Counseling Transgendered, Transsexual, and Gender-Variant Clients

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The emergent consciousness and political activism within the transgender community has important implications for the field of counseling. In the current paradigm, the focus has shifted from using surgical and hormonal interventions and thereby enabling transgendered persons to "pass" within the traditional gender binary of society to affirming the unique identities of transgendered persons. To prepare counselors, counselor educators, and counseling supervisors for this important challenge, the authors describe the evolving nature of the transgender community, discuss mental health issues and counseling interventions for use with transgendered clients, and present a case study detailing the progression of counseling with 1 transgendered client.

Despite the recent focus on multiculturalism and diversity within the counseling field, the transgender population has been given insufficient attention in research and in counselor training. Although gay, lesbian, and bisexual issues are beginning to receive much needed attention in multicultural texts and professional journals (e.g., the 1998 special issue in *The Counseling Psychologist*, the recent publication by the American Psychological Association titled *Handbook of Counseling and Psychotherapy With Lesbian, Gay, and Bisexual Clients*, by Perez, DeBord, & Bieschke, 2000), discussion of transgender issues is rare in such publications. For the most part, mental health practitioners' views about transsexuals, transvestites or cross-dressers, and others with transgender status have "not been informed by objective empirical research" (Fox, 1996, p. 31). Consequently, counselors are ill-prepared to meet the needs of such clients. The purpose of this article is to inform counselor educators, counselors, and supervisors about the salient clinical issues that arise when working with transgendered clients. Specifically, the following areas are addressed: (a) the emerging and evolving definition of the transgender community, (b) the politicization of the transgender movement, (c) clinical issues and interventions for use with transgendered clients, and (d) the presentation of an actual case that details the progression of personal therapy with a transgendered client.

EVOLVING DEFINITIONS

The term *transgender* was coined in the late 1980s by men who did not find the label *transvestite* adequate enough to describe their desire to live as women (Prosser, 1997). Alternately, the term *transsexual* was deemed inappropriate because many nontraditionally gender-identified persons did not necessarily want to reconfigure their bodies surgically and hormonally and did not share the desire to "pass," or to fit into normative gender categories of male and female. Included in the full spectrum of people with nontraditional gender identities are pre- and postoperative transsexuals, cross-dressers or transvestites, intersex persons, and those who are disinterested in passing. Among the many terms used interchangeably to describe this community are *transgendered persons*, *gender-variant persons*, and *trans persons*. For consistency in this article, we use *transgendered persons* and its variations.

Today, the continued proliferation of identifying terms within the transgender community, including *gender-bender*, *gender outlaws*, *gender trash*, *gender queer*, *transsexual lesbian*, and so forth, reflects the diversity within this community as well as the ongoing struggle for self-definition. Novelist Leslie Feinberg (1998), who is transgendered and an activist for this community, observed that "our lives are proof that sex and gender are much more complex than a delivery room doctor's glance at genitals can determine, more variegated than pink or blue birth caps" (p. 5).

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For many counselors, these variations in terms and identifications within the transgender community are confusing. We have found Eyler and Wright's (1997) "nine-point gender continuum" (p. 6) to be a helpful framework for us to organize our understanding of the multiplicity of gender identifications that exist. Eyler and Wright's continuum depicts possible gender identities ranging from "female-based" identities to "male-based" identities, with "bigendered" identities (defined as alternating between feeling/behaving like a woman and feeling/behaving like a man) in the center.

Attempts to estimate the prevalence of transgendered persons have been problematic because such efforts have been based on counting persons who request surgical reassignment of their sex and who therefore would very likely be considered transsexuals (Ettner, 1999). Ettner (1999) maintained that the prevalence of persons with "gender dysphoria," defined as psychological discomfort with one's biological sex, is "grossly underreported" (p. 28). She indicated that estimates vary from a range of 3% to 5% to a range of 8% to 10% of the general population. Whatever the figures, it is likely that mental health care providers will encounter at least one transgendered client at some point in their professional career (Ettner, 1999).

THE BIRTH OF THE TRANSGENDER MOVEMENT

As Parlee (1998) and Denny (1992) noted, the emerging political activism and organization of the transgender community is both the cause and the consequence of several recent sociocultural events including (a) the closing of university-affiliated gender clinics and subsequent opening of private clinics(Reader's note. According to Cole, Denny, Eyler, & Samons, 2000, the disaffiliation of universities from their respective gender clinics was in large part precipitated by the release of a scientific publication by J. K. Meyer & Reter, 1979, which reported no improvement in the lives of patients after sex reassignment. The report was later discredited.); (b) the organization of the 1992 International Conference on Transgender Law and Employment Policy to fight for the legal and social rights of transgenderists; (c) the First International Conference on Gender, Cross-Dressing and Sex Issues in 1995; (d) the demonstration on behalf of the rights of infants born with ambiguous genitalia, who routinely undergo corrective pediatric surgery, by the Intersex Society of North America (ISNA), at the 1996 meeting of the American Academy of Pediatrics in Boston; (e) the publication by ISNA of the newsletter titled Hermaphrodites With Attitude; (f) the formation of TOPS (Transgendered Officers Protect and Serve for transgendered police, firefighters, military, etc.); and (g) the formation of Gender PAC (political action committee), the first transgender political education fund. Several authors (e.g., Denny, 1997; Gagne, Tewksbury, & McGaughey, 1997; Whittle, 1998) also attributed much of recent transgender activism to the increasing use of cyberspace. The plethora of Web sites and chat rooms has provided possibilities for transgendered persons to communicate and support one another with anonymity. The media attention given to this issue and the visibility of transgendered persons in movies and popular culture (drag queen RuPaul and the Lady Chablis, star of the film Midnight in the Garden of Good and Evil, Eastwood, 1997) have enabled activists to challenge public intolerance and grow in self-confidence and affirmation.

Perhaps more than any of the aforementioned events, the publicity surrounding the hate crimes perpetrated against transgendered persons has stimulated, mobilized, and activated the transgender community. Indeed, most, if not all, transgendered persons know only too well the consequences of straying from compliance with the definition and appearance of what is considered "normal" gender expression. Gagne and Tewksbury (1998) observed that transgendered persons who are neither masculine nor feminine must deal with "the ubiquity of the binary system's dictate that all social actors 'do gender and do it right'" (p. 100). Such persons are truly on the margin of society and are at most risk for social ostracism and discrimination. As Bornstein (1994) noted,

There is most certainly a privilege to having a gender. Just ask someone who doesn't have a gender, or who can't pass, or who doesn't pass. When you have a gender, or when you are perceived as having a gender, you don't get laughed at in the street. You don't get beat up. You know which public bathroom to use, and when you use it, people don't stare at you or worse. You know which form to fill out. You know what clothes to wear. You have heroes and role models. You have a past. (p. 127)

In 1993, the death of Brandon Teena, a female-to-male (FTM) transgendered person, captured the headlines and was the focus of a popular film titled Boys Don't Cry (Peirce, 1999). Brandon was brutally raped and murdered after two male acquaintances discovered that he was biologically female. The death of the transgendered woman Tyra Hunter, who was left unattended by paramedics at the scene of a car accident after they opened her pants and discovered that she had a penis (Stine, as reported by Parlee, 1998), horrified and outraged many in the transgender community. Leslie Feinberg (1998), a lesbian, described being near death and refused treatment by a physician in the emergency room of a hospital because of "hir" (pronounced like "here") gender expression. (Feinberg expressed a preference for the term "hir" because it blends the pronouns him and her.)

As a result of such sociocultural phenomena, many in the transgender community have rejected the use of such clinical terms as gender dysphoria. The use of diagnostic terms contained in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994), such as transvestic fetish and gender identity disorder, were also rejected because they seem to pathologize and dehumanize persons with nontraditional gender identities. The medical and psychiatric communities are viewed with suspicion by many in the transgender community because they have historically served as regulators and gatekeepers in the gender transition process. Beginning in 1979, persons seeking hormonal therapy or sex reassignment, or both, were required to seek counseling and adhere to a series of procedures defined in "the standards of care," developed by the Harry Benjamin

International Gender Dysphoria Association (W. Meyer et al., 2001). These standards dictated that hormonal and surgical candidates receive counseling and obtain official letters of recommendation by qualified mental health professionals. Those interested in surgical reassignment were also mandated to live as their desired gender for approximately 1 year (called "the real life experience") prior to surgery. Many now seek to "define themselves rather than asking or allowing themselves to be defined by helping professionals," and thereby "do as little or as much as they wish to their bodies" (Denny, 1997, p. 37). For example in 1993, at the Conference on Transgender Law and Employment Policy, the International Bill of Gender Rights had specifically included the right to "freedom from psychiatric diagnosis and treatment" and thereby reflected the desire by many not to have to conform to a prescribed regimen dictated by the medical and psychiatric establishments (i.e., Standards of Care of the Harry Benjamin International Gender Dysphoria Association; W. Meyer et al., 2001).

THE CRITIQUE OF PASSING

Although many transsexuals are able, with the aid of hormonal and surgical interventions, to successfully pass as their desired gender without detection, it is important to note that others are less successful in doing so. Either the medical procedures are too costly and painful or their basic body morphology makes their attempt to transition more noticeable to others. It is partly for this reason that many transgender activists (e.g., Feinberg, 1998; Stone, 1991) have advocated that transsexual persons "come out" and identify themselves as transgendered and, in so doing, "begin to write oneself into the discourses which have been written [about us]" (Stone, 1991, p. 299). On the basis of his extensive interviews with persons with nontraditional gender identities, Hill (1997) noted that the majority preferred to identify themselves as "transgendered" and did not want to "reedit" their biographies or to "pass" in mainstream society. As Feinberg (1998) stated, "We are oppressed for not fitting these narrow social norms, and we are fighting back" (p. 5). Bockting (1997) observed that by affirming their identities as either transsexuals or transgendered persons, persons with nontraditional gender identities can alleviate the shame, isolation, and secrecy that often accompany attempts to pass as a desired gender.

IMPLICATIONS FOR COUNSELING

The emergent transgender consciousness and political activism emanating from this community have important implications for the field of counseling. Treatment issues no longer center on assisting "gender dysphoric" persons in their adjustment to their new gender but include the possibility of affirming a unique transgender identity (Bockting, 1997). In this paradigm shift, the focus is not on transforming transgendered clients but rather transforming the cultural context in which they live. To assist counselors, counselor educators, and supervisors with this challenge, we adapt

the multicultural counseling competencies described in Sue, Arredondo, and McDavis (1992), Sue et al. (1982), and Sue and Sue (1999) to address the crucial *counselor attitudes, knowledge,* and *skills* that are needed for work with transgendered persons.

Counselor Attitudes

We believe that clinicians need to rethink their assumptions about gender, sexuality, and sexual orientation and to adopt a "trans-positive" or "trans-affirmative" disposition to counseling. A trans-affirmative approach necessitates that counselors affirm transgendered persons; advocate for political, social, and economic rights for the transgendered; and educate others about such issues. Such an approach is similar to the practice of "sex-positive" therapy (Queen, 1996) and gay-affirmative therapy with gay men, lesbians, and bisexual persons and requires that, first and foremost, counselors, supervisors, and researchers should recognize that they may not only have a role in alleviating the emotional distress of clients who challenge the binary gender system but may also be responsible for contributing to or exacerbating it. Counselors must be sensitive to the fact that the medical and psychiatric establishments have long histories of pathologizing transgendered persons. Ettner (1999), for example, has observed that counselors have communicated reductionist either-or messages, such as counseling clients out of sex reassignment procedures because of "somatically inappropriate" body types, facial features, and so forth. In their qualitative study of MTF transsexuals, Gagne et al. (1997) found that the majority reported having been actively involved in psychotherapy and indicated that they were pressured by their therapists to come out to others and appear as women. In these cases, therapists may fail to take into account the possible repercussions, such as violence and harassment, that may ensue if clients are not adequately psychologically, financially, and emotionally prepared for such a rapid transition. There are still incidents of counselors who adamantly believe that transsexual people are "fundamentally homophilic but cannot consciously accept their sexual orientation" (Fagan, Schmidt, & Wise, 1994). In contrast to the common stereotypical assumption that transgendered persons are gay or lesbian, the clinical literature has within the last several years reflected the reality that many transsexuals are bisexual (Bolin, 1988; Denny & Green, 1996). Denny and Green, for example, observed that many postoperative transsexuals (persons who have completed the surgical reassignment process) find bisexual partners attractive because they are not exclusively focused on gender as a determinant of sexual and emotional attraction.

Counselor Knowledge and Skills

To help counselors build an adequate knowledge base for understanding transgender issues in counseling, they must have information regarding the political, historical, and psychological contexts in which transgendered clients live. Counselors need to become familiar with the evolving terminology

and politics of the transgender movement. Because the growth of transgender studies was partly facilitated by the use of autobiographies of transgendered persons (Parlee, 1998), training efforts should incorporate such narratives. We recommend that counseling professionals read such biographical texts as *Stone Butch Blues* (Feinberg, 1993) and *Gender Outlaw: On Men, Women, and the Rest of Us* (Bornstein, 1994) and general texts, such as *Transgender Warriors: Making History From Joan of Arc to RuPaul* (Feinberg, 1996), *Confessions of a Gender Defender: A Psychologist's Reflections on Life Among the Transgendered* (Ettner, 1996), and *My Gender Workbook* (Bornstein, 1998). Such films as *Paris Is Burning* (Livingston, 1991), *Ma Vie En Rose* (Berliner, 1997), *The Brandon Teena Story* (Muska & Olafsdottir, 1998), *Boys Don't Cry* (Peirce, 1999), *Outlaw* (Lebow, 1994), and periodicals such as *Gendertrash, Transgender Tapestry,* and *Chrysalis Quarterly* are also helpful in exploring the culture of transgendered people. As Parlee (1998) pointed out, the opportunities created by academics "working outside positivist research traditions, using methods that allow transgendered persons to speak for and about themselves to researchers they trust" (p. 131) has permitted a more complex level of theorizing about gender than ever before.

We advocate that counselors familiarize themselves with the burgeoning of postmodern analyses across many academic disciplines including sociology, literature, and philosophy. The postmodern deconstructionist movement critiqued the belief in "universal truths" and acknowledged that some identities are socially constructed with the purpose of privileging some categories and not others (Layton, 1998). Those analyses and the subsequent emergence of Queer and Transgender studies opened up new possibilities for academic counseling to challenge traditional binary notions of sex/gender. Adhering to the work of Foucault (1980), "queer" theorists believe that *discourse,* which refers to the use of language as a form of social practice, typically places people in different power positions. Foucault insisted that the discourse of sexuality, the discourse that defines "the homosexual" as a separate species, is a discourse of power. Perhaps one of the most influential contemporary theoreticians is Judith Butler (1990) whose text, *Gender Trouble: Feminism and the Subversion of Identity,* argued against the view of gender as a biological given. She contended that feminine or masculine behaviors are performative and are the by-product of cultural norms.

It is essential that counselors working with the transgendered population have adequate knowledge of local, regional, and national support networks for the transgender community. The significance of collective organizing to enhance self-esteem in this population has been documented (Lombardi, 1999; Mason-Schrock, 1996). In Mason-Schrock's qualitative study of support group interaction, he viewed this community as performing an integral function in preoperative transsexuals' narrative construction of the "true self." Lombardi reported that the greater the social network, the greater the opportunities for members to talk about gender issues with one another. As Parlee

(1998) pointed out, the growing sense of community serves to challenge the pathologizing medical community and the violence and discrimination that have arisen both in the past and the present.

It must also be noted that despite the trend in transgender communities to build coalitions between subgroups like cross-dressers, intersexed, MTF transsexuals, FTM transsexuals, and so forth, tension and differences within the transgender community sometimes interfere in this process. Many authors (e.g., Bornstein, 1998) have commented on the sometimes uneasy alliance between the gay and lesbian community and the transgender community. Lorber (1998) observed, "despite attempts of queer theorists to include lesbians, gays, bisexuals, transgenders, and hermaphrodites under one transgressive category, they themselves have broken up into multiple groups with different political goals" (p. 436). Halberstam (1998) noted, for example, the tension between FTM transsexuals and lesbian feminists. It is important that clinicians not assume that all transgendered persons have the same consciousness about gender identities. For example, in Gagne and Tewksbury's (1998) study of transgenderists (the majority of their volunteer sample consisted of preoperative MTF transsexuals and cross-dressers), most desired to refigure their bodies in such a way as to pass as women. Only a minority of those in their sample expressed a desire to live as transgenderists and to break out of the traditional gender binary.

Bockting (1997) advocated that counselors assume a client-centered approach. Given the societal discrimination that transgendered persons must continually confront, the issue of trust is paramount when working with such clients. For this reason, constructivist therapy approaches are particularly helpful in working with transgendered clients. Laird (1999) advocated that practitioners assume a narrative stance in which clients fully tell their own stories unburdened by the prior assumptions of the therapist about gender and sexuality. Basically, counselors need to create an atmosphere in which the larger cultural narratives concerning heterosexism and gender are deconstructed. Laird recommended adopting an "informed not knowing" stance (Shapiro, 1996) in which the counselor leaves "behind her own cultural biases and pre-understandings, to enter the experience of the other" (Laird, 1999, p. 75). Laird also advocated that therapists bring the stories of their clients to the professional literature and into the political arena.

We recommend that counselors working with transgendered clients strike a balance between facilitating client self-discourse and incorporating more directive interventions. Ettner (1999) advocated that mental health professionals who work with the transgendered population possess what she called "cognitive flexibility" and that they adapt a more directive, holistic style to therapy. Effective counseling with this population also requires not only that counselors possess effective clinical skills but also that they be adept at consultation, referral, and case management. Frequently, the counselor's role is one of clarifier, aiding clients in distinguishing between sexual fantasies, sexual attractions,

and gender identity (Denny & Green, 1996) and in recognizing the full spectrum of gender identities and options that such persons have in terms of partial or complete change in primary or secondary sex characteristics (Bockting, 1997). Counselors may need to explore with their transgendered clients the "merits of various physical changes in the context of the individuals' identity development with an emphasis on personal comfort and well-being" (Bockting, 1997, p. 51).

Clinical Issues

Transgendered persons seek counseling for a variety of presenting issues including depression, alcoholism and other substance abuse, fetishism, inability to perform at school or work, and physical abuse from parents or peers (Denny & Green, 1996). Because of the intense discrimination that transgendered persons experience, feelings of low self-esteem and depression may be especially intense. As previously noted, counselors have historically assumed gatekeeping functions regarding the gender identity process. As a result of negative reaction to this role, there is the possibility that transgendered persons may be less than forthcoming with counselors about the severity of their depression. Counselors need to consider the possibility that such symptoms constitute ways of coping and may be the by-products of the discrimination and prejudice that transgendered persons experience in today's culture. Another important issue that is particularly germane to the transgendered population concerns the lack of knowledge about HIV risk and safe sex (Bockting, Robinson, & Rosser, 1998). Previous studies have indicated that HIV/AIDS has already significantly affected transgendered persons. Bockting et al. (1998) observed that many transgendered persons do not identify themselves as persons who engage in high-risk sexual behaviors. Attention must also be paid to issues of relationship violence and personal safety. As Bockting et al. noted in their focus groups with transgenderists, MTF transsexuals are especially vulnerable to sexual assault because of their lack of experience with sexual advances by biological males. The interested reader should consult the following texts for further information concerning counseling issues and interventions with transgendered clients: *Gender Blending* (Bullough, Bullough, & Elias, 1997); *Gender Loving Care: A Guide to Counseling Gender-Variant Clients* (Ettner, 1999); *Counseling in Genderland: A Guide for You and Your Transgendered Client* (Miller, 1996); and the book chapter titled "Issues of Transgender" by Cole et al. (2000).

CASE STUDY: *T* IS FOR TERRY AND FOR TRANSGENDERED

Because narratives of transgendered persons have played such an integral role in the growth of the transgender rights movement, we chronicle the experiences of Terry (fictitious name), a transgendered client who presented for therapy with the second author. Terry first came to the counseling center in

1998 for an intake interview. Terry was born a biological male in the northeastern United States and was named by her parents after a popular professional athlete. This decision by her parents points out how even at birth, they had definitive expectations of their "son," expectations which included that "he" excel at sports and be drawn to stereotypically "masculine" pursuits. Once she entered elementary school, Terry immediately became aware of her gender difference. She quickly discovered how she differed from her peers by the assaults on her nontraditional gender identity. On a regular basis, she faced taunts, ridicule, and isolation from her peers. Terry became aware that the social penalties imposed against feminine boys (boys who exhibited gender-atypical qualities) were rigidly enforced. Taunts on the playground escalated into more severe persecution in junior high school when Terry was frequently called "faggot" and "queer." At this point in time, when Terry was 13 years old, being differently gendered was perceived as synonymous with homosexuality by Terry's peers. In addition to enduring the onslaught of epithets, Terry was the victim of frequent physical harassment including punching, pushing, and kicking. Terry's sense of isolation reached a peak during these years as she searched for role models of other differently gendered individuals. She felt ostracized from her peers as well as her own family as a result of her efforts to adjust to life on the gender margins. Throughout junior high school, she felt suicidal and battled with an ongoing sense of depression, isolation, and fear of physical harm. Although Terry's family recognized her gender-atypical behaviors from an early age, they struggled both to sympathize with and to protect Terry by encouraging her to conform. For example, Terry was prodded to try out for Little League during second grade. Terry was not interested in Little League but felt compelled to comply with their wishes in order to fulfill the "correct" role of a boy.

Due to a change in schools, Terry's high school experience was more positive, but her sense of desolation and detachment continued to escalate. Terry would frequently scour the campus library desperately searching for nuggets of information regarding "transvestism" and "sex changes." The long, rich history and culture of the transgender community was not readily available to Terry, and this added to her sense of alienation. A critical element in Terry's survival was a very positive, therapeutic relationship that enabled her to negotiate gender identity in the face of a hostile environment. Terry's first therapeutic experience lasted throughout her 4 years in high school. After 2 years in therapy, Terry came to identify herself as a transsexual and actively desired sex reassignment surgery. Because of the overwhelming pressure to conform, Terry was not yet aware of the full spectrum of options available to her along the gender continuum. At that time, Terry believed the only way for her to survive in society was to surgically and irrevocably alter her body.

Once Terry started her undergraduate career, she began to discover more resources regarding a specifically transgendered identity. Terry discovered that the specificities of transgender experience allow for a more fluid expression of gender and

an opportunity to blur the lines of the traditional gender paradigm. Terry started voraciously reading the literature from the burgeoning transgender liberation movement. She became increasingly comfortable with defining herself as a "gender outlaw," an individual whose gender expression defies easy categorization within American society's bipolar system. In 1993, during Terry's freshman year, Terry started to be referred to as "she." (Ironically, Terry, like many transgendered persons, does not support the use of traditional gender designations. The fact that alternative designations such as "hir," "s/he," "ze" and "sie" are not common knowledge or popularly used illustrates the extent to which the gender binary is so embedded in our culture and the way that language can function as a barrier to transgendered expression, empowerment, and liberation.) Although she made the decision not to surgically or hormonally alter her own body, she resolved to fully support others who choose hormonal therapy and surgical reassignment. Terry has decided that perhaps in the future, she may even take advantage of these options. This is further evidence of the fluidity of gender to Terry and her desire not to be categorized in an essentialist way.

When Terry, now a graduate student, presented for counseling with the second author, she identified the following treatment goals: (a) to become more comfortable with her transgender identity in her new midwestern surroundings, (b) to learn techniques to manage symptoms of depression, and (c) to increase social interaction. At first glance, these goals seemed reasonable and attainable. These same goals were frequently identified by graduate students who have relocated, are not yet familiar with the area, and have no social network. Terry was, however, diagnosed with major depressive disorder soon after beginning therapy. The severity of symptoms seemed to fluctuate with Terry's feelings of isolation. There were times when it was physically and psychologically exhausting for Terry to perform even the most routine tasks. During these times, Terry experienced frequent suicidal ideation. Terry coped with these thoughts and feelings by creating a safety plan in therapy and by talking with supportive friends and allies. Although Terry continues to struggle with symptoms of depression, she has found the coping mechanisms learned in therapy to be useful in managing her suicidality.

The cognitive behavioral techniques that might otherwise have been used to treat her depressive symptoms and facilitate goal achievement were not sufficient with Terry. Terry's cognitions were not distorted; she was not assuming others were staring, they were; she was not worried needlessly about being verbally assaulted, she had been assaulted; she was not imagining "transphobic" reactions from peers and faculty—there was concrete evidence of such reactions. Who would not be depressed under such horrendous circumstances? Depression management techniques were and are effective to a point, as are pharmacological interventions. But despite such efforts, Terry's reality would remain the same. The society in which she lives is often an oppressive, threatening, and unsafe place for a transgendered person.

Outside of counseling, Terry struggled in her social interactions and in making close friendships. At the age of 26, Terry often felt like she was revisiting the "ghosts" of junior high school because petty insults and abusive epithets continued to be a common experience for her. In general, transgendered individuals are constantly bombarded with the messages that they are "freaks" who do not belong. Terry often described herself as a "voiceless body" because the physical nature of her gender expression was brazenly apparent on campus. Terry's height and "masculine" physical features seemed to conflict, in their eyes, with her "feminine" dress, speaking, and comportment. Terry was often recognized or "read" as a biological male who did not meet the rigid gender role requirements of her transphobic surroundings. The campus, located in a rural midwestern community, is overwhelmingly White and conservative. The conventional attire of many of the students, as well as their conformity to rigid gender role standards, left Terry feeling perpetually on the margins. The irony of the situation was that Terry was visible, but only in a negative manner. The physicality of her transgender expression was noticeable and provoked hostile conduct followed by behavior aimed at minimizing Terry's existence. Terry experienced harassment in a variety of places on campus, including the student union and the library. Because of the level of ostracism she faced, she often internalized the negative comments aimed at her. This affected her ability to trust and to take risks to initiate and establish relationships.

Throughout the counseling process, Terry was encouraged to seek out a community of accepting individuals. At her counselor's urging, Terry sought out progressive campus groups, such as the Gender Equality Association, whose focus was to advocate for gender equity on campus. Although the original mission of the association was focused on gender equity, Terry worked with the group to expand the definition of "gender equality" to include transgender and gender-variant constituencies. Thus, gender equality took on a more sophisticated valence and fostered a transpositive atmosphere for all members. Terry began to initiate other social contacts for her own personal and political development. With some prompting, she became involved in various campuswide projects, including the development of a women's center for the university. Terry was also encouraged to make contact with individuals whom she perceived to be supportive, like those professors and staff members who displayed pink triangles (e.g., one of the more popular and widely recognized symbols of the gay community, with historical roots in Hitler's concentration camps) and pink "safe space" ally signs on their office doors and windows. Through these contacts, Terry was able to access trans-affirmative individuals and groups outside the campus community.

Although Terry was able to develop some mutual, healthy relationships as a result of reaching out, her efforts were also met with rejection and hostility. In counseling, Terry's feelings of rejection and hurt after these experiences were validated. She was assured that it was quite possible that her identity as a transgendered person might at least be partially to blame for being socially rejected. She worked very hard at not allowing

others' phobic reactions to define her worth and to develop strategies for optimizing her social success. Even if Terry was rejected, she was able to perceive "reaching out" as progress and an investment in her future. Terry's willingness to take risks was facilitated by consistent, positive validation in therapy. For her, the counseling center constituted a safe zone, a place to which she could return and where she would feel the support and encouragement to persevere. *Safe zones* for transgendered individuals are defined as places where gender diversity is not only accepted but celebrated. The whole rainbow of gender expression is affirmed and welcomed.

Despite positive gains, Terry still experiences depression, isolation, and frequent harassment. She earned her degree despite the "transphobia" and because of the "transpositive" persons she encountered there. Terry believes there is a curious fascination with transgendered bodies in our culture, but there is a dearth of genuine interest in the personal and political realities of gender oppressed people. Often she feels like a "deviant" body perpetually on display, a body that effectively has no voice. This sense of feeling stripped of subjectivity, of being turned into an object, makes Terry feel powerless. Therefore, venues for educating the campus community are vitally important to Terry because they enable her to recover the passionate voice that is so often stolen. Terry continues to be an advocate for gay/lesbian/bisexual/transgender and feminist causes and issues. In addition to producing a video on gender diversity, she has conducted countless workshops and delivered many presentations to university and community organizations. This work has helped to heal the scars of her childhood because she feels like she is ushering in a new era of gender freedom. In addition to recognizing the value of speaking up for her empowerment, Terry is a strong believer in the personal benefits of a therapeutic relationship.

On the basis of our clinical experiences, we find that the essential elements of therapy with Terry as with many other transgendered persons include *listening, empathy, the assumption of an "informed not knowing" stance, and the provision of a safe zone*. As is consistent with a constructivistic approach to counseling, listening is critical because it allows clients to tell their story and to be heard. The story is not told only once; the story continues each day with new social contexts, but key themes of pain and isolation echo throughout Terry's narratives. Repeated validation of feelings is paramount to the therapy process because of the rigidity of the gender system in society and the subsequent oppression this creates.

CONCLUSION

As supervisors and counselors, we believe that an understanding of transgendered clients' life histories is pivotal to comprehending the complexity of issues brought to therapy. Our experiences working with transgendered clients have been unlike any other in our professional careers. Our respective knowledge bases regarding transgender issues have naturally expanded and our abilities as clinicians have improved. After overcoming our initial ignorance and misinformation, we are now comfortably familiar with relevant resources for both client and counselor. These improvements, however, are fairly standard after exposure to a new presenting problem or clinical population. Most significant to us has been the tremendous personal growth we have achieved through our relationships with transgendered clients. Because of our research and clinical experiences with this population, we take more time to really listen to *all* of our client's stories. We have learned to no longer take for granted the fact that we can walk across our respective campuses, take in a movie, or shop for groceries without verbal abuse or harassment. We no longer take for granted the feeling that we belong—whether to our families, our places of employment, our social circles, or society as a whole. The extent of "gender privilege" is both alarming and ubiquitous. Our consciousness of transphobia has been raised since learning of the intensity and frequency of harassment directed against differently gendered individuals. Although the sexual orientation of many gay, lesbian, bisexual people may not be immediately apparent to others, many transgendered persons do not or cannot "pass" (conceal the fact that they are differently gendered) and, therefore, are the most frequently targeted group for social persecution. We do not think any of us in the majority who fit into the normative gender categories of male and female can imagine the paradoxical situation of being very obvious and yet invisible at the same time. Perhaps, most of all, our experiences with the transgendered have taught us, as Laird (1999) suggested, to realize our serious professional obligation to take the stories of our transgendered clients into the professional literature and into the streets to enable a more humane and just world for all gender identities.

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APPENDIX

Glossary of Terms

Please note that the following terms and their definitions are not necessarily universally accepted. Variations exist both within and outside trans communities in the usage and interpretation of these terms.

Cross-dresser: An individual who dresses in clothing that is culturally associated with members of the "other" sex. Most cross-dressers are heterosexual and conduct their cross-dressing on a part-time basis. Cross-dressers cross-dress for a variety of reasons, including pleasure, a relief from stress, and a desire to express "opposite" sex feelings to the larger society.

Drag King: A term usually reserved for individuals who identify themselves as lesbians and who cross-dress for entertainment purposes in lesbian and gay bars.

Drag Queen: A term usually reserved for individuals who identify themselves as gay men and who cross-dress for entertainment purposes in lesbian and gay bars.

Gender: A complicated set of sociocultural practices whereby human bodies are transformed into "men" and "women." Gen-

der refers to that which a society deems "masculine" or "feminine." Gender identity refers to an individual's self-identification as a man, woman, transgendered, or other identity category.

Gender bender: An individual who brazenly and flamboyantly flaunts society's gender conventions by mixing elements of "masculinity" and "femininity." The gender bender is often an enigma to the uninitiated viewer, who struggles to comprehend sartorial codes that challenge gender bipolarity. Boy George, a popular culture icon, was often referred to as a "gender bender" by the press.

Gender dysphoria: A term used by the psychiatric establishment to refer to a radical incongruence between an individual's birth sex and their gender identity. An individual who is "gender dysphoric" feels an irrevocable disconnect between their physical bodies and their mental sense of gender. Many in the transgender community find this term offensive or insulting because it often pathologizes the transgendered individuals due to its association with the *DSM–IV*.

Gender identity: see Gender.

Gender outlaw: A term popularized by trans activists such as Kate Bornstein and Leslie Feinberg, a gender outlaw refers to an individual who transgresses or violates the "law" of gender (i.e.., one who challenges the rigidly enforced gender roles) in a transphobic, heterosexist, and patriarchal society.

Gender queer: A term that refers to individuals who "queer" the notions of gender in a given society. Gender queer may also refer to people who identify as both transgendered *and* queer (i.e., individuals who challenge both gender and sexuality regimes and see gender identity and sexual orientation as overlapping and interconnected).

Gender trash: A term that calls attention to the way that differently gendered individuals are often treated like "trash" in a transphobic culture.

Gender variant: A term that refers to individuals who stray from socially accepted gender roles in a given culture. This word may be used in tandem with other group labels, such as gender-variant gay men and lesbians.

Intersex: Formally termed *hermaphrodites,* individuals termed *intersex* are born with some combination of ambiguous genitalia. The Intersex movement seeks to halt pediatric surgery and hormone treatments that attempt to normalize infants into the dominant "male" and "female" roles.

Queer: Queer is a term that has been reclaimed by members of the gay, lesbian, bisexual and transgender communities to refer to people who transgress culturally imposed norms of heterosexuality and gender traditionalism. Although still often an abusive epithet when used by heterosexuals, many queer-identified people have taken back the word to use it as a symbol of pride and affirmation of difference and diversity.

Queer theorist: An individual, usually an academic, who uses feminism, psychoanalysis, poststructuralism and other theoretical schools to critically analyze the position of gay, lesbian, bisexual, and transgendered individuals in cultural texts.

Sex: Separate from gender, this term refers to the cluster of biological, chromosomal, and anatomical features associated with maleness and femaleness in the human body. Sexual dimorphism is often thought to be a concrete reality, whereas in reality the existence of the intersex points to a multiplicity of sexes in the human population.

Sexuality: An imprecise word that is often used in tandem with other social categories, as in race, gender, and sexuality. Sexuality is a broad term that refers to a cluster of behaviors, practices, and identities in the social world.

Sexual orientation: This term refers to the gender(s) that a person is emotionally, physically, romantically, and erotically attracted to. Examples of sexual orientation include homosexual, bisexual, heterosexual, and asexual. Transgendered and gender-variant people may identify with any sexual orientation, and their sexual orientation may or may not change during or after gender transition.

Trans: An umbrella term that refers to cross-dressers, transgenderists, transsexuals and others who permanently or periodically dis-identify with the sex they were assigned at birth. Trans is preferable to "transgender" to some in the community because it does not minimize the experiential specificities of transsexuals.

Transgender: A range of behaviors, expressions, and identifications that challenge the pervasive bipolar gender system in a given culture. This, like trans, is an umbrella term that includes a vast array of differing identity categories such as transsexual, drag queen, drag king, cross-dresser, transgenderist, bi-gendered, and a myriad of other identities.

Transgendered lesbian: An individual, regardless of biological sex, who identifies as both transgendered and lesbian. This could include male-to-female transgenders who are sexually attracted to women, or to biological females who identify as lesbians and who often "pass" as men or who identify to some degree with masculinity or with "butch."

Transgenderist: Coined by Virginia Prince, this category refers to an individual who dis-identifies with their assigned birth sex and lives full time in congruence with their gender identity. This may include a regime of hormone therapy, but usually transgenderists do not seek or want sex reassignment surgery.

Transphobia: The irrational fear and hatred of all those individuals who transgress, violate, or blur the dominant gender categories in a given society. Transphobic attitudes lead to massive discrimination and oppression against the trans, drag, and intersex communities.

Transsexual: An individual who strongly dis-identifies with their birth sex and wishes to use hormones and sex reassignment surgery (or gender confirmation surgery) as a way to align their physical body with their internal gender identity.

Transvestite: An older term, synonymous with the more politically correct term cross-dresser, that refers to individuals who have an internal drive to wear clothing associated with a gender other than the one that they were assigned at birth. The term *transvestite* has fallen out of favor due to its psychiatric, clinical, and fetishistic connotations.