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Inviting "Kate's" Authenticity: Relational Cultural Theory Applied in Work with a Transsexual Sex Worker of Color Using the *Competencies for Counseling with Transgender Clients*

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This practice-based article presents our work with Kate, a transsexual woman of color, sex worker, and child abuse and hate crime survivor who, despite initial mistrust, sought counseling for an assessment of readiness to begin hormone therapy. In our counseling journey with Kate, we employed the American Counseling Association's (ACA) Competencies for Counseling with Transgender Clients *through relational-cultural theory (RCT), a feminist model of social justice in human development. We navigated RCT's core tenets of connections and disconnections throughout the counseling journey, allowing us to overcome obstacles of Kate's mistrust of the counseling relationship that were due to perceived barriers in seeking a gender identity disorder diagnostic assessment. Our practice of RCT demonstrates a growth-fostering relationship that supported and empowered Kate within the context of the diagnostic assessment.*

KEYWORDS, relational-cultural theory, sex-worker, transgender, transsexual

Client empowerment and strengths-based counseling have emerged as central considerations in the newly developed *Competencies for Counseling with Transgender Clients* (American Counseling Association [ACA], 2009). These competencies provide direction for some of the most challenging work

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(Reicherzer, 2006) with transgender women and men, including the assessment of gender identity disorder (GID; American Psychiatric Association, 2000) for clients who are seeking medical referrals for hormone replacement therapies (HRTs) and sexual reassignment surgeries (SRSs). Relational-cultural theory (RCT), a feminist model (Jordan, Surrey, & Kaplan, 1991) that has evolved to address racism (Walker, 2004) and transphobia (Patton, 2009) as social justice concerns, provides a theoretical structure to carry out the principles and aims of the *Competencies for Counseling with Transgender Clients* (ACA, 2009).

RCT scholars and practitioners have worked to refocus problems of living from a diagnostic, stigmatizing framework to a strengths-based model. In doing so, a RCT conceptualization places emphasis on the effects of marginalizing forces that serve to block people from accessing growth-fostering connections. What have traditionally been seen as mental health disorders are more appropriately considered to be manifestations of disconnections that occur through broader forces of social stratification and opprobrium (Jordan et al., 1991; Walker, 2004). Applying RCT principles to counseling transgender clients results in a focus on the inherent problems associated with diagnosing as disordered the lived experiences of gender migration and fluidity (Patton, 2009; Reicherzer, 2006). RCT seeks to reconceptualize the concept of GID as movement toward gender congruity (Patton, 2009). This effort presents a challenge in that the World Professional Association of Transgender Health *Standards of Care* (Meyer et al., 2001) recommended that a diagnosis of GID is to be made by a mental health professional for transgender women and men who wish to begin HRT. Two letters are recommended for those who are seeking SRSs. Thus, RCT practitioners are faced with the task of supporting clients through the medical assessment process by engaging medical language in describing the client, all the while maintaining focus on the issues of social justice that affect the client experience.

This practice-based article describes our use of RCT in a year-long counseling journey with a client for whom we will use the alias "Kate," a transsexual woman of color who made her living as a sex worker, and who had experienced severe abuse as a child and adult. In addition, we demonstrate the application of the *Competencies for Counseling with Transgender Clients* (ACA, 2009) in our work. Kate's vocation as a sex worker and complex histories of abuse and poverty created barriers in her ability to authentically represent herself in seeking a GID assessment and medical referral. Jason (first author) was Kate's counselor in weekly individual work. Stacee (second author) was Jason's professional mentor who consulted with him weekly on the case. Consultation is a practice recommended by the *Competencies for Counseling with Transgender Clients* (ACA, 2009; Helping Relationships Competency C.11, Professional Orientation Competency E.5). Kate graciously agreed to allow us to share her story for this article. Our purpose in doing so is that we wish to demonstrate the value of RCT, with its focus in social

justice–oriented counseling work, as a model for addressing the needs of transgender women with extremely marginalized backgrounds like that of Kate.

As an important caveat in describing our use of language, we use the term *transgender* throughout this document to refer to Kate's experience of having considered herself to be female throughout her life. She considered herself to be "transsexual" as a result of the transitioning process. This is a widely accepted format for the use of this terminology (Patton, 2009; Reicherzer, 2006).

Empowerment of clients with histories of marginalization has been a developing focus for the counseling profession. The Association for Multicultural Counseling and Development's (AMCD) Multicultural Counseling Competencies (Arredondo et al., 1996) represented an early effort to address experiences of racism for the counselor and the client. Similarly, the ACA *Advocacy Competencies* (Lewis, Arnold, House, & Toporek, 2003) have called upon counselors to identify and address socioenvironmental factors that impede clients' abilities to meet basic needs, such as human service or medical entities that deter client wellness and progress. Following in this tradition of mobilizing counselors to address issues affecting disempowered client communities, the *Competencies for Counseling with Transgender Clients* (ACA, 2009) provide specificity for counselors so that they can remove barriers and advance the welfare for transgender persons.

Clarity in the developmental impact of marginalization is a central emphasis in RCT, as is the active process of removing social barriers to clients who experience social mistreatment (Walker, 2004). RCT scholars posit (Miller & Stiver, 1997) that growth-fostering relationships are the building blocks of human wellness, and thus the means through which healing, worth, and competence take place in counseling. By providing a context of intense caring that promotes wellness and clarity through a healthy mutual witnessing between the counselor and client, the counseling relationship gives the client necessary skills to create and sustain other growth-fostering connections. The client may also choose to practice what Miller and Stiver (1997) identify as a disconnection, in which she or he withdraws at times that feel most vulnerable. Disconnections occur when the client purposefully removes herself or himself from authentic connections with the counselor to feel safer and less vulnerable (e.g., infusing humor, changing a subject, or minimizing an experience to move away from feeling a moment of particular intensity). These strategies of disconnection (Jordan et al., 1991) are a valuable source of insight for the counselor and the client to observe together as they help clarify the client's choice-making and resilience strategies in determining how and what to share (Walker, 2004).

Counselor genuineness and the use of compassionate and intentionally focused radical respect (Zeedyk & Greenwood, 2008) around moments of disconnection help support the client to choose when and how she or he

moves back into connection with the counselor. RCT counselors recognize that although a client is temporarily moving out of a moment of connection, the desire to again feel intensely heard and cared about in sharing vulnerable elements of the client's life will bring the client back into connection. As a continuing relational cycle, the counseling journey, according to RCT, moves progressively to support the client through the most vulnerable components of the client's journey, allowing sustained personal growth and clarity.

Disconnections also occur as broader social forces that inhibit clients' abilities to trust their own worthiness to participate in relationships (Walker, 2004). For clients whose histories include extreme abuse, either within a smaller family unit or within a broader societal form of oppression, there is a tendency to not trust feelings of connection that occur within the counseling relationship. Our observation of counseling work with transgender women is that there have often been such extreme forms of social mistreatment that include overt hostility, exploitation, and multiple forms of discrimination leveraged against them that these women find it difficult to trust others, particularly people who gatekeep services needed for their gender transitions. Transgender clients may experience barriers to authenticity when seeking assessment letters (Patton, 2009; Reicherzer, 2006), often presenting what they believe counselors need to hear to determine readiness for HRTs or SRSs. As Namaste (2000) explained in discussing transsexuals' access of assessment services, "They analyze the case studies and theoretical positions of prominent psychiatrists so that they can enter the clinical setting, present the 'classic' transsexual narrative, and receive the health care and medical technology they desire" (p. 192).

Clients' choices to present without authenticity are often driven by lack of faith in counselors' abilities to provide transpositive client services (Carroll, Gilroy, & Ryan, 2002). In Reicherzer's (2006) grounded theory of transgender experiences in counseling, participant Lanelle, in describing preparations she was making for the assessment to undergo SRS, identified her expectation that the counselor would try to play "head games" (p. 228) to convince her not to have surgery. Another of Reicherzer's participants, Baia, illustrated this ambivalence further: "I'm having to follow the rules established by somebody else to correct something which is fundamentally my possession, which is my gender identity" (pp. 171–172).

Very little evidence-based research or clinical case reporting exists to guide counselors in assessment work with transgender clients who have particularly traumatic histories, or who are employed as sex workers. Information that exists on transsexual sex workers has primarily focused on risk factors associated with HIV and AIDS, depression, and substance abuse (Sevelius, Grinstead Reznick, Hart, & Schwarcz, 2009), or socioeconomic barriers that prevent these women from being served by any types of health care or counseling service (Sanchez, Sanchez, & Danoff, 2009). In our work with Kate, we had to rely primarily on our clinical experiences in work with the

transgender community, and our personal acquaintances with transgender sex workers.

OUR STORY WITH KATE

Prior to our work with Kate, we have spent innumerable hours annotating our lives, our genders (Helping Relationships Competency C.2), our preconceived notions of how transpersons present (G.7), and how we might best meet these clients' needs (Professional Orientation Competency E.4, Appraisal Competency G.13). For instance, Stacee, the second author, discusses how as a transsexual woman she is frequently solicited by men who anticipate that she is a sex worker, even when she is dressed in conservative office apparel. A significant component of our relationship has been in recognizing how this is a challenge not shared by both of us. Our journey with Kate began with an understanding that she was seeking a letter recommending medical evaluation for HRT to begin her gender transition. Like many transgender persons (Patton, 2009), Kate came to counseling with an initial "best foot forward" presentation, in which she had always solely described her life as a woman in the wrong body.

Kate's History

Kate was at first reluctant to share much of her history, particularly in written format, so her intake paperwork was notably sparse. She wrote "No problems" instead of answering the extensive list of questions, which we have found to be typical for transgender clients who are afraid that divulging life problems might preclude their consideration of readiness for a hormone letter. Much of what would normally be known to counselors prior to or during an initial consultation was learned through numerous sessions with concerted effort on developing a relationship and building trust with Kate.

Kate grew up in a single-parent household under the care of her mother, with whom she had lived until she was about age 16 years. She had two sisters whom she felt received the bulk of their mother's positive attention in childhood. Kate attributed her mother's neglect to herself and her own inferiority. Much of the time, Kate and her sisters were left to look after one another, as their mother would be gone for days at a time. Kate's sense was that her mother spent this time drinking, using substances, and spending time with lovers. The children were disinclined to speak up about her absence, as their mother was prone to rage. Kate reported that she had a small number of friends; it was difficult for her to trust others.

Kate was forced to find employment from an early age. After this time, her mother vacillated between being unenthusiastic and discouraging of any

attempts to continue her education. Kate saw this as a limiting factor in her life. After convincing her to drop out of school, Kate's mother permanently kicked her out of the house in reaction to Kate's feminine presentation. Kate had difficulty finding shelter during that time but had a vivid recollection of a woman who noticed her tattered clothing as she slept on a bench at the bus station. The woman benevolently offered to buy her clothing and offered her a place to stay for week while she made other arrangements. Kate soon landed her first job and received public assistance for a period while staying with various friends. A number of years went by before Kate made the choice to permanently move away from her family; she acknowledged conflicting feelings of love and commitment that she experienced for her mother and sisters. Upon moving, she felt freer to express herself and pursue personal interests without admonition.

Prior to our work together, the only psychological and psychotherapeutic interventions in which Kate had participated were focused on depression with concomitant suicidality. This had occurred at a time before she had begun living with gender congruence. She had been reluctant to share anything about her gender experience with these doctors, as she believed they would associate this with her mood disorder. Instead, she shared with these doctors some information pertaining to her childhood. As she explained to Jason, these doctors did not foster enough trust for Kate to share any elements of her transgender identity, believing, as she stated, "They wouldn't get it."

By the time she began her work with Jason, Kate had begun living outwardly as a woman most of the time. Kate's sole presenting concern was her intent to receive a letter of diagnosis for GID. She indicated that she would do whatever it took to receive this letter. As such, she was aware that some level of psychotherapy would be involved in the process.

RCT Case Conceptualization

Kate's history with her mother had led to an experience of profound disruption to what RCT conceptualizes as her own "relational competence." In other words, she learned to doubt her abilities to exist in and carry out meaningful relationships (Jordan et al., 1991). Significantly, Kate had very few close bonds in childhood and adolescence except for those with her sisters and select others. This challenge to creating connections continued into adulthood, making it difficult for Kate to trust her previous doctors or Jason. Although she had been deprived of much formal education, she had clearly learned important survival skills in her early childhood experiences with her sisters and the self-sufficiency required of her early adolescence.

Very little could be determined at the earliest points of counseling with Kate, but the history she presented of extreme, long-term disconnections in her family led us to conclude that she was experiencing what RCT

scholars Miller and Stiver (1997) term *condemned isolation,* in which a pattern of disconnection leads a person to believe that she or he is unworthy and incapable of growth-fostering connections. The enduring, subjugating dynamics in Kate's life led her to believe that her humanity had been called into question. Through her previous experiences with mental health professionals, she had been able to identify that her depressive symptoms were at least partially related to these early experiences in life. Thus, Kate held some clarity on the impact that relational loss had presented for her. She attributed much of this loss to her limited education and history of childhood neglect; this was further associated with later accounts of abuse from her family members and others, and mistreatment from the medical community. As Kate progressively began to live with greater gender congruence, these problems in living manifested as an exponential form of transphobia, racism, and classism. Whereas Kate had previously experienced social oppression as an economically marginalized feminine male of color, her decision to live with congruence served to deepen the dimensions of opprobrium in her life (Social and Cultural Foundations Competency B. 5–6; ACA, 2009).

To ameliorate these effects, the treatment plan devised by us placed significant focus on identifying the sources of strength and resilience in Kate's life. A number of these were validated in this process, including her commitment to fostering her spiritual self, and acknowledging the power of enduring relationships with her sisters and their children. Our treatment plan also included behavioral tracking and means for quantifying distress in times when Kate felt incapacitated by depressive symptoms and potential suicidality. An emerging, process-oriented conceptualization of Kate's case reflects the unfolding and increasing self-disclosure that occurred in her relationship with Jason.

Reflecting on the RCT Counseling Journey

Kate completed her initial phone intake in a way that reflected the continued legacy of the medical and mental health community's participation in the stigmatization and pathologization of transpersons (Helping Relationships Competency C.8, Professional Orientation Competency E.1; ACA, 2009). She not only indicated a lifelong, wholly-female identification, she also clearly stated that she had "no issues, [she] just [needed] a hormone letter."

As Kate and Jason sat together for the first session, a number of points of difference and potential inequity were readily apparent. Jason noticed that she was fully unsighted in one eye, had mobility challenges with her right leg, and was out of breath from walking to the clinic. Jason wanted to make conscious effort to connect, to respond to the differences of power between the two of them: ethnicity (Jason is White), physical ability,

ostensible gender conformity, socioeconomic status, and level of education. They acknowledged these and other differences of valance during this session.

As the conversation continued, Kate and Jason became increasingly comfortable. Of note, Kate never removed her knapsack from her lap. Jason noticed that she held it protectively before her, a physical representation of the emotional barriers to connection that would later be recognized. As a result of this, Jason felt compelled to spend time reflecting on the need for Kate to feel safe in the room, and do so quickly because of the risk that her lack of safety might lead to her decision not to return to counseling. Jason recognized that barriers to authenticity and connection occur in relationships during which the counselor and client physically present as different genders (Patton, 2009). This led him to reflect with Kate on the real-world challenges to authenticity that she was experiencing in setting out on the counseling journey. Kate and Jason concluded the first session with her reiteration that she was fully prepared to start a process of body migration, beginning with HRT, through fruition with SRS (Professional Orientation Competency E.3, Appraisal Competency G.1; ACA, 2009).

Kate's second session began with a generally more relaxed feel. Jason commented to Kate that it felt like something seemed to have "shifted" since the last session. Kate said she had spent the previous week mulling over her first counseling session, and that it was "different" than she had imagined. She had explored her preconceptions of the counseling process. Jason received this as an invitation to disclose his mixed emotions about being a gatekeeper, in which counselors hold significant power in the function of assessing HRT readiness (Appraisal Competency G.4; ACA, 2009). This led Jason to express his reverence for the trusted position of opening doors, as well as discomfort with being perceived as one who might not be willing to do so. This vulnerable self-disclosure invited Kate's own vulnerability, exemplifying an effort to support the mutuality espoused by RCT.

"Momma used to beat the shit outta [sic] me," Kate said with bitter and fast tears. As Jason's own eyes watered in joining response, Kate moved to lift her sleeves, revealing scars from being abused. She came to realize that she had "touched [Jason's] tears on another plane," an acknowledgement from her spiritual understanding that she was being heard and understood by Jason. Jason named that his tearful response came from his place of transformative respect and awe for Kate's resilience in moving through this deeply hurtful journey. This was, for both of them, an experience that RCT scholars (Miller & Stiver, 1997) conceptualize as mutual empathy, in which the counselor and the client are moved by the emotional and visceral impact that each has on the other. Rather than removing himself emotionally from the experience in an effort to recompose or otherwise appear "in charge" or "pulled together," Jason endeavored to bring himself more fully into the relationship by being free enough to show an exposing, genuine emotional

response. This shared vulnerability brought Kate and Jason further into connection.

Kate began to discover that the abuse she had experienced was a result of her mother's transphobic belief that she was "possessed," because of her "girly" behavior. As we explored Kate's disclosures in the following consultation session, we had a shared sense of kinship with Kate that was embedded in our awareness that people act, sometimes violently, out of transphobia. When Jason took this awareness and acknowledgement back to Kate (Social and Cultural Foundations Competency B.3; ACA, 2009), Kate responded with what seemed momentarily to be stoicism, or at least nonresponse. Jason quickly learned that she was actually integrating and processing information that would later transform her perceptions.

"I hadn't thought about it, but I guess it's people's fears that almost killed me," Kate said after minutes of silence. She went on to explain that a man had attacked her in her apartment a couple of years prior to Jason's work with Kate; this man had hit her repeatedly about the head, neck, and back with a brass lamp, leaving her for dead. Kate had survived this physical assault but had some deterioration in brain and physical functioning. Again, Jason allowed himself to be affected by her words, practicing counselor authenticity. This brought Kate and Jason further into awareness of unacknowledged, and for Kate, inwardly focused outrage over the impact of transphobia.

A major disconnection between Kate and Jason in counseling occurred, however, shortly thereafter. Jason and Kate agreed that they were going to process the hate crime trauma to initiate her healing. However, when Kate asked if it was possible that her injuries would "do something to [her] brain and force [her] to transition," Jason advised that he and Kate needed to seek neurological consultation. Although Jason recognized neurological impairment would not be a feature in recognizing the necessity of a gender transition, Jason did want to assure that Kate's neurological reasoning capability had not been compromised. When we consulted following the session, we agreed that there was a need to clarify that Kate had full ability to reason through the task and consequences of medical interventions for gender transitioning. Our goal was to work toward supporting Kate in her abilities to make reasonable decisions, in alignment with Appraisal Competency G.2 (ACA, 2009), which encourages counselors to "identify challenges which may inhibit desired treatment" (p. 15). Jason also wanted Kate to know that even though they needed to take this step, it would not necessarily preclude her from beginning HRT. This is supported by Appraisal Competency G.16 (ACA, 2009), which provides recommendations for communicating the need for stabilization as a compliment of, but not necessarily contraindication to, continuing the assessment process.

Kate was understandably upset because she believed that revealing her physical trauma and related fears of how the trauma affected her decision

making may have created an additional roadblock for her. She elucidated that it seemed as if the hurdles that she had anticipated were coming true. Kate left with a commitment to come back to another session but was unhappy with this turn of events. When we consulted, we lamented the situation. We wanted to support her and her wishes, and yet we also felt we had an ethical responsibility to make sure that she was prepared for all of the many changes that would lie ahead and had the neurological functioning required to make these decisions. This ethical awareness was in accordance with the World Professional Association of Transgender Health *Standards of Care* (Meyer, et al., 2001) and the *Competencies for Counseling with Transgender Clients* (ACA, 2009). Further, our decision operated from a relational concern that we were providing a responsible counseling relationship to Kate, recognizing that not only did we need to do this to manage the real-world issue of liability that counselors hold as gatekeepers, but that knowledge of Kate's neurological ability would be necessary for her long-term health and wellness self-care.

In the next session, as Kate sat again with her knapsack securely in her lap, she and Jason discussed how the last session had ended. Jason expressed how unpleasant it had been to create a perceived barrier. Eventually, Kate came to express her understanding that Jason was doing his best to support her, even if it felt like she was being derailed. We identified that the Department of Rehabilitative Services (DARS) would be able to coordinate the neurological assessment needed. This decision was consistent with the *Competencies for Counseling with Transgender Clients*' (ACA, 2009) recommendation that counselors assist clients to access community resources (Professional Orientation Competency E.6), and work with medical professionals to provide wraparound care offered to transgender persons (Professional Orientation Competency E.12; ACA, 2009). Upon receiving approval from Kate, Jason spoke with her case worker at DARS and cleared up confusion related to Kate's gender presentation versus legal documentation, consistent with Professional Orientation Competency E.7's emphasis on addressing barriers that clients encounter as a result of incongruence between their gender presentations and legal documents. Kate followed through with DARS's recommendations, found that her complex reasoning had not been adversely affected, and was provided additional supportive career and health services. She was profoundly relieved and ultimately thankful for the referral.

Kate and Jason were brought closer by moving through this disconnection. In their increased confidence, she told him that sometimes she felt like the attack had been her fault. She informed Jason that the event had occurred when she had met the attacker and invited him into her home in the context of sex work. Jason could tell that she was intently tracking his reaction to this disclosure. More than shock, he experienced a sense of profound connection that she felt safe enough to share this with him. Kate and Jason explored her history of sex work, pondering, in accordance with the *Competencies for Counseling with Transgender Clients* (ACA, 2009), whether

she believed that this was all that was available to her (Career and Lifestyle Development Competency F.4). With Jason's radically respectful response, her tone and expression changed dramatically. She was freer in discussing matters that had not been explored before. For example, she said in felt camaraderie, "Girl, you know I love it. Sure I was stupid to take a man and not tell him I was hiding my candy (that she had male genitalia). But you know what? (conspiratorially) . . . *I wouldn't do anything else even if this paid half as much* [emphasis added]." Jason worked to clarify Kate's knowledge of safer sex practices and acknowledged with her the higher rate of HIV among transgender women, consistent with Social and Cultural Foundation Competency B.7 (ACA, 2009). However, and most fundamentally to his work with Kate, he supported her right to self-determine her vocational choice and own the choices she made for her body.

The rest of the counseling journey was equally rich and complex with additional stories of resilience shared that resulted in Jason's affirmation of Kate's relational worth. As Kate grew in her ability to trust Jason in sharing even the most vulnerable details of her life, she developed awareness that her life had meaning and impact on Jason as her counselor. At all times, Jason worked to uphold RCT principles of radical respect and keeping the connection, honestly naming the natural moments that felt less truthful or authentic. There were a few of these minor disconnections, like when she asked Jason to attend services with her at her place of worship and he respectfully declined, citing the counseling contract. They moved through these disconnections, continuing to grow in connection. Jason noticed the importance of her spiritual beliefs, as she incorporated Buddhism, psychic traditions that had been practiced in her family (foretelling, teleology), and a personal understanding of metaphysics and interconnection. Her spiritual identity had emerged after a series of transphobic interactions with other spiritual institutions. An example of this occurred when she received housing and living assistance from a protestant church that was contingent upon attending services; she was hurt and "shamed" during these services because of frequent sermons that maligned and condemned transgender persons. This kind of negative interaction with a religious institution is an experience that many transgender individuals share, as noted in the *Competencies for Counseling with Transgender Clients* (Social and Cultural Foundations Competency B.12; ACA, 2009).

Jason also came to understand that Kate's familial and cultural background gave her language that might have been otherwise misassessed as comorbidly occurring conditions. For example, she often spoke of herself in the third person, saying "I'm in touch with Katie today." Katie was not an alter emanating from an underlying dissociative identity disorder (APA, 2000) but was the childlike and free part of herself that more fully emerged during the course of their work. Kate's mother had used similar language when she was "feeling her oats," experiencing a similar ability to be open and

unreserved. Through our consultation, Jason was able to consider how his own experiences have provided a limited perspective on the world, and had he generally not worked to "be with" his client, he would not have likely recommended her for HRT treatment for these and other reasons. Jason's reflective awareness is addressed in the *Competencies for Counseling with Transgender Clients* (Appraisal Competency G.7; ACA, 2009), which identify the need for counselors to be aware of their own cultural perspectives that may limit or inhibit their abilities to recognize their clients' worldviews.

At the conclusion of counseling, Kate shared that she felt supported by Jason as her counselor. She received the letter she wanted and started HRT after 3 months of counseling. The remainder of Kate and Jason's work together was focused on supporting her movement through the gender transitioning process and creating growth-fostering relationships. During this time, she felt progressively more confident. Kate opted to take some career-related classes that were offered to her by DARS, but she again told Jason in playfully hushed tones, "I'm still gonna trick on the sides, just for the hell of it!" At her wish, Kate left counseling with the anticipation of recommitting to therapy at some point in the future.

IMPLICATIONS FOR CLINICAL PRACTICE AND FUTURE RESEARCH

Our work with Kate taught us valuable lessons in guiding clinical practice with transgender clients. These include

- the assessment process for GID may be the only period during which a transgender client seeks the services of a professional counselor
- transgender clients living experiences of condemned isolation and severe trauma may feel even greater pressure to present a "best foot forward" in approaching counselors for assessments
- trauma work should consistently be approached from an model that supports the client's disclosure at a time and pace that maintains the client's boundaries and mental wellness
- vulnerability invites vulnerability in counseling. For instance, Jason's ability to freely express his emotions in response to Kate's story of surviving a hate crime brought them closer together, resulting in her willingness to share increasingly risky and painful elements of her life
- counselors who work with transgender clients need to be prepared to advocate for their clients' care and anticipate institutionalized unfair practices from other agencies who lack transgender awareness
- *radical respect* implies that we dismantle our "hang-ups" with preconceived notions of issues such as sex work in our movement toward support without conditions

- transgender clients who have experienced multiple life difficulties like those of Kate should be recognized and celebrated as resilient, rather than pathologized according to perceived deficiencies
- continued mentorship and consultation, even for seasoned counselors who are well experienced in work with transgender clients, supports the counselor and the client.

Additional scholarly research and clinical examples demonstrating the use of RCT in work with a variety of transgender persons, including non-English native speakers, people with severely debilitating problems in living (such as schizophrenia or dissociative disorders), and those with significant intellectual impairments are necessary. The authors also identify a need for qualitative research that examines the precise points of connection and disconnection in RCT counseling with transgender sex workers, which would help establish a greater understanding of the most vulnerable aspects of disclosure. In addition, studies are needed that build upon Reicherzer's (2006) study of transgender perceptions of the assessment process using large and diverse samples that include cross-sections of the transgender community, specifically including those in poverty, transpersons of color, trauma survivors, and transpersons with disabilities. Finally, more research is needed that examines transgender resilience from a strength-based perspective, identifying choices to survive and thrive in the face of social adversity.

CONCLUSION

Our work represented growth-fostering relationships for not only Kate, but also for us. As the counselors who were responsible for Kate's care, we found within ourselves great respect for the humbling responsibility she gave us, and certainly for her trust in sharing intensely vulnerable personal material. We discovered that RCT is extremely well developed for not only addressing the *Counseling Competencies for Work with Transgender Clients* (ACA, 2009), but also in fostering our own development for joining clients.

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