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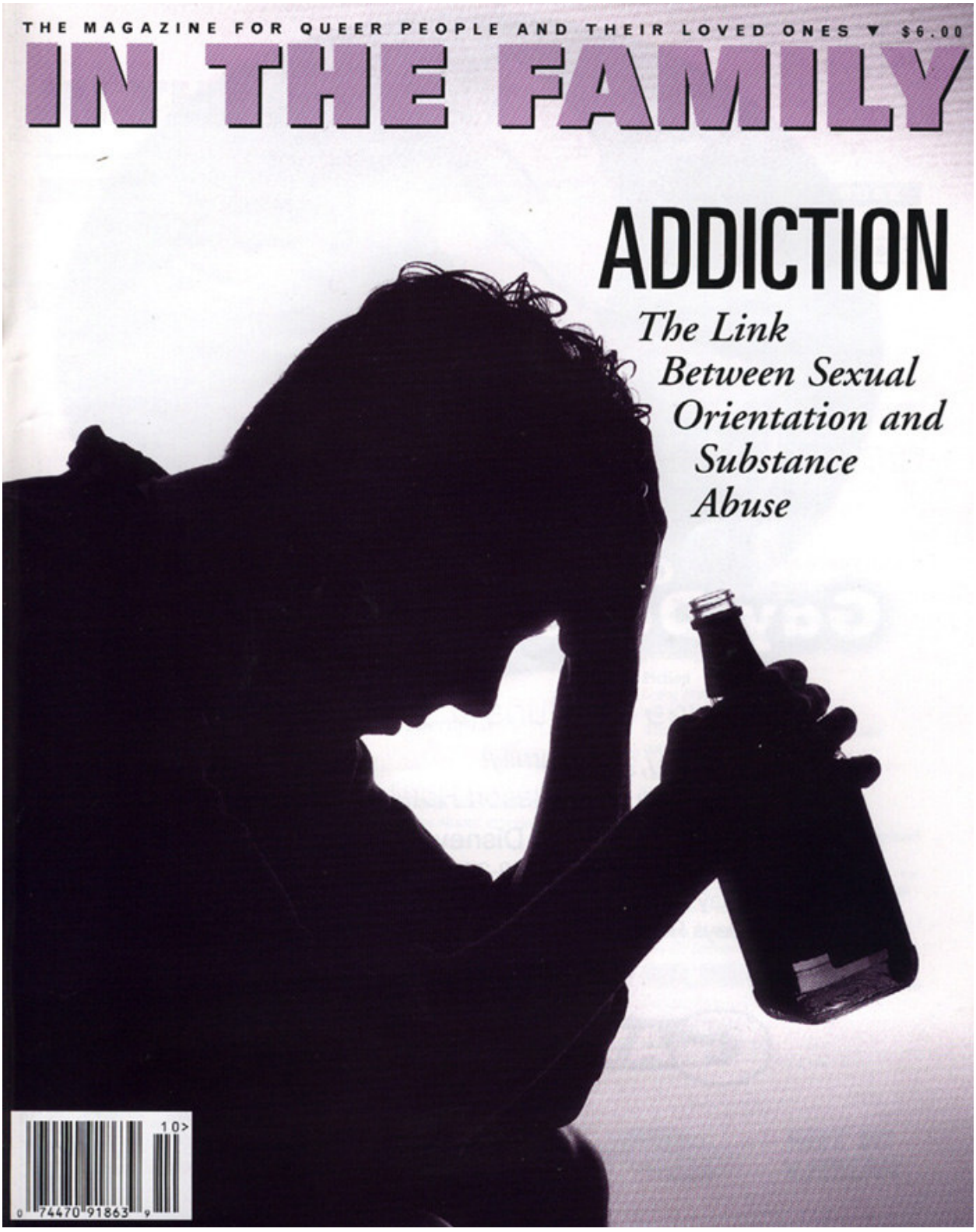
The Link Between Sexual Orientation and Substance Abuse



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IN THE FAMILY

VOLUME 8, NUMBER 2 ▾ FALL 2002

THE LINK BETWEEN SEXUAL ORIENTATION AND SUBSTANCE ABUSE

Affirming their gay son.

DEPARTMENTS

Holding Up A Mirror

In the Therapy Room with a Trans Therapist and Her Trans Clients

By Melanie Spritz

There is no way I can ever really convey to you what it's like being a male-to-female transgender human being. I can only give you anecdotes about the pain of my childhood, which I endured in confusion and awkwardness in a boy's body, when I had affinity for a girl's body. I can only offer you stories about my family—the courageous ways they helped me and attempted to understand me and love me, and their anger, disgust and rejection. I can try to explain what it was like to be completely alone with my reality as a trans girl and then as a trans woman. I don't think even gays and lesbians and bisexuals, who experience their own isolation, confusion and fear, can comprehend what it's like to be alienated from one's own body. No one could tell me why, from my earliest memory, I had the deepest certainty that I was female. And because of this cognitive gap between us, I don't think you can understand why I voluntarily, and to my great relief, underwent dangerous and painful surgeries and chemical interventions to transition from male to female. ▼ Imagine if you were my therapist, and I washed up on the beach of your waiting room, already battered by a few decades of ridicule, rejection and loneliness. How would you begin to understand me? Would it be in terms of pathology—Gender Identity Disorder? Would you try to "cure" me? Would you secretly theorize that I was a homophobic gay man who needed to "become" a woman in order to accept my desire for men? (And how would you understand me if I told you I was a straight transwoman after living a life as a straight man?) Would you blame my father for not being too manly, or for being hyper-masculine, or my mother for smothering me or pushing me away or secretly wishing she had gotten a daughter instead of a son?

In the past decade, mental health professionals have finally begun to listen to trans people and develop helpful guidelines for treatment. The current bible of the trans treatment community is *The Harry Benjamin Standards of Care, Sixth Edition*, which has codified some of the basic understandings about transgender as a phenomenon that has existed since humans have existed. There are a growing number of clinicians who are competent to work with gender-transgressive or gender-discordant clients. But what has been missing even from these fine additions to the literature is the voice of the transgender therapist who works with trans clients. As a post-operative transsexual woman and psychiatrist, I have the distinction of having sat on both sides of the couch. What I've learned from working with trans clients is that we have to both treat the transgender/transsexual issue, and also treat the human being. Each client is unique, and his or her life experiences may share some similarities with mine, but there is so much variation that I can't take anything for granted. Even when the client presents with a story similar to my own, I have to investigate and question my own assumptions.

When my non-trans colleagues ask for consultations with me about their trans clients, they are often surprised to hear that I make mistakes with my trans clients, that I can miss the mark as easily as they can even though I am trans. Gay and lesbian and bisexual therapists know that just because they share the same sexual orientation, it doesn't mean they are perfect therapists for their queer clients. That being said, below I offer two case studies of my work with trans clients. I define "transgender" as any gender-transgressive or gender-discordant individual, without regard to the question of the person's sexual orientation. Within this category are a subcategory of transsexuals. This term refers to those who have the desire to undergo Cross Gender Hormonal Therapy (CGHT) and/or Sexual Reassignment Surgery (SRS). Basically, they want to live a life congruent with the gender they feel they are, i.e., the opposite of their birth gender. I use the word "trans" to signify a member of the transgender community, since this is in the idiom of that community.

Chloe: Male-to-Female Youth

Chloe was a 14-year-old Latina male-to-female (MTF) trans youth. She was referred to me through a child services agency in New York City. Chloe's young life had already been punctuated by multiple placements in residential treatment facilities. Her parents, both addicts, had died from substance abuse when she was young, and since the age of 8 or 9, she had been in and out of foster care and group homes. Despite pressure from the adults in whose custody she was placed, Chloe had increasingly displayed feminine mannerisms and behaviors, adopted a female name and participated in drag balls. She ended up running away from each placement after fights with adults there about her effeminate behavior and her inability to follow the rules. As a runaway, she lived on the street and engage in prostitution. She used marijuana and alcohol, and was arrested for stealing as well as for solicitation. Later, when I asked her about this, she told me she did those things to get money so she could buy clothes, hormones, and other things she needed to become female.

At times, I found myself trying to allay my own political guilt—after all, shouldn't I be the first to understand Chloe's desire for hormones? What was I doing getting in her way of realizing her dream to become a female? I felt guilty being "the establishment," being an agent of the system, not her liberator.

Chloe defined herself as a female, sometimes using the term "she-male," a common term of self-definition by street transsexuals on the East Coast. Although she had above-average intelligence and no developmental delays, her school attendance was erratic and her behavior problems led to her placement in Special Education classes. She could be charming, but none of the adults in her life noted any evidence of her taking responsibility for her behaviors. She showed no desire to stop stealing, to finish school, to tell the truth. Even when caught in a lie, she refused to take any responsibility for her actions, demonstrating her lack of insight and judgment. This occurred even in the most ideal of circumstances, where her transgender behavior was accepted and not seen as a pathology. Her previous therapists and the counselor at the drop-in center at the youth center all said the same thing: Chloe continually jeopardized herself and her goals.

For her first session with me, Chloe presented as androgynous, although she demonstrated what I considered exaggerated effeminate mannerisms. When she sat down, for example, she pinched her knees together and delicately perched on the edge of the chair. She was well-groomed, and dressed in typical teenage uniform of jeans and a t-shirt. Her voice was soft and pitched high, and for that first session, she did not wear make-up. My purpose in seeing Chloe was to help her figure out who she was and what she needed to have the life she wanted to have. The agency certainly hoped I would guide her so she could "fit better" in society as a trans person. Chloe's purpose in seeing me was clear from the first moment we met. She was obsequious and fawning in her attempts to curry favor with me so I would prescribe hormones. She believed she needed them in order to be a "real woman."

I am sure Chloe thought it would be a snap to get me to prescribe hormones. I know I would have felt the same way if I had seen a MTF therapist when I was a young person! I explained that I first needed to do a thorough assessment. Despite her insistent lobbying for hormones, I was determined to proceed cautiously. Chloe implied, and later threatened, that she would get them on her own if I would not cooperate—we both knew hormones could be bought on the street, and that this method of transitioning was rife with danger because the hormones were not regulated by a medical professional, dosages would be erratic and potentially harmful to her

physically and emotionally. I told her we had a lot of talking to do before I was going to be ready to prescribe hormones, and that I was open to the possibility that she would be a good candidate for CGHT, but that it was too soon to say.

I invited her to talk about herself, but Chloe resisted me at every turn. The only thing she wanted to discuss was her need for hormones. Since she was not willing to talk about her past, evading all my questions, I asked her about her aspirations for the future. She described her fantasy of becoming a wealthy female lawyer living in the suburbs and married to a heterosexual man. When I gently asked her what her plans were for finishing school, going to college and then on to law school, she lashed out at me. Other times, when confronted with the differences between her present reality and the idealized self of her dreams, she stormed out of the session. It was clear that Chloe didn't want to be in therapy. She viewed our sessions as means to her end of obtaining CGHT and, she hoped, SRS.

I use the Harry Benjamin International Gender Dysphoria Association's Standards of Care (SOC) in my work with trans clients. It calls for a minimum 3-to-6 month period of psychotherapy to explore notions of gender and sexuality as they apply to the patient, making sure the patient fully understands the risks, limitations and benefits of CGHT. It's also a time for the therapist to explore any concomitant mood disorder (especially depression and dysphoric states), and personality disorders. Because of the nature of hormones, it's imperative that patients get treatment for these issues before they start CGHT. Many trans people are at high risk for suicide, so a careful assessment is absolutely imperative.

As I do with all my trans clients, I summarized the SOC to Chloe in our first session, and I loaned her a copy to read. She let me know over and over again that she was not interested in exploring the reasons and the motivations for her transsexual desire. She wouldn't address any of my questions about whether she felt she was ready for the responsibility of such a profound, life-long change to her body, her health and perhaps her mental health. Previous psychotherapists had refused to recommend CGHT for Chloe because she was only 14, and the minimum age recommended in the SOC is 16. I didn't refuse to start her on CGHT because of her age, but because I firmly believed she needed first to deal with her underlying emotional issues. I never doubted Chloe's determination to become a transsexual. That wasn't the point. Hormones are dangerous; they can create an emotional roller coaster. The patient has to be in a fairly steady place to handle these kinds of changes. I wasn't convinced Chloe had the introspection or self-knowledge to be able to handle it yet.

As I always do during the initial interviews with a transgender patient, I had brought Chloe literature about the wide spectrum of transgender and transsexual options so she could start to think about her own gender identity and sexual orientation. I included a pamphlet from PFLAG about transgender teens, and a list of books and resources on the web. Throughout her therapy, Chloe was unwilling to read any of the material I recommended. I specifically asked her to read the SOC and reminded her of the loaned copy from our first session. In subsequent sessions, she stated she lost it, she read it, she "already knew it." She grew angry when I brought it up, ignored me or raged at me. The missing copy of the SOC became our metaphoric sticking point for the therapy. I needed her to read it so that I could have some sign that she was ready to take responsibility for the big step of CGHT. She stubbornly refused.

Instead of talking about her trans identity or her past history, Chloe started talking about having an eating disorder. She noted an increasing preoccupation with food and her figure. She said she needed "a lot of work" to look like the models in the magazines, but she denied any self-induced vomiting or binge behavior. She became increasingly preoccupied with plastic surgery, and focused on her nose and breast development as being inadequate to her female identity. I questioned her emphasis on models in magazines as female role models, and tried to emphasize more practical feminist role models such as Alicia Keys. She was not open to my suggestions, preferring to stay in her fantasy world of Barbie-doll models. I noted two things about this period of her therapy: one was that Chloe was extremely evasive whenever I wanted to talk about the SOC. The second was that her discussions about eating disorders and plastic surgery seemed like a diversion. I worked on establishing better rapport with her in the hopes that she would finally trust me a little and open up, but she remained guarded whenever there was any discussion about her past. She blamed everything bad in her life on transphobia. During one session, I thought we were making progress when she finally exhibited some transference. She was talking about her past therapists and said, "They didn't understand me because I'm a transsexual, and I feel that you can understand me since you've been there yourself." I used this moment to try to break through our logjam over the SOC. I felt a glimmer of an opening in Chloe to what I was saying about why I felt a discussion with her about the Standards of Care would help me better understand her experience as a transsexual. She sat speechless and motionless in her chair, absorbing this information, not responding, but, for once, not evading, either.

Obviously, transphobia was an issue in her life, and we discussed many ways in which her gender identity played a role in her behavior problems, and how the effects of living in a system that discriminated against her impacted on her life choices. Chloe was open to the idea of herself as a victim, but not as a person who could also take responsibility for her actions and choices or deal with her emotions in a constructive way. During this phase of therapy, she became angry and enraged, especially if I mentioned the copy of the SOC I loaned her. She began using food, alcohol and marijuana impulsively, and alluded to suicide attempts she had made in the past. Her moods shifted from manic to depressed. She started sleeping on the couch at the youth center all day. She became overly preoccupied with her appearance, staring at her reflection in the mirror for 15 minutes at a time and primping her hair to look exactly right for our sessions. She began to dress provocatively in low-cut blouses and very short skirts. I worried about her. She exhibited many of the traits of borderline, narcissistic and histrionic personality disorders. I knew how desperately she wanted me to prescribe CGHT, but nothing she was doing was convincing me that she could handle it.

After 4 months of therapy, I told her yet again that I didn't feel we could move forward toward her goal of CGHT until she grappled with some of the identity issues laid out in the SOC. I explained that I needed to feel she had full, informed consent regarding all the procedures inherent in sexual reassignment, including hormone therapy, before I could responsibly recommend her for it. I told her I was curious about why she was so unwilling to read or talk about the SOC. What was her theory about it? Why did she often says she would bring it to the next session and never do so? She knew this was my one requirement, the one thing I needed from her in order to help her get what she wanted, yet she continued to

refuse. Why? She became enraged with me, rose out of her chair and screamed, "I know everything in that booklet!!" I asked her to tell me the reason, then, that most therapists do not treat adolescents under the age of 16 with CGHT. She was surprised, "They don't?"

I said, "It's there in the booklet. Did you really read it?" She attacked me verbally and then ran out of the room.

Chloe was at the youth center for two more weeks before she was moved into a residential treatment facility, and during those two weeks, she actively ignored me and skipped our appointments. It was 3 months later when I saw her again at the center. She surprised me by apologizing for her behavior and asking if I would work with her again. I agreed, and saw her that same day. It was markedly different from our previous sessions. She started by asking me what I thought about "harm reduction." Harm reduction is giving a patient access to medications as in a needle exchange or via a methadone program so as to enable the patient to become included in the medical system and therefore not use medical drugs or devices without prescriptions. I said I didn't believe in it, since all the results I had seen had been detrimental to the patients. I asked her what motivated her to ask about it. She explained that she wanted me to write her a prescription for hormones as a means of harm reduction to defer harmful consequences of her using hormones on the street. "Aha," I thought, "same old Chloe." I pointed out that based on my observations of her from the past, as well as the manipulation implied in her present request, I didn't believe she had sufficient maturity to deal with the problems of CGHT. I said there was no way I would write a prescription for her under until she dealt with her behaviors and their consequences. She dropped her compliant and polite facade. She called me a few names before storming out the room. That was the end of her psychotherapy with me.

There are many ways to look at this case. We could see it as a case of a recidivist adolescent with poor impulsivity and an unwillingness to deal with her deeper gender issues. We could view Chloe as an adolescent who was thwarted in her sexual identity and gender issues, and as someone who became symptomatic as a result of maltreatment by society because of her expression of transgressive gender identity. I am most curious about the ways in which the patient's transference and my own countertransference came into conflict. The fact that we shared a common experience as trans MTFs did not change the fact that we had very different power in our relationship. Mistrust, suspicion and hostility were transferential reactions elicited from the patient because of our different race, class and education levels.

I try to encourage my patients to accept, not erase, the past. I showed Steve my own transition photographs as a means of explaining who I was then, and who I am now. I wanted to model for Steve that it was okay to integrate past and present, that I did not feel ashamed of my past as a male, and that he didn't have to try to erase any part of himself either.

This mistrust and hostility led to intense anger at me both times I challenged Chloe's dream of being a female lawyer living in the suburbs. When I had tried to use that as a way to talk about her current life choices, I was also bringing up, implicitly but unspoken, issues of class and race, which were difficult areas in Chloe's life to make sense of, much less talk about. While I meant it to be a discussion about the differences between her reality and her fantasy life, it provoked in Chloe a whole other level of feeling disempowered and angry.

My own countertransference was complicated. I often found myself denying our obvious differences in socioeconomic class. At times, I found myself adopting the stance of a kind of clinical anthropologist as a means of denying any of my own mistakes with Chloe. I also exhibited countertransference of pity for the patient, which served as a means of allaying my own political guilt—after all, shouldn't I be the first to understand her desire for CGHT? What was I doing getting in her way of realizing her dream to become a female? I also felt guilty because I knew other therapists had misunderstood Chloe because of her transgender. I felt like I should have been the "good" therapist. And I also felt guilty being "the establishment." I was an agent of the system, not her liberator.

Looking back, I can see how at times I distanced myself from Chloe when she needed me to hear her frustrations with a society that did not understand or tolerate gender transgressiveness. I instead tried to focus on transgender identity, perhaps to the detriment of hearing Chloe's pain. Did these multiple transferential and countertransferential relationships doom the therapy from the beginning? I don't think so. I think these issues are important for me to look at and learn from, but I continue to believe that Chloe was not ready to look deeply at her life, and that this is one of the foundations of the SOC, and frankly, needs to be.

Steve: Female-to-Male Adult

Steve was a 32-year-old Female-to-Male (FTM) transgender. He was not taking any hormones and had not had any sexual reassignment surgery. He was a white, middle-class, educated professional (a chiropractor). He asked me to be his therapist because he wanted to work with a trans person and believed I would be better able to understand his issues than a non-trans therapist. Steve was androgynous in appearance, showing up for his first session in jeans and a sweater, with hair cut short in what might have been a page-boy. During his initial session, I asked him to talk about his feelings of being a man. He replied without hesitating that he had felt this way from earliest childhood. In kindergarten, he wanted only to play boy's games and wear boy's clothes. In answer to my query, he said wearing men's clothes didn't create any sexual arousal, but it did create stormy scenes with his mother, who didn't understand or approve of his desire to be a man.

Steve surprised me by revealing that he was

engaged to another man, and that his fiancé knew that he wanted to become a man. I questioned Steve about his fiancé's feelings regarding being in a gay male relationship after what was previously a heterosexual relationship (Steve had gotten into this relationship presenting and identifying as a female). The patient grew silent, thinking. After a time, I broke into his silence and asked what his parents knew about his decision to transition. He said he had not told them. I asked Steve what kinds of thoughts he had had about the pressures he might face from them and from others when he started to transition. He said he had thought about it some, and said that was why he had decided to come to therapy—he wanted to start to prepare.

Steve had not heard of the Harry Benjamin organization, but had heard of the SOC, and I gave him a copy of the SOC, and talked about the process we would go through before I would be ready to recommend him for CGHT. He expressed his willingness to follow the SOC guidelines and welcomed all the help I could give him. I also brought up to him that as a transgendered woman, I was rather ignorant of the trans-man world, as well as FTMs, since the transgendered world is dominated by MTFs or trans-women. I cautioned that other therapists might view our therapy relationship as problematic because of my own transgender identity. He responded, "Well, you and I are both doctors, and I feel that you'll know what I'm saying better than anyone else." I shook his hand and the session ended.

At the beginning of the second session, I asked Steve what he thought of the SOC. He brought up numerous misgivings. For a start, he didn't like how it viewed transgender as a psychiatric disorder. He asked my opinion about Gender Identity Disorder as a psychiatric diagnosis. At first, I told him my opinion wasn't important, that I was interested in how he felt about it, but he persisted in asking me what I thought about it. Finally, I said that many mental health professionals believe that the wish for a sex change is psychotic in and of itself, but that due to my unique position as a psychotherapist, as well as being transgendered, I had a unique and very personal view of the subject. I also pointed out that the way society enforces gender-congruent behavior and punishes gender-transgressive behavior is to pathologize them. I explained that many transgender people suffered from depression, and that part of the reason for having a long waiting period before starting hormones or surgery is to determine if the person actually suffers from depression that is unrelated to discomfort from biological gender, and to diagnose and treat any mood disorders.

Steve digested all this, and then asked, "Are there any other reasons for the delay in getting hormones?" I said the other reasons would be to explore the dynamics of gender and sexual orientation, and also to ensure that there is some stability in the patient's life so that he or she will have support and be prepared to deal with the issues of another puberty (with all of its concomitant morphological changes). Also, I said, clients need to work on how to handle family and friends when they go through the momentous change. Steve challenged me, saying, "That's a pat answer!"

Steve was angry at the existence of the diagnosis of Gender Identity Disorder and at me maybe because I was a representative of the psychiatric profession, or maybe because I wasn't as "activist" as he had expected or hoped. I suggested that he read more about some of these issues and offered him some literature. When he saw the issue of *Transgender/Tapestry*, his eyes lit up. After that initial confrontation, Steve showed an eagerness to read and discuss more and more about the transgender world, it's various communities and controversies. He called during the week to thank me for guiding him to the information.

The following week, Steve came in buzzing with excitement about the FTM support group I had referred him to. He described feeling relieved that he was not alone, not the only one, and said he found some of the guys in the group attractive. With the mention of attraction to one of the other FTM support group members, I expanded the conversation to his relationship with his fiancé. Steve said he felt that his fiancé was distancing, although he viewed the relationship as still active. I asked Steve if his fiancé had expressed any feelings about Steve's upcoming change in gender, and Steve showed me a photograph of himself as a woman, with a group of young men playing football. Because he had always presented as very androgynous, he believed he would not have any problems in his relationship or in his professional life because of transitioning. I didn't challenge this assumption, but turned the discussion to his parents and his relationship with them. He said neither of his parents wanted their daughter to become a son. His father didn't say so, but would agree with his mother when she said things like, "I will never call you Steve. You are my daughter, Samantha, and nothing but Samantha!" His mother would also show Steve pictures of himself as a young girl in a dress and say, "Samantha, you looked so pretty and cute. Why do you want to change from such a beautiful woman?" Steve appeared distressed as he told me these stories. I said that it is not only us, the transgendered, who undergo transition, but our families as well. Steve gave me an angry look and said, "Why do you give such phony, pat answers? You know the truth from your own life; tell me how your own family dealt with your transition!"

I heard his anger at me as displacement of his anger about his own family's possible rejection of him as a male. So, I replied that his therapy was to talk about his issues, not to discuss what did or didn't happen in my family when I transitioned, and that, in fact, my experience had no bearing on his transition. But he insisted, and I heard that he needed me to be more of a guide and less of a neutral sounding board, so I shared a little of my story. I told him that while some in my immediate family accepted me, some of the others did not. He then pressed for more details, and I told him that what applied to me had its applications only to me, and that I felt that the presence of at least one family member in the patient's corner, helped create some stability and offered at least some shield against a transphobic society. I emphasized that he would be wise to attempt to find someone, even a cousin, to aid him in his own transition. He then looked at me and said, "Well, you're the doctor, we're both doctors, I guess you're right."

As therapy progressed and I felt Steve was grappling with his issues and getting closer to being able to handle CGHT, I sent him to an endocrinologist to get a baseline physical and check hormonal levels to make sure he wasn't already using hormones. In Steve's case, it was almost a given that he would qualify for hormones, so when I gave him the literature on the pharmacological effects of testosterone, as well as anti-androgens, he absorbed the information readily and even looked up other references online to educate himself to the risks and the benefits of CGHT. When I made the referral to the internist, I urged him to discuss any hesitations he might have with the doctor. Steve asked me why I was referring him to this particular doctor, since he had heard through the transgender grapevine as well as with his own FTM support group that the physician had a poor bedside manner and that he was homophobic and trans-

phobic. I stated that although the physician did not have the best way of speaking to his transgendered patients, he gave excellent medical care to his transgender patients. Steve was satisfied with that answer and did not question me further.

During our next session, Steve talked about some of his fears about taking hormones, and his eagerness to have his breasts removed. He spoke about some of the guys in his FTM support group who had had "top surgery," (double mastectomy) and their differing results. He then asked me whether I recommended a particular surgeon in the area. I told him that it was too early for this discussion, since by next week he would be on testosterone, and just beginning to deal with a deeper voice, acne, beard growth and muscular growth. The patient was eager to discuss all the changes that awaited him, and the session ended on a happy note. The following week, he reported on his visit to the physician and said he had been given his first injection of testosterone. He noted that his libido had increased, and that he felt great for the first time in his life. He thanked me profusely and spent the greater part of the session complimenting me on my insights into him, and into the transgendered world.

I was glad he was happy, but I wondered if Steve was going to use therapy only as a means to get hormones and surgery. Many transgender clients do so, because they have to go through therapy to get approval to take hormones and have the surgeries. I asked Steve directly about it, and he said he knew other trans people used therapy that way, but he really wanted to be in therapy. He talked about how his relationship with his fiancé was deteriorating. We spent the rest of the session talking about that. I noticed that when I asked him about his parents or other family members, Steve artfully changed the topic back to his fiancé. I wondered if Steve was resistant to talking about his parents because that relationship was more hostile to him than his relationship with his fiancé.

As therapy progressed, Steve talked about becoming masculine. He reveled in the physical changes, but after a few weeks of relating his triumphs and delight in transitioning from female to male, he started to talk about having a hard time relating to others as a woman, and he began to appear sad and depressed. When I noted this, he started to cry, and I handed over a tissue. I heard myself make a joke that "real men don't cry." Even as I was asking him what was going on, I was noting my comment and wondering why I was reinforcing gender-congruent behavior. What was that all about? Luckily, it seemed that Steve wasn't thinking about my joke, but was talking about how his mother had declared that he was not welcome in her home as a male, and that his fiancé had left him because he didn't want to be seen as a gay man. Even though I had tried to get him to prepare for this possibility, Steve appeared bewildered by these rejections, and afraid. I gently said again that I believed families transition along with the transgender person. This time, he didn't call it a cliché, but nodded in agreement.

Early on in the therapy, Steve told me that he believed he was a gay man, and he asked my thoughts on the matter. I related the story of Louis Sullivan, a trans-man who identified as gay in San Francisco at the beginning of the HIV/AIDS epidemic, and was successful in petitioning the American Psychiatric Association (APA) to reconsider its stance ignoring homosexuality and homoeroticism among its transsexual patients. Sullivan won the argument with the APA with the statement, "I am a gay man! I have HIV, which is a gay man's disease. Why, then, am I not considered a gay man, simply because I was borne with a female body?" Steve appreciated the story, and I said to him, "If you see yourself as a gay man, then who am I to disagree with you?" At various points during his therapy, Steve brought up problems with being perceived as a man in the gay world. He would tell me about being attracted to a man in a gay bar, only to be rejected later because he had a vagina, not a penis. He also informed me of his continued activities with the FTM support group, and of the multiple liaisons that the men in the group had with each other.

After his fiancé left him, Steve told me about his desire for another man in his FTM support group, of their shared interests and the fun they had when they were drinking together. Steve also related the fact that he did not feel that a support group was necessary to his existence; since it was primarily geared toward new MTFs and that he felt no desire to listen to others state some of the same problems in transition that he had complained of himself six months earlier. I gave him permission to leave the group, since he felt it wasn't satisfying his needs. He then asked me, hesitantly, what I thought of his relationship with this other man, and I replied that was also a sign of continued growth. Steve appeared relieved by my support.

My relationship with Steve progressed and changed with time, as he became more confident in his male role. His chiropractic practice hardly suffered a loss of patients, and as he progressed in his relationship with his trans-man lover, he reported their deepening intimacy. It was without any hesitation that I sent my recommendation that Steve be considered for "top surgery." After the surgery, he felt relieved that his breasts were gone. Steve told me, "Samantha is dead now." This metaphor is often used in trans society as a means of erasing the past life, even the good parts. I try to encourage my patients to accept, not erase, the past. I showed Steve my own transition photographs as a means of explaining who I was then, and who I am now. While this entailed some self-disclosure, I wanted to model for Steve that it was okay to integrate past and present, that I did not feel ashamed of my past as a male, and that he didn't have to try to erase any part of himself either. Steve got a real kick out of seeing my yearbook photo and even made a crack about me being such a handsome man that he might have dated me if I was still a guy. He also was fascinated to see the changes in my face and body, realizing that I really had gone through a lot of the changes that he had—not the same, of course, but the same process. He left the session thoughtful and quiet.

The following week, he reported that he had gone to see mother. The two of them looked at old photographs of him as a young girl. Doing this, they were able to reconcile themselves to the changes in him now. He allowed his mother to love the little girl he had been. She realized she didn't have to lose that little girl; now she had to learn how to love her son. He then told me how happy he was to have parents that loved him.

During our final sessions, Steve discussed "bottom surgery" and decided not to do it. That was our last big discussion. He was becoming more integrated into his life as a gay transman, and didn't need therapy as much. Gradually, he began to cancel appointments. His new life was in full swing, and I suggested he might be done with therapy. I told him he could call if he ever needed me. As he went to open the door to leave, he turned and gave me a hug.

Certainly, I was aware that Steve's therapy, unlike Chloe's, was a lot less stuck because Steve and I were of similar class, race and socioeconomic background, and we were close in age. The power differences were subtle. I was born a man—something he longed for—and became a woman.

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explained: "When I met my partner and we realized our relationship would be permanent, it made sense to me to take her name. I like her family a lot-and taking her name made me feel like I was part of a sane, healthy family-and made us, as a couple, feel more like a family too." Another respondent created a new last name with her partner to demonstrate their love and commitment to each other. She explained, "My partner and I wanted to share a last name to reflect the fact that we got married/committed our life to each other. The last name is Spanish for penguins. Penguins have become our family's symbol, and Spanish is a language we both love."

Of the 12 respondents who did not change their last names, seven reported making a conscious decision not to change. Several gave more than one reason, including not wanting to change out of respect or affection for their family-of-origin names and the history of those names; because their last names were an integral part of their identity ("Even if I were straight and legally married, I wouldn't change my name"); because they had established name recognition in their professions; because they did not like their partner's last name; because keeping separate names would promote equality in their relationships ("[it] reflects our desire not to merge into a couple-being and to remain two separate individuals"); because they could not agree on what their new name should be; and because it would be inconvenient to have to explain the name change to others.

Lesbians' reasons for changing their last names are vastly different from those offered by heterosexually married women. Heterosexual women focus on creating an internal sense of family. Lesbians focus on external recognition and acceptance of the family they have created with their partner (and children). While opposite-sex couples and their children are endorsed as a legitimate family form by United States culture, same-sex couples have no legal status as a family unit. Having the same last name as one's partner is a way to claim family status. ▼

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He was born a woman—something I had longed to be—and was becoming a man. Because I had already gone through the transition, Steve was compliant and took my suggestions as credible, except when he felt provoked or scared. Our shared experience of transphobia solidified our trust and rapport, and Steve often reinforced that by saying how well I knew him and understood him. While it may have helped strengthen his resolve when dealing with difficulties during the transition, I hope his identification with me didn't hinder him from expressing different transgender identities other than transsexual.

I believe my being an MTF therapist helped Steve work through his questions and problems and fears during his transition because, in the best of therapies, the clinician is someone a little bit ahead on the path, at least in some areas, and can give guidance based on experience and success. I believe in this case, unlike in my work with Chloe, these multiple transferential and countertransferential relationships set Steve's therapy up for success.

I believe the next important step mental health professionals need to make is to demystify and destigmatize those who are transgender. Much of society views transgender people as freaks to be seen on the Jerry Springer show. Even many mental health professionals look upon the transgender journey as being a movement away from integration of the self a psychotic solution to an insoluble problem. My knowledge of both male and female experiences has given me a rather unique history, and because of that I can just about relate to everyone on this planet. Perhaps my most valuable asset to all my clients, trans and non-trans, is that my journey as a trans person has taught me how to be at home with myself. I know who I am, and that knowledge is invaluable to anyone in the healing professions, especially therapists. ▼

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Wisdom (continued from p. 4)

nity of gay men and lesbians who were also parenting. But different from their previous bond with the gay and lesbian community, which was based on common sexual orientation, their new gay and lesbian parenting community bonded around childrearing issues and shared concerns about how homophobia and heterosexism would affect their children.

Gay dads also found new connections with the straight community. Most said that before they became dads, their interactions with the straight world were limited, but once they became parents, they spent more time socializing in the straight world with straight couples and their children. Many of the men in my study left urban areas and moved to the suburbs when they became parents. They described finding a new sense of belonging in their (mostly straight) neighborhoods because, as parents, they shared common ground with straight neighbors with whom, before parenthood, they probably would not have shared many interests.

On the surface, gay dads may seem no different than their heterosexual counterparts, adapting their lifestyles to put first the needs of their children. But it is important to note the obstacles that gay men who created families through adoption, foster care and kinship had to overcome to finally become dads. Adoption, foster care and surrogacy only recently became options for gay men, especially those who are not wealthy and white. Today's gay dads are pioneers, and often had to wait years—even decades—to realize their dream of becoming parents. I believe the persistence and patience they had to cultivate to become dads have helped forge them into wonderful parents to countless children in need of permanent families. In a country where more than 134,000 children are available for adoption on any given day, gay dads have stepped up and offered their love and commitment to many children in need. With so little literature about them, I hope that this inquiry leads to further study by other researchers in the years to come. ▼

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