

This article was downloaded by: [Rachlin, Katherine]

On: 5 June 2011

Access details: Access Details: [subscription number 936117780]

Publisher Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Journal of Gay & Lesbian Mental Health

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title~content=t792304010>

Challenging Cases for Experienced Therapists

Katherine Rachlin^a; Arlene Istar Lev^{bc}

^a Private Practice, New York, New York, USA ^b Choices Counseling and Consulting, Albany, New York, USA ^c University at Albany, School of Social Welfare, New York, New York, USA

Online publication date: 08 April 2011

To cite this Article Rachlin, Katherine and Lev, Arlene Istar(2011) 'Challenging Cases for Experienced Therapists', Journal of Gay & Lesbian Mental Health, 15: 2, 180 – 199

To link to this Article: DOI: 10.1080/19359705.2011.553783

URL: <http://dx.doi.org/10.1080/19359705.2011.553783>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.informaworld.com/terms-and-conditions-of-access.pdf>

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Challenging Cases for Experienced Therapists

KATHERINE RACHLIN, PhD

Private Practice, New York, New York, USA

ARLENE ISTAR LEV, LCSW-R, CASAC

Choices Counseling and Consulting, Albany, New York, and, University at Albany, School of Social Welfare, New York, New York, USA

The authors, both experienced gender therapists, engage in an interactive discussion of two cases that involve ethical dilemmas and complex psychological presentations. Three themes are discussed: (1) writing letters of recommendation for hormonal or surgical treatment when the clinical presentation involves complicating factors, (2) providing support for transgender persons who are not expressing their authentic gender and choose to remain closeted, and (3) the flexible use of the World Professional Association for Transgender Health's (WPATH's) Standards of Care. The authors each present a case and then discuss various strategies that are affirming of transgender identities.

KEYWORDS *transgender, transsexual, crossdresser, nontransitioning, standards of care, sex reassignment surgery, gender affirmation, gender therapy, hormonal therapy*

The following case presentations were developed for an advanced clinical workshop presented at the Gay and Lesbian Affirmative Psychotherapy (GLAP) conference. Our goal was to examine clinical cases that involve ethical dilemmas and complex psychological presentations. The presenters were Katherine (Kit) Rachlin and Arlene (Ari) Lev, both experienced gender therapists, with the intention of discussing detailed cases and sharing the clinical issues and challenges we faced. The workshop focused on four clinical cases; we are presenting two in this article.

Our cases revolved around three themes. The first theme involved issues of writing letters of recommendation for hormonal or surgical treatment when

Address correspondence to Katherine Rachlin, PhD, 49 West 24th Street, 9th floor, New York, NY 10010. E-mail: kitrachlin@gmail.com

the clinical presentation involved complicating factors that made the therapist hesitate or resist supporting the client in undergoing medical treatment or surgery at that moment in his or her life. The second theme concerned a transgender person who is not expressing his or her authentic gender and remains closeted. The last theme regarded the flexible use of the World Professional Association for Transgender Health's (WPATH's) Standards of Care.

As gender specialists, we are often called upon to write letters of evaluation and support for people who request hormones or surgery. Most individuals are well-informed and highly capable of making their own decisions regarding their transition and medical care. However, not all cases are so easy. A review of Kit's files indicated a number of circumstances that caused her concern and created resistance to writing letters for clients. The presence of these factors did not mean that she would refuse to write a letter of support, but it did make her hesitate. The factors were:

- Psychological instability
- Lack of contact with other transgender or transsexual people
- Lack of interest in educating self
- Rush to surgery without insight or thoughtfulness about the process (usually accompanied by minimal time living in the affirmed gender role)
- Introversion and poor social and survival skills

Ari agreed with the above and also added:

- Substance abuse issues
- Severe psychiatric or cognitive issues
- Relational/marital complications and unwillingness to address or be honest with family
- Severe Axis II issues creating bizarre communication patterns that impact social relationships and reality testing

Both of us had similar clinical experiences and independently discovered similar concerns. A wealth of research verifies that these concerns are bona fide signs for caution. The outcome research on individuals who undergo gender-confirming medical procedures has shown that those most satisfied and happy with life after transition (transition is usually defined in the research as including surgery) have good mental health and engage in psychotherapy and a real-life experience in their affirmed role prior to surgery (Carroll, 1999; Vercruyse & De Cuypere, 2009; Pfafflin & Junge, 1998). These are not the only important factors, but they are relevant for the purposes of this paper. Naturally these results vary from person to person, and not all of the research draws the same conclusions. However, there is enough

consistency to indicate that clients and clinicians should attend to these factors as part of the transition process.

CASES

Note: All clinical material, including names, has been changed to protect client identity, and cases have been “blended,” mixing more than one case history.

Don/Daphne (Presented by Arlene Lev)

Don is a 42-year-old natal male of mixed European heritage. He takes great pride in ancestors who arrived on the Mayflower. He has no religious affiliations and is nominally Christian. He was referred to me by a psychologist regarding his gender issues. The psychologist had worked with Don for a few months and had diagnosed him with an array of mental health problems, including social anxiety, depression, schizoid personality features, and possibly Asperger’s syndrome. He had never told her about his gender issues, although he often wore a blouse or earrings. When questioned about this, he simply said, “I just like it.” He denied any confusion about his gender or any dysphoria and had only recently heard the term transgender for the first time. He stated he was not really sure what it meant. Don does not report any gender-related issues in childhood. He started wearing kilts about 10 years ago, and in the past five years wore women’s clothing more and more frequently. He denies any sexual feelings related to his clothing and is adamant that he “just likes to dress that way. What’s the big deal?” I will refer to Don by his male name and male pronouns because that is what he used for the majority of the time I have worked with him.

Don presented with a sharp, intense, and rather masculine assertiveness. He speaks decisively and directly. However, what he speaks about are his difficulties communicating, extreme shyness, problems in social relationships, lack of friendships, and intimate relationships. The presentation and content are dissonant, and when asked about that he smiles an odd, intimate smile, leaning in to me, and saying, “I know, but that’s the way it is.”

Don’s skin has a sallow quality to it. He is extremely thin, of which he is very proud. He often makes harshly critical comments about other people’s weight, and I suspect that he has an eating disorder that has not yet been addressed. He is not reserved about his opinions about weight and seems oblivious to how that might impact me; it is possible he is being purposely hurtful, or even challenging me in some manner.

Don is not conventionally feminine, except in his clothing. He has sometimes come to sessions dressed “high femme,” with stiletto heels, short skirts,

and many bangle earrings. He, however, wears no makeup, speaks in a deep voice, and does not use a female name. His presence is conventionally male, perhaps hypermasculine, except for the way he crosses his long, thin legs. He is very proud of his legs (“Most women would die to have legs like mine”) and what he refers to as his “exquisite” taste in clothing.

Don has had sporadic intimate relationships with women but is unable to describe or discuss them in depth. He is derisive when describing these women: he complains about their substance use or bad decisions. He expresses no sadness that these relationships ended and shrugs, again with an intimate smile, saying, “That’s the way I am.” He has one child, a teenage girl, from a previous relationship. Don has had minimal contact with her, although he does send money occasionally and takes her out to lunch a few times a year. He has little insight into who she is and seems not to consider how she might react to his gender-bending attire. He has not explained any aspect of his gender presentation to her and does not see a reason to because she “seems to accept it fine.” The girl’s mother has little contact with Don, except to arrange these lunch dates.

Don has no heat or electricity in his house because, he says, “Who needs it anyway?” When asked how he takes care of his hygiene, he says he showers at work once a week or so. He looks somewhat unkempt. His clothes are rumpled. His hair, which he wears long, looks like it could use a washing. When I asked Don how he washes his clothes, he said, “I don’t wash them.” He says he has an “unbelievable amount” of clothing and only washes them once every year or two.

He admits that he “hoards” stuff, and although that has not been a focus of our work, he recently stated he is “getting rid of everything” and seems to be disposing of some of his belongings in dumpsters. He is rarely home. He returns home late in the evening and goes right to sleep. He says, “It’s warm enough from the tenant downstairs; their heat rises.” He again looks at me intensely. “You do know that heat rises?” he asks.

Don has also been involved with numerous legal and work-related problems. He wears women’s clothing to work, despite working in a traditionally male career. He repeatedly gets into trouble for violating the dress code. He has never spoken to anyone at work about his clothing and feels it is none of their business. He often talks about hiring attorneys and “getting back at” people at work by filing a discrimination suit for asking him to follow a dress code.

Don once brought his mother into session. She is in her late 80s and has numerous health problems. Neither of them noticed that the building was wheelchair accessible, so she walked up a flight of stairs. She brought in his elementary school report cards and spent most of the session discussing her anger at a teacher who, 35 years earlier, had said, “I think your son is going nowhere.” Apparently in response, she showed me a list of “all the places [they’d] gone” (i.e., places at which they had vacationed). She seemed to

have no awareness that the teacher was using a figure for speech and not talking about their travel plans. At the end of the session, she brought up Don's attire: "It's a bit strange, don'cha think?"

Recently, after doing research on the Internet, Don decided to take the name Daphne and began to identify as transgendered. His desire for hormones has been sudden and insistent. With that same knowing smile, he tells me, "I can get hormones on the Internet, you know." He expressed anger that I "refused to give him hormones." When I let him know he had never mentioned that he wanted hormones or had asked me about them, he said, "Do you think I have communication problems?"

Lastly, Don recently announced that he had "taken care of one," which caused a cryptic back-and-forth discussion, until he confessed to removing one of his own testicles. He said this happened two days before and that it did not hurt, because he "knows how to do these things."

Don presents with a complex case that does not fit what has been seen as a typical transsexual trajectory. He has been cross-dressing for many years but without any consolidated female identity. He decided that he is transgender only within the past few months and took a female name within the past few weeks. He has significant social and legal difficulties and lacks any social connections. His cognitive and relationship skills are extremely impaired. When asked to fill out the psychosocial assessment form I use with all clients contemplating transition, he responded to the question "How do you deal with stress?" by saying, "There is no stress in my life." When I asked him when he first realized that his relationship to his sex/gender was different from others, he said, "Two days before responding to this questionnaire."

Kit's Response to Don/Daphne's Case and Ari's Questions

Ari: Does Don/Daphne have comorbid mental health issues, especially Axis II diagnoses (personality disorders, including antisocial, borderline, narcissistic, and paranoid features)?

Kit: Don has qualities typical of a number of different DSM Axis II diagnoses, though he does not fulfill the complete criteria for any one of them. He clearly has serious issues with hygiene and hoarding. He is socially impaired and probably has a Narcissistic Personality Disorder. He seems to be generally uninterested in other people's well being. His affect and presentation are off-putting and uncompromising. All of these characteristics will impact his gender expression in that he will not adjust his expression to accommodate other people's expectations. It will also affect his ability to engage in psychotherapy, as he is not able to work cooperatively with others and suffers from a disconnection between thoughts, feelings,

and behaviors. Given his interpersonal challenges, it is impressive that he has maintained a long-term alliance with Ari. His attendance at sessions indicates commitment to the treatment.

Ari: How do other mental health issues (Axis II or depressive features) impact cognitive reflection and readiness for transition?

Kit: In my estimation, Don is a gender-variant person with a mental illness. We know that mentally ill people can be transgender and can benefit from freedom of gender expression, hormones, and surgery. The treatment of Axis II diagnoses is generally challenging, and this case is no different. It is desirable to treat the comorbid conditions prior to transition, but even with gender affirming treatment people sometimes remain highly dysfunctional and mentally ill—even though they may feel more comfortable in their body or gender role.

One way to gain insight into Don's limitations is to look at the brief encounter with his mother. Her focus on seemingly inconsequential details and her anger and resentment from past slights is echoed in his behavior. She knows that his cross-dressing is significant but does not know how to talk about it or what it means. This kind of avoidance or denial is frequently part of an established family dynamic, which he predictably reenacts with others. Does growing up with this mother make him more likely to be disorganized and dysfunctional? Or is it an innate limitation that both share? Not only did he not see the ramp and elevator, but neither did she!

Let us look at the following communication from his mother: "His teacher said, 'Your son is going nowhere,'" followed by, "Here is a list of places we went on vacation," followed by, "Isn't it strange that he wears women's clothing?" We might interpret this to mean: "There was a problem identified early on. I did my best to give him a good upbringing. But something is still wrong. I am concerned that he is dressing as a woman. What does it mean?"

Her inability to make these statements directly is comparable to his inability to make direct statements about these issues. Neither can engage in reflective discussion regarding his antisocial behavior or internal experience of gender. Many of the clinical difficulties and questions that Ari has identified are related to this avoidance and lack of insight. In addition, both Don and his mother are hampered by a concrete style of thought. This is revealed when the teacher says, "Your son is not going anywhere," and the mother, says, "We have been many places on vacation."

Ari: Is Don/Daphne transsexual, transgender, or gender nonconforming?

Kit: Don is gender nonconforming, and I accept his self-definition as transgender. He may think that he is expressing himself in a female or feminine way, but his ability to communicate and speak the ordinary language of female dress, vocal tone, and body language will be impaired by his lack of attention to social cues. He is only marginally fluent in relating to others,

but he is capable of externalizing his female self in ways that are visible to him.

Don has a long record of cross-gender behavior, even if the expression is somewhat antisocial. He has been cross-dressing in his daily life for at least five years and presenting some mannerisms (e.g., sitting with legs crossed) and statements (e.g., attitudes regarding his legs and figure) to hint at his feminine identification. I interpret his lack of sharing thoughts and feelings regarding gender as symptomatic of his disconnection from other people. He may also experience some disconnection from himself, as he has limited desire or ability to engage in self-analysis or reflection.

Experiences such as gender therapy and going to a support group may lead another person to undergo a thoughtful process of exploration and transition, but Don will likely react to those same experiences with the behavior that we have already seen—a clumsy announcement of desire for hormones, bizarre attire, and a new name. All of these might be natural milestones in a process of gender exploration, but when Don enacts them the feeling to an observer is different. His behavior seems to come from nowhere, as does his aggression. The truth is that he cannot share the place from which it comes and aggression is his habitual affect.

In addition to the gender-transition milestones mentioned above, there is the possibility that Don has removed his own testicle. This would put him in a smaller group of individuals who have engaged in self-castration; specifically, included among the clinical examples given in the DSM-IV-TR for the diagnosis of Gender Identity Disorder NOS (APA, 2000). Don fulfills the general criteria for this diagnosis.

Self-castration most often occurs when people are desperate to rid themselves of male genitalia but have no access to surgery or other medical options (Vale et al., 2010). What is remarkable in Don's case is that he was working with Ari, who is well positioned to support him in changing his body if he had decided to go through transition. By performing surgery on himself, he cut her out of the loop and did not attempt to engage her support and assistance. There could be a number of reasons for this, such as the fear of being denied what he wanted, concern about her reactions to his desire, or impatience. He seems to be uncomfortable asking for help and does not see others as helpers. If we listen to his report, it sounds as if he regarded his action as safe because he "knew how to do these things" and there was therefore no reason to deny himself what he wanted. But even more, it seems to reflect his oppositional or confrontational attitude regarding relationships—which he acts out in therapy. He presents the news as if declaring his independence. There is something disturbingly irrational and childish about the dynamic. I have no doubt that Ari treats him as an adult, but rather than utilizing her expertise and support, he rebels against it.

Ari: Although Don has been dressing in female clothes for a while, has he actually been “living full time as a woman”? Does he fit the criteria of the standards of care (SOC) (Meyer et al., 2001), and is he ready and eligible for medical treatment? Now, I am flexible about those determinations regarding SOC, but Don seems oblivious to what it means to cross-dress in our culture, and until recently did not see himself as trans but just “liked” women’s clothes. The question of living full time as a woman is a reference to the “real life experience” (RLE) recommended by the WPATH SOC (Meyer et al., 2001). The current standards recommend either three months of psychotherapy or three months of living in the chosen role prior to hormones. They recommend a year of living in the chosen role prior to surgery. The SOC also discuss the need for flexibility so that treatment can be tailored to individual cases.¹

Kit: Because Don has been in therapy for more than three months, he has fulfilled the SOC recommendations. I would also like to expand the concept of the real life experience to its true intention and make the question more general: Is Don living before hormones the way he plans to live after hormones? He may not intend to live completely as a woman. His lack of attention to the usual details of dress and voice may prevent him from being perceived by others as a woman. His current presentation may be his ultimate presentation. It is not necessary to know that prior to hormone administration. He has been in therapy and his visible gender nonconformity has been stable.

The evolution of his request for hormones does not strike me as impulsive, which it may appear on the surface. There is something rather ordinary about his request. We know that peer support is powerful and that people often come to decisions about their gender identities based upon interactions with other transgender people. It is one reason that it is essential to go into transgender community and have transgendered friends. Don began using the term *transgender* as soon as he understood it, which may indicate that once he had integrated a word to describe his experience, he was confident of that word. That he had not heard it before, or even that he had known it but not used it before, does not mean that it did not describe him. Most who identify as transgender go through some process of adopting that term to describe themselves. There is an “Aha!” experience. Unfortunately, one can pick up more than empowerment in community, such as rumors about therapists and even some of the mythology that fuels an adversarial relationship, such that someone will say “I’ll get it with you or without you,” rather than utilizing the experience and help of the expert therapist.

Ari: Does he understand the impact of hormones and transition?

Kit: He embraces the term transgender and wants hormones. He either cannot or will not articulate these reasons. A demonstration of basic understanding of medical treatment is required in order for a person to give

informed consent. Perhaps he will be more willing to engage in that conversation with the medical provider who prescribes hormones, and you can discuss this with the medical provider.

Ari: His behavior and attitude often feel to me to be belligerent, hostile, confrontative, and hypermasculine. Should that affect my decisions?

Kit: Dealing with such hostility can make me want to withhold my cooperation, cave into demands, or avoid the person entirely. It should not disqualify him from receiving medical treatment but it should be communicated to the medical provider in the letter. I am particularly concerned that people who are chronically dissatisfied, see themselves as victimized, or are litigious will bring that to the physician, and I think the physicians depend upon therapists to include that information in their letters or reports.

As for his masculinity, I see that as separate from gender identity. Some people who are female-identified appear feminine and others do not. Don has a masculine presence and style of communication. I would not want to discriminate against him because he is using the language that he was socialized to speak.

Ari: Given his relationship to “rules” (social and legal), it is unlikely he will follow my rules and probably get hormones on the Internet. Should I write a letter so he is at least under medical care?

Kit: Absolutely write a letter! I do not see a reason to withhold the letter at all. Think of it in terms of harm reduction. He is an adult with long-term gender nonconformity. His particular mental disorder makes certain aspects of compliance with SOC unlikely. I am far more concerned about surgery than hormones. If he has performed self-orchietomy, then there may be an argument for harm reduction in surgery as well. I wonder if the doctor who prescribes hormones can confirm for you the story about the orchietomy.

Ari: Is he ready and eligible for medical treatment?

Kit: When evaluating people for medical treatment it is necessary to evaluate their judgment. Don’s judgment is questionable at best. His gender presentation and articulation of identity are difficult to interpret, not because he is gender nonconforming but rather because he is difficult to interpret as a person. That makes this a truly complex and difficult case. This calls for a harm reduction protocol for someone who may not proceed in any ideal way. He may not use language or narrative to be reflective or cooperative. He is unable or unwilling to describe his internal experience but gives indications that some strong female expression is most comfortable. He has demonstrated a history and track record of gender nonconformity and has been in therapy for a long time. It can be expected that his

dysfunctional, antisocial, and bizarre behavior will continue, whatever his gender expression.

Ronnie (Presented by Kit Rachlin)

Ronnie is male-bodied and female identified. I will be using female pronouns because that is what she finds most affirming. She is second generation, of German-American descent, 54 years old, and lives in the male role as a dedicated husband and father. She had no previous psychotherapy and is an accountant with her own practice. She and Laura, her wife of 26 years, have two daughters in college. Ronnie presents as a soft and petite man, trim and neatly dressed. She usually wears men's shirts with wide sleeves, soft fabrics, and pleasing solid colors. She has very small feet and wears gender-neutral women's shoes (of the sort that would be identical in the men's and women's section). In recent sessions she has taken to removing her shoes and curling up on the couch with her legs tucked to the side.

Ronnie experiences internal pressure to express herself as a woman and has been taking feminizing hormones for more than seven years. For the first year, she obtained hormones off the Internet and self-medicated without doctor supervision. After a year of these hormones, she disclosed to Laura that she felt she was a woman and that she wanted to become more physically feminine. The disruption in their relationship caused by that revelation led her to contact me.

According to Ronnie, her wife felt betrayed and confused, and Ronnie was overwhelmed with guilt. It was creating distance between them. Though there was a clear couples issue that needed to be addressed, Ronnie came to treatment alone, rejected suggestions regarding the need for Laura to participate, and refused to give me permission to ever contact or communicate with Laura (for reasons discussed below).

Ronnie and I met weekly for eight months. During that time we explored her experience of gender over her life, and she came to a comfortable definition of herself as internally transsexual. We also spent much of the time talking about the daily challenges of work, parenting, and her marriage. After eight months, she felt that her life and relationship were stable and decided that she did not need regular therapy but wanted ongoing contact for maintenance and problems that might arise. We have seen each other monthly or bimonthly for the past six years (although sometimes we go several months without a session). Ronnie calls when she feels a desire to talk, and we can usually set up an appointment within a week. She pays me in advance for 10 sessions (her suggestion at our first session, if I would give her a discount, which I did). This style of payment has created a sense of continuity and connection even when the sessions are irregular. She is conscientious and always a bit early for her appointments.

One of the initial goals of treatment was to evaluate the need for hormones and ensure that any medication was properly supervised. Ronnie quickly established her position regarding hormones; she liked the physical and emotional effects and she was going to continue to take them, with or without medical supervision. I connected her to a competent endocrinologist and she has maintained a good working relationship with him. For most of the past six years, she has been on a very low dose of Spironolactone.²

Hormones are one of the many things Ronnie does to nurture her female self in ways that are nearly invisible to other people. Her hair is long enough to curl softly around her face, and during its longer phases people who see her from behind sometimes perceive her to be a woman and call her "Ma'am." She finds these incidents affirming, but they distress her wife and are often followed by a haircut. Her preferred shoes and items of clothing are not obviously women's, but she knows that they are feminine, and this is soothing to her. She has worn women's underwear all of her adult life. She told her wife about the underwear after they had been dating for a year. Her explanation was that it was simply more physically comfortable. After about a year of therapy, Ronnie had a session with a person who does makeovers and showed me the photographs of her visit. In the photos she was attractively dressed in age-appropriate slacks and a sweater with a short wig and a big smile.

On intake Ronnie told me that Laura was her best friend and that their relationship was the most important thing in her life. In their daily life she and her wife had very little time together and would go months without a real conversation. Laura runs a small business of her own. She usually goes to bed after 2:00 AM and Ronnie wakes at 5:00 or 6:00. Before the children went to college, Ronnie's and Laura's interactions were focused on parenting. Vacations usually include the children. Laura has repeatedly said that she could only stay in the relationship if she did not have to see or hear anything about Ronnie's female identity. Over time, whenever the subject comes up between them, Laura has continued to express her fear that the gender issue will take over their relationship, and they both shy away from having any conversation that puts gender at the center. However, when such conversations do occur, Laura expresses sadness and suffering at losing her male partner or embarrassment at Ronnie's femininity in public. After these conversations, Ronnie calls to see me and discuss it as soon as possible. Ronnie has repeatedly stated that she does not like "to rock the boat." I have challenged her assumption that her relationship with Laura is so fragile. I encourage her to think beyond avoiding conflict. She usually shakes her head, digs in her heels, and reiterates her goal of maintaining peace in her relationship.

Ronnie believes that if she was not married she would undergo a full gender transition. She has undergone some feminization from hormones and usually shaves her chest or cuts her chest hair (whatever she can negotiate with Laura). It is physically and emotionally difficult for her to perform

sexually in the male role. Prior to hormones, the couple had sex approximately every month or two, but that decreased as Ronnie's body became more feminine and there has not been any sexual contact for several years. Ronnie describes their previous sex life as very routine, with an almost complete avoidance of discussions about sex. Ronnie says that neither of them misses intercourse but that she does miss physical intimacy. Laura has been increasingly less physically affectionate and Ronnie suffers from the longing to be hugged and held.

When Ronnie moves too much into her female self, Laura's negative reaction brings her back to a more masculine façade. When Ronnie makes compromises, such as cutting her hair or removing jewelry, she experiences bouts of depression. She is exhausted by her daily efforts to "balance" her needs to express herself as a woman and Laura's need to see her as a man. She states that she requires affection and warmth from Laura to sustain her in this inner struggle but that the lack of affection and warmth lately (due to Laura's discomfort with Ronnie's femininity) makes the daily fight to live as a man more difficult.

Though Ronnie sought out a therapist who was experienced in supporting people through gender transitions, she said that she called me because she read on an online referral list that I also supported people who do not transition. She has rarely wavered from her original position that even though it is painful to live as a man, she is not up to the sacrifices and social and professional challenges of transition.

We have known each other for a long time and have had very some active conversations upon occasion, but generally Ronnie likes to use me as a sounding board, fill the session with her thoughts and feelings, and have someone listen to and witness her experience. When I do reflect or give input (no matter how simple and obvious) she almost always corrects me. It is an argumentative, compulsive style that makes it almost impossible for her to hear a comment from me and not want to edit it. There are times when she seems hungry for feedback and other times when she is ambivalent about hearing my perspective because she is fearful that I will "rock the boat" with suggestions or interpretations that may lead to change. She has articulated that the greatest value of the therapy is that she can be herself and talk to someone who knows who she really is.

Ronnie's gender issues are an obstacle in her life. Every moment of the day she seems to be interacting through this dysphoria, constantly aware of her wrong body and wrong social role and the need to fight on to keep up appearances. She used to focus on the need to maintain balance and resist her desire to transition. That was her previous definition of success. In the past year she has changed this and has articulated her position as "transitioning at a glacial pace." She says that she needs to feel that she is moving in that direction even as she does not really want to make big changes in her life. Her relationship with her wife has improved since the children went away to college and she and Laura began to see more of each other.

Ari's Responses to Ronnie's Case and Kit's Questions About Treatment

Ari: My first reaction to Kit's presentation of Ronnie is that she is very familiar to me. I have over the years worked with a number of people who have a similar history and experience and whose lives evoke similar questions for me as the consulting therapist.

There are a few issues that jump out at me upon hearing the case. The first is the sense of profound sadness that I feel from Kit. Perhaps she is reflecting the client's sadness, but I cannot help but wonder if there is a countertransferential quality to the sense of grief. What is it that Kit is mourning, and how much does Ronnie need Kit to be in a state of mourning? Kit clearly views Ronnie as being in a "holding pattern," and she sees her therapeutic role (in part) to be serving as an "oasis" for her. What if this is not a "holding pattern" but a way of life: a delicate, tenuous, balancing of two impossibilities? What if Ronnie cannot live fully as a woman or as a man? What if it is not that she is stuck, but that she has chosen this path? What if this state of chimerism—of life as both/and—is the most authentic life for Ronnie? Perhaps Ronnie needs Kit to mirror this both/and place, to applaud her for balancing this unsteady teeter totter and to not mourn her inability to walk either of the two divergent paths? I have an image from Robert Frost's famous poem that as Ronnie is faced with the fork in the yellow wood, she should perhaps just sit down and have lunch or perhaps build a shelter there. Making her home at the crossroads might be a solution to the dilemma of seeing herself as "stuck" there.

Kit refers to Ronnie using female pronouns. Indeed, therapy with Kit is the one place that Ronnie is free to be completely female and to be seen for who she "really" is. Yet the female self that Kit sees, acknowledges, and mirrors is only a small part of Ronnie's life—a hidden, secretive part. I cannot help but wonder how this distorts our view of clients, only seeing this secret part of them in the consulting room. Mary Pipher tells a moving story in her book *The Shelter of Each Other* (1996), in which she is working with a couple on the verge of divorce. Her sense is that the marriage is truly over and there is no hope, and she encourages them to end their marriage. Mary Pipher lives (as I do) in a small city, and later in the day she sees the couple, with their children, bicycling through the local park. They are happy and laughing, and she realizes that she only sees a small part of their lives in her therapy office. Who is to say whether what we see is the most "authentic" self? How can the self that lives and walks through the world every day be completely "inauthentic"?

As I was preparing this article for press, I was taking a break by reading Facebook, another small city in which I live. I found this on a friend's page: "The most important part of a Transgender person's journey

of transition is the integration of the whole person and moving ahead through life. In other words, it is the process of becoming whole and authentic individuals" (De Sube, 2010). However, what I inferred from this statement is that one cannot become "whole and authentic" unless one "transitions." The author continues, "Before transition, Transgender folks deny a very important part of themselves."

There is no doubt that most of the clients who seek our help for gender-related issues have long histories of denying a "very important part of themselves," and the process of therapy can liberate this hidden, closeted, often frightened self. What an amazing idea, that one can actually live out one's dreams! However, no human being can live out all his or her dreams. One can only follow so many paths. The choice to marry and have a family for many people means they do not get to have the artist's loft in the city or to freely spend income on hobbies or to follow every whim of the libido. The fulfillment of some dreams can mean the demise of other dreams. Aging itself brings the end of certain dreams; for some the realization that "I will never..." (fill in the blank: hike the entire Appalachian Trail, compete in the Olympics, or become a veterinarian).

Kit holds a space for Ronnie, wherein the dream of transition remains possible. There, in the therapy room, Ronnie is fully in this dream—a dream she could authenticate, a dream that most of the transcommunity will tell her she *should* authenticate. Outside of the consulting room, Ronnie is male, currently living life as a man. Ronnie is not a she but a "he," a husband, father, and employee, whom people see and acknowledge using the titles "Mr." and "Sir." Kit is the one person for whom Ronnie is always female. When Kit presents the case, we perceive the woman Ronnie, and the man is a shadow, perhaps in some ways a deformed, unformed self. But to the world outside, to the children who call her "Dad," Ronnie is a fully formed man whose feminine mannerisms are an aberration, a distortion. Who is to say which narrative is the "authentic" one?

Ronnie, of course, has the final say. In session with Kit, Ronnie is clear that her female identity is authentic. But I cannot help but wonder if Kit would be so sure if we were to visit her at the Thanksgiving table. I am not belittling Ronnie's true self, only acknowledging that there is more than one true self and that we are all in some sense multiple personalities. How does Ronnie see herself aging? Now that the children are grown, yes, she can authenticate herself as a woman, but can she also grow old with her wife? I am not saying these two images are not compatible, but for Ronnie they may seem like two separate paths.

The reason Ronnie struggles to shed her male self may be because it is an integrated, whole, and important part of self, that is not so easily discarded. Clinically speaking, is the therapeutic alignment with

Ronnie as an “authentic woman,” with an “inauthentic male persona,” acknowledging her true identity or complicit with her illusion/fantasy? How does the case change if we read it again using male pronouns? Can we clinically support Ronnie’s female identity without seeing the male self as inauthentic? Can we help Ronnie imagine an authentic and complex female self that includes being a spouse and parent to her children?

Kit: The most challenging issue in this treatment is how to support someone in a situation that is, and will likely continue to be, painful. It has been Ronnie’s goal to remain in a holding pattern. I am meeting her where she is and I have fulfilled her goal for treatment, which was to help her to not transition (or “transition at a glacial pace”) and maintain her marriage. I wrestle with respecting her wish to maintain the status quo. I fully respect her values, which put her family ahead of her own happiness. How does this play out in therapy?

Ari: This, to me, is the crux of the clinical dilemma: “How to support someone in a situation that is, and will likely continue to be, painful.” I think this is where Kit’s sadness comes from, in seeing Ronnie’s pain, and effectively mirroring it. However, if we step outside of the issue of authenticity, is Ronnie’s life any *more* painful than anyone else who lives with compromises (which one might argue is all of us)? What if Kit were to change the frame, from “moving at a glacial pace” to “standing firm as a mountain”? What if the mirror is not sadness but celebration: “How great to balance these two worlds!”

Kit says that she has met the client where she is (a major social work tenet) and “fulfilled her goal for treatment,” for which I commend her. This is hard work, being the only one holding the space for Ronnie the woman. Kit says she “wrestles” with Ronnie’s “wish to maintain the status quo.” I would question why Kit has to “wrestle” with this? There is no doubt that to continue to live as a man fits the status quo for mainstream America, but does it fit the status quo for the transcommunity? In the transcommunity, particularly online, the assumption is that the only way to live an authentic transgender identity is to “come out” and “be yourself.” Ronnie talks about her difficulty connecting with the transcommunity and feeling alone, which may be precisely because she is not following the expected trajectory. Ronnie (i.e., as a self-identified transwoman) is not maintaining the status quo at all. For that matter, her choice is viewed as “inauthentic,” “painful,” “closeted,” and for some members of the transcommunity, “a lie.”

I believe that Kit “fully respects” Ronnie values to place her marriage ahead of her gender identity, but I also think that she continues to wrestle with it, which is how it “plays out in therapy.” I wonder if Kit stopped “wrestling” if Ronnie would wrestle more? Is the goal of therapy to provide Ronnie with a supportive place to be fully female, or is the goal of therapy

to push Ronnie to confront the stuckness in her life. What is Ronnie really asking for?

Kit: Ronnie gets relief now and then with small gestures towards self-expression, but overall the situation is emotionally painful. What can I do to help reduce her pain, to help her to manage the stress of the gender dysphoria, and to reduce dysphoria, if possible?

Ari: I wonder if the therapeutic goal is to reduce her pain or increase it? Kit says, "I get the feeling that she does and does not want me to give her feedback. Her reactions indicate that she is fearful that I will 'rock the boat' with suggestions or interpretations that may lead to change."

Yes, of course she is fearful. And this raises the question of whether our therapeutic stance should be to simply be present and mirror her experiences, or challenge her to address the conflicts in her life and the dysphoria that it fosters. Is it the therapist's job to "rock the boat"?

She has articulated that the greatest value of the therapy is that "she can be herself and be with someone who knows who she really is." So does this mean her wife does not know who she "really is"? Or is "who she really is" so fragile it cannot be challenged? Perhaps this is the intervention: You are not really "who you really are . . . you are hiding yourself, and even the self you show is very fragile. What would it mean to fully become yourself, consistent throughout your social world?" I wonder if it is best to not "decrease" her gender dysphoria but rather to increase it, that is, make her more aware of the discomfort in her life and more willing to address the duality and challenges inherent in being a married man who wants to be/is a woman.

Kit says, "When she feels hopeless, she talks more of transition." Is it the dysphoria that feels hopeless, or is something else happening (or not happening) at home or in her work life? Does the dysphoria increase when there are difficulties in her life? This is the major disadvantage of not having any contact with her wife. I have no doubt that there are situations and circumstances in her daily life that are challenging, and perhaps unrelated to gender issues, that cause her to want to escape into her fantasized life as a woman. The literature has long examined the role anxiety can play in cross-dressing and gender dysphoria (Doctor, 1988). Part of being closeted in the way Ronnie lives allows for the maintenance of a fantasy of what a life living fully as woman would be like. I am sure that fantasy does not include daily relationship negotiations or leaky roofs. I would question more about the rest of her life when she presents feeling hopeless.

Kit: In her online encounters with other transgender people, Ronnie has not found anyone with whom she fully relates. She did recently attend a transgender voice workshop and enjoyed it but went to only one session and felt too exposed and public. She is not now, and may never be, "out." It has been difficult for her to find peer support for people in her situation,

that is, fully female-identified and committed to living as men. In other words, nontransitioning people. One of the reasons I wanted to present her case is that I see many clients in this situation. Their perspective is rarely represented in community or in the literature. What can she do to feel less alone?

Ari: Well, one part of me says she is creating this “aloneness” by having two worlds that need to be managed. She also creates this aloneness by the (male) distance she maintains in her marriage. In my experience, she is far from alone, and as I said earlier, Ronnie is familiar to me—there are other transwomen making similar compromises in their lives. Why isn’t she able (willing?) to make contact with them? Is it too painful to be faced directly with the dilemma that she lives with? Sometimes it is easier to live in denial than to see your own pain mirrored in someone else.

Kit: A primary goal of treatment has been to improve the relationship with her wife—increase their communication and Ronnie’s ability to negotiate her needs within the relationship. (Ultimately, the goal is to have Laura come to therapy!) It was clear to me from the beginning that working with Ronnie was doing couples therapy with only half a couple. Ronnie was emphatic that including Laura in the therapy was out of the question. I have never given up hope of the possibility of including Laura in treatment, with me or some other couples therapist, but Ronnie has remained unmoved on this point. When I bring it up she lets me know that my suggestion demonstrates a lack of understanding regarding the situation. It is my goal and not her goal. Is it okay for me to have goal for her that she rejects? I believe that couple’s therapy would be useful. What can I do to get her to advocate for this?

Ari: This case is a clear example of the need for couple and family therapy. The client’s resistance is so extreme that it only highlights the importance—the lady doth protest too much, methinks. Why does she assume her wife will not come with her on this journey? Is there any concern that the story Ronnie is telling is only partially true? I have sometimes worked with husbands who present their wives’ positions quite differently than the wives would. Of course, there is no way to know this if Ronnie refuses contact. It does, however, make me somewhat suspicious of Ronnie’s perspective of his wife’s experiences, as well as the veracity of what he presents of his marriage.

It raises the question, should one ever “insist” on couple’s therapy (as if we could insist on anything), especially before a referral for hormones? I have sometimes worked with an endocrinologist and, as a team, we sometimes require that in order to start a client on hormones we need the wife’s involvement. In Ronnie’s situation, it was imperative to get her on medically monitored hormones, so that “carrot” was not available.

As a family therapist, this aspect of the case is most troubling. I would assume that Ronnie's resistance to any negotiation about working with her wife on this issue is proof that Ronnie really does not want to live full-time as a woman. She may say she does, she may think she does, but she is not willing or able to take the necessary risks to do so. I trust that she knows that pushing this issue at home will have cataclysmic results, especially now that their youngest child has left for college. She is not willing to "rock that boat," and if that boat is all she sees in a vast expanse of ocean, it seems that boat is where she should be to remain safe.

Kit: Ronnie finds value in the therapeutic relationship as if it is an end in itself. I believe that there is value in holding and maintaining this space for her. It provides an oasis for her to express her thoughts and feelings. She needs some expression and therapy is one of her outlets. She also enjoys writing and keeps a journal. Gender-oriented therapy is often the only safe space for gender expression. Is there any problem with that situation?

Ari: There is no problem with holding a safe space for Ronnie. There is a problem, however, if the safe space is viewed as a prison sentence by either the therapist or the client. If Ronnie has a good life, then that should be honored. If Ronnie does not have a good life, that should be addressed. Having an oasis is a good thing, but is her life really a desert? Such images come up in the case: deserts, oceans, holding pattern, slow-moving glaciers—is Ronnie's life really a small place in this vast wilderness?

Kit referred to Ronnie's "argumentative, compulsive style which makes it almost impossible for her to hear a comment from me and not want to edit it." I am familiar with this style in older male-to-female people struggling with transition issues. I think this may be what the older generation of gender therapists referred to as Axis II issues. I find it frustrating. I find they are even argumentative when I am agreeing with them!

However, I learned a lesson a few years ago. I was working with a client who had argued with everything I ever said to him. I found the sessions incredibly frustrating, and when I tried to confront this he argued with me that he never argued with me! Years later, after she transitioned, she told me how helpful I had been, even inferring that I had saved her life. I was truly shocked because I thought therapy was a negative, hellish experience for her. She said, "That is just the way I process things. I dissect them and argue them, and then try them on. I guess I forgot to tell you that I was actually listening to you."

One of the truisms about parenting might be equally true about the therapeutic process: you often need to repeat things over and over again, and even though it seems they are not listening, they are really taking it all in and building a life on the wisdom they seem to reject. Ronnie keeps coming back, and even pays you in advance for the sessions she will have in the future. In the vast wilderness of her life, you are more than just an

oasis—you are the space in which she is trying to build whole her life, from the many parts, not all of which she is ready to bring to you. I think you can risk confronting her more than you do. I also think you should feel less sad about the crossroads where she lives. Maybe paradoxically, the more you accept this place she lives in, the more she'll argue her way out it!

NOTES

1. "The SOC are intended to provide flexible directions for the treatment of persons with gender identity disorders. . . . individual professionals and organized programs may modify them. Clinical departures from these guidelines may come about because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol" (Meyer et al., 2001, p. 2).

2. Spironolactone suppresses testosterone. Effects of this medication include (but are not limited to) softening of the skin, reduced growth of body hair, breast growth, and reduced libido. In many people it affects sexual functioning by not only decreasing drive but also diminishing erectile and orgasmic response. This varies from person to person. Most of the transgender people who enjoy the effects of Spironolactone enjoy the absence of the feeling of testosterone in their system. They are relieved by cessation of ego-dystonic erections and the changes in thought and energy that result from a decreased focus on sex and reduced aggression. Spironolactone works through suppression. People who want to undergo full gender transition will usually supplement this with estrogen in order to strongly feminize their body in a more dramatic way.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association.
- Carroll, R. (1999). Outcomes of treatment for gender dysphoria. *Journal of Sex Education and Therapy*, 24, 128–136.
- De Cuypere, G., & Vercruyse Jr., H. (2009). Eligibility and readiness criteria for sex reassignment surgery recommendations for revision of the WPATH standards of care. *International Journal of Transgenderism*, 11(3), 194–205.
- De Sube. (2010). Trans talk. Retrieved from <http://destrantalk.blogspot.com/2010/05/transgender-transition-and-integration.html>
- Doctor, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior*. New York, NY: Plenum Press.
- Johnson, V. K. (2010). The development of standards of care for individuals with a male-to-eunuch gender-identity disorder. *International Journal of Transgenderism*, 12(1), 40–51.
- Meyer, W., Bockting, W. O., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., . . . Wheeler, C. (2001). The Harry Benjamin gender dysphoria association's standards of care for gender identity disorders (6th version). *Journal of Psychology & Human Sexuality*, 13, 1–30.

- Pfafflin, F., & Junge, A. (1998). *Sex reassignment thirty years of international follow-up studies SRS: A comprehensive review, 1961–1991*. Düsseldorf, Germany: Symposium Publishing.
- Pipher, M. (1996). *The shelter of each other: Rebuilding our families*. New York, NY: Ballantine Books.
- Vale, K., Johnson, T. W., Jansen, M. S., Lawson, B., Lieberman, T., Willette, K. H., Wassersug, R. J. (2010). The development of standards of care for individuals with a male-to-eunuch gender identity disorder. *International Journal of Transgenderism*, 12(1), 40–51.