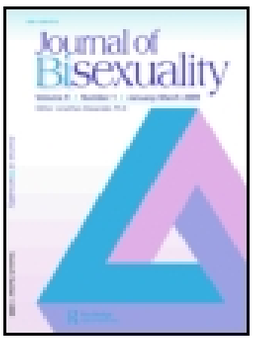

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SUMMARY. Affirmative psychotherapy positively affirms identity without promoting a particular perspective, making it a particularly effective technique for individuals exploring GLBT identities. This article explores the application of affirmative therapy with bisexual transgender individuals. Definitions of transgender and bisexual identities, as well as their intersections, are discussed to illustrate the particular relevance of affirmative psychotherapy. Case examples illustrate the benefits of affirmative psychotherapy with bisexual transgender individuals.

KEYWORDS. Bisexuality, transgender, transsexual, gender, psychotherapy, counseling

INTRODUCTION

Bisexual and transgender issues share some interesting commonalities and intersections of history, visibility and emergence in the field of psychology. Very few theorists considered the possibility of both identities occurring in one individual (Denny & Green, 1996; Devor, 2000). Until recently, these issues have been the subject of limited attention, misunderstanding and pathologizing in both popular culture and as subjects of scientific study. Currently, the body of literature on bisexuality enjoys steady growth; the literature on transgender is in earlier stages of development but is growing as well. Current research and theory have revealed enough commonalities that therapists can consider the use of techniques effective in therapy with lesbians and gays with bisexual and transgender clients (Devor, 1997; Dworkin, 2000; Gainor, 2000).

Affirmative psychotherapy provides support for identity without promoting a particular perspective or imposing the therapist's value system on the client's identity construction process. Affirmative therapy is an effective technique for individuals exploring any aspect of identity, but it is particularly useful for individuals with GLBT identities.

Most sexual orientation theories utilize a rigidly categorized object vs. perceiver to describe orientation (Bohan, 1996; Klein et al., 1985; Rust, 2000). Thus, if a male is attracted to both males and females, he

would be considered bisexual. If the same man is attracted to males only he would be characterized as homosexual. How does the characterization change if the individual declares himself "third gendered (neither man nor woman)"? The object of his attention remains male, but homosexual behavior is defined as male with male. Is the individual in question still homosexual? We could call him bisexual, but what would he call himself? In order to understand the application of affirmative therapy with bisexual transgender individuals it will be helpful to review some theory which describes transgender and bisexual behavior. This will help in understanding some of the intersections of these identities as well as highlight some unique applications of affirmative therapy.

To avoid the confusion which would arise by attempting to accommodate all labeling strategies or by attempting to use labels with uncertain definitions, I will use behavioral definitions of both bisexuality and transgender and will be working from within the binary gender system. There is a risk of compromising individual self determination if we include individuals in a population using a label which they would not endorse. As will be seen below, an individual who endorses one label at one point in their life may reject it and adopt another at a another time. However, terms such as bisexuality and transgender depend upon these dimorphic gender categorizations and labeling framework.

For the purpose of this discussion, *opposite gender* can be understood to mean the gender category to which the individual was not assigned at birth. *MtF* should be understood as female, *FtM* should be understood as male. The term transition refers to the changing of one's outward appearance (hormone surgery and/or sexual reassignment surgery) or legal status to reflect identification with the target or opposite gender.

Bisexuality and transgender discourse both challenge the sex/gender binary and move us closer to accurate descriptions of human behavior (Owen, 2003). Within psychiatry and psychology, there has been a recent trend toward non pathological views of both transgender and bisexual individuals (Alexander & Yescavage, 2003; Mathy, Lehmann, & Kerr, 2003). The literature on bisexuality has reflected this trend longer (Firestein, 1996; Fox, 1996; Klein, 1993; Rust, 2000).

Both transgender and bisexual people have history within the gay and lesbian community; both have been there from the beginning, and both share a history of lack of acceptance and validation within the gay and lesbian community (Alexander & Yescavage, 2003). Both groups share a history of pathologizing, sensational and misleading treatments by popular media.

For both bisexual and transgender people, there is a wide variety of sexual behavior, leading to some confusion about how to apply the terms. For example, some people identify as transgender until they transition, and afterwards use a sex-dichotomous label. Others identify as transgender whether or not they transition (Gagne & Tewkesbury, 1998). In the same way, some identify as bisexual and then later identify as hetero or homosexual, and later may return to identifying as bisexual (Klein, 1993). A more dynamic view of both would more closely reflect the reality of these identity development processes.

TRANSGENDER IDENTITY

Transgender is a term which refers to individuals who do not fit into the predominately dimorphic structure of gender in Western society. Transgender people report that their experience, internal sense or expression of gender does not correspond with what is required of them according to the gender assigned to them at birth (Pauling, 1999). Historically, literature in the medical community treated transgender issues as pathological, excluding from consideration individuals who never requested treatment. This view is reflected in popular culture's almost exclusive attention to individuals who transition (transsexual) or cross-dress. The growth in literature in psychology reveals a diversity of transgender identities and a concomitant need to understand all facets of transgender life.

Transgender identity has been discussed from both essentialist and social construction perspectives (Gagne & Tewkesbury, 1998; Hart 1984). The essentialist position supports the assignment of gender identity based on biological factors, as well as the maintenance of rigid gender boundaries through categorization, pathologizing and sex reassignment. The social construction perspective argues that gender is dynamic, and supports affirmative practices, which allow for individualized identitity development and expression.

Pauling (1999) proposed a five state model of transgender identity development, based on a social construction perspective. These are called states, rather than stages, to acknowledge the fact that identity development does not always proceed in a linear fashion and that an individual's commitment to an aspect of identity is not always permanent.

Nascience is a naïve state where identity is not salient or the individual is unaware of it. *Salience* is when transgender identity becomes critically salient and becomes the subject of problem solving. Another state

is a process of *Exploration* of gender identity and alternate sexual identities. *Internalization/extermination* comprises an attempt to *internalize* the target identity, versus assigned gender, or an attempt to *exterminate* target gender characteristics and thereby reinforce or internalize assigned gender characteristics. *Commitment* involves an adherence to gender dichotomy and assigned or reassigned gender, or movement to gender diversity and identity as transgendered.

Klein (1993) posited four types of bisexuality. The *transitional* type is where bisexuality is considered a stage in the process of coming out gay or lesbian. *Historical* bisexuality is when there are both homosexual and heterosexual attractions, behaviors, or relationships in a person's life. *Sequential* bisexuality refers to monogamous relationships, and *concurrent* bisexuality is the maintenance of more than one relationship at the same time, at least one of which could be characterized as homosexual or bisexual.

Therapists need to be aware of personal and professionally based preconceptions (thoughts, feelings and perceptions based on outdated literature) about gender and sexual orientation in order to be able to provide effective therapy. The following issues may be of particular interest.

Assumptions Made on the Basis of Bisexual Identity

Historically, when considering sexual reassignment, individuals risked being considered not ready for transitioning because they were seen as not having made a choice regarding their sexuality (Bolin, 1988). Confusion about the object of sexual desire creates confusion about gender. Also, therapists' values may divert attention from issues the client considers more relevant; for example, a therapist may identify bisexuality as infidelity and address it as a contributing factor to a client's distress about sexual and/or gender identity.

Invisibility Is an Important Factor

When the perceiver and object fit the description of heterosexuality, their queerness becomes invisible and invalidated. For transgender people with same gender partners who, in effect, become opposite gender partners after transition, the connection with queer community disappears as the couple appears heterosexual in public. Bisexuality is invisible unless announced or otherwise known. Both cases create barriers to connection to and forming of community.

Fluidity of Identity Development

The fluidity of identity development is more visible for bisexual transgender individuals: they may identify as bisexual, then reject this label in favor of another, and later may return to acceptance of the label. As they transition (or not), the process of sexual and gender identification becomes apparent in their choice of partners. Thus, the dynamic process of identity development often is seen as pathological.

CLINICAL CASE EXAMPLES

The details of the cases described below (including names) have been altered to preserve the anonymity of the clients. Transition issues are not discussed in describing therapy with these individuals to avoid the controversial issues that arise when doing therapy with the goal of transition, and to emphasize the fact that transition is not the only reason transgender people request treatment. All of these clients identified as bisexual, either in the past or while in treatment. Two clients identified as transgender when they elected to have surgery since it was required to do so; they no longer identify as transgender.

The Case of Jenny

Jenny was a 28-year-old European American, a lifelong New England resident who said by way of self-identification, "I am a woman." At the time of treatment, she had been transitioning for four years. She had undergone electrolysis, was undergoing hormone therapy, and had received breast implants. The presenting issue was relationship issues, and the diagnosis was *Adjustment Disorder*. She was in therapy for six months, with treatment terminating when she moved to another community.

Jenny is MtF. She takes hormones, has had breast implants, but does not intend, at least right now, to have "bottom surgery." She lives as a woman. This is part of her relationship history. Until 10 years ago she exclusively dated women and had gone so far as to propose to one. Then for several years she explored relationships with men while continuing to date women. She then underwent a period of celibacy and decided to transition. For the past five years she has dated only biological males who, she says, are interested in dating transgender women.

Jenny's requested therapy to help her resolve issues which she says keep her from being able to find a long term partner. Her initial concern was that she was still in a period of bisexuality as transition and she wondered if she should try dating women.

Jenny's treatment lasted about 6 months before she moved out of the area. The move was part her strategy to establish herself in a new area where fewer people would know her history. Before she left her understanding of her attractions was more crystallized, and she described herself this way: "I thought I was interested in women, but I think what I'm looking for there is more like the intimate friendships I see them have. That's hard for me because before (she means before she transitioned), I turned all those relationships into sexual relationships." Jenny feels she's clearly interested in a male long term relationship partner, and has closed off other options. She also resolved to continue working on this in her new location.

For Jenny, it was important to have the label "transsexual" in order to obtain the medical treatment she needed. Otherwise she would not accept it. She was clearly uncomfortable with the label bisexual, but did feel that it described her behavior. She was willing to accept it as past behavior. Depending on the criteria used, we might be tempted to categorize Jenny's sexual behavior as male with male. If we used the criteria I used for this article, Jenny would be categorized as a bisexual transgender individual. I might attempt to help Jenny come to terms with her bisexual behavior and accept the label. An affirmative stance allowed room for her to come to the conclusion that she was no longer bisexual. Jenny's period of celibacy saved her from having to declare an attraction to men, a sometime criteria for sexual reassignment. She told me that when she got her letters she had every intention of remaining celibate, but was interested in men. She minimized her attraction to women because at the time she felt it was not relevant.

I included Jenny because her case raised for me an interesting question about transgender states: could the same criteria proposed by Klein (1993) be applied in the case of transgender individuals? Jenny would meet the criteria for a transitional transgender (as well as bisexual). Individuals who never transition, as well as most individuals who alternate (cross dressers, drag kings and queens, transvestites) would meet the criteria for sequential transgender. Historical transgender individuals would include those who tried forms of transgender expression and no longer engage in the behavior or in any transgender self-labeling. Finally, individuals who identify with both or neither gender would meet the criteria for concurrent transgender.

The Case of Bill

Bill is a 51-year-old African American who describes himself as possibly a gay male, but more likely bisexual. He identified as transsexual while transitioning but now feels this is less descriptive of him now. He is a New England resident who moved here from Philadelphia 10 years before starting current treatment. He underwent full transition, including surgery and hormones, between the ages of 48 and 49, and came in for counseling for depression related to relationship problems. He was seen for six sessions.

Bill is FtM and a person of color. These are, he says, his two most visible characteristics. No one questions his sexuality, though they did before his transition. His family was comfortable with his lesbian identity. They are less comfortable now that he has completed his transition and come out as bisexual. Bill requested therapy when his relationship with his long term female partner was failing, possibly due to his emergent bisexuality. Bill struggled with her characterization of his explorations as cheating on her. She was not convinced of his attraction or commitment to her and eventually left him. This was his last relationship with a biological woman, but he doesn't rule out the option.

Bill noted that as he began to explore relationships with men, he found himself drawn to group of gay men, and once socializing with them, became sexually attracted to them. It is interesting to note that similarly to Peter, Bill felt attracted to men before he transitioned. He often fantasized about sex with them, but never followed through because he feared being treated as a woman.

Bill was seen for a few sessions in which he addressed his attraction to men and resolved his grief about the loss of his long term partner. He terminated treatment as he felt he could continue to resolve his grief with the help of friends and his new cohort. He felt that the most valuable part of the treatment was the validation of his identity as bisexual. He did not feel any need to address transgender issues as he felt he had resolved those in earlier treatment.

The Case of Paul

Paul is a 42-year-old who has not undergone any hormonal or surgical transition, and prefers to be called a Black (vs. African American) man. He is a New England resident who moved from New York 7 years ago. His issues are depression, PTSD, transition questions. He is currently in therapy, ongoing since 18 months ago.

Paul reports that it never occurred to him to think of himself as particularly female, even after he was raped. He reports that he has worn men's clothing since high school, and was not challenged by his family or peers. People most often think he is a male, and he does not do anything to correct them. He has a deep voice, wears his hair short and shaves once a week. He uses the men's room in emergencies but otherwise does not use public restrooms.

Paul originally identified itself as a lesbian then as a bisexual and finally as a bisexual male. He says that he had dealt successfully with his PTSD symptoms and terminated from therapy when he discovered a biography of a female to male transsexual and witnessed the transition of a store owner in his neighborhood. He researched the issue and joined a support group. He started therapy again to deal with issues of identity, but has not decided whether he wants to undergo any medical process. He is afraid it is too expensive (he does not have health insurance) and risky. He is requesting therapy to address this feeling that he is a male but not wanting to lose his female history, to make a decision about transitioning, and to get support about coming out to family and friends. He also wants to get more information and support from transgender organizations. His main complaint is that he cannot find a therapist that is knowledgeable about transsexuality unless he travels a long distance from his rural town.

The Case of Peter

Peter is a 40-year-old European American FtM, a New England resident, who relocated from New York State. He has completed top surgery, and is currently on hormone therapy, with no further surgeries planned. He has been diagnosed with bipolar disorder and he has questions about his sexual behavior. He was in treatment one month, and transferred when his therapist left the agency where he was being seen. He describes himself as a bisexual man.

Peter says he's always been a man, so transgender terms have no meaning for and should not be applied to him. He has had hormonal treatment and some surgery to correct the most prominent of his birth defects, but some corrective surgery is inaccessible to him because of cost. He has always been bi, but says his appearance had made relationships with men impossible because they inevitably treated him like a woman and engaged in sexual behavior that left him cold. Since the surgery he has had moderate success attracting the kind of male he'd like to engage with, but his encounters with females have suffered. He ques-

tioned whether his medical treatment resulted in some changes that made him less attractive to women. He openly identifies as bi, and tells dates about his physical condition before engaging in sexual activity. This is a new strategy: before starting therapy, he would wait until someone questioned his condition; if there were no questions asked (he says often there weren't), he did not give any answers.

Peter has had a number of experiences with more than one partner; he was unsure how to identify his relation to his partners. In one case partners were a man and a woman, an ongoing relationship, in the other case there were several different encounters with two women. Peter was questioning his sexual activity when he started therapy as his psychiatrist questioned its relationship to his being bipolar; one of the possible symptoms of a manic episode is hypersexuality.

Peter was included because although he does not identify as transgender, most practitioners would assign this label to him. He identified as transsexual in order to facilitate his medical treatment. He did identify as bisexual. It was important for him to find a therapist who did not judge his lifestyle or automatically attribute it to his being bipolar.

A PERSONAL NOTE

How do I describe myself? I'm a black man. I've spent most of my life trying to be a woman, and gladly gave up when I realized I didn't have to do that. I came out to my family as bisexual years before I came out as transgender. I didn't use therapy to explore either of these identities. I identify as transgender and bisexual depending on the audience. At work, circumstances forced a change in pronouns, and the transgender aspect is highlighted because some days I look female. An interesting note is that my clients seem to have an easier time than some of my colleagues with adjusting to the information.

Even living in a community reputed as open and accepting, I have encountered a substantial amount of ignorance and prejudice. Sadly, incidents occur frequently. Recently two colleagues argued with me that an adult client's parent was seriously mentally ill; one because the parent was "having a sex change" and came to a family gathering cross-dressed; the other argued that the parent must be mentally ill because the parent was too old to be transitioning. The parent's transgender status was initially suggested to be the client's delusion, and later the source of the client's crisis. Another time, a colleague expressed disapproval of an eighteen-year-old who had completed sexual reassignment surgery,

calling the process a double mastectomy, and opining that the client was too immature to make such a decision.

As I considered sexual reassignment surgery, I shopped for therapy and encountered resistance from therapists who, among other things, stated that they thought I was too pretty to be a man, that I should make a feminist statement by not changing my body, or that I should immediately make plans to have surgery. I found no one willing to consider both paths (transitioning or living as a man without transitioning) equally. Most questioned whether my bisexuality was an accommodation of my transgender status. Others felt it was an excuse for infidelity, since at the time I had two partners: one who acknowledged my masculinity and one who struggled with it. These experiences reinforced my philosophy of therapy: that I am here to help people make informed decisions, not to "help" them in any particular direction.

Many of the issues discussed here are issues I've dealt with, and as a therapist who is a person of color, transgender, and also bisexual, it is important for me to make the world a safe place for me and people like me. Affirmative therapy appears to hold promise for making that safety a reality, if not in the larger world, then at least in the therapy room.

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