School of Medicine, drawing on 769 patients and 74 operations, charted a similar situation. The “Stanford experience,” though indicating a cautious approach in the fact that less than 10 percent of patients were actually operated on, made it evident that transsexualism as a category had become a catch-all for people best defined in other gender dysphoric ways. While some of the discussed misdiagnosis was either historical or the problem of other clinics—“many non-transsexuals, having read [Harry] Benjamin’s book, presented themselves to physicians as classic Benjaminian transsexuals”—it is obvious that Stanford was providing surgery for male-to-female patients diagnosed as effeminate homosexuals and transvestites as well as those considered to be true transsexuals. More than a third of male-to-female patients thus operated on were classified as effeminate homosexuals rather than transsexuals.¹⁵⁰ And if it is true that the Stanford experience claimed to refuse surgery to those patients deemed psychotic, neurotic, or sociopathic, it is also evident that its medical experts began their report with a description of their patients as those “whose determined quest for rehabilitation *via* surgery is an almost psychopathic drive.”¹⁵¹ It must have been hard to separate the psychopaths from the psychopaths.

Stanford had hosted an international symposium on gender dysphoria in 1973 and the proceedings of that gathering of gender identity experts certainly give pause. A Stanford representative, Norman Fisk, admitted to an early “inexperience and naiveté” in their program. A “great emphasis was placed upon attempting to exclusively treat only classical or ‘textbook cases’ of transsexualism”: a life history of feeling that one belonged to the other sex; non-erotic cross-dressing; an aversion to homosexuality; and a conviction that their mere request for transsexual surgery confirmed their transsexual status. Unsurprisingly the Stanford experts were offered a string of identical textbook cases: “far too many patients presented a pat, almost rehearsed history, and seemingly were well-versed in precisely what they should or should not say or reveal.”¹⁵² Fisk, in hindsight, considered this less a case of deliberate fabrication than a pattern of retrospectively rewriting sexual histories to conform to the expected transsexual stereotype: “Here, the patient quite subtly alters, shades, rationalizes, denies, represses, forgets, etc., in a compelling rush to embrace the diagnosis of transsexualism.”¹⁵³

As the Stanford team became more experienced and more inclusive and flexible in their gender conceptualizing, shifting their diagnostic focus from transsexualism to gender dysphoria, and considering surgery for dysphoric patients not in the transsexual category, what Fisk termed a “liberalization,” they found—again unsurprisingly—that the histories they were given were more “honest, open, and candid.”¹⁵⁴

Definitions varied, and the most fixed classification disguised uncertainty. Identification of transsexuality was beset with substantial diagnostic complications.

Assessment

Another major issue was assessing the success or otherwise of treatment. Stoller, we saw, was scandalized by the paucity of follow up studies of (and this was another criticism) an unknown number of possible patients. Kubie was concerned about the reliability or even feasibility of such research: “How does one obtain the objectivity necessary to evaluate the concepts, the practices and consequences of sex-change operations? The methodological problems are extraordinarily difficult.”¹⁵⁵

The postsurgical picture from the University of Minnesota’s 1960s’ transsexual research project was not encouraging. Twenty-five operated male-to-female patients were assessed five years after surgery (most of the operations occurred in 1968) and reported on as part of the research project that had provided free surgery in return for the subjects’ participation (the practice changed shortly afterwards). The author, Donald Hastings, summarized patient satisfaction as good, “Not excellent, but good.”¹⁵⁶ However, many of the extracted patient case notes are more negative in terms of patient progress, surgical success, and psychiatric attitudes: “Sociopath”; “Sociopath, public prostitute, marginal IQ”; “Vaginal repair NYC 12/69”; “Probably gave lues [syphilis] to husband of another transsexual”; “attempted suicide by shooting self in abdomen in front of boy who jilted her”; “Calls suicide ‘hot line’ to complain how fast whiskers grow”; “Alcoholic; 10/69 serious suicide attempt”; “Developed severe infectious hepatitis; long period of sexual maladjustment due to surgical complications”; “Severe sociopath.”¹⁵⁷ Hastings concluded that the “surgical route” was the only rather than the best course, and he was candid in his admission that patients detected

his "disapproval."¹⁵⁸ It was hardly a ringing endorsement of the treatment of transsexuality.

Wardell Pomeroy, a former member of the famous Alfred Kinsey team at the Institute for Sex Research at the University of Indiana, was similarly ambivalent in his 1969 report on the sexual lives of twenty-five pre- and post-operative male transsexuals whose histories he had collected.¹⁵⁹ It was a small study: only eight of the eleven patients who had received gender reassignment were interviewed about their lives after surgery. And it was a bleak survey, despite Pomeroy's conclusion that the "conversion operations were beneficial."¹⁶⁰ The discussed cases included new women with little or no experience of intercourse, masturbation, or orgasm (Cases 1, 7, and 8) and one with a vaginal opening too small for intercourse (Case 2). Pomeroy thought them people with "rather low rates of overt sexual behavior but a very great fantasy life."¹⁶¹ He was skeptical about the orgasms of the claimed orgasmic: "it is doubtful from her description that the patient has ever had an orgasm since the operation" he observed of at least two cases.¹⁶² Although Pomeroy was supportive of facilitating transsexual transitions and considered his subjects' lives improved as females, this may merely have indicated the true desperation of their former male condition.

Green, a psychiatrist, wanted to impart realism into therapy and surgical expectations: "Many transsexuals have led lonely, isolated lives prior to surgery. They optimistically look forward to reassignment as a rebirth. They may harbor unrealistic expectations of an immediately blissful life, exciting and romance-filled."¹⁶³ Thus male-to-females should not expect to achieve "idealized female proportions" from taking estrogen. They should be aware of the costs and time involved in electrolysis. They were informed of vaginal vagaries.¹⁶⁴ Female-to-male transsexuals should not assume breast reduction from testosterone treatment and might anticipate that the desired growth in their bodily and facial hair might also be accompanied by acne. They could anticipate clitoral growth but not a "phallus of penile dimensions." As for constructive surgery: "Female transsexuals should know that construction of a penis is still in an essentially experimental stage."¹⁶⁵

Experienced practitioners at Johns Hopkins were very indecisive about their patients' emotional prognosis after reconstructive surgery but quite sure that they were not working any miracles, informing readers of the specialist *Plastic and Reconstructive Surgery* that the male-to-female "reassignee . . . is not—and never will be—a real girl but is, at best, a convincing simulated female. Such an adjustment cannot compensate for the tragedy of having lost all chance to be male and of having, in the final analysis, no way to be really female."¹⁶⁶

Some were candid in their assessment of surgical complications. Stanford's 1974 report stated that almost half of the male-to-female post-operatives and a quarter of the female-to-males suffered complications. Recto-vaginal fistulas, narrowing or closing of the vagina and/or urethra, blood loss, and infection were among the problems listed (it is not certain whether "Excessive emotional attachment to surgeon" and "Desire to shoot genitals of surgeon, with a shotgun" were complications for the patient or the doctor).¹⁶⁷ Those operated on elsewhere but coming to Stanford for treatment provide hints of a potentially far worse situation, including many male-to-female patients with "inadequate . . . or no vaginas."¹⁶⁸ A disconcerting feature of the Stanford experience is that it was an experiment. "In our program, transsexualism has been questioned as a disease, and its surgical treatment has been investigated in a clinical trial." The verdict in

1974 for a program started in 1967 was that “surgery is *not proven* to be the treatment for the transsexual condition.”¹⁶⁹

Stoller provided a somewhat pessimistic summary of what he also termed the “transsexual experiment” in a collection of his late 1960s and early 1970s writings—and this was from an acknowledged pioneer. He suggested that even after surgery, and despite bodily reconciliation with what was perceived as their true identity, male transsexuals were still psychologically—and therefore sexually—troubled by the “boy” that still lingered inside them. “Each sex act was not only an erotic experience but also a test of the success of her body transformation, and since her partner’s penis was in where “he” (her boyhood) still lived, the patient could never relax into the safety of a complete sense of femaleness.”¹⁷⁰ Though Stoller does not seem to have made the connection, one of his published case histories reveals that the boy inside was more than mere memory. As this patient pointed out, “I mean, after all, I have still got the same penis. It’s just differently arranged that’s all.”¹⁷¹ Stoller wrote of the “removal of the unwanted male sex” failing to extirpate a deeper sense of maleness.¹⁷² Yet it was even more problematic given that the phallus was inverted as a vagina rather than removed; the transsexual’s partner’s penis was actually inside his penis. The point is that sexual adjustment after surgery was difficult—what the earlier-quoted patient referred to as a “pussy bummer.”¹⁷³

Lothstein’s *Female-to-Male Transsexualism* also raised questions about the claimed accomplishments of reassignment surgery. He took the case of Tina/Tim, a female-to-male transsexual, whose surgery was proclaimed successful and who was deemed to have adjusted satisfactorily. Yet when Lothstein explored the test results more deeply and arranged for follow-up testing he discovered that Tim had lied about his satisfaction with his penis because he had not wanted to disappoint his therapist. He felt socially isolated and seemed regretful about his surgical path. “In effect,” wrote Lothstein, “her real penis was not as powerful as her imaginary one.”¹⁷⁴

Conclusion

It is clear, then, that the history of transsexuality should include this extensive critique. The 1978 selected proceedings of the Fourth International Conference on Gender Identity, published in the journal *Archives of Sexual Behavior*, provide a good snapshot of the mood as the 1980s approached. One expert contributor observed “a proclivity for the creation of self-fulfilling, self-validating, reinforcing cycles.” It was “a theorist’s paradise—for in the absence of any objective criteria, the stage is set for a happy collusion of fantasies between therapist and patient.”¹⁷⁵ The transvestite Virginia Prince referred to sex reassignment surgery as a “communicable disease,” easily spread among the “susceptible . . . transvestite and drag queen population.”¹⁷⁶ A therapist from the University of Pennsylvania warned that they had to deal with sexual stereotypes “in a time when sexual stereotyping is not generally applauded.” “We cannot act as if we are somehow participating in the nostalgia of these persons using techniques of the 1970s to create a caricature of the 1940s movie version of a woman.”¹⁷⁷ (In an effort to impose some reality on the situation, he sent some of his candidates to feminist group sessions.¹⁷⁸)

Nor were the symposium’s reports of surgical advances without their downside. The Stanford-constructed female-to-male penis did not have a urethra, was

not capable of erection (without a removable prosthesis, or unless scarring and fibrosis provided a semi-erect state), and its recipient still depended on his clitoris for sexual stimulation. Post-surgical complications were common. Testicular implants (Stanford experimented with lead in silicone!) seemed especially problematic: of ten procedures, six became infected and three of those patients lost their implants.¹⁷⁹ Urologists and plastic surgeons from Cook County Hospital, Chicago, reported an increase in post-surgical complications involving male-to-female patients, mostly, they stressed, those who had had surgery elsewhere. Most common was a closing of the vagina, often the result of inadequate postoperative care, but more surprising was the problem with penial stumps—"These stumps of corpora cavernosa became engorged and painful during coitus and forbid the patient from further attempts at intercourse."¹⁸⁰ Photographs of disfigured genitalia provided visual confirmation of this rather grim verdict.¹⁸¹

There are several references to patients who shopped around for treatment—one of the problems for follow-up studies was that their subjects had moved on.¹⁸² Those at the larger gender clinics knew that since the vast majority of their patients were turned down for sex reassignment that it was inevitable that they went elsewhere ("surgeon shopping").¹⁸³ Charles Ihlenfeld, in private practice, said that he was sure that many of those he treated were "fugitives from university gender identity groups" and was clearly disillusioned with his clientele: "after six years and several hundred patients . . . I feel manipulated and blackmailed to the point where I seriously question whether patients really should be seen in this way."¹⁸⁴ The spokesperson for the Stanford University Gender Dysphoria Program wrote that "many" of their patients grew impatient with the cautiousness of their approach and sought a solution elsewhere, with, he thought, damaging results. "The human wreckage in this group is astonishing testimony that sex conversion at inappropriate times and for inappropriate candidates is a devastatingly destructive procedure."¹⁸⁵ There were also the inexperienced practitioners eager to meet the market demand. The doctor from the Pennsylvania Hospital at the University of Pennsylvania said that there were physicians who "will prescribe hormones to virtually anyone who requests them," and claimed an "estimated 200 self-diagnosed male-to-female transsexual candidates in the Philadelphia area alone who have received estrogen therapy for one or two years without *ever* having seen a psychiatrist."¹⁸⁶ Other doctors discussed the "tremendous black market" in liquid silicone injections—by non-physicians.¹⁸⁷

There is an argument, then, for a counter history. One major strand, we have seen, and that Meyerowitz has identified, was the psychoanalyst's misgivings about the efficacy—indeed desirability—of transsexual surgery.¹⁸⁸ Meyer told the *New York Times* that his "personal feeling" was that surgery "was not a proper treatment for a psychiatric disorder, and its clear to me that these patients have severe psychological problems that don't go away following surgery."¹⁸⁹ However, the critique was evident on an impressive variety of fronts, including representatives of most of those involved in the transsexual experience. Psychiatrists (recall Lothstein) questioned the diagnoses of other psychiatrists. Psychologists criticized each other. Suzanne Kessler and Wendy McKenna wrote of clinicians who used their own sexual interest and concepts of female beauty to decide the legitimacy of their patients' claims to male-to-female transsexuality.¹⁹⁰

Sociologists critiqued the whole phenomenon. Dwight B. Billings and Thomas Urban, two social scientists familiar with the medical literature, who had

interviewed both patients and practitioners in the US, and one of whom had been a two-year participant observer in a sex-change clinic, wrote in 1982 that "There is hardly a more dramatic instance of contemporary professional authority than so-called 'sex-change' surgery. . . . transsexualism . . . only exists in and through medical practice."¹⁹¹ Billings and Urban stressed that "transsexualism" flattened out the complexity and variety of "gender role distress."¹⁹² They were damning of the attitudes of some of the medical experts that they encountered, one reputedly proclaiming "We're not taking Puerto Ricans any more; they don't look like transsexuals. They look like fags."¹⁹³ They also stressed patient dishonesty: transsexuals told their therapists exactly what they wanted to hear, providing the rehearsed histories needed for surgical permission.¹⁹⁴ They concluded that "Transsexual therapy, legitimated by the terminology of disease, pushed patients toward an alluring world of artificial vaginas and penises rather than toward self-understanding and sexual politics."¹⁹⁵

As the sociologists' comments remind us, there was repeated disapproval of the patients. A paper presented at a meeting of the International Gender Dysphoria Association in 1981 alleged multiple cases of fabricated transsexual patient sexual histories and even "the hiring of actors to impersonate family members."¹⁹⁶ Millot thought that the female-to-male transsexuals she had encountered hovered on the border of hysteria and delusion.¹⁹⁷ "Some dream that one day it will be possible to transplant the penises of dead men. They madly place their hopes in the possibility of erection, and even procreation. For them, there are no limits to the power of science. It's simply a question of time."¹⁹⁸ Even transsexual autobiographies contained mockery of those considered less than ideal exemplars of a presumably shared condition. Richards wrote disparagingly of the occupants of Benjamin's waiting room, "I surveyed the room and found it full of creatures who were neither fish nor fowl. . . . A lot of them looked as if they had lost their senses."¹⁹⁹

There was no smooth path to transsexual acceptance.

Endnotes

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