Becoming Visible
Counseling Bisexuals Across the Lifespan

EDITED BY Beth A. Firestein
BECOMING VISIBLE

COUNSELING BISEXUALS ACROSS THE LIFESPAN

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TRANSGENDERED PEOPLE have long suffered from popular and scientific misunderstandings and reductionistic assumptions about their sexuality. Much of this confusion has centered around their perceived sexual orientation.

Because access to medical treatment has often been limited to those having a “correct” (i.e., heterosexual) sexual orientation after sex reassignment, transsexuals have been most directly affected. In 1974 an article in Archives of Sexual Behavior reported on the “apparent” heterosexuality of two male individuals seeking sex reassignment (Barr, Raphael, and Hennessey 1974). The authors were skeptical about the purported sexual orientation of the individuals involved, but found their sensibilities challenged—so much so, in fact, that they generated the journal article to raise the consciousness of their peers: “This case . . . makes it clear that a request for SRS is not invariably associated with a homosexual orientation” (p. 330).

Female-to-male transsexuals endured similar misconceptions. There was considered to be but one “type” of FTM—a masculine female with an exclusive sexual interest in women: “All transsexual biological females are homosexual in erotic object choice, and all of them wish to have a penis” (Steiner 1985:353). Pauly (1992) has described the difficulties of FTM Lou Sullivan, who, because he identified as a gay man, had difficulty obtaining needed medical procedures in the 1980s (see also Sullivan 1989). Sullivan died of AIDS in 1991.

The assumption of the day was, of course, that all male-to-female transsexuals were sexually attracted to males; likewise, all female-to-male transsexuals were believed and expected to be sexually attracted to females. This conviction was so strong among professionals that heterosexual-identified individuals who sought sex reassignment were often diagnosed as nontranssexual and denied treatment (Abel 1979; Denny 1992; Dixen et al. 1984; Newman and Stoller 1974). This was still happening in some treatment settings in the 1990s (Petersen and Dickey 1995) and is no doubt still occurring. Some clinicians still cling to the naive and outdated notion that transsexualism is a form of repressed homosexuality and transsexu-
als are gay men or lesbians who cannot accept their sexual orientation (cf. Fagan, Schmidt, and Wise 1994). Similar simplistic presumptions color the autogynephilia theory of Ray Blanchard and his proponents (Bailey 2002; Blanchard 1989a; Lawrence 1998) and are codified in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (APA 2000).

Belief in the universal homosexuality of transsexuals and other transgendered persons dates to the work of the early sexologists, who conflated sexual orientation and gender variance, in particular Krafft-Ebing (1894) and Ulrichs. Ulrichs, writing at the close of the nineteenth century (his work was not translated into English until 1994), believed homosexuality was caused by a “contrary sexual feeling,” a feminine or masculine spirit that did not match the body. Ellis (1906) believed this sexual inversion was a sign of latent bisexuality:

The “invert” was part male, part female, or rather part “masculine” and part “feminine.” The male invert’s “feminine” side desired men; the female invert’s “masculine” side desired women. Thus human sexuality could still be imagined according to a heterosexual model. It was “bisexuality” that produced homosexuality. Indeed, the two terms were often used as virtual equivalents. (Garber 1995:239)

It was not until around the time of the Stonewall riots (in 1969; see Duberman 1993), that gay identities and gender variance began to be differentiated in the public consciousness. Before that time, male homosexuals were typically characterized and popularly depicted as effeminate men and lesbians as masculine women. Masculine men and feminine women who had sex with gender-nonconforming homosexuals were generally not considered homosexual. In some parts of the world even today—particularly in the Middle East and Latin America—masculine, male-identified men who have sex with feminine, often crossdressing males are not considered gay, although their partners are (cf. Kulick 1998). In contrast, in contemporary Western culture the typical gay male couple is comprised of two masculine, male-identified men. The lesbian community has once again begun to embrace butch identities (cf. Burana, Roxxic, and Due 1994), but most lesbians identify unambiguously as women and female.

In 1952 intense media coverage of Christine Jorgensen’s sex reassignment catapulted the as-yet unnamed phenomenon of transsexuality into public consciousness (cf. Ex-GI becomes blonde beauty). An immediate result of the publicity surrounding Jorgensen was a deluge of frantic requests from men and women wanting sex reassignment procedures (Hamburger 1953). It was in response to this demand, and to the intense anguish that characterized the phenomenon that would soon be named transsexualism (Benjamin 1966), that the treatment system typified by Barr and colleagues evolved.

The first real challenge to the orthodoxy of universal homosexual orientation in gender-variant individuals came from an unlikely source—a forming com-
munity of male crossdressers with heterosexual identities. Charles (later Virginia) Prince published widely on the heterosexuality of crossdressers, both in her own journal, *Transvestia*, and with P. M. Bentler in a variety of professional journals (cf. Bentler and Prince 1969; Prince 1957; Prince and Bentler 1972). Bentler and Prince convincingly demonstrated the heterosexuality of the majority of their sample of male crossdressers. Their data were the first to challenge the popular notion that gender-variant persons were invariably homosexual.1

By the 1970s clinicians had begun to recognize not only that some male-to-female transsexuals were attracted to the opposite biological sex but also to identify two clinically distinct subsets of male-to-female transsexuals. One group tended to be younger, more feminine in appearance and behavior, and sexually attracted to men (Person and Ovesey 1974a). Those in the second group tended to present for treatment later in life, had more difficulty in passing as female, and were attracted to women (Person and Ovesey 1974b). Other authors made similar distinctions (cf. Freund et al. 1974). These clinical subtypes came to be called, respectively, primary and secondary transsexuals. The primary differentiating characteristic was considered to be sexual orientation.

Unfortunately, clinicians continued to regard all female-to-male transsexuals as all "of a type," despite a flourishing and highly visible culture of gay- and bisexual-identified FTMs. This did not begin to change until Devor (1993a) introduced a taxonomy of gender variance in natal females. Researchers began to take note of the sexual orientation of their transsexual clients and sometimes kept demographic information (cf. Dixen et al. 1984; Pauly 1992; Sörensen and Hertoft 1986), but although these workers sometimes demonstrated sexual attractions of transsexuals to both males and females, they did not explore bisexual identities.2 The literature has been and continues to be largely silent on the issue of bisexual identities in gender-variant people.

**Bisexuality in Transsexual and Other Transgendered Persons: What Does the Literature Say?**

Denny and Green (1996) have reviewed the existing literature on bisexuality in gender-variant persons. Here, I extend their review.

Any number of transsexuals and other transgendered persons have publicly identified themselves as bisexual and explored just what that signifies. In 1973 the late cartoonist Vaughn Bodé appeared on the front and back covers of the comic *Schizophrenia/Cheech Wizard* in photographs, crossdressed; inside, the character that represents Bodé declares himself/herself "auto-sexual, heterosexual, homosexual, maso-sexual, sado-sexual, trans-sexual, uni-sexual, omnisexual" and cries, "Mama, you made me a transvestite!" Transgendered and transsexual people who identify as bisexual have contributed significantly to the
now-out-of-publication bisexual magazine *Anything That Moves* (cf. Franek 1998; Lano 1998; and Valerio 1998) and have elsewhere written chapters and articles illustrating their bisexual identities and experiences. In an edited volume Alexander and Yescavage (2004a) have summarized and provided quotations from some of these works, most notably essays by Hemmings (2002) and Martin-Damon (1995). Alexander and Yescavage’s book includes additional essays and explorations on what they term “the interSEXion of bisexuality and transgenderism” (cf. Alexander 2004; Chase 2004). At last the convergence of sexual orientation and gender identity is producing discourse.

Although some clinicians have long recognized the complexities of sexual orientation in gender-variant persons (cf. Bockting 1987; Coleman, Bockting, and Gooren 1993; Pauly 1989, 1992), the psychomedical literature has for the most part viewed transgender sexuality in simplistic ways—sometimes to the point of deliberate obtuseness. As late as 1997 one prominent clinician with whom I was collaborating refused to acknowledge the existence of female cross-dressers, even though I referred him to articles by self-identified female cross-dressers. I find it ironic but in retrospect hardly surprising that the seeds that would lead to a transgender paradigm shift in the 1990s were sowed not by clinicians but by anthropologists and sociologists (Kessler and McKenna 1978; Bolin 1988; and Devor 1989). Clinicians were for the most part too bound up in their work to gain perspective (Denny 1993).

In the psychomedical literature there are two early case reports of bisexual identity in gender-variant persons (Stoller and Newman 1971; W. L. 1956). The former is in a professional journal and concerns transsexuals, the latter is a chapter in a pseudo-scientific popular press book by D. O. Cauldwell and concerns a transvestite. The first real data on bisexuality in transsexuals, however, came not from a clinician but from an anthropologist. Bolin (1988) studied a group of male-to-female transsexuals in the Midwest:

Of Bolin’s seventeen subjects who provided data on sexual orientation, one reported being exclusively heterosexual, one reported being heterosexual by preference but open to bisexuality, one was bisexual but preferred males, six were bisexual, six were exclusively lesbian, one reported a lesbian preference but was open to bisexuality, and one did not know her preference. Sexual preferences were reported according to the subjects’ roles as women; thus a heterosexual relationship was a relationship with a man. (Denny and Green 1996:93)

Bolin (1988) noted the challenge this diversity of sexual orientation placed on clinicians:

The assumption behind the conception of transsexual heterosexuality is that if one wants to be a woman then the only appropriate sexual object choice is male.
One vignette of a caretaker-client interaction is illuminating in this respect. Tanya, a preoperative transsexual, saw a psychiatrist as part of an agency employment requirement. Because in this situation the psychiatrist was not going to conduct her psychological evaluation, Tanya, a bisexual, discussed a recent lesbian encounter and her openness to a lesbian relationship postoperatively. The psychiatrist was incredulous. He asked, “Why do you want to go through all the pain of surgery if you are going to be with a female lover?” (p. 62)

Weinberg, Williams, and Pryor (1994) described eleven male-to-female transsexuals, eight of whom identified as bisexual:

Most of the transsexuals . . . still defined themselves as “bisexual” (eight of the eleven). They did not necessarily behave “bisexually” though, as only three of these eight reported having had sex with both male and female partners in the last year. And all of these three worked as prostitutes. Of the remaining eight transsexuals, five had only male partners in the last twelve months and three had only female partners. Overall, more of the transsexuals reported a decrease in the number of sexual partners they had compared to five years ago. Seven of the eleven reported fewer male partners than five years ago, one more, and three the same. Six of the eleven reported fewer female partners than five years ago, three more, and two the same. About half of them had had no partners at all in the last year. (p. 235)

Devor (1993b) published data on the sexual orientation and identities of forty-five FTM transsexuals: “While all but one of the participants in Devor’s study reported having been attracted to women, more than half of them were also attracted to men at various times in their lives. Devor reported a 275 percent increase in the number of post-transition participants who began to find themselves sexually attracted to men” (Denny and Green 1996:94). Devor found that the sexual attractions of FTMs to other men often did not develop until years after their transitions (see also Devor 1997).

Blanchard (1980b) believed bisexual individuals with gender dysphoria to be basically heterosexual. Blanchard has written:

The comments of previous clinical observers suggest that markedly bisexual gender dysphories are basically heterosexual; that their "homosexual" interests are qualitatively different from, and discontinuous with those of preferential homosexuals, and that this homosexual behavior is in fact much more closely related to fetishistic cross-dressing (Benjamin 1967; Freund 1985; Person and Ovesey 1975b, 1986). Benjamin (1967), for example, found gender-dysphoric transvestites to be "bisexual but generally on a low psychosexual level—they are heterosexual in
their male role, but can temporarily respond homosexually when they are [cross-dressed] (p. 109). (p. 321)

Person and Ovesey (1978), who, like Benjamin, regarded the basic sexual orientation of transvestites as heterosexual, also remarked that some of their transvestite patients on occasion enjoyed homosexual practices, but only when dressed as women. They pointed out that such interactions ... are regarded by the transvestite as heterosexual acts in which he is the “woman.” Person and Ovesey concluded that “although the sexual practices may occasionally be anatomicallly homosexual, neither the conscious or unconscious memory appears to be homosexual” (p. 318). Blanchard’s theory of autogynephilia extends this same unproven assumption of basic heterosexuality to male-to-female transsexualism; according to the theory, sexual arousal at the image of themselves as being female or having female body parts fuels the gender dysphoria of MTF transsexuals who are primarily attracted to women (Blanchard 1989a).

TRANSGENDER SEXUAL ORIENTATION TODAY

In the 1990s a richer and more complex view of transgender sexuality began to emerge. As the transgender community came to embrace its diversity and move beyond the stigmatizing terms and identities bestowed by medical professionals, gender-variant people gave new interpretations to their experiences and coined new terms to describe themselves. One such term was transgender, a word that evolved from transgenderist, which was coined by Prince in the 1970s to refer to someone who, like herself, lived full-time in the non-natal gender role without surgical modification of the genitals. By 1991, transgender was being used as an umbrella term to refer to all gender-variant people (Boswell 1991); by 1993 or 1994, it could be found in mainstream publications. It has now largely replaced the terms crossdresser, transvestite, and transsexual.

Of course those identities still exist (and some transsexuals don’t consider themselves in any sense transgendered), but gender-variant persons now find themselves free to move beyond labels and take on individual or even idiosyncratic gendered presentations and identities (Bolin 1994). In 1994 Jan Roberts and I surveyed 340 transgendered men and women about the Standards of Care of the Harry Benjamin International Gender Dysphoria Association, Inc. (Denny and Roberts 1997). By including an “other” category in the demographic question about self-identity, we obtained a total of 44 different self-identities, ranging from the traditional transsexual and crossdresser to identities such as metamorph, man wanting to live with breasts, crossdresser/sissy, and confirmed correct gender.
With the freedom to choose among manifold gender identities, create new identities, or eschew labels altogether, transgendered and transsexual people have begun to view their sexual orientation in more complex ways. Some heterosexual crossdressers, for example, consider themselves male lesbians—a term fraught with political implications for feminists. Levels of homophobia and denial of sexual attraction to the non-natal sex, once endemic in the crossdressing community, have decreased greatly, but still exist in some support organizations in the form of exclusionary membership policies (no gays, no transsexuals), even while many of the members engage in same-sex sexual play with one another. Similarly, some individuals who might have earlier identified as transsexual now consider themselves a third sex or as a member of both sexes or as having an essential transgender nature: "Applied to sexuality, one transgendered individual stated to me: 'My sexuality is a transgender sexuality, different from both male and female sexuality.' . . . This illustrates the contribution of social construction to one's identity and sexuality" (Bockting 1997:51).

It is commonly said in the transgender community that one must figure out who one is before one can figure out one's sexual orientation. This is certainly true, but this aphorism refers to the label rather than the individual's sexual attractions. Most transgendered and transsexual persons are not, as some have claimed, "gender confused" (Smith 2002). We know exactly who we are, and many of us are well aware of and comfortable with our sexual attractions. From our vantage point, it seems that the confusion lies in a society that cannot deal with gender variance—not us.

Still, transgendered people have much to sort out with regard to sexuality. This is especially true for transsexuals, as transitioning one's gender role calls sexual orientation into question in the most fundamental ways:

Any discussion of transsexual sexuality is bound to be very confusing and, we would argue, ultimately very instructive about the nature of sexuality in general, and especially of bisexuality. Should homosexuality be considered in relation to the individual's natal sex, or their new role? Is a transsexual woman who is still fulfilling the role of husband in a marriage in a lesbian relationship? Certainly, it does not seem so to the world, which sees a heterosexual relationship. And yet five years later, when the individual has transitioned into the woman's role, the same couple, if publicly affectionate, will be perceived as lesbian. What of a post-transition nonoperative transsexual woman in a sexual relationship with a male? The public sees a heterosexual couple, and yet, in the bedroom, their genitals match. Should their sexual act be considered heterosexual or homosexual? Does it matter if the feminized partner does or does not take the active role in intercourse? And what if the same individual then has surgery and finds a female partner? Is this relationship homosexual or heterosexual? Finally, what if a nonoperative transsexual man has as a partner a post-operative transsexual man? Is this a
gay relationship? A straight one? Are any of these people bisexual? And most significantly, can the term bisexuality have any meaning at all when gender is deconstructed? (Denny and Green 1996:88–89)

Martin-Damon (1995) makes this poignantly personal:

If asked, I say I am bisexual. If I were to say I am gay or straight, it would in some sense be a lie, even if I choose to identify either way for the rest of my life. Similarly, I am both genders and neither. As one FTM said... “I never knew what it was like to be a woman, even though I gave birth to six children. But I also don’t know what it’s like to be a man.” (Quoted in Alexander and Yescavage 2004:247–248)

Today, at the midpoint of the first decade of the twenty-first century, transgender sexuality is complex and fluid—and understudied. Gender-variant people are free to choose from a variety of gender identities and many are exploring not only their sexual attractions, but other aspects of their sexuality, including fetishism, BDSM, and other varieties of eroticism.

ISSUES FOR THE THERAPIST

Transgendered and transsexual persons seek therapy for any number of reasons that might also bring nontransgendered individuals to the therapist—grief, loss of job, substance abuse, depression, problems with their relationships, or any of the hundreds of psychiatric disorders listed in the DSM—but common reasons for entering therapy are to sort out and find help for their feelings of gender dysphoria, or to deal with problems caused by acting on those feelings, or to get help with relationship problems caused by their transgender feelings or behavior. They may be natal males or natal females, young or old, black, white, or Asian, married or single, rich or impoverished, fat or thin, transitioned or non-transitioned, passable or nonpassable, attracted to males or to females or to both or to neither. Moreover, they will vary in the ways in which they define themselves and in just what they wish to accomplish. Some will embrace their transgender feelings and some will fight them. Some will come into therapy with clear ideas about what they want to do with their bodies and their lives and some will be undecided or ambivalent. Some will be well-informed about their life options, others uninformed. Some may want help with transition, some may want support for their decision to remain in their natal gender. Some may be racked with religious or other guilt, some will be free from shame.

There is a particularly practical reason for transsexuals to consult a therapist: access to medical treatment, particularly to hormonal therapy and genital sex reassignment surgery, requires letters of authorization from one (in the case of
hormones) or two (in the case of genital surgery) mental health professionals. These requirements are built into the Standards of Care of the Harry Benjamin International Gender Dysphoria Association, Inc.

While I am convinced the HBIGDA standards safeguard transsexuals by preventing them from making hasty decisions they might later regret (there is, sadly, after twenty-five years of the Standards still no data to substantiate this), they present a considerable obstacle for the therapy process. The required and often desperately desired authorization letters are the proverbial elephant in the living room. The power imbalance set up by the standards can and has led to game playing by both therapists and transsexuals (cf. Stone 1991). In those instances in which authorization letters are at issue, it’s critical that both the client and the therapist have clear expectations and are in agreement on any requirements for obtaining them. This agreement should be in writing and should be negotiated early in the therapy process.

There is considerable literature by clinicians directed at other clinicians who work with transgendered persons. Much of the earlier literature is colored by assumptions about transgender lifestyles and personality characteristics that history has shown to be unverified—and, occasionally, by what seems to be the personal distaste of the authors (for instance Laub and Fisk 1974, who began their paper with the statement “To change a person’s God-given anatomic sex is a repugnant concept”). More recently, new literature has emerged that focuses on helping the individual explore his or her life options rather than on gatekeeping (cf. Anderson 1998; Brown and Rounsley 1996; Cole et al. 2000; Israel and Tarver 1998; and Lev 2004; all are, in my opinion, excellent resources for therapists with transgendered and transsexual clients).

Even the most mentally healthy and well-adjusted transgendered and transsexual persons will be challenged by their condition. In the past the literature has tended to view their psychological reactions to their guilt and fear, their responses to discrimination, persecution, violence, or various losses they endure as the result of coming out or of being discovered as symptoms of their gender dysphoria (cf. Levine and Lothstein 1981). Current thinking is that these stressors, and not the inherent nature of gender dysphoria, is responsible for much and probably most of the psychopathology that has been ascribed to transsexual and other transgendered persons (Califia 1997; Wilchins 1997).

Transsexuals who decide to transition are faced with great personal loss as well as social and economic obstacles. They risk rejection by family members, friends, acquaintances, churches, schools, and governmental agencies; they may lose their jobs and be unable, because of discrimination or the poor job market, to find another; they may be ridiculed, harassed, or persecuted in public; they are at risk for violence; and they will have substantial bills related to transition (therapy, electrolysis, hormones, surgery, and new wardrobe). They may have expenses due to life changes like divorce, loss of minor children with
a resulting requirement to pay child support, loss of residence, retraining after loss of employment, or relocation to a new geographic area.

On top of all this, it is necessary for transsexuals in transition to examine their sexual attractions in light of their new gender role. It's only human nature to seek to put a name to things, and many clients will want to do just that in regard to their sexuality. In the new role, will they be homosexual, bisexual, heterosexual, or asexual? The therapist can help them explore and put a name to their sexual attractions.

It should be noted that transgendered clients will be inclined to name their sexual attractions based on their gender identity (and, in the case of transsexuals, new physical characteristics) rather than on their natal sex. There is a history in psychological and medical literature of using natal sex as an anchor, but most transgendered persons consider this offensive and insulting (Cromwell, Green, and Denny 2001). Therapists should be careful to consider the wishes of their clients and use respectful language in their interactions with them. This means using pronouns that are geared to their gender of presentation and identity rather than their biology and the terms homosexual and heterosexual in relation to their gender identity rather than their sex at birth. Thus a relationship of a female-to-male transsexual and a natal male is homosexual in nature, and a relationship between a male-to-female transsexual and a natal male is heterosexual.

Many transsexuals will find they are developing new attractions. For instance, formerly heterosexual males, after transition, often find themselves increasingly attracted to males (and thus once again heterosexual). Samons (2001) found that sixteen of ninety-seven of her male-to-female clients changed their sexual orientation in this direction in the course of therapy. Conversely, many post-transition FTM transsexuals find themselves attracted to men for the first time (Devor 1993b). Clearly, the social dynamics, physical interactions, public reaction to, and change in self-image inherent in such a newly arisen (or, in some cases, newly self-permitted) sexual attraction are issues that can be explored in therapy.

Even when sexual attractions don't change, there will be new stressors. For example, a natal male with a lifelong attraction to females may find herself, after transition, in a relationship that is, to the public eye, lesbian. The rules for public displays of affection, the reactions of strangers, even the language used in reference to the relationship will be new and challenging—and not only to the transsexual; the partner may find herself equally challenged. A relationship that is suddenly publicly lesbian may lead to the loss of acquaintances and alliances and the formation of new friendships and social activities. Moreover, even in lesbian circles the relationship and the individuals in that relationship may be suspect and the couple may find themselves shunned or excluded as not “real” lesbians. A formerly heterosexual relationship that is socially redefined because of one partner's decision to transition from female to male faces similar
hurdles; so also do relationships in which the male partner is a crossdresser. Cole (1998) has described some of the challenges faced by female partners in such relationships.

Minor children will also be affected, especially when the transsexual is the custodial parent. Children may, for the first time, find themselves with parents who are in a socially homosexual relationship—or vice versa; children who have been in a gay male or lesbian household may find themselves with parents who are seemingly heterosexual. Children may be additionally stressed by the nontranssexual parent, who may be rejecting and scornful of the transsexual parent.

When the transgendered person chooses not to transition, there will be other issues. Many transsexuals, and even many crossdressers who choose to remain in the natal gender role, don't do so because it's their heart's desire. Often there is great stress and distress in fighting their wish to transition, and they require ongoing support to remain in their original gender role. Just as with transsexuals who transition, the therapist can be of great value in helping the nontransitioning individual live with the consequences of his or her decision not to transition. Some may attempt to deny their gender dysphoria; this can lead them to substance abuse, depression, sexual acting out, or risk-taking behaviors. It goes without saying that while the therapist can help the transgender client work through these issues, he or she should not try to direct or force a specific outcome.

Many nontranssexual transgendered persons find that their transgender identity or crossdressing opens the door to new sexual attractions and behaviors. Perhaps, as Kinsey and colleagues (Kinsey, Pomeroy, and Martin 1948; Kinsey et al. 1953) as well as others have argued, all human beings have a bisexual potential and crossdressing lowers inhibitions that are ordinarily firmly in place. Perhaps, as Blanchard (1986b) believes, this bisexual behavior is a manifestation of a paraphilia in male heterosexuals. Or perhaps, as Pauly (1974) has suggested, some people prefer or are attracted to relationships that can be described as heterogenderal (one of each), feeling equally comfortable as either the male or female in such relationships. This is an intriguing question, one with practical consequences for both those who do and don't transition.

Whatever their reasons, many natal male transgendered persons give themselves license, when crossdressed, to engage in sexual behavior they otherwise would not and do not engage in. This includes not only male-to-female transsexuals who are exploring their femininity, but transgenderists and crossdressers. Often, this behavior includes flirtation with and sexual experimentation with other males. For instance, it's common in the transgender community for crossdressers to play the role of the male in escorting crossdressers who are attired as female. This sometimes culminates in oral or anal sex which is rationalized as heterosexual or (if both participants are crossdressed) lesbian.

Paradoxically, many natal male transgendered and transsexual persons don't view their sexual behavior with other males as homosexual. This is because they
view themselves as a woman in the context of that relationship. Often, this rationalization leads to unsafe sex practices and risk of venereal disease and HIV.

How common is this? A mid-nineties survey by the Ohio open transgender support group CrossPort of its members resulted in the selection of the sexual orientation "heterosexual except when crossdressed" over heterosexual, homosexual, and bisexual options.

In the context of a life that is otherwise heterosexual and monogamous, the danger posed to marriage and the health of the female partner by such sexual experimentation is apparent. Indeed, crossdressing organizations that stress the heterosexuality of their members do the wives of those members a disservice by disguising and denying the deep-seated feelings of gender dysphoria and sexual experimentation of a significant number of their members (Denny 1996). Not surprisingly, wives are rarely fooled by this posturing (see Boyd 2003 for a cogent analysis by a female partner of a crossdresser).

Certainly, when transgendered or transsexual clients are in denial about the essential male-to-male nature of such sexual encounters, and particularly when they place themselves and their spouses at risk of HIV or other sexually transmitted diseases, the therapist should help them to understand that the risks they face are the same as those faced by gay men. Analogously, FTM transsexuals who, after a lifetime of partnering exclusively with women, find themselves increasingly attracted to men may be in denial about the health risks they face in sexual experimentation with men.

Even when transsexuals are settled into and comfortable with their post-transition sexual orientation, their transsexualism continues to play a role in defining their relationship. Even when the individual in question passes well and has anatomy that is consistent with their gender role, there is a tension around both their homosexual and heterosexual relationships. This tension stems from the problems with defining their attractions and behavior using the usual terms of sexual orientation. Can their relationships accurately be defined as heterosexual or homosexual, or are they something else entirely? I don't presume to know the answer to this; I only know that the tension exists.

When a transsexual is in "stealth mode" there is a constant risk of exposure—and exposure can result in reinterpretation of their relationship by both partner and society. This can lead not only to rejection by their partners and others, but to violence and even murder. The "transsexual panic" defense is frequently used as an argument to justify violence toward transgendered persons (see Wilchins et al. 1997 and the "Remembering our Dead" Web site: http://www.gender.org/remember for statistics on violence toward gender-variant persons.)

Many transsexuals consider themselves heterosexual after transition. Others identify as gay men or lesbians, a phenomenon called transhomosexuality by
Clare and Tully (1989). A considerable number identify as bisexual; of the terms of sexual orientation, this poses less of a conceptual dilemma than do homosexuality or heterosexuality. Thus a social identity as bisexual can be a healthy one for both crossdressers and transsexuals. If an individual identifies as bisexual, that removes the tension as to whether their relationships are gay or straight. This is the case also with asexuality—indeed, a significant percentage of transgenders and transsexuals are, whether by choice or chance, asexual.

Increasingly, transgendered and transsexual people are partnering with one another. Such relationships place extreme challenges on the language of sexual orientation (and sometimes on therapists). Newman and Stoller (1974) cynically wrote of one such relationship, in which a candidate for male-to-female sex reassignment married a post-op MTF, “One hesitates to predict the next act” (p. 439).

Scholars and transgendered persons themselves are only beginning to talk about the complexities of sexual orientation when gender variance is factored in. It is clear at this early stage, however, that unless they are moored to sex or gender, the terms of sexual orientation—heterosexuality, homosexuality, and bisexuality—lose their meaning (Denny and Green 1996). For this reason, we need to create new terms or expand the existing terms to adequately describe the relationships and attractions to be inclusive of individuals with nontraditional gender identities, gendered presentations, or bodies that do not conform to the male/female dichotomy.

More than that, we must ask ourselves if the challenge raised by transgendered and transsexual people renders the entire vocabulary of sexual orientation moot.

NOTES

1. The focus of Prince’s outreach was to proclaim her own heterosexuality (again, basing the notion of “opposite” on her sex of male assignment at birth) and the heterosexuality of male crossdressers in general. The organizations she founded continue to belabor this point and have met with some success, as demonstrated by the fact that today few people are dumbfounded or disbelieving when a man in a dress tells them he is attracted to women. This was assuredly not the case in the 1950s when Prince started her work.

2. In some instances I have used the term sexual attraction; I would ordinarily write sexual orientation. This is because the terms of sexual orientation become muddy when applied to transgendered persons and especially to those who transition gender roles.

3. HBIGDA is the principle organization for professionals who work with transsexual and other transgendered people. Their Standards of Care (see http://www.hbigda.org) are consensual minimal guidelines for the provision of hormonal and surgical treatment.
REFERENCES


Maricarmen