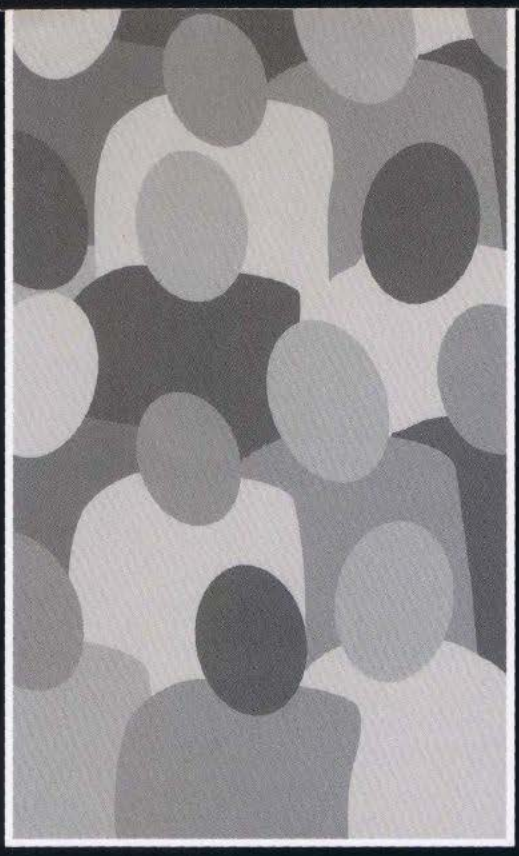

Beth A. Firestein
Editor

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Contents

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Gender Identity and Bisexuality

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If bisexuality marks the intersection between homosexuality and heterosexuality, then transgender identity can be seen as either the virtual melting pot of biological and social distinctions or as the final arbiter of the interaction between an individual's self-concept and the object of her or his sexual desire. What we are talking about here is the confusion of sex and gender and the role of anatomy in determining sex, gender, and sexual orientation.

Intersexed and transsexual people make for convenient focal points in social, political, and scientific debates about such issues. Transsexualism, in particular, has been used to justify myriad positions. Some assert that transsexuals do not break down gender stereotypes but only reinforce them (Raymond, 1979, 1994), whereas others point out that "the transsexual currently occupies a position which is nowhere, which is outside the binary oppositions of gendered discourse" (Stone, 1991, p. 295). There are some who believe that in actuality, "there are no transsexuals; we are all transsexuals" (Halberstam, 1994, p. 226).

The confluence of sex and gender is a confusing area of the mind and body, made all the more challenging by virtue of finding ourselves in a society that has barely cracked open the door leading to our ability to discuss these topics. What is sex? And what is gender? What is gender identity? And what does all this mean for the concept of bisexuality?

Vignettes

The following vignettes are composites, pastiches of the lives of the authors and the lives of others.

Michael started his life in a female body. He grew up as a girl named Deborah, and he was never attracted to women. Even though he had (then) heterosexual relationships with men at the time, he always felt something was wrong, that he was really more male than female. Deborah married a man and gave birth to a child, and still the feelings of male gender identity did not abate. Eventually, Deborah divorced and, after a long process of self-examination, went through hormonal and surgical sex reassignment. Deborah fully expected that as Michael, (s)he would continue to be attracted to men and would assume a homosexual identity. However, after several years of living as a man, Michael was surprised to realize that he was not attracted to gay men. Instead, he was attracted primarily to heterosexual women and occasionally to men. He now identifies as a bisexual man.

Charlene was pronounced a boy at birth and given the name Charles. Until she was five, she thought she was a girl. Eventually, she realized that her body was male and resented that fact very much. Although most of her sexual relationships as an adolescent and young adult were with women, Charlene had a number of casual encounters with men, always while cross-dressed. Yet whenever she would have sex with a man, she would feel dissatisfied because her partner would treat her like another man instead of the woman she knew she really was. When she made love to a woman, she felt she was using her partner to learn about female behavior; she wanted not only to love her female partners but to be them, and she wanted to be a woman when she had sex with men. Charlene's desire to be a woman culminated in hormonal and surgical sex reassignment at age 34, after which she dated men exclusively for several years. One night she wound up in bed with a close female friend. Their relationship lasted several years, after which she began dating both men and women. Today, she considers herself to be bisexual.

Definitions

For purposes of clarity, we must begin by defining some terms. Every human being has biological sex, gender, gender identity, gender role, and sexual orientation. The meanings of these common terms are shown in Table 3.1. A number of terms refer particularly to people who experience gender differently from the way that it is commonly

Table 3.1 Common Sex- and Gender-Related Terms and Definitions

Term	*Definition*
Biological sex	An individual's chromosomal makeup, external and internal genitalia, hormonal state, and gonads.
Gender	A social construct which is independent of biological sex: one is male or female because of one's biological sex, but one is a boy or girl, man or woman because of one's gender identity or gender role.
Gender identity	One's sense of self as a boy or girl, woman or man (or, as we are increasingly realizing, as a nongendered, bigendered, transgendered, intersexed, or otherwise alternatively gendered person).
Gender role	A set of expectations that one will look, dress, and behave as a man or woman.
Sexual orientation	Refers to the object(s) of an individual's sexual desire.

experienced. These terms include intersexuality, transgenderist, transvestite, transsexual, and related concepts.

Intersexuality occurs when an individual is born with physical evidence of sexual ambiguity or duality, such as a micropenis, androgen insensitivity (which results in an XY [chromosomally male] child with a vagina who is assigned as a female), enlarged clitoris, hypospadias (congenital urinary condition in males), and/or ovotestes. Intersexed people often receive surgical intervention to assign—or reassign—their sex while they are still infants; often, this intervention is problematic physically or psychically, for the treated individual (Alvarado, 1994; Fausto-Sterling, 1993).

A *transgenderist* identifies with both the male and female roles or as a member of an alternative sex. Many transgenderists live full-time as members of the nonnatal sex but with no desire for genital modification (as distinct from a transsexual individual who makes a decision not to pursue surgery because it is imperfect, disfiguring, or costly). Transgenderists do sometimes modify their bodies with hormones, electrolysis, or plastic surgery.

A *transvestite* is an individual, usually a male, who cross-dresses for personal reasons. Women's fashion permits cross-dressing by women to go unnoticed; it thus escapes being labeled as a clinical pathology. The organized community of cross-dressers prefers the term *cross-dresser* to transvestite; consequently, a cross-dresser is defined as a man who wears women's clothing or a woman who wears

men's clothing for one or more of a number of private reasons. The individual may or may not find the clothing or the wearing of it erotic.

Transsexual people are those who have a long-standing desire to live as the opposite sex of their "normal" genitalia and who wish to have the primary and secondary sex characteristics of the other sex. Transsexual people usually—but don't always—seek medical intervention as adults to reassign or realign their sex to match their psyche. A transsexual woman is a biological male who has a long-standing desire to live as a woman, and a transsexual man (also called a "female-to-male," or "FTM") is a biological female who has a long-standing desire to live as a man. We use these terms regardless of whether the individual has actually transitioned into the other gender role. We realize that the terms *male transsexual* and *female transsexual* have been widely used in the clinical literature to refer respectively to biological males and females with transsexualism, but this terminology is offensive to many transsexual people (including us) and, we believe, fundamentally disrespectful. We do not use the word transsexual in isolation, for transsexualism is but one aspect of a human being with the condition called transsexualism; instead, we use the terms *transsexual person, transsexual people,* or *a person with transsexualism.*

Sex reassignment refers to the complex process of therapy, electrolysis (for transsexual women), hormonal therapy, social reorientation, and (if desired) surgery that allows an individual to live as a member of the nonnatal gender (R. Green & Money, 1969). Transsexual men and women can be postoperative or preoperative, depending on whether or not they have had surgery to modify their genitals. Nonoperative transsexual people have made a conscious choice not to have genital surgical procedures but nonetheless identify totally as a member of the new gender (Schaefer & Wheeler, 1983). Many transsexual people hope to discover that they are, in fact, intersexed so that there will be a concrete, medically accepted reason for their "gender dysphoria" and so that insurance companies might consider their necessary surgeries "corrective" rather than "elective," "cosmetic," or "experimental."

Transition begins when the transsexual individual prepares to live full-time in the new gender role and usually ends after genital reconstruction or when the individual senses that the transition has ended and is no longer concerned about it. Transition is characterized by profound physical changes and tremendous social stress, amplified by the constant effort that must be applied to finding one's place in the world, and an acute awareness of how "fitting in" is distinguished from "difference" in every social encounter. The individual in transition

often experiences both euphoria and depression: the first arising from the actualization of a long-standing desire, the second rooted in the often debilitating consequences of that action. Depression may set in because of the length of time the transition takes to accomplish or the failure of the transition process to achieve the desired goal, such as when the effect of hormones is insubstantial, too extreme, or adverse (requiring cessation), or when surgical procedures go awry. Challenges arise during transition with relation to one's family, in the workplace, among friends, with social institutions (identification, school transcripts, military records, licenses, etc.), between sexual partners or in dating, and with the expense or scheduling of medical procedures. These difficulties can also contribute to depression.

Transition ends gradually, with the individual's recognition that he or she feels at ease with himself or herself and feels fully integrated into society, whether or not he or she continues to identify as transsexual in private, in public, or both.

Gender identity disorder or *gender dysphoria* are the terms used in the clinical literature to describe the constellation of attitudinal and behavioral indicators commonly manifested by those who wish to change their bodies and social role—but this use is unfortunate, for it needlessly pathologizes a set of behaviors that has manifested in all cultures throughout history and appears to be natural for a certain percentage of human beings. However, when an individual is in extreme distress because of having transgender feelings, he or she can appropriately be said to be experiencing gender dysphoria. The term *transgender* is commonly used to describe the global community of cross-dressing and transsexual persons.

Transsexualism and Bisexuality

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 bisexuality. Should homosexuality be considered in relation to the individual's natal sex or in relation to 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. Yet 5 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 posttransition nonoperative transsexual woman in a sexual relationship with a male? The public sees a heterosexual couple, 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 postoperative 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?

Transsexual persons must make some sense of their self-identity as members of the other sex and of their sexuality in a world largely ruled by traditional gender beliefs (Garfinkel, 1967). The experience of feeling or being perceived as "transgendered"—that is, being someone who crosses or blurs gender boundaries—is different for someone who chooses to cultivate such a persona from time to time than it is for someone whose gender identity persistently does not match his or her body. Transsexual men are often perceived by others as transgendered, masculine, or lesbian women prior to transition and as feminine men, gay men, or simply as men afterward. Transsexual women are often perceived as men, gay men, or feminine men prior to transition and as women, transvestites, transsexual women, or masculine women afterward.

The feeling of being transgendered comes from the knowledge that one's body and mind (psyche) are not in accord or that one has adopted a manner of coping with the dominant two-gender-only system by moving across the line to a position of discord between mind and body that others might perceive as a false premise—that the individual is, in fact, more comfortable outside the stereotypical definitions of gender. When a person comes into a sexual relationship from such a position, the words defining sexual behavior may be less important than the self-definition of the individuals involved.

Although clearly their primary issue is one of gender identity and not of sexuality, transsexual persons, like all humans, are sexual beings and must deal with their sexuality before, during, and after their transition. An orientation that is viewed as homosexual at one point in their lives may be seen as heterosexual at another point and vice versa.

Garfinkel (1967) noted that there are a number of beliefs that people traditionally hold about gender (see Table 3.2 for a list of these beliefs). The existence of transsexualism challenges all eight of these beliefs. Transsexual people defy categorization into either one of the two gender roles and so cast doubt on the belief that there are only two genders. Most infuriatingly, they traverse between roles, seriously challenging the view that biology is destiny. Consequently, many

Table 3.2 "Natural" Attitudes Toward Gender

1. There are two and only two genders (female and male).
2. One's gender is invariant. (If you are female/male, you always were female/male and you always will be female/male.)
3. Genitals are the essential sign of gender. (A female is a person with a vagina; a male is a person with a penis.)
4. Any exceptions to two genders are not to be taken seriously. (They must be jokes, pathology, etc.)
5. There are no transfers from one gender to another except ceremonial ones (masquerades).
6. Everyone must be classified as a member of one gender or another. (There are no cases where gender is not attributed.)
7. The male-female dichotomy is a "natural" one. (Males and females exist independently of scientists' [or anyone else's] criteria for being male or female.)
8. Membership in one gender or another is "natural." (Being female or male is not dependent on anyone's deciding what you are.)

SOURCE: Reproduced from *Gender: An Ethnomethodological Approach* (pp. 113-114), by S. J. Kessler and W. McKenna (1978). Copyright © 1978 by John Wiley. Reprinted with permission. Based on original material in *Studies in Enthnomethodology* (pp. 122-128) by H. Garfinkel (1967).

people find transsexualism (and transsexual people) threatening and react to them with hostility and scorn.

Those who subscribe to Garfinkel's traditional belief system would describe a relationship between a biological male and a postoperative transsexual woman as homosexual (and would no doubt be very confused by the idea of a postoperative transsexual man with a nontranssexual man). Others, less bound to these "rules," would describe the first relationship as heterosexual and the second as homosexual. Many clinical settings are based on some of these traditional beliefs, with the result that transsexual people are forever categorized by their natal genitalia so that all their sexual behavior is classified by this "fixed" reference point, as if to delegitimize the person's identity as well as any reconstruction that might occur.

For transsexual people at least and perhaps for everyone, it may make more sense to describe relationships as homogenderal or heterogenderal (Pauly, 1973). That is, gender, rather than sex, is the critical component in defining their sexual behavior. A relationship between a biological female and a transsexual woman is homogenderal, regardless of whether the transsexual woman has had or plans to have genital surgery. Similarly, a relationship between a posttransition transsexual

woman and a posttransition transsexual man is heterogenderal, regardless of their respective surgical states (i.e., there is a man and a woman, even if they are such by choice and not by biology) (Pauly, 1973).

If all this seems confusing, it is because it indeed is. Our long-established notions and vocabulary of sexuality and gender are no longer sufficient, and a new system is not yet fully *in* place, although "work is in progress."

Review of the Literature on Transsexualism and Bisexuality

Much of the transgender literature is highly clinical in nature, what one of us has called elsewhere "a collection of papers by clinicians explaining to other clinicians how to deal with such troublesome people" (Denny, 1993). Unfortunately, historical, sociological, and anthropological analyses of transsexualism that accord transgender behavior a respected position within cultures tend to be overlooked or dismissed by clinicians, who have assembled a literature that is naive and full of superficiality (Bolin, 1988; Denny, 1992, 1993, 1994; Stone, 1991). For example, in a review of Ann Bolin's (1988) *In Search of Eve,* Mate-Kole (1992) wrote that Bolin's book "may offer greater assistance to the student or avid reader in sociology/anthropology than to the clinician or psychology/psychiatry student" (pp. 209-210). This is an extremely shortsighted view, for *In Search of Eve* offers a cogent analysis of the interactions between transsexual people and their "caregivers." Bolin (1988), like Kessler and McKenna (1978), points out that the expectations and treatment goals of transsexual people who desire hormonal and surgical treatment are often in conflict with therapists, who see themselves as "gatekeepers," the ultimate arbiters of who will and will not be allowed access to body-changing medical technologies.

One of the truisms of this literature is that transsexual people must necessarily be attracted only to those of the same natal sex. With a few exceptions (cf. Bentler, 1976), the clinical literature has only within the past 10 years started to reflect what transsexual people have always known—that many are bisexual or attracted to members of their new gender (Bockting, 1987; Bockting & Coleman, 1992; Coleman & Bockting, 1988, 1989; Coleman, Bockting, & Gooren, 1993; Pauly, 1989a, 1989b, 1989c, 1990, 1992a, 1992b). Some clinicians still don't "get it." As recently as 1994, Fagan, Schmidt, and Wise (1994) of the Sexual Behaviors Consultation Unit at Johns Hopkins University

stated their conviction in a letter in *The New Yorker* that female-to-male transsexual people are "fundamentally homophilic but cannot consciously accept their sexual orientation" (p. 15). This is both manifestly untrue and incredibly disrespectful of the ways in which transsexual people choose to live and love.

Objections to transsexualism are almost invariably made on ideological grounds and tend to be based on unverifiable assumptions. Stoller (1969), who worked in the field from the 1960s until his untimely death in 1991, has noted that the most vocal opponents of sex reassignment know the least about transsexual people.[2] Clinicians lacking knowledge of transsexual people continue to contribute to the literature. In a letter written to another professional in the summer of 1994, psychiatrist Paul McHugh expressed incredulity that a transsexual woman could be attracted to other women (McHugh, personal communication, April 29, 1994). McHugh (1992) has admitted that he took a position at Johns Hopkins University to shut down their gender identity clinic, a task he accomplished in 1979, to the detriment of many transsexual people and to the study of gender identity issues in general.[3]

Despite the heterosexist and clinical bias in much of the literature (cf. Denny, 1994), the balance of the literature and our respective personal experiences suggest that there is a great deal of bisexuality among transsexual persons. In his 1966 textbook, Harry Benjamin discussed bisexuality in transsexualism. Benjamin (1966) took it for granted that all transsexual women would be sexually attracted to males, and all men would be sexually attracted to females. He noted that before transition, many transsexual people function in marriages and long-term relationships with the other biological sex, but he never seemed to consider that after transition the individual might wish to continue a relationship that would now be considered "homogenderal."

Other clinicians also assumed that transsexual persons would, after transition, inevitably wind up in heterogenderal relationships. Barr, Raphael, and Hennessey (1974) were surprised to find two male applicants for sex reassignment who stated that they were not erotically attracted to men. Unfortunately, their observation was largely ignored.

Following the opening of the Gender Identity Clinic at Johns Hopkins University in 1967, applicants for sex reassignment were rigidly screened. Sex reassignment was considered at Hopkins and other centers to be highly experimental, and access to feminizing and masculinizing medical procedures was restricted to those who best fit the often stereotyped and sexist notions of what transsexual people were like (Denny, 1992). Kessler and McKenna (1978) noted the following:

> A clinician during a panel session on transsexualism at the 1974 meeting of the American Psychological Association said that he was more convinced of the femaleness of a male-to-female transsexual if she was particularly beautiful and was capable of evoking in him those feelings that beautiful women generally do. Another clinician told us that he uses his own sexual interest as a criterion for deciding whether a transsexual is really the gender she/he claims. (p. 118)

Present-day clinicians have begun to incorporate the notion of bisexuality into their work with transsexual people. Coleman and Bockting (Bockting, 1987; Bockting & Coleman, 1993; Coleman & Bockting, 1988, 1989, 1993) have taken a lead, doing much needed descriptive studies. Blanchard (cf. Blanchard, 1989, 1990a, 1990b), Clare (1984, 1991), Clare and Tully (1989), and Money and Lamacz (1984) have taken typological approaches, inventing complicated terms such as *autogynephilia* and *transhomosexuality* to refer to the sexual desires of transsexual people. But the most exciting findings have come from field studies. Bolin, an anthropologist, found a high degree of bisexuality in her participant observation study of a small group of male-to-female transsexual persons in the Midwest. Of the 17 participants who provided data on sexual orientation, 1 reported being exclusively heterosexual, 1 reported being heterosexual by preference but open to bisexuality, 1 was bisexual but preferred males, 6 were bisexual, 6 were exclusively lesbian, 1 reported a lesbian preference but was open to bisexuality, and 1 did not know her preference. Sexual preferences were reported according to the participants' roles as women; thus, a heterosexual relationship was a relationship with a man. Bolin (1988) wrote the following:

> 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. . . . 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)

Clearly, those conducting much of the assessment and treatment of transsexual people have not themselves been clear on the difference

between gender identity and sexual orientation. In much of the published research seeking to find correlations between sexual orientation and gender identity, the heterosexual model as "norm" is the starting point. But gender identity in general is not an indicator of sexual object choice.

Recently, Devor (1993), a sociologist with no "gatekeeping" power over her interview participants (that is, she could not influence their access to hormones or surgery), published data on the sexual orientation identities (SOIDs) of 45 transsexual men. Devor's article gives probably the most cogent analysis done to date. This article contains an excellent summary of previous theories and clinical literature. Her study includes one of the largest FTM research samples used to date.

Devor found that these men were reluctant to specify their physical selves as the most important factor in selecting their SOIDs. In other words, there is more to defining one's sexuality than the shape of one's genitals, whether pre- or postoperatively. Although 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% increase in the number of posttransition participants who began to find themselves sexually attracted to gay men:

> The participants who developed an interest in sexual relations with gay men after they themselves had become men tended to be among the furthest into their changes, averaging 10.75 years since beginning their transitions. More significantly, they averaged 7.4 years into their transition before starting to find men sexually attractive. (p. 311)

Devor also writes, "It is important to remember that, for many people, SOID is not stable. SOIDs are, in part, built on a foundation of sex and gender identities. These are not static for most transsexual persons" (p. 306). In other words, sexual orientation identity is not necessarily tied to the formation of one's genitals or indelibly etched into stone after one's first experience of arousal. SOID is composed of a complex amalgam of feelings, beliefs, attractions, repulsions, and drives, and these not only vary between individuals but can also change within individuals over time. Although Devor's study cannot be considered the definitive last word on the formation of gender and sexual orientation identity, it goes a long way toward illuminating this complex subject.

Recognizing that bisexuality does exist among transsexual people makes it easier for clinicians to view their clients diagnosed with

"gender identity disorder" as more than people who are homophobic concerning their primary sexual attraction to people of their natal sex and who may be seeking to "legitimize" that attraction by changing their bodies to achieve a heterosexual effect. However, another distorted view of transsexual people is promulgated in *Dual Attraction* (Weinberg, Williams, & Pryor, 1994). The chapters on transsexual bisexuals are riddled with derogatory language, and the use of quotation marks when referring to orientations and sex organs ("heterosexual," "lesbian," "vaginas," etc.) reveals the authors' lack of awareness as they delegitimize the feelings, desires, and physical realities of transsexual people. The small research sample (10 transsexual women, 1 transsexual man) makes the data highly questionable and far too weak to support the conclusions stated. Most offensive is the following assertion: "Given too that attracting a partner, any partner, presents a problem for the transsexual, adopting a bisexual identity widens the range of potential eligibles" (Weinberg et al., 1994, p. 64). Many transsexual people are secure in their gender identity and do not have difficulty finding partners. At the same time, many transsexual people may find bisexually identified partners attractive because people who are not monogenderal in their affinities may be better able to relate to the experience and perspectives of transgendered people.

Like bisexuals, who challenge the norm of monosexual orientations, the highly varied transgendered, intersexed, and transsexual people who embody the concepts of fluid, changeable, or contraphysical gender identity also break down a rigid binary system that has been used for centuries to control society. Bisexuals are the most likely class of people to understand and easily embrace the concept of gender identity as separate from sexual orientation. But as marginalized groups struggle for mainstream acceptability, there is a temptation to jettison cargo that might impede progress. Transgendered people have long received a cold shoulder from the now mainstream lesbian and gay communities. And not all bisexual people are ready to admit a connection between transgenderal and bisexual issues.

There are still many more questions than there are answers. Recognizing each individual's need to define himself or herself with respect to gender, as well as sexuality, can generate provocative inquiry and may lead us to a deeper understanding of ourselves.

Suggestions for Therapists

The period when the clinician is most likely to encounter the transsexual adult is just prior to and during transition. Many transsexual

people, especially those who have not reached the age of majority, are likely to first seek out therapists for other problems, such as confusion over sexual orientation; lack of self-esteem; inability to perform in school, work, and social situations; depression; substance abuse; or oppression, physical abuse, or both from parents or peers because of perceived gender difference. Furthermore, the more transgendered one appears, the more likely he or she is to be physically or verbally attacked.[4]

When a client presents with issues concerning gender identity that may or may not include questions about the client's understanding of his or her sexual orientation, the therapist's most important task is to assist in clarifying the issues. If this is to occur, the therapist must be able to understand the distinction between sexual orientation and gender identity and to distinguish between biological sex, gender role, gender identity, and sexual orientation. The client's issues may not lie in any of these concerns specifically, but distress can manifest as a disturbance in any of these areas.

Transgendered or transsexual people may present with a variety of masking conditions, such as alcoholism, fetishism, or depression that, when addressed, give way to the underlying gender issue. Therapists must be sensitive to the tremendous fear that the client may have concerning his or her revelation of gender identity issues and his or her reluctance to deal with them in a forthright manner.

It is also possible for an individual to think they are transsexual, when in fact they are not. An individual with bisexual attractions may equate those feelings with confusion or concern about their gender identity. Some people may confuse the attraction dynamic with a desire to *have* the body of the "opposite" sex. It is important to assist clients in distinguishing between sexual fantasies, sexual attractions, and gender identity. Not everyone who fantasizes about having "other" genitalia is transsexual, though some clients might wonder about themselves or even convince themselves that this is the case. Frank discussions about the realities of the transsexual process (i.e., the impact of hormones and surgery) are necessary to ensure that clients are able to make informed decisions concerning body alteration.

Transsexual people who have come to terms with their gender identity, and who have researched the topic and know what they want, are not always the most cooperative clients. Under other circumstances they would not seek therapy, but because of the Standards of Care of the Harry Benjamin International Gender Dysphoria Association (Walker et al., 1985), they are required to be in therapy to obtain clearance to proceed further along the path toward physical transformation. They may be resentful that they have to pay money, especially

if they feel that they know more about the condition of transsexualism than does the therapist (and this is too frequently the case). The therapeutic relationship is not facilitated by a power struggle between provider and client.

Therapists who are not trained in gender identity issues, transsexual processes, and issues of transition should be able to refer clients to others with applicable special knowledge. The Resource Appendix at the end of this book lists important resources for transsexual clients and their therapists.[5]

Transgendered persons are awakening to the realization that the desire to cross-dress or to modify their bodies with hormones and surgery is not in and of itself a pathology, and that transgender feelings are not something that must be "cured" or "resolved" but may be accepted. Clinicians have been slower to realize this and continue to use value-laden, pathologizing terms such as *gender dysphoria, male transsexual,* and *deviancy* to refer to transsexual persons. It is of obvious importance that clinicians use the terms that transgendered persons have chosen for themselves rather than continue to use stigmatizing jargon.

Clinicians have invented needlessly complicated terms such as *transhomosexuality* (Clare, 1984, 1991; Clare & Tully, 1989) and *gynandromorphophilia* (Blanchard & Collins, 1993) to refer, respectively, to the sexual attractions of transgendered persons and those attracted to them. These terms are misused, unless the person has a specific attraction to that category of person, as opposed to an attraction to an individual. A man who has a sexual relationship with a transsexual woman, and who may even marry her, is more likely to do so despite her transsexualism than because of it. Indeed, considering the quality of male-to-female genital surgery, he may never even be aware of her transsexualism. Certainly, he is not a "gynandromorphophile." On the other hand, some men who specifically prefer transsexual women qualify for the term.

By the same token, a posttransition transsexual woman who considers herself to be a lesbian, or a posttransition transsexual man who identifies as gay, need not be considered as "transhomosexual" but simply as lesbian or gay. Similarly, it is not uncommon for transsexual persons to choose other transsexual persons as their sexual partners, but this is more often a matter of opportunity than of specific preference for other transsexual people.

The clinician must be prepared not only to assist the transsexual client with issues of identity but also with the complicated issues of sexual attraction in relation to gender identity. The concept of bisexuality makes no sense without the traditional binary gender system.

There is no bisexuality or, for that matter, sexual orientation without gender. Without gender, there is no social dynamic to charge the relationships between people—there are only bodies and the mechanical joining or friction between them. Human beings tend to be attracted to other human beings, regardless of labels. Perhaps that is the bottom line.

Notes

1. Both authors contributed equally to the writing of this chapter.

2. Certainly this is true of Janice Raymond, who argued that transsexualism should be "morally mandated out of existence" (Raymond, 1979, 1994). About the first (and to date the only) clinical book written exclusively about transsexual men (Lothstein, 1983), Sullivan (1989), transsexual historian and activist, remarks on the ongoing psychological damage incurred by readers seeking knowledge about their own condition.

3. See Ogas (1994) for the story of the closing of the Gender Identity Clinic at Johns Hopkins. And for a textbook example of science misused for political purposes, see Meyer and Reter (1979) and the critique of that article by Blanchard and Sheridan (1990).

4. For documentation of the risk of transgendered identity, see the report of the San Francisco Human Rights Commission, *Investigation Into Discrimination Against Transgendered People* (Jamison Green, principal author), issued September, 1994, available from the SFHRC, 25 Van Ness Avenue, Suite 800, San Francisco, CA 94102-6033, 415-252-2500.

5. Resources for transgendered and transsexual people include the American Educational Gender Information Service, Inc. (AEGIS), FTM International, the Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA), and the International Foundation for Gender Education (IFGE). Detailed contact information is available in the Resource Appendix at the end of this book.

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