Issue 31 FTM NEWSLETTER July '95

FTMs Making History

Momentum Grows Towards August Conference

by James Green

The FTM Conference of the Americas is really shaping up to be something spectacular. At this writing (over one month before the August 18 opening day) we have just over 150 registrants, and I expect we will have over 200 by the time it starts. People are coming from all over the U.S., including Alaska, New York, Kansas, Texas, New Jersey, New Mexico, Ohio, Washington. Massachussets, Oregon, Tennessee, Utah, Illinois, Connecticut, well, you get the picture. We've had inquiries from Brazil, Canada, and Japan, too. I sure hope we will have an international conference. For those of you who can't attend, we hope to have audio tapes available of some of the most popular sessions, and possibly even a video tape of the four hour medical session. More information about these items will be published in the October issue. If you haven't signed up for the conference yet, and think you want to come, do it. Some "work/study" scholarships are available. We are doing everything we can to keep this event affordable, educational, entertaining, and unforgettable. This will be an historic event in the history of FTM community. Don't miss it, if at all possible!

FTM International is still growing at an amazing rate. Our May support meeting yielded attendance of over 30 members for a spirited discussion of topics close to the hearts of many emerging FTMs. Especially poignant were the fears and concerns of older FTMs who are just beginning to acknowledge their gender issues and seek treatment close to age 50. Often it seems that new men arise only from the ranks of the young, but that is not true. Many of our members are over 40 and 50, and a few are over 60. While some of the concerns of older "new" men may be different from those of their younger counterparts, many of the feelings and experiences members of both age groups go through in early transition are closely parallel. Unlike traditional community models, in which only the old have the wisdom of experience, young FTMs can sometimes have more experience as men than their older FTM brothers!

At the June informational meeting, over 60 attendees watched a video of the Charles Perez show in which Dan (one of our members) and I tried to defend the honor of transsexual men who do not regret either surgery or being transsexual. And what a battle it was! There were six MTFs on the show, three of whom had never even heard of —let alone seen— transsexual men, and one of whom implied that "facing the loss of the lifegiving female organs [makes having transsexual surgery a] much more difficult [a] decision for the female-to-male," to which I responded: "You are projecting your stuff about femininity onto transsexual men. " All in all, the show was a horrible experience, full of mis-information, exaggeration, pompous statements and grandstanding by some participants, so that the reasonable people were completely overshadowed. Let me advise you right now that when a talk show producer tells you that they want to tell the real story and be sure to be fair to all sides, etc., etc., they are after nothing more than a show. They don't care about us or our issues, no matter how sincere they sound. They are in the entertainment business, and it is a tough environment. I actually knew all this going in, and I am a sophisticated (if I do say so myself) public speaker. Yet without having any knowledge of the other guests or how the host would twist the topic around to make his audience squirm, I had no control over the situation. All I could do was wait until I had a moment to speak, and then I had to try to remain in control of myself, because I couldn't control anything else. I know there have been a few excellent talk shows with some of our members represented, and we always get a flurry of inquiries after any TS talk show is broadcast (which is good because of the outreach it offers), but the majority of these programs are travesties when it comes to real education about gender issues and TS civil rights. If you are approached by any of them, take heed, beware, heads up, watch your back, and go at your own risk.

Also at the June meeting, French TS activist Armand Hotimsky gave a report on the state of FTM surgical techniques in Europe. It seems there is very good work in both the chest and phalloplasty procedures being done in Belgium and in Switzerland. It doesn't do most of us in the United States any good, though, because these countries have nationalized health systems, and they won't treat Americans. I understand it could be possible to have surgery done in Belgium at reasonable prices, even if you are American. Armand says that the metoidioplasty procedure is considered unacceptable to Europeans because it just doesn't provide enough of a penis. Armand also chides Americans for working for civil rights when we don't have good surgery: he thinks good surgery and medical treatment should come first, then civil rights, while "you" [Americans?] seem to think that obtaining civil rights will get us good surgery. Personally, I think we have to work on both fronts, and while getting good surgery is of critical importance to those who are going under the knife, obtaining TS civil rights will benefit many more people, including TS-identified people who choose not to have surgery, and non-TS people, too. Armand is right: getting civil rights will not necessarily get us good surgery. Only good doctors will give us good surgery. But the effort to acknowledge TS civil rights will enable more doctors to think about our surgical and medical difficulties, and encourage doctors to treat us more humanely, too.

Following his visit to San Francisco, Armand went to Houston for Transgen, the International Conference on Transgender Law and Employment Policy. [Armand also visited Southern California prior to his San Francisco stop, and hung out with some of the members of the Under Construction Club there.] In Houston, Armand gave an excellent presentation on the status of transsexuals under the law in various European countries. Stephen Whittle of England augmented Armand's presentation with elaboration on TS status in the United Kingdom. I could only be there for just one day (I went to receive the Transgender Pioneer award for my work as a non-lawyer in San Francisco establishing the new law that protects transgendered people here), and I wished I could have stayed for all of the four-day conference because some very articulate, very energetic, very bright TS/TG people were assembled who are working hard to gain political and legal ground for us and it was a privilege to be among them. I urge anyone who can do so to attend the Transgen conference in Houston next year.

On a more personal note, once again I am asking for someone to step forward and help take on the responsibility for this quarterly newsletter. I'm looking for an assistant editor, ideally one who would like to take on full editorial responsibilities eventually. You should live in the San Francisco Bay Area, because much of the work of the FTM Newsletter editor revolves around pick-

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The Penis Makes The Man...Not! *an update*

by Blake Powers

In the April 1994 FTM Newsletter there was an article about a 22-month-old South African boy who was kidnapped, badly mutilated and left to die. Attackers had cut off his penis and testicles, sawed off his thumbs, cut his eyelids, strangled him, and tried to gouge out his eyes. Miraculously, he survived. This is an update on his story, interspersed with excerpts from the original.

The initial newspaper coverage focused almost exclusively on the decision of pediatric surgeons to reassign Nhlanhla Mkwanazi as a girl. Less mention was made about why the attack took place. Nhlanhla was one of a number of boys in South African townships who were apparently the victims of "muti" attacks. "Muti" is the South African term for black magic and "muti killings" are ritual murders performed as a component part of that magic. Although many traditional healers are respected for the medicine they provide, there are a small number of outlaw witchdoctors who use organs taken from live victims to make potions. Township residents who were interviewed for The Reuter Library Report of September 3, 1992, said that the ritual killings usually involve four people: the patient seeking the magic potions, the person who chooses the victim, the witchdoctor who performs the surgery, and another man who dumps the victim's body. Several boys aged 1 to 6 were found in 1992 with their genitals completely removed, their thumbs missing, and their eyelids cut. Nhlanhla was the only one to survive. Since that time, local communities and police have moved to crack down on such murderers. Times Newspapers Limited on September 6, 1992, identified Buti Moses as the prime suspect in these attacks. It is not known if he was ever caught.

Nhlanhla's wounds were initially repaired using skin grafts. Approximately one year later, he began a series of surgical procedures that transformed him into an anatomic female. The surgeries may have been successful, but he is still a boy. The original FTM Newsletter article had this to say: "...Converting him into an anatomic female carries uncertainty of success with regard to the development of his gender identity, which becomes established around two years of age." This was corroborated in a recent article by Victor Khupisco that appeared in The Sunday Times of Johannesburg: "When a Soweto boy's genitals were cut off during a muti attack two years ago doctors decided the best thing was to turn him into a girl. But after the sex-change operation, little 'Lucky', now four, refused to wear dresses or play with dolls. He wouldn't even mix with girls. Now doctors admit that their plan has failed and that he will never think of himself as a girl. "The child's mother said her 'daughter' refused to wear dresses, rejected dolls and demanded to play only with boys. Whenever the family tried to dress him like a girl, he cried and demanded trousers.'We thought he would change after the operation but he is more like a boy than ever,' his mother said. "'We have tried to treat him like a girl, but he does not want to accept it. He still considers himself a boy. Now that he is growing up, he has started asking difficult questions. He asks me where his missing private parts are and says he wants to relieve himself like his friends. He wants to know why he is not like other boys. He feels rejected and an outsider. It's heartbreaking. The people who did this to my child have ruined our future.' "...The head of the psychiatric department at the hospital, Dr. Ethelwyn Rebelo, said the child had developed a strong gender identity by the time he was mutilated.'He already knew that he was a boy. When he was discharged from the hospital, he came back to the same friends and community that knew his history. These factors have combined to ensure that he continues to view himself as a male. We have decided to allow him to decide what he wants to be.'"

"We thought he would change after the operation but he is more like a boy than ever"

The behavior and feelings attributed to this child are very similar to those of the FTM. With the exception of castration trauma, FTMs share his unalterable male identity.

As children FTMs know they are different. They also feel misplaced. As with Nhlanhla, the attitude of the medico-psychological complex toward the FTM is that gender lies in the genitals. The trauma of dealing with the medical community can compound rather than resolve the trauma faced in everyday life. Doctors decided for Nhlanhla that he could not possibly have "quality of life as a man." Dr. Joao Fonseca of Baragwanath Hospital said, "Once the male genitals are cut off, no testosterone can be produced and the child can no longer function mentally or physically as a male and we could never construct a functional phallus."

What Dr. Fonseca has found out is that this child does continue to function mentally as a male and that it is the reassignment surgery that has delayed even further the day when he can function physically as a male. What was declared impossible in 1992, is now deemed feasible. Here is another quote from the Sunday Times of Johannesburg: "The surgeons say they will be able to undertake reconstructive surgery —to give him male sexual organs—after his eighteenth birthday. Until then, 'Lucky' will retain his female organs, but will not go onto medication that would develop his breasts...

The head of the paediatric unit at Baragwanath, Dr. Joao Fonseca, who was part of the operating team, said tests would be done on the child at puberty. 'He was never given pills that will develop female (secondary sexual characteristics). It is a very complicated thing.'" Nhlanhla's mother said that the attack still haunts her son, who relives it through nightmares. "We are desperate for help. I just want my child to have something in his life that will help him forget his terrible experience. But life is grim."

Nhlanhla Mkwanazi needs support from those who are sensitive to his overall situation. In addition to the trauma of the initial attack, he now has to endure the trauma of living inside a female body until he can have phallic reconstruction surgery. Furthermore, his father was shot to death in September of last year and his mother is currently unemployed. He stopped attending school when his schoolbus was hijacked last February. Dr. Rebelo describes him as clever, with potential. She has also expressed concern for his future.

Letters of outrage and concern should be addressed to:

Joao M. Fonseca MD
Chief Pediatric Surgeon
University of the Witwaterland Medical School, Baragwanath Hospital
Johannesburg, South Africa

Letters of support can be sent to Nhlanhla's mother, Ms. Triphina Mkwanazi in care of Baragwanath Hospital. Donations should be in the form of international money orders made payable directly to Ms Mkwanazi in South African currency (Rands).

Belonging

by David Hughes

"You'll never be a man! I can't talk right now." The phone clicked and the dial tone buzzed in my ear. I laid the receiver down and swallowed with dejection. That was the last I heard from her... my friend? We had been friends since sophomore year in high school. When I met her, I saw that she was the lonely one because she was obese. We had become fast friends. By peer exclusion, we were ostracized along with the dweebs, nerds, African Americans and weirdoes. And with the click of a phone, that 14 year relationship was over.

"Bye," I said. The only reply I got was dial tone. And *that* ended a 30 year relationship with my mother. I sighed dejectedly.

I know my transition was no more and no less rougher than anyone else is. But I "feel" the pain of this life. I had no original family or friends with which to talk. I relied on the friends within the community to get through my psychologically rough period; what I call "high crisis." I was reclusive and in mourning for a year. But at the same time, I was celebrating my rite of passage, reflecting on the man I wanted to be. And then one day, every part of me passed over the threshold from my former life. I finally felt free.

As time went on, I was humbled by my experience of newness. I was ever aware of my new role and ever learning about how people perceived me. I was working on my self-worth and self-confidence. I was still fighting the feelings of shyness and I didn't like the roles of initiating and being the position of rejection. But figuratively after 202 attempts of wooing women, the 203rd was a charm. A woman noticed me and I noticed her. I took my time getting to know her and tried not to expect anything. I casually inquired about her views regarding social and gender issues. She said she didn't know much about people who change, but she thought that the body makes the man or woman. I wanted her to know me and the sum of all my personality. I wanted her to know that she must trust that the experiences I have are real and believe that my experience with respect to my role in society is life long. If she was to know me, I was placed in the position of presenting to my lady friend a very dynamic world.

I made an effort to be a gentleman at all times. One day she asked me why I hadn't been forward with her like other men. I told her that I don't perceive the world like other men. And then I told her about me. She didn't believe me at first, then she saw that I was serious. The atmosphere of the relationship changed. She was quiet or a few minutes, then she broke the silence with a new subject. I knew that the subject would stay on her mind and she would want to think about it alone. I gracefully eased into parting for the day. Before I left her, I let her know that I knew she would want to talk with someone about it, but "outing" me to people I didn't know would take away my opportunity to tell other people about me. I conveyed that their fear would be dangerous for me. I hoped she would understand. Now, it was just a matter of trust and time would tell me what was in her heart.

I received a letter from a sister I never met. She addressed the letter to my former self. It was a strange feeling to see that name again. The way that I had come to know about her existence was through finding family members from my paternal side. Members of my paternal side never told her of my existence until she was a teenager. When she became an adult, she acquired my address. Little did she know that she was contacting someone in a situation she of which she never heard. I thought she should know me as I am and I wanted to make her acquaintance. I had no reason to lie or be ashamed. I wrote her back and told her everything she needed to know. I told her that I would understand if she never wanted to contact me again. I had no expectations. I received her response and she welcomed me with open arms and an open heart. As one door closed, another one opened. She replace the feminine energy I lost from my mother and she was very glad to have a functional male in her life. When she calls me big brother, it rings in my ears like wind chimes.

I have had the privilege to be in the company of a great man. He has a zest for scholarship that far exceeds lover's enchantment. I know that when he arrives at those special forks in the road, he will blaze a trail straight up the split and whatever is left behind will be established pavement. I wish him luck in all his pursuits. Without his help, I would not have developed as much testicular fortitude. To me, he is my big brother.

He sat on that hard wooden chair and was so livid that I thought the chair would burst into flames. All this time he felt that he had been deceived and certain information withheld from him. He was told not to go to group because it would have a negative influence on him. I had no idea that this person and I would become so close. I had no idea that he would shed that anger like an old shirt. I hardly recognize him from his former self of yesteryear. He has enjoyed almost every moment of his personal growth. Anytime I see him, he is smiling. The sun is shining on his day and when he approaches me, I can't help but feel sheer celebration. He doesn't take a whole lot for granted. I know I am fortunate to know such a happy man. They are few and far between.

My lady friend became more distant after I came out to her. I took it in stride because I didn't allow myself to get attached. I expected that she would not return. I telephoned her once to test the waters. When I suggested that we meet for coffee sometime, she appreciated the offer, but declined. She added by announcing she was dating other men. I thanked her for giving me time. She admitted that she had thought long and hard about my gender status. She said she still didn't know what to think or feel. She said she couldn't imagine what I would have looked like as my former self. And then we said good-bye.

There are people who were in our lives that we'll never see again. These people taught us much. Our exposure to some helped us to learn that we're not alone, our acquaintance with some helped build our sense of community, our friendships with some showed us how to play, our love for some taught us devotion, and our dislike or hate for some showed us our limitations. Sometimes the people that we never see again are our original family members.

For some of us, we are abandoned or ignored. When our former self ceases to be, in some people's mind we have died. They are not receptive to a stranger who looks like the one they have lost one that shares the same memories as they. Some families may ignore us for a moment, others for a few years and others may die without another word. I wasn't put on this earth to be ignored. I am somebody, I am worthy of love and I strive to be whole. I contribute to the history of the world and to peoples' lives.

When relationships are lost, all is not; friends can be family thereafter. A lot of us fulfill family roles now: brothers, brothers-in-law, uncles, nephews, cousins, grandsons, sons, step-sons, husbands, partners, guardians and fathers. If we are privileged to hold these roles, we are gifted. For those of us who lost roles in our former lives, we are fortunate to keep the friends we have and the friends we will make. Who said that family are only the ones of blood? Sometimes, a "common bond" is thicker than blood. To belong to a community/family means commitment: A commitment can be made or broken at any time. Therefore, our family can be the friends that we chose. The family I adopted is Brotherhood. With the Brotherhood, I have shared my joy, my suffering, my gifts, my life. Because of this, I have a better understanding and deeper appreciation for family.

I was in the record store looking for my favorite artist. Briefly glancing up, I saw a contoured chest wrapped in a flowery summer dress. Incredulous, I sighed and went back to what I was doing. Feeling I was being watched, I looked up.

"Have you renounced women?" Lady friend had a bright smile on her face. I hadn't seen her in several months. My jaw dropped, then I closed it and cleared my throat. I grinned impishly and replied.

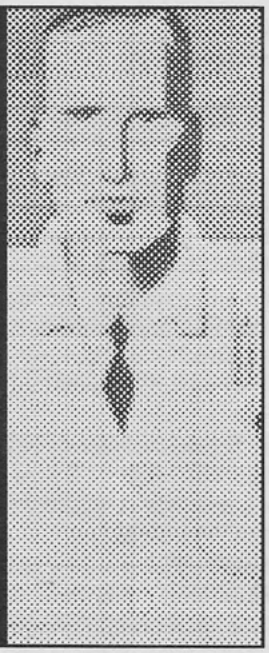
"Well, there's women that I renounce and there's women that I don't."

"Am I one of those you renounced?"

"I don't know," I said as I shifted my weight to the other leg. She lowered her eyes and nodded. "But I'll listen to strong arguments for why I should keep your company." She looked up and smiled coyly.

A few months later, my lady friend admitted to me that compared to other men, I treated her with a deeper appreciation. She said she liked the way I celebrated my life and that she was a part of my celebration. It's a nice feeling to belong to somebody.

When relationships are lost, all is not; friends can be family thereafter.



Testosterone News

Digging for the real dirt on the "male" hormone

The following article is abstracted from an article by Natalie Angier published in the Medical Science section of the New York Times, Tuesday, June 20, 1995. Editorial comments in brackets are by James Green.

Tired of testosterone as cultural myth, as an excuse for machismo and obnoxiousness? Sick of the ubiquitous references to testosterone poisoning? Do you think it unfair to blame this one lousy little chemical for war, dictatorships, crime, Genghis Khan, Gunga Din, Sly Stallone, the N.R.A., the N.F.L., Stormin' Norman Schwarzkopf and the tendency to interrupt in the middle of a sentence? Ready to give the so-called male hormone a break and retire all the testosterone cliches with a single pound of Iron John's drum?

Retire away. As it turns out, testosterone may not be the dread hormone of aggression that researchers and the popular imagination have long had it. If anything, this most freighted of hormones may be a source of very different sensations: calmness, happiness, and friendliness, for example. *[Maybe they should have asked some of us. We could have told 'em...—ed.]*

Reporting last week at the annual meeting of the Endocrine Society *[in Washington]* researchers said that it was a deficiency of testosterone, rather than its excess, that could lead to all the negative behaviors normally associated with the androgen. Studying a group of 54 so-called hypogonadal men, who for a variety of reasons were low in testosterone, Dr. Christina Wang of UCLA and her colleagues found that before treatment, the men expressed a surprising suite of negative emotions. They did not feel passive or depressed or timid, as the standard idea of testosterone deficiency might predict. Instead they described feelings of edginess, anger, irritability. Aggression.

When the men were given testosterone replacement therapy...their general sense of well-being improved markedly. Their anger and agitation decreased, their sense of optimism and friendliness heightened.

Dr. Wang's work is in keeping with similar findings from other laboratories that question how relevant testosterone is to human aggression. Some studies even indicate another, improbable source of aggression: estrogen. *[They could have asked us about this, too!—ed.]* Other work presented at the meeting showed that when male mice were genetically deprived of their ability to respond to estrogen, they lost a lot of their natural aggressiveness, becoming much less likely to fight with other males or to display the general paranoia exhibited by ordinary male rodents.

Considered together, the new work underscores how primitive is science's understanding of the effects of hormones on human and even animal behavior. Testosterone was first isolated nearly half a century ago, yet its influence on the brain and behavior remains largely a matter of creative speculation. ...But scientists are beginning to question the relevance of animal behavioral studies to human emotions *[At last—the light dawns!—ed.]* and even to wonder what subsidiary effects the testosterone injections could be having on laboratory animals to explain their increased aggression (both male and female rats given injections were more likely to attack intruders or to begin mounting anything that moves). *[Behavior, animal or human, occurs in a complex web of relationships between the individual and his or her environment, past and present. It is about time researchers became conscious of the inadequacy of experiments performed in isolation when the results are applied to non-isolated populations.—ed.]* As for the human studies, they are contradictory and open to various interpretations. For example, stress can affect hormone levels in ways that are only now being mapped out, and prisoners *[long held as examples of men with high testosterone levels...—ed.]* are likely to be under extremes of stress.

"...testosterone may not be the dread hormone of aggression that researchers and the popular imagination have long had it."

Dr. Wang notes that while competitive athletes may report feeling pugilistic on anabolic steroids, this is a highly select group of subjects with a particular psychological makeup. And the drugs they take are not native testosterone, but usually a synthesized mix of androgens, with who knows what effect coming from each. *[I thought bodybuilders used testosterone cypionate and testosterone enanthate, same as most of us in the U.S. do. Are there any bodybuilders out there who can tell the FTM Newsletter whether competitive athletes are using other androgens, and/or in what dosages and frequencies athletes usually take them so we can compare this with our own usage?—ed.]*

So far, there have been no good, controlled studies seeking to evaluate the effect of giving excess testosterone to androgenically normal men. In lieu of such studies are recent experiments comparing the mood states of hypogonadal men before and after treatment, like Dr. Wang's work. One missing element of this report, however, is a conventional control group seeing what happens to men with low testosterone if they are given a dummy medication rather than real testosterone. Do they, too, feel happier and friendlier? Such an experiment would be unethical, said Dr. Wang, because hypogonadal man who visit the clinic are ill and need treatment to restore muscle and bone mass and healthy cholesterol levels. Denying them

testosterone would be like denying a diabetic insulin. *[It is interesting to see this analogy here, since it is one I often use in lectures when explaining that TS's must take hormones for the rest of our lives. It certainly helps non-TS's to understand the medical aspects of our situation.—ed.]*

Offering a partial explanation, Dr. William J. Bremner, a Seattle endocrinologist, and his colleagues reported in the June 1994 issue of The Journal of Clinical and Endocrinological Metabolism their results of seeing what happens to healthy men when they are artificially and temporarily brought to a state of low testosterone. Some of the subjects were immediately given testosterone replacement, while others received dummy medication. The study was mainly intended to look at the effects of testosterone on libido, but the researchers noted that the men with a drug induced state of hypogonadism reported increased levels of aggression. Dr. Bremmer's (and other's) studies have found that testosterone is profoundly important to a man's sex drive, though not to his mechanical abilities in bed. Hypogonadal men report a sharp drop in sexual interest, which testosterone replacement quickly restores. The androgen may also play a role in female sexuality, and a growing number of menopausal woman are asking that testosterone be added to their hormone replacement regimen to restore a lackluster libido. But the data linking sex drive and testosterone in women are fiercely debated.

Testosterone therapy also appears to give men and women more energy, vim, the desire to leap out of bed in the morning and embrace the demands of the day with can-do concentration. That zestiness is not the same as aggression, which if anything is often accompanied by poor concentration and underlying malaise, researchers said.

If testosterone qua testosterone is not the demonic potion of legend, its yangian counterpart, estrogen, may not be so innocent *[as popularly assumed—ed]*. Reporting last month at the annual meeting of the American Pediatric Society, Dr. Jordan W. Finkelstein, Dr. Howard Kulin and their colleagues at Pennsylvania State University said that they compared the effects of giving estrogen therapy to girls who suffered delayed onset of puberty with that of giving testosterone to boys who likewise were late in sexually maturing. The girls showed earlier and larger increases in aggression than did the boys, until the boys received the last and highest dose of testosterone.

The researchers propose that for both sexes, the cause of the teen-age spike in aggressive and very likely insolent behavior is estrogen. As scientists are only lately beginning to appreciate, most of the effect of testosterone on the brain is paradoxically estrogenic in nature. That is because the brain is rich in the enzyme aromatase, which converts testosterone into estrogen. The newly transformed hormone then acts on the nerve cells of the brain through estrogen receptors, proteins designed specifically to link up with it.

A male's brain also has some receptors for testosterone, but they are far fewer in number or distribution, and the converting enzyme aromatase does not leave much testosterone around to hook up with these androgen receptors anyway. Thus in both boys and girls, as they reach adolescence and their respective sex hormones surge, the influence of either hormone on the brain and behavior probably works its dark art as estrogen. In the Pennsylvania study, the girls may have had a jump on aggressive behavior over the boys because they were given direct injections of estrogen and therefore their brains did not need to go through the work of converting testosterone to estrogen.

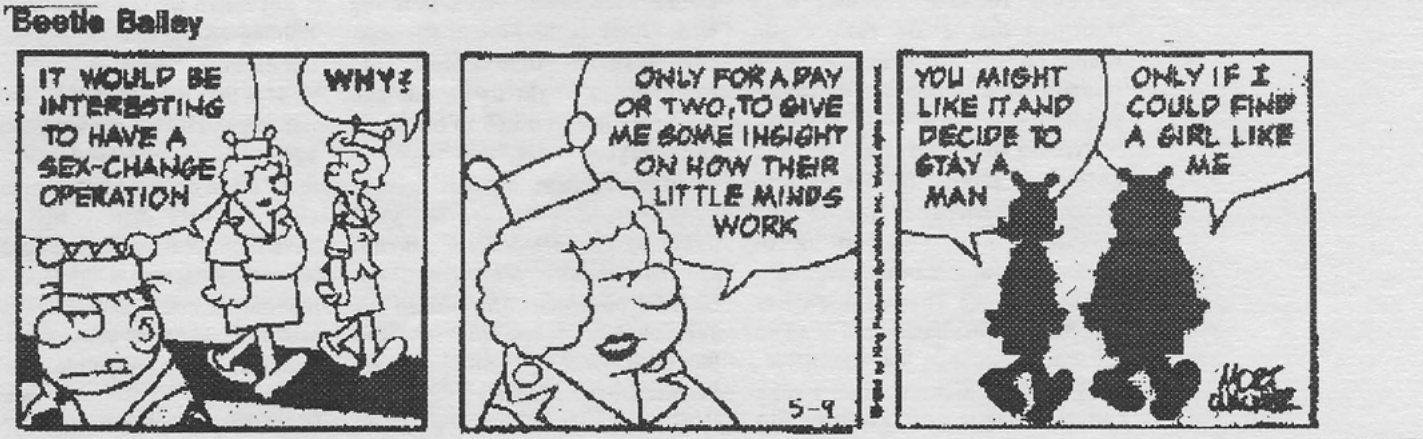
The centrality of the brain's estrogen receptors to aggressive behavior was highlighted by a new study of receptor-deficient mice, presented at the endocrine meeting. Dr. Donald W. Pfaff of Rockefeller University in New York, his student, Sonoko Ogawa, and Dr. Kenneth S. Korach of the National Institutes of Health, have analyzed male mice genetically altered so that they lack nearly all estrogen receptors. Testing the male mice in a variety of circumstances, the researchers determined that they were unusual in many ways. Normal male mice do not tend to wander across open fields as females do, but prefer to skulk along borders; males without estrogen receptors generally took the female attitude, and freely walked where they pleased. Ordinary males respond to intruders in their territory with violent attacks, chasing, biting and generally seeking to harm the interloper. The altered males react to newcomers tepidly if at all, perhaps nipping if the animal comes too close, but never attacking the stranger outright. Significantly, the altered males still have all their androgen receptors intact. It is only the ability of their brain to respond to estrogen that is defective.

Researchers have yet to report of the behavior of female mice lacking estrogen receptors. Those results will probably break a few paradigms of their own. Until then, perhaps it is time for a new hormonal cliche to explain aggression. How about this: The estrogen was so thick you couldn't beat it down with a rolling pin. *[While it is amusing to see the tables turned, exchanging one negative stereotype for another is about as useful as promulgating ignorant theories that masquerade as science. Obviously society has a long way to go to understand hormones and behavior; meanwhile we are walking experiments and a resource that has gone virtually untapped. Please read the next article to find out how YOU may be able to participate in a scientific research project that can possibly open many doors for us.—ed.]*

VOLUNTEERS NEEDED:

Brain Research Project in SF Bay Area

In a show of admirable cooperation, several San Francisco Bay Area MRI scanning facilities are donating their resources to a team of transgendered and trans-friendly researchers who are attempting to apply corpus colosum scan data showing sex differentiation of the brain to transgendered and transsexual men and women.



John Lotter Convicted in Death of Brandon Teena

John Lotter has been convicted of three counts of first-degree murder in the deaths of Brandon Teena, Lisa Lambert and Phillip DeVine, as well as three counts of use of a deadly weapon and one count of burglary. The jury of ten women and two men delivered its verdict on May 25, 1995.

Lotter will face sentencing, along with Marvin Nissen, who has already been convicted in the deaths, some time during the week of July 24th . Lotter faces a maximum penalty of death by electrocution. Because Nissen reached a plea bargain agreement with prosecutors in exchange for his testimony, he now faces a maximum penalty of three years imprisonment.

Lotter's attorney, Mike Fabian, was unsuccessful in preventing Nissen from testifying against Lotter during the trial. In his opening arguments Fabian told the jury that the evidence suggesting Lotter was involved in the triple slaying was circumstantial. Fabian also told jurors in his opening arguments that some testimony would be "gut-wrenching," but asked the jurors to not allow that to affect their deliberation. "It was a horrible crime, and I'm not asking you to put that fact aside," he stated. "What I'm asking you is to put aside the emotion that I think clouds the facts of this case."

Nebraska State patrol investigators testified that on the night after the bodies were discovered they found a gun and a sheathed knife bearing the name "Lotter," and tests indicated that blood on the blade was the same type as Brandon Teena's. Forensic tests indicated that a .38 caliber gun found on the ice was the same weapon used to commit the triple slaying.

Nissen testified that he and Lotter had plotted for six days to murder Teena, after raping and assaulting him. According to Nissen, he and Lotter originally planned to take Teena somewhere and chop off his hands and head so his body couldn't be identified. They brought along an axe, a rope and a change of clothing to Lincoln, but failed to find Teena. They spent the next five days drinking and plotting; their plot took on added urgency after Brandon identified them as his rapists. Thinking he might be at the home of Lana Tisdale, whom he'd been dating, Nissen and Lotter drove there, but were told that Teena was staying at the home of Lisa Lambert. On the drive to Lambert's farmhouse in nearby Humboldt, Nissen told Lotter that if they killed Brandon at someone else's home, they would have to kill everyone else there as well.

When they arrived there was no sign that anyone was at the farmhouse. They kicked the front door open, entered, and found Lisa Lambert lying in bed, her eight-month-old son in a nearby crib. After discovering Brandon lying on the floor under a blanket, Nissen pulled him to his feet. Lambert, Lotter and Nissen were all yelling and the baby was crying. Nissen testified that he turned around to calm the baby, and when he turned around again, Brandon Teena was lying on the bed. Nissen asked Lotter for the knife, grabbed Brandon by the shoulder, and stabbed him in the abdomen. Lotter then shot Lambert in the stomach and went in search of Phillip DeVine, who he brought into the room. Lotter shot Lambert again, then DeVine.

Nissen admitted that he had changed his story several times, but insisted that he was now telling the truth. John Lotter's former girlfriend, Rhonda McKenzie, testified that Lotter had threatened to kill Brandon Teena at the same Christmas party where Teena was raped and assaulted by Nissen and Lotter. McKenzie, who was living with Lotter at the time of the murder, testified that Lotter told Brandon, "I ought to go out and kill you since you lied to my sister and everybody else."

[adapted from a press release from Davina Anne Gabriel, publisher of TranSisters, the journal of transsexual feminism. Ms. Gabriel obtained information for her article from the Omaha World-Herald and the Richardson County Judge's Office—ed]

Transgender Action Against Human Rights Campaign Fund

When the Employment Non-Discrimination Act of 1994 (ENDA) was first introduced in Congress, the Human Rights Campaign Fund (HRCF) actively worked to exclude transpeople from he language of the bill. Chai Feldblum, the drafter of the bill for the HRCF, acknowledged to the International Conference on Transgender Law and Employment Policy that transpeople were purposely omitted from the language of the bill. On June 16th, the HRCF did it again, and transpeople have once more been excluded from the protection offered by ENDA. This time, transpeople have decided to fight back.

In a move unprecedented in the history of the transgender movement, three of the largest and most vocal transgender rights organizations—It's Time, America!, Transsexual Menace, and Transgender Nation—have agreed to take joint action in a protest of the HRCF. The organizations will immediately picket and/or hand out informational pamphlets at the HRCF's fundraising events around the country.

What will it take for the transgender rights groups to end their protests?

(1) HRCF must immediately cease their opposition to transgender inclusion in ENDA.

(2) HRCF must Issue a press release stating that the they will immediately become transgender inclusive.

(3) Issue a separate statement recognizing transgender inclusion in the Queer Rights Movement.

In return we will offer in-service training on transgender inclusion, at our expense.

It is time that the HRCF, and similar organizations actively working against transgender inclusion, learn that "When decorum becomes repression, the only dignity free people have is to speak out." And speak out we will. If you would like more information, or would like to organize a protest in your area, contact Riki Ann Wilchins (riki@pipeline.com) or Sarah DePalma (fingers@phoenix.phoenix.net).

Basic Vs. Deep

by Bee Bell
(thanks to Chris for the idea!)

Skin deep, a movie made by Canadian director Midi Onodera, appeared at the S.F. queer film festival on June 11th. It had premiered in New York the previous week. [also in London before that—ed.] Apparently, queers on both coast—including a lot of transgendered people have been very critical of the movie, seeing it as a kind of FTM version of *Basic Instinct*. I think *Skin deep* is much, much better than that, and here's why.

First, in case you missed the whole phenomenon, *Basic Instinct* was a big early '90s Hollywood thriller starring Michael Douglas and Sharon Stone in a plot that involved a crazed bisexual woman psycho killer offing a series of husbands with her trusty icepick. Queer Nation in L.A. protested the movie throughout its filming, and later many QN chapters picketed *Basic Instinct* at theatres around the country. Their reasoning: Hollywood does NOT need to make more millions off the tradition of depicting queers as psychotic and dangerous. I could get with that program, so I didn't see the movie during its first run.

Here are some of my favorite things that happened during that time: one Queer Nation affinity group, Catherine Did It, would secretly plaster Los Angeles movie theatres with broadsides that gave away the ending of the film. Presto no one wanted to see it. And at a Women's Health Action and Mobilization (WHAC!) meeting in New York, some dyke stood up during a *Basic Instinct* discussion and said, "I don't get it. It's a movie about a queer woman who kills off a bunch of straight white men, right? What's the problem?"

I finally saw the flick, and I would say there are three main problems with it. It's bad. A lousy movie. Dumb plot, lame ass dialogue, etc. But nothing could be as bad as (2) Michael Douglas. Sharon Stone throws over a big beautiful butch dyke (the other murder suspect) for that ugly Douglas: unthinkably bad taste. And (3) Queer Nation made a good point. *Basic Instinct* fit right in with a happy Hollywood tradition of making money from thrashing queers. Hollywood will never do that again without meeting resistance, and *Basic Instinct* will always be remembered for the intense political reaction that it drew.

Skin deep suffers neither from (1) nor from (2). And I would argue that it avoids (3) in that, although it's not a movie about FTMs, Skin portrays one in an honest, mostly useful way'Stinct's plot depends on queers, and does so in a stupid, evil way. So what is *Skin deep* about? It's about a Japanese Canadian film director making a sexy SM picture involving tattooing. It's about this character's dyke life, friends, and lovers, and about her getting of a clue about the people around her. One of these people is Chris, a young person born female and passing as male without benefit of hormones or surgery, who lives in a tiny town and has never met a fellow FTM. Alex, the director, summons Chris to the big city to work on her film after he answers her advertisement for someone who is turned on by getting tattooed. His job is to tell her what this kind of turn on feels like so she can convey the sensation to her actors. Understandably, once Chris arrives at the chaotic scene of the filming he does not know exactly where his own role starts and where it ends (sound familiar?). Alex, overwhelmed by the hellish details of making an independent film, ends up asking Chris to take on little duties here and there, takes him dancing, and otherwise confuses the guy while also messing up every other relationship in her life.

Chris, lonely, pained, and stimulated by Alex's intensity, falls for her. And okay, Chris is kind of a crazed stalker: but he is far from being the chick with the ice pick in *Basic Instinct*. The only violence Chris ever does is to himself. And *Skin deep* spells out Chris's motivations for obsessing over the protagonist with a truthful, heart wrenching clarity: he's been subjected to the humiliation of living in a girl body, he's been harassed, beaten, and sexually ridiculed, and he's got a teenage style crush on this beautiful, older woman who has carelessly flirted with him. So? The worst thing Chris does in the whole movie is to clean up the apartment of somebody who likes it messy. Granted, that's pretty scary and invasive, but it ain't murder. And, also unlike your usual Hollywood psycho-queer, Chris gets stronger and more self-aware by the end of the movie.

Skin deep sorts through a lot of tough ideas besides gender: race, class, sex, and art all get examined in a way I found very true-life and attention-grabbing. We get to see the main character's confusions as a woman of Japanese descent, speaking none of the language but wanting to work with a Japanese master of tattoo artistry who continues the work of her own grandfather—while she lives in this very different world of funky urban Canadian dykes and queens. Alex struggles with Montana, her African-Canadian lover who is also the assistant on the film, and refuses to put up with the second-class treatment that she gets in more ways than one. All of us live in a world where race impacts human relationships and impedes economic and professional progress. This movie would make points worth seeing—even if it had no gender-bending characters.

There are disappointments. Yeah, I would like to see a happy FTM, with his shit together, sauntering through this movie to slap Chris on the back and help him through it. The many drag queens in the film are great, but their strength and solidarity make for a lopsided contrast with Chris's self-denial and isolation. And I wish the film had more information for the under informed or isolated FTM. Except for this last complaint, though, even in its harsh unevenness the film reflects the reality of FTM life: drag queens are more ubiquitous than kings, and confident, out FTM's are not found on every street corner yet either—especially in rural Canada, where Chris came from. So I recommend checking out this film, especially for its hauntingly dead-on pictures of the tortures and revelations that life reserves for us.

A Guided Tour Through Phalloplasty

This piece came to FTM as a letter to the editor, however, we found it to be so informative we decided to run it as a feature article. We have retained the original format.

Dear James,

It was good to meet you at the recent gathering of the F2M Fraternity in New York. As you know, our support group has been instrumental in supplying information, medical referrals, shared experiences and mutual support to the female-to-male community. We are very fortunate, as a group, to have the input of Dr. Katherine Rachlin, a licensed psychologist, who is currently fulfilling the requirements needed to specialize in Gender Dysphoria. We have also had the benefit of lawyers and doctors attending our meetings.The knowledge of these professionals is indispensable.

Our group is composed of individuals ranging from those who desire only to cross-dress to those of us who've chosen complete surgical correction ending in some form of genital alteration. Needless to say, our group is completely confidential and supportive of all types of lifestyles. We've even had the opportunity to get our stories out to the community through journalistic interviews in an effort to help dispel the myths and sensationalism which so frequently permeate the topic of transsexualism.

That said, I would like to share with your readers my personal experience of the journey through radial forearm free-flap phalloplasty. Anyone contemplating phalloplasty in any serious sense of the word would be well-advised to educate themselves completely. The individual should have reasonable expectations of outcome and sound reasons for undergoing this most complex surgery. I believe one must be well-motivated and committed to a plan of action that will help ensure a successful overall outcome.

I chose to do a tremendous amount of research in various medical libraries. Having some medical background helped in deciphering the complex medical terminology. A medical dictionary is a tremendous asset in decoding medical jargon. In addition, I spoke and met with individuals who were undergoing or had undergone some form of phalloplastic surgery. I also spoke and met with several surgeons around the country who specialize in phalloplasty. I stayed with a friend who had recently undergone a radial forearm free-flap phalloplastic technique, and witnessed first-hand the results, his fears, pain and complications. This was an excellent opportunity to get close to the true reality of another's personal journey to fulfillment. Each individual has his own unique circumstances and responses, but experiencing another's journey is probably as close as you can get until you experience your own.

Another factor one must consider when embarking on this process is how it will be paid for and how much financial expense will be incurred. Contrary to popular opinion, many insurance companies have paid some if not all expenses associated with this procedure. Yet even companies that have done so for one policyholder may deny another. One factor in the decision-making process is the type of policy. It is crucial that one read and understand their policy thoroughly and be willing to resubmit their claim and possibly take the insurance company to court. The old adage "The squeaky wheel gets the grease" is certainly true in this case.

Medicare insurance to this day flatly denies any claims regarding gender alteration. However, the states' Medicaid programs have been known to pay for these services on an individual basis. There is some case history on this in the law libraries. Many times it is necessary to fight a legal battle to obtain coverage. More progressive states, such as Minnesota, are more lenient in granting sex change procedures and tend to pay higher rates to hospitals and physicians.

This brings me to another point: Medicaid in general pays very poorly, and many physicians may refuse to perform surgery at such drastically reduced rates even if you win your case under Medicaid.

I myself have been blessed beyond my wildest dreams—but not without a long, tedious, embittered battle with New Jersey Medicaid. Sheer will and determination cannot be long denied. I had the benefit of a pro bono lawyer, the testimony of my therapist, letters from surgeons all across America to help me produce a precedent-setting case in granting the first known request for phalloplasty in the state of New Jersey under their Medicaid program. I had already selected the surgeons I deemed the best in this country who had given me wonderful letters of support that were instrumental to my court appeal. Through the work of my lawyer, a Medicaid representative, the head of the physicians' group and head hospital administrators, the financial arrangements ensued. The process took close to a year as I impatiently waited helplessly on the sidelines. Normally, insurance companies would have to pay upwards of $100,000 for this procedure; I believe the hospital received 70% of their normal rate, and the physicians received probably less than 5% of their requested fees. I can give only the highest praise possible to my team of physicians for granting me a new lease on life which otherwise would not have been afforded. Dr. Larry Gottlieb from the University of Chicago Hospitals is the finest, most dedicated humanitarian plastic and reconstructive surgeon in this country. Dr. Larry Levine, currently at Rush/St. Luke Presbyterian, is a tremendous urologist with the most experience of anyone in this country in implanting penile prostheses in a totally reconstructed penis. I can never thank these physicians enough. The care I received at both hospitals was outstanding. My experience has been an adventure and challenge, and I have absolutely no regrets.

June 2, 1993, a day that remains indelibly imprinted on my mind, was the day I had waited for my whole life—to realize the complete physical transformation of my being. One would probably expect to be quite nervous anticipating a surgical procedure that would take 20 hours, but there was a quiet calm within me and an assuredness that I had done everything conceivable to pave the way to surgical success. I had quit smoking, after being a smoker for 26 years, because most surgeons say that smokers run many risks with healing and circulatory problems. Some individuals have completely lost their penises through tissue necrosis (tissue death), for which smoking can be the deciding culprit. Nationwide, 10% of free-flap procedures end up with varying degrees of tissue necrosis. The U of C Hospital has a more successful rate of 95%. Of the 5% that do experience tissue necrosis, another 2-3% are saved. I believe this success rate can be attributed to the surgeons' skill and the monitoring system that is meticulously set in place post-op. A dopler is utilized hourly to check the pulse in the neo-phallus. By monitoring the health of the penis on a frequent basis, the physicians are able to keep complications to a minimum.

When I woke up in Intensive Care I was in tremendous pain and vomiting projectilely. I had a morphine drip at my disposal, but the morphine seemed to increase my nausea and I wasn't quite cognitive enough to work the drip effectively. Each individual has their own tolerance for pain; I assume in most cases pain can be well-controlled. I endured the pain because I didn't know any better and believed that the morphine could do only so much. At the time I did not realize that what I was experiencing was out of the norm. I therefore advise voicing your complaints.

My left forearm, wrist and fingers felt as if nails were being driven through them, and there was a tingling numb sensation in the majority of

my hand. The let forearm had been chosen as the donor site, which is usually utilized for a variety of reasons. The vessels in the forearm fit well to those that will be hooked up in the groin. The tissue is easier to work with, ultimately creating a better aesthetic appeal. There is a higher degree of sensation, generally speaking, in the forearm than in any other possible donor site. There is less hair on the inner surface, making this flap a good choice for urethral construction. Hair in the urethra is to be avoided as it can cause the formation of stones. This procedure of microsurgical hook-up of nerves, veins and arteries is the Rolls Royce of phalloplasties and requires tremendous knowledge, skill, expertise and artistry on the part of the plastic surgeon. Is it any wonder there are so few who take up the challenge?

The creation of a urethra is probably the most challenging, complicated aspect of this surgery. The surgeon strips away the skin on the side of the forearm near the little finger. From forearm to wrist this tissue is de-epithelized {its protective surface is removed—ed.}; it is then folded around itself to create a tube which will become the neo-urethra. On the opposite side of the forearm behind the thumb another tube is created to house the penile implant. What appears at the end of this process are two tubes within a tube. Nerves, arteries and veins are dissected and repaired. While one team is creating the neo-phallus another team is preparing the recipient site.

If a hysterectomy has not been performed it will be now. It may even be best not to have a hysterectomy prior to this, as the physicians do have a preferred method to preserve nerves and eliminate scarring. In addition, Dr. Larry Gottlieb can perform a procedure to take part of the abdominal rectus muscle to build a larger scrotum. A vaginectomy is performed, removing the vagina and its glands. The labia minora are utilized to form an extension to the native urethra. This is one of the tricky parts: as a male urethra hooks up, the problems associated with this construction can easily result in strictures, which is a narrowing of the urethra (usually due to scar tissue) which could ultimately result in the inability to void. Surgical intervention may be necessary to restore urinary function if catheterization and dilation are unsuccessful. Because it takes hundreds—if not thousands—of stitches, layer upon layer, the likelihood of fistulas forming is an ever present concern. A fistula is an unnatural opening or exit to the outside of the body or another bodily organ. My fisutlas occurred at this common junction of the urethral hook-up. I had four holes at the base of my penis. Sixty percent of these fistulas require surgical intervention; fortunately, I was in the 40% who self-heal. The head of the penis is also created at the time of this initial surgery. The labial tissues are repositioned and sewn together to create a scrotum complete with mid-line raphne *{a ridge or furrow that marks the line of union of the halves of various symmetrical parts—ed.}*.

In addition to the above complications, infections, hematomas (pooling of blood), and stones are not uncommon. I had a hematoma due to a failed wall in the hook-up of my urethra. I also had urinary tract infections, and a staph infection that was caught and treated immediately. In addition to surgery to correct the hematoma, I underwent carpal tunnel surgery in the donor arm. Carpal tunnel syndrome and other neuropathics associated with donor site complications are not generally the norm. However, some individuals may have a propensity for this type of complication. I've gone through months of physical therapy to restore strength and minimize the hypersensitivity in my hand. There is still presently some residual numbness and tingling.

The drawback to utilizing the non-dominant forearm for a graft is the large, and many believe unsightly, scarring. I am pleased with the healing of my forearm, and from an aesthetic perspective it doesn't bother me. Some may also consider this donor site unacceptable as the length of one's penis will be dependent on the length of their particular forearm. Most patients will end up with a penis five to seven inches in length. The fat content in the forearm has some bearing on how much girth the new penis will have. In addition, the donor site can more than likely be reconstructed through the technique of tissue expansion if one is distressed by the loss of forearm bulk and scarring.

The average stay in the hospital for this long and complicated procedure is 10 to 14 days. My stay was three weeks with an additional one week readmission for the carpal tunnel surgery and the reinsertion of a catheter that had broken. I initially awoke on June 3rd with a supra-pubic catheter (a catheter inserted directly into the bladder) which then acts as the catheter that drains the urine. Also, my penis had a foley catheter that initially provides a mechanism to maintain the urethral tunnel. Later, urine can be diverted through this foley catheter, but initially no stresses are desired on the penis, thus the supra pubic catheter is used.

My foley catheter was in place for approximately three months due to the delayed healing of fistulas. The process of catheterization contributes to urinary tract infections and bladder spasms. I found catheritization very uncomfortable and inconvenient. It necessitates wearing a leg bag when up and around, emptying and cleaning the bags. Still, if I had to do it all over again, I would do so without hesitation.

I stayed in Chicago for over two months because of the instability of my catheterization. My supra pubic catheter which w as stitched into my abdomen continually broke loose and had to be stitched several times. Eventually it completely worked its way out. Fortunately, by then I was able to void through the penile catheter. Through my experience and from knowing others who have gone through this surgery, you will not want to or be able to run around, lift weights or resume your normal course of daily activities for several weeks or months post-op. Complications are the norm and patience will go a long way in the healing process.

Another complication that can occur, though rare, is anterior compartment syndrome. I have a very good friend who suffered this casualty in both legs. He has undergone many surgeries to restore function to his legs. This condition can arise because the legs do not get complete circulation and are put in a compromised position for a very extended period of time. Surgeons are to take precautions to avoid this problem but no one can guarantee completely successful results, and as long as people are human, mistakes will happen. Other complications associated with surgery of any nature are possible risks.

Because I had been on a catheter for so long, when it was eventually removed I became incontinent (unable to control urinary impulse) and had to use Depends (diapers) for a few days. My fear of permanent incontinence was relieved by Dr. Gottlieb, who informed me that this surgery does not include the native urethral sphincter and so the problem will resolve in a short time.

During one of my follow-up visits I requested that Dr. Levine scope my urethra just to make sure everything was in order. It was discovered at this time that I had urinary tract polyps, a stricture, and residual stones from a long period of catheterizations. I was operated on through laser surgery to remove this problem and was released the same day.

In August 1994 I chose to have a penile pump implant inserted so I could engage in sexual intercourse. I was orgasmic through manual stimulation four months post-op and at this point I had fairly good sensation except for the dorsal (top) aspect of my penis, which had necessitated utilizing a flap of natural genital tissue that never developed sensation. This flap isn't normally used, but the fat content in my forearm had been underestimated and normal procedural closure had been impossible. I was in the hospital four to five days for this implant procedure. Immediately upon awakening I found that complete sensation on the right side of my penis had been knocked out. My surgery had been complicated due to the fact that I had a tremendous amount of scar tissue that had to be cut away. In addition, I had a particularly long nerve that tended to coil. Instinctively I felt that this condition was not going to self-correct. Only time would tell, as it can take six months or more for a nerve to begin to regenerate. This side of my

Phalloplasty Continued....

penis had been the more sensate side. Still, I did not mourn my loss and believed there would be a solution to the problem.

Dr. Levine utilizes a technique that he has developed to help prevent extrusion of the implant and erosion or tip necrosis. He creates a sleeve made from gortex which is a substance acceptable to the body (the body generally does not reject gortex). He inserts the cylinder of the implant into the sleeve which is then anchored to the pubic bone which also provides some stability. Normal penises will accommodate two cylinders housed within the native corporal bodies. Because a reconstruction does not have these corporal bodies two cylinders are advised against. One patient went against these recommendations and suffered some loss of sensation. Yet, I followed typical procedure and lost half of my available sensation. There just aren't any guarantees in life. Always weigh the risks to the possible rewards when making decisions.

Most physicians do not have the expertise to perform successful penile implant procedures in a completely reconstructed penis. Some will lie and say it simply can't be done. Do not believe them: it is being done. As a matter of fact, a team of doctors who told me several years ago that it was impossible have finally hopped on the bandwagon and started to insert prostheses in the 40-odd penises they already crafted. They decided to change the methodology of the procedure and experienced a very high failure rate.

In order to be a good candidate for this procedure one should wait long enough for healing and hopefully complete sensation to occur or at least acquire sensation at the tip of the penis (approximately one year). During this procedure a pump is inserted into one side of the scrotum, a cylinder inserted into the shaft of the penis and a reservoir is placed under the stomach muscles. When the bulb of the pump is squeezed several times the saline in the reservoir is transported into the cylinder in the penis, adding stiffness and in the smaller, lighter penises possibly erection. When sexual activity is completed the opposite rectangular side of the pump is squeezed and held to release the saline back into the reservoir housed under the abdominal musculature. Again there are risks associated with this, as with any surgery.

I had been self-catheterizing with a device called an entrac catheter since about October 1993. Initially I was instructed to insert a deflated cylinder covered with K-Y jelly into my penis until I felt it enter my bladder—at the opposite end of this cylinder was a syringe filled with water. Squeezing the syringe filled the deflated cylinder and expanded the urethra. This was held in place for ten minutes every day. Eventually, one is weaned off this exercise. I have not self-catheterized since my implant surgery of August 1994. Hopefully, my situation will remain stable and there will never be a need to do so again.

After receiving my implant I was instructed to perform another exercise a few weeks post-op. I would pump up the implant and keep it erect for 15 minutes twice a day. This apparently helps to encapsulate the implant in the tissue and also helps one to become adept at being ready at a moment's notice. I also was instructed to gently tug on the pump housed in my scrotum and also to milk the shaft gently in an effort to set the implant and pump. I experienced intercourse for the first time on New Years Eve 1994 in a romantic Atlantic City setting. Though I was unable to orgasm, the experience was none the less thrilling. Because of my current sensation deficits I have trouble knowing when I fall out of my lovers' vagina. Also, some positions are difficult if not impossible because my penis seems not to have enough rigidity at its base. The use of two condoms helps firmness, yet further hinders sensation. Regardless, I will be patient and find alternatives if not solutions.

At the present writing (March 26, 1995) I am recuperating in a Chicago patient hotel room. I was operated on March 13th for seven and a half hours. The coronal ridge was formed on the head of my penis, the scarred insensate genital flap was removed, my scrotum was enlarged through a tissue flap harvested from my left inner thigh, my penis was made more circular as it had a flat wedge-type shape before. The base was reduced, hopefully helping with some rigidity. And since I was opened, the nerve damage was explored, and found to be trapped in a bed of scar tissue. It took so long to locate the nerve that swelling of my penis made it impossible to perform a primary closure and another skin graft had to be harvested from my right inner thigh in order to close the surgical incisions. Still, there is no guarantee that this partial nerve release will bring back sensation. However, at the present I feel some internal sensation where there had not been any before. I feel confident that time or possibly another surgical procedure introducing a new nerve into the area will eventually bring more erotic sensation into my penis.

This time I stayed in the hospital eight days. I had some delayed healing and because I have an implant that could possibly get infected the doctor took the proper precautionary measures. If surgical procedures go too deep and depose the implant, there is the possibility of inflection that may necessitate removal of the device as it generally does not tend to self-correct. I am in God's hands and am confident I will continue to survive. My penis looks like dog meat, what with its many shaded bruises and blackened head, a skin graft that is oozing and raw, and blisters to boot—but still, it is my penis, and with God's help it will heal.

Scrotal implants go for $1000 a nut. *{Prices vary; consult your surgeon—ed.}* Again they carry the risk of extruding, or working their way out of the body. With the many billion dollar lawsuits that have been ridiculously launched against the companies that make breast and testicular implants, they are becoming rarer to find. Many companies have stopped making silicone implants. Mentor still has them on he market—get them while they last, as they may be the last of the hot nuts. It is best not to even think about putting a nut in the side of the scrotum where the pump is housed. You'll have difficulty working the pump. Also, you're adding more risk of complication and you'll probably walk bow-legged.

A few more words of advice I would like to offer to anyone who decides to opt for phalloplasty:

(1) Have a supportive, nurturing person or persons available to help you post-operatively with personal care and wound care, someone who will understand that you may suffer from depression and irritability. The nicest people in the world can become ornery in view of the pain, uncertainty and drugs. Also have a therapist available to help with all this.

(2) Visit with as many board certified physicians as possible who have performed this procedure successfully on a number of people. Ask to see pictures, possibly journals they've contributed to, patient referrals of people that would be willing to share their opinions and experiences. Don't enter into anything without having all your questions and concerns addressed. I personally highly recommend the doctors who performed my surgery. I have heard horror stories from several patients of other physicians, and I know for a fact that some doctors can be less than honest. Also, some doctors perform procedures strictly out of their own ego needs, not what's in your best interest.

(3) Do not allow price to determine your choice of procedure or physician if at all possible. Negotiate price with the doctor you deem most appropriate for you.

(4) Choose the procedure that best matches your needs and comfort level, including the choice not to undergo surgery at all.

(5) Do not enter into this surgery to please a lover or anyone else. Do it because you are driven to make this change and are willing to pay the price for the possibly tremendously satisfying results.

(6) Envision your arm as if it is already scarred. Envision your new penis, fully functional. If you can adjust to the scar in your mind's eye before you see it in reality your adaptation will be much easier.

(7) Gather as many facts as possible but do not

become paralyzed by analysis.

(8) Quit smoking. Eat a balanced diet fortified with mega vitamins. Don't do drugs or alcohol, and get into your best physical shape. Lose weight if possible, if you are overweight. Get rest and relaxation. Don't let worrying or nervousness consume your energy or alter your judgment.

(9) Trust in your doctors, have a good rapport with them, ask questions and inform them of anything you feel is unnatural in your healing process. Ask for pain medication or other items of comfort such as an egg crate mattress (it does wonders for your back).

(10) Follow your doctors' instructions of post-op care to a 't'. This is not a time for you to determine the rules of post-op care. I have witnessed the complications that can result when one alters accepted protocol.

(11) Pray and have others pray for your successful and speedy recovery. Be patient, have faith and endure the hardships, for the winter will eventually turn into spring.

(12) If insurance coverage is unavailable, negotiate fees with your doctors and the hospitals. Ask to be put on a lifetime payment plan if necessary.

(13) If a staff member neglects to perform a service such as emptying your urine bag or rehooking the leg compression devices, gently remind them that this is your body and someone else's errors can affect your life.

(14) Plan to stay in the area at least some time after release from the hospital—you will need to see your doctors post-op, and it is comforting to know they're only a cab ride rather than a plane ride away.

(15) Do not believe those who declare that a functional penis is impossible to construct. My research, though a small sampling, indicates that those individuals who had the psychological need for a sensate penis that was also capable of urination and intercourse were more satisfied with the results than those who choose the old Stanford abdominal flap method. It is technically possible today to have it all—even though there are few doctors able to skillfully provide it.

(16) Finally, don't beat your meat against the toilet seat until your doctor tells you you can now enjoy that treat!

(April 23, 1995) I feel compelled to add more to my original letter. I have experienced a rare and devastating setback. The blackened areas on my penis, which were believed to most likely heal on their own or with some slight debridement (scraping away of dead tissue), turned out to be much more serious. I was readmitted to the hospital for another 22-day stay, and have undergone two more surgeries. Unfortunately, I lost half of my penis and much of its larger girth. My once large member looks to me now like a pea shooter (no pun intended).

One positive result of my misfortune is that the doctors have broadened their base of knowledge. The pattern of necrosis revealed to them that any revisions should be made prior to the placement of the penile implant. The tissue around the implant had become ischemic (lacking oxygen due to compromised blood flow) and had become necrotic (had died). I remember posing my question to my doctor over a year ago: "Would it matter if the penile implant surgery was selected before doing aesthetic revisions?" My doctor did not believe at that time that it would make any difference. He now knows that it can indeed make a world of difference.

Needless to say, I suffered the usual feelings of denial, depression, anger and frustration that anyone would suffer with major loss. I was wise enough to seek the counsel of the hospital staff psychologist in working through these feelings and, surprisingly, I had entered into the acceptance stage within a week postoperatively. When I wrote my original letter I never believed that at this stage of the game I would have to go through those experiences I found to be less than comforting. I am again on a supra-pubic catheter and a foley catheter. During my readmission to the hospital the doctors were initially unable to get a foley catheter completely into my bladder. A cystogram revealed some form of blockage (initially thought to be a stricture). I was put under via a spinal anesthesia and a cystocopy revealed a diverticulation. The urologist told me that removal of the diverticulation would make it more possible to place the foley catheter. He said that removal would not affect the flow of urine either way. However, he stated that he must be very careful, for a mistake could leave me incontinent. I said to go ahead.

In hindsight I don't know if I would have made such a casual choice if I had not been under the influence of anesthesia. I guess I won't know for certain if this procedure was a success until I am removed from these blasted catheters. This time, on these catheters, I am not utilizing any bags. My bladder is being trained, and when I get the urge to urinate I unclasp the foley and the urine drains out. The supra pubic is a backup in the event that I'm unable to void normally through my pea shooter. I really think that will be no problem, as urine is flowing through my penis and the catheter now.

Now, what to do about Stubby (my small penis). My surgeon tells me this problem is not insurmountable. He must wait and see the results of healing to determine what the best course of action would be. It may be wiser to go for a full reconstruction, which may include sacrificing my right forearm. He may decide to add on to Stubby or revise what I now possess. Without all the pros and cons it is difficult for me to even begin contemplating the choices. I am exhausted from this ordeal and wonder why this had to happen to me. It is believed that this incident had less than a one percent possibility of occurring. Hopefully, my misfortune will save some of your readers from this fate. Now that you have this piece of knowledge you can make more educated decisions. Still, with all my hardships and complications I do not regret making the decision to undergo phalloplasty. I do regret that I lost what I had. However, maybe in the end I will have a result that will be better than what I would have had if these events had not taken place. In less than two years I have undergone eight surgeries and been treated for many infections. My goal is not to discourage you from choosing phalloplasty but to show you how to reduce risks, realize the possible price, and make educated, informed decisions. I still believe that I have chosen the best team of surgeons in this country. This surgery holds the possibility for many complications. One must have the stamina, courage, hope and fortitude to press on to one's dreams. For me it is the quality, not the quantity, of life that is most important. Even with my small ill-formed penis I am far better off than I was prior to my genital surgery. For me, anyway, the price I have paid is still worth what I have gained.

It may be necessary to remove the implant in my scrotum (the pump). I have been experiencing quite a bit of pain since the penile cylinder had to be removed. The implant surgery bill was about $25,000. I had sex six times—that's at about $4000 a pop. Luckily, I did not pay much financially—my cost was about $500. However, I now face the possibility of not having medical insurance when and if I choose to have an implant reinstalled. Well, that decision is probably at least a year or more into the future. I must take one day at a time, for to view the total process could overwhelm me at this point.

Dear readers, may your venture to and through phalloplasty be more successful than that undergone by those who have come before you. My case, fortunately, is not the norm. I have had more work and complications of my penis than any of the other 18-20 penises my doctors have created.

I trust that the information I have provided has not scared you away from your dreams but has given you food for thought so you can make the choices best suited for your individual needs.

Good luck and happy pecker hunting, Martin Kincaid, F2M Fraternity Member

Marty, your story is a sobering one. I am so grateful to you for taking the time to write the truth of your experiences. Many new men will surely gain from your effort. Let's hope for the best for you, and encourage others to share their stories, too. The bravery of our pioneers must be acknowledged.—James.

malebox

Mad As Hell

Dear FTM:

I am feeling angry, frustrated, and very sad. See, my reflection in a hand mirror reminds me of the place I run out of body. Most of the time I avoid thinking about it, but it's more difficult now that I have a woman in my life I care deeply about. I want to experience the physical intimacies that my spirit feels—to mount her, to penetrate her body with mine—and yet I have nothing to send into her open receptivity, and I scream inside my head as hot searing pain crashes, wave after wave, through my soul. It's painful to run out of body.

I have a rubber dick. I have a fucking big ass rubber dick. I have a goddamn rubber dick so big, few men could stand equal! I can fuck. I can fuck all fucking night if I want to. I can out-fuck any man...with my rubber dick.

I want to take my fucking rubber dick off and throw it across the room! I want to rage at it. I want to throw that rubber dick across the ocean! I want to throw that fucking big ass rubber dick in the sky so high it slaps my God upside the head!

"See?" I want to say. "See, you forgot something!!"

Goddamn, I'm mad as hell.

Chris

For The Record

Dear James,

I was happy to receive my FTM Newsletter today, and just as soon as I started reading it my eye hit a name oh so very dear to my heart, Janus Information Facility, because 1) it was formed or rather renamed by Paul Walker, in about 1977 and 2) I was Assistant Director of the Janus Information Facility from 1978 to 1980,in Galveston, Texas, which meant that I answered all the mail.

Perhaps you can already see what I am getting at. Loren's memory of where he got his information at age 12, which would be 1971, is very inacccurate. In 1971 there existed a wonderful organization called The Erickson Education Foundation. This was funded by a FTM named Reid Erickson, and I know you know about him. He was never publicly known as a TS. Erickson was founded in about, I believe, 1969, and after ten years of funding on an extremely generous level, and directed by a most beloved woman in the gender dysphoria field, Zelda Suplee, Reid decided he didn't want to fund it anymore and ordered all the files, etc. thrown away. Paul was moving to Galveston to direct the Gender Clinic at the University of Texas Medical Branch and he asked Reid if he could have all the files, books, resources of the Erickson Foundation. Additionally, he asked Zelda to move from New York City to tiny Galveston, Texas, an island about 50 miles long and with a permanent population of about 50,000 people at that time, and most of them employed by UTMB. Well, both answered yes to his requests and so he renamed it Janus Information Facility, he persuaded UTMB to donate the space, a huge loft in the historic Customs Building of Galveston, where many immigrants to the US came through as their first sight of US soil, and also to fund all mail costs. Zelda worked for no salary. In 1978, when I went to work with Paul, Zelda had her 72nd birthday and wanted to retire and move out of the boonies and live in Hollywood. And so I inherited her job, which I considered an honor and privilege. In June of 1980 Paul and I bid farewell to UTMB and moved to San Francisco, where Janus resided until the time when Jude Patton and Sister Mary Elizabeth (then Joanna Clarke) agreed to run it and renamed it J2CP. Thus the 2 Js, C for Clarke and P for Patton. The reason is that Paul could no longer afford the cost of running Janus because mailing and printing costs took all of the donations and then some. You are running into the same problem now, I think, because the need for these services does not diminish with time, but is increasing, as media coverage via TV causes more enlightenment. Of course, J2CP also hit the dollar wall and then is when AEGIS took over the several times evolved Erickson Educational Foundation (I can't remember if it was Education or Educational and don't want to look it up).

So, such a long letter to clear up a major error in Loren C's memory book. It's up to him and you if you want to correct this information in a later issue. Please let him know that I admired his photographs and his work is very handsome.

If he indeed get his information from Erickson, it was from Zelda Suplee. If he got it after August, 1978 to June 1980, it was from me. If he got it from Paul in San Francisco, it was after June 1980.

With very best regards, Alice Webb, LCSW, Executive Director of HBIGDA (Harry Benjamin International Gender Dysphoria Association)

Making History

Continued from page 1

ing up and answering the mail, and helping to coordinate the monthly group meetings. You should also have a computer, preferably with a modem and laser printer. I need a rest, a break, a change. I need cooperative, responsible volunteer help. There is no remuneration other than the knowledge and friendships that you will gain, along with the satisfaction of knowing the service you are providing is an important lifeline to hundreds of people around the world. I wish I could say there was a salary, or even minimal cash compensation for this work. (If there was a salary, maybe I wouldn't be getting so tired!) But there is only money to pay for the actual production costs, materials, and postage. I sure hope someone will come forward, because I must draw the line and retire soon. I'm giving notice now that the January 1996 issue will be my last. That's 5 years of service. I promise to be available as a consulting editor, and I promise to keep writing for the TS/TG audience, but I just can't continue to do all that I have been doing. Depending on how the membership decides to pursue non-profit status, I may stay on as executive director, or in some other advisory or reduced service capacity. Meanwhile, my own life, my own health and growth demands that I give this Newsletter up. Others should have an opportunity to grow as I have through service to this burgeoning community. If no one who is qualified steps forward, this Newsletter will be suspended after the January issue until such time as a suitable editor is found, or until I have rested long enough to feel ready to take up this responsibility again. If I do have to suspend publication activities, I don't want people who have sent in subscription money to feel cheated so I will come up with some refund mechanism, or some way of making people feel they've gotten their money's worth. I really hope this publication doesn't have to be suspended. If you are interested in editorial and group leadership responsibility, call our voicemail number and leave me a message, or write to me at the FTM mailing address. Thanks to all our readers for understanding my situation, and for helping to make the FTM Newsletter (and FTM International) all that it has been, is, and I hope it will be.

networking

FTMS NEEDED FOR STUDY

Joy Shaffer, M.D., is looking for 100 good men. Dr. Shaffer has laurched what she hopes will be a definitive study of the brain anatomy of transsexuals and "normal" controls in cooperation with Stanford's Lucas Magnetic Imaging Center and Vision MRI of San Jose. Using sophisticated magnetic resonance imaging (MRI) equipment, the researchers hope to show that the corpus callosum of transsexuals exhibits the same sexual dimorphism as controls, along gender identity lines. Positive results would show that FTMs have brain anatomy similar to that of "normal" males, and MTFs have brain anatomy similar to that of "normal" females, or would show some other significant indicator of difference. This could lead to proof that transsexualism has a biological basis, and therefore is a condition deserving of more humane treatment from physicians and medical institutions, as well as treatment coverage from insurance companies. Dr. Shaffer is looking for 100 FTMs and 100 MTFs to participate in the study.

Dr. Shaffer (who is TS herself) will take each participant's health history, and, after that, each participant will be identified by a unique code number. Each participant will be scanned for about 10 minutes on one of the MRIs in San Jose, Walnut Creek, Carmichael, Huntington Beach, and Laguna Niguel. The digital images will be analyzed blindly using computer graphics software. No compensation is available for subjects, who must all be volunteers. There are no known risks or side effects of the non-contrast MRI scanning. The MRI images will become the property of the researchers. Since individual results are not meaningful and may be misinterpreted, personal results will not be reported to test subjects. And the results will not be published until a quantity and quality of data is available to pass rigorous peer review. Collaborators with Dr. Shaffer in this study include Dr. Barton Lane, Stanford Department of Neuroradiology, Dr. Virginia McCarter, UCSF Institute for Health Policy Studies Statistician, and Dr. Shannon Burke of Norcon in San Jose.

To volunteer to participate, call Dr. Shaffer's office at the Seahorse Medical Clinic in San Jose at 1-800-DRJOYMD, and say you want to be part of the MRI study. This is a chance to help make history, and to really make a difference in the quality of care and treatment for transsexuals.

CHRIS MORTON MOVED

Dear FTM: If you know of any FTMs in the Southern California area, such as San Bernardino, Riverside, Los Angeles even, please give them my new address: [redacted] **E. 17th St., San Bernardino, CA 92404** (or print whatever it takes to get the message to them). It gets rather lonely down here (smile). Thank you. **Chris Morton**

CORRECTION

The phone number listed in last issue for Dr. Turner (who is looking for TS family histories) was incorrect. **The correct toll-free phone number is 1-800-448-1291, or call Dr. Turner collect at 1-505-343-1291.** Thanks to Jonathan for the correct information.

Dear FTM: I'm just getting started in my FTM transition and eagerly await the days of hormones and possible surgeries. I'm looking for friends who "really" understand me and can advise me as I take steps into my new world. You don't have to live close to write, and you just never know when our paths may cross. Any information from anyone, anywhere will be greatly appreciated. Thanks, **Matt Howard, P.O. Box 71, Elizabeth, IL 61028-0071**

SUPPORTIVE S.O.

Dear FTM: Hi, my name is Sonia. I am 22 years old and live in Melbourne, Australia with my partner Troy who is an FTM. Recently Troy wrote in and requested the back issues of the FTM Newsletter and let me tell you, I couldn't keep my hands off them! I read them from cover to cover and they are fantastic!! They had progressed from a simple and informative single sheet to fabulous, supportive, encouraging and informative newsletters. I was very sad to read about Lou Sullivan's death. He came across in the newsletters as a very understanding, remarkable man! We would have loved to have met him.

I read in Issue #29 that you will be putting out a booklet "The Best of FTM." I encourage everyone to buy a copy. It's really great! One thing I really regret is that we can't attend any of your meetings, so the best we can do for now is to eagerly await the summary of the meetings in each of your newsletters!

Troy and I have been together for over three years. I have been with him throughout his transformation. He has been receiving testosterone injections for over a year now, and has changed quite a bit in physical appearance: he looks great!. To whoever came up with the saying, "If you love the interior, you can easily adapt to the exterior" was more than correct.

Troy is a pre-op FTM, but will soon be having his first operation. I have tried to be very supportive and understanding. I know it's frustrating for him. I can understand what he's going through, but I can't really know.

I am interested in corresponding with any other partners of FTMs. To share stories, experiences, to give support and encouragement to each other, as we are all here for the same reason, which is to help our loved ones as much as we can during this difficult period in their lives. Anyone else is also welcome to write.

One more thing before I sign off: I love you, Troy, and will be there for you ALWAYS...! Sincerely, **Sonia, [redacted] Burwood Hwy., East Burwood 3151, Melbourne VIC, AUSTRALIA**

James responds: Sonia, thanks for the compliments about the FTM Newsletter. It's nice to know our efforts are appreciated. Troy is one lucky guy to have a supportive partner like you. I hope you will get plenty of letters from other partners. I have to report, though, that we are not yet ready with the "Best of FTM" booklet—with all the preparations for the upcoming conference we just couldn't make that happen. Back issues of the FTM Newsletter are available only in full sets at a cost of $30.00 U.S. (plus $5.00 for international orders for the additional postage). Thanks again.—James

THE LUCKY GUY

Dear FTM: Thanks, James, for your time and effort with sending me out all the back issues of FTM. I found it most helpful and interesting. The founder of FTM, Lou Sullivan, was a legend!! I would like to purchase all his published work, especially "Information for the Female-To-Male Cross Dresser and Transsexual." Please send me out the names of his books and their prices.

I am very interested in purchasing a copy of the video titled "Linda/Les and Annie," and if anyone has a copy of the Hustler magazine in which they appeared, I would be grateful to purchase even any photocopies.

Also, to all the readers of FTM, I recommend for everyone to purchase the back issues of the FTM Newsletter—it is invaluable reading!!!!!

I would like to hear from any FTMs anywhere to exchange information about hormones and surgery, and just general correspondence. Please write to:

Troy S., [redacted] Burwood Hwy., East Burwood 3151, VIC. AUSTRALIA

James responds: Troy, thanks for you letter, too. Information about obtaining the two books Lou Sullivan wrote is included on the back page of Issue #30. You can also obtain both books from IFGE, P.O. Box 376, Wayland, MA 01778 U.S.A. Write them for their free publications catalog for to get the current pricing.—James

CONTINUED PAGE 14

MORE NETWORKING

TRANSGENDER QUEERS

I would like to know if anyone is currently working on an anthology of writing about transvestites and transsexuals whose sexual preference renders them gay, lesbian or bi. If so, I would be interested in contributing. If not, I'd like to get it started. The book I envision would contain non-fiction articles (including personal accounts, biography, history), fiction/poetry, photography, etc. It would include articles by FTMs who consider themselves gay or bi, MTFs who consider themselves lesbian or bi, and partners thereof. I would also be interested in finding out if anyone knows of any already printed fiction about or biographies/autobiographies of FTMs with gay male sexual preference—either books or shorter pieces. If you have information about or are interested in contributing to a project such as the one I've outlined, please contact me.

Also, I saw in an old issue of FTM you were looking for copies of Emergence. I do have one, if the person is still looking for it.

Chris Leonard, [redacted] Park Street, Redwood City, CA 94061. [redacted], email [redacted]@aol.com.

DELAWARE PARTNERS MEET

A support group for female partners of FTMs meets for dinner on the first Sunday of the month. The next meeting will be August 6th at El Sombrero, Elkton-Newark Rd., Newark, DE. For more information, email [redacted]@aol.com.

ANNOUNCEMENTS

SYMPOSIUM IN GERMANY

The Fourteenth Harry Benjamin International Gender Dysphoria Symposium will take place in Bavaria, Germany September 7-10, 1995. The conference, sponsored by the Harry Benjamin International Gender Dysphoria Association and the Department of Psychotherapy at Ulm University in Germany, is entitled "Gender Dysphoria: Transcultural Perspectives/Transsexualism: State of the Art Treatment." Topics include body image, personality factors in transsexualism, and reports on a multitude of studies. Of special interest to FTMs are updates on new techniques in phalloplasty.

For more information, contact Friedemann Pfafflin, M.D./Department of Psychotherapy/Am Hochstraess 8/D-89081 Ulm, Germany.

CHELTENHAM, ENGLAND

FTM Get-Together October 7th, 1995. Speakers, entertainment, dancing. £9.00 per person. **Contact Tony, [redacted] Oakland Ave., Cheltenham, Glos, GL52 3EP**

RESEARCH QUESTIONNAIRE

Dr. Jan Eder of the Transgender counseling and Research Center in San Diego is doing research on FTM transsexuals to complete the work she has done on MTF transsexuals. Anyone interested in filling out her questionnaires can reach her at: **[redacted] Park Blvd., Ste. 207, San Diego, CA 92116. [redacted]**. All information will be kept anonymous, all material so sent will include pre-paid postage. Simply fill out and return. Your participation is greatly needed.

SOUTHERN COMFORT

Southern Comfort is the premier gathering of the transgender community in the Southeast, taking place this year **Sept 28 through Oct 1. Cost is: Single attendee, before 9/1/95–$175/after 9/1--$200. Couple, before 9/1/95–$325/after 9/1--$375.** Programs will address everything from appearance, voice, and the philosophy of passing, to legal concerns, identity issues, medical procedures, transgender civil rights and political awareness. Evening brings a full measure of entertainment and enjoyment for which Southern Comfort has become so well known.

Your registration fee includes admission to all seminars, complimentary regularly scheduled mini shuttle bus service, two night-time banquets, three luncheons and access to the vendor areas. Meals included with your Conference registration are: Lunch-Thursday, Friday and Sat. Dinner-Friday and Saturday. Entertainment programs follow dinner both evenings. The conference will be held at the recently renovated Holiday Inn in midtown Atlanta, Georgia. All convention activities are centered at the hotel, and the entire convention area is dedicated to the conference.

Included as seminars: **Male/Female Communication Styles**–Celeste Richards, **Discovering your Male Self**–Dr. Delia Van Maris, **Transformational Images of Female-to-Male**–Mariette Pathy Allen, **Transitioning: Before, During and After**–Maxwell Anderson and Panel,**Hormones (with or without SRS) and General Health Issues**–Dr. Rebecca Allison, **Plastic Surgery for the MTF & FTM**–Dr. Douglas Ousterhout, **SRS for the MTF & FTM**–Dr. Yvon Menard, Dr. Eugene Schrang, Dr. Toby Meltzer, **Coping with Undesirable Surgical Results**–Jason Cromwell & Panel, **A Couple's Panel**–Dr. JoAnn Roberts, **Alternative Lifestyles**–Phyllis Frye, Jason Cromwell, Maxwell Anderson, **Dating & Relationship within the Community**–Maxwell Anderson, Debbie Leonard, **Berdache, Hijra & Other Two-Spirit Traditions**–Dr. Anne Bolin, Jason Cromwell, Wendy Parker, Marisa Richmond, **Transgender Paradigm Shift to Free Expression**–Martine Rothblatt, Holly Boswell, Callan Williams, Riki Anne Wilchins, **Pros & Cons of Media Exposure**–Marisa Sherrill Lynn, James Green, Jason Cromwell, **Transgender Outreach and Activism**–James Green, Phyllis Frye, Dallas Denny, Riki Anne Wilchins, Holly Boswell.

Contact information is as follows: **Southern Comfort, P.O. Box 77591, Atlanta, GA 30357-1591. (404) 633-6470. Email: SCC95@aol.com.**

MAX SPEAKS!

During the week of the FTM Conference in San Francisco, Max Wolf Valerio will read excerpts from his new book *The Joker is Wild* to be published by William Morrow in 1996. The Location of the reading will be announced during the conference. Max Wolf Valerio is a poet, actor, musician. He is featured in the Monica Truet film Female Misbehavior and his writings have been published in *This Bridge Called My Back, Animal Magnetism,* and *Visions,* among other publications.

Books

Mary Diana Dods, A Gentleman and a Scholar

by Betty T. Bennett

While researching Mary Shelley's letters, Betty T. Bennett came across some oddly intimate correspondence between Shelley and two acquaintances-David Lyndsay, an author, and Walter Sholto Douglas, an aspiring diplomat and the husband of one of Shelley's close friends. Although it seemed that both men soon ceased to play a part in Shelley's life, they did not disappear entirely from the historical record-and the truth about the two, as Bennett found after years of investigation, proved quite a bit stranger than fiction. For it turns out that both men were actually the same person and, remarkably, that person was a woman: Mary Diana Dods, the illegitimate daughter of a Scottish aristocrat. In recounting all the startling twists and turns of research and speculation which led her to Dods' secret, Bennett has composed a surprising and entertaining book in the spirit of A.S. Byatt's *Possession*-only this one is true! *In limited supply.*

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FTM RESOURCES

UNITED STATES

California

FTM International, 5337 College Avenue #142, Oakland, CA 94618 VOICEMAIL: 510•287•2646 E-Mail: FTM News@aol.com

Under Construction, P.O. Box 922342, Sylmar, CA 91392. Contact: Jeff Shevlowitz

Florida

Eden Society

P.O. Box 1692, Pompano Beach, FL 33061-9316. Contact: Maxwell Anderson & Jake Taylor. Phone: (305) 784-9316. Nature/Services: Open transgender support group. Notes: Newsletter is EdeNews

Massachusetts

East Coast Female-to-Male Group

P.O. Box 60585, Florence Station, Northampton, MA 01060. Phone: (413) 584-7616 (Bet Power), (617) 926-7691 (Lonnie). Nature/Services: Support group for female-to-male persons and their significant others

Enterprise, P.O. Box 629, Jamaica Plain, Mass 02130-0006 (617) 3264. Contact: Harris Brown

BiMonthly FTM Group, c/o IFGE, P.O. Box 367, Wayland, MA 01778, (617) 899-2212 - An FTM support group which meets at 7pm on the first and third Monday or every month in the offices of IFGE.

Wisconsin

Gemini Gender Group. PO Box 44211 Milwaukee, WI 53214. Voice mail #414-297-9328. Notes: My SO and I are the only FTMs who attend, but it's a really nice group of people and FTMs are DEFINITELY welcome (and people go out of their way to make FTMs comfortable). The local "professional" TG program in town is PATHWAYS, directed by Gretchen Fincke (and Roger Northway). The program offers a connection to endocrinologists, surgeons, etc. The program has separate FTM and MTF groups. Currently the FTM group has about 8-9 guys. Gretchen is always welcoming more FTMs! The phone # for Pathways is 414-774-4111. I'm thinking about starting a "social" support group for FTMs in the Chicago/Milwaukee areas. There seems to be a growing # of FTMs within these 2 cities and we have special needs and concerns that aren't getting addressed for a lot of guys. Feel free to put my # down as a contact (and potential group)– #414-276-8877. Michael.

INTERNATIONAL

Australia

Boys Will Be Boys, BWBB, P.O. Box 5393, West End, Brisbane, Australia 4101. Nature/Services: Newsletter and network for FTM persons. Notes: Boys Will Be Boys newsletter

Belgium

Kortrijk, Genderstichting (Belgian Gender Foundation), Pluimstraat 48, Belgium B-8500

France

C.A.R.I.T.I.G, B.P. 17.22, 75810 Paris Cedex 17, France

United Kingdom

London

F to M Network, Box 7624, London WC1N 3XX, England. Contact: Stephen Whittle, Phone: 061 225 1915. Nature/Services: Support group for female-to-male persons

Manchester

Female to Male Network, 367 Upper Brook St., Victoria Park, M13-0EP

NOTE: Send in your meeting times! Please keep us informed about organizations, support groups, newsletters and other services which specifically cater to and/or include FTMs. There are many more resources out there than are listed here, and we'd like to know about them so we can tell you!

FTM Meeting Schedule 1995

FTM meetings are on the 2nd Sunday of each month, from 2 to 5 p.m., in San Francisco. Call FTM Voicemail (510-287-2646) for details. Mark your calendars in advance!

Support	Informational
September 10, 1995	August,13, 1995
November 12, 1995	October 8, 1995
January 14, 1996	December 10, 1995

FTM International Conference-Aug 18-20, 1995 in SF

FTM INTERNATIONAL NEWSLETTER

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Our friendly staff of professionals is ready to serve you... *from left to right: Stafford, JordyJones, and David Harrison.*

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