Trans* Sexualities

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Evidence suggests that gender-variant people have existed in many societies around the world and throughout time. In some cultures they have well-defined roles and have enjoyed some social acceptance, whereas in others there has been little or no tolerance for significant gender nonconformity (Bullough 2007). While gender has been universally used by societies as a main organizing principle, understandings of the importance of gender, and the criteria used to determine gender conformity and variance, have been diverse. Moreover, sexuality is generally seen as an integral component of what constitutes gender, though this, too, has varied significantly (Jacobs 2014).

Gender-variant people in Western societies include a wide range of people who, for various reasons and to various degrees, feel that the sexes and/or genders to which they were assigned at birth are not consistent with their own identities. Recent estimates of the incidence of trans*-identified people in Western urban societies run between 0.5 % and 1 % (Conron et al. 2012). There are many terms with which such people might describe themselves. While the language of gender variance is in constant flux, we offer explanations of some of the more commonly-used terms to anchor our discussion. We acknowledge that what we offer is only an incomplete and approximate snapshot taken at a particular time and place.

11.1 Introduction to Some Key Terms

In everyday usage, the terms "sex" and "gender" are commonly thought of as having the same meaning. Furthermore, the words "sex" and "sexuality" are frequently used as synonyms. Although a relatively clear understanding can generally be taken from the context in which they are used, when considering gender-variant people, these terms are best treated as having distinct, although related, meanings.

Distinctions between what is signified by "sex" and what is signified by "gender" are key to understanding gender-variant people. In the simplest version, "sex" refers to the biological characteristics of a person, whereas gender refers to social characteristics. Transgender activist

Trans* is defined by GATE-Global Action for Trans* Equality as: "Anyone who has a gender identity which differs from the gender they were assigned at birth and who chooses, or prefers, to present themselves differently than what is expected of the gender they were assigned at birth. This includes people who identify as transsexual, transgender, cross dressing, gender variant, gender fluid, genderqueer, agender, and many other identities, and serves as a placeholder term to refer to a wide variety of gender variance without reducing any one identity to characteristics of other identities." (GATE-Global Action for Trans* Equality, n.d.).

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Virginia Prince is widely attributed with having quipped "Sex is between the legs. Gender is between the ears".[1] However, things are rarely that simple.

Sexes and genders may be *assigned* to people at birth, may be *identities* that develop and change over time, and may be *attributed* by others on the basis of observed characteristics. *Sex* can be comprised of many variables, such as chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics, all of which may appear in a myriad of combinations. Furthermore, which characteristics are definitive of the sexes of individuals have been the subject of intense public, legal, legislative and medical debates, with outcomes varying among times and places. The widespread occurrence of such debates highlights that sex statuses are ultimately the result of contingent and socially negotiated agreements, rather than the inevitable results of physiological imperatives.

Sexes are generally assigned at birth on the basis of a quick visual inspection of the genitals of new-born infants. In most common practice, people are assigned as female, male, or intersex.[2] Intersex people are assigned, generally as soon as possible, as either males or females, usually based on an assessment of genital appearance, less often as a result of more extensive testing (Lee et al. 2006). Further investigations into assigned sexes are rare, even for trans* people who express dissatisfaction with their assigned sex.

In addition to their assigned sexes, individuals also have *sex identities*, that is to say that people feel that they belong in particular sex statuses. For most people, their assigned sex is also the sex with which they identify, whereas among gender-variant people, this may not be the case. Other people also make assumptions and draw conclusions about the sexes of people they meet, most frequently on the basis of a cursory visual appraisal of the person's outward appearance and without being privy to detailed physical information. Such sex attributions can contribute positively or negatively to the identities and self-esteem of individuals.

In common parlance, *gender* is thought to be synonymous with sex. The genders of men and women are presumed by many to be natural and inevitable social attributes based on biological imperatives. From this perspective, women and men are thought to look, think, feel, and act the way they do because they have physical sexes which cause them to do so (Davis 2008). Others have argued that genders are entirely the result of the forces of socialization (Carter 2014). The dominant expert opinion is that genders are a result of a mixture of biological and social influences. Genders, like sexes, may be *assigned*, may be *identities*, or may be *attributed*.

Genders are social statuses originally assigned at birth on the basis of the presumed correspondence between sexes and genders. Because it is common that sex and gender are two words which are used interchangeably for the same thing, when a sex is assigned at birth on the basis of genital inspection, the corresponding gender is, in effect, also assigned. Males are assigned as boys, later to become men. Females are assigned as girls, later to become women. People form their gender identities partially as a function of their acceptance of their assigned sexes, and partially on the basis of their comfort with their assigned genders.

When people are accepting of their assigned sexes and genders as correctly representing their inner senses of themselves, the term *cisgender*[3] may be used as a descriptor, either as an identity

[1] The exact quotation from 1973 is: "Any kind of carving that you might do on me might change my sex, but it would not change my gender, because my gender, my self-identity, is between my ears, not between my legs" (Prince 2005b, p. 30).

[2] Intersex refers to a wide range of conditions wherein physiological indicators of maleness and femaleness are combined in non-standard ways in a single individual. In earlier literature, intersexed people were often referred to the "hermaphrodites" (Dreger 2000). This is now considered derogatory. Current medical literature will often use the term "DSD," as an abbreviation for Disorders of Sexual Development. Some activists prefer to use DSD to mean Diversity of Sexual Development.

[3] The prefix "cis" comes from the Latin meaning "on this side of" and is used to refer to people whose gender identities are congruent with those to which they were assigned at birth. Variations on the terms cisgender (e.g., cis man, cissexual) have been adopted as parallel terms to transgender-based terms.

or as an attribution. When people feel that their originally-assigned sexes or genders are not appropriate to who they feel themselves to be, they may identify as *transgender* or *trans**.

An increasing number of people find that the traditional division of genders into men and women is not adequate to capture their own gender identities and experiences. They may identify as *gender fluid*, *genderqueer*, or a range of other identities that do not reinforce a binary notion of there being only two genders. Most gender fluid or genderqueer people do not wish to be identified as men/males, women/females, or trans*, although they may incorporate some aspects of these identities into their gender presentations. Often, they will prefer the use of gender neutral pronouns. The gender expression of gender fluid and genderqueer individuals may encompass elements of both standard genders, and although they may be comfortable with sometimes appearing as the standard genders, they want the freedom to move among them, and to other gender expressions, at will. Still others find that their gender identities fall outside of binary conceptions, or outside of gender, altogether. Those who do not identify with any gender may refer to themselves as *agender*, *neutrois*, or *eunuchs*. Those people who were assigned as female at birth and who do not fully identify as females/women, or have adopted another gender identity, are usually referred to as being on the *transmasculine* spectrum, whereas those who were assigned as males at birth and who do not fully identify as males/men, or have adopted another gender identity, are usually referred to being on the *transfeminine* spectrum.

Attributions made by observers about the genders and sexes of other people are made in daily life almost exclusively on the basis of how observers interpret the gender expressions of the people they are observing (Devor 1989; Kessler and McKenna 1978). People who express a femininity that appears to be natural are attributed with being women as well as female. People who make naturalistic presentations of masculinity are attributed with being men as well as male. Most members of social groups accept that gender expressions are highly socially variable and will not question their attributions of genders and sexes on the basis of small variations or anomalies of gender expression. Indeed, the presumed correspondences between sexes and genders are so strong in the minds of most people that once they have made gender and sex attributions, few things can cause them to reassess their attributions. Evidence of an originally-assigned sex that does not match a gender presentation will frequently cause the validity of an otherwise-acceptable gender presentation to be overturned (Devor 1987, 1989). These dynamics, which are largely invisible in the lives of cisgender people, are of great importance in the lives of trans* people.

Sexuality concerns patterns of both romantic and erotic interests which may, or may not, involve the presence of other people in actuality, in fantasy, or virtually. People may have their own sexual *identities*, and they may have sexualities *attributed* to them by others. Sexual identities and attributions may be based on fantasies about, or desires for, romantic or sexual activities in the presence, or absence, of actual sexual activities. People may experience sexual fantasies, desires, and practices which are not all equally consistent with their sexual identities, or with the sexualities attributed to them by others. As well, individuals' experiences of their sexuality may change in different contexts. Individuals, and those who are making attributions about them, will therefore differentially weight various aspects of sexuality when constructing their sexual identities, or when making attributions about others.

Sexualities involve both bodies and genders. When only cisgender people are part of the equation, sexual identities and attributions may be relatively uncomplicated: genders and sexes align in the usual fashion, and sexual identities and attributions can be made on the basis of either sexes or genders. However, trans* and genderqueer people often have bodies which exhibit non-standard mixtures of sex characteristics, and which do not align in the usual ways with typical gender categories. The bases for sexual identities and attributions thus become considerably more nuanced (Devor 1993; Page and Peacock 2013; Schilt and Windsor 2014).

11.2 Older Ideas About Gender and Sexuality Persist Along with Newer Ones

While people who appear to contemporary eyes as trans* have always existed, early research on gender-variant people took place as part of more general attempts to understand the interplay of human sex, gender, and sexuality (Bullough 2007). As medicine became accepted during the latter half of the nineteenth century as the legitimate authority over studies of sexual and gender variance, medical researchers increasingly turned their attention to non-heterosexual sexual practices (Cole and Meyer 1998; Reicherzer 2008). This greater medical attention to sexuality and gender took place under an ontological orientation that conflated sex, gender, and sexuality. In this context, human sexual and gender variance came to be labelled as pathological.

This conflation of sex-gender-sexuality[4] was based on a number of common social norms, which largely continue in popular discourse today. In its contemporary form, the conflation of sex-gender-sexuality can be summarized as follows (Devor 1989; 2000):

- Sexes are social statuses believed to be intrinsic biological characteristics. There are thought to be two, and only two sexes, male and female. All humans are believed to be either one sex or the other. Normally, no one can be neither; no one can be both; and no one can change sex without major medical intervention.
- Genders are social statuses that are considered to be the social manifestations of sexes. There are supposed to be two, and only two genders, men and women (boys and girls). All males are expected to be either boys or men; all females are expected to be either girls or women. Normally, everyone is either one gender or the other; no one can be neither; no one can be both. Because of the widespread belief that genders are rooted in biological characteristics, it is believed that no one can change gender without major medical intervention.
- Gender role styles are viewed as culturally-defined ways of expressing or displaying sex and gender statuses. There are two main gender role styles: masculinity and femininity. Most males are masculine men. Most females are feminine women. Many people do not exactly fit their expected gender roles and it is commonly believed that this is due to poor socialization or psychological pathology.
- While a wide range of sexual practices are commonly recognized, people are normatively expected to be heterosexual as part of their gender expression which, in turn, is presumed to be biologically determined. Because of this conflation of sexuality with sex and gender statuses, gay men are often assumed to be womanly men and lesbian women are assumed to be manly women (Freeman et al. 2010).

Within the context of wide-spread acceptance in the nineteenth century of the idea of causative links between sex, gender and sexuality, Karl Heinrich Ulrichs (1864–1880/1994) linked homosexuality with a discomfort with one's body and with one's sex. Ulrichs postulated that same-sex desires were best explained as being the result of having the mind of one sex in the body of the other (Meyerowitz 2002), describing homosexual men using a conceptualization later widely taken up to describe transsexual people, "*anima muliebris virili corpore inclusa*" (a female psyche confined in a male body) (Ulrichs 1864–1880/1994, p. 289). Posited this way, homosexuality could be seen as a form of heterosexuality inherent in a gender-variant mind, rather than as a challenge to the "natural" alignment of gender and sexuality (Dreger 2000). Similarly, in 1886, psychiatrist Richard von Krafft-Ebing (1886/1998) also linked same-sex desires with gender variance. He conceptualised gender variance as having one's "psychical personality" unduly influenced by sexual feelings.

During this same period, physicians were also attempting to understand intersex conditions, which were then called hermaphroditism. The accepted wisdom of the time was that most

[4] To differentiate between contemporary uses of sex, gender and sexuality, and historical uses which conflate the concepts, hyphens are used to denote when any subset of these terms is conflated.

instances were actually "pseudo-hermaphroditism" wherein a "true sex" could be eventually uncovered. However, some people, having had their "true sex" diagnosed at birth, later felt that the sex assigned to them had been incorrect. This opened up the possibility of a person's "true sex" being found in something other than genitalia and gonads, and problematized the accepted link between sex-gender-sexuality (Dreger 2000).

This line of thought was continued by Magnus Hirschfeld who outlined two major challenges to the conflation of gender-sexuality. Firstly, Hirschfeld (1991/1910) proposed a theory of intermediaries, positing that every human is a unique natural combination of maleness and femaleness, and so has a unique sex identity that is neither simply male nor female. Secondly, he argued that transvestism can occur separately from homosexuality; and thirdly, that it is not a priori pathological (Hirschfeld 1991/1910). Havelock Ellis (1913) further extended Hirschfeld's work by delineating two types of people who crossdress: those who wore the clothing of the other sex without feeling like they belonged to the other sex, and those who felt like the other sex–thus presaging the emergence of the concept of transsexualism (Ellis 1913).

In 1949, pop sexologist D.O. Cauldwell named the desire to be the other gender as "transsexuality." Although opinions regarding gender variance were changing, those of Cauldwell were typical of the day. Cauldwell (1949) considered transsexuality to be delusional, psychopathic, and linked with homosexuality (Ekins and King 2001; Sullivan 2008). Cauldwell further considered transsexual people as "an adversary to the ethical, law-abiding citizen" (Irving 2008, p. 43), and suggested that any acquiescence to transsexual people's demands for surgery amounted to collusion with "psychosis" (Cauldwell 1949; Stryker 2008).

In 1966, endocrinologist Harry Benjamin published *The Transsexual Phenomenon* in which he argued that transsexuality was distinct from transvestism and homosexuality, and deserving of hormonal and surgical treatments. Benjamin's most provocative claims were that transsexuality had mixed biological, environmental and psychological causes, that all humans had some characteristics of the other gender (what he termed "bisexuality"), and that the existence of transsexuals challenged the assumptions of binary gender by embodying that "bisexuality" (Benjamin 1966, 1969).

However, his greatest influences on discourses of gender variance come from two other arguments. The first was his contention that all true transsexuals desired—and requested—medical intervention. Although this can be traced to the fact that the only gender-variant people physicians encountered at the time were those seeking medical interventions (Cole and Meyer 1998; Denny 2006; Reicherzer 2008), the idea nevertheless has had a lasting impact on popular understandings of trans* people. Benjamin also considered profound psychological distress to be a defining characteristic of transsexualism, locating the source of that distress in the patient having the "wrong body." Indeed, because Benjamin's work was hugely influential among professionals and trans* people alike, the idea of being in the "wrong body" became deeply embedded in both institutional and personal discourses on transsexuality (Stone 1992).

Around the same time as the publication of Benjamin's book, Johns Hopkins University opened the first hospital-based gender clinic, supported by funding from the Erickson Educational Foundation (Devor and Matte 2007) and with the professional involvement of John Money, Richard Green and Robert Stoller (Ettner 2007; Gherovici 2011; Stryker 2008). Within a few years, a number of gender clinics were set up around the world. These clinics propagated many of the same assumptions about the nature of gender variance, and further reinforced them by providing patient data "proving" the original assumptions (Denny 2006). Most notably, heteronormative gender presentations and attitudes were required of trans* people who wished to qualify for treatment, and treatment was predicated on the assumption that trans* people all desired full medical sex and gender reassignment.[5]

[5] See Sect. 4 for a discussion of techniques which may be used to alter one's gender presentation.

One voice in opposition to the model of gender variance promoted by medical authorities was that of Virginia Prince, an early and long-lived advocate for social acceptance of cross-dressing among heterosexual males. She did not believe that gender variance was a psychiatric disturbance and made it "her mission to educate the medical profession" that crossdressing need not be a threat to social order, nor an expression of homosexuality (Ekins and King 2005, p. 7; Prince 2005a). Prince argued that it was possible to live as one's chosen gender without genital surgery, what Prince referred to as living as a "transgenderist" (Prince 2005c). While her motivation may have been largely grounded in her reluctance to request medical validation for a life that she did not consider disturbed or abnormal (Ekins and King 2005), her advocacy also furthered the conceptual separation of gender from sex and contributed to an expansion of the boundaries of gender expression.

11.3 Methodological Concerns

Earlier research on trans* people's lives, including trans* sexualities, was almost exclusively done by cisgender people in ways that did not meaningfully credit trans* people with expertise about their own lived experiences (Cromwell 1999; Namaste 2000). This research drew almost entirely on two types of samples: people who came to gender clinics looking for access to medical resources, and people who joined transgender organizations. In practice, this meant that most research samples were limited to transsexually-identified people around the time of their transitions, and members of organizations for socially and politically outgoing male heterosexual crossdressers. Due to the social skills required to successfully access gender clinics, cultural aversions to transition among some groups (Roen 2001), and the financial resources required to transition or to participate in crossdressers' lifestyle and advocacy organizations, this sampling technique also had the effect of biasing samples toward white, urban, middle- and upper-middle-class transfeminine people (Vecolli 2014).

People who attend at gender clinics requesting evaluation and medically-assisted gender transitions represent only a very small slice of the entirety of trans* people. Many trans* people have little or no desire for such services, some are medically or socially unable to transition, or some do not have the social abilities, geographical proximity, or financial resources to access clinics. Furthermore, contemporary research indicates that, for the small slice of the trans* population who do engage in medically-assisted transitions, the time between deciding to transition and completing transition is when trans* people experience distress at levels high enough to significantly increase their likelihood of attempting suicide. Distress, suicidal ideation and attempts decrease significantly once trans* people have been able to accomplish satisfactory transitions (Bauer et al. 2012). The limitations of studying trans* people at the time of transition were often compounded by the fact that few trans* people chose to remain available to clinic-based researchers once they had received the treatments that they had sought (Rachlin 2007). As a result, samples drawn from people attending gender clinics have over-represented the degree of distress and self-harm experienced by the larger trans* population, and have contributed to an over-focus on transition issues to the near exclusion of study of any other aspect of trans* lives. Data gathered from clinics also has a tendency to be skewed by the fact that trans* people wishing to obtain such services commonly educate themselves about the criteria in use by clinics, and ensure that they present themselves in ways that will prove successful in obtaining the results that they seek (Bolin 1987; Denny 2006). As well, especially in the early years of trans* research, most European and North American clinics saw a preponderance of transfeminine people. Therefore, it is not clear that such data ever provided either an accurate picture of trans* people in general or of clinic attenders.

Support and advocacy groups for male crossdressers in the latter half of the twentieth century often specifically defined their membership as excluding female crossdressers and gay men. As well, they often based their arguments for

acceptance on claims related to their conservative middle-class "respectability" when dressed as women. People who conveyed any other kind of trans* gender expressions were excluded from these groups (Bullough 2000), and thus also from the research which used group members as research subjects, contributing further to the paucity of early research on transmasculine people.

More recent research has continued to make use of gender clinic samples but has expanded into other areas as well. Trans* people have also begun to be more active in conducting research involving their own communities, reaching out to a wider variety of trans* people, including those who do not make use of the services of gender clinics (Beemyn and Rankin 2011). One particularly useful innovation which is being increasingly taken up in population-based surveys is the use of a two-step process for identifying trans* people wherein step one asks about sex assigned at birth and step two asks about current gender identity (Tale et al. 2013). Nonetheless, sampling biases continue to be common.

Ongoing issues related to using clinic-based sampling are demonstrated well by research into the HIV risks of trans* people. Because many studies have depended on urban HIV testing sites, people who are economically marginalised and people of colour have been overrepresented, whereas those who do not have access to clinics have been missed (Bauer and Scheim 2013; Miner et al. 2012).

Internet sampling has been increasingly used as access to the Internet has grown. This has offered some significant benefits over in-person surveying, such as recruiting participants who do not frequent clinics, reaching people who may not feel comfortable identifying themselves to another person as trans*, reaching people who are using the Internet as a way to explore aspects of themselves that they might otherwise feel unable to explore in the "real world," and access to people spread over more geographically dispersed areas (Kuper et al. 2012; Miner et al. 2012). Internet surveys have also permitted much larger samples to be gathered at considerably less expense.

However, online participants must have access to the Internet and be visiting specific sites or forums, or know someone who does, in order to become aware of research advertisements (Iantaffi and Bockting 2011; Kuper et al. 2012). When using Internet-based sampling, researchers lack of control over data collection settings, are neither able to enforce inclusion and exclusion criteria nor respond to participant questions (Miner et al. 2012). Internet sampling also tends to be biased toward social-media-savvy younger trans* people, as well as those with a college education and a higher socioeconomic status (Schilt and Windsor 2014). Furthermore, sampling via the Internet continues to suffer from a bias toward trans* people who are being surveyed around the time of their greatest gender flux early in their transitions because they are the people most frequently viewing trans*-specific web sites (Iantaffi and Bockting 2011).

11.4 Sexualities Involve Bodies. Sexualities Involve Genders.

Genders and sexualities are related in heteronormative societies in that most people, at least in the early stages of sexual attraction, are attracted to others on the basis of gendered appearances and assumptions. In other words, when most people are attracted to someone, they unthinkingly make stereotypical assumptions, based on gender and sex attributions, about what kinds of bodies those people might bring to sexual encounters (Devor 1993). This, however, is disrupted by people whose bodies do not align with stereotypical assumptions, and often necessitates a reconsideration, and sometimes even a renegotiation, of sexual practices, sexual and/or gender identities on the part of both trans* persons and their intimate partners (Page and Peacock 2013).

Some trans* people actively wish to be easily identified as such; many prefer to appear cisgender but are nonetheless recognizably trans* due to aspects of their physical presence; some trans* people are able to live the majority their everyday lives very comfortably and unrecognizably in their preferred gender. However people may

present their genders, sexualities involve bodies (see Chap. 9). Moreover, sexualities are understood through the interactions of the sexed and gendered bodies and identities, which may align in a seemingly limitless array of combinations (Devor 1993; Schleifer 2006).

Some trans* people find that it is not necessary to permanently change their bodies in substantial ways in order to effectively communicate their gender identities. Many trans* people, however, will take steps to transform their secondary or primary sex characteristics so as to better express their gender identities (Factor and Rothblum 2008). Techniques used by trans* people to express their gender identities may include changes to deportment, body, facial- and head-hair styles, clothing, cosmetics, jewellery, fashion accessories, body fat, and muscularity. Trans* people may also strategically employ voice and speech modifications, padding, concealment devices, sex toys, genital or breast prostheses, genital enhancement or diminishment devices, tattooing, or piercings. More permanent changes may be brought about by hormone therapy, gender confirmation surgeries[6], and ancillary masculinising or feminising procedures–any of which can occur in various combinations.

Some trans* people who feel that they are *neither* of the two most commonplace genders, or that they are some mixture of the two, may combine any of the above techniques in unusual and fluid ways which disrupt common assumptions about the usual correspondences between sexes and genders. Some people feel a periodic need to step outside of their quotidian genders to inhabit other forms of gender expression for shorter periods of time. They may make wholehearted attempts to present themselves as the other normative gender, they may make symbolic partial gestures in this direction, or they may make parodic or hyperbolic presentations that nonetheless serve as valid and satisfying forms of gender identity expression for them.

Other trans* people find that they need to alter their bodies in more long-lasting ways. Such alterations may involve treatment with sex steroid hormones, surgical sex reassignment procedures, and ancillary procedures to feminize or masculinize facial features or body contours. These treatments and procedures are typically combined with at least some of the techniques described above. The range of combinations is as varied as the gender identities of the trans* people who employ them.

The effects of sex steroid hormones (depending on one's specific genetic inheritance) can be quite dramatic. In transmasculine-spectrum people the effects may include: lower pitch to the voice, thickening and increased oiliness of skin, growth of facial and body hair, loss of head hair, increased muscularity, masculine body fat distribution, cessation of menses, and growth of the clitoris. In transfeminine-spectrum people the effects may include: increased softness and decreased oiliness of skin, growth of breasts, slowed growth of facial and body hair, slowed loss of head hair, decreased muscularity, feminine body fat distribution, loss of erectile function, decrease in testicular and penile volume, decrease in fertility.

Surgical interventions for transmasculine-spectrum people include: breast reduction, breast removal (mastectomy), recontouring the chest for a masculine look, removal of the internal reproductive organs (hysterectomy, salpingo-oophorectomy), removal of the vulva (vulvectomy), removal of the vagina (vaginectomy), transformation of the enlarged clitoris into a small penis (metoidioplasty), construction of a penis (phalloplasty), rerouting of the urethra (urethroplasty), construction of scrotum and testicles (scrotoplasty and testicular implants), erectile implants, liposuction (most commonly of hips and thighs), voice-masculinizing surgeries, facial masculinizing surgeries, chest implants, calf implants.

Surgical interventions for transfeminine-spectrum people include: breast augmentation (mammoplasty), removal of the testicles (castration), removal of the penis (penectomy), construction of a vulva (vulvoplasty), clitoris (clitoroplasty) and vagina (vaginoplasty), rerouting of the urethra (urethroplasty), voice-feminizing surgeries, brow, chin, or Adam's apple, recontouring (facial

[6] Also frequently referred to as sex reassignment surgeries, or gender reassignment surgeries.

feminization surgery and lipofilling), scalp hair implants, hip and buttocks augmentation (implants and lipofilling).[7]

However, due to individual choices, social realities, and technical limitations, very few trans* people are able to live the entirety of their lives without some disclosure of their trans* identities. This is especially true in sexually intimate situations involving close physical contact with, or observation of, physical bodies. Thus, while the physical changes undertaken by trans* people are usually most deeply motivated by their gender identity needs, in many instances the expression of their own sexuality, and that of their partners, will also be impacted by the bodily alterations they undertake to bring their gender identities and bodies into better alignment.

In day-to-day interactions, some trans* people may strategically deploy stereotypical masculinity or femininity in order to be recognised as their gender and sex identities by making use of the common assumption that people possess bodies that match their gender presentations in normative ways (Devor 1987, 1989; Dozier 2005). However, this becomes more difficult to accomplish in the context of sexuality, particularly in situations that involve either disrobing, or other kinds of physical contact that would expose non-stereotypical bodies. When sex characteristics and gender presentations are known to not align in typical ways—which is much more likely to become known in sexual situations—trans* people become much more vulnerable to a number of indignities and dangers (Lombardi 2009). They may be objectified or fetishized, have their gender identities invalidated, be denied due respect, or be abused, violated, assaulted, or murdered.

Some trans* people choose to brave some of these risks because to do otherwise would be to hide their gender identities. Other trans* people's gender identities are such that, under most non-sexual circumstances, their gender presentations are sufficiently conforming to normative expectations that their risks of adverse outcomes are low. However, every trans* person, even those who most approximate cisgender appearances, remains vulnerable to the entire catalogue of invalidations and dangers should information about their gender identities become known, which will happen in the majority of partnered sexual encounters. Hence, trans* people are continually attempting to strike a balance between true-to-themselves gender and sexual expressions, and their safety.

When trans* people contemplate sexual contact they have to make strategic decisions about how, when, and what to disclose to potential partners about their bodies (Reisner et al. 2010). Such disclosure decisions and acts are often a source of anxiety for trans* people. This adds an extra, and thick, layer of apprehension to the usual acceptance and performance anxieties inherent in most sexual encounters (Iantaffi and Bockting 2011; Kosenko 2011).

Many sexual practices of trans* people and their partners may change when trans* people undergo bodily changes. When trans* people feel that their gender identities are being correctly perceived by others, they often feel invigorated and more firmly situated in their physical selves. This can result in increased sexual confidence and changes in sexual interests (Brown 2010). Among transmasculine people who use hormonal treatments, in addition to a generalised masculinisation of bodies, increased testosterone and decreased estrogens usually result in increased libido, often accompanied by increased sexual adventurousness and decreased emotionality, as well as diminished fertility. Among transfeminine people, in addition to a generalised feminisation of bodies, increased estrogens and decreased testosterone usually have the obverse effect on libido and sexual adventurousness, as well as decreasing erectile functioning and fertility (Coleman et al. 2011). Moreover, both

[7] Any surgical procedure will result in scarring which will affect tissue sensitivities, including sexual sensitivities. Post-surgical complications can further reduce tissue sensitivities. However, one of the goals of genital surgeries is to allow gender-congruent use of genitalia, including sexual use. Successful metoidioplasties generally result in increased sexual satisfaction. Phalloplasty techniques vary, as do the resultant sexual sensitivity levels. Successful genital reconstructions for transfeminine-spectrum people result in orgasmic capacity in the majority of cases (Cotton, 2012; Klein and Gorzalka, 2009; Lief and Hubschman, 1993).

hormone-induced and surgical alterations to primary and secondary sex characteristics will necessarily change the sexual practices associated with them.

Sexuality generally involves other people, real, desired, or virtual. When trans* people change their gender identities and/or gendered appearances, the categorisations of relationships involving them may correspondingly change as well (Aramburu Alegría 2013; Devor 1993, 1994). Furthermore, trans* people may also find that their patterns of sexual attractions change as their gender identities change (Coleman et al. 1993; Devor 1993; Dozier 2005). This may cause established sexual relationships to become transformed into other varieties of sexual relationships, into nonsexual relationships, or to end (Brown 2009; Hines 2006). Thus the sexual identities and practices of trans* people, and those of their sexual partners, may be significantly affected by changes both in identities and in bodies.

Because trans*bodies often disrupt the assumed heteronormative understandings of the relationships between sex, gender and sexuality, trans* people, and their sexual/romantic partners, often find that they must consciously negotiate and articulate the meanings of their sexual identities and sexual interactions (Edelman and Zimman 2014; Schilt and Windsor 2014; Devor 1993). Thus, when trans* people engage in sexual practices that are congruent with their gender identities, they can lead the way in creating new understandings of relationships between genders, sexed bodies, sexual practices, and sexual identities. And, because most trans* people have sexual relationships with cisgender people, the ways in which they, and their partners, together understand and practice their sexualities are gradually creating more opportunities for trans* people and cisgender people alike to engage in more diverse and affirming sexualities.

11.5 Stability and Change in Sexualities

In relationships only involving cisgender people, determining accurate descriptions of sexualities may be difficult enough. People may form their own identities, and others may make attributions, based on a variety of criteria. They may consider current, or relatively recent, or lifetime fantasies, desires, or behaviours as being valid bases for determining their own sexual identities, or making attributes about those of other people. However, because people's behaviours, desires, and fantasies are not always consistent over time, nor are they necessarily all consistent with any particular sexual orientation at any one time, some aspects of individuals' sexualities will be given more credence while other aspects may be disregarded as anomalous and unimportant. For cisgender people, the most common sexualities of heterosexual, homosexual, and bisexual are based on binary conceptualizations of the sexes-genders of the individuals involved. Increasingly, those cisgender people who do not feel that these options properly encompass how they see themselves have adopted queer as a sexual identity that allows them more flexibility.

When trans* individuals have gender identities which do not match their bodies in standard sex-gender ways, when individuals have bodies which do not correspond to standard sex configurations, all of the difficulties inherent in situations involving only cisgender people are further compounded, and it becomes more difficult to make use of the standard sexual categories. An approach used primarily by professionals in reference to both cisgender and trans* people is to describe sexualities on the basis of the types of people one finds attractive: *androphilic* and *gynephilic*. However, these terms are generally used with an assumption that attractions are to cisgender people and so leave undefined the question of whether "andro" refers to male bodies, men, or masculinities and whether "gyne" refers to female bodies, women, or femininities.

The further designator of *autogynephilia* has been developed in reference to some trans* people. While there have been sporadic attempts to extend the usage of the term to include cisgender women (Moser 2009) and to define a parallel term, *autoandrophilia* (Bockting et al. 2009; Knudson et al. 2011), the concept has been used almost exclusively in reference to people assigned as males at birth. Autogynephilia has been proposed as a sexual orientation wherein

male-bodied persons live much of their lives as masculine heterosexual men while periodically taking sexual pleasure in presenting and seeing themselves as females and/or women. This kind of activity is more commonly referred to as crossdressing. In many cases, this is a clandestine activity. In some cases, it becomes overt on a part-time basis. In a smaller number of cases, usually later in life, it may lead to partial or complete gender and sex reassignment (Blanchard 1989; Lawrence 2013).

Most contemporary researchers accept self-reports concerning trans* people's sexual identities, and among those trans* people whose bodies do not align with their gender identities in stereotypical ways, people tend to claim their sexual identities more on the basis of their gender identities than on the basis of their physical bodies (Devor 1993; Samons 2009). However, in older research it was not uncommon to see trans* people's sexualities attributed to them by researchers on the basis of their sex assigned at birth. For example, androphilic transmen have been variously referred to as "non-homosexual female gender dysphorics" (Olsson and Möller 2006) and "non-homosexual female-to-male transsexuals" (Chivers and Bailey 2000). Underlying differences between older and newer approaches is a question that appears to be one of the willingness of researchers to accept that trans* people's self-identifications provide accurate data.

The majority of transmasculine people report that they are gynephilic both before and after undertaking transition (Dozier 2005; Schilt and Windsor 2014). Prior to identifying as trans*, many transmasculine individuals identify as lesbians, later rejecting that identity in favour of ones which better recognize their gender identities (Devor 1997b; Rubin 2003). Most commonly, after transition transmasculine people identify as heterosexual or as some non-standard sexual identity such as queer or pansexual (Beemyn and Rankin 2011).

While only a small minority of transmasculine people are androphilic prior to transition (Bockting et al. 2009; Coleman et al. 1993), a substantial minority of transmasculine people are androphilic after transition, and sexually active with cisgender men who identify as gay, bisexual, or queer. Many of the transmen, and their cisgender partners, involved in these encounters and relationships see their relationships and sexual activities as gay (Brown 2009; Devor 1993; Lewins 2002). This is true even in those relationships where sexual activities involve pleasurable use of transmen's non-surgically-altered genitals (Bockting et al. 2009), which the individuals involved may recast in ways consistent with their identities by using terms such as "mangina" or "man hole" (Coleman et al. 1993; Zimman 2014).

Among adult transwomen who report having been trans*-identified from a very young age, most report having been androphilic and highly gender nonconforming throughout their lives (Samons 2009). Some of them spend time in gay men's communities prior to their transitions (Lev 2004). They may identify as gay, queer, straight, or any number of other sexual identities prior to transition, and most commonly identify as bisexual or heterosexual after transition (Beemyn and Rankin 2011).

In addition to the many transwomen who are androphilic before and after transition, a sizeable portion of transfeminine people are gynephilic throughout their lives, some are bi-, omni-, or pansexual, and some are asexual (Blanchard 1985, 1988). Prior to transition, many of those who are gynephilic have fully male heterosexual lives, marrying and fathering children. After transition they may identify as lesbians, bisexual, queer, and a variety of other less common sexual identities (Kuper et al. 2012), including many transwomen who do not undergo sex reassignment surgeries (Samons 2009). Some transwomen who were gynephilic prior to transition engage in androphilic or bisexual activities after transition (Daskalos 1998; Lawrence 2013).

The majority of autogynephilic individuals live overtly heteronormative lives and only engage in autogynephilic sexuality clandestinely. Some autogynephilic individuals supplement their autogynephilic sexual interests with occasional sexual interactions with gynephilic or bisexual males. However, those autogynephilic transfeminine individuals who live full time as women, with or without sex reassignment

surgeries, are almost exclusively gynephilic and most often identify as lesbian or queer (Lawrence 2013).

Many trans* people prefer sexual partners who are themselves gender variant. They generally sexually identify on the basis of their own gender identities and those of their partners, rather than the sexes they were assigned at birth. They most often use the common identifiers of straight, gay, lesbian, or bisexual (Bockting et al. 2009; Schleifer 2006; Schrock and Reid 2006). People in relationships which involve one or more gender-variant persons may also describe their relationships as some variant of queer as a way to recognize that they do not, and in many ways cannot, fit into more traditional binary-based conceptualization of sexuality (Kuper et al. 2012).

11.6 Sexualities Involve Other People

As trans* people change their gender expressions and their bodies, their sexual partners often find that they must also recalibrate their own understandings of their mutual sexual activities, and of their own sexual identities. Moreover, such renegotiations can be ongoing, as bodies and understandings evolve, with identities and definitions at first depending more on heteronormative gender sexual scripts and slowly relaxing over time as both partners become more settled and secure in their new realities (Brown 2010; Dozier 2005). In particular, trans* body parts may need to be renamed, whether or not they are physically altered, and certain acts will often be discontinued while others are taken up. Such adjustments can be crucial to achieving successful continuation of relationships originally established under a rubric of hetero- or homosexuality as one or more partner moves from living as one sex and/or gender to another.

When trans* people describe their sexual histories/stories, they tend to do so in ways that validate and align with their current gender identities (Bockting et al. 2009; Schleifer 2006; Schrock and Reid 2006), which may have the effect of obscuring or recasting past relationships and the roles of other people who were in them. While this may be confirming of their present identities, some trans* people, and their partners, can find the resultant invisibility of some parts of their personal history to be distressing (Brown 2009). Among those who describe their relationships in ways that align with heteronormative ideals many report that they simultaneously feel both more understood, accepted, and gender confirmed by mainstream society and, at the same time, some people experience lower levels of self-esteem due to the lack of explicit recognition of their full life histories (Iantaffi and Bockting 2011).

Comparisons of relationship stability among transmen and transwomen indicate that, prior to transition, transmen tend to form more stable relationships than do transwomen (Kockott and Fahrner 1988). Post-transition, transmen and lesbian transwomen have the most stable relationships (Lewins 2002), and cisgender women in relationships with post-transition transmen report relationship satisfaction and stability equivalent to that reported by cisgender women partnered with cisgender men (Fleming et al. 1985; Kins et al. 2008; Kockott and Fahrner 1988).

While a large majority of transmen are gynephilic and active as lesbians prior to transition, a smaller majority continue to be gynephilic and identify as heterosexual or queer after transition (Bockting et al. 2009; Devor 1993, 1997a; Rubin 2003). Feminine cisgendered women partners of transitioning transmen, who initially identify as lesbian women in relationships with masculine women, sometimes find it difficult to relinquish their lesbian identities which they have had to aggressively claim in order to garner accurate sexual attributions from others (Brown 2009; Joslin-Roher and Wheeler 2009). This can be a source of relationship strain which causes many such relationships to dissolve (Brown 2009; Lev 2004).

While some transmen are androphilic prior to identifying as trans* and engage in sexual relationships with men, they often take limited satisfaction from such relationships in which they appear to be women in heterosexual relationships, rather than men in homosexual relationships.

Among those transmen who are androphilic after transition, it is most common for them to realize their trans* identities before they realized that they were androphilic. After transition, gay transmen report feeling increased confirmation of their gender and sexual identities (Bockting et al. 2009; Devor 1997a; Schleifer 2006) and similar levels of relationship satisfaction as do gay cisgender men (Dozier 2005).

Disclosure of trans* identity within already established relationships, and the changes which usually follow, inevitably add strain to relationships. The stress of accepting the changes that a trans* partner may undergo are often very difficult for their partners to navigate (Aramburu Alegría 2010, 2013). In addition, when trans* people in sexual relationships change their identities, their partners may be unable to change their own sexual desires and identities in concert (Alexander 2003; Aramburu Alegría 2010, 2013). One study found that only just over half of the couples studied were still together five years or more after one partner disclosed a trans* identity (Aramburu Alegría 2013).

It is not unusual for wives or long-term partners of male crossdressers to find out that their husbands are part-time crossdressers many years into a relationship. Not infrequently, they find out by discovering women's clothing in their male partners' possession. Many feel betrayed that their partners could have kept such a secret from them for years and trust between them can become undermined. Few female partners are able to enthusiastically share their male partners' passions for crossdressing. Most become anxiously concerned that disclosure will expose the family to unbearable stigma, and most demand that their male partners' crossdressing activities remain private (Erhardt 2007; Weinberg and Bullough 1988).

Factors contributing to couples staying together may include emotional honesty, a willingness to embrace new sexual practices and identities, greater age at disclosure, and longer relationships prior to disclosure (Alexander 2003; Aramburu Alegría 2010, 2013; Hines 2006). Among those who are able to weather the stress of changing gender identities, some find that their sexual lives together improve, and some find that their sexual lives dwindle.

11.7 Sexual and Reproductive Health

Questions of sexual health for trans* people involve three main areas of concern: sexual satisfaction, health of sexual organs, and sexually transmitted infections. In addition to health of sexual organs, reproductive health issues for trans* people include banking of reproductive gametes, and intentional and unintentional pregnancies.

Among those trans* people who engage in medically-assisted gender reassignment procedures, sexual satisfaction generally improves to the extent that the procedures produce the desired results (De Cuypere et al. 2005). However, there have been reports of instances wherein poor functional or cosmetic surgical outcomes have had the opposite effect and, in some cases, ability to orgasm has been diminished or entirely lost (Sohn and Exner 2008). Furthermore, as noted above, although trans* individuals may find increased sexual satisfaction in inhabiting bodies which better reflect their gender identities, their partners may be unable to sexually transition with them, in which cases, trans* people may experience temporary, or more long lasting, diminishment in sexual satisfaction.

Many trans* people experience discomfort and shame concerning sexual parts of their bodies, especially prior to completing whatever gender and sex transitions they desire. Some continue to feel this way throughout their lifetimes, generally because of lack of access to technically satisfactory surgical results. One result of these feelings is that many trans* people are reluctant to access routine medical screening and maintenance procedures such as vaginal exams, pap smears, and breast exams for transmen, and prostate and testicular exams for transwomen. Their reluctance may be further compounded by hesitations due to concerns about the prevalence of ignorant or hostile care providers; by concerns about being required to access care, or being denied access to

care, at facilities dedicated to providing services for people of their birth-assigned sex; or being denied needed services on the basis of their current sex or gender (Hartofelis and Gomez 2013; National Center for Transgender Equality 2012; Silverman 2009).

Elevated rates of HIV infection are of particular concern in certain segments of trans* populations, especially among people of colour as well as transfeminine-spectrum people (Hwang and Nuttbrock 2014). A disproportionate number of trans* people live in poverty and suffer from mental health, drug and alcohol abuse problems (National Center for Transgender Equality 2012). One result is that a disproportionate number of transwomen and a small number of transmen engage in survival sex work. For many of those who engage in it, sex work provides the only source of income sufficient to allow them to finance the costs of their transitions (Israel and Tarver 1997; Namaste 2000, 2009; Nemoto et al. 2014) while also increasing their exposure to risky sexual practices.

Risk of HIV infection can also be elevated in non-commercial sexual relationships involving trans* people. Concerns about genital adequacy can also undermine trans* people's sexual confidence, one result of which can be that trans* people may be insufficiently assertive about protecting themselves against risks of sexual infections (Bockting et al. 1998; Nemoto et al. 2004). Trans* people who feel that their relationships with cisgender people may be insecure because of their being trans* may also be more likely to impair their judgement through the use of drugs or alcohol. They may be more willing to risk HIV infection than risk losing their relationships by insisting on proper protection against HIV (Hotton et al. 2013; Nemoto et al. 2004; Sevelius et al. 2009). Those trans* people whose partners are active as gay or bisexual men are at compounded risk of infection due to the higher rates of infection in those sexual communities (Reisner et al. 2010; Rowniak et al. 2011).

Hormone treatments used by many trans* people decrease, or completely block, fertility. Removal of reproductive organs, of course, eliminates most capacity for reproduction. For these reasons, the World Professional Association for Transgender Health (WPATH) recommends reproductive counselling for all people considering any of these treatments (Coleman et al. 2011). Trans* people who wish to have children using their own gametes after hormonal or surgical treatments can bank sperm or eggs, prior to transition, for later use (Coleman et al. 2011). Gynephilic transwomen with intact reproductive organs, and who are sexually active, can impregnate. Similarly, androphilic transmen with intact reproductive organs, and who are sexually active, can become pregnant. As well, a small number of transmen, of a variety of sexual orientations, have interrupted their hormonal treatments specifically for the purpose of becoming pregnant either through sexual intercourse, or by way of artificial insemination (Coleman et al. 2011; Murphy 2010). However, the availability of trans-specific reproductive health care is limited (National Center for Transgender Equality 2012).

11.8 Future Directions

Most of the research into trans* sexualities is limited to that which looks at the time around transition and the first few years beyond. As a result, little is known about sexuality in the lives of trans* people in the years before and after transition, or in the lives of those who identify as trans* and do not transition. These would be fruitful areas for future research.

Many trans* people are attracted to opportunities to experiment with alternatives to the limitations that they feel on the basis of their bodies. To that end, many trans* people are active in cybersex, fantasy, and science-fiction arenas where they are not bound by physical bodies and may take on whatever characteristics they wish to explore (Hansbury 2011). Similarly, many trans* people enjoy BDSM sexuality (bondage and discipline, dominance and submission, sadomasochism) for the role-playing opportunities it affords them to try out alternative sexual roles (Bauer 2008). Both of these areas are understudied and would be valuable areas of focus for future research.

The paucity of research about the sexualities of older trans* adults is part of a larger pattern of

neglect concerning sexualities of people over the age of 50 years (Jablonski et al. 2013; Kazer et al. 2013; Witten and Eyler 2012; Zeiss and Kasl-Godley 2001). While there is some evidence that many of the same sexual patterns seen in younger trans* adults also hold true as trans* people age (Cook-Daniels and Munson 2010), much more research is needed. As trans* people age they have particular needs in terms of health care and housing which, in turn, further complicate questions about sexuality. Further research is needed in this area as well.

On the other end of the age spectrum, although research about trans* youth is increasing, particularly in the areas of gender identity support and treatment, research concerning trans* youths' sexualities is still very limited. The heteronormative conflation of gender expectations and sexual expectations, and their special intensity for teens and young adults, combine to make sexuality especially fraught for trans* teens and young adults who struggle with additional identity issues beyond those that plague most young people (Grossman and D'Augelli 2006). This conflation also complicates sexuality education, which has yet to address the needs of trans* students (Gowen and Winges-Yanez 2014). It also intersects with various forms of victimization, and together these have a notable effect on rates of relationship violence (Dank et al. 2014) and sexual risk-taking by trans* youth (Robinson and Espelage 2013). This would also be a welcome area for further research.

Finally, although increasing, little work has been done into the experiences of trans* people of colour, and even less into the sexualities of trans* people of colour. Much of the research done to date has over-represented the risks of HIV infection among trans* people of colour in Western societies, or has been about trans* people of colour in other cultures. More research is needed about the sexualities of trans* people of colour.

11.9 Conclusion

The sexuality of trans* people is as varied and complex as human imagination will allow. However, trans* people and their sexual partners, as is the case for cisgender people and their sexual partners, must find ways to make sense of their bodies, their fantasies and desires, and their sexual practices within the context of a social system which still largely confers intelligibility and social acceptance only upon binaries versions of sex, gender, and sexuality. Nonetheless, many trans* people, and their partners, are forced by the realities of their lives to mount challenges to accepted ways of being. Some do this enthusiastically, some reluctantly, some with equanimity. All contribute to the advancement of sexual and gender diversity.

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