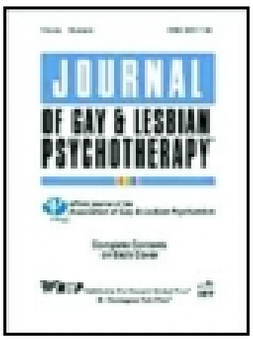

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Transactivism as Therapy: A Client Self-Empowerment Model Linking Personal and Social Agency

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Transactivism as Therapy: A Client Self-Empowerment Model Linking Personal and Social Agency

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SUMMARY. The author, a trans-identified transactivist and psychotherapist, outlines a number of ways in which elements of advocacy and activism can be added to the therapeutic process as appropriate and potentially effective interventions. A case study illustrates how these interventions optimize client agency, efficacy, resilience, and quality of life. doi:10.1300/J236v11n03_05

KEYWORDS. Activism, Adlerian psychology, advocacy, community, mental health, psychotherapy, self-disclosure, transactivism, transgender, transphobia, transsexual, two-spirit

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INTRODUCTION

This paper is written from the perspective of a transactivist and psychotherapist working out of an LGBTT[1] program in a community-based health centre in Toronto. Drawing upon the author's combined clinical and community activist experience, this paper presents a working model of therapist-facilitated, client self-empowerment. The practical application of this model is demonstrated through the author's work with a transsexual, transgendered, and two-spirit client population. Grounded in an existential-psychodynamic framework, and based on anti-oppression practice, the model links the personal and social agency of the client through the cultivation of his/her/hir[2] self-advocacy and community activism skills. The applied model integrates psychoeducational and psychotherapeutic interventions. It provides creative opportunities to facilitate both the self-empowerment (personal agency) and the interconnectedness (social agency) of trans-identified clients, who are typically marginalized, individually and as a group. These interventions include: (1) appropriate therapist self-disclosure and modeling of particular transactivist activities; (2) assisting clients in building self-advocacy skills, both with respect to health care and social service providers, and with a view towards transferring these skills to community advocacy; (3) delivering workshops on how to develop and enhance activist skills for both seasoned and novice transactivists for both client and non-client populations; and (4) facilitating opportunities for transactivism to interested transsexual and transgendered clients. Such treatment interventions provide creative opportunities to facilitate self-empowerment and interconnectedness for trans clients.

A TREATMENT MODEL OF CLIENT SELF-EMPOWERMENT: LINKING PERSONAL AND SOCIAL AGENCY

The treatment model presented here is existential-psychodynamic in nature, based on the work of the followers of Alfred Adler (Hooper and Holford, 1998; Lundin, 1989; Sweeney, 1998), Viktor Frankl (1984) and Anne Vitale (1997), coupled with a gay positive social justice or anti-oppression framework described by Harold Kooden (1991) and Armand Cerbone (1991). The working model, as developed and applied in this paper, is predicated on the fundamental Adlerian principle of "encouragement"[3]–specifically, the encouragement and cultivation of a client's personal and social agency. The underlying theoretical principles involve

interconnectedness, power, meaning, and authenticity (including both existential and genderal[4] authenticity). The practical aspect of the model involves skills development (including self-advocacy and community activist skills), in addition to a variety of other clinical interventions.

Theoretical Underpinnings

Adlerian psychology traditionally identifies a drive for interconnectedness called *social interest*.[5] Interconnectedness (social interest), power (empowerment), and meaning (authenticity) are inextricably interlinked. These can be conceptualized both a cluster of drives/values (when used as nouns), and as a cluster of character traits (when used as adjectives: socially interested/interconnected/empathic/conscientious, powerful/empowered, meaningful/authentic). Meaning and authenticity are intertwined, existential concepts formulated by Viktor Frankl (in his therapeutic model of *logotherapy*), and later developed by a number of successive psychodynamic therapists, including Anne Vitale (1997).

These concepts are critical for transpeople who live in an extraordinarily oppressive environment. For transpeople, who seek both a place to belong and a way to be-in-the-world congruent with who they truly feel to be inside, one way to self-actualize is through personal empowerment. This can be done by means of gender expression/presentation and/or medical transitioning–especially for transsexuals–and by "meaningful connections," i.e., a connection to the trans community. Such congruence between the mind and the body (a sense of "being comfortable in one's own skin") is clearly a form of psychosexual integrity or genderal authenticity.[6]

Genderal authenticity is the clinical focus of Anne Vitale, a trans-identified, American psychologist specializing in existential-humanist psychotherapy. Vitale provides therapeutic support for cross-dressing and gender-divergent clients in such a way as to skillfully combine therapist advocacy and self-empowerment of the client. Specifically, she employs a client-centred, open-minded approach to helping her trans and questioning clients to take responsibility for discovering and actualizing their own particular form of life meaning and personal power. This supported quest for identity and validation typically involves a dovetailing of genderal integrity, community connection, and existential authenticity.

Using the above concepts, what follows is a working model of "transactivist therapy-in-action," a client-empowering process whereby the transactivist therapist helps the client work through any existing

symptoms of internalized transphobia, helping him/her/hir re-channel the "righteous rage" arising from societal discrimination waged against transpeople, and develop effective skills around self-advocacy and community activism.

THERAPEUTIC INTERVENTIONS

Therapist Self-Disclosure, Modeling, and Mentoring

A clinician who also plays an activist role in the community has a unique opportunity within the clinical forum to model the attitudes and behaviors of an effective agent for social change. The combined interventions of therapist self-disclosure, modeling, and mentoring have been described by several LGBTT "activist therapists" (Cabaj, 1991; Cerbone, 1991; Kooden, 1991). They propose that a therapeutic alliance, enacted through the clinical work itself, can bring about effective change within the client through the intentional use of "discretionary therapist self-disclosure." The costs and benefits of therapist self-disclosure should be carefully weighed by the activist clinician on a case-by-case basis. Some therapists choose not to reveal their sexual or gender identities, or their queer or trans activism (or only do so selectively with certain clients or colleagues, or in specific situations), whereas, others see it as "grist for the mill" and a valid treatment intervention.

Cerbone (1991) advocates a shift from "therapeutic neutrality" (non-disclosure of the therapist's sexual identity and/or LGBTT activism) to a model of therapist authenticity. One goal is to balance the legitimate needs of the clinician (both as a gay or Trans person and as a professional healer) to incorporate his/her/hir activism in the therapeutic work at hand–while being clinically sound (i.e., appropriate, relevant and effective for the client) and also ensuring professional boundaries. Therapist self-disclosure can precede modeling and mentoring. Information about the clinician might be already known to a prospective client. Therapist self-disclosure can take place through a clinician's published work (Patton, 1979; Raj, 1997; Vanderburgh, 2003), or during an initial consultation or therapy session.

Kooden (1991) emphasizes both "historical disclosure" (i.e., statements revealing information about the therapist's past and current life: age, background, education, sexual orientation, relationship status, community involvement and relevant personal experiences, etc.), and

"philosophical disclosure" (i.e., discursive statements about psychotherapy, spirituality, homophobia, morality, nutrition, safer sex, etc.) as purposeful interventions within the clinical context to address specific issues such as challenging clients' internalized homophobia and facilitating their coming-out process and connectedness to the queer community.

Clinical discretion should be an operating principle here, ensuring mutual safety for both client and therapist. As Kooden (1991) cautions, every instance of therapist self-disclosure must be clinically appropriate–enhancing the therapeutic goals of the client, rather than advancing the personal agenda of the therapist. Unwise or untimely revelations about the therapist could engender client misinterpretations, misperceptions and distorted expectations, resulting in "unhealthy boundaries." For instance, a trans client might want to see a trans-identified therapist as a close community colleague or even as a friend.[7]

In addition to therapist personal example and modeling, there is a vital need for trans-identified and transactivist mentors, especially for trans youth, but also for the older transperson who is "born again" in middle age or in their "golden years." The reason for this substantial need for transpositive role models and mentors stems not only from the glaring invisibility, resounding silence and omnipresent "erasure" of transpeople in society (Namaste, 2000), but also from the "trauma" inflicted on transsexual and transgendered individuals (individually and collectively) by the religious, social conservatives (condemnation and/or excommunication as "abominable sinners"), the social conservative mental health professionals (pathologization as "abnormal" or misperceived as repressed or "failed" homosexuals), and the sensationalist media (Jerry Springer's "freaks" and "losers").

The therapist who discloses his/her/hir trans status, and who is a living example of an "effective" transactivist or a "successful" transperson, is in an opportune position to model activist skills by virtue of the therapeutic alliance and the counseling process. Such modeling may also serve as a mentoring function in some instances.

Connecting the Dots Between Self-Advocacy (Personal Agency) and Community Activism (Social Agency)

Intuitively, it is not a quantum leap from the point of learning how to advocate for oneself (personal agency: "taking up one's rightful place in the universe"; becoming vocal and visible) to that of learning how to advocate for one's peers, one's community (social agency). Indeed, this interconnectedness between self and community is eloquently articulated

by Jamison Green (a transman and a transactivist) in his autobiographical book and teaching tool, *Becoming a Visible Man* (2004). In fact, it can be highly beneficial to teach clients to recognize the link between self-advocacy and community advocacy (i.e., transactivism), precisely because many of the advocacy and activist skills are naturally interchangeable.

Such a transition necessitates an explicit link between the internal world of the client and the larger social world. Thus, psychodynamic (insight-oriented) therapy is a particularly effective intervention, which can be elegantly applied in therapy sessions (as dictated by client relevancy) by helping a less aware trans client to make the all-important connections: not only between past trauma and present conflicts (PTSD), and between early childhood attachments and adult relational patterns (attachment theory), but also, between particular instances of oppression (transphobia) directed against oneself (an individual transperson) and societal oppression (institutionalized transphobia) that systematically targets one's peer-group (the trans community) as a whole. To take this one step further, the therapist can now go on to help develop client insight into the resulting logical connection between self-advocacy and community-activism–and the related skills development in both of these areas.

This can be formalized as a two-tiered, multifactorial treatment goal, whereby, the therapist aims to facilitate the self-empowerment of the trans client by: (1) initially helping the client to cultivate (access, harness) his/her/hir personal agency (which reflects a positive self-identity and promotes a "healthy" narcissism; and subsequently (2) assisting the transperson to expand and evolve this personal agency to one of social agency (which engenders a positive collective/community identity and precludes an "unhealthy" narcissism).

Interventions employed would typically include: the development of insight, building of self-esteem, validation of trans identity, acknowledgement and addressing of (societal and/or internalized) transphobia, working towards healing of the trauma, linking to trans (and other) communities, and the enhancement of life skills, including those skills/strategies which directly address feelings of despair, anger and rage, suicidality, self-harm and substance use, stress, and interpersonal relationships.

By providing an opportunity for the client to learn how to build critical skills in terms of accessing both personal power and community connection, the transperson can directly benefit in a variety of psychologically adaptive ways. Specifically, the combined effect of self-advocacy

(personal agency) and community activism (social agency) in action may serve to diminish the client's sense of despair, invisibility, alienation and isolation, while enhancing a sense of hope, visibility, and personal and collective/communal identity, as well as the emergence of several more adaptive personality-trait clusters. These include: (1) interconnectedness/social interest (Adler)–resulting in empathy/compassion, selflessness/cooperation (Hooper and Holford, 1998; p. 93) and mutual peer-support/community-building; (2) power (Adler): personal *and* social empowerment; and (3) meaning: (Frankl): existential and genderal (Vitale, 1997) authenticity.

Additional benefits gained from learning skills and strategies that enable the trans client to advocate not only for him/her/hirself, but also for the extended trans community (our "trans sisters and brothers"), involve the potential transformation of hopelessness and rage (the "victim mode") to a place of personal and social power.

Transforming "Righteous Rage" and Debilitating Despair into Self- and Community Empowerment

Transpeople are often targeted by *societal transphobia* (Gapka and Raj, 2003, pp. 12-13). This is a form of individual or systemic (Whittle, 2003) discrimination, harassment or violence (Namaste, 2000) directed against transsexual, transgendered, genderqueer, and gender-divergent individuals. It is usually based on ignorance, fear or hatred of someone who transgresses society's binary gender norms. As well as political and legal discrimination, transphobia can also take the form of verbal, emotional, physical or sexual abuse ("transbashing"), thereby, typically inducing anger or "righteous rage" in its victim.

Some members of the trans community might also experience *internalized transphobia* (Raj, 2002a), an intrapsychic dynamic which commonly manifests itself as self-hatred or impoverished self-esteem, guilt, shame or embarrassment. It can take the form of parasuicidal or self-harm behaviors (e.g., cutting, head-banging, wall-punching, substance use, pounding of the breasts or genital mutilation, etc.) or self-sabotaging acting-out behaviors (e.g., getting "high" on club drugs, unsafe sex practices, bad monetary investments, obsessive-compulsive gambling, spending or sexual activity, etc.).[8]

Trans-Relevant Bibliotherapy

With discretion, bibliotherapy can be enormously useful for trans clients in the therapeutic work, serving as "grist for the mill" in terms of

self-identification, exploration, motivation, and growth, as well as the development of strategies around transitioning and the building of skills related to personal advocacy and communal activism. Books, e-zines, websites, listserves, videos, and DVDs, which specifically focus on transactivism, can be helpful for both the would-be and the established transactivist by deconstructing harmful myths and stereotypes in favor of promoting transpositive images, effective role models and a message of hope that there *is* a place for transpeople even in a gender-binary world. It is crucial for the clinician to recommend only those resources that are relevant, trans-inclusive or trans-specific, age-appropriate, and otherwise beneficial. A therapist who works with trans clients has a responsibility to become increasingly culturally competent (Raj, 2002a) in terms of keeping up with ever-evolving trans culture and the highly diversified trans communities.

Material by transactivists and trans-identified professionals who build advocacy into their work (e.g., Denny, 1998; Devor, 1997; Feinberg, 1998; Gapka and Raj, 2003; Green, 2004; Israel and Tarver, 1997; Namaste, 2000; Raj, 2002b; Vitale, 1997; Whittle, 2002) can often assist the trans reader to "connect the dots" between self-advocacy and community activism by providing an intersectionality (sometimes through first-person accounts) of experienced transphobia and personal direct action as well as community action. Such activities might involve individual interpersonal reaction (e.g., clear communication, consciousness-raising, self-assertiveness, confrontation, conflict resolution, self-protection strategies, human rights litigation, etc.), as well as collective proactive action (e.g., transpositive diversity training, policy-making re: trans-inclusivity, combating hate crimes, fighting against transphobic discrimination in employment and housing, making schools and our communities safe, debunking myths about child abuse and sexual trauma, validating, "trans forming" families, celebrating trans culture and trans community, building alliances, etc.).

Psychoeducational, Therapeutic & Community-Development Group Work

Group work is an effective medium to use to teach critical life skills to clients. This includes utilizing staff-led (usually a therapist or peer-provider) peer-groups for trans youth and adults in creative ways to help them develop those interpersonal and social skills which are crucial to their emotional well-being, and will hopefully help them find a place–and a way–to belong in the world.

The source of this psychosocial skills development comes not only from the group facilitator(s), but also (and equally important) from the group members themselves. The benefit to participating in such a therapeutic group is the multiple impact on a transperson's life, for example: normalizing and celebrating one's "otherness" ("transness"); building self-esteem and personal power; reducing isolation and developing a sense of "real" community; and learning how to advocate for oneself and for one's fellow community members ("connecting the dots").

Trans-Activist Skills-Building Workshops & How-To Manuals

Interactive and educational resources on how to develop and enhance advocacy and activist skills for both seasoned and novice transactivists is a critical piece which is largely missing in trans communities.

In the past, this writer has collaborated with a number of trans and two-spirited community members in putting on educational or anti-oppression workshops for a wide variety of audiences, including providers, educators, researchers, students, clients, patients, community members, and their loved ones. Additionally, a transactivist colleague and myself are currently in the process of putting together one or more (possibly a series) of workshops specifically designed to help transpeople to empower themselves (individually and collectively) by learning how to build and hone their self-advocacy and transactivist skills. Of course, any worthwhile activist workshop must include a linking of oppressions (i.e., the ways in which racism, classism, ableism, ageism, sexism, homophobia, transphobia, poverty, homelessness, etc. intersect). Similarly, any anti-oppression workshop should also incorporate practical strategies that build on participants' advocacy and activist skills and resources. Indeed, anti-oppression work, advocacy, activism, alliance-building and community development are all inextricably inter-linked.

Facilitating Opportunities as Critical Points of Entry

Even non-therapists are often in a position to provide this significant intervention, which can, in many cases, prove to be a new opening or a turning-point in the transperson's process (inner work) and progress (outer work, also including biopsychosocial transition, if applicable). Linking up a trans client, regardless of age, with someone else in the centre or out in the community who is looking for a trans-identified presenter or panelist can sometimes be one of the most pivotal interventions for that particular transperson at that particular time in her/his/hir

life. So can asking the transperson to volunteer on a committee (e.g., our centre's Trans, Two-Spirit & Intersex Working Group or our Trans Pride Day Planning Committee). In all my years of clinical and community experience, I have yet to see anything match that deep sense of self-worth, personal power and pride experienced by a transperson when she/he/sie[9] is asked to take an active part or a leadership role in a trans-specific program or community event. This is truly therapeutic for the trans client and might be one of the rare times she/he/sie has ever been validated and empowered in this way before, or has been permitted, at long last, a visible profile and a genuine place in the world (i.e., interconnectedness, power, and meaning).

Application to a Case Study

Annabelle, is a 20 year old transwoman of mixed race, who has been in treatment for about 2 years. Although most (65-85%) of the clients who access the health centre where she is seen have numerous and often complex health issues (including trauma). However, Annabelle was even more severe in terms of both the extent and the intensity of her presenting problems, as well as her extreme degree of alienation, victimization and traumatization. The multiple layers of trauma she experienced started in early childhood and continued into young adulthood. They included familial, societal and internalized oppression. Their cumulative impact contributed to the client's Post-Traumatic Stress Disorder, as well as a deep-rooted self-hatred and feelings of utter loneliness and chronic despair.

Annabelle was a highly troubled youth when she first presented in therapy who felt: "I really don't feel there is any hope for me." She had just overdosed a few days prior to the initial session. Subsequently, she presented with multiple mental health issues and psychiatric diagnoses: PTSD (involving physical, verbal and emotional abuse, but not currently known if sexual trauma occurred), societal transphobia (harassment and bashing extended from childhood into adulthood), internalized transphobia (guilt, shame, embarrassment), Dysthymia, General Anxiety Disorder, panic attacks, social phobia, Attention-Deficit Disorder, possible psychosis, paranoia, self-hatred, low self-esteem, negative body image, Gender Dysphoria (Gender Identity Disorder), suicidality, self-harm behavior, substance use, eating disorder, family dysfunction, mother-daughter conflict, relationship problems, community ostracism, and extreme social isolation.

Given the complexity of the case and her issues, Annabelle was supported by an interdisciplinary team ("the circle of care") that included a psychotherapist (this writer), a consulting psychiatrist, a primary care physician, a family practice nurse, and a client resource worker.

In the ongoing psychotherapy (initially weekly, then bi-weekly), the client worked on a broad range of clinical issues. The overall goal was to facilitate client empowerment and agency. Specifically, the goal was to be actualized through the combined interventions of insight-oriented therapies (grounded in existential and psychodynamic theories such as the works of Frankl and Adler), trauma work (including Dialectial Behavior Therapy, Attachment Theory, etc.), self-esteem building, and skills-development via self-advocacy and community activism, in addition to strategies related to "working out" anger and stress. Essentially, these series of treatment interventions comprised a holistic "client self-empowerment model," in which interventions were always driven by the overarching framework, which strove to facilitate the empowerment of the client by linking her personal and social agency. The therapeutic work simultaneously involved the transforming of self-hatred into positive self-worth, and the normalizing and re-channelling of general anger as well as specifically transphobic-generated rage. Throughout the course of therapy, Annabelle learned how to fight against societal transphobia in healthy and strategic ways, while also acknowledging, and working through, manifestations of internalized oppression (i.e., transphobia, racism, sizeism[10]). "Healthy" refers here to personal agency (self-advocacy) and "strategic" to social agency (community and political advocacy).[11]

Over the course of therapy, Annabelle has shown substantive progress in terms of meeting her goals and improving her quality of life. She has demonstrated remarkable success in gradually learning how to assert herself and how to negotiate for the things she wants. The following vignette will serve to illustrate the client's progress over the months which followed a particularly dramatic/traumatic incident.

After one month into therapy, Annabelle requested female hormone therapy but was initially denied it. The decision was based on the primary care provider's concerns that this might be contraindicated for the client at that time, given her intense levels of self-harm behavior (e.g., cutting, head-banging), suicidality, and substance use, as well as possible psychosis (indicated by reports of voices and visions), and PTSD symptoms (e.g., flashbacks, "night terrors"). Annabelle's immediate reaction to this denial was to run out of the physician's office and the centre, stating that she did not wish to come back for her care.

This writer was subsequently able to persuade the client to stay on and work together with all members of the "circle of care with a view towards eventually working through the issues which specifically precluded the prescription of estrogen at that time. Annabelle agreed, and over the following two years, met on a regular basis with her care providers. Together, we devised a Client-Centred Interdisciplinary Care Plan for Annabelle, which included specified treatment goals respectively addressing four domains: the body (biological/medical), the mind (psychological/mental), the social environment, and the spirit (spiritual/existential), as modified in Table 1.

All four domains of the treatment plan (biological, psychological, social and spiritual) were viewed as equally critical to the overall wellness and well-being of the client. However, the clinical challenge, is to determine which issues–and which interventions–must come first, while trying to respect and balance the needs and goals of the client. In a client-centred collaborative care model this can be effectively addressed by means of contracting between clinician and client provided that a clear therapeutic rationale is given to the client, as well as an option for discussion and negotiation, as appropriate.

The treatment plan for Annabelle was implemented according to the priority (urgency) of the client's needs: emotional stabilization (i.e., addressing suicidality, self-harm behavior, despair, depression, anxiety, stress, psychoses, etc.), and access to safe (transpositive) and affordable housing were the first and foremost considerations, with sequential supports following over time, as clinically assessed (i.e., addictions recovery, losing weight, healing her recent adult trauma, initiating the transsexual transition, addressing societal transphobia and safety issues, re-channeling her anger, building self-esteem, healing her early childhood trauma, etc.), ultimately culminating in the linking to community and spiritual resources, encouraging the seeking out of supportive friends and a potential life partner, and possibly reunion with her family.

Specifically, psychiatric intervention included diagnostic assessment and the prescription and monitoring of psychotropic medications (anti-depressants, anxiolytics, and anti-psychotics). Medical support took the form of overall assessment, treatment, and monitoring of all primary health issues, including the eventual prescription and monitoring of anti-androgen medication and female hormones (estrogen). Nursing care involved the co-monitoring of anti-androgen and estrogen as well as general health issues. Limited case management was provided by the client resource worker as indicated, specifically providing information on legal name change procedures, linking up with subsidized housing

TABLE 1. Client-Centred Interdisciplinary Care Plan

Presenting Issues	Treatment Goals	Treatment Interventions	Responsible Staff
Biological/Medical:			
*GENDER DYSPHORIA ("Gender Identity Disorder")	*GENDER REASSIGNMENT:		
	*Hormone Therapy	*Estrogen & Anti-Androgen (assessment, prescription & monitoring)	*Psychiatrist *Physician *Nurse
	*Electrolysis Treatments	*Research/Education/ Referrals	*Psychotherapist *Client Resource Worker
	*Sex-Reassignment Surgery	*Research/Education/ Referrals	*Psychotherapist *Client Resource Worker
*OVERWEIGHT (eating disorder)	*Lose Weight	*Healthy Diet *Physical Exercise	*Physician *Nurse

TABLE 1 (continued)

Presenting Issues	Treatment Goals	Treatment Interventions	Responsible Staff
PSYCHOLOGICAL/MENTAL:			
*MENTAL STATE (despair, depression, anxiety, psychoses, ADHD)	*Stabilize Mood & Foster Hope	*Psychotropic Medication (assessment, prescription, monitoring)	*Psychotherapist *Psychiatrist *Physician
*GENDER DYSPHORIA (gender distress)	*Gender Reassignment (gender identity, presentation, etc.)	*Education & Support	*Psychotherapist
*EARLY & RECENT TRAUMA(PTSD)	*Healing Process	*Ongoing Therapeutic Work (DBT, Attachment Theory)	*Psychotherapist *Psychiatrist
*SUICIDALITY	*Decrease/Cease	*Monitoring & Support	*Psychotherapist *Psychiatrist
*SELF-HARM BEHAVIOUR	*Decrease/Cease	*Monitoring & Support	*Psychotherapist *Psychiatrist
*SUBSTANCE USE	*Decrease/Cease	*Regular Monitoring *Relapse Prevention Strategies	*Psychotherapist *Psychiatrist *Physician
*SELF-HATRED (internalized transphobia)	*Transform to Positive Self-Esteem	*Insight-Oriented Therapy, Validation & Support	*Psychotherapist
*ANGER (general)	*Transform to Self-Empowerment	*Cultivate Personal Agency & Develop Self-Advocacy & Anger Work-Out Skills	*Psychotherapist
*SOCIETAL TRANSPHOBIA & RESULTING RAGE	*Transform to Self- & Community Empowerment	*Cultivate Social Agency & Develop Community-Activist & Anger Work-Out Skills	*Psychotherapist
*STRESS	*Manage/Reduce	*Develop Strategies & Skills	*Psychotherapist

Social/Environmental:

*ABUSIVE HOME LIFE	*Move into Safe, Affordable Housing	*Link up with Housing Officer & Monitor Progress	*Client Resource Worker *Psychotherapist
*TRANSSEXUAL TRANSITION	*Disclosure *Relationships *Trans Connections *Legally Change Name and Sex Status	*Support *Support *Link to Trans Community *Research Process	*Psychotherapist *Client Resource Worker
*SOCIETAL TRANSPHOBIA, DISCRIMINATION & VIOLENCE	*Equity under the Law *Ensure Safety	*Learn Human Rights Legislation *Develop Safety Strategies	*Psychotherapist *Client Resource Worker
*COMMUNITY STIGMATIZATION & SOCIAL ISOLATION	*Re-connect with First Nations Community & Connect to Other New Communities	*Link to LGBTT First Nations Allies & Two-Spirit Peer-Support Groups	*Psychotherapist
*FAMILY REJECTION	*Eventually Possibly Reunite with Family	*Support Client *Potential Family Therapy	*Psychotherapist
*SEEKING RELATIONSHIP	*Find Supportive Life Partner	*Support Client *Build Relationship Skills	*Psychotherapist

TABLE 1 (continued)

Presenting Issues	Treatment Goals	Treatment Interventions	Responsible Staff
Spiritual/Existential:			
*SPIRITUALITY	*Develop Spiritual Identity & Connect to Spiritual Community	*Support Identity Development & Link to Two-Spirit Community	*Psychotherapist *Client Resource Worker

[Note: Under "Responsible Staff," where the Psychotherapist and the Client Resource Worker are both cited, the responsibility can either be shared or delegated to a sole provider. In some cases, the responsibility might be shared by the overall "Circle of Care."]

resources, connecting to specific trans community peer-providers, etc. Group work consisted of a 12-week, expressive arts therapy group for trans-identified youth.

In terms of the transsexual transition as a specialized intervention (or rather, a series of staged interventions), this comprehensive treatment program intersects at least three of the four domains: (1) Biological/Medical (initially hormone therapy, subsequently or simultaneously electrolysis treatments, and eventually sex-reassignment surgery [SRS], if desired), (2) Psychological/Mental (validating client's self-identification as a transwoman while also assessing for possible diagnoses other than "Gender Identity Disorder," helping client deal with societal transphobia and/or internalized transphobia [self-hatred] and resulting rage and despair, teaching strategies around how to stay safe), and (3) Social/Environmental (linking to trans and two-spirit communities and facilitating possible later involvement in transactivism, researching how to legally change one's name and/or possibly one's sex status, if SRS has been undergone). There is no absolute rule for the ordering of specific steps, however, there are recommended guidelines which can provide general direction (Meyer et al., 2001; Raj, 2002a: Appendix D: Figure 1a: A Continuum of Transpositive Support; Figure 1b: A Continuum of Transpositive Para-Medical and Medical Interventions).

Nearing the 16-month-mark of treatment, Annabelle started to experience accelerated levels of frustration, anger, anxiety and despair (in addition to increased gender discomfort and negative body image), due to the fact that she felt she was not close to reaching her goal of medically transitioning.

At this point, this writer suggested a case conference with Annabelle and all three care providers to allow her an opportunity to express her feelings. She agreed wholeheartedly and further asked to have her new friend sit in the conference to provide her with moral support. This writer encouraged and coached Annabelle around these incipient efforts at self-empowerment and self-advocacy, resulting in unconditional agreement on the part of the providers. This writer also urged the client to take ownership of her treatment/action plan, and suggested she might wish to modify the printed plan as it now stood. Annabelle rose to the challenge and personalized and updated the plan in a way that put her much more in control of her own life destiny and transitional and health care goals. Essentially, she added in several more goals: (1) to eventually access sex-reassignment surgery; (2) to find a compatible lifelong partner in the very near future; (3) to crystallize her two-spirit identity through connecting with the two-spirit community;

and (4) to hopefully one day re-connect with both her family and her First Nations community.

Beyond these limited examples of evolving self-advocacy skills ("baby steps" reflecting a gradually strengthening ego), Annabelle had also tentatively begun, over these past several months, to spread her wings. After her self-esteem had improved, she decided to reach out to others like herself. Specifically, Annabelle made a connection with the trans and the two-spirit communities by actively contributing to several organizational programs and activities (e.g., 2-Spirited People of the 1st Nations–peer educator/advocate/activist; AIDS Committee of Toronto–trans presenter/workshop panelist; Sherbourne Health Centre–Trans Pride Day planning committee member; Supporting Our Youth–TransFusion Crew event planner). Following directly from this newfound sense of community identity and inclusiveness (which, in turn, fostered her self-confidence and sense of personal power), she started to become even more involved on an educational and political level, learning the necessary skills to do activist work fighting oppression and improving the quality of life of her transsexual/transgendered and two-spirit sisters and brothers. The skills specifically involve developing a political analysis based on an understanding of anti-oppression practice, educating various publics, and lobbying politicians for social reform. These community advocacy skills arose out of Annabelle's slowly evolving social agency and sense of community empowerment, and were largely facilitated by her prior skills in learning how to advocate effectively for herself, which was grounded in her personal agency and sense of self-empowerment. Her personal identity (as a two-spirited transwoman) gradually expanded to include a spiritual, a community, and a political dimension, thereby transforming into a combined personal and collective identity. In other words, "the personal becomes the political" (to paraphrase the classic feminist adage), as Annabelle follows her personal-existential quest for interconnectedness, power, and meaning. Genderal integrity (i.e., the relief of Annabelle's gender distress by means of medical gender-reassignment interventions as well as the validation and crystallization of her two-spirit nature) infuses existential authenticity (i.e., her way of spiritually being-in-the-world), and vice versa.

CONCLUSION

This paper offers a perspective on yet another innovative way to do therapy: employing the combined use of client self-advocacy and community activism as a clinical intervention–and helping clients connect

the dots between personal and social agency, and between individual and collective skills-building. The client focus in this case was transsexual and transgendered people, and the therapeutic/educational interventions used were trans-specific self-advocacy and transactivism.

The perspective provided was multi-dimensional insofar as the writer identifies as a transperson (personal lived experience), a clinician, researcher and educator (professional academic and clinical expertise), and as a transactivist (sociopolitical change and community development).

This writer encourages other mental health care practitioners to take the seeds planted here and cultivate them in creative ways to help your trans-identified clients' blossom and grow–and ultimately take up their own power and rightful place in the Universe.

NOTES

1. LGBTT is an acronym for "lesbian, gay, bisexual, transsexual and transgendered."

2. Pronounced "here." A term coined by Leslie Feinberg in hir 1998 book: *Transgender Liberation* (p. 1).

3. "Encouragement is a key concept in Adlerian psychology which teach clients that although they cannot change events, they can change their attitude towards these events. This can be an exciting discovery and clients are encouraged to re-write their own part in the drama in new and more self-fulfilling ways" (Hooper and Holford, 1998; p. 101). Such therapeutic reframing can take the form of re-channelling transphobia-derived "righteous rage" to more effective forms: i.e., advocacy and activism.

4. Genderal is a term used to describe gender used in reference to the trans community

5. It is also known as "social feeling," "community feeling," "communal intention," and "community interest" (Hooper and Holford, 1998; pp. 90-93; Sweeney, 1998; pp. 8-9). More often referred to today as "social conscience" or "sense of community," Adlerians believe this to be an innate drive reflecting a basic connection to the human community, in particular, and to the Cosmos as a whole. They also believe the concept is highly correlated with positive mental health and that a lack of social interest is associated with the genesis of neuroses, psychoses, antisocial behavior, and crime (Lundin, 1989, pp. 39-47). Adler assigned equal significance to the fundamental human drive that he called a "striving for power" (nowadays referred to as "self-empowerment"). The Nietzchian notion of a "will-to-power" was closely related to Adler's concept of a "striving for superiority" (Lundin, 1989, pp. 36-39). Essentially, Adler's twin strivings for power and for superiority were theorized as deeply embedded in human nature and represented a will to dominate others. In some cases (predominantly found in neurotic individuals), the striving for superiority could be a way to compensate for earlier feelings of inferiority. Eventually, Adler re-formulated this primary drive for power as a dynamic force for superiority or perfection, which included the idea of self-esteem.

6. In the case of transpeople who experience gender dysphoria, their intense (and often chronic) gender distress typically transcends the genderal to embrace the existential.

7. Inappropriate boundaries within the clinical context, such as these noted here, are often the result of therapist "overidentification" with a client or vice versa (Cabaj, 1991; Cerbone, 1991). Cabaj (1991) conceptualized such overidentification as a form of transferential or countertransferential distortion, whereby the therapist or the client projects his/her/hir own traits or needs onto the other person. As he suggests, marginalized, stigmatized or otherwise "invisible" individuals or groups (such as gay men, in his case and transpeople, in mine) are especially vulnerable in terms of falling into the traps of overidentification or questionable boundaries precisely because of the still-prevalent homo- and trans- phobia, coupled with the general lack of positive role models.

8. This writer hypothesizes that there often exists a correlation between a sense of powerlessness, hopelessness and alienation, on the one hand, and that of anger or depression, on the other-and further, that often these intense feelings are manifested through "acting out" and self-harm behaviors. In some cases, the rage is turned outwards–possibly looking for someone to blame, or fix, "Nature's cruel joke;" in others, a sense of acute desperation is turned inwards-in the form of depressive symptoms or parasuicidal or self-harm behaviors. It is this author's belief that once individuals begin to feel empowered (power), have a sense of purpose (meaning), and find a place or a way to belong in the world (interconnectedness), the acting out and self-harm behaviors should eventually decrease or cease altogether.

9. Pronounced like "see;" see above (Feinberg, 1998, p. 1).

10. "Sizeism" refers here to the client's negative valuation of her obesity, which, in turn, is a reflection of society's stigmatization of those who are overweight.

11. This writer presented the client with a selected excerpt of the classic, self- and life-affirming poem, Desiderata, by Max Ehrmann, as a starting point to motivate her to want to, and to learn how to, be seen and heard. An excerpt, personalized with Annabelle's name on purple paper, read: "*You are a child of the universe, no less than the trees and the stars; you have a right to be here*." The interesting fact about the word, "you," is that it can connote both the individual self (transperson) and the collective (trans) community–thereby planting a seed in the client's psyche on connecting the dots between self-advocacy and community activism.

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