TOWARDS A MORE AFFIRMING PERSPECTIVE: CONTEMPORARY PSYCHODYNAMIC PRACTICE WITH TRANS* AND GENDER NON-CONFORMING INDIVIDUALS

By Clare McBee
School of Social Service Administration
University of Chicago

Abstract

This paper presents new psychodynamic treatment options for trans* (transgender, transsexual, gender-variant, genderqueer, gender fluid, agender, two-spirit) and gender non-conforming (GNC) clients. It addresses the need for these options by highlighting the pervasive heterosexist and transphobic attitudes within the mental health field, including the history of pathologizing trans* identifications and experiences within psychodynamic theory itself. Its focus is on the recent and ongoing transformations of the field as it relates to trans* and gender non-conforming individuals and suggests how contemporary psychodynamic practice might be used to empower trans* and gender non-conforming clients.

Trans* (transgender, transsexual, gender-variant, genderqueer, gender fluid, agender, two-spirit) and gender non-conforming (GNC) clients have utilized psychotherapy in large numbers ever since German endocrinologist Harry Benjamin published *The Transsexual Phenomenon* in 1966. Mental health practitioners seeking the origins of gender variance have explored the psychoanalytic and cognitive-behavioral aspects of sex and gender development and social learning, conducted studies on the human brain and endocrine system, and utilized feminist theories on the social construction—and oppression—of sex and gender. While many contemporary psychodynamic practitioners do not subscribe to the heterosexist views of gender development instantiated more than a century ago by Freud, when it comes to queer and trans* identities, pathologizing

tendencies are still seen throughout psychoanalytic literature and practice (Lev 2004). This paper provides an overview of the problematic ways psychodynamic practitioners have historically engaged with trans* and gender non-conforming clients. It consolidates recent and ongoing transformations of the field as it relates to gender variance and suggests ways psychodynamic theory can be used to empower trans* and gender non-conforming individuals.

Terminologies for LGBTQ identifications continue to evolve and intersect in complex relationships to race and socioeconomic status. "Transgender" has often been used as an umbrella term for gender-variant identifications, but contained within this classification is a spectrum of experiences and terms (FTM/MTF, transman/transwoman, post-op, pre-op, transsexual, genderqueer, gender f**k, gender non-conforming, drag king/queen, etc.). Some gender non-conforming people of color may not feel that "transgender" adequately represents their lived experiences, because it is felt to be a White, privileged term (ALGBTIC 2009). Recently *trans** has been adopted, the asterisk representing a wide range of gender expressions that do not in some way conform with binary concepts of sex and gender. The term "cisgender" is used to describe a person who is not transgender—one whose birth sex and gendered sense of self are in alignment according to heteronormative formulations of sex and gender. The term cisgender does not speak to one's sexual orientation, which could still be queer. Cisgender is preferred over "non-transgender" by many trans* people and allies because it disrupts the assumption that anyone—regardless of their identification—has an internal and binary sense of being male or female that matches their birth. With full understanding of the limitations of language, I will proceed by using *trans*/GNC* in an effort to include as many gender-variant identifications and communities as possible.

Clinicians who work with gender variance in the United States rely upon the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which contains the classification of Gender Identity Disorder (GID), and the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th ed.), published by the World Professional Association for Transgender Health (American Psychiatric Association 2000; WPATH 2011). For adults seeking medical interventions to transition (hormone therapy or surgery), a diagnosis of GID is required in order to gain access to such technologies; if individuals do not meet the criteria for GID by performing the particular narrative of transgender development (the theme of being "trapped in the wrong body" since birth) contained within the DSM, they may be denied access to a medical transition (Lev 2004).[i] Arlene Istar Lev's (2004) foundational work, *Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and Their*

Families, argues that while the DSM gives no definition of healthy gender/sexual development, it does put forth a classification of deviance based on prevailing notions of normative gender expression, and is thus a mechanism for oppression rather than empowerment. Lev concludes that, "as long as psychology continues to condemn people for their sexual and gender differences, they will continue to manifest mental health problems related not to their differences but to their being labeled pathological" (167).

Psychology's condemnation can be seen in the description of trans*/GNC people as narcissistic, developmentally and emotionally immature, impulsive, obsessive, withdrawn, schizoid, and borderline (Hansbury 2005; Lev 2004).[ii] For example, Steiner (1990) tells therapists, "You should be prepared to see individuals who may present physically looking somewhat bizarre, either flamboyantly or inappropriately dressed, or looking like a man in 'drag'" (96). Chiland (2000) describes trans*/GNC clients this way: "Enclosed as they are within their narcissistic shells, they do not care about their analyst's inner reactions to what they say" (28). Steiner (1990) encourages therapists to be wary of their clients and to "withstand transsexuals' demands to know why you have not surgically reassigned them yesterday" (95-96).

Therapists frequently adopt the problematic role of gatekeepers, from whom trans*/GNC clients must obtain a GID diagnosis in order to achieve medical transition. A therapist's position becomes one of unmerited power; the privilege to determine the "appropriate" application of medical interventions by pre-emptively pathologizing trans*/GNC clients. As Conover (2002) puts it, "[therapists] who operate out of sickness theories about transgender people do not draw their mandate from science but rather from a defense of current cultural traditions. They wrap themselves in the mantle of science to justify their professional status, their control, and their fees" (149). In turn, trans*/GNC patients, who are typically more educated about gender identity development than most therapists, are compelled to perform the particular "transsexual narrative"[iii] endorsed by the DSM in order to gain access to gender affirming hormones or surgeries (Lev 2004). In the vicious circle of distrust, pathologizing, and disengagement that has developed between (even well-intentioned) clinicians and trans*/GNC clients, a fundamental and precious aspect of the helping process has broken down:

> sexual orientation and transgender microaggressions committed by the clinician jeopardize the therapeutic alliance, as they may epitomize the various types of discrimination the LGBT client experiences daily. So, rather than providing an environment for protection, safety, and space to learn and grow in therapy, the practitioner has created the contrary. (Nadal, Rivera and Corpus 2010, 235)

Some clinicians are beginning to understand that trans*/GNC patients exhibit symptomatologies of distress due to the effects of developing within a cultural climate that persistently shames and stigmatizes their gender identities—pathology is not inherent to trans*/GNC people, but rather a product of an oppressive and dehumanizing environment (Lev 2004). Trauma is a frequent characteristic of trans*/GNC experiences, often arising as a result of intersecting processes of gender, class, or racial discrimination (Lev 2004; Singh and McKleroy 2011). However, a reformulation of the psychodynamic curriculum on trans*/GNC experiences is already taking place, one largely driven by members of queer and trans*/GNC communities who are also practitioners.[iv] The DSM-V (due to be released in May 2013) will replace Gender Identity Disorder with "Gender Dysphoria," which was viewed as a less pathologizing classification. Criteria for Gender Dysphoria will be more flexible and account for the fact that not all trans*/GNC people fall within a particular "transsexual narrative" (American Psychiatric Association 2011). At the same time, Transvestic Fetishism (a paraphilia in DSM-IV) will be renamed "Transvestic Disorder," and diagnostic criteria will be considerably broadened in a manner that many advocates argue only further pathologizes gender variance (American Psychiatric Association 2012; Blanchard 2010; Winters 2011).

Some advocates maintain that trans*/GNC identities should not even appear in the DSM, while others argue that removing any diagnoses relating to trans*/GNC identities from the DSM would produce additional barriers to accessing trans*/GNC affirming healthcare (Beredjick 2012). The notion that trans*/GNC people could access hormones and surgery "on demand" without a proper diagnosis is unacceptable to most clinicians, but if the diagnostic system fails to account for the authentic lived experiences of many trans*/GNC people, then assessment and treatment practices will be flawed as well (Lev 2004). Therefore, Lev (2004) advocates a clear distinction between trans*/GNC clients who present symptoms of mental disorders that are independent of gender identity development, and those who manifest "symptomatology or sequelae to the difficulties of living as a transgendered person in a dimorphic and transphobic social world" (Lev 2004, 194-195).

Beyond this is the need to address potential unexplored negative countertransference reactions between cisgender therapists and their trans*/GNC clients (Hansbury 2005). In Wachtel's (2011) model of cyclical psychodynamics, a self-reflective focus on the therapeutic alliance is crucial in order for clinicians to move past the "pathocentric tendency" within the mental health professions of diagnosing and treating problems in order to "consciously and explicitly seek out as well the elements of strength in the patient and the potential to live differently" (83).

FRAGMENTATION: INTERNALIZED TRANSPHOBIA

Trans* affirming psychodynamic perspectives can be useful in understanding the context and meaning of gender variance, as clients examine the impact of their gender transition on self and relational life (Lev 2004; WPATH 2011). Within this contemporary psychodynamic framework, gender identity development is seen as a profoundly relational experience that shapes inner representational models of self and others. In the words of Susan McKenzie (2010, 92),: "Is it a boy or a girl? This is the primal question asked at the moment of a child's birth. With the declaration of a child's sex comes a preprinted operations manual describing the outer gender performance of the model and assumptions about its inner workings as well." Early attachment experiences with primary caretakers contribute positively or negatively to the development of a conscious sense of gendered self (McKenzie 2006). From a Winnicottian perspective, development of the gendered self is made possible by accurate mirroring from others (Borden 2009; Winnicott 1965, 1971). Accurate mirroring is then internalized by the subject, as gender comes to be experienced in the maturing body and is elaborated "into a conscious category in the mind, into a gender position" (McKenzie 2006, 413).

The ways in which gendered behaviors are transcribed onto individual bodies and selves are intimately connected to broader cultural patterns of normative behavior. According to Sullivan (1956), "the child has to be educated to a very complex social order, long before reason and the good sense of the whole thing can be digested, long before it becomes understandable—if it ever does" (4). McKenzie (2006) borrows Jung's concept of the collective unconscious and suggests that heterosexist norms are collective "artifacts" produced at the cultural level, transmitted to each generation through collective memory, and subject to historical and ideological shifts. As a collective artifact, gender has no essence, but is rather defined by difference—the space between masculine, feminine, and other—and is "culturally conceived, interpersonally negotiated, and intrapsychically experienced" (Dimen 2002, 49-50).

Due to the collective stigmatization and invisibility of gender non-conformity, trans*/GNC self expressions are not mirrored back (at any stage of development) by social actors (Fraser 2009). Winnicott emphasizes that the "developmental basis for feeling real . . . lies in the true self" (Borden 2009, 98). The development of a gender non-conforming identity, therefore, can have a profoundly destabilizing effect on the subject, because inner representations of self are in direct conflict with the social sphere (McKenzie 2006). Unlike gay, lesbian, bisexual, pansexual, or queer identified people, trans*/GNC individuals who express their authentic gendered selves (whether through behavior, dress, or bodily modifications) cannot remain closeted;

they "must engage in a transaction process with others who will witness and react" to their perceived deviance (Lev 2004, 233). Those who openly demonstrate gender variance may experience shaming and corrective behavior from caretakers, ostracism from peer groups, or possibly even neglect, abuse, discrimination, and hate crimes, or be cast out of their families and homes (Grant, Mottet and Tanis 2011; Witten 2009). Many trans*/GNC individuals who receive negative feedback in response to their non-conforming gender expressions, or are acutely aware of the imagined consequences, may adapt by repressing their true selves and put forth a compliant or false self out of defense (Borden 2009; Ehrensaft 2009; McKenzie 2010; Winnicott 1971) . Awareness of potential discrimination may be even more present for trans*/GNC people of color, who must navigate multiple minority identifications (Balsam et al. 2011; Pinto, Melendez and Spector 2008). Hansbury (2005) utilizes a Kleinian perspective to illustrate how some trans*/GNC individuals "describe a wide split within themselves, between the persecuting body-self and the good mind-self" (23). Out of pressure from a social environment that does not accurately mirror their authentic gendered selves, trans*/GNC people repudiate their "not-me," "real," or shadow selves in favor of a "good-me" or "idealized self" (Borden 2009; Jung 1954; Shelley 2008). In such cases, the individual's authentic gendered self (or true self) goes unrecognized (Ehrensaft 2009).

According to Scheman (1999), clinicians who require the performance of a particular transsexual narrative end up facilitating the client's adoption of a compliant/false self:

> the only way to be a "certified" transsexual is to deny that you are one, that is, to convince the doctors (and agree to try to convince the rest of the world) that you are and always have been what you clearly are not, namely simply and straightforwardly a woman (or a man). Since you cannot have a history that is congruent with such an identity, you are left without a past. (75)

Lev's (2004) argument that the high incidence of mental illness in trans*/GNC communities is a direct result of having to adapt gender-conforming selves—"It is literally *crazy making* to live a false self" (196; emphasis in original)—is therefore a strong reminder of the risks posed by transphobic clinicians. Winnicott (1971) believes that, in adapting a false/compliant self, the subject sacrifices healthy, creative modes of being and is forced to adopt a "sense of futility" and may feel that "life is not worth living" (65). Trans*/GNC people incorporate and are shaped by the destructive hegemony of heterosexism—this is internalized transphobia at its most insidious level (Shelley 2008; Lev 2004). From her practice, Lev (2004) contends that the symptoms manifested by some trans*/GNC individuals mimic those expressed by clients who have experienced

significant trauma. The vicious circle of stigma, anxiety, and repression/dissociation that many trans*/GNC people endure highlights Rank's (1936) observation that, "All symptoms in the last analysis mean fear" (157). Rather than viewing problems in living that may arise from ego fragmentation as pathology, Hansbury (2005) argues that they should be seen in trans*/GNC individuals as defensive strategies for self-preservation.

Recognizing ego fragmentation and thereby displacing a pathologizing analysis does not, however, automatically foster a strong therapeutic alliance. Fraser (2009) writes that an understanding of the splitting processes in some trans*/GNC experiences has been used to disempower patients who have attempted to utilize psychotherapy:

> Many transgender people complained that therapists, who operated from psychodynamic theory indicating that the transgender self is a failure to separate, a defense, a false self or even a psychosis and never potentially a healthy part of the self, did not seem to understand the reality of their lived experience. (128)

Several psychodynamically oriented practitioners who work with trans*/GNC patients have attested to the high level of mental health and functional behavior present within this population, despite the trauma of being forced to present false selves during development—a testament to the resilience of trans*/GNC individuals (Ehrensaft 2009; Fraser 2009; Hansbury 2005; Lev 2004; Shelley 2008). Feminist, queer, and trans*/GNC theorists have deconstructed our understanding of ego and identity development, leading to the notion that identities are fluid, relationally constructed, and constantly in flux (Butler 1990; McKenzie 2010). The relationship between mind and gender has been given special attention in postmodern theory; as McKenzie (2010) writes, "Just as mind is not in us, we are in mind; gender is not in us, we are in gender. We are investing gender with meaning" (108). GNC consumers of therapeutic services seek the same things that anyone else might, "to develop a healthy self and self-in-relation, experience empathy and trust, develop the capacity for intimacy and live an authentic life" (Fraser 2009, 130).

FOSTERING EMERGENCE AND COHESION OF THE SELF

According to practitioners who work with trans*/GNC clients, as well as feedback from clients themselves, the key aims of psychotherapy with gender non-conforming individuals should be fostering the emergence of an authentic gendered self, helping to restore cohesion of self, and modeling acceptance and empathy in order to restore relational integrity (Ehrensaft 2009; Fraser 2009; Hansbury 2005; Lev 2004). This may require therapists

to operate outside of an ego-psychology model in order to explore other options for empowering clients (Lev 2004).

Working from a Jungian perspective, Fraser (2009) fosters individuation in his practice with trans*/GNC individuals by helping the client to develop "a healthy self and find meaning in relation to his or her own ego (the self with a little "s"); to others (e.g., intimate partner, family, friends and community); to work; and to the Self (with a big "S," which some call God or Higher Self)" (129). In Jung's (1954) own words: "My aim is to bring about a psychic state in which my patient begins to experiment with his own nature—a state of fluidity, change, and growth where nothing is eternally fixed and hopelessly petrified" (46).

Lev (2004) adopts an emergence framework in her practice with trans*/GNC clients, by "allowing the false parts of self to recede so that an authentic self can emerge" (207). She views the act of fostering emergence in the familiar language of "coming out" and has operationalized the trans*/GNC emergence process as a progression through six stages: (1) awareness; (2) seeking information/reaching out; (3) disclosure to significant others; (4) exploration of identity and self-labeling; (5) exploration of transition issues/possible body modification; and (6) integration and acceptance of post-transition self (Lev 2004, 235). Lev (2004) explains that trans*/GNC clients may enter psychotherapy at any stage of emergence. The initial awareness stage can be destabilizing and distressing for some clients, while those in the second phase (seeking information/reaching out) typically possess a more integrated sense of self and are seeking to establish supportive relationships with others. Regardless of how trans*/GNC people experience their stages of emergence, Lev outlines primary therapeutic tasks such as normalizing, facilitating linkages to resources, supporting clients' wishes to disclose or not disclose their trans*/GNC status, and encouraging self-exploration (Lev 2004). Lev's emergence paradigm is put forth as a counter-narrative to prevailing concepts of trans*/GNC psychopathology, instead viewing emergence as a normative developmental process and recognizing trans*/GNC identifications as legitimate.

The second aim of therapy with gender non-conforming clients is to restore coherence of self (i.e., resolve ego splitting and fragmentation), which in Fairbairn's framework is achieved by restoring "integrity of the self" and the "capacity for core-to-core connection with actual people in the outer world" (Borden 2009, 83-84). Sullivan's similar conception of the "self as process, shaped by interactive experience in relational life" is equally useful (Borden 2009, 120). From a Jungian perspective, restoring integrity of the self occurs when the shadow—the oftentimes frightening and unacceptable gender non-conforming self—is consciously integrated and wholeness is achieved (Fraser 2009; Jung 1954). The clinician must

help the client reconstruct a cohesive life narrative, which many trans*/GNC individuals have been robbed of, and which is essential to establishing a unified self. As Prosser (1998) writes, "Transsexuality is always a narrative work, a transformation of the body that requires the remolding of the life in a particular narrative shape" (4). This is in striking contrast to traditional psychopathology approaches with trans*/GNC people in which clinicians required post-transition patients to annihilate their past histories entirely and start over as men or women (Cook-Daniels 2006, 2010; Lev 2004).[v]

The role of the therapist within this new approach is to reframe the gatekeeping position into one of advocacy by establishing a strong therapeutic alliance (Lev 2004). From Sullivan's perspective, the therapist who works with trans*/GNC patients functions as a "participant-observer" (Borden 2009). Lev (2004) describes how clients "hear themselves into existence" (221) through accurate and supportive mirroring of the client's authentic gender expression (using correct pronouns and names, relating to the client in their preferred gender) (Ehrensaft 2009; Fraser 2009). Winnicott (1971) describes this process as "giving back what the patient brings," rather than simply making interpretations and positioning oneself as an expert (117). Secondly, facilitation of the true self's emergence is achieved through empathic responsiveness and the creation of a holding environment for clients who may experience significant vulnerability and anxiety during the emergence process (Fraser 2009; Borden 2009). Lev (2004) characterizes empathic responsiveness as "relaxed comfort" and "compassionate neutrality" with a patient's preferred gender expression (138; 239). Fraser (2009) argues that, because some clinicians will be personally challenged by moving beyond taken-for-granted binary concepts of sex/gender, a Jungian perspective is useful in working with trans*/GNC clients because it is not as "culture bound and can be contextual and relational, which opens a wider frame in which to connect with the Self" (129). Furthermore, Fraser observes that, "Many clients experience relational naiveté in general and especially in their new gender role" (138). For this reason, invoking Rank's examination of transference and countertransference can be useful in assisting clients to "renegotiate the effects of earlier trauma" and in resolving relational naiveté (Borden 2009, 56). Lev (2004) also urges therapists to be aware of, and incorporate, dialogue regarding political theory and the oppression of trans*/GNC people, as well as the potential spiritual dimensions of gender transition.

CONCLUSION: THE CASE OF WILL

Will[vi] is a 26-year old Caucasian transman who has expressed gender-variance his entire life, but only in recent years has he transitioned from an identification as a queer female-bodied person to one along the transgender spectrum. In 2011, Will began receiving weekly injections of testosterone and legally changed his name and gender to male. Will's process of self-realization has been characterized by significant challenges: "The world doesn't really work in the way that I see myself, so there's a challenge involved in that inherently." For approximately six years of his childhood, Will was sexually abused by his father.

Will continues to reflect on the ways that his gender identity and childhood sexual abuse—as Will calls them, his "competing narratives of being an abuse survivor and also having a trans* body"—may or may not be connected. At various stages of his development, Will utilized psychotherapy to process the abuse and explore his gender identity in early adulthood. As he undergoes a significant transformation in his social, physical, and emotional selves, Will is establishing a different relationship to the outside world:

> More and more people on the phone think I'm a guy. In social dynamics, I have started to walk a line where—even if I don't pass or come off as a cisgender male immediately—it's easier for people to use their imaginations now. My sense of myself socially has never been as important as my sense of my body, so suddenly having to be playing by these rules of gender, I'm like *what now?!* But I think this is where a lot of people find comfort in the idea of transgender identity—if not as an innate quality, at least one that is global.

While he began expressing masculine characteristics as a child, Will's experience was not one of being "trapped in the wrong body" from birth. As Will states, "I know so many trans* people who don't have that formative gender experience—they don't have this moment where they're four and are like *I'm a guy, where's my penis*?" As Will explains: "I was aware of gender very young, but between being allowed to be a tomboy and not having any pushback, and also feeling pretty confused about gender within the context of a pretty dysfunctional family dynamic, I didn't know how to place myself until I was much older."

Now entering the final integration stage of emergence, Will says:

> There was some person in me, who was me, that knew what I needed to do but had never done it. And I still feel like the part of me that is more conscious is still trying to explain why I did this … the only real doubts I have come from the part of me who tries to explain it … so much of what I've done in the last year has just been *this is what needs to happen now*.

Will indeed discovered a sense of spirituality as predicted by Lev; he feels that this has helped him to overcome some of the isolation and anxiety of transitioning:

> Ultimately I think it's about getting over my sense of separateness, which I think is a spiritual crisis that from a young age I've been in . . . which is why I'm so drawn to spirituality, because I think it's a lot of reframing, universalizing, and normalizing of that feeling, and trying to create ways to connect to the world around you and the people around you. For a while with the transition I felt so different and did not know how to not feel so different. I think in the last month or so, I've been experiencing a kind of turn where my accepting of myself in this situation has made me feel like I'm not that abnormal, this is not a crazy situation.

If gender non-conformity were celebrated rather than pathologized, the trans*/GNC emergence process—while still socially and emotionally challenging—would be far less so due to a less hostile cultural environment (Lev 2004). Will's experience demonstrates the immense potential of a psychodynamic framework that affirms and empowers diverse trans*/GNC expressions. This less pathologizing approach to the processes of ego splitting that some trans*/GNC people experience might entail what Dimen (2002) describes as "not merely remembering the other pole but being able to inhabit the space between them, to tolerate and even enjoy the paradox of simultaneity" (56). Will aptly summarizes this approach when he speaks of "gender dissonance" as a universal phenomenon:

> Being transgender is having a gender dissonance, not in a pathological way because it's a universal thing … the way in which people choose to handle that dissonance—whether they transition hormonally, or whether they wear clothing of the sex they identify with, do a combination of things, or use pronouns—is a relieving of that dissonance in a world that does not recognize trans* people. But being trans* is a natural, or at least a universal experience. I like that because I feel like it allows room for everybody without a hierarchy, and I think that's really important.

In addition to exploring internal representational models (and encouraging authenticity, even ambiguity), psychotherapists are coming to address the "larger social context of oppression and environmental assaults on . . . personhood" that have generated problems in living for gender non-conforming patients (Lev 2004, 196). The process of reformulating sickness theories of trans*/GNC experiences may even lead some therapists to become activists (Fraser 2009). While the everyday reality of transphobia—violence, discrimination and structural inequality—continues to threaten the well-being of trans*/GNC people, Fraser (2009) argues that

psychodynamic practice must expand its engagement with this reality in an empowering manner: "As clinicians, we are responding to what we hear and see in our practice (the lived experience of transgender people) as well as these human rights concerns, fitting the theory to the people and not the other way around" (127). While the field of psychotherapy still has much repair work to do with trans*/GNC communities, McKenzie (2010) expresses hope in the ideological shift that is slowly taking root:

> Finding one's initial place on the gender map is not too difficult for those males and females whose interior sense of gender is a good enough fit to their culture's gender myth. They tend to colonize within their territory, digging moats and raising barricades to keep out the misfits. Those of us who are not comfortable, whose gender feelings do not fit the gender myth and assigned gender location, are scouts in the borderlands of gender, sending messages back to those in the comfortable interior. Lately it seems that the messages are better received. (96)

As Will has come to realize, "there's nothing wrong with being trans*. Being trans* is probably what I was born as, or at least something fundamental to my personality, and it's kind of awesome."

NOTES

[i] Some masculine spectrum trans*/GNC people may wish to masculinize without fully transitioning, while some feminine spectrum trans*/GNC people may desire hormones to be more feminine but do not want to undergo gender affirmation surgeries (also known as Sex Reassignment Surgery or SRS). Strict adherence to the GID guidelines would render these individuals ineligible for medical treatment (Lev 2004).

[ii] "The transsexual is conceptualized as a problematic figure who cannot accept the limits of the body, or who treats the body as a fetish, thus insisting on becoming a 'real' man or woman, one who could be complete or whole." (Gozlan 2008, 541-542)

[iii] "The transsexual narrative as it has been developed contains all the important rules for constructing an intelligible story… These stories show a temporal ordering of events (e.g., cross-gender identity since early childhood, persistent desire to be the opposite sex), causal linkings (e.g., continued desires throughout adolescence and early adulthood), demarcation signs (e.g.. childhood cross-dressing, lack of genital pleasure in adult sexuality), and a 'valued endpoint' (reassignment surgery)" (Lev 2004, 216).

[iv] The American Psychological Association (APA) is addressing this issue via a specialized Task Force on Gender Identity and Gender Variance, which has published several recommendations for conducting empowering practice and advocacy with the trans*/GNC population (APA 2009). See also the Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) *Competencies for Counseling with Transgender Clients* (2009) and Bockting, Knudson and Goldberg (2006).

[v] "For many years it was considered part of therapeutic treatment to encourage clients in transition to cut off all ties with their past and consciously reconstruct a false history in their new gender." (Lev 2004, 222)

[vi] All quotations and ethnographic content are from an interview conducted on November 22, 2011. The individual's name has been changed, and permission to use interview content in this article has been obtained from the participant.

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ABOUT THE AUTHOR

Clare McBee is a second-year clinical student at the School of Social Service Administration. She holds a B.A. in anthropology from Wellesley College and an M.A. in anthropology and women's and gender studies from Brandeis University. For the past ten years, Clare has worked as an ally with trans* and gender non-conforming communities in Boston and Chicago. She spent three years as a community health worker and program manager at PACT Project/Partners in Health, a home-based HIV/AIDS intervention in Boston. She interned at Chicago House and Social Service Agency, where she supported efforts to create employment and housing interventions specifically for the trans* community. She recently completed an internship at Affinity Community Services through the University of Chicago Human Rights Internship Program. Currently she is a Behavioral Health Intern at Howard Brown Health Center.