# 8
# Transsexual Desire in Differently Gendered Bodies

ARLENE ISTAR LEV and SHANNON SENNOTT

The very nature of transgender "sex changes" evokes images of shifting identities, bodily alterations, and transgressive sexuality. The media sensationalizes transsexual body modification, focusing on surgical operations and physical transformations (Serano, 2007), ignoring the psychological disembodiment that compels people to publicly transition. The medical community has pathologized transsexuality, classifying it as a mental illness in need of psychological intervention (Lev, 2005; Winters, 2009) and ignoring the long history of gender variance throughout history and across diverse cultures (Blackwood & Wiering, 1999; Bullough & Bullough, 1993).

Despite the public gaze on transsexual bodies and the clinical pathologization of the transgender identities, there has been little attention paid to the actual sex lives of transgender, transsexual, and other gender-nonconforming people. Transgender eroticism is unexamined and poorly documented within the scholarly literature despite the unique experiences transgender people have of their embodiment (Lev, in press). Indeed, even in discussing transgender identity and sexuality, communication is muddied by the changing use of language for a community at the beginning of identity development. *Transgender* is generally used as an umbrella term to include all gender-nonconforming people. However, many *transsexuals*—people who have fully transitioned their sex through surgery, hormones, and legal documents—do not identify with the larger transgender umbrella. Gender-variant behavior can include a wide spectrum of human expression and behavior; hence, here we will use the term *trans* to include as many people as possible and thus, we hope, avoid offending anyone.

The lack of attention to the erotic lives of differently gendered people is hardly surprising, given the overwhelming silence regarding all serious inquiry in the sphere of human sexuality. Despite the commercial exploitation of sex in advertising and the popular media and the widespread proliferation of pornography, especially on the Internet, sexuality and eroticism remain inadequately explored areas in virtually all aspects of the social sciences and clinical research. From the societal fears of teaching sex education in public schools to inadequate funding of sexual research in higher education, discussion of human sexual response is guided by a "Don't ask, don't tell" philosophy. This is especially noteworthy in an academic context, where sexuality remains a taboo topic within psychology and social work programs devoted to marriage and family counseling (Pope, Sonne, & Greene, 2006).

The silence that surrounds all clinical studies of human sexuality grows deafening when examining trans identity. Human bodies modified by hormonal treatments and surgeries are judged as unattractive or even "deformed," with body parts that may be scarred and attributes that appear "odd." Paradoxically, trans people are summarily dismissed as "sexual perverts"—they are eroticized and exoticized—except when they are viewed as asexual, as if they have been cut off from potential human intimacy as a direct result of their gender-modified bodies.

In truth, transsexuality has been so infrequently studied that much of what is "known" is based on inference and conjecture. Since trans identities by their very nature cross the

traditionally established sex binary, sexual relations frequently (though not definitively) defy traditional expectations. When congruence and embodiment must be sought and achieved, sexual exploration must negotiate complex issues of sexual orientation and passion, and erotic pleasures may be revealed that defy heteronormative expectations.

## Theory and Research: Past to Present

### *The Conflation of the Sex and Gender Binaries*

Prodigious attempts to gather research data for this chapter were met with professional silence and sometimes hostile or bemused reactions. Pairing the words *transgender* or *transsexual* with *sex*, *sexual*, or *erotic* in extensive academic interlibrary searches repeated yielded "zero results" or, occasionally, a general article on "LGBT social services," since the *T* follows the *LGB* even when the topic has nothing to do with trans issues. The same words plugged into Internet search engines revealed a colorful pornographic netherworld, displayed in overlapping pop-up windows downloading furiously to a home-based computer, initiating a sudden paralyzing fear of the potential consequences that could befall a scholar of sexuality living in a post–Patriot Act America.

There has been little substantial research on human sexual behavior (with the notable exception of Kinsey's exhaustive data collection in the mid-1940s) and transsexual practices have rarely been the focus of empirical studies. In the nineteenth century the relationship between what we now call homosexuality and transsexuality was not as clearly delineated as it is today. The emerging field of sexology as exemplified in Krafft-Ebing's seminal work *Psychopathia Sexualis* (1886/1999) viewed homosexual desire as a kind of gender dysphoria. Hekma (1994) says, "[Krafft-Ebing] assumed that men were attracted to men as if they were women, while women attracted to women should feel like men.... Homosexual preference and gender inversion were completely intertwined" (p. 226). This conflation of same-sex desire and gender nonconformity continues to challenge scholars of modern human sexuality; as we examine historical identities through a modern lens, the distinctions between sexual orientation and gender identity still baffle many clinicians today.

Medical science in the eighteenth and nineteenth centuries scrutinized, and even dissected, the bodies of intersex people, then labeled hermaphroditic, while they sought to find their "true sex" hidden in their gonads (Dreger, 1998). It was unthinkable to medical scientists that sexed bodies could exist outside of a male–female binary. In contrast, sociological and anthropological studies of cross-gendered people reveal a long historical record of human beings across the globe expressing complex and multigendered identities (Blackwood & Wiering, 1999; Bullough & Bullough, 1993; Roscoe, 1998). These studies have, however, focused more on the social identities of gender-nonconforming people rather than their sexual practices. When Freud began his explorations of human sexuality, he analyzed the sexual libido presumably hidden deep in the unconscious mind, and using psychoanalysis as his scalpel he tried to dissect human sexual response. With a probing intellect of a taboo topic, Freud was nonetheless a product of his repressive and sexist Victorian culture. His complex legacy of human sexuality does not address gendered sexuality outside the male–female binary.

Despite the seismographic cultural wave impacting sexuality in the past 60 years, including the impact of feminism and the sexual liberation movement, comprehensive scientific study into actual sexual practices has been minimal. Masters and Johnson (1966) and Helen Singer Kaplan (1974), the first modern sex researchers, presented a more expansive vision of human sexuality, yet neither mentions the existence of trans people in any depth, nor how their models of sex therapy might be adapted for people of transgender experiences. Models of human sexuality remain heteronormative in belief and practice, and "normal" human sexuality is assumed to include sexual intercourse with a penis and vagina (always leading to orgasm, of course). The

"obsessive genital focus" (Tiefer, 2001, p. 39) of most research is steeped in heterosexist assumptions about the body parts people bring to bed with them and, most important when discussing trans bodies, how people experience those body parts or want to use them sexually.

*The Medical Pathologization of Trans Identities and Sexualities* Contemporary research into transsexuality was developed within a medical model that has viewed trans people through a pathologizing lens. Indeed, the research participants were often people who sought medical treatment through established gender clinics (Denny, 1992). Since participants were dependent on the researchers' approval for treatments they desperately desired, it likely impacted their honesty and willingness to reveal information that might prevent them from continuing treatment. In order to receive medical treatment, participants were expected to articulate a "transsexual narrative" (Prosser, 1998), an autobiographical narrative that mirrored the trajectory of gender dysphoria outlined by Harry Benjamin (1966). These official narratives found in autobiographies (and which are now easily accessible on the Internet) became a blueprint for the only acceptable case histories with which participants could attain their treatment. It is thus no surprise that trans people seeking treatment have purposely lied to researchers (Lewins, 1995; Walworth, 1997), raising critical questions about the validity of the extant research on transgender and transsexual sexuality.

The only other avenues of research data, in addition to the information gleaned from gender clinics, are sociological studies on heterosexual cross-dressers and their wives (G. R. Brown, 1998; Doctor, 1988; Weinberg & Bullough, 1988), and sexual practices were never the primary purpose of these studies. These two threads of research focus on small population samples of White middle-class cross-dressing males and male-to-female transsexuals. There has been a paucity of studies on the masculine identities of natal females or the impact of race, ethnicity, or class on trans experience. Most of the research has focused on psychosocial adjustment, postsurgical sexual satisfaction, and the incidence of regret following transition (Pfäefflin & Junge, 1998). Complicating any analysis of research, concepts are defined and operationalized differently across studies; and given the wide diversity of people with gender-variant experience, it is difficult even to identify the parameters of who is being studied (Namaste, 2000). As mentioned earlier, even the words *transgender* and *transsexual* are used differently within different communities. Researchers do not uniformly examine the same populations; for example, have they included only those individuals who have had surgery, or have they included part-time cross-dressers or those living full-time without surgery? Despite the limitations of the research, a brief overview follows.

*Studies of Transsexual Sexualities and Sexual Practices* Early research on male-to-female (MTF) transsexuals revealed that MTFs were commonly asexual, both before and after surgical reassignment (Benjamin, 1966; Person & Ovesey, 1974). Indeed, low sex drive was considered a necessary criterion for diagnosis of transsexualism (Lewins, 1995). Given the aforementioned widespread use of an approved "transsexual narrative," whether individuals were afraid to admit to erotic desires remains unclear; such an admission often raised "a red flag" as to whether the surgical candidate was really transsexual and should be considered for medical treatment (Ramsey, 1996, p. 49). *Perhaps MTF transsexuals viewed their sexuality "as something that must be sacrificed* in order to live in [their] chosen gender" (Tobin, 2003, para. 43, Pt. 1). Or perhaps rather than being asexual, they suffered from anatomical dysmorphia and experienced confusion or disgust regarding using their body parts sexually (Tully, 1992). The process of transitioning is a very intense time, and some people withdraw from social and familial interests to focus exclusively on their transition, which might, for some, include withdrawal from sexual activity (Devor, 1997; Lewins, 1995). Exogenous hormone treatment also impacts sexual desire and functioning for

MTF transsexuals, including causing a lowering of their sex drive and causing difficulties maintaining and achieving orgasms, which may lessen their sexual interest and activity.

Female-to-male (FTM) transsexuals, however, have been described in the literature as highly sexual, in part a result of the effects of testosterone on the human libido. Research studies and personal accounts have consistently shown that FTMs have increased sexual arousal following hormonal treatment (De Cuypere et al., 2005; Devor, 1997; J. Green, 2004; Hansbury, 2004; Valerio, 2006). Although research attests to the stability and longevity of intimate relationships for FTMs throughout their transition (Fleming, MacGowan, & Costos, 1985), there is scant research on FTM sexual practices and little attention has been paid to the process whereby couples negotiate the complexities of gender transition as it affects their sexual relationships.

Although few studies actually define sexual satisfaction, research has consistently shown that transsexual men and women identify sexual fulfillment following transition (De Cuypere et al., 2005; Pfäefflin & Junge, 1998) and that transsexual women experience orgasms following surgical transition (Lawrence, 2003; Schroder & Carroll, 1999). Sexual satisfaction and postsurgical adjustment often hinge on the success of the surgical results (Pfäefflin & Junge, 1998; Schroder & Carroll, 1999), which continues to improve as the surgical techniques for sex reassignment are refined (De Cuypere et al., 2005; Pfäfflin & Junge, 1998). This is a particularly challenging area for trans men, since genital surgeries are prohibitively expensive and surgical results for trans men are far less advanced than for trans women (Rachlin, 1999). Consequently, many FTMs do not have bottom (i.e., genital) surgeries, although genital changes, including an enlargement of the clitoris, do occur from exogenous hormone treatment for trans men.

The older research is extremely patholgizing, as exemplified in Steiner and Bernstein's (1981) statement of bewilderment as to why a "normal biological female would chose a 'penis-less man' as a partner" (p. 178). Although the majority of FTMs would likely choose to have genital surgeries if the cost were not prohibitive and the results showed greater functionality, research concludes that FTMs are able to establish stable male-gender identities (Fleming et al., 1985; Kockott & Fahrner, 1987). Trans men who for personal, medical, or financial reasons have transitioned without genital surgery have, to some extent, redefined social norms of masculinity and manhood (J. Green, 2004; Kotula, 2002; Vanderburgh, 2007) by developing satisfying sexual relationships with their partners without the presence of a phallus. It is possible that transitioning without bottom surgeries may provide more sexual consistency and familiarity for trans men's sexual partners, making it easier to adapt to the vast changes in other areas of their lives.

*Emerging Perspectives of Trans Identities* In the past two decades sociocultural understanding of transgender identity underwent a paradigm shift, transforming the political landscape and heralding in a reevaluation of psycho-medical paradigms that pathologize trans identities (Denny, 2004). Treatment models are being developed that are respectful of diverse transsexual expressions, incorporate family and couple issues, and address posttransition identity and relationships (Bockting, Knudson, & Goldberg, 2006; Lev, 2004; Malpas, 2006; Raj, 2002; Vanderburgh, 2007). In 2010, the World Professional Association for Transgender Health (WPATH) released a statement urging the depsychopathologization of gender variance worldwide (WPATH, 2010); and in 2008, the American Medical Association (AMA) passed a resolution affirming the effectiveness of medical treatment for transsexuals and calling for an end to discriminatory denial of health insurance coverage for transsexual treatments (AMA, 2008). In addition to trans-positive policy statements from the American Psychological Association (APA; 2008) and the National Association of Social Workers (NASW; 2005, 2010), the Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (2009) developed a clinical competency statement specifically for working with transgender clients.

These vast changes in public policy and medical care are changing how trans people are viewed socially and politically, which will impact clinical care as well as research for years to come. The erotic lives of trans people is underexplored and rarely clinically examined. The research has only peripherally focused on issues related to family life, intimacy, and sexuality, but changes in the sociopolitical climate have set the stage for studies of transsexuality to begin.

## Societal and Familial Stressors and Resiliencies

### *The Impact of Stressors on Transsexuality and Desire*

There are numerous societal and familial stressors that impact the sex lives of trans people. Such stressors as dating, intimacy, forming partnerships, fertility, and transitioning within an already established relationship are specifically associated with sexuality. There are other aspects of trans people's lives that are not as directly related to their sexuality, however, but may impact it, for example, medical treatments, insurance or medical costs, work-related transition issues, parenting, and constant social scrutiny during the transition process.

The reality of violence, discrimination, and bias in the daily lives of trans people has been well documented, as has the negative impact this abuse has on their psychological stability (Lombardi, Wilchins, Priesing, & Malouf, 2001; Nuttbrock et al., 2010). Trans people face bias in child custody decisions (R. Green, 2006), for instance, and they have difficulty accessing competent and skilled health care (Kenagy, 2005). Workplace discrimination is ubiquitous; in one study, nearly 50% of trans people experienced an adverse job-related action, and 97% experienced mistreatment or harassment at work (NCTE & NGLTF, 2009). It is difficult to imagine that such daily stressors as these do not impact the sexual desires, behaviors, and experiences of trans people.

Social and familial challenges related to transitioning can cause great strain in people's lives, especially in interpersonal relationships. Friendships are tested, and intimate relationships may not survive the transition process. Frequently, it is not the transition itself that is challenging for partners and families but, rather, the immense discrimination and social stigma related to being differently gendered. Despite these challenges, many transgender and transsexual people successfully navigate the difficulties and maintain or create significant, ongoing, intimate relationships. Trans people are wives and husbands, lovers and partners, and single; and despite the outdated research, there is no reason to assume that trans people are less interested in sexual intimacy than are nontrans people. However, as Wilchins has noted, the partners of trans people "must be willing to negotiate the ambiguity of the terrain" (1997, p. 120); sadly, becaue of prejudice and transphobia, some people are not.

Trans people who are single and seek out intimate relationships may experience rejection, just as any single person might; and although there are bars, community centers, and Internet dating sites that are welcoming, isolation is an all-too-common experience. It is invaluable for trans people to have a network of friends and family to turn to for support because social prejudices are amplified when exploring dating. Even those individuals who are posttransition face questions of when and how to reveal their transition history to a new sexual partner (Vanderburgh, 2007). There are people (trans and nontrans) who are specifically eroticized by transgender bodies. Although appreciated by some trans people, this is a source of distress for others who resent having their trans status exoticized and fetishized; they want to date people who will simply honor their affirmed identity.

Historically, it was assumed that being trans was reason enough for a spouse to end a long-term marriage. Shocking to a modern viewpoint, transition protocols once expected transsexuals to divorce their spouses as part of the standard procedure to be approved for gender reassignment (Clemmensen, 1990). This clinical stance has led to increased isolation for trans people and the severing of familial ties and parental relationships. The fact that clinicians could

not even imagine spouses wanting to remain together speaks to the underlying assumptions and prejudice toward differently gendered people and their intimate partners. It is only recently that narratives have been revealed and protocols been developed to assist couples with a trans partner to remain together (Erhardt, 2007; Lev, 2004; Malpas, 2006; Chapter 5, this volume).

*Ways to Nurture Resilience in Transsexualities and Practices* Gender-variant people who are in the early stages of recognizing and addressing their trans identities can begin to build a support system by confiding in a loved one about the feelings they are having. Sometimes it is easier to first open up to a close friend than to an intimate partner. Support groups can also be invaluable in staving off feelings of isolation and loneliness. This process of reaching out for support can include revealing an interest in cross-dressing behavior or anatomical dysphoria, or confiding in their partners their desire to seek out gender-affirming hormones or undergo gender-affirming surgical treatments. The partner or spouse of a trans person will often move through a predictable developmental trajectory that includes a process of discovery and disclosure, turmoil, negotiation, and finding balance (Lev, 2004). Part of the negotiation stage often involves coping with the sexual aspects of intimate relationships, especially when the trans person's body is changing from the effects of exogenous hormones. The spouse or partner may be deeply disturbed and confused by feelings that can range from revulsion to arousal. Spouses who continue their exploration may find themselves sexually excited by the gender transition (Erhardt, 2007). Individual therapy, as well as support groups for partners, can be helpful; sometimes these resources and groups can be accessed through local LGBT community centers. The more awareness partners have about their own prejudices and biases related to trans identities, the more able they will be to connect with their trans partners on an intimate and sexual level.

Transgender and transsexual people represent a wide spectrum of individuals, who express diverse sexual behavior and varied sexual relationships. For some trans people, gender dysphoria interferes with their sexual expression and comfort in their bodies; for others, living in mixed-gendered bodies is experienced as sexually exciting and something to celebrate—a gender "euphoria." As is true for all individuals, there is a broad continuum of sexual behavior for gender-variant people. Some trans people are very conventional in their sexual behavior, whereas others appear more interested in atypical sexual practices. What sets trans people apart is that when they seek out sexual relationships with others they have to navigate the socially constructed assumptions and biases related to their transgender status.

### Assessment and Treatment of Sexual Concerns

#### *Understanding the Gender Identity and Sexuality*

The first issue regarding assessment when working with trans people is to understand the diversity of gender presentations and identities that people can experience. Older models rely on medicalized classifications that belay the multiple and complex solutions trans people develop to understand their gender identities and express and present their gender within the social world. For example, although erotic cross-dressing in males has long been recognized, female cross-dressing has been an unacknowledged area of transgender studies; it has been suggested that this area remains unexplored because male clothing holds no erotic attraction for females (Ettner & Brown, 1999). However, the use of male clothing in lesbian culture as a way of expressing masculine identities has been consistent throughout queer and lesbian history. Female cross-dressing in the bondage, discipline, sado-masochism (BDSM) and kinky sex subcultures (Hale, 1997) and among drag kings (Volcano & Windh, 2005) is evidence that there exist erotic aspects to female masculinity and cross-dressing (Halberstam, 1998).

The predominant theory of transsexualism is based on the idea that transsexuals seek medical treatments in order to migrate from one side of the sex binary to the other. Although this is certainly a common reason to transition, emerging research shows that trans identities exist outside of a simple binary. Ekins and King (2007) discovered in their research a wide spectrum of patterns of gender mobility, including those who *mix* or *blend* gender, those who *oscillate* or move back and forth from one gender to the other, and others who attempt to *erase* their sexed body. Blending gender and expressing androgyny have been identified as emerging strategies for resolving gender dysphoria (Kane-Demaios & Bullough, 2005; Lev, 1998; Nestle, Wilchins, & Howell, 2002). As transgender communities organize and politicize (Lev, 2006), tension has developed between trans individuals with a more "traditional" understanding of their gender (i.e., crossing the binary from one sex to the other) and those who express more fluid genders (Roen, 2001). Clients present with many different ways of expressing their gender, and therapists must support trans people in determining their own gender identity and identifying their own gender expression. It is also important for therapists to advocate for people seeking medical treatments who may present outside of the traditional "transsexual narrative" (Lev, 2009).

Researchers have noted within transsexual subcultures a co-occurrence of what they call fetishistic behavior (Tobin, 2003; Tully, 1992), and personal narratives attest to BDSM sexual practices (Hale, 1997), although further study is necessary to determine the frequency and occurrence of kinky sexualities practices within various trans communities.

Until the late 1990s the bulk of the research on transgenderism focused on MTFs. Considered uncommon, FTM individuals were thought to be exclusively attracted to women, primarily heterosexual women. However, more current accounts have revealed that FTMs have a wide range of sexual attraction and behaviors, including relationships with both heterosexual and lesbian women (Devor, 1997). Further, some FTMs also recognize sexual attraction to men and identify themselves as gay or bisexual men (Coleman & Bockting, 1988). Although cross-dressers were always presumed to be heterosexual men, research shows that some cross-dressers identify as gay (Bullough & Bullough, 1997). Rankin and Beemyn's (2011) current research also reveals a wide range of sexual orientations in trans people. Approximately 32% of their respondents identified as bisexual and 30% identified as heterosexual; in addition, many identified as "other," stepping outside traditional categories of sexual orientation.

Sexual orientation can sometimes change following transition (Daskalos, 1998; Israel & Tarver, 1997; Lawrence, 2005; Schroder & Carroll, 1999), and some trans people have sexual relationships with each other (Devor, 1997), obscuring such concepts as same-sex and opposite-sex sexual orientations. Tobin (2003) has concluded, "It has become more and more clear that trans people come in more or less the same variety of sexual orientations as non-trans people" (para. 27, Pt. 1). Indeed, it is critical to not to make any assumptions about sexual orientation or sexual practices but instead embrace the multitude of possibilities for sexual desire and partnership.

The desire for particular categories of sexed or gendered people may not be the best way to describe the complexity of any human sexual desires, but the notion is especially confounding when examining the erotic and intimate relationships of gender-variant people and their sex partners. Currah (2001) states that the term *sexual orientation* "remains intelligible only if sex and gender remain relatively stable categories" (p. 182). Transgenderism disrupts this stable boundary of gender and sexual orientation, rendering such concepts as heterosexual and homosexual inadequate to describe the sexual experiences of those engaging in intimate and sexual behavior. Similarly, having a sexed body that is mixed or blended can impact sexual orientation, desire, and identity. Rankin and Beemyn's (2011) document that some of the unique sexual orientation identifications trans research participants used to describe themselves include "pansexual," "queer," "transgender lesbian," "heterosexual lesbian," lesbian with bisexual leanings,"

"omnisexual," "attracted to genderqueer people," and "bisexual when dressed in female clothes otherwise heterosexual." Nichols (2000) says, "There are problems inherent even in arriving at common definitions of sexual minorities, because the phenomena we are attempting to define are so variable and complex" (p. 337).

*Identifying Therapeutic Needs for Trans Individuals and Their Partners*

Kleinplatz (2001) critiques traditional sex therapy on a number of grounds, including stating that sex therapy tends to emphasize performance rather than subjective meaning and experience, marginalizes diversity rather than embracing it, and assumes a "norm that involves two able-bodied heterosexuals in a monogamous relationship" (p. 116). Iasenza (2008) echos Kleinplatz's concerns, saying, "Medicalization of sexual functioning promotes one-size-fits-all models of sexual response" (p. 539), illuminating the tendency to try to fit differently gendered individuals into sexual categories that are, at best, not relevant and, at worst, extremely oppressive and damaging to the therapeutic relationship. Kleinplatz challenges sex therapists not to simply "stretch our sexual norms" but to "learn from those we label as 'other' to fundamentally question and revise our conceptions of sexuality" (p. 116). This is the exciting challenge of doing sexuality work with couples where one or both partners are trans.

It is crucial when working therapeutically with trans individuals and their partners to honor and celebrate the desires of each partner equally and not to assume that relational discomfort or discontent is directly linked to the transition. Iasenza (2010) discusses the need to create "a safe holding environment" for all couples, and to "create [an] expansive erotic space by inquiring about, exploring, and, if necessary, normalizing and reframing queer experiences" (p. 298). She recognizes that gender transpositions and genderqueer fantasies, as well as internalized shame regarding these feelings, are important to explore in all sexual pairings, not just those that are identified as trans or queer. The field of sex therapy has taken a giant leap forward in recognizing the queer possibilities inherent in heterosexual, opposite-gender sexuality.

Male-to-female transsexuals in heterosexual marriages may struggle with sexual problems (Tully, 1992), related in part to their wives' reluctance to engage in "lesbian" sex. Research has shown that heterosexual wives have identified a lack of sexual arousal toward their partner's cross-dressing (Doctor, 1988), although, in one study 43% of women stated they continued to engage in sex with husbands while they were cross-dressed (Weinberg & Bullough, 1988). Some of the difficulties wives identify are related to sexual functioning; other difficulties involve frustration with the spouse's preoccupation with stereotypical femininity or his refusal to act "like a man" (Boyd, 2003). Erhardt (2007) says, "The libido of a gender-variant natal male may flourish if the wife welcomes the femme persona in the bedroom" (p. 208). The libido also might diminish, however, if she cannot welcome the persona—and she often simply cannot—leaving both partners with unmet sexual needs.

For example, Steven and Marcy had been married for over 20 years and had raised two children, now in college, when Steven revealed his transsexual identity. Although Marcy was aware that Steven enjoyed cross-dressing, she was shocked to find that "Stephanie" had been living a secret life for many years. Both were committed to maintaining their relationship and worked hard in therapy through many layers of shame, betrayal, and disclosure. Marcy identified as a heterosexual woman, and as Stephanie moved along in her transition, developing breasts and dressing publicly as a woman, Marcy was not sure how to continue a sexual relationship with Stephanie. Stephanie remained sexually attracted to women and longed for the experience of being in bed with her wife, as a woman; however, the idea of lesbian sex did not appeal to Marcy. Stephanie did not pursue sex reassignment surgery, partially because of her ambivalence about the necessity of it, and also because of the financial constraints it would place on the family. The female hormones had impacted Stephanie's ability to have or maintain an erection, and

Stephanie seemed more sexually aroused by wearing sexy lingerie than she was in pleasuring Marcy, which caused Marcy to feel rejected, angry, and "like a fool" for trying to maintain a sexual relationship with her husband's female body.

Boyd (2003) debunks the facile assumption that there are two kinds of wives, "the ones who accept their husband's cross-dressing and those who don't" (p. 52). She says that a woman may be both types "depending on the day or the week or the moment" (Boyd, 2003, p. 52). In the case of Marcy and Stephanie, it took them a series of difficult conversations in therapy for Marcy to express her anger with Stephanie. At first Stephanie could only hear Marcy's anger as rejection of her as a trans woman, but over time she was able to empathize with Marcy's situation. With Stephanie's compassion, Marcy began to grieve what she had lost because of the gender transition. As the newness of Stephanie's transition faded, she was able to become a more attentive, less self-absorbed, partner. It is unlikely that sexual intimacy will emerge unscathed by the massive changes gender transition evokes, although many transsexual women and their wives are able to develop working accommodations and maintain a positive sexual relationship.

Although trans men and their partners also experience complex relational challenges during transition, trans men commonly remain in stable relationships with female partners both during their transition and afterward (Fleming et al., 1985; Kockott, & Fahrner, 1988; Steiner & Bernstein, 1981). This pattern can be explained in part by the fact that before their transition, most FTMs expressed their gender with a masculine aesthetic, which their partners found attractive. For FTMs, there is little shift in their social gender impression or the expression of their gender within the context of their sexual relationship, unlike for the female partners of trans women who are negotiating the loss of heterosexual privilege as well as the serious social challenges invoke by their spouses' public "sex change."

Female partners of trans men are often comfortable with the public masculinity of their partners and share with them a sense of being "different" or even "queer" not only as lesbian couples but in some cases also as couples identified as butch–femme. When butch or masculine females begin to transition their sex, however, lesbian partners, especially those who are femme identified, often face unique psychological challenges to their identity (N. R. Brown, 2005; Mason, 2006). Having a partner with a male identity and who is using male pronouns can bring with it unexpected heterosexual privilege; a lesbian partner may be more likely to reject than embrace being perceived of by others as a heterosexual wife. For lesbian-identified women, losing membership in the lesbian community can be very emotionally challenging.

For example, when Lucas began his transition, his partner Sally was supportive. They had met on a butch–femme Internet community bulletin board, and their sexual attraction was built upon their erotic dance of their gender expressions. Sally was sexually excited by Lucas's masculinity and understood that he experienced some dysphoria in his body. When he decided to resolve this dysphoria by having chest reconstructive surgery and taking gender-affirming hormones (i.e., testosterone), Sally initially shared his excitement in the journey. However, as Lucas's body began to change, including the deepening of his voice and the removal of his breasts, and was consistently perceived in public as a male, Sally became withdrawn and depressed. She found his facial hair and body smells repulsive and hated being viewed as heterosexual in her daily life. She felt confused about her own sexual identity; she wondered, if she could be involved with a trans man, why not a bio man, and what did that mean for her sense of herself as a lesbian? Lucas enjoyed his changing body; and as he grew increasingly comfortable as a man, he wanted Sally to embrace his changes. He felt rejected by her resistance to his transition and her unremitting stance to identify as a lesbian.

For some lesbian identified women like Sally, negotiating sexuality across the gender binary is psychologically complicated. Adjusting to shifts in a partner's identity and body may be easier for women who are bisexual, in either identity or practice (Glassmire, 2009). It is also true

that some previously lesbian-identified women have come to love, embrace, and value their partner's changing body, and they find it sexually appealing and erotic (N. R. Brown, 2005; Mason, 2006). In order to work therapeutically with Lucas and Sally as a couple, it is important to affirm their identities and aid them in recognizing that sexual identities can be fluid. Lucas has to come to accept the salience of Sally's lesbian identity—that it is more than a statement of her sexual expression; that it is, rather, a core part of her identity. Although Lucas would like to have lived his life as man and leave his lesbian history behind, he has come to understand that he cannot do that and remain lovers with Sally. Sally has had to really examine her views about men and masculinity and what it meant for her to truly love Lucas, not as he was, but for who he had become.

Although the sexual issues for trans people and their partners may be somewhat unique, as Doctor (1988) says, "they are by no means entirely different" from other issues that couples bring to therapy (p. 181). Coping with intimacy, honesty, communication, and changing bodies over time are universal concerns. Effective sex therapy with transgender people and their intimate partners must foster sexual communication that allows for the multiple experiences within changing bodies and erotic desires. The therapist must create a holding environment that can contain both the negative emotionality and anxiety caused by the changing identities and bodies, and the possibility of future sexual satisfaction.

*The Therapist's Role in Treatment: Self-Awareness, Self-Education, and Transparency*

Providing therapy for trans people and their partners requires an understanding of the trans person's gender emergence and the partner's experiences, as well as the dynamic relational process that emerges for the couple (Lev, 2004; Malpas, 2006). In addition, therapy based on models that incorporate empowerment, advocacy, and transfeminist principles creates a safe environment for the couple to explore the development of intimacy and sexuality (Lev & Sennott, in press).

Self-awareness on the part of the therapist is the first component of a strong therapeutic connection with differently gendered clients. It is important to be aware of one's blind spots stemming from personal beliefs. If a therapist comes to a countertransferential impasse regarding aspects of trans identities, he or she ought not subject clients to this impasse but should seek out supervision with a trained gender therapist who is also familiar with marital and family issues or refer the couple to someone who can provide affirming gender and sexuality treatment.

If the discomfort a therapist feels is based on a lack of knowledge, then self-education can be the most effective way to move forward. Being honest with a client about your level of experience is helpful, for such disclosure lets the client know that though you are not an expert in trans issues, you are willing to educate yourself on the issues and work together with the clients. Educating yourself does not mean asking the client to be the educator, however, for such a situation can feel retraumatizing for some trans people. Note that some clients might "use" the therapist's lack of knowledge to misinform the therapist or redirect the therapy away from necessary clinical explorations. A clinician's discomfort in talking openly about sex in general and transsexuality in particular can add to the oppressive dynamic in the therapeutic relationship.

It is constructive to destigmatize transsexualities with clients so they can approach communication with their partners more easily (Malpas, 2006). The therapist models a depathologizing approach, which encourages relational honesty and openness between the partners, taking a stance of affirming curiosity while mirroring the language used by the client regarding preferred name and pronouns. Using the correct pronouns with clients is not always easy; even therapists sometimes make mistakes, which should be acknowledged in the room as a step in building trust and establishing an alliance with the client. Therapists can help clients to express their feelings of betrayal when pronouns are misused and repair damage created within the therapeutic

relationship; this approach also models successful communication around other difficult topics (i.e., sexuality, gender difference, and atypical sexual practices), not only in therapy but also with partners and family members. This approach reframes an individual problem into a normative relational adjustment (Malpas, 2006).

Last, when working clinically with trans and gender-nonconforming people, transparency is vital to the therapeutic alliance. After the therapist has explored issues of countertransference and has engaged in self-education, it is the relational action of transparency that indicates to clients that the therapist does not assume any specific narrative of trans lived experience (Malpas, 2006). Each couple is going to experience transition differently, in part because of the trans partner's identity and experience and in part because of the couple's particular relational dynamics. This approach will allow a more complex and individualized story to emerge and also aid in integrating past identities with present and future experiences, as well as disclosing fears about transition. The transparency of the therapist's unique reactions and experiences to the emerging narrative can communicate to clients that they do not need to fit into a typical or predetermined trans life story. Transparency with differently gendered clients is a blending of psychotherapy, notions of alliance building, and the ethics of social justice and feminist practice, that is, the transfeminist therapeutic approach (Sennott, 2011). In order to foster a trans person's self-definition of his or her own gender, therapists must be knowledgeable and supportive of diverse gender identities and expressions, as well as understand their own relationship to gender, sexuality, and identity The process of self-awareness, self-education, and transparency will enable therapists to bring language and understanding to the experiences of transition and help them communicate about sexual desires and practices within intimate relationships.

### Case Scenario

Gracie and Maggie have been married for 35 years. They have three grown children who are living on their own and who were adopted as a sibling group at ages 3, 5, and 7 through the foster care system. Gracie and Maggie have always had difficulty finding time for intimacy since becoming parents of children with an extensive trauma history. Parenting took a significant focus their energy and time for nearly 20 years, and their relationship and sexuality were neglected. When Gracie, then Greg, revealed his transsexual identity 25 years into their marriage, while they were actively raising three teenagers, Maggie was shocked, having had no idea that her husband had any concerns about his gender. While the couple were managing issues of disclosure to the children, Maggie's feeling of betrayal and Gracie's emergence process became the focus of years of intensive therapy, little of which focused on their sex lives.

However, Maggie has long been concerned about their sexual difficulties, and in fact, one year before Gracie came out to Maggie as being "a trans woman, and maybe genderqueer too," Maggie had searched for a sex therapist for them to see together to discuss their lack of intimacy. Gracie avoided the appointments, making excuses and sabotaging the process because "he" was deeply struggling with his gender identity and was afraid that his life-long secret might be detected by a sex therapist. Maggie was very hurt by her husband's behavior and had begun to give up hope of having an intimate connection with him. Only after Gracie's transition and their children's launching into their own lives were they able to begin to explore their sexual desires.

Maggie is struggling on two levels in relation to her intimacy with Gracie. The first is that they have had almost no sexual connection for at least 10 years; the other is that Maggie is not sure how to understand her consistent attraction to Gracie during and after transition. Maggie had always considered herself to be a heterosexual woman but is now grappling with sexual feelings for Gracie that both surprise and amaze her and also, on a deep level, are "disgusting"

to her. She is able to acknowledge that these feelings are partly her lack of understanding and familiarity about transsexualism in general and sexual minorities issues in particular. Maggie is still shocked to find herself part of an "LGBT community."

As the therapist helped Maggie explore her feelings about the "disgust" she feels, Maggie is asked "who" the disgusted voice reminds her of, and she admits that she is hearing the voices of her mother and brother, both of whom are extremely homophobic and close minded. Gracie begins to realize that she needs to stand up to her family's judgments about Gracie's transition so that their messages would hold less power and she would feel more free to explore her sexual attraction for Gracie.

Although Gracie and Maggie have lived together for over 3 decades and successfully reared into adulthood three children with challenging issues, they have not had a functioning sex life for many years despite sharing other forms of intimacy and closeness. Gracie spent years avoiding Maggie because of her own lack of embodiment. For both women there are years of distrust, betrayal, anger, and feelings of sexual rejection that must be explored. The journey toward each other will likely be slow and cautious. However, as a couple with 35 years together, having weathered the trials of foster adoption, parenting, and the emergence of transsexual identity, they have a strong foundation on which to develop a healing sexual relationship.

The therapist's reactions, conscious and unconscious, will strongly influence the success of the therapy. Certainly, education is essential regarding trans identities, couple dynamics, and sex therapy. In addition, the therapist must be cognizant of his or her own reactions to this couple's struggles. Perhaps younger therapists might find themselves surprised that a couple can neglect their sex lives for "so many years," or the therapists might even think that there is no point to work on sexuality for a couple in their 50s. Perhaps an experienced LGBTQ therapist might be annoyed or even angry at Maggie's "disgust" at her desire or frustrated with her heterosexual privilege and resistance to identifying as a member of a minority group. A heterosexual therapist might overidentify with Maggie's ambivalence, encouraging her to "go slow," perhaps mirroring the therapist's own need to go slow. For trans persons, it might be difficult to contain the relational dynamics, which might reflect their own histories and experiences, and therefore pain.

## Recommendations for Future Research, Treatment, Assessment, and Intervention

As previously noted, there is scant research on trans people in general and even less on trans-sexuality in particular. The bulk of the extant research was completed before the rise of the transgender liberation movement and expression of genderqueer identities; it is not clear how closely the research represents modern sexual practices. With the advent of the Internet, transgender people and trans sex practices have become a somewhat more visible subculture (Lev, 2006), yet few researchers are examining trans sex lives. There is especially a dearth of research on transgender people of color, those living with disabilities, and the implications for aging trans individuals.

## Summary

Trans identities by their very nature cross the traditionally established sex binary, making it easy to assume that sexual relations between trans people and their sexual partners will also defy traditional expectations. However, it is often not the transition itself that is challenging for partners and families but, rather, the immense discrimination and social stigma related to being differently gendered. Despite these challenges, many transgender and transsexual people successfully navigate through the difficulties and maintain or create significant, ongoing, intimate relationships. When working with trans people, clinicians need to understand the diversity of gender presentations and identities that people can experience. Clinicians must utilize newer models

of assessment and treatment that respect the emerging paradigms of identity that trans people have developed to understand their gender. It is at the junction where gender identity and sexual orientation meet that intimacy, desire, and sexuality take shape and new language is created to describe it; this pattern may be true of those individuals who fit neatly into the gender-sex binary as well as those who are differently gendered. Effective sex therapy with trans people and their intimate partners will challenge clinicians to think differently about bodies and identities, including body modification and the complexity of sexual orientation. Trans sex therapy can foster healthy sexual communication and can cultivate erotic desires within changing bodies.

## References


American Medical Association (AMA), GLBT Advisory Committee. (2008). *Removing barriers to care for transgender patients* (H-185.950). Retrieved from http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.shtml

American Psychological Association (APA). (2008). APA Policy Statement: Transgender, Gender Identity, & Gender Expression Non-Discrimination. Retrieved from http://www.apa.org/about/governance/council/policy/transgender.aspx

American Psychological Association (APA). (2010). Transgender Identity Issues in Psychology: Resolution Supporting Full Equality for Transgender and Gender-Variant People. Retrieved from http://www.apa.org/pi/lgbt/programs/transgender/index.aspx

Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2009). *Competencies for counseling with transgender clients.* Alexandria, VA: Author.

Benjamin, H. (1966). *The transsexual phenomenon.* New York, NY: Julian Press.

Blackwood, E., & Wiering, S. E (Eds.). (1999). *Same-sex relations and female desires: Transgender practices across cultures.* New York, NY: Columbia University Press.

Bockting, W., Knudson, G., & Goldberg, J. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9,* 35–82.

Boyd, H. (2003). *My husband Betty: Love, sex, and the life of a cross-dresser.* New York, NY: Thunder's Mouth Press.

Brown, G. R. (1998). Women in the closet: Relationships with transgendered men. In D. Dallas (Ed.), *Current concepts in transgender identity* (pp. 353–372). New York, NY: Garland.

Brown, N. R. (2005). *Queer women partners of female-to-male transsexuals: Renegotiating self in relationship* (Unpublished dissertation). York University, Toronto, Canada.

Bullough, B., & Bullough, V. (1993). *Crossdressing, sex, and gender.* Philadelphia: University of Pennsylvania Press.

Bullough, B., & Bullough, V. (1997). Are transvestites necessarily heterosexual? *Archives of Sexual Behavior, 26*(1), 1–12.

Clemmensen, L. H. (1990). The "real-life" test for surgical candidates. In R. Blanchard & B. W. Steiner (Eds.), *Clinical management of gender identity disorders in children and adults* (pp. 121–135). Washington, DC: American Psychiatric Association.

Coleman, E., & Bockting, W. (1988). Heterosexual prior to sex reassignment, Homosexual afterward: A case study of female-to-male transsexual. *Journal of Psychology & Human Sexuality, 12,* 69–82.

Currah, P. (2001). Queer theory, lesbian and gay rights, and transsexual marriages. In M. Biasius (Ed.), *Sexual identities—Queer politics* (pp. 178–197). Princeton, NJ: Princeton University Press.

Daskalos, C. T. (1998). Changes in sexual orientation of six heterosexual male-to-female transsexuals. *Archives of Sexual Behavior, 27,* 605–613.

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., … Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679–691.

Denny, D. (1992). The politics of diagnosis and a diagnosis of politics: The university-affiliated gender clinics, and how they failed to meet the needs of transsexual people. *Chrysalis: The Journal of Transgressive Gender Identities, 1*(3), 9–20.

Denny, D. (2004). Changing models of transsexualism. In U. Leli & J. Drescher (Eds.), *Transgender subjectivities: A clinician's guide* (pp. 25–40). Binghamton, NY: Haworth Medical Press.

Devor, H. (1997). *FTM: Female-to-male transsexuals in society.* Bloomington: Indiana University Press.

Doctor, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior.* New York, NY: Plenum Press.

Dreger, A. D. (1998). *Hermaphrodites and the medical invention of sex.* Cambridge, MA: Harvard Univer Press.

Ekins, R., & King, D. (2007). *The transgender phenomenon.* London, England: Sage.

Erhardt, V. (2007). *Head over heels: Wives who stay with cross-dressers and transsexuals.* Binghamton, NY: Haworth Press.

Ettner, R., & Brown, R. (1999). *Gender loving care: A guide to counseling gender-variant clients.* New York, NY: Norton.

Fleming, M., MacGowan, B., & Costos, D. (1985). The dyadic adjustment of female-to-male transsexuals. *Archives of Sexual Behavior, 14*(1), 47–55.

Glassmire, J. (2009). The experience of transgender couples: Toward the development of couples therapy guidelines for this sexual minority population (Unpublished dissertation). Argosy University, Washington, DC.

Green, J. (2004). *Becoming a visible man.* Nashville, TN: Vanderbuilt Press.

Green, R. (2006). Parental alienation syndrome and the transsexual parent. *International Journal of Transgenderism, 9*(1), 9–13.

Halberstam, J. (1998). *Female masculinity.* Durham, NC: Duke Press.

Hale, C. J. (1997). Leatherdyke boys and their daddies: How to have sex without women or men. *Social Text 52–53*(153/154), 223–236.

Hansbury, G. (2004). Sexual TNT. In U. Leli & J. Drescher (Eds.), *Transgender subjectivities: A clinician's guide* (pp. 7–18). Binghamton, NY: Haworth Medical Press.

Hekma, G. (1994). A female soul in a male body: Sexual inversion as gender inversion in nineteenth-century sexology. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 213–240). New York, NY: Zone Books.

Iasenza, S. (2008). Queering: The new view. *Feminism Psychology, 18,* 537–545.

Iasenza, S. (2010). What is queer about sex? Expanding sexual frames in theory and practice. *Family Process, 49*(2), 291–308.

Israel, G. E., & Tarver, D. E. (1997). *Transgender care: Recommended guidelines, practical information & personal accounts.* Philadelphia, PA: Temple University Press.

Kane-Demaios, J. A., & Bullough, V. L. (Eds.). (2005). *Crossing sexual boundaries: Transgender journeys, uncharted paths.* Amherst, NY: Prometheus Books.

Kaplan, H. S. (1974). *New sex therapy: Active treatment of sexual dysfunctions.* New York, NY: Random House.

Kenagy, G. P. (2005), Transgender health: Findings from two needs assessment studies in Philadelphia. *Health and Social Work,* 30, 19–26.

Kleinplatz, P. J. (2001). A critique of the goals of sex therapy, or the hazards of safer sex. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (pp. 109–131). Philadelphia, PA: Brunner-Routledge.

Kockott, G., & Fahrner, E.-M. (1987). Transexuals who have not undergone surgery: Follow-up study. *Archives of Sexual Behavior, 16*(6), 511–522.

Kotula, D. (Ed.). (2002). *The phallus palace.* Los Angeles, CA: Alyson.

Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299–315.

Lawrence, A. A. (2005). Sexuality before and after male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 34,* 147–166.

Lev, A. I. (1998, October). Invisible gender. *In the Family,* 8–11.

Lev, A. I. (2004). *Transgender emergence: Counseling gender-variant people and their families.* Binghamton, NY: Haworth Clinical Practice Press.

Lev, A. I. (2005). Disordering gender identity: Gender identity disorder in the DSM-IV-TR. *Journal of Psychology and Human Sexuality, 17*(3/4), 35–70.

Lev, A. I. (2006). Transgender communities: Developing identity through connection. In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (2nd ed., pp. 147–175). Washington, DC: American Psychological Association.

Lev, A. I. (2009). The ten tasks of the mental health provider: Recommendations for revision of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism, 11*(2), 74–99.

Lev, A. I. (in press). Sexuality issues for transgender, transsexual and gender-nonconforming people. In S. L. Morrow & R. E. Fassinger (Eds.), *Sex in the margins: Erotic lives of sexual minority people.* Washington, DC: American Psychological Association.

Lev, A. I., & Sennott, S. (in press). Understanding gender nonconformity and transgender identity: A sex positive approach. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives.* New York, NY: Routledge.

Lewins, F. (1995). *Transsexualism in society: A sociology of male-to-female transsexuals.* South Melbourne, Australia: MacMillian Press.

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality, 42*(1), 89–101.

Malpas, J. (2006). From otherness to alliance: Transgender couples in therapy. *Journal of GLBT Family Studies, 2*(3/4), 183–206.

Mason, M. E. (2006). The experience of transition for lesbian partners of female-to-male transsexuals (Unpublished dissertation). Alliant International University, San Francisco.

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response.* New York, NY: Bantam Books.

Namaste, V. K. (2000). *Invisible lives: The erasure of transsexual and transgendered people.* Chicago, IL: University of Chicago Press.

National Association of Social Workers (NASW). (2005). Social work speaks: Official statement concerning homosexuality from the National Association of Social Workers (7th ed.) [Abstract]. *NASW Policy Statements Abstracts.* Retrieved from http://www.socialworkers.org/resources/abstracts/default.asp

National Association of Social Workers (NASW). (2010). Social work speaks: Gender identity disorder and the DSM: Policy statement on gender identity [Abstract]. *NASW Policy Statements Abstracts.* Retrieved from http://www.socialworkers.org/diversity/new/lgbtq/51810.asp

National Center for Transgender Equality (NCTE) & National Gay and Lesbian Task Force (NGLTF). (2009, November). *National transgender discrimination survey preliminary findings.* Retrieved from http://transequality.org/Resources/NCTE_prelim_survey_econ.pdf

Nestle, J., Wilchins, R., & Howell, C. (2002). *GenderQueer: Voices from beyond the sexual binary.* Los Angeles, CA: Alyson.

Nichols, M. (2000). Therapy with sexual minorities. In S. R. Leiblum & R. C. Rosen (Eds.), *Principles and practice of sex therapy* (4th ed., pp. 353–367). New York, NY: Guilford Press.

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12–23.

Person, E., & Ovesey, L. (1974). The transsexual syndrome in males: I. Primary transsexualism. *American Journal of Psychotherapy, 28*, 4–20.

Pfäfflin, F., & Junge, A. (1998). Sex reassignment: Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961–1991 (Trans. R. B. Jacobson & A. B. Meier). *International Journal of Transgenderism* [Symposion electronic books]. Retrieved from http://symposion.com/ijt/pfaefflin/1000.htm

Pope, K. S., Sonne, J. L., & Greene, B. G. (2006). *What therapists don't talk about and why: Understanding taboos that hurt us and our clients.* Washington, DC: American Psychological Association.

Prosser, J. (1998). *Second skins: The body narratives of transsexuality.* New York NY: Columbia University Press.

Rachlin, K. (1999). Factors which influence individual's decisions when considering female-to-male genital reconstructive surgery. *International Journal of Transgenderism, 3*(3). Retrieved from http://www.symposion.com/ijt/ijt990302.htm

Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgendered clients. *International Journal of Transgenderism, 6*(2). Retrieved from http://www.symposion.com/ijt/ijtvo06no02_04.htm

Ramsey, G. (1996). *Transsexuals: Candid answers to private questions.* Berkeley, CA: Crossing Press.

Rankin, S., & Beemyn, B. (2011). *The lives of transgender people.* New York, NY: Columbia University Press.

Roen, K. (2001). "Either/or and both/neither": Discursive tensions in transgender politics. *Signs: Journal of Women in Culture and Society, 27*(2), 501–523.

Roscoe, W. (1998). *Changing ones: Third and fourth genders in native North America.* New York, NY: St. Martin's Press.

Schroder, M., & Carroll, R. (1999). New women: Sexological outcomes of male-to-female gender reassignment surgery. *Journal of Sex Education and Therapy, 24*, 137–146.

Sennott, S. (2011). Gender disorder as gender oppression: A transfeminist approach to rethinking the pathologization of gender non-conformity. *Women and Therapy, 34*(1/2), 93–113.

Serano, J. (2007). *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity.* Emeryville, CA: Seal Press.