Informed and Supportive Treatment for Lesbian, Gay, Bisexual and Transgendered Trauma Survivors

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Informed and Supportive Treatment for Lesbian, Gay, Bisexual and Transgendered Trauma Survivors

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SUMMARY. It is widely acknowledged that sexuality is often a key area of conflict for individuals who have been traumatized and exploited in childhood. Most treatment regimens for trauma survivors include some focus on enhancing client’s capacity to create a healthy adult sexuality, with the goal of replacing rigid, maladaptive beliefs and behaviors, rooted in childhood patterns of oppressive sexuality, with those that enable them to develop a mature and satisfying life. However, though sexuality is emphasized as a significant aspect of human functioning and one in which a traumatized individual frequently needs help, there is often little acknowledgement that there are a range of healthy expressions of sexuality and gender. Though most clients and most therapists are het-
erosexual, those clients who do not fit the norm in this regard need a therapeutic context in which their expressions of gender identity and sexual orientation are acknowledged and clearly supported, so that their psychotherapy process will enable them to learn to live freely and fully, rather than reinforcing the marginalization they experienced as abused children and as adults who practice sexualities which are not widely accepted and fully supported in our society. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com> © 2002 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

Most individuals who suffer from severe dissociative disorders report childhood histories of sexual abuse and exploitation. They tend to have many distorted and self-destructive beliefs about sexuality and particularly their own sexuality. As children and adolescents, they have often known sex as enforced or manipulated, as shameful and secretive, and they are unlikely to perceive their adult sexuality as a positive expression of their most authentic selves.

Similarly, many lesbians, gay men, bisexuals, and transgendered individuals (LGBT), whose experience of gender and sexual desire is all too often labeled “abnormal,” meaning not only different but bad, must struggle with both external and internal prejudice. People with histories of sexual exploitation tend to be particularly vulnerable to the psychological effects of living in a climate of pervasive homophobia. The challenge of being lesbian, gay, bisexual, or transgendered is difficult enough to manage for someone who has not been traumatized in childhood. That challenge is exponentially increased when the individual is also struggling with a history of sexual abuse.

Psychotherapists who treat LGBT trauma survivors must be prepared to address both aspects of our clients’ struggles. This article will examine some issues of relevance to mental health professionals who treat trauma survivors with the goal of enabling us to engage in an informed and constructive therapeutic dialogue that will lead to greater satisfaction with treatment and improved quality of care for our lesbian, gay, bisexual, and transgendered clients.
No problem. I can treat anyone. Human beings are all alike, and I am not prejudiced.”

It is not uncommon for mental health professionals to discount the notion that we might be limited in our capacity to understand the struggles of our clients who are not heterosexual. Whether we have had any training in working with lesbian, gay, bisexual, and transgendered clients or not, few clinicians consider that treating such clients might be outside our area of competence (American Psychological Association, 1991; Clark & Serovich, 1997; Garnets & Kimmel, 1991; Hancock, 1995). Therapists frequently declare that people are people, and what they do in their bedrooms is their own business. It is important in this, and other areas, that we question the assumption that our education, training, and life experience as middle-class professionals necessarily equips us to offer informed treatment to anyone of any race, class, culture, or sexual orientation.

We may be guilty of a sort of selective blindness regarding experiences not our own, including the particular experience of the lesbian, gay, bisexual, or transgendered client. Mental health professionals are no less likely than anyone else to be socialized in our formative years to conventional and unexamined beliefs about sexuality. Even if we are not obviously homophobic, we are unlikely to be free from heterosexism—that worldview that assumes heterosexuality to be the standard against which every other form of gender and sexual expression is measured. Such is the degree of pervasive heterosexism in our culture that even therapists who are not themselves heterosexual may sometimes deny, denigrate, or stigmatize non-heterosexual forms of behavior, identity, relationship, or community. This can result in the devaluation of vital aspects of the lesbian, gay, bisexual, or transgendered client’s life and healthy, functional relationships within the client’s sexual and gender communities (Group for the Advancement of Psychiatry, 2000).

The difficulty is not that therapists are particularly prejudiced. With a few atavistic exceptions, the majority of mental health service providers exhibit much lower levels of homophobia than the general public (Breschke & Matthers, 1996; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993). However, many practitioners, despite a general willingness to be supportive of their lesbian, gay, bisexual, and transgendered clients’ sexual and gender identities, are both vulnerable to acting on the basis of stereotypes (Garnets & Kimmel, 1991; Gelso et al., 1995; Hayes & Gelso, 1993) and not aware of the unique issues con-
fronting the LGBT client (Buhrke & Douce, 1991; McHenry & Johnson, 1993; Morrow, 2000).

There is very little education in professional training programs about the experiences of lesbian, gay, bisexual, or transgendered individuals that would be likely to challenge, enrich, or offer some balance to the pervasive heterosexist values we learn as children and which are reinforced every day of our lives as adults. Therapists’ prejudices and myopia are, therefore, rarely uncovered in our training. They can easily go unnoticed and then be enacted in ways that are harmful to our clients. This can lead to pathologizing aspects of the client’s functioning, simply because certain beliefs and practices that are deeply meaningful to a client are not familiar or are anxiety-provoking to the therapist.

Without specialized continuing education and consultation, therapists may ignore central concerns in the lesbian, gay, bisexual, or transgendered individual’s life. We may not be able to help our clients with the daunting challenges of living in a homophobic environment that continually assaults the sense of self. We may not be able to support our LGBT clients in creating self-affirming identities, satisfying relationships of which they can be proud, and active supportive communities (Brown, 1995). The result can be clients who terminate therapy as oppressed—or even more so—than when they began.

A more pervasive, and possibly less obvious, consequence of a heterosexist viewpoint is the limitations it places on the capacity to create an empathic therapeutic relationship. Empathy—the therapist’s ability to allow another individual’s experience to resonate within, such that it can be processed from a similar vantage point—is a basic tool of the psychotherapy process. When the therapeutic relationship is one in which the client can count on the therapist to provide an atmosphere of steady empathic connection, only occasionally ruptured with significant misunderstanding, this can provide a powerful healing matrix. Most persons’ sense of self is enhanced by the awareness that someone else is focusing on them with a high degree of absorption, accurately understands their inner experience, and is responding with acceptance. Even when challenges to the person’s thinking or behavior are offered, the empathic basis of the relationship offers the client the assurance that the self and the relationship are being enhanced rather than destroyed by such confrontations. Over time this empathic connection creates a milieu in which profound personal transformation can take place (Rivera, 1996). Any significant limitation on the therapist’s capacity to develop the empathic aspect of the therapeutic relationship radically curtails the degree to which the client can grow and change within that context.
One of the ways in which mental health professionals can increase the likelihood of understanding the experiences of their lesbian, gay, bisexual, and transgendered clients is to familiarize themselves with the growing literature that addresses particular issues that may arise over the course of treatment. There is now a range of such resources. Until twenty-five years ago, almost all professional discussion of the issue assumed that “homosexuality”–as all LGBT behavior was invariably labeled–was a sign of profound psychopathology (Bergler, 1956; Caprio, 1954; Ellis, 1965; Socarides, 1968). These articles were mostly theoretical in nature, and the few empirical studies involved participants from hospitals or prisons (Moses & Hawkins, 1982). Kinsey and his colleagues (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) provided the earliest empirical data demonstrating that more people experience same-sex attraction, fantasy, and activity than had previously been believed. A few years later Hooker (1957) found no appreciable differences in the response profiles of thirty-five heterosexual men and thirty-five gay men to the Rorschach and the Thematic Apperception Test. This landmark study was the first of many to refute the prevailing assumption that same-sex orientations are pathological (Bieschke, McClanahan, Tozer, Grzegorek, & Park 2000).

Though a few mental health professionals still believe that same-sex or bisexual orientations are symptoms of mental illness, they are decidedly now the exception. In 1973, the category of homosexuality was removed as a mental disorder from the Diagnostic and Statistical Manual of the American Psychiatric Association, and gays, lesbians, and bisexuals were no longer officially deemed, by virtue of their sexual orientation, to have a mental disorder. In the past twenty years, popular and medical attributions of homosexuality as deviant have been thoroughly refuted, and there is now a body of social science literature that makes it clear that lesbians, gays, and bisexuals are no more likely to have psychological problems than anyone else (Lewis, 1980; Gottman, 1989; Green & Bozett, 1991). A careful review of the scientific literature indicates that there is no demonstrable relationship between sexual orientation and psychopathology (Gottman, 1989; Green & Bozett, 1991; Hooker, 1953; Hopkins, 1969; Lewis, 1980; Thompson, McCandless, & Strickland, 1971). Lesbian, gay, and bisexual clients seek treatment for the same reasons heterosexual clients do–Axis I & II psychiatric disorders and day-to-day stress, leading to decreased quality of life, suffering, and disability (Group for the Advancement of Psychiatry, 2000).

The mental health profession has not yet amassed research sufficient to decide the question of whether the transgendered person’s experi-
ence of gender identity may be—like the orientations of lesbian, gay, and bisexual people—a normal variant, or whether it is a form of psychopathology, as is frequently assumed. The only two studies addressing the issue have found no empirical documentation for the general understanding that gender dysphoric individuals are severely pathological. An American study (Cole, O’Boyle, Emery, & Meyer, 1997) examined co-morbidity between gender dysphoria and psychopathology in 435 individuals. They found less than 10% evidenced problems associated with mental illness and suicide attempts. A subgroup completing the MMPI (N = 137) demonstrated profiles that were largely free of psychopathology, except that the Mf scales were more normal for the desired sex than the anatomical sex. A Norwegian study (Haralsen & Dahl, 2000) compared transsexuals (N = 86), personality disorder patients (N = 98), and healthy adult controls (N = 1068) on the SLC-90. They found that transsexuals scored significantly lower than personality disorder patients on all measures of psychopathology, and although the transsexuals generally scored slightly higher than the controls, their scores were well within normal limits. This is an area where more research is needed, but in any case, the transgendered person is likely to be on the receiving end of many of the same social prejudices (and, indeed, a few additional ones) that plague the lives of many lesbian, gay, and bisexual people and that result in a great deal of debilitating stress.

Many clinical books and articles have been published that present a positive view of lesbians, gays, and bisexuals, as well as direction for counseling them in evolving a healthy sexuality and a happy productive life (for example, D’Angelli & Patterson, 1995; Garnets & Kimmel, 1993; Gonsiorek & Weinrich, 1991; Perez, DeBord & Bieschke, 2000; American Psychological Association Guidelines for Treating Lesbian, Gay and Bisexual Clients, www.apa.org). There is very little social science literature that addresses the needs of transgendered clients, but mental health professionals should read with discrimination what there is (for example, Benjamin, 1966; Benjamin, 2001; Brown & Rounsley, 1996; Israel & Tarver, 1996) plus some literature from other fields (for example, Devor, 1997; Fineberg, 1993, 1996; Griggs, 1998), so as to increase our capacity to respond with accurate empathy to our transgendered clients.

An understanding of the particular issues facing lesbian, gay, bisexual, and transgendered clients can enable the psychotherapist to make a helpful assessment of an individual’s difficulties and an effective plan for resolving them. Being aware of the pressures that LGBT individuals experience living as a sexual or gender minority in a homophobic and
transphobic world, the informed practitioner can differentiate emotional disturbance that is largely reactive to present-day stresses from Axis I psychiatric illness. Axis II symptomatology, in which deep characterological problems may well be combined with difficulties adjusting to life as one of a sexual and/or gender minority, can be diagnosed without ignoring either the character pathology or the genuine life stresses that exacerbate personality problems. A sensitive and thorough assessment of this sort makes a planned therapeutic intervention much more likely to lead to deep, lasting, and positive psychosocial change, rather than diminishment and damage.

**LESBIAN, GAY, BISEXUAL, TRANSGENDERED—NOT ALL THE SAME**

Lesbians and gay men have sexual minority status in common, but their socialization as gendered beings, as women and men respectively, usually results in the development of a significantly different set of values and beliefs. (Brown, 1995; Downey & Friedman, 1995; Roth, 1985) Lesbians’ socialization as women is likely to condition them to connect sex with love and commitment, thus the many jokes about what lesbians do on the second date (“hire a moving van”). The privileging of sex for its own sake is more rarely a value among lesbians, in contrast to gay men, though, of course, there are many exceptions to such generalizations.

Sexually abused lesbians, socialized as women to be the nurturer in relationships, are likely to feel pressured to engage in sexual activity that makes them uncomfortable because they believe that is their responsibility to meet their partners’ needs, rather than because they must live up to an image of themselves as sexually avid and skilled lovers (as some gay may need to do). When, often as part of a recovery process, the lesbian comes to understand that meeting another’s needs at the expense of your own is neither necessary nor necessarily truly caring, she is much more likely to abstain from sexual expression altogether, without much awareness of the toll such abstinence can take on an intimate relationship if her partner still wants to have sex. Such all or nothing thinking—“I have to have sex no matter when or how anyone demands it,” “I do not like sex,” and “I will never have sex again”—is not uncommon in women whose sexuality is still powerfully tied up with early abuse experiences and is therefore more childlike than adult. Helping the lesbian abuse survivor develop a set of beliefs about herself that are
more complex and adaptive to her present-day life, to replace the dichotomous ones learned in an oppressive childhood, is often part of an effective therapy process.

A primary definition of the gay man, both within the gay community and in the wider society, is through his sexuality—the presumption of intense and pervasive sexual interest and constant availability (Troiden, 1989; Green, 1996). For some survivors of child sexual abuse, who may experience sex as a reenactment of their childhood abuse, this focus may serve to reinforce deeply-held beliefs that are painful, shaming, and isolating. This may occur in a variety of ways, depending on the individual and how he incorporates and lives out his life experiences, past and present. Some gay male sexual abuse survivors, like any other survivors of childhood sexual abuse, are frightened by sexual activity. Not only do they not center their lives in a positive way around the expression of their sexuality, they may be afraid to touch and be touched and afraid even to talk about their fears. This difference can lead them to experience themselves as outsiders in the gay community, just as they felt like outsiders, different, and silenced throughout their childhood. Other gay male abuse survivors engage in compulsive and indiscriminate sex, despite getting little satisfaction from their experiences, believing that presenting themselves as objects for the use of others is the only way they can create the human connections they long for. This dynamic sometimes leads to exacerbated self-hatred and hopelessness about building lives in which sexual relationships can be based on mutual respect and love.

In the gay male community, a youthful appearance (adolescent body, smooth skin, slight build) is frequently privileged. Pornographic/erotic images are often accepted as an aid to sexual expression and may portray young men involved in a range of sexual activities. These images can be powerfully triggering for the gay male abuse survivor. What his peers find erotic, titillating, or even funny, may retraumatize him. An effective therapy with an individual who has difficulties identifying positively with other gay men because of his childhood abuse eventually helps him separate his experience of abusive sex as a child from his adult sexual relationships. This can make all the difference in his ability to develop a mature and satisfying sexual life. This does not mean that he has to conform to anyone else’s values regarding sexuality—he may be an anti-pornography activist if he so chooses. But he can create his own beliefs from the position of a thoughtful adult, rather than from the reactivity of a helpless child.
Individuals who experience themselves as bisexual challenge the binary frameworks that characterize our conceptualizations about the diversity of human sexuality. In fact, monosexuality is probably a derivative of a primary bisexual or ambisexual plasticity in the human species. It is most likely our socialization, rather than a biological imperative, that makes us proponents of monosexuality (whether heterosexual or homosexual) as normative. Theorists and researchers from Freud onward have demonstrated that the boundaries between sexualities are quite fluid and that many more people than those who label themselves bisexual manage to experience multiple forms of sexual expression with partners of both sexes despite cultural dictates and institutional arrangements (Kinsey et al., 1948, 1953; Bell & Weinberg, 1978). In fact, Kinsey and his colleagues suggested that bisexuality may be more prevalent than homosexuality and encouraged researchers to think of sexuality in terms of a continuum, rather than as a set of dichotomous categories. Subsequent research has supported this notion of the fluid nature of sexual orientation (Blumstein & Schwartz, 1977; Klein and Wolf, 1985). However, despite this reality, there is little room for the ambisexual in our cultural, and sexual abuse survivors who experience themselves as bisexual may be seen as simply afraid to come out as lesbian or gay and may be pressured by peers to “get off the fence.” Disapproval of bisexuality is particularly prevalent in the context of HIV/AIDS. Individuals who have sex with both men and women are often blamed for the transmission of the disease to “innocent victims,” as if certain groups are especially entitled to immunity from this disease. Bisexual men are charged with spreading AIDS to their heterosexual female partners, and bisexual women are seen as importing AIDS into the lesbian community (Weinberg, Williams, & Pryor, 1994; Namaste, 1998), thus indicting bisexual orientation rather than an individual’s dishonesty about multiple sexual partners and/or irresponsibility about safe sex, behaviors that are practiced by people of all sexual orientations.

Our society has been rigid in maintaining a two-gender system, to the exclusion of social and biological variations. However, some people with male biology grow up experiencing themselves as female; some with female biology as male. Others experience themselves as a blend of both male and female (androgynous), and still others experience themselves as neither male nor female but as an unidentified third gender or no gender at all (Cope & Darke, 1999). The term “transgender” has only recently come into popular use and includes all people whose felt sense of core gender identity does not correspond to their assigned
sex at birth (MacDonald, 1998). People who are not able to fit into the binary gender categories (male/female) that we take for granted self-identify in a variety of ways. The term "transgendered" is used to describe a range of people who cross socially constructed gender boundaries. In this article, “transgendered man” and “transgendered woman” refer to the identity claimed by the individual, regardless of their sex assignment at birth or their status as pre, post, or non-operative transsexuals.

Transgendered women and men present even greater challenges to the way in which we invent categories, pigeonhole people, and try to force them to conform to our socially constructed expectations. The question of sex and the question of gender, though inextricably bound with each other, are not the same question (Rubin, 1984). Unfortunately, any distinction is all but erased in the public mind where effeminacy is often conflated with the identity of gay men and masculinity with that of lesbians. In fact, the most intense prejudices directed toward non-heterosexual individuals focus on their refusal to conform to gender stereotypes rather than the manner of their sexual expression. Drag queens, effeminate men, and butch women are the targets of the most vicious attacks from gay-bashers determined to beat them into submission to the gender codes our culture endorses. Not all transgendered individuals are lesbian or gay, but their inability or unwillingness to conform to our social imperatives about what women and men should look and act like links them with others who transgress social dictates about gender and sexuality.

**CHILDHOOD SEXUAL TRAUMA AND HOMO/TRANSPHOBIA**

Many adolescent and adult survivors of childhood trauma, especially those who have developed severe dissociative conditions, have experienced a range of traumas, including child sexual abuse (Putman, Guroff, Silberman, Barban, & Post, 1986; Ross Norton, & Wozney, 1989). It is developmentally normal for children to understand themselves as the source of all their experiences. They cannot understand the concept of random assignment of good fortune or ill treatment. They are assaulted and exploited because of who they are. Abused children are convinced that they must not let anyone know about what goes on in their lives because, though everyone can see that they are different, the best that they
can hope for is that no one sees just how strange and how pernicious they are.

Similarly, lesbians, gay men, bisexuals, and transgendered people frequently struggle with internalized homophobia, fear and hatred of oneself as a sexual being with same-sex desires and affectional preferences, and/or internalized transphobia, fear and hatred of oneself as a person whose sense of gender identity does not match one’s body. These are understandable responses to coming up repeatedly against the hatred and fear of any sexuality and gender identity that does not conform rigidly to cultural norms. Lesbian, gay, bisexual, and transgendered adults who were sexually exploited, assaulted, and oppressed as children find their experiences of being singled out, made to feel different, and hated and hurt by people in authority, and often by peers as well, replicated and perpetuated in adolescence and adulthood.

No matter which comes first, the abuse that entails some kind of attack on the body or the abuse that entails an attack on the sexual and/or gender identity of the person, the effect can be similar. Minimizing the effects of such attacks on one’s self is critical. Unable to change the external world, the child, and later the adult, must develop ways to cushion the internal effects. There are a number of ways to accomplish this—dissociation, fantasy, drugs or alcohol, self-injury, use of food, sex, exercise, work, computers or any other substance or activity in a way that alters one’s physical and or psychological chemistry. The problem with these methods is that they work well—temporarily. When children who have been sexually abused begins to notice their same-sex sexual attractions, or the children who have been scapegoated from very young because they do not conform to gender norms are then sexually assaulted, defenses that have worked to ameliorate the first painful reality are ready-made for this new situation. The therapist must be able to recognize the reality of both oppressions to help such an individual face and deal with each as it is reinforced by the other (Rivera & Wachob, in press).

**ORIGINS OF SEXUAL ORIENTATION AND GENDER IDENTIFICATION**

The issue of “Why am I lesbian, gay, bisexual, or transgendered?” is quite likely to arise in treatment. Some individuals who have been sexually abused in childhood frame their sexual orientation or gender identification in a reductionist and self-denigrating way, as the outcome of
their abuse experiences. Unfortunately, they are likely to be encouraged in this way of thinking by relatives, friends, clergy, and even some mental health professionals, who see their sexual orientation and/or gender identification as one more terrible problem in their blighted lives.

Therapists of LGBT people have the responsibility to develop an educated perspective on the origins of sexual orientation and gender identification, independent of the perspective the client brings to treatment. Though much, of course, can be learned from listening to one’s client, therapists whose only source of knowledge about LGBT people is what their clients tell them are unlikely to be able to create an empowering context in which these clients can struggle with their difficulties. A client might declare with utter conviction and sincerity that he knows he will no longer experience the sexual feelings for other men that he has felt since early adolescence when he has dealt with his abuse experience in therapy. A therapist who does not know enough to caution the client that this is unlikely to be the case and who in any way reinforces what is, in the vast majority of cases, wishful thinking, is colluding with the client in his internalized homophobia and is implicitly making promises about the therapy process that cannot be kept. Such a treatment will eventually lead to further self-hatred and despair.

There are still some mental health professionals who are working with lesbian, gay, bisexual, and transgendered clients who interpret their clients’ attraction to people of the same sex or inability to conform to gender-identity norms as pathological (Falco, 1991; Fox, 1995; Silverstein, 1991). Some even counsel that to find happiness their clients must cure their deviant patterns of arousal or re-shape their sense of gender identity. Even a relatively recently published book about personality disorders (Akhtar, 1992) proffers outdated psychoanalytic dogma about gender and sexuality, as if these were scientific observations rather than the expression of a set of cultural attitudes and values:

A cohesive gender identity is concordant with one’s biological sex and shows harmony between core gender identity, gender role, and sexual partner orientation. This translates into heterosexual object choice and an overall gender-appropriate demeanor including attire, gestures, roles, social priorities, sexual behaviors, and interpersonal relationships. (pp. 35-36)

Even when professionals do not go so far as to advocate a change in gender identity, sexual desire, or object choice, they may see any fantasies, desires, and practices with which they are not personally familiar
as deviant, thus colluding in disciplining clients to conform to narrow social standards. A wide array of activities—including cross-dressing, polyamory, and enactments of sexual fantasies (for example, domination/submission)—are frequently discounted by mental health professionals as de facto pathological. Therapists should make every effort to learn about differences in sexual practices or gender expression before assuming that all such differences are psychological problems to be altered through therapeutic intervention.

Therapists are frequently taught that sexual orientation is a stable and fundamental aspect of an individual’s identity, and there are some interesting studies in three disciplines—neuroanatomy, endocrinology, and genetics—that examine the ways in which biology may play a part in the development of sexual orientation in some individuals (LeVay, 1991; Hamer, Hu, Magneson, Hu, & Pattatucci, 1995; Money, 1987; Swaab, Gooran, & Hofman, 1992; Kirk, Baily, Dunn, & Martin, 2000; Dawood, Pillard, Horvath, Revelle, & Bailey, 2000; Bailey, Dunne, & Martin, 2000; Pillard & Bailey, 1998; Herron & Herron, 1996). Every new study tends to be hailed as if the results offer a simple answer to a simple question, but so far there are no data that point to genes, life experience, or brain morphology as the sole and simple source for the many variations in the ways in which sexual desire, longing for affiliation, and gender identity manifest themselves in different people. Clients have a right to hold whatever opinion suits them about the subject. It is, however, incumbent upon mental health professionals to inform ourselves, so that we do not unintentionally implant or reinforce damaging views that are not empirically supported.

**GENDER AND SEXUALITY EXPRESSED THROUGH DISSOCIATIVE STATES**

Individuals who have been the victims of severe and chronic childhood abuse, including child sexual abuse, frequently develop dissociative defenses to enable them to manage what they cannot escape or understand. As adults, severely dissociative individuals often express their experiences and understanding of their sexuality and gender identity rigidly in concrete and demarcated states of consciousness that they may experience as male, female, gay, straight, and bisexual.

Exploring a patient’s self-identifications in terms of both gender and sexual orientation can offer both patient and therapist a wider and deeper understanding of some of the patient’s core therapeutic issues.
Unpacking individuals’ beliefs as they are manifest in personality states can be illuminative of the evolution of their sexuality and gender identity in many ways. In 1989, I distributed questionnaires about dissociative states and sexual expression to a small number of individuals diagnosed at that time as suffering from multiple personality disorder (Rivera, 1996). The responses illustrated the richness and diversity of the pathways that these people traveled in developing their understanding of themselves as gendered and sexual. Respondents were asked to explore their views, attitudes, and behavior regarding sexuality as expressed in altered states of consciousness. As the questionnaire was long and detailed, only individuals who experienced gender and sexuality as significant issues for them would have been likely to have filled it out. Given that I did not select by sexual orientation, it is interesting that all of the questionnaires that were returned were from individuals who either identified as lesbian (N = 10) or gay male (N = 2), or who identified as bisexual (N = 8, all female).

I did not conclude that more severely dissociative abuse survivors were gay than straight from this small and not particularly randomly selected group of individuals seen in my practice, the practices of a few colleagues, or who attended a local self-help group or attended a forum “For Multiples Only” at a dissociation conference held in Toronto. In fact, research indicates that the same percentage of women who self-identify as lesbians have a history of childhood sexual abuse—38% (Loulan, 1987)—as women in studies in which sexual orientation was not noted (Russell, 1986). I hypothesized that, for individuals struggling to understand their sexual desires, same-sex sexuality needed more explaining—and from severely dissociative people, more dividing up—to make it manageable than heterosexual sexuality.

The rich and detailed life stories that were written in response to the questionnaire illustrated the complexity of the construction of sexuality as it plays itself out in the lives of trauma survivors. The following were common configurations:

- Child personality states who wanted affection and were horrified when the affection turned sexual;
- Anhedonic states in which individuals experienced themselves as asexual and sometimes non-gendered as well;
- Hypersexual teenagers, sometimes promiscuous;
- Stereotypically heterosexual feminine personalities who voiced conventional desires for security, safety, and a vine-covered cottage and saw sex as a means to those ends;
Male-identified personalities in women’s bodies who were actively sexual with other women and framed the behavior as heterosexual;

Female-identified personalities in men’s bodies who were passively sexual with other men and framed the behavior as heterosexual;

Sexually aggressive personalities in both lesbians and gay men, usually experienced as male by both women and men;

Personalities who knew they were lesbian or gay and were comfortable with that awareness;

Personalities who thought it was silly to choose the people to whom you wanted to relate intimately by whether they were men or women, rather than by what they were like in so many other ways.

There were scores of permutations and combinations of personality states with different self-understandings about their gender and sexual identity in the twenty questionnaires that were fully filled out. The respondents (N = 5) who had had a lot of therapy and appeared to have resolved a great many of the most dysfunctional aspects of their dissociative coping mechanisms described the evolution of their understandings about their sexuality. Some personalities who had endorsed stereotypical (and often viciously intolerant) perspectives about same-sex sexual expression as an unnatural (and usually ungodly) abomination became more accepting of the desires and the practices of the others. Eventually, in the less rigidly divided person, earlier self-loathing about same-sex relationships was replaced with general acceptance and only the occasional deprecatory self-judgment. Child personalities were gradually subsumed into the general category of childlikeness or vulnerability, and those aspects of the individual, as described by some individuals, disappeared during sexual activity or, as described by others, became a playful aspect of sexual expression.

By termination, clients who complete a thorough and successful psychotherapy process usually resolve much of their confusion and dividedness about gender and sexuality. The assertiveness that initially could only be expressed when the individual experienced herself as a man becomes increasingly integrated with the sensitivity and vulnerability that she has always associated with femininity and has expressed in personality states she understands to be female. Gradually, (at least for those who are not transgendered) gender issues become less central and only occasionally emerge from the background. Most integrated in-
individuals come to experience some degree of comfort with their biological sex, their gender identity, and their sexual orientation.

**TRANSGENDER:**

**CHALLENGING ASSUMPTIONS ABOUT GENDER**

Our diagnostic system assumes that those who are not willing or not able to conform to our gender-identity norms have a mental disorder. However, we have not yet validated this assumption, and, in fact, the research that has been conducted thus far (Cole et al., 1997; Haraldsen & Dahl, 2000) contradicts it. At present, such framing of the transgendered person’s experience of him/herself as a psychiatric disorder (“gender identity disorder”) is ideological, rather than being based on any empirical data. It has its roots in genderism, the belief that there are only two genders that are natural and that everyone’s gender identity should match his or her biological sex. Thus far, there is no evidence that transsexuality is psychopathological; the category “gender identity disorder” simply refers to a difference in the experience of gender identity from the norm. Until there is empirical validation for the link between a transgendered identity and psychopathology, the diagnostic category “gender identity disorder” is an expression of prejudice rather than a scientifically-based description of a mental illness. Surely, the medical community is capable of finding appropriate medical terminology to describe the need of some transsexuals for hormone therapy or sex re-assignment surgery that does not involve diagnosing patients who exhibit no psychiatric symptoms as mentally disordered! As with any other medical procedure, a psychiatric assessment can and should be ordered when there is evidence that mental illness may influence the patient’s capacity to consent to treatment or to benefit from it.

Psychiatric medicine has a long history of creating linguistic categories that reify ethnocentric values that support exclusions and oppression. In the antebellum southern United States, for example, Samuel Cartwright, a highly respected and widely published medical doctor, invented the disorder, “drapetomania,” defined as “the morbid compulsion to be free.” This category was applied to slaves who tried to escape from captivity. In Cartwright’s popular article (1851/1967), “Diseases and Peculiarities of the Negro Race,” such slaves were not only seen as disobeying the law that bound them as property to their owners but as mentally ill for experiencing a desire that was socially unacceptable at the time. Dr. Cartwright offers this advice to slave owners, “With the
advantages of proper medical advice, strictly followed, this troublesome practice that many Negroes have of running away can be almost entirely prevented” (http://www.pbs.org/wgbh/aia/part4/4h3106.html).

To date, no empirical evidence suggests a need to treat gender identity dysphoria as a mental disorder. Could it be that, like the creation of the category “dрапетомания,” the need to define difference in gender identity and presentation as a mental disorder may be nothing more than a reflection of social prejudices? It is our responsibility as social scientists to learn from the history of our profession and avoid creating and reinforcing diagnostic categories that reify bias and further marginalize those who challenge social norms to which most of us conform without much thought or effort.

Individuals’ gender identity is usually established at an early age, and most transgendered individuals are the targets of pervasive discrimination throughout childhood. The markers of their biological sex are usually a source of great distress to them. They are frequently pressured or even forced into dress and activities that are profoundly ego-dystonic, as a routine part of sex-role socialization. Forcing a child who experiences his gender to be male to wear a dress or a child who thinks of herself as a girl to participate in an all-boy hockey league exacerbates their pervasive sense of shame and highlights their need to hide from others who they are. As they grow older, most find ways to accommodate their cross-gender identity to increase their own comfort level without risking the loss of their social status and all that goes with it, including family acceptance, jobs, intimate partnerships, and children. Many of these individuals struggle daily to find just the line of gender expression in dress and stance so that they can be somewhat comfortable with how they present themselves to the world without risking constant social censure.

One transgendered man described in a group therapy session an encounter with a young child and her mother on the street. “Hi, man,” the little girl spoke to him cheerfully. He smiled and was about to greet her in response, feeling happy to meet such an outgoing, confident child, when the mother grabbed her daughter’s hand and pulled her away, saying, “That’s not a man, and don’t talk to her.” He continued walking on home, trying to cover his shame and sadness with anger. “It always happens,” he muttered to the group, “It always happens.”

Some transgendered individuals eventually choose to be open about their gender identity. This can be a great relief, just as lesbians, gays, and bisexuals experience a sense of liberation when they decide they will no longer hide their sexual orientation. However, coming out as a
transgendered person can be even more fraught with social peril than coming out as gay, lesbian, or bisexual. Many people feel perfectly free to contest the gender identity of a transgendered individual. “You look just like a woman; I never would have known you are not one.” “You may not come into this shelter; it is only for real women, women who were born women.” The refusal to use the name or the pronouns that the person prefers is one of the ways in which this discomfort can be expressed by family, friends, and sometimes therapists as well.

Transgendered men and women often experience their childhood abuse as being related to their inability to fit into gender stereotypes. One transgendered man, brought up as a girl with three sisters, was certain that his father had anal sex with him for ten years because he was a boy, but a boy with female body parts. His experience of himself as a boy pre-dated the abuse, but the abuse reinforced his sense of shame about his body and his conviction that this was the type of treatment he could expect, and perhaps deserved, for having a body that did not match who he was.

The individual solutions offered to people suffering from a profound disruption between their bodies and their sense of themselves as gendered tend to perpetuate the denial that is at the heart of the transgendered person’s dysphoria. Post-operative transsexuals are often advised to invent a new childhood for themselves and to destroy all evidence of their previous sex. As Kate Bornstein (1994) notes, “Transexuality is the only condition for which the therapy is to lie” (p. 62). Proposed societal solutions, such as “gender doesn’t matter,” implicitly or explicitly criticize transgendered people as gender conformists and facilely deny the felt reality of their personal torment. Transcending the constraints of gender (or playing at doing so when it suits us) is a luxury of those who have a comfortable sense of gender identity that conforms to social norms and very little recognition of the many ways in which we ourselves participate in the maintenance of a strict sex/gender social system (MacDonald, 1998).

Therapists of transgendered women and men must be open to the wide range of healthy gender and sexual expression if we are to help our clients deal with their experience, past and present, of living in a society that is not accepting of their expression of gender identity. Without extending our own knowledge base, challenging our own preconceptions, and widening our empathic capacity, we are in danger of becoming one more source of oppression in our transgendered clients’ lives by framing as problematic and a target for therapeutic change what may be utterly core to their sense of self.
Gender issues are often difficult for many severely dissociative trauma survivors, those who are transgendered and the majority who are not. Most individuals suffering from Dissociative Identity Disorder have personality states in which they experience themselves as cross-gendered (Putman et al., 1986; Ross et al., 1989), and daily conflicts about what clothes to wear to present oneself as appropriately masculine or feminine are very common. By termination, clients frequently resolve their confusion and dividedness about their gender, and they come to experience some degree of congruence between their biological sex and their gender identity. The assertiveness that initially can only be expressed when the individual experiences herself as a man becomes increasingly integrated with the sensitivity and vulnerability that she has always associated with femininity and has expressed in personality states she understands to be female. Gradually, gender issues become less central and only occasionally emerge from the background.

Transgendered individuals who suffer from Dissociative Identity Disorder may well also experience gradually less confusion and dividedness regarding gender identity as they make some gains in therapy, but they experience increasing certainty that their gender is not congruent with their biological sex. Some may choose to undergo sex-reassignment surgery, but for many this is not desirable or even possible. Some gender identity clinics exclude individuals with a history of mental illness. Others do not consider a psychiatric disorder a contraindication for sex re-assignment surgery or hormone treatment, as long as the clients’ perspectives regarding gender identity do not fluctuate with the psychiatric disorder and they are reasonably stable emotionally (Benjamin, 2001; Brown & Rounsely, 1996).

There has been no published research on the topic of treatment outcomes for DID clients who are transgendered, although there are two published case studies on individuals who were diagnosed with severe dissociative disorders after they had undergone sex-reassignment surgery (Saks, 1998; Schwartz, 1988). I have worked with a small number of dissociative individuals who have consolidated cross-gendered identities (sometimes with periodic hormone therapy and always without surgery). They each found a way to come to terms with themselves as transgendered and to make reasoned choices they could live with relatively peacefully.

One transgendered man officially changed his name from one that identified him as a female, transformed his appearance through a combination of a hormone regimen and replacing all clothes that were even slightly feminine, and gradually lived life openly as a man. As there
were no employment issues for him to consider, and his children were
tolerant of his transformation, he was able to be open about his experi-
ence of himself as a man. However, rather than denying his history (as is
often recommended in gender identity clinics as part of the process of
cross-gender transformation), he acknowledges that the parts of him
whom he had experienced as female are valuable aspects of who he is,
and he works at incorporating his feminine qualities into his sense of
himself as a man who is both assertive and tender.

A transgendered woman, who works in a traditionally male job
where stereotypically masculine qualities are privileged and any open
gender ambiguity would be not only scorned but dangerous, chooses to
live a bifurcated life. At work, she is as tough as the job requires. At
home, she lives her life as a woman. She seems no more conflicted
about her way of life than many individuals who have to be less authen-
tic at work than they would like to have a successful career, and though
she gets considerable satisfaction from her challenging job, she also
looks forward to retirement and a move to a different city where she will
be free to live more fully as a woman.

In both of these cases, the basic consolidation of a cross-gendered
identity occurred long before all the issues related to their trauma histo-
ries and dissociative adaptations had been unearthed and resolved in the
therapeutic process. The relief and well-being that came from acknowl-
edging and living out their transgendered identity appeared to give
these individuals the confidence eventually to explore extremely diffi-
cult issues more fully and deeply.

**DID AND GENDER IDENTITY DISORDER–
DIFFERENTIAL DIAGNOSIS**

When assessing gender dysphoric individuals presenting for hor-
mone treatment or sex re-assignment surgery, who have a history of
childhood trauma and report or exhibit signs of psychopathology, it is
extremely important that physicians and mental health professionals
consider a dissociative disorder, and particularly Dissociative Identity
Disorder (DID), in their differential diagnosis (Brown & Rounsley,
1996; Devor, 1994; Saks, 1998; Schwartz, 1988). Though a history of
trauma and a dissociative disorder do not preclude genuine transexuality,
any radical and irreversible treatment should only be undertaken with
the full awareness of its life-altering effects. Informed consent cannot
be provided by a client who is unaware of his or her beliefs, experi-
ences, and behaviors in dissociated states of consciousness, or who is unwilling to explore them. Saks (1998) recounts the case history of a biological female who had developed a dissociative disorder in response to severe childhood abuse. In adulthood, two male alter personalities dominated for eleven years, during which the individual cross-dressed, lived as a man most of the time, and passed all the psychological tests to qualify for sex re-assignment surgery, consciously hiding from the clinic personnel information about her history of dissociative symptomatology. Three surgeries were performed, and ten years later the client had a mental breakdown during which Dissociative Identity Disorder was diagnosed. Alter personalities have emerged in subsequent treatment who understand themselves as girls and women, presumably creating significant internal conflict about the surgically-altered body. Schwartz (1988) reports the case of a post-operative female transexual who was diagnosed with multiple personality disorder years after sex reassignment surgery. Although in this case the male alter personalities concurred with the decision to be female, Schwartz cautions that it is crucial to uncover and treat dissociative disorders before recommending surgery.

CONCLUSION

This article touches on only a few of the issues that mental health professionals treating lesbians, gay, bisexual, and transgendered clients with trauma histories may face over the course of psychotherapy. There is very little published on the treatment of lesbian, gay, bisexual, and transgendered clients with dissociative disorders. This is an important area for the creation of constructive theory, the publishing of clinical experience, and the development of research studies that will enable the mental health profession in general, and the trauma and dissociation field in particular, to practice more sensitively and effectively with our lesbian, gay, bisexual, and transgendered clients.

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