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## A “Fierce and Demanding” Drive

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IN *HOW SEX CHANGED: A HISTORY OF TRANSEXUALISM IN THE UNITED STATES*, JOANNE MEYEROWITZ authored a masterful account of the emergence of transsexualism over the course of the twentieth century. *How Sex Changed* was the first book-length work of transgender scholarship to rely on exhaustive archival research into primary source materials, and it thus relates the story of transsexualism with unprecedented authority. Meyerowitz relied not only on medical accounts, but also on media coverage and the views of transgendered people themselves, to craft a nuanced tale of how transsexualism helped reshape our culture’s beliefs about the meaning—and interrelatedness—of biological sex, psychological gender, sexual orientation, and social gender role.

In the selection below, “A ‘Fierce and Demanding’ Drive,” Meyerowitz describes how, in the wake of publicity about Christine Jorgensen’s transsexual surgery, transsexuals and their doctors negotiated with one another to gain or grant access to medical procedures for altering the sex-signifying characteristics of the body. In much of the contemporary scholarship prior to Meyerowitz, notably in the work of Marjorie Garber and Judith Shapiro, transsexuals had been represented as passive vessels for their doctor’s intentions, who merely parroted back the medical discourses espoused by their service providers, and who lacked real agency or critical awareness of their own embodied situation.

Meyerowitz’s careful scholarship reveals the delicate politics involved in the 1950s and 1960s in creating the procedures, institutions and frameworks within which transgender people sought to address their needs, and over which doctors sought to exercise control.

In the 1950s and 1960s hundreds of people wrote to, telephoned, and visited doctors to inquire about sex-change surgery. A few may have asked for information on a whim or out of curiosity, and a few may have temporarily seen a change of sex as a way out of other personal problems. But most had what they described as deeply rooted, longstanding, and irrepressible yearnings, and they wanted medical treatment, sometimes with an urgency that bordered on obsession. For some of the prospective patients, the growing coverage in the press shaped their inchoate desires to transform their bodies. For others, the news stories renewed their hopes that doctors might actually respond to their already formulated requests. In the 1950s and afterward they used the press and the medical literature to label their longings, to place themselves in a recognizable category, and to find the names of doctors who might help them.

While the doctors and scientists debated the meanings of sex and gender, many transsexuals simply rejected the notion that the bodies they were born with represented their true or permanent sex. For many, the truth of sex lay in the sense of self, not in the visible body. One FTM remembered that as a young child he had refused to wear dresses because “something inside me just told me that I was a boy.” Others acknowledged the common late twentieth-century perception that sex resided in the

chromosomes. An MTF stated that "sex cannot be changed, and I am painfully aware of the fact." Nonetheless, she said, "external body appearance can be changed sufficiently that a person who is psychologically miserable any other way can safely, happily, and legally assume the status of woman and live and be accepted as such."<sup>1</sup> Sometimes they expressed their desires with the language of "being"—being the sex they knew they were. At other times they positioned their longings as matters of "becoming"—becoming the men or women they knew they ought to be. However they defined the quest, they laid claim to their own sense of authenticity and their own self-knowledge about whether they should or could live and count as women or men.

Their requests to alter their bodies resonated with other trends in modern American culture. In the mid-twentieth century Americans routinely encountered prescriptions for how they might remake themselves in pursuit of self-fulfillment. Humanist psychologists called for "self-actualization"; advertisements for cosmetics and diet aids invited people to refashion their faces and bodies; educators and book publishers promised to improve the minds of students and readers. Democratic ideals, however imperfectly practiced, suggested that all people had or should have equal opportunities to change their station in life, and twentieth-century liberal individualists increasingly insisted on the rights of "consenting adults" to determine their own course as long as they refrained from behaviors that might cause harm to others. In a society that valued self-expression and self-transformation, why not permit people to decide whether they wanted to live as men or as women, and why not allow them to change their bodies in the ways they desired?

In their interactions with doctors, transsexuals dreamed of the new possibilities created by medical science. But as they urged their doctors to enter uncharted territories of medical treatment, they bumped up against the power of medical gatekeepers, the costs of commodified medical care, and the limits of technology. In response, they learned that only persistence produced results. They needed the cooperation of doctors, but as they applied unsolicited pressure, they and their doctors ended up in conflict. It was in this troubled milieu that a few Americans entered the new terrain of "sex-reassignment surgery." In traditional medical histories, doctors often stand as pioneers in science. In the history of transsexuality, doctors, with a few exceptions, lagged behind, reluctant pioneers at best, pushed and pulled by patients who came to them determined to change their bodies and their lives.

In the mid-twentieth-century United States, Denmark looked like a liberal haven to people who hoped to change their sex. Jorgensen had found not one but several doctors who had rallied to her cause and seen her through her bodily change. Her doctors had taken her seriously, acknowledged her sanity, and used their authority and their technical expertise to change her life for the better. To Danish officials, however, Jorgensen stood as an isolated case. Her surgery, they said, would not serve as a precedent for future medical treatment. Although they still supported the Danish law permitting castrations, the officials at the Medico-Legal Council of the Danish Ministry of Justice, startled by a flood of requests for sex-change surgery, soon announced their decision to refuse the petitions of foreigners.<sup>2</sup>

Nonetheless, in the early 1950s transgendered people wrote repeatedly to the Danish endocrinologist Christian Hamburger, whose sympathetic treatment of Jorgensen had appeared in the American press. In less than a year after the Jorgensen story entered the public domain, Hamburger received "765 letters from 465 patients who appear to have a genuine desire for alteration of sex." Of the 465, 180 wrote from the United States. The letters, Hamburger wrote, ranged from "faulty attempts at presentation in writing" to "stylish masterpieces," from "almost undecipherable bits of paper" to "faultlessly typed reports of up to 60 foolscap pages." He read the letters as "a cry for help and understanding."<sup>3</sup>

Hamburger referred his American correspondents to doctors in the United States. Just one month after the Jorgensen story broke, he responded to a male-to-female correspondent who had already sent

him “three letters . . . a collection of photos . . . and . . . Christmas greetings.” He had received “several hundreds of letters,” mostly, he said, from “men, suffering from the same disease as you.” The letters impressed him, and he felt he had a “duty to help.” He himself, however, could now help “persons of Danish nationality only.” He told this correspondent and others to contact Dr. J. W. Jailer, an endocrinologist in New York.<sup>4</sup> Jailer, it turned out, had little interest in transsexual patients. Without providing any details, one MTF described her reply from Jailer as “distressing,” and Harry Benjamin noted that others, too, had had “unfortunate experience[s]” with him. Within months Hamburger realized he had sent his correspondents to the wrong doctor. He began to advise them to “get in contact with Dr. Harry Benjamin.” He told one letter writer: “If anybody can give you advice or help, it is Dr. Benjamin. I have referred several patients to him, and they have all found an understanding doctor or even friend in him.”<sup>5</sup>

Into the 1960s, most roads led to Benjamin. Hamburger sent him patients, and so did the public transsexuals Christine Jorgensen and Tamara Rees, both of whom came under Benjamin’s care. From the United States and abroad, other doctors also gave out his name, especially after he published his first articles on transsexualism. Dr. David O. Cauldwell, who coined the English word *transsexual*, and Dr. Walter Alvarez, who wrote a syndicated medical column, told letter writers to contact Benjamin, and later Dr. Robert Stoller, the psychoanalyst at the University of California at Los Angeles, sent him numerous patients. As his name appeared in the press as an expert on transsexualism and especially after his book came out in 1966, the letters snowballed in volume. New patients brought their friends and acquaintances to Benjamin’s attention, and each new contact seemed to lead to others.<sup>6</sup>

Would-be patients traveled to meet Benjamin in his offices in New York City and San Francisco. He examined them, counseled them, and prescribed hormones, and he also engaged in voluminous correspondence with patients and nonpatients who asked for his help. The drag queen Margo Howard-Howard, who never seriously considered surgery, portrayed Benjamin as a “charlatan” who encouraged sex change for virtually anyone who crossed his door. “If Joe Lewis, champion fighter, had walked in for a routine examination,” she wrote, “Benjamin would have told him he ought to be a woman.” But more of Benjamin’s patients appreciated his warmth, his concern for their well-being, his old-world charm, and the nonjudgmental way in which he accepted their unconventional desires. In her autobiography *Second Serve*, male-to-female Renée Richards, a doctor herself, remembered Benjamin, whom she first met in the 1960s, as “a likable fussbudget, very much in the tradition of the Old World general practitioner.” At first she thought him “kindly and decent” but “hardly one to inspire unreserved confidence.” Then she “began to realize that this old man really did understand.” In her autobiography *Conundrum*, the journalist Jan Morris, also a male-to-female transsexual, expressed the same sentiment. She remembered Benjamin as “the first person I met who really seemed to understand.”<sup>7</sup>

By all accounts, the prospective patients reflected the diversity of the population. They came from “all cultures, ethnic groups, and socioeconomic levels.”<sup>8</sup> In one study of letters from 500 people requesting evaluation for surgery at Johns Hopkins Hospital in the late 1960s, 116 reported their race: 103 reported themselves as white, 13 as African Americans. Among 100 FTMs who participated in a counseling group in Yonkers, New York, in the late 1960s, the “ethnic groups” represented included “Irish, Italian, and German,” followed by “English, Puerto Rican, Blacks, Polish, French, Greek, Spanish, Swedish, and Welsh,” plus one “Canadian, Chinese, Columbian, Cuban, Danish, Hungarian, Indian, Rumanian, Russian, or Turkish” apiece. Case studies of patients in the West include several mentions of Mexican Americans.<sup>9</sup> The letters they wrote came from rural areas, small towns, and cities, and the jobs they mentioned spanned the spectrum from manual day labor and service work to working-class trades and clerical work to middle- and upper-class professions. Some had spent their entire lives in a

single location; others had led rootless lives, drifting from job to job and from place to place. But the stories they told rarely dwelled on, and frequently failed to mention, the categories that sociologists tend to use to classify the population. There was no single plot to their stories, no single life trajectory from birth to transgendered adulthood to the request for surgery. But despite the wide disparities in social background, their stories reveal a few common patterns.

In their initial contacts with Benjamin and other doctors, many conveyed a sense of angst that hinted of suicidal despair. In a letter to Jorgensen, Benjamin described the "phone calls and letters" he had received as "frantic." An FTM wrote Benjamin from Florida: "I have reached the point where it is impossible for me to do much of anything constructive . . . Please forgive my extreme feelings of urgency, for I can truly not stand this feeling of being an impostor any longer. I have done all I can to help myself." An MTF wrote from the West Coast: "I find it increasingly difficult to go on living with myself. I am ready *now* to go to whatever extremes . . . necessary to have a 'sex change.' It is the only way I could ever hope of finding my peace of mind . . . I am tired and I am not willing to fight against my real desire any longer."<sup>10</sup>

They told of doctors who had offered every kind of treatment except sex-change surgery. One MTF had "been advised to have psycho therapy, [carbon dioxide] therapy, shock treatments, lobotomy, go out and live as a woman, join a homosexual colony, and commit myself to a mental sanitarium." Other MTFs encountered doctors who injected them with male hormones, and psychiatrists or psychologists who pushed them to relinquish their feminine ways. One FTM had "undergone everything from 'religious training' to self-hypnosis and shock treatments." Others reported lengthy psychoanalyses and months or years in mental institutions. Both MTFs and FTMs found doctors who promised operations and then backed away.<sup>11</sup>

In their exchanges with doctors and researchers, they tried to explain themselves, sometimes guilelessly and sometimes in ways patently calculated to convince doctors to recommend surgery. By the mid-1950s they had the label "transsexualism" to describe their longings, but they still needed to make themselves intelligible to doctors and others who dismissed them as insane. One MTF wrote her life history as a way to "clarify" her mind before she tried to persuade her doctor to recommend surgery. She understood her mission: "I have to make a person who is without doubt a normal person see my point of view as I, who am not normal, see it and I have to make my abnormal thoughts and conclusions seem as real and logical to him as they are to me."<sup>12</sup>

Many MTFs and FTMs recounted long and arduous journeys to change their assigned sex. Not all told tales of unremitting hardship, but most wrote sad, and sometimes desperate, letters emphasizing the difficulties of their lives, perhaps in part to impress upon doctors the seriousness of their requests. Some cast their lives in the plots they found in the popular press. Like Christine Jorgensen, they often portrayed themselves as pilgrims or pioneers who struggled against adversity. They vacillated between a persistent optimism in which struggle merited reward and a lurking pessimism in which insurmountable obstacles prevented them from moving on. From the 1950s on, they portrayed themselves as social beings whose outcast status excluded them from the sense of community for which they longed, and they also stressed personal freedom and presented themselves as individualists who asserted their right to live as they chose.

In recounting their lives to doctors, most emphasized a sense of difference that had begun in childhood. From an early age they had played with the toys and dressed in the clothes prescribed for the other sex. "I was eight," an MTF recalled, "when I announced myself a girl and demanded to play with dolls, dress in girl's clothes, and let my hair grow long." An FTM "had always felt that something was wrong." Since the age of four or five, he had "preferred male activities and toys."<sup>13</sup> As they had matured, their feelings had intensified. Some FTMs reported a sense of humiliation or "disgust" as

their breasts developed and menstruation began, and some MTFs expressed a feeling of hatred or revulsion toward their genitals. They described a growing alienation from their own bodies, a sense that the body itself was a mistake. A young FTM explained: "Nothing about me seems abnormal, except I have the wrong body."<sup>14</sup>

Many reported years of ridicule for their unconventional presentations of gender. Their parents had misunderstood them, their siblings had teased them, and their peers had taunted and bullied them. One FTM from Arkansas told a doctor he had been "harassed" by "everybody" and called a "freak,' 'homo,' or 'hermaphrodite.'" His wife explained: "He was always considered a public freak. He has always been scorned, humiliated and ridiculed beyond all measure." A number of MTFs had joined the armed services in a futile attempt, as one described it, to "make a man of myself," but their peers in the military had not necessarily welcomed them. An MTF serving in the U.S. Army wrote Benjamin: "people disrespect and insult me constantly. I would rather die than be a man all my life. It is a life of torture."<sup>15</sup> The stories of ridicule included accounts of violence, "being hit, beat, raped . . . just really being punished."<sup>16</sup>

The police rarely offered protection. Both MTFs and FTMs told doctors about their "fear of arrest and persecution" at the hands of law-enforcement officials. Many worried about being arrested for crossdressing. Through the 1960s, some local governments used vagrancy and other statutes to regulate and restrain those who dressed in public as the other sex. In the early 1950s, for example, an MTF arrested in California served "six months probation. All because her drivers license said male." A friend of hers explained to Benjamin: "Now she is scared."<sup>17</sup> Publicity about arrests could lead to loss of jobs, as in the 1960s case of a male-to-female transvestite, an airline pilot, whose conviction for crossdressing cost him his job and pension a year before retirement. MTFs could expect harassment, and sometimes assault, when they were booked, and unless they went in the "queens' tank," the cells reserved for feminine men, time in jail could result in rape by other inmates. By the mid-twentieth century the police more frequently arrested male-to-female crossdressers, who appeared more shocking in dresses than FTMs appeared in pants. But FTMs who lived as men also knew, as one described it, "the apprehension of risking discovery and imprisonment." Another described his fears when using public restrooms: "In using a men's room, when dressed in male attire, I subject myself to possible apprehension as a 'male impersonator.' In using a women's room, other women there might possibly regard me as a man invading their privacy." He had, he said, "an insoluble and potentially dangerous problem."<sup>18</sup>

The doctors' records also report arrests for running away from home and other infractions. Transgendered youth sometimes tried to escape their unhappy pasts and to lose themselves in the anonymity of larger cities, where they might also find doctors and friends to help them. One FTM with "fanatic religious" parents was arrested en route from Tallahassee to San Francisco to meet with Harry Benjamin. Sometimes family members called in the police. The mother-in-law of another FTM had him arrested for taking money on false pretenses, but she objected primarily to his "unnatural" marriage to her daughter. The arrests often led to referrals to psychiatrists and sometimes to incarceration in jails or mental institutions.<sup>19</sup>

They might avoid such conflicts, but only, they said, at a psychic cost. The transsexual child, one MTF believed, had a choice: "whether to flaunt his desire . . . and launch himself on a defiant life of non-conformity and endless conflicts with society and the law—or to bury deeply his feminine inclination . . . no matter what the cost to mental well-being." Before her surgery, she chose to hide her femininity. She had, she said, "few friends," and her "tolerable world was the world of fantasy." She secretly dressed as a girl, and she had fantasies of "exotic surgical operations in which my brain would

be transferred to the body of a beautiful girl." She contemplated suicide before eventually finding her way to doctors who agreed to help her.<sup>20</sup>

Whether they exposed themselves to ridicule and arrest or hid their desires protectively, they often portrayed themselves as misfits. Their stories, like Jorgensen's, were frequently tales of isolation, of people who may have had family and friends but still lacked and longed for a sense of belonging. By the 1960s more of them came to know and rely on other transgendered people, especially in the cities.<sup>21</sup> But even as they developed their own sense of community, they frequently presented themselves as seekers who looked for a place in the world where they might feel at ease and at home. Although they asked the doctors for surgery to change the insignia of sex, the quest itself was not solely or even primarily about breasts or ovaries or penises or testicles. In a letter to Robert Stoller, one FTM described it as "yearnings for release from . . . bondage." "A more complete transformation," he wrote, would provide "enough freedom to find . . . a real identity and a dignified existence." He did not want either "a temporary refuge" or a life "alone and apart."<sup>22</sup>

The request for surgery, though, was not just a strategy for self-protection or an attempt to escape from ridicule, violence, arrest, and isolation. It was also an active form of self-expression. Transsexuals often presented their personal quest as an overwhelming commitment to an unshakable sense of an authentic inner self. Increasingly they used a modernized variation of Ulrichs' nineteenth-century formulation, "a female soul in a male body." They spoke of "a female trapped in a male's body" or "a male entity . . . somehow imprisoned in a female body."<sup>23</sup> By the 1960s, this became a shorthand rendition for a particular life history in which the desire to change sex reflected the assertion of an inner self.

Among postmodern academics today, it is decidedly unfashionable to speak of a "true self," an "inner essence," or a "core" identity beneath a surface appearance. But transsexuals, like most people, had a deeply rooted sense of who they were. We need to attend, as psychoanalyst Lynne Layton reminds us, to "the specificity, construction, and experience of an individual's inner world and relational negotiations." Layton refers to a core identity as "something internal that recognizably persists even while it may continuously and subtly alter." For many late twentieth-century transsexuals, the "true" or "inner" or "trapped" self referred to this core identity and provided the dominant metaphor to summarize a "life-plot" of crossgender identification.<sup>24</sup>

Those who were more educated sometimes explained this sense of self with the modern language of psychology. Stephen Wagner referred directly to the "self-actualization" of postwar humanist psychology. He "had a hunch that the reason why some of us choose to become women is because of the basic pioneering spirit which is very essential in all of us . . . It is related very closely to the principle of nonconformity as well as to that of creativity." In this view, crossgender behavior and sex change were bold forms of self-improvement, creative acts of "individuality and individual freedom" that pushed against the limits of conventional mores. Others used the more traditional language of religion. The desire to change sex came from God or resided in the soul. An FTM told Robert Stoller: "God created me a girl, so maybe I should be. But I couldn't be, and which is more important, your mind or your body? God created my mind too, and if my mind is working that way, He created that." From a different spiritual angle, an MTF speculated on past lives and reincarnation and concluded, echoing Ulrichs, "maybe once in a great while a female spirit or soul accidentally incarnates in a male body."<sup>25</sup>

While some adopted the language of psychology and religion to express their understandings of themselves, more turned to biology to explain the source of their unconventional desires. Their crossgender identification felt so substantial and their desire to change their bodily sex so firmly rooted that most could not perceive the condition as anything but physical. Despite the publicity about Jorgensen, some transsexuals, especially FTMs, still presented themselves to doctors as hermaphrodites and

pseudohermaphrodites. Several FTMs believed they had testicles hidden internally. One imagined his testicles in a lump in the groin and another in “swellings on either side of the vaginal outlet.” They diagnosed themselves as biologically male and “rejected any other interpretation.” To convince their doubting doctors, they sometimes requested (and occasionally underwent) exploratory surgery in an attempt to prove the existence of hidden male gonads.<sup>26</sup>

MTFs also favored a biological approach. Like FTMs, some portrayed themselves as intersexed, hoping perhaps, as one psychiatrist phrased it, to “substantiate a biological basis for their condition, and thus obtain the change of sex operation.” A few who knew otherwise presented themselves as hermaphrodites because this seemed a more convincing story. “I realize my own condition perfectly,” one MTF told Benjamin, “but to quite some few people . . . the idea of hermaphroditism is easier to explain and understand.”<sup>27</sup> Others focused on hormones. One MTF explained herself to her children with the theory of bisexuality: “in each man and each woman there is a remnant of the opposite sex, and . . . the balance between the two is not always at the same point.” Like Jorgensen, she explained her problem “in terms of hormones and ductless glands.” Another MTF wrote to Benjamin: “All of us feel that there is something different about our chemical make-up.”<sup>28</sup>

Some acknowledged the possibility that the desire to change sex was not a physical condition, but they insisted that the longing for transformation was too compelling and too authentic to eradicate. One MTF insisted: “I still feel that somehow . . . there must be a physical reason for the way I feel. It is such an overpowering feeling.” Another MTF explained:

At first I thought that there might be some organic cause or reason for my feelings, but now I'm not so sure. My family doctor and a psychiatrist that I went to told me that it was not organic but psychological. The psychiatrist wanted to rid me of the feelings but they are so strong and intense that I have no desire to change them . . . I can't imagine just why I feel as I do but the feelings are real and not put-on.

Another MTF “had no idea” why she had “always wanted to be a girl,” but she considered it “a form of mental suicide,” the death of her self, to abandon her femininity.<sup>29</sup>

As they related their life stories, they hoped for a sympathetic ear. For some, simply writing or talking to a humane doctor was “in itself a tremendous relief.”<sup>30</sup> But usually they wanted more. Some sought doctors’ advice on various treatment options, but many came already convinced that they wanted surgery. The surgery promised real benefits. They might live legally as the sex they desired without fear of arrest, assault, or exposure. “I want to work and live openly,” one MTF told Benjamin, “with assurance of freedom from prosecution by law.” Also, with bodily transformation, others might see and treat them as the men or women they knew or wanted themselves to be. An FTM who had lived as a man for twenty-three years explained to Benjamin: “I have to live in fear all the time . . . whenever it came to lite [sic] that I wasn't a man as they thought but a woman, then I would lose my job. I have suffered years of embarrassment [sic] and ridicule.” With surgery, they hoped, they might “just liv[e] without the feeling of being a misfit.”<sup>31</sup> But surgery was also symbolic. It was the coup de grâce that ended a “sham existence” or “a life of deceit.” Surgery was not the only part or even the most important part of the quest for authentic self-expression. For some, however, it became a defining event. An MTF told Benjamin: “I think of nothing else but the operation.”<sup>32</sup>

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Operations, though, were not easy to obtain. First, they required money. In the American market economy, the quest for self-expression increasingly involved the purchase of goods and services that promised a better life. For the American transsexual, surgery was such a commodity, a desperately desired consumer item, available only to those who could afford it. The United States did not (and does not) have a national health plan that covered surgery, and private medical insurance would not

cover "elective" procedures, especially ones that had not won the approval of mainstream doctors. Christine Jorgensen had found doctors who treated her for nothing as part of their medical research. Those who followed often hoped for similar treatment. "Maybe," one MTF said, "some doctor might want to operate . . . as a sort of experiment."<sup>33</sup> But transsexuals without substantial savings rarely found doctors in the United States or abroad who responded positively to requests for surgery. In 1955 Harry Benjamin wrote to urologist Elmer Belt: "Those who have no money or too little of it are simply out of luck. I feel a bit ashamed of the medical profession to allow such a state of affairs to exist." Ten years later Robert Stoller responded to a request for a "sex transfer": "I would say that your chances of getting such help are small, especially if you do not have a lot of money."<sup>34</sup>

Even patients with money had difficulty finding surgeons who would perform transsexual operations. Through the 1960s, the demand for sex-change operations well outpaced the supply. In 1966 Johns Hopkins Hospital announced its program to perform sex-reassignment surgery. Over the next two and a half years the doctors there received "almost 2000 desperate requests" for surgery. They turned almost all of them down, performing surgery on only 24 patients, just slightly more than one percent of the total.<sup>35</sup> In this bottleneck situation it took money, persistence, and unwavering will to find a doctor who would agree to surgery.

Facing obstacles at every turn, some transgendered people gave up. Stephen Wagner, for example, had searched for male-to-female surgery since the 1930s. After the publicity about Christine Jorgensen, he wrote Alfred Kinsey, "If I had the money, I would fly to Denmark at once!"<sup>36</sup> He renewed his efforts to find an American surgeon, corresponding with Christian Hamburger, Walter Alvarez, and Harry Benjamin, among others. Meanwhile, in his hometown of Chicago he visited doctors who he thought might offer operations. Dr. William S. Kroger, Wagner recounted, promised surgery and then changed his mind. According to Wagner, Kroger advised him "to move away from Chicago and live as a woman without . . . operations." Another doctor gave him injections of male hormones "to become more masculinized," which Wagner stopped against the doctor's wishes.<sup>37</sup> But aside from the doctors who failed to give him what he requested, Wagner expressed concerns of his own. When Harry Benjamin offered to see and treat him in New York, Wagner wondered how he would find a job and a home and worried how his sister and brother-in-law would react. He longed for operations to change his sex, but he also "hate[d]" himself "for being so overwhelmed by that horrible desire." And he did "not relish the idea of being a 'weak facsimile' of a woman." The lack of local doctors to help him conspired with his own anxieties and kept him from acting on his stated desires. In 1958 Harry Benjamin annotated his correspondence with Wagner: "Never met him. Not operated."<sup>38</sup>

For other transsexuals, the obstacles to surgery only strengthened their resolve. Debbie Mayne (pseudonym), an MTF with few financial resources, tried every possible avenue to find herself a surgeon. She wrote to Christian Hamburger, Harry Benjamin, and other doctors, convinced a reporter to help her find a surgeon in Europe, asked a transsexual friend to castrate her, and cooperated with the research of Drs. Frederic Worden and James Marsh in Los Angeles in the hope that they would recommend her for surgery. By the end of 1954 all her attempts had failed. Yet she told Benjamin: "I am *extremely confident* and determined . . . This drive is [so] fierce and demanding that it frightens me." She determined to "find me a quack in Mexico" who would perform the operation.<sup>39</sup> Others sought underground practitioners in the United States. An FTM had his breasts removed on his sister's kitchen table. According to one report, other transsexuals "resorted to abortionists, in the belief that these criminal operators would do anything for money."<sup>40</sup>

With or without surgery, transgendered people sometimes experimented with other forms of bodily change. Some FTMs bound their breasts to flatten their chests and decided to live fulltime as men. Tom Michaels (pseudonym), an FTM, described his transformation: "In a matter of months I

progressed from my usual jeans and shirt to flannel slacks and tie to completely masculine attire and ‘passing.’”<sup>41</sup> Some MTFs began the painful and lengthy process of electrolysis to rid themselves of their facial and body hair, and some crossdressed in public despite the risks of violence and arrest. Caren Ecker (pseudonym) lived for a while as a woman in Mexico City until the experiment ended “in disaster” when a “pawing drunk” discovered her secret. A few MTFs attempted other forms of self-induced physical change. In the mid-1960s one MTF bought “female hormone facial cream” and ate it, and also attempted “to push my testicle back up inside my body.” Another attempted to create breasts by injecting “air, hand cream, mother’s milk and water” into her chest.<sup>42</sup>

FTMs and MTFs usually took hormones under the care of doctors such as Harry Benjamin, but some managed to obtain solutions and tablets on their own. After a few months of testosterone injections, FTMs underwent visible, audible, and permanent changes. Their voices dropped to a lower pitch. Gradually their clitorises increased in size, their skeletal muscles developed, and their facial and body hair multiplied. Some FTMs also noticed weight gain, acne, a slight shrinking of the breasts, or male-pattern balding. As long as they took the hormone, it enhanced their libido and inhibited menstruation. It could also produce a surge of energy akin to the jolt from caffeine. For MTFs the visible changes were subtler. After taking estrogen, often combined with progesterone, MTFs noticed swelling in their breasts, sensitivity of the nipples, and sometimes softer hair and smoother skin. Their testicles atrophied, their libido declined, and their erections and ejaculations diminished or ceased. With prolonged doses, they experienced a more visible redistribution of subcutaneous fat and more pronounced growth of the breasts. For many, estrogen also seemed to have a soothing or calming effect. To quicken the process of change, some exceeded the recommended dosage, despite the risks of heart disease and liver damage for FTMs and thrombosis for MTFs. For this reason, Harry Benjamin warned against “self-medication.”<sup>43</sup>

For some, binding their breasts or crossdressing or taking hormones was sufficient. Louise Lawrence, born in 1913, had lived fulltime as a woman since 1944. By the 1950s she saw surgery as one possible way of accommodating crossgender identification, but she did not seek it for herself. A friend said Lawrence considered herself “to [*sic*] old” for surgery, and Lawrence told a correspondent: “As in most everything else in life there are numerous ways of achieving a given result.” Still, she recognized the urge to change sex and told Harry Benjamin: “I firmly believe that MOST transvestites have that same urge but in varying degrees and areas.” She lived as a woman until her death in 1976, and under Benjamin’s guidance she experimented with hormones.<sup>44</sup>

Others moved in fits and starts toward surgery. After he decided to don men’s clothes, Tom Michaels spent years living as a man, some of them in “grossly anti-social behavior” with criminal associates, “the first social grouping which accepted me on my own terms.” Ashamed of his life, he eventually decided to pursue “professional ambition” and earned a bachelor’s degree in zoology. He reverted to living as a woman and spent a year in medical school. But he could not relinquish his desires. In the mid-1960s he contacted Robert Stoller in search of “a more complete transformation.” It “would be infinitely easier,” he wrote, “with medical help rather than opposition.” He wanted the “necessary alterations” and also hoped for “moral support.” He began taking testosterone and looked forward to surgery.<sup>45</sup>

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For MTFs the search for surgery often began with castration. As doctors rebuffed them, some MTFs reached the point of desperation and cut off their own genitals. According to one review of the medical literature, published in 1965, 18 of 100 MTFs had attempted to remove their own testicles or penises, and 9 had succeeded.<sup>46</sup> At the age of forty-three, for example, Caren Ecker, now living in northern California, gave herself local anesthetic, removed her testicles, and, in her own words, “almost bled to

death." Eventually Dr. Karl Bowman, of San Francisco's Langley Porter Clinic, recommended additional surgery to remove the penis. At the end of 1953 Dr. Frank Hinman Jr. performed the surgery at the University of California at San Francisco. As in cases of botched self-induced abortions, doctors sometimes felt more comfortable cleaning up afterward than providing medical care from the start.<sup>47</sup>

Annette Dolan (pseudonym) sent Harry Benjamin an autobiographical account of her self-surgery. (Later a different version of it appeared in print, under a pseudonym, in *Sexology* magazine.) "For years," she said, doctors had told her "there was no 'help' for me, and I accepted this [as] gospel." After Christine Jorgensen made the news, though, she made up her mind to undergo surgery. Initially hesitant, her doctor, probably Benjamin, eventually suggested she go abroad for castration, after which he could help her find a surgeon in the United States to perform the rest of the operations. Lacking funds for surgery overseas, she decided to perform the operation herself. She read medical texts outlining the operation and bought the surgical equipment needed to perform it. "I learned to ligate, suture and anesthetize," she said; "I studied the surgical procedure step by step and memorized its sequence." She excised her testicles successfully in an hour and later presented her doctor with the *fait accompli*. With any legal obstacles literally removed, she found a surgeon to complete the work. In 1954 Elmer Belt, a urologist at UCLA, performed the rest of her surgery, including construction of a vagina.<sup>48</sup>

Like many surgeons, Belt had a certain bravado. He took pride in his technical skills and saw new forms of surgery as a challenge to his expertise. He had, as he told Benjamin, "a strong sense of compassion for these poor devils" and also "an intense curiosity." He considered himself a "softie" who found it hard to turn away desperate patients.<sup>49</sup> In the 1950s he operated on other MTFs, including Barbara Richards Wilcox, who had made the news in the early 1940s when she had gone to court to change her legal gender status. Belt used a procedure in which he preserved the testicles, pushing them through the inguinal ring out of the scrotum and into the abdomen. He thought it medically best to preserve the testicles and the hormones they produced, and thereby managed to avoid whatever legal liability castration might potentially involve. At the end of 1954 Belt temporarily ceased his work when a committee of doctors at UCLA, including urologist Willard Goodwin and psychiatrist Frederic Worden, decided against the surgeries. In the late 1950s he quietly resumed his sex-reassignment practice, but in early 1962, under pressure from his wife, son, and office manager, he decided to stop for good. He complained about searching for hospitals that would let him perform sex-reassignment surgery, he feared that a dissatisfied patient would sue him and ruin his practice, and he groused about the impoverished patients who failed to pay their bills. When he learned that Dr. Georges Burou, a French surgeon with a clinic in Casablanca, was doing good surgery, he opted out.<sup>50</sup>

Other MTFs found a handful of other surgeons, mostly abroad, who would perform the operations. In 1954 and 1955 several of Benjamin's patients had operations in Holland. But European doctors were not as accepting as some transsexuals had imagined. After initial surgery in Holland and plastic surgery in Denmark, one MTF told Benjamin: "The 'favorable' doctors . . . are in the minority in Europe." And most of the "favorable" doctors refused American patients after 1955. In the mid-1950s other MTFs, including Debbie Mayne, went to Mexico for surgery with Dr. Daniel Lopez Ferrer. In the early 1960s Burou replaced Belt as the surgeon of choice for those who could afford his fees and the costs of international travel. For years afterward his widely acclaimed surgical skills brought him a steady stream of patients from Europe and the United States. In the early and mid-1960s operations were also occasionally performed "rather secretly," according to Benjamin, in the United States, as well as in Japan, Mexico, and Italy.<sup>51</sup> Dr. Orion Stuteville did "a few such procedures" in Chicago, as did Drs. Jaime Caloca Acosta and Jose Jesus Barbosa in Tijuana and Professor Francesco Sorrentino in Naples. By the end of the 1960s a few university hospitals—Johns Hopkins, University of Minnesota, Stanford, and University of Washington—had begun to provide surgery for a small number of MTFs.<sup>52</sup>

The techniques differed from place to place. Some surgeons removed only the testicles and penis, or one or the other, but most also performed plastic surgery to create labia, usually from the scrotum. Increasingly surgeons also created vaginas at the same time. Doctors had performed vaginoplasty since the nineteenth century, when they experimented with various methods for constructing vaginas for women born without them or for women with deformed or damaged ones. By the mid-1950s the most common method used skin grafts from the thigh, buttocks, or back. Occasionally surgeons used mucosal tissue from the intestine, but this entailed more-invasive surgery. By the late 1950s a few doctors preserved the sensitive skin of the penis, turned it inside out, and used it to line the vagina. In Morocco, Burou attracted patients by perfecting this method. In the late 1960s a handful of American doctors adopted his technique.<sup>53</sup>

The surgery itself was painful and harrowing. For Patricia Morgan, who underwent surgery with Elmer Belt in 1961 and 1962, the first operation lasted around eight hours. Belt removed the penis and pushed the testicles into the abdomen. When Morgan woke up, she saw “all the wires and tubes and catheters.” “I was just a glob of aching flesh,” she wrote later. After two and a half months Morgan returned for eight more hours of surgery to create a vagina. After the second operation, “the pain inside was even worse than before.” After three days Belt removed the bandages. “I was sickened by the stench of the blood and the dead flesh,” Morgan remembered. “There was swelling something fierce down there. I couldn’t look.” For two more weeks in the hospital, “the pain remained unbearable,” and for a while after her release she still could not walk and bled profusely from her vagina.<sup>54</sup>

Before and after genital surgery, some MTFs sought other operations. Some wanted to enlarge their breasts. In New York in the 1950s Dr. Else K. La Roe, a German-born surgeon, gave breast implants to a few MTFs, including Charlotte McLeod. Other MTFs hoped to change the shape of their noses or shave off the more prominent cartilage on their “Adam’s apples.” Their goal in general was to appear as nontranssexual women, and the additional surgery often helped keep strangers from reading them as men. Faced with repeated requests for surgery, some doctors complained of “the tendency of these patients to desire polysurgery” and advised restraint in offering additional operations. But MTFs persisted, and occasionally their requests outstretched the medical technology. A few patients hoped that doctors could reduce their height or enable them to bear children. “In the most successful operation we ever had,” Elmer Belt wrote, “the patient came in after all was done expressing dissatisfaction because there was not a uterus with tubes and ovaries . . . and she could therefore not have a baby.” Another MTF approached Else La Roe in tandem with an FTM. They asked for “a mutual transplantation of their sexual organs,” a request they may have borrowed from the realm of science fiction.<sup>55</sup>

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Although doctors today usually posit equal numbers of FTMs and MTFs, in the 1950s and 1960s they believed that MTFs far outnumbered FTMs. The ratios (MTF:FTM) offered by various studies in Europe and the United States ranged from 8:1 to 2:1. They reflect the numbers of MTFs and FTMs that doctors encountered in their practices or in reviews of the medical literature. By the mid-1960s, for example, Benjamin had diagnosed and treated 152 MTFs but only 20 FTMs. At the end of the decade, when Johns Hopkins Hospital reported almost 2,000 requests for surgery, only one-fifth came from FTMs.<sup>56</sup> As a result of the numbers, some researchers considered transsexualism in the same way they considered fetishism or transvestism, as a largely, if not wholly, “male” condition. They sometimes speculated that sex differences in neuroendocrine development or in the psychodynamic processes in which the infant separated from the mother led to a skewed sex ratio in the prevalence of crossgender identification.<sup>57</sup>

For this reason, FTMs sometimes had trouble convincing doctors to take them seriously as candidates for surgery. In 1954, before he had FTM patients, Harry Benjamin did not know what to make

of a correspondent who asked about female-to-male surgery. "There is no operation possible," he responded, "that would change a female into a male. In some rare cases a male has been operated on so that he later on resembles a female, but nothing like that is possible if the patient is a normal girl." At the end of the 1960s doctors at UCLA's Gender Identity Research Clinic debated privately whether FTMs even qualified as transsexuals. From 1968 to 1970 they held at least fifteen meetings devoted to FTMs. Robert Stoller wondered "whether there should be such a diagnosis as 'transsexualism' for females." After twelve years of treating FTMs, he could not find "etiological events which hold from case to case or even a very consistent clinical picture, other than the raging desire to become a male." His colleague Richard Green disagreed. He attempted "to convince the world (or at least our microcosm) of the existence of a syndrome of female transsexualism."<sup>58</sup> But the interest at UCLA was somewhat unusual. In the main, doctors focused their research and their attention on MTFs.

For their part, fewer female-to-male transgendered people asked doctors for surgery. They may not have seen examples in the press of successful surgical transformations, and they may have avoided a surgical solution that still could not produce a functioning penis. The subordination of women may also have played a role. Those who had grown up as girls may not have had the same sense of entitlement to medical services as did MTFs or the same insistent attitude with doctors, and those who lived and worked as women may have had fewer economic resources to finance medical intervention. The diverging constraints of masculinity and femininity may also have entered into their decisions. Female-to-males could dress as men with less risk of arrest. By midcentury, women frequently dressed in pants. On the streets, onlookers often treated a masculine or butch woman with hostility and contempt, but police rarely arrested her simply for her attire. Furthermore, in the postwar era some highly masculine women could find an accepting community in butch-femme working-class lesbian bar networks, but highly feminine men were increasingly reviled, even among gay men.<sup>59</sup> In addition, with hormone treatments most FTMs could live as men without arousing suspicions. If they grew facial hair they could usually expect casual observers to see them as men. For these and other reasons, female-to-male transgendered people often stopped short of surgery.

Still, some FTMs begged doctors for surgery and took it where they could find it. If they could not convince American doctors, they sometimes went to Europe or Mexico in search of operations.<sup>60</sup> In the early 1960s, for example, a twenty-six-year-old South American FTM came to the United States in search of surgery. In one "eastern medical center," operations were "advised but . . . not available"; in another, surgery was refused. He then "travelled to Denmark," where doctors refused to treat him because he "was neither a citizen nor a resident." Eventually he found doctors in New York who promised what he wanted. He began testosterone injections. In 1965 he underwent "bilateral mastectomy," and in 1967 he had "all internal genitalia" removed and his vagina closed.<sup>61</sup>

In most cases, surgery for FTMs meant removal of breasts and internal reproductive organs. These were procedures that surgeons performed routinely on women. They did not require unusual technical skills. Patients could sometimes convince doctors that painful menstruation, cysts, or other ailments justified the surgery. For many FTMs, mastectomy came first because breasts, especially large ones, made it difficult to live as a man. A 1968 study of six FTMs found that "they all hated their breasts and found them . . . mortifying." All six subjects gave "precedence to flat-chestedness over cessation of menstruation, much as they were repelled by the idea of having to menstruate."<sup>62</sup> Next they sought excision of the uterus, fallopian tubes, and ovaries, which would not only remove their reproductive organs but also end their menstrual periods (if they were not already taking testosterone) and eliminate their chief source of estrogen.

Through the 1960s, FTMs rarely underwent phalloplasty. The procedure was technically difficult, and few doctors attempted it. Surgeons first reported on phalloplasty after World War I, when they

attempted to reconstruct penises for men whose had been amputated. By midcentury the favored technique was a “tube-within-a-tube,” in which the internal tube served as the urethra. In the late 1940s the plastic surgeon Sir Harold Gillies described the technique, developed in part by others, in an article on men with “congenital absence of the penis.”<sup>63</sup> In Britain, Gillies himself constructed a penis for at least one FTM in the late 1940s.<sup>64</sup> In the United States, though, there is no evidence of phalloplasty for transsexuals until the early 1960s, when Seth Graham (pseudonym) underwent surgery with Dr. D. Ralph Millard Jr. in Miami, Florida. Millard knew Gillies’ work well: in the late 1950s they had coauthored a landmark book, *The Principles and Art of Plastic Surgery*, which included an illustrated description of the surgical procedure. In the case of Graham, Millard performed thirty operations over the course of three years as he attempted to perfect the penis and scrotum he had constructed. Eventually Graham refused to come back for more, even though Millard still wanted to “put a corona atop the terminus.” By his own account, the medical treatment cost Graham around \$10,000, only about \$1,000 of which went directly to Millard. The remainder, he said, paid for two earlier unspecified operations, perhaps mastectomy and hysterectomy, and “the high cost of hospitals and drugs.”<sup>65</sup> In the late 1960s surgeons at Johns Hopkins Hospital began performing phalloplasties on a handful of patients, and by the mid-1970s a few more surgeons, such as Ira Dushoff, in Jacksonville, Florida, and Donald Laub, at Stanford University, had experience with the operation.

As Seth Graham’s account suggests, phalloplasty involved multiple stages of surgery, performed over a course of weeks, with unpredictable results. In the “tube-within-a tube” pedicle procedure, doctors created two tubes, usually from the skin of the abdomen. They incorporated the smaller tube, with skin surface turned inward, within the larger tube pedicle, with the skin surface outward. In a pedicle, the flap of skin, sutured into a tube, remained attached at both ends to the body, looking, as one FTM described it, like a “suitcase handle.”<sup>66</sup> This supplied blood to the raised tissue, which was gradually moved end over end to its new position. Doctors implanted one end of the tube-within-a-tube on the clitoris and later freed the other end. The complicated procedure also involved skin grafts to the abdomen, and required extending the original urethra so it could reach the new urethra in the tube. Doctors aimed for “a satisfactory esthetic appearance . . . that would allow the patients to stand while voiding.”<sup>67</sup> But even after multiple surgeries, the constructed penis did not necessarily look normal, and it sometimes failed to take. For erections, doctors might use cartilage or other implants to create a permanent stiffness, or they might leave the penis flaccid.

Some FTMs were “entirely pleased with the results of hormone therapy, breast amputation, and hysterectomy,” but others hoped for genital surgery despite the dearth of doctors, the multiple surgeries, the expense, and the imperfect results. Without a penis, some continued to fear “discovery” and exposure.<sup>68</sup> But equally important, a penis, like a flat chest, provided one more sign that the body approximated the male sense of self. In the late 1960s Mario Martino took hormones and underwent operations to remove his breasts and reproductive organs, but he still wanted phalloplasty. “To have my body reflect my image of myself as a male,” he wrote, “I would pay any price, do anything within honor.” He had heard “vague rumors about surgeons . . . overseas” who created penises, but “nothing could be verified.” Eventually he found a surgeon in the United States. The first attempt, from a tube pedicle on the thigh, failed because of infection. Four years later, Martino found another surgeon in the Midwest, who created a penis from a tube pedicle on the abdomen. Despite the pain and the problems, Martino expressed his satisfaction with the “new part of me,” which he had “always conceived of myself possessing.” “It completes outwardly,” he said, “a picture of myself which I have always carried in my head.” It served as “an acknowledgment” of his “maleness.”<sup>69</sup>

Other FTMs sought additional forms of surgery. In 1969 Rob Dixon (pseudonym) began to live as a man while receiving hormone injections. A year later psychiatrist Richard Green reported: “This

patient still insists on having surgery and feels that he hates the female aspects of his body." Dixon wanted "to have both breasts removed . . . as well as the uterus and ovaries." He also hoped for the surgery suggested by the UCLA urologist Willard Goodwin: an operation "to free up the enlarged clitoris and redirect the urethral orifice" as well as "insertion of prosthetic testes."<sup>70</sup> In the former operation, more common today, the doctor cuts the ligaments around the clitoris, enlarged by testosterone, to create an organ resembling a small penis. (It does not today involve repositioning of the urethra.) In the latter operation, the doctor constructs a scrotum from a skin graft and follows it up with implants in the shape of testicles. In 1960, for example, Lauren Wilcox, one of Benjamin's patients, had plastic testicles implanted at the time of hysterectomy. In a few cases doctors also closed the vagina when operating on FTMs. Of Benjamin's first twenty FTM patients, at least fourteen had some kind of surgery, but only one had his vagina closed.<sup>71</sup>

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Before and after surgery, transsexuals engaged their doctors in a complicated give-and-take, fraught with trouble and conflict. On one side, patients felt angry at doctors who dismissed their desires for bodily change. The difficulty of finding surgeons who would perform the operations, the doctors' brusqueness, ignorance, or condescension, the expense of the treatment, and the complications attending surgery fed the frustrations of patients. On the other side, doctors bristled at the demands of patients who pressured them for treatment. They felt betrayed when patients tailored their stories in order to qualify for surgery and angry when patients failed to express gratitude for the risks taken on their behalf. More fundamentally, the conflicts brought up questions of control. Who could decide whether a person was or should be a man or a woman? Who could decide whether to change the bodily characteristics of sex? Transsexuals hoped to decide for themselves, but they needed the consent and cooperation of doctors.

The conflicts involved issues of knowledge and authority. Transgendered people often had more knowledge about their own condition than the doctors they approached. They had their firsthand stories of crossgender identification, and many of them had also read widely in the medical literature. They had their own compelling reasons to follow newspaper stories, track down case studies, and follow them up for leads on the impact of hormones and new surgical techniques. "Why," one MTF wondered, "did I know about the [sex-reassignment] procedure and doctors didn't?" Yet the doctors had the cultural authority, whether or not they had ever encountered, studied, or thought about transsexuality. Journalists turned to the medical profession to define the problem publicly and propose solutions. On a more personal level, doctors also had the power to determine exactly who would qualify for treatment. From the start, patients protested the clout of doctors "who do not know anything on the subject."<sup>72</sup>

In this situation, some transgendered people worked to educate the doctors. In San Francisco, Louise Lawrence devoted herself to teaching medical authorities and scientists about transvestites and transsexuals. From the mid-1940s, when she started to live as a woman, she worked with Karl Bowman at the Langley Porter Clinic to help doctors there understand transvestism. In the late 1940s she met Alfred Kinsey and began to send him letters, clippings, photos, books, and manuscripts. Eventually Kinsey paid her for her efforts.<sup>73</sup> He introduced her to Harry Benjamin, with whom she corresponded frequently to discuss reports in the medical literature and the popular press. Both Kinsey and Benjamin relied on Lawrence as a key source of information on transsexualism. Lawrence, for example, informed Benjamin of David O. Cauldwell's earlier writings on transsexuals. Benjamin, as two of his former colleagues noted, used her "as a sounding board for . . . many of his ideas." And Lawrence appreciated Benjamin as "one of the few medical men in this country who has any understanding of this problem."<sup>74</sup>

After the Jorgensen story broke, Lawrence redoubled her efforts. She saw the negative response of American doctors as an example of their “rigid attitude toward the acceptance of new and progressive ideas.” In correspondence with an MTF, she speculated that the doctors who repudiated sex-change surgery had their own form of castration anxiety. “If only some of these American medical men could . . . not continually imagine that their own penis was removed when Christine’s was, maybe we would see some sound thoughtful, imaginative progress made in this field.” With Benjamin as her liaison, she corresponded and met with Jorgensen. She hoped to reply to the letters that Jorgensen did not have time to answer and to use them for scientific study. Jorgensen would not relinquish the letters, but she did refer some correspondents to Lawrence. Lawrence told one such letter writer that she was “trying to gather as much information . . . as possible in order that medical men . . . will be able to help people who come to them.”<sup>75</sup>

The patients understood that they themselves provided the raw data that doctors and researchers used to formulate their descriptions and their theories. Debbie Mayne told Benjamin that after reading his article “Transvestism and Transsexualism,” her mother had commented, “why you have been telling me this right along.” “Of course I have,” Mayne said she replied; “where do you think the doctor gets his information?” For this reason many early transsexuals agreed, and even sought, to participate in research projects. In the late 1940s and early 1950s Alfred C. Kinsey took an avid interest in transvestites and transsexuals. With the encouragement of Louise Lawrence and Harry Benjamin, several transsexuals agreed to cooperate with him. Caren Ecker gave her life history to Kinsey “in hopes that any information . . . may in its small way eventually be of help to others of my kind.” Like Ecker, others hoped to shape the scientific literature, with the longterm goal of increasing knowledge and public understanding. After reading *Sex and Gender*, an FTM wrote Robert Stoller: “perhaps in the same spirit one donates one’s body to a medical school for the good of posterity, I would like to offer my psyche-soma to your group for what you could make of it.”<sup>76</sup>

Caren Ecker referred to her educational efforts as “missionary work for our cause.” While recovering from her surgery in San Francisco, she gave the curious doctors offprints of Benjamin’s article, with the goal of “promoting interest and tolerance.” Later she worked with Louise Lawrence for public education, and cooperated with Frederic Worden and James Marsh in their research project at UCLA. She was “trying to sell” Worden and Marsh, she said, “the true idea that I’m happy with my new life, and the idea that for suitable subjects it is right to make these changes.”<sup>77</sup> These early, unorganized efforts to educate doctors and scientists were precursors to an organized transsexual rights movement that emerged in the late 1960s. From early on, though, transsexuals discovered how difficult it was to convince the doctors to treat them in the ways they wanted.

They quickly learned that researchers had their own agendas. For the MTFs interviewed by Worden and Marsh, the lesson came as a painful blow. In letters to Benjamin, four of the five subjects expressed outrage at their treatment. From the start, they resented the clinical attitude of Worden and Marsh, who wanted to test them but failed to listen to what they had to say. After psychological testing, Carla Sawyer (pseudonym) wrote: “I feel as if I have been flattened out, and rolled up and pushed through a knot hole and I told them so, too.” When Marsh interviewed her, she said, he “didn’t even seem to know about what my case concerned,” and when Worden interviewed her, “he hadn’t even taken the time to look at” a six-page letter she had given him. “I told them,” she said, “I was getting pretty tired of it.”<sup>78</sup>

Of the five MTFs interviewed, three had already had surgery, but two others, Carla Sawyer and Debbie Mayne, hoped their participation in the research would convince the doctors to recommend operations. Apparently Worden held out some possibility of surgery at UCLA. Despite her misgivings, Sawyer stuck with the research project. She told Benjamin: “there is not much else that I can

do except make myself available to them... the only thing I care anything about is having my sex changed."<sup>79</sup> Debbie Mayne, the most volatile of the group, spent a year working with Worden, waiting impatiently for approval for surgery. Louise Lawrence told her "NOT to blow [her] top." "I will agree," she wrote, "that Dr. Worden is probably a very young man who has a lot to learn... [but] for the sake of all of us try and hold your emotional reactions in check." With a heavy dose of paternalism, Harry Benjamin also tried to keep Mayne calm. "It isn't very wise and very diplomatic of you," he warned, "to antagonize Dr. Worden... Do try hard to give the impression of a well-balanced sensible person... you must not expect everybody... to understand this problem... do be a sensible girl." Not so easily reined, Mayne replied: "This girl is going to keep on raising hell until I get my operations." Ultimately, though, Worden refused to recommend surgery, leaving his subjects more frustrated and angry than before. Worden, Mayne concluded, "has never recommended anything for anybody... he doesn't know too much to begin with."<sup>80</sup>

Other participants in the research expressed their anger after Worden and Marsh published their article in 1955 in the *Journal of the American Medical Association*. They objected to the way the doctors had used their interviews to cast transsexuals in a negative light. The article, Janet Story (pseudonym) told Benjamin, "certainly was a cruel thing." Annette Dolan went into greater detail. She sent her objections to the *Journal of the American Medical Association*, Elmer Belt, and Harry Benjamin as well as to Frederic Worden. "In general," she said, "my words were twisted to suit their purpose." Point by point, she disputed their interpretations of her own responses and more generally of their understanding of transsexuals, and she wondered how they could draw conclusions from interviews with only five subjects. But mostly, she expressed her outrage at the cold approach and condescending tone of the researchers. Worden and Marsh, she wrote, had not "made a genuine attempt to establish a rapport with their subjects"; they had tried "to milk scientific information from them in the approximate manner laboratory animals are used." As she told Elmer Belt, she could "sense the subtle ridicule heaped by the authors on their subjects." Worden and Marsh had rewarded her willingness to participate in their research with a damaging portrayal of transsexual pathology, and she rightfully resented it.<sup>81</sup>

The episode with Worden and Marsh reflected ongoing conflicts. For decades to follow, both transsexuals and doctors confirmed the troubled relations between the patients who sought surgical sex change and the medical authorities who hesitated to recommend it. In the mid-1950s, Robert Stoller, then new to the field, "tried to reverse" Carla Sawyer's "sexual tendencies" and thereby "antagoniz[ed] the patient." Other doctors responded to would-be patients with the rankest of prejudice. In her autobiography, Vivian Le Mans remembered doctors "who threatened to have [her] arrested" for requesting sex-change surgery. "One doctor," she recalled, "even had his janitor chase me out of the office with a mop! He said he didn't want to contaminate his hands."<sup>82</sup>

In order to qualify for surgery, patients sometimes stuck, at least temporarily, with doctors whom they disliked and distrusted. In the late 1960s, Phoebe Smith went to a psychiatrist who attempted to kiss her to see, he said, how she would react and later tried to burn her with a cigarette to find out, he claimed, whether she would defend herself. Eventually she concluded that "the doctor had problems of his own." Around the same time, Mario Martino found a doctor who administered hormones and conducted monthly group therapy sessions where Martino gladly met other FTMs. But the doctor, Martino found, "took no real personal interest in me as a patient... nor in any of his patients." "One by one," Martino recalled, "his patients began to mistrust him," especially after the doctor could not refer them, as promised, to a surgeon. Martino began to wonder, "Was I patronizing a quack?" His skepticism rose as the doctor showed excessive interest in "sex and the sex act." Eventually Martino turned to other FTMs for the referrals, counseling, and advice he wanted.<sup>83</sup>

Increasingly, patients kept their guards up and avoided the kinds of self-disclosure that might

damage their chances for surgery. Those who hoped for surgery had to tell their stories to doctors, but they soon learned to censor themselves as well. Patients tried to tell the doctors what they thought the doctors wanted to hear. Even with sympathetic doctors, they sometimes tailored their accounts to make themselves fit into the recognized diagnostic categories, to convince doctors that they were not just garden-variety homosexuals or transvestites, and to reassure doctors that they would not bring trouble after the operations were done. In order to impress their doctors with their need for surgery, MTFs attempted to demonstrate conventional femininity, and FTMs masculinity. They tried to persuade the doctors that they would lead “normal” and quiet lives after surgery. And they tried to convince doctors of their sense of urgency. “In order to get surgery,” one MTF claimed, “you have to tell the doctor that if you don’t get it you will commit suicide.”<sup>84</sup>

Before the “sexual revolution” of the 1960s, many transsexuals refrained in particular from expressing overt interest in sexual relations. After her surgery, Debbie Mayne told Harry Benjamin that she wanted “the sex life of the woman . . . I would not admit this before because I thought it might prevent me from getting the operation and I lied.”<sup>85</sup> The surgeon may well have applauded Mayne’s heterosexual interest, but she saw it as dangerous to mention any sexual interests at all. Transsexuals knew that “normal” meant heterosexuality after surgery, but if they expressed such interests, they might appear as overly interested in sex or they might come across, in the preoperative state, as homosexuals who did not qualify for surgery. This reticence about sexuality appeared in various records. Take, for example, the 1953 case study of an FTM, hospitalized against his will. “I never had any desire,” he told a doctor. “I’ve never had any sex relations of any kind in my life. My wife said it never bothered her, that she could take it or leave it.” He wanted “that operation,” he said, but it did not have to do with sexuality. As if to underscore the point, he repeated later, “Sex isn’t important to me.” Or take the letter an MTF, hoping for surgery, wrote Harry Benjamin in 1955: “You can rest assured that all I ever want from life is something moral and right, and marriage and men are only minor things, because the really important thing is to dress as a woman and be accepted by society.”<sup>86</sup> Perhaps these particular patients had little interest in sex, but maybe they saw the double bind and simply omitted, as did Debbie Mayne, the sexual acts or interests that they imagined would trigger the doctors’ disapproval.

By the 1960s, doctors realized that their transsexual patients often structured their life histories to maximize their chances for surgery. The well-publicized story of “Agnes” served as a key case in point. In 1958, Agnes came to the UCLA Medical Center, seeking genital surgery. She met with a number of doctors, including Robert Stoller, and convinced them all that she qualified for surgery as an intersexed patient. She was, as the researchers recalled, “a 19-year-old, white, single secretary,” living as a woman, but with male genitalia.<sup>87</sup> She had grown up as a boy in a Catholic working-class family, but she had always seen herself as a girl. During puberty, she had developed female secondary sex characteristics, including breasts, and at the age of seventeen, had begun to live as a woman. Earlier tests, conducted in Portland, Oregon, had shown that she had male (XY) chromosomes and neither a uterus nor ovaries nor a hypothesized tumor that might have produced estrogen. After exhaustive examinations, the doctors at UCLA recommended the surgery she sought. In 1959 a team of surgeons, including Elmer Belt, removed her male genitals and constructed labia and a vagina.

With her male genitals, feminized body, and high levels of estrogen, Agnes was wholly unlike any other intersexed patient that the doctors had encountered in their own observations or in the medical literature. The doctors pondered, publicly and privately, what she represented, and they used her case study in scholarly presentations and publications. Three medical doctors joined Stoller in authoring “Pubertal Feminization in a Genetic Male.” They hypothesized that Agnes had “a diffuse lesion of the testis” which had produced the estrogen which had, in turn, produced her breasts. To Stoller, Agnes’s bodily changes during puberty seemed to confirm the usually hidden “biological force” underlying

gender identity. A congenital physical factor, which manifested itself later in the growth of her breasts, explained why "the core identity was female" even though "the child was an apparently normal-appearing boy and . . . also genetically male."<sup>88</sup> Stoller presented his findings on Agnes in 1963 at the International Psychoanalytic Congress in Stockholm and also published them in scholarly journals.

But all along, Stoller and his colleagues noted some suspicious evidence. During the seventy-odd hours of interrogation, Agnes refused to engage a number of topics, and she also refused to allow the doctors to interview her family. Furthermore, from the physical evidence gathered, the doctors had to acknowledge a "clinical picture that seemed to suggest the superimposition of an excess of estrogen upon the substratum of a normal male."<sup>89</sup> They discussed among themselves whether perhaps Agnes had given herself estrogen to induce the growth of her breasts. In the end, they convinced themselves that she had not. She herself denied that she had ingested estrogen. More important, her conventional feminine presentation impressed the doctors as genuine and ran counter to their stereotypes of "caricature" and "hostility . . . seen in transvestites and transsexualists." "It was not possible," they wrote, "for any of her observers, including those who knew of her anatomic state, to identify her as anything but a young woman."<sup>90</sup> Elmer Belt, impressed by the size of her breasts, remembered her in private correspondence as "very beautiful—well stacked."<sup>91</sup> The other doctors also suspended their disbelief in the face of contradictory anatomical evidence and convincing gender presentation.

Then, in 1966, seven years after her surgery, Agnes confessed. She told Stoller that her body had changed during puberty because she had taken estrogen tablets since the age of twelve. She had stolen the hormone from her mother, who had used it after her hysterectomy. As Stoller later reported, "The child then began filling the prescription on her own, telling the pharmacist that she was picking up the hormone for her mother and paying for it with money taken from her mother's purse." Posing as a unique example of an intersexed condition, Agnes had convinced her doctors to give her the surgery they routinely denied to male-to-female transsexuals. In the wake of her confession, Stoller wondered about his theories. Richard Green attempted to reassure him. "Do not despair about the biological force behind gender identity," Green wrote Stoller. "I am sure there is one somewhere and there are other cases to consider which are supportive of the idea."<sup>92</sup> Still, an embarrassed Stoller had to admit that Agnes "is not the example of a 'biological force' that . . . influences gender identity . . . rather, she is a transsexual."<sup>93</sup> He retracted his earlier findings at the International Psychoanalytic Congress in Copenhagen in 1967 and also published Agnes' revelations in 1968 in the *International Journal of Psycho-Analysis* as well as in his book *Sex and Gender*.<sup>94</sup>

The lesson was not lost on the doctors. Various researchers had already concluded that transsexuals were "unreliable historian[s] . . . unable to recall very well, or inclined to distort."<sup>95</sup> By the end of the 1960s, the medical literature on transsexuals regularly noted that transsexuals shaped their life histories and even fabricated stories that might convince doctors to help them. As a few more American doctors began to perform sex reassignment surgery, candidates less often portrayed themselves as intersexed, as had Agnes, but instead "as textbook examples of 'transsexuals.'" They presented "their personal histories," one article suggested, "to conform to the prevailing 'scientific' fashions." If they could prove to the doctors that the diagnosis fit, then perhaps the doctors might recommend the surgical treatment. As the doctors acknowledged the medical context that encouraged patients to coordinate their autobiographies with scientific accounts of transsexualism, they increasingly questioned "the extent to which the patient's stories and self-descriptions can be trusted."<sup>96</sup> In short, the patients mistrusted the doctors, and the doctors mistrusted the patients.

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For transsexuals, the problems did not end when they convinced doctors to recommend and perform surgery. The fees, as Mario Martino remembered, were "staggering." In the mid-1950s, Harry Benjamin

wrote: "I have my hands full with patients . . . who should have the operation but do not have the necessary funds." The funds needed varied, depending on the doctor and the surgeries performed, but in the 1960s, they generally ran a few thousand dollars. In some cases, disappointed patients, accepted for surgery but unable to afford it, talked of suicide or self-surgery. A number of MTFs engaged in prostitution to raise funds for their operations. Others tried to negotiate the costs. In the mid-1950s, with Benjamin's help, Debbie Mayne had the "extravagant fees" for her surgery in Mexico reduced and then agreed to pay on the installment plan. In 1970, Lyn Raskin convinced Georges Burou to reduce his \$4000 fee to \$1500.<sup>97</sup> Such arrangements required confrontations with doctors who generally did not expect patients to bargain with them for their services. The fees not only alienated the patients, but led, as one doctor described it, to "unpleasant experiences."<sup>98</sup>

In the doctors' offices and at the hospitals, wary patients observed the behavior of doctors and staff members who treated them unprofessionally. At Elmer Belt's clinic in Los Angeles, Annette Dolan sensed "an undercurrent of uneasiness caused by our presence." She also noted that her confidential records lay out on the business manager's desk, used, she said, "in the same manner as a best seller."<sup>99</sup> A few years later, at the same clinic, Aleshia Brevard remembered, Belt himself was "condescending and rude." In other cases, hospital staff treated the patients as oddities. When Mario Martino, with a full beard, entered the hospital for a hysterectomy, "everyone outside the department," he remembered, "lined up to take a look at the new specimen: *me*."<sup>100</sup>

Pain at the hands of doctors also heightened patients' discomfort. For months after surgery, MTFs had to dilate their vaginas frequently to keep them from closing. The first dilations were particularly painful. Carla Sawyer noted the "rough physical treatment" she received at the clinic of Elmer Belt, and a few years later, Patricia Morgan also recounted the pain. She said it took Elmer Belt and his son, also a doctor, fifteen minutes to force "a piece of plastic shaped like a man's penis" into her new vagina. "I grabbed the bars on the bed," she recalled, "and gritted my teeth."<sup>101</sup> While some patients accepted the pain as a necessary evil, others questioned the competence and motives of their doctors. The pain he endured during a routine pelvic examination made Mario Martino "suddenly apprehensive." He wondered: "Was this doctor as professional as he first appeared? Was he just impersonal? Or did he enjoy inflicting pain?"<sup>102</sup>

Given the less-than-perfect medical technology, the operations themselves often created additional sources of frustration. For both MTFs and FTMs, there were infections, grafts that failed to take, and scar tissue that changed the appearance of the chest or labia. It was not unusual for new vaginas to close, new penises to wither, and urethras to constrict. FTMs who had phalloplasty regularly encountered post-surgical problems. In his first attempted phalloplasty, Martino reported how the tube pedicle failed: It "was shriveling, curling in on itself like a snail." In the second attempt, the head of the new penis "turned dark, signifying death of the tissue." Three months later he returned to the surgeon for another skin graft and "repairs."<sup>103</sup> Even after successful phalloplasty, FTMs often had "urinary problems in the form of fistulae, . . . infections, and incontinence." Frustrated patients, both FTMs and MTFs, returned to their doctors again and again with post-surgical problems. They sometimes underwent additional surgery to "correct a small vagina, a tender urethral stump, or a deformity of the labia," "to release strictures," to remove infected implants, or to attempt another graft after the first one had failed.<sup>104</sup>

The disappointments mounted when the bodily transformations did not have the appearance or the functions the patients wanted. One follow-up study on nine MTFs showed that all expressed "some dissatisfaction with the physical results of their surgery," especially with the size of the vagina or the "appearance of the labia and external genitalia." The doctors, aware of the limits of medical technology, acknowledged the "conflict with the surgeon." They admitted that "duplicating either sex in a perfect

anatomical way is impossible."<sup>105</sup> Some tried to forewarn patients to lower their expectations about what the technology could accomplish. Harry Benjamin wrote one patient: "Please . . . do not expect either one-hundred per cent success, or one-hundred per cent happiness. There is no such thing."<sup>106</sup>

On top of it all, the patients knew that the doctors often saw them as mentally ill, irritating, or hostile. In the published medical literature, some psychiatrists, in particular, pathologized their transsexual patients. As Richard Green and Howard Baker noted, "the psychiatric literature is replete with deprecatory descriptions." Many doctors had, it seems, little experience with patients whose sense of urgency led them to insist on unusual forms of medical treatment. They seemed perplexed by the "extreme impatience" and the "anger" of patients who pushed them to stretch the boundaries of acceptable medical practice.<sup>107</sup> Accustomed to deference, they encountered patients whose determined demands surprised and annoyed them. Even the more sympathetic doctors sometimes lambasted their patients. In a letter to Willard Goodwin, Elmer Belt wrote: "These patients are simply awful liars. They lie when there is no need for it whatever." In letters to Harry Benjamin, he occasionally referred to his transsexual patients as "queers" or "nuts."<sup>108</sup> Robert J. Stoller considered MTFs "dissatisfied," "exhibitionistic and unreliable." "Some of these patients," he wrote to another doctor, "can be a real pain in the neck . . . even after surgery some of them can be quite persistent."<sup>109</sup> In his published writings, Harry Benjamin, the most sympathetic of the crew, wrote of the "selfishness, unreliability and questionable ethical concepts of some male and female transsexuals." A benevolent paternalist, he responded graciously to those who expressed "gratitude and loyalty" in response to his efforts.<sup>110</sup> But in a moment of pique, after a patient accused him of lying, he wrote, "You have been unappreciative and ungrateful."<sup>111</sup>

Those who underwent sex-change surgery encountered a range of daunting problems that went well beyond their dealings with doctors. Before and after surgery, they had to deal with families and friends who did not necessarily approve of the change of sex. They could choose to sever contact and move to a new life in which no one knew of their pasts, or else they could confront, and risk rejection by, anyone who knew their histories. They needed to find employment in their new gender status, often without the benefit of references from previous employers. They worried about the "apparent handicap they [had] in finding someone [who] will offer them employment," and they feared "being detected on the job."<sup>112</sup> As they changed their lives, a few transsexuals courted publicity, especially MTFs who hoped to follow in Jorgensen's footsteps, but most feared exposure in the press and also in daily life. Caren Ecker worried that the newspapers would print stories about her surgery. "I could see nothing of the financial good that came to Christine," she told Benjamin, "and only confusion to the plans I have made to continue my nursing career . . . publicity at this time would wreck all my chances." MTFs, in particular, worried about "passing," especially when their height, voices, facial features, or facial hair defied conventions of femininity. If they did not appear to be women, they risked the same harassment and arrest after surgery that they had faced before.<sup>113</sup>

The more sympathetic doctors did what they could to help their patients through the transition. Harry Benjamin tried to take care of "his girls." Aleshia Brevard, whom Benjamin treated in the early 1960s, remembered, "He really went to bat for me." Benjamin "talked to [her] parents" and "set up everything that there was to be set up, the meeting with the psychiatrist . . . all the legal rigmarole . . . it was all relatively painless because of him."<sup>114</sup> Benjamin, Belt, and others provided patients with letters attesting to the surgical change of sex. A typical letter, written by Elmer Belt in 1956, read: "This is to certify that a surgical operation performed for \_\_\_\_\_ has altered the genitalia of this patient, converting the sex from male to female, and that \_\_\_\_\_ in my opinion should legally be considered as belonging to the female sex."<sup>115</sup> The patient could show the letter to police if picked up for crossdressing or to skeptical bureaucrats who hesitated to change the name and sex on a driver's license, passport, or

social security record. Benjamin also worried about the employment prospects of his patients and tried to encourage them in the job search. Mario Martino's surgeon hired him as a nurse, but few doctors went so far as to find jobs for their patients.

As the doctors advised their patients, they also inadvertently encouraged their dependence, which ultimately fueled frustrations. Benjamin and others urged post-operative patients to hide, and even to lie about, their past lives as the other sex. This placed the doctors among the few confidantes to whom the patients could turn. When the doctors failed to provide assistance, the patients felt betrayed. In Los Angeles in the mid-1950s, Annette Dolan, for example, hoped that Frederic Worden and Elmer Belt would help her and another MTF find jobs. "We are of the opinion," she wrote, "that an all out effort should have been made to give us a new start in life." When she asked Willard Goodwin for help, "he was," she said, "cold as ice."<sup>116</sup> Benjamin told her not to "expect anything from others" and also warned her that her "tactless" behavior might "rob" her "of some friends and sympathies." But she explained her sense of urgency: "What you fail to realize is that I literally am fighting for my life."<sup>117</sup>

For a few, the long struggle did not seem worth it in the end. In the available records, a handful of transsexuals expressed regrets about their new lives. One MTF failed to find employment as a woman and had to revert to living as a man. "I am not doing this," she told Belt, "because I desire to go back to an unhappy life, but I have to survive. It is a bitter pill, the bitterest I ever took, but there is nothing left to do." Another MTF decided after surgery that she had "a man's mind," that her "new body was all wrong." She made a good living as a "Latin Bombshell" stripper, but she disliked the aggressive men who expected her to have sex with them. She had lost her interest in sex with either men or women, and she found her life "lonely beyond belief."<sup>118</sup>

On the whole, though, those who managed to obtain surgery rarely regretted it. They overwhelmingly endorsed medical treatment, even though they had disappointments with the arduous process and imperfect results. Despite their persistent conflicts with doctors, they expressed their appreciation. In an article on FTMs, one doctor noted: "the patients demonstrate an attitude of extreme gratitude." In letters to Harry Benjamin, MTFs gave their thanks for the ways he had helped them fulfill "a life long dream" and find "peace of mind." "Nothing else in the world," one MTF wrote, "means or could ever mean so much to me as accomplishing this goal."<sup>119</sup> Surgery, of course, could not solve everything. "I guess that loneliness is the thing in this life that I now dread the most," Caren Ecker explained. "Still, I am grateful that my biggest problem is so well solved, that is, as well as it is possible to solve such a problem, and much better than I would have ever believed possible a few years ago."<sup>120</sup>

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By the end of the 1960s, then, transsexuals had persuaded at least a few American doctors to move from theory to practice. They insisted that they could determine their own rightful sex and gender, and they convinced a handful of doctors to make their bodies accord with their minds. The request for bodily change distinguished them from other sexual "deviants." Homosexuals and transvestites did not have the same longings for medical intervention. For the most part, they wanted doctors to leave them alone. Doctors noted the differences, and so did transsexuals themselves. In the medical literature, the doctors engaged in and elaborated on the differential diagnoses that created the scientific classifications of sexuality, and in daily life, self-avowed transsexuals staked out their claims to identities of their own.

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49. Elmer Belt to Harry Benjamin, August 15, 1960, Elmer Belt, 1959-1962 folder; Belt to Benjamin, October 16, 1962-1965 folder, both in box 3, Series IIC, HBC
50. On Belt's surgical technique, see Elmer Belt to Alfonso de la Pena, April 25, 1960, Elmer Belt, 1959-1962 folder, box 3, Series IIC, HBC. On this decision to quit, see Elmer Belt to Harry Benjamin, October 16, 1962, Elmer Belt, 1962-1965 folder, box 3, *ibid.* On Barbara Richards Wilcox, see Leah Cahan Schaefer and Connie Christine Wheeler, "Harry Benjamin's First Ten Cases (1938-1953): A Clinical Historical Note," *Archives of Sexual Behavior* 24:1 (February 1995), 80. Schaefer and Wheeler call Wilcox "Carol."
51. R. J. to Harry Benjamin, April 27, 1955, R. J. Folder, box 5, Series IIC, HBC; Benjamin, *The Transsexual Phenomenon*, 118.
52. Robert J. Stoller to D. B., November 14, 1968, General, A-G, 1968-1969 folder, box 37, RSP; Harry Benjamin to J. E.,
53. For a brief history, see Edgerton, Knorr, and Callison, "Surgical Treatment." See also James Fairchild Baldwin, "The Formation of an Artificial Vagina by Intestinal Transplantation," *Annals of Surgery* 40 (1904), 398-403; Howard W. Jones, "Operative Treatment of the Male Transsexual," in Green and Money, *Transsexualism and Sex Reassignment*, 313-317; Benjamin, *the Transsexual Phenomenon*, 102-104.
54. Patricia Morgan, as told to Paul Hoffman, *The Man-Maid Doll* (Seacaucus, N.J.: Lyle Stuart [c. 1973]), 60, 63.
55. Jones, "Operative Treatment," 316; Elmer Belt to B. O., September 5, 1956, B. O. folder, box 6, Series IIC, HBC; Else K. La Roe, *Woman Surgeon: The Autobiography of Else K. La Roe, M.D.* (New York: Dial, 1957), 359. On Else La Roe and breast implants, see Watson Crews, Jr., "The Full Facts about Sex Change," in *New York Sunday News*, March 22, 1964, 26. For an early fictional account, in which a doctor changed (and then rechanged) the sexes of a married couple, see I. S. (Isadore Schnedier), *Doctor Transit* (New York: Boni and Liveright, 1925).
56. Pauly, "Male Psychosexual Inversion," 179; Benjamin, *The Transsexual Phenomenon*, 119, 147; Edgerton, Knorr, and Callison, "Surgical Treatment," 39.
57. See, for example, Richard Green, "Change-of-Sex," *Medical Aspects of Human Sexuality* 3:10 (October 1969), 101.
58. Harry Benjamin to L. M., May 20, 1954, L. M. folder, box 6, Series IIC, HBC; Robert J. Stoller to Harry Guntrip, March 4, 1969, General, A-G, 1968-1969 folder, box 37, RSP; memorandum from Richard Green to Dr. Baker et al., February 7, 1970, Gender Clinic Meetings, 1962-1970 folder, box 16, RSP.
59. On butch-femme working-class culture, see Elizabeth Lapovsky Kennedy and Madeline Davis, *Boots of Leather, Slippers of Gold: The History of a Lesbian Community* (New York: Routledge, 1993). On the declining vogue of "faries," see George Chauncey, *Gay New York: Gender, Urban Culture, and the Making of the Gay Male World, 1890-1940* (New York: Basic Books, 1994), 358.
60. Benjamin, *The Transsexual Phenomenon*, 156.

61. Warner and Lahn, "A Case of Female Transsexualism," 478–480.
62. John Money and John G. Brenna, "Sexual Dimorphism in the Psychology of Female Transsexuals," *Journal of Nervous and Mental Disease* 147:5 (1968), 495–496.
63. Sir Harold Gillies, "Congenital Absence of the Penis," *British Journal of Plastic Surgery* 1 (1948), 8–28; see also John E. Hoopes, "Operative Treatment of the Female Transsexual," in Green and Money, *Transsexualism and Sex Reassignment*, 335–352; Edgerton, Knorr, and Callison, "Surgical Treatment," 40.
64. See Liz Hodgkinson, *Michael, Née Laura* (London: Columbus Books, 1989), chaps. 4–5.
65. S. G. to Harry Benjmain, November 8 and 18, 1963, S. G. folder, box 4, Series IIC, HBC.
66. Martino, *Emergence*, 261.
67. Edgerton, Knorr, and Callison, "Surgical Treatment," 44; see also Sir Harold Gillies and D. Ralph Millard Jr., *The Principles and Art of Plastic Surgery*, vol. 2 (Boston: Little, Brown, 1957), 376, 384.
68. Hoopes, "Operative Treatment," 341.
69. Martino, *Emergence*, 163, 191, 263.
70. Richard Green, Consultation Notes, November 20, 1970, Richard Green section, box 3, RSP.
71. Schaefer and Wheeler, "Harry Benjamin's First Ten Cases," 77; Benjamin, *The Transsexual Phenomenon*, 156.
72. Phoebe Smith, *Phoebe* (Atlanta: Phoebe Smith, 1979), 27; A. D. to Harry Benjamin, November 13, 1954, A. D. folder, box 4, Series IIC, HBC.
73. On Lawrence and Kinsey, see Joanne Meyerowitz, "Sex Research at the Borders of Gender: Transvestites, Transsexuals, and Alfred C. Kinsey," *Bulletin of the History of Medicine* 75:1 (Spring 2001), 72–90.
74. Schaefer and Wheeler, "Harry Benjamin's First Ten Cases," 81; Louise Lawrence to B.S., June 7, 1954, Alfred C. Kinsey folder, LLC. On Cauldwell, see Louise Lawrence to Harry Benjamin, October 28, 1953, TRNSV notebook, LLC. Lawrence appreciated recognition, but she published her own article under a pseudonym because the editors of the journal thought "it would be safer"; Louise Lawrence to Alfred C. Kinsey, June 4, 1951, Alfred C. Kinsey folder, LLC.
75. Louise Lawrence to E. E., April 14, 1953, TRNSV notebook, LLC; Louise Lawrence to B. S., June 1954.
76. D. M. to Harry Benjamin, November 3, 1953, D. M. folder, box 6, Series IIC, HBC; C. E. to Harry Benjamin, October 5 [1953], C. E. folder, box 4, *ibid.*; G.S. to Robert J. Stoller, February 1, 1970, General, Q-Z, 1969–1970 folder, box 37, RSP.
77. C. E. to Harry Benjamin, January 4, 1954, October 5 [1953], January 27 and Mary 9, 1954, C. E. folder, box 4, Series IIC, HBC.
78. C. S. to Harry Benjamin, November 21, 1954, C. S. folder, box 7, Series IIC, HBC.
79. *Ibid.*
80. Louise Lawrence to D. M., February 16, 1954; Harry Benjamin to D. M., March 14, 1954; D. M. to Benjamin, March 17, 1954; D. M. to Benjamin, December 18, 1954, all in D. M. folder, box 6, Series IIC, HBC.
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88. Arthur D. Schwabe, David H. Solomon, Robert J. Stoller, and John P. Burnham, "Pubertal Feminization in a Genetic Male with Testicular Atrophy and Normal Urinary Gonadotropin," *Journal of Clinical Endocrinology and Metabolism* 22 (August 1962), *Journal of Psycho-Analysis* 45 (1964), 225. See also Harold Garfinkel, *Studies in Ethnomethodology* (Englewood Cliffs, N.J.: Prentice-Hall, 1967), 134.
89. Schwabe et al., "Pubertal Feminization," 843.
90. Stoller, Garfinkel, and Rosen, "Passing," 380.
91. Elmer Belt to Willard Goodwin, June 20, 1966, Male Transsexualism section, box 9, RSP.
92. Stoller, *Sex and Gender*, 136; Richard Green to Robert J. Stoller, June 15, 1966, Richard Green folder, box 34, RSP.
93. Stoller, *Sex and Gender*, 136.
94. After the Agnes episode, Stoller seemed to place less emphasis on the "biological force," which he now regarded only "as a possibility only in some extremely rare cases." See Robert J. Stoller to Saul I. Harrison, May 15, 1970, General, H-P, 1969–1970 folder, box 37, RSP.
95. Pauly, "Male Psychosexual Inversion," 175.
96. Lawrence S. Kubie and James B. Mackie, "Critical Issues Raised by Operation for Gender Transmutation," *Journal of Nervous and Mental Disease* 147:5 (November 1968), 435, 437.
97. Martino, *Emergence*, 173; Harry Benjmain to C. J., March 7, 1955, R. J. folder, box 5, Series IIC, HBC; Benjamin to D. M., December 22, 1954, D. M. folder, box 6, *ibid.*; Lyn Raskin, *Diary of a Transsexual* (New York: Olympia Press, 1971), 57, 84.
98. F. Hartsuiker to H. F., July 31, 1954, H. F. folder, box 4, Series IIC, HBC.

99. A. D. to Harry Benjamin, November 13 and December 23, 1954, A. D. folder, box 4, Series IIC, HBC.
100. Interview with Aleshia Brevard Crenshaw by Susan Stryker, August 2, 1997, transcript, 39, GLBTHS; Martino, *Emergence*, 213.
101. C. S. to Harry Benjamin, December 15, 1955, C. S. folder, box 7, Series IIC, HBC, Morgan, *Man-Maid Doll*, 63.
102. Martino, *Emergence*, 165.
103. *Ibid.*, 260, 262.
104. Hoopes, "Operative Treatment," 342; Edgerton, Knorr, and Callison, "Surgical Treatment," 44.
105. Edgerton, Knorr, and Callison, "Surgical Treatment," 44; Norman Knorr, Sanford Wolf, and Eugene Meyer, "Psychiatric Evaluation of Male Transsexuals for Surgery," in Green and Money, *Transsexualism and Sex Reassignment*, 279.
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109. Stoller, "Treatment of Transvestism and Transsexualism," 98; Robert J. Stoller to John Romano, February 28, 1968, General, Q-Z, 1967-1968 folder, box 37, RSP.
110. Harry Benjmain, "Newer Aspects of the Transsexual Phenomenon," *Journal of Sex Research* 5:2 (May 1969), 138. See also Harry Benjamin to Alfred C. Kinsey, December 3, 1954, Correspondence file to Harry Benjamin, KI.
111. Harry Benjamin to J.D., July 16, 1956, J.D. folder, box 4, Series IIC, HBC.
112. C. S. to Harry Benjamin, November 21, 1954, C. S. folder; G. S. to Harry Benjamin, April 2, 1954, J.S. folder, both in box 7, Series IIC, HBC.
113. C. E. to Harry Benjamin, January 22, 1954, C. E. folder, box 4, Series IIC, HBC.
114. Crenshaw interview, 31.
115. Elmer Belt to To Whom It May Concern, June 28, 1956, A. D. folder, box 4, Series IIC, HBC.
116. A. D. to Harry Benjamin, November 13 and 22, 1954, A. D. folder, box 4, Series IIC, HBC.
117. Harry Benjamin to A. D., December 3 and 22, 1954; A. D. to Harry Benjamin, December 23, 1954, all in A. D. folder, box 4, Series IIC, HBC.
118. M. H. to Elmer Belt, June 23, 1958, Elmer Belt, 1958-1959 folder, box 3, Series IIC, HBC; Latina Seville, "I Want to be Male Again," in Abby Sinclair, *I Was Male!* (Chicago: Novel Books, 1965), 90, 91, 94, 95.
119. Hoopes, "Operative Treatment," 346; A. D. to Harry Benjamin, February 2, 1955, A. D. folder, box 4, Series IIC, HBC; D. M. to Harry Benjamin, April 17, 1955, D. M. folder, box 6, *ibid.*; D. P. to Harry Benjamin, February 24, 1955, D. P. folder, box 7, *ibid.*
120. C. E. to Harry Benjamin, December 31, 1956, C. E. folder, box 4, Series IIC, HBC.