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Psychotherapist Understanding of Genital Self-Mutilation Amongst Male to Female Transsexuals

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LOYOLA UNIVERSITY CHICAGO

PSYCHOTHERAPIST UNDERSTANDING OF GENITAL SELF-MUTILATION AMONGST
MALE TO FEMALE TRANSEXUALS

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIAL WORK

BY

MICHAEL KENNEY

CHICAGO, IL

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ABSTRACT

Self-mutilation of the genitals is a complex phenomenon that can provoke strong countertransference reactions amongst mental health clinician. Transsexuals who engage in self-inflicted mutilation of the genitals face a potentially increased risk of alienation from healthcare providers due to marginalization and lack of understanding by treating clinicians. Frequently, assumptions are made regarding the motivation for the behavior that fails to take into account the complex interplay between contributing psychological, social, and environmental forces.

This qualitative study explored the experience of four psychotherapists who had encountered the behavior in their work with transsexual clients in order to gain a more accurate picture of how psychotherapists understand the phenomenon. Participating psychotherapists engaged in semi-structured interviews which were transcribed and analyzed utilizing an interpretative phenomenological theoretical framework.

Data analysis revealed nine emergent essential themes. These themes were mapped onto the domains of therapist activity inherent in the interaction with the phenomenon. Within the domain of conceptualization, therapists understood the manifestation of the behavior as connected to the client experience of psychological pressure, constraints on the client sense of agency, and attempts to protect the self of the client through action. Within the domain of treatment, concepts shaping the

interventions of the therapists included affirming female gender identity, mediating the vulnerability associated with the client coming out process, and using safety planning to promote the client's self-reflective capacity. Within the domain of the impact of the phenomenon on the self of the therapist, relevant themes included the therapist's experience of countertransference as a parallel process to the client's experience, the therapist's desire to engage in competent practice in the context of emotional stress, and active coping on the part of the therapist to manage personal and professional challenges associated with treating clients who engaged in genital self-mutilation. The author concludes the investigation with relevant clinical recommendations to assist clinical social workers and psychotherapists in competently assessing and intervening with this behavior amongst this population.

CHAPTER I

INTRODUCTION

The object of study of this research is to explore the experience of psychotherapists working with individuals who exhibit the behavior of genital self-mutilation. More specifically, this research provides an in depth account of mental constructs mediating the participating psychotherapists' understanding and interaction with male to female transsexual clients who engage in this behavior. As readers will observe, the psychotherapists interviewed for this study worked with vulnerable clients; their description of their clients' struggles depict the challenges clients coped with as they navigated a transphobic culture which taxed the clients ability to function emotionally and within their social environment. While the research focuses on the psychotherapists' perspective of their encounters with their clients, the concepts which undergird and influence the psychotherapists' professional knowledge and actions with their clients must be examined. This is so as to better understand how the therapists construct their views of the phenomenon of genital self-mutilation amongst male to female transsexuals. Influences on the meaning making process regarding this phenomenon apparent in the psychotherapists' conversations with the researcher include the cultural construction of gender and the category of the transsexual, discriminatory and oppressive practices within the healthcare system, ideas related to

the ethical practice of psychotherapy with self-harming clients and psychological theories of assessment and intervention with transsexual clients.

As the aforementioned influences represent complex sets of ideas, it is important that the reader be able to grasp the sometimes technical language the psychotherapists utilized in order to fully understand their perspective and so as to be able to critically evaluate the conclusions generated by this research project. To this end, this document will be structured so as to provide the readers with some sense of context regarding the available knowledge on the subject of genital self-mutilation amongst male to female transsexuals. Additionally, a discussion regarding how gaps in the available knowledge pose dilemmas for clinical social workers and/or psychotherapists in their attempts to serve an oppressed population of clients will offer the reader further background relevant to understanding the meaning making process of the psychotherapists who elected to participate in this study. Again, the goal in providing such background information is to enable the reader to fully participate in assessing the dialogue that occurred with the research participants and the quality of the conclusions generated from those dialogues.

This chapter begins by exploring the problem that inadequate professional knowledge of the phenomenon of genital self mutilation amongst male to female transsexual clients poses for psychotherapists who seek to serve this population. This leads into a discussion of factors relevant to the psychotherapeutic treatment of such clients including social oppression of transsexual individuals which contribute to the

threat of inadequate access to competent healthcare services. Additionally, issues such as the need for the clinician to manage reactionary feelings to the behavior of genital self-mutilation and the lack of an in depth understanding of the phenomenon from a social work perspective are explored. This leads to the statement of the purpose of this research study, the definition and critical understanding of the terms of the study including controversies regarding the terms transsexual and self-mutilation, and the rationale for the study including the significance of the research for the social work profession. The chapters following the introduction include an in depth literature review, a summary of the methodology of the research study, a description of the findings of the research, and a discussion of the implications of these findings for clinical social work practice.

Statement of the Problem

Clinical Social Workers strive to understand the context, motivation and consequences of various client behaviors through the course of the professional relationship with the client. One behavioral phenomenon that challenges the worker to understand the client's suffering in depth is that of self-mutilation. The behavior of self-mutilation may manifest in various forms and intensities ranging from superficial cuts or burns of the arms or legs with minimal injury to the individual to more severe forms such as head banging or self-enucleation resulting in organ damage or the risk of death (Favazza, 2011; Walsh & Rosen, 1988). As the form of self-mutilation varies, so too does the correlated client population in which the phenomenon is typically observed.

For example, self-enucleation is associated in the professional literature with individuals who were assessed to be psychotic at the time of the injury (Briere & Gil, 1998).

One observed form of mutilation involves self-inflicted damage to the genital region. While the literature reports this type of behavior to be a rare phenomenon (Briere & Gil, 1998; Eke 2000), it has been associated with distinct clinical populations and is more frequently observed in males than females (Favazza, 2011). Observed injuries in biological males vary from needles or sharp objects inserted into the urethra or meatus of the penis, tying bands around the testicles to constrict blood flow, to attempted self-castration and attempted autopenectomy (Eke, 2000).

According to the existent professional peer reviewed literature regarding this phenomenon, the clinical populations associated with self genital mutilation include individuals coping with thought disorders, individuals who were intoxicated at the time of injury, and individuals labeled as male to female transsexuals (Greilshheimer & Groves, 1979; Young & Feinsilver, 1986). Given the diversity of clients who might engage in such behavior, it is possible that Clinical Social Workers may encounter this phenomenon within their efforts to provide mental health treatment to such populations. As such, an informed understanding of the biopsychosocial implications of such behavior becomes paramount to the clinician in performing competent assessment and intervention.

Social Oppression and the Transsexual Individual

Of the aforementioned clinical populations, *some* transsexual individuals experience significant social oppression (Lev, 2004). While it is important not to

generalize assumptions about any population to the individual, it is essential to be mindful of the consequences of social marginalization on the quality of life for the individual who is the target of stigma. Labels may be one means of perpetuating oppression of a minority, particularly if they are imposed from outside the perspective of the individual human being. The label “transsexual” in and of itself has generated controversy. Some view it as a medical construct that imposes and upholds patriarchal assumptions of gender on the individual. Others see it as an identity that describes the challenge of an individual’s drive to express a deep felt sense of gender that is experienced as a quest for self-definition (Coolhart, Provancher, Hager, & Wang, 2008; Goldner, 2011). The term transsexual will be further explored and explicitly defined in the subsequent definition of terms section of this proposal.

Some transsexual individuals cope with discrimination, violence, and difficulty accessing healthcare professionals with adequate training and sensitivity to transsexual identity (Kenagy & Bostwick, 2005). Additionally, institutionalized healthcare practices, such as the construction of the psychiatric diagnosis Gender Identity Disorder within the Diagnostic and Statistical Manual of Mental Illness (Winters, 2005) and the prerequisites necessary to obtain hormone treatment or gender confirmation surgery [World Professional Association for Transgender Health (WPATH), 2011] can impact the transsexual individual in an adversarial manner, breeding distrust of the mental health profession in general (Lev, 2009). Given that clinicians utilize standard practices such as diagnosing using the DSM or relying on the *Standards of Care* as a potential template to

guide their understanding and intervention with a transsexual client, it is important that the assumptions of these documents be scrutinized so as to be mindful of the impact on both the client and the clinician.

Oppressive Assumptions Influencing Healthcare Workers Regarding Transsexuals

The inclusion of the diagnosis of “Gender Identity Disorder” within the DSM-IV generates controversy in that the construct has been questioned with regards to both its validity and its perpetuation of stigma around diverse gender expression (Ault & Brzuzy, 2009; Corneil, Eisfeld, & Boster, 2010; Winters, 2005). Some advocates argue that the DSM’s inclusion of gender variance as a diagnosis not only contradicts its own definition of mental illness (i.e., mental disorder cannot be defined by deviant political, religious or sexual behavior or conflict between individual and society), but that the construct bears similarity to inclusion of the diagnosis of homosexuality within previous editions of the DSM. It is argued that the diagnosis pathologizes an identity that can be experienced by the individual without distress and is based on rigid, heterosexist definitions of normal “male” vs. “female” roles and behavior (Ault & Brzuzy, 2009).

Rather than a continuum of gender expression, the DSM diagnosis establishes the “naturalness” of two exclusive genders, male and female. This reinforces the binary assumption of gender undergirding the diagnosis and disallows for a multiplicity of gender expressive behaviors (Butler, 2006). Thus, instead of postulating a continuum of gender expression, gender identity is rigidly dichotomized within this document

(*Professionals Concerned with Gender Diagnoses in the DSM*, retrieved from <http://gidconcern.wordpress.com>, 6/7/11).

Other criticisms of the DSM's construction of the diagnosis of Gender Identity Disorder include the argument that the diagnosis lacks specificity and is heavily influenced by stereotypical notions of gender rather than being based on scientific criteria. As such individuals who are not gender dysphoric but who eschew "traditional" gender norms qualify for some of the diagnostic criteria as they are currently written (Winters, 2005). Some authors believe that the diagnosis represents a thinly veiled attempt to justify a means of pathologizing children and adolescents, particularly gay and lesbian adolescents, when they fail to conform to rigid definitions of what constitutes a man's behavior or woman's behavior (Lev, 2004; Winters, 2005). Additionally, the diagnostic criteria have been criticized for being more focused on regulating cross gender preferences or behavior of boys rather than girls, perpetuating a preoccupation with rigid definitions of masculinity (Goldner, 2010).

Thus, some advocates argue that the necessity of obtaining a diagnosis of gender identity disorder in order to qualify for hormone treatment or gender reassignment surgery places both the transsexual and the evaluating clinician in a double bind where access to treatment is obtained through labeling an individual's psychological identity as "disordered" (Ault & Brzuzy, 2009; Hill, 2005; Lev, 2009).

Additionally, the *Standards of Care*, published by the World Professional Association for Transgender Health (WPATH), is the document that frames "best

practice” with the transsexual client. This document assumes that a transsexual client will benefit from undergoing a mental health evaluation with a psychotherapist in order to determine if the criteria of “eligibility” and “readiness” have been met so as to obtain authorization to pursue body modification in the form of hormone treatment or gender reassignment surgery (WPATH, 2011). While the intent may be to assist the transsexual client to obtain adequate, ethical medical care, the question arises as to why the transsexual individual is subjected to the scrutinizing gaze of the mental health professional. This practice places the mental health professional in the role of “gatekeeper” for the transsexual client with regards to access to treatment rather than promoting the role of the psychotherapist.

According to current DSM criteria, the transsexual must be labeled mentally ill (diagnosed with Gender Identity Disorder) by the treating clinician regardless even when there are no significant features of psychological disturbance so as to gain necessary medical treatment (Winters, 2005). From a systems perspective, the healthcare professional is in some ways reliant upon the diagnosis of Gender Identity Disorder so as to justify medical or psychological intervention and to be able to receive payment for services rendered.

The transsexual client must be diagnosed with Gender Identity Disorder for the purpose of legitimating hormonal or surgical intervention to pursue body modification. While diagnosis might facilitate communication amongst helping professionals, it is unclear whether it empowers the transsexual individual. A medicalized understanding

of the complexity of the individual often reduces a whole person to a pathological description which then limits how others view the individual. Additionally, diagnoses tend to be reified and may resist scrutiny of the population that strives for self-definition. It positions the mental health clinician as the “expert” on the client’s life and may reinforce conflicts within the mental health clinician as they endeavor to treat the client. The medical model on which diagnosis is based is the dominant discursive explanation of all forms of behavior in all settings where diagnosis is made. Its influence is so pervasive that it has been taken for granted as an authoritative and therefore expert position (Crowe, 1996).

To reiterate, assumptions regarding gender contribute to social factors can place the transsexual client and the mental health provider at odds with each other. The clinician may feel a tension between a dual role of the “gatekeeper” who determines the client’s psychological stability and appropriateness to pursue hormonal or surgical interventions versus the therapist who assists the client in their pursuit of self understanding (Lev, 2009). This dual role is largely the result of the guidelines set forth by the *Standards of Care* as best practice which stipulates that the transsexual individual must obtain letters of permission from a therapist in order to begin hormonal or surgical treatment with a physician (WPATH, 2011).

Threats to Receiving Adequate Mental Health Treatment for Transsexual Clients

A client who is interested in obtaining mental health services may be wary of what is perceived as outsider interference in the quest to consolidate one’s identity.

The transsexual client may feel compelled to distort their self-narrative so as to eliminate the possibility of being rejected by the clinician as an unsuitable candidate for surgery. The clinician on the other hand may feel torn by a wish to help the client versus enforcing practice guidelines. Thus, the working alliance between therapist and transsexual client may be tenuous from the start depending on the client's motivations for seeking consultation. Again, given these historic tensions between client and clinician, the question arises, how might the behavior of self genital mutilation impact on an already fragile alliance? As clinical social workers rely on the relationship with the client in order to assist the client in enacting change (Saari, 1986), the ethical mandates of the profession demands that attention must be paid to resolving challenges to cultivating a helping relationship with a vulnerable population (NASW code of ethics, 1996).

Bearing this challenge in mind, it should also be noted that some transsexual individuals are at risk of experiencing discrimination and even violence in the larger society. This risk of harm frequently stems from the potential visibility to others when the transsexual individual is perceived as transgressing patriarchal gender norms in the attempt to express their own felt sense of gender (Lev, 2004). This makes it vital that the process of contact with the mental health professional be supportive so as to counteract the denigration of the transsexual identity within the larger society. However, the question arises, are there any particular behaviors in combination with the restrictions both ethical and systemic as well as personal placed upon the mental

health provider that pose a challenge to creating a supportive relationship with a client who identifies as transsexual?

Healthcare Professionals' Reactions to Genital Self Mutilation within this Population:

The Risk of Further Rejection and Stigmatization of Vulnerable Individuals

Within this population, peer reviewed literature describes a small subgroup of male to female transsexual individuals who engage in self-inflicted genital mutilation (Baltieri & Guerra de Andrade, 2005; Brown, 2010; Eke, 2000; Favazza, 1989, 1996; Greilsheimer & Groves, 1979; Haberman & Michael, 1979; McDuffee & Brown, 2010; Mellon, Barlow, Cook, & Clark, 1989; Money & De Priest, 1976; Nakaya, 1996, Young & Feinsilver, 1986). Transsexuals who engage in self-inflicted mutilation of the genitals face a potentially increased risk of alienation from healthcare providers due to the dramatic nature of the injury. Some of the peer reviewed literature describes health care professionals reacting to such a phenomenon with disgust, patronizing curiosity, or hopelessness (Favazza 2011; Greilsheimer & Groves, 1979; Young & Feinsilver, 1986)

While no official estimates of the prevalence of this behavior within this population have been published (McDuffe & Brown, 2010), it should be noted, that this is a small subgroup of individuals and that not all individuals who identify or who are labeled as transsexual engage in such behavior. Nevertheless, it is possible that such a phenomenon might negatively impact a clinician's willingness to work with a transsexual client and may act as a deterrent for the mental health provider in recommending physiological interventions designed to confirm the individual's gender identity.

The Need to Reduce the Risk of Stigmatizing Countertransference Reactions

A heightened risk of potential rejection of the client or obstruction of the development of a helping stance towards the transsexual client by the mental health professional may be dependent on whether the provider views such behavior as a sign of psychopathology or as a failure of the healthcare system to adequately meet the needs of this population (Corneil et al., 2010; Ehrbar & Gorton, 2010). In order to reduce the possibility of estrangement from healthcare providers, a transsexual individual who engages in self genital mutilation would benefit from contact with a mental health clinician who thoroughly understands the intersection between self-harm behavior and the psychological and social pressures inherent to navigating a society that is intolerant of transsexual identity. As self-harm behavior tends to be targeted for therapeutic intervention amongst any population with whom social workers interact, it is important to specify how social workers might go about conceptualizing and enacting such an intervention with this specific population.

Missing Social Work Perspective on the Issue: Inadequate Peer Reviewed Literature

Unfortunately, the literature to date examining the phenomenon of genital mutilation in male to female transsexual individuals does not originate from a Social Work perspective of client empowerment with the aim of the cultivation of a helping relationship between client and clinician. Therefore, the professional literature does not adequately prepare social work clinicians in gaining a deeper understanding of this phenomenon. The existing literature typically depicts the behavior from a medical or

psychiatric perspective, and goals of assessment and intervention are frequently discussed according to the medical paradigm. This viewpoint tends to focus on precipitating events and medical complications arising from the act of self-mutilation and the need to stabilize the patient so as to avoid further health complications (Greilsheimer & Groves, 1979; Haberman, 1979; Murphy, Murphy, & Grainger, 2001; Young & Feinsilver, 1986). While attention to the psychological state of the patient is sometimes discussed, from a social work perspective what is missing is the sense of the individual's relationship to the environment and how this might complicate or contribute to the presenting behavior as well as the constricting assumptions regarding gender that may constrain a sensitive healthcare response to these individuals.

Some of the literature discusses cases in the context of a patient presenting to the emergency room for treatment (Mellon et al., 1989; Murphy et al., 2001; Young & Feinsilver, 1986). The limitations of this type of case discussion include lack of discussion regarding how the patient is supported psychologically and environmentally beyond hospital discharge. Additionally, these articles tend to attribute the behavior to the patient's dissatisfaction with a wait for gender reassignment surgery (Balitieri & Guerra de Andrade, 2005; Murphy et al., 2001). It is possible that the reasons for such behavior might be more complex, for example, ideas concerning what the genitals represent symbolically to the self and others, or a self-medicating attempt at decreasing production of testosterone within the body (Brown, 2010).

This raises the question of how clinicians attribute motivation for this behavior. Regardless of the depicted motivation for the behavior, discussion of how such behavior might impact a previously existing psychotherapeutic relationship with such a client or how such behavior might be addressed in an outpatient psychotherapy that extends beyond crisis management is relatively nonexistent. Additionally, issues of how this behavior might impact a clinician's willingness to work with this type of client, how it might impact potential requests or recommendations for hormone treatment or gender reassignment surgery, and the impact of such behavior on the client's relationships and support network is neglected. These are all potential issues of significance to consider in working with a population that requires an ally and advocate in negotiating relevant systems such as the medical or legal institutions in the effort to establish an identity both physical and social that corresponds to the subjectively felt gender identity. From a social work macro perspective, such issues call for a greater need to reflect on the impact of helping institutions on the individual and to investigate whether reform is called for to minimize undue burdens on this population.

While social workers may certainly be involved in triage assessment of male to female transsexuals who have engaged in genital self-mutilation, limiting the understanding of client behavior to information obtained in an emergency situation obscures the complexity of the phenomenon from a developmental and environmental standpoint. Additionally, it does not promote an understanding of the potential benefit to the client that may be derived from the clinically relevant information that can

emerge in the supportive holding environment that a psychotherapeutic relationship might offer. Finally, it deprives the clinician of process data that might be relevant to understanding the client's psychology, interpersonal relationships and how these might have influenced the behavior in question.

Incomplete Theoretical Foundations for Understanding the Phenomenon

The medical case description approach of this behavior tends to neglect an overarching theoretical foundation relevant to the social work perspective from which to formulate interventions for addressing this behavior. The medical case literature contrasts with a few articles which subsume the behavior under the psychodynamic understanding of gender development and gender dysphoria (Fisch, 1987; Money & De Priest, 1976). While these articles contribute a particular understanding to the psychology of the individuals discussed; it is difficult to generalize these analyses past the cases presented in the service of offering the clinician a comprehensive guide to managing such a phenomenon in an outpatient setting.

Of the published peer review literature, it is evident that many authors neglect the social context influencing the behavior and do not thoroughly explore the systemic factors which might contribute to the expression of the behavior. Possible exceptions include Walsh (2006) and Favazza (2011) whose work will be described in greater detail in the literature review section of this proposal. Social Work clinicians who require support in decision making processes when working with this population should not be limited to referencing the DSM or the WPATH *Standards of Care* as these documents

reflect particular assumptions regarding the nature of gender diversity. Difficulty arises when these documents shape the clinical lens through which the client is viewed. When the therapeutic relationship is jeopardized as a result of an imposed gatekeeper role, or as the client reacts to the potential stigma of psychiatric diagnosis, further reflection on the part of the clinician regarding the social forces at play is necessary.

While an environmental transactional approach or a systems perspective does not necessarily outweigh intrapsychic or interpersonal dynamics in terms of conceptualizing behavior, it is therefore important to discern whether the clinician working with such a population takes environmental factors into consideration in formulating an understanding of the behavior. For example, the cost of medical interventions such as hormone therapy, cosmetic surgery, and gender reassignment surgery to relieve the psychological distress of feelings of gender dysphoria for the transsexual individual can be prohibitive (Lev, 2004). Additionally, the transsexual may not be guaranteed support or legal protection in maintaining current employment or securing employment while undergoing the gender transition process. Rejection by family members and isolation due to lack of a support network are not uncommon to transsexual individuals resulting in further emotional distress for the transitioning individual (Lev, 2004).

The institutional and social marginalization many transsexuals must cope with is relevant to the stress the individual experiences in seeking to confirm and consolidate their psychological identity. Ultimately, the impact of the social work profession's

values with respect to the stance towards the client should be taken into consideration regarding any theoretical formulation put forth as a potential means of understanding client behavior. Environmental vulnerabilities seem highly relevant to any discussion of motivation of behavior for transsexual individuals.

Statement of Purpose of the Proposed Research

In order to better elucidate the complexity of the phenomenon amongst the male to female transsexual population, and to begin to establish a sense of the mental frameworks clinicians rely on in addressing such clients who do engage in self genital mutilation behavior, it might be useful to elicit detailed accounts of the experiences of mental health professionals who regularly have contact with the male to female transsexual population. Thus, the purpose of this study is to pursue and understand the lived experience of mental health clinicians who work with male to female transsexual individuals in the context of a psychotherapeutic relationship who have either revealed thoughts or plans regarding self genital injury, or have engaged in actual self-mutilation of the genitals. Questions being asked include how does the therapist conceptualize the phenomenon from a behavioral, intra psychic and interpersonal perspective? How might the therapist envision the goals of treatment with such an individual? How might the clinician consider such behavior as well as the client's opinions regarding the behavior in the context of establishing a therapeutic alliance? How might a clinician ascertain the likelihood of a successful outcome of treatment in addressing the needs of this particular client and their behavior? How might the clinician's actions and thought

process in working with such a client be influenced by various theoretical understandings of the motivation of such behavior? How might the clinician's actions and thought process be influenced by the client's goals as well as the ethical demands made on the therapist in the context of treating such a client? How might the clinician understand whether the expression of such behavior is influenced by social conditions and how the client adapts to the challenges of their environment? How might the clinician's opinions regarding the process of gender transition be impacted by the experience of working with this type of client?

Definitions and Critical Understanding of Terms

Facilitating a shared understanding of the terminology relevant to this investigation is necessary so as to explicitly limit the parameters of the study sample and to further clarify the phenomenon being investigated. Given that many of the labels or terms used in discussing transsexualism overlap; or have the potential to cause confusion to both the general public and health professionals, terms regularly utilized in the literature and in discourse concerning gender variant behavior and identities will be discussed.

However, it should be also noted that frequently many of these terms are put forth, particularly in the context of medical literature, without a critical understanding or questioning of the cultural assumptions underlying them (Fausto-Sterling, 2000; Hausman, 1995). This poses a challenge for the mental health clinician in that being able to deconstruct assumptions regarding ideas that define the discourse on gender

variance can be ultimately helpful to both the individual client and the clinician. The mental health clinician must hold a critical awareness of how cultural discourse can simultaneously illuminate and oppress the subject of concern. For the population of interest of the current study, theoretical constructs hold a particular relevance as they can influence the options available to a particular client in terms of pursuit of gender expression with regards to accessing hormonal or surgical treatment.

Thus, in addition to a definition of terms, some criticisms of the assumptions inherent to the terms will be included in the discussion. Ultimately, in terms of the data generated by this study, it is possible that there will be a range of participant understandings and assumptions specifically regarding the construct of “transsexualism” and/or other terms/labels that frequently arise in the discussion of treating these clients. The same holds true for the term “self-mutilation.” In the interest of approaching the phenomenon of interest in this study with an open and self-reflexive stance, the definition and then deconstruction of commonly used terms should be helpful to the analysis of data generated through interviews. Self-reflexivity means the individual’s willingness to engage in critical self-examination of one’s assumptions, thoughts and feelings regarding the phenomenon of interest. This bears particular relevance to the current proposed study and will be discussed in further detail in the methodology section of this document.

Perhaps the primary category/label to define and discuss is the idea of “gender” and the multiple associated terms that rely on the concept of gender. This appears

necessary as the transsexual in case literature is typically depicted as being exclusively preoccupied with the properties of masculinity or femininity. For the purposes of this study, gender may be defined as follows: the behavioral, cultural, or psychological characteristics that are socially constructed to express femininity (associated with females) and masculinity (associated with males) (Morrow, 2006, p. 472)

It should be noted that this definition of gender is influenced by a social constructivist ontology which emphasizes gender as a cultural creation rather than an “essential” biological characteristic found in nature. However, it is important to take into consideration, as recent feminist scholars have pointed out (Butler, 2006; Fausto-Sterling, 2000; Grosz, 1994) that gender cannot be simply reduced to an either/or argument which pits nature against nurture, or the influence of culture on the subject versus the biological reality of the body. This represents a false dichotomy per these scholars who indicate that biology and culture are coexistent, interdependent, interpenetrating forces that simultaneously produce the emergence of qualities that are understood as masculinity or femininity.

This bears relevance to the discourse on transsexualism as challenges have been voiced on the one hand regarding the authenticity of the transsexual identity and whether it represents a false consciousness or socio-medical construction which serves to reinforce oppressive cultural stereotypes of masculinity and femininity (Billings & Urban, 1982; Hausman, 1995). On the other hand, emphasizing a biologically predetermined program for gender runs counter to the argument of the importance of

choice and self-determination regarding how gender is performed and expressed.

Indeed, many scholars advocate the idea of gender as a performance which is informed by cultural standards but may simultaneously rely on biological markers for a convincing presentation (Butler, 2006; Grosz, 1994).

Ultimately, it must be acknowledged that there is a political element to how the phenomenon of gender is conceptualized, discussed and expressed by medical and mental health practitioners. Unfortunately, for the transsexual subject, while current medical discourse may advocate for procedures which allow the alteration of the physiological markers typically associated with gender, it fails to acknowledge the persistent legacy of how a gender identity that deviates from cultural expectations is defined as inherently pathological and how cultural values play a role in defining which behaviors are considered normal. Deciding which behavior is 'disordered', 'abnormal', or 'dysfunctional', especially without any particular guidelines to determine 'ordered', 'normal', or 'functional', is inherently a political act of judging the acceptability of human behaviors based to some extent on their frequency and commonness (Lev, 2004, p. 151).

The pathological construction of variant gender identity is most evident in the creation and inclusion of the category of Gender Identity Disorder in the DSM-IV (APA, 2000). Gender Identity Disorder or GID is the diagnostic nomenclature utilized by medical and mental health professionals that replaces the previously used term "transsexualism" in the DSM-III. As previously discussed, multiple criticisms have been

levied against this psychiatric classification of gender variance as the standard does not allow for the possibility of a healthy, normative transsexual identity. It is not possible to be diagnosed with Gender Identity Disorder and not experience “distress and impairment” (APA, 2000, p. 58).

There are two components to Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is of the other sex...There must be evidence of a persistent discomfort about one’s assigned sex or a sense of inappropriateness in the gender role of that sex. (APA, 2000, p. 576)

The term “gender identity” can be defined as “a person’s self concept of their gender” (Lev, 2004, p. 397), it has been likened to a subjectively felt sense of oneself as being “masculine,” “feminine,” a combination of masculine and feminine, or neither (Lev, 2004; Green, 1987; Money, 1972). The term “gender expression” is used to denote the overt demonstration of behavior that corresponds to a subjectively felt sense of gender. This occurs through assumption of roles, behavior, or dress that may be construed or are associated with identification with societal perceptions of the qualities of the categories masculine, feminine, a combination of the two, or an androgynous presentation. As stated earlier, gender can be viewed as being “performed” or “enacted” through presentation and role behavior. The terms “Gender variance” or “gender variant behavior” refers to embodiment or performance of gender that confounds typical cultural expectations. Consonant with the DSM’s construct of GID, the term, “Gender dysphoria” refers to the emotional suffering an individual experiences regarding their gender. The DSM-IV defines gender dysphoria as follows:

denotes strong and persistent feelings of discomfort with one's assigned sex, and the desire to possess the body of the opposite sex, and the desire to be regarded by others as a member of the opposite sex (APA, 2000, p. 535).

Historically, patriarchal cultural belief systems limit gender expression to a binary assumption of the essence of gender as being male or female. This assumption is built on the idea that only two sexes exist in nature. Sex can be defined as follows: the physiological makeup of a human being, referred to as biological or natal sex...sex is a complex relationship of genetic, hormonal, morphological, biochemical, and anatomical determinates that impact the physiology of the body (Lev, 2004, p. 398).

From this perspective, the categories "male" and "female," or what is referred to as "biological" or "natal" sex, are assumed to be preexistent to cultural understanding, influence and expression and are seen as static entities outside of social meaning making processes. The presence of XY chromosomes and a penis signifies the male sex and the presence of XX chromosomes and a vagina signifies the female sex.

In patriarchal belief systems, the concept of gender is frequently conflated with the signifier of the genitals. The cultural expectation is that gender identity is largely determined by a correspondence with genitals and denies the possibility that an individual may psychologically experience themselves as something other than what their genitals represent socially. These assumptions create difficulty for those individuals who are born with genitals that are not easily categorizable by others as well as denying that a binary definition of gender is inadequate to capture the variety of

human endowment and experience. This frequently translates to social oppression of diversity through the limitations imposed by an essentialist binary conception of male and female. Intersexed children are subjected to genital surgery at birth that conform them to cultural standards of male and female. Gender variant children's behavior is frequently regulated by stigma and a sense that they must be treated by mental health professional (Zucker, 1995).

Currently, medical and mental health professionals who work with gender variant individuals acknowledge that natal sex does not imply a foregone conclusion regarding the individual's gender identity. Thus, in this view, an individual with a natal sex of male may claim a gender identity of female. While this may allow for more diversity regarding the human experience and expression of gender, the question arises whether the DSM's construct of GID may also be viewed as perpetuating the binary assumption of what is considered "natural" as language utilized tends to stereotype the definitions of male and female behavior (Winters, 2005). The dilemma for the medical and mental health profession then becomes how to utilize language to describe the experience of gender variance in a respectful, non-oppressive manner. Encouraging the client to self-identify as opposed to imposing a label on the client is one means of expressing respect.

Controversy Regarding the Terms Transsexual and Transgender

Apart from the use of the term GID, this raises the controversy regarding the use of the term "transsexual" or "transsexualism" versus "transgender" or "transgenderism"

(Roen, 2002). It should be noted that many individuals self-identify as transsexual and that many individuals self-identify as transgender. Are the categories distinct and what are the boundaries of such identities? Both terms at times have been used to denote positions of social and psychological identity as well as political stances on human rights related to gender variant behavior. Additionally, the term transsexual has a historical basis in the larger cultural awareness of gender variance (Lev, 2004; Roen, 2002) as gender variant individuals seeking sex reassignment surgery were initially referred to in medical and public literature as transsexuals (Califia, 1997). Finally, there is a controversial aspect to whether the identity of transgender is inclusive of that of transsexual and whether transsexuals are willing to be identified with the transgender community (Roen, 2002). To increase understanding of these issues, it is necessary to explore the constructs in further depth.

The term transsexual can be defined as “someone who believes that their physiological bodies do not represent their true sex” (Lev, 2004, p. 400). It should be noted that individuals may self-identify as transsexual prior to contact with any medical or mental health professional. Commonly, transsexuals are described and categorized by physicians and mental health professionals as individuals suffering from a mental illness who seek out hormonal or surgical modification of the body to acquire characteristics of the opposite sex in order to reduce cognitive dissonance and emotional distress resulting from the perceived gap between physiology and a personal felt sense of gender (APA, 2000; Lev, 2004; Pfafflin, 2006).

However, it should again be noted that this depiction of the transsexual subject as a psychologically disturbed individual is closely tied to a narrative originating within the context of the medical profession's historical response to intersexuality and also to what was socially viewed as aberrant gender behavior, namely a desire to live as a member of the opposite sex, through the creation of technologies that permitted hormonal and surgical alteration of sex characteristics (Hausman, 1995). For the transsexual individual, the effort to acquire the characteristics of the gender one feels oneself to be is aimed at confirming one's gender identity. From a self-definition perspective, the idea of gender confirmation rather than sex reassignment poses the possibility of a less pejorative stance towards the phenomenon of transsexualism.

Again, this contrasts with the typical medical narrative which in some ways ironically reifies the idea of two preexistent "natural" sexes, male and female. This view asserts that the transsexual moves from one position to the other with medical assistance designed to alleviate the pathology of incongruence between body and mind. Thus, the terms "male to female" or "female to male" transsexual denotes the individual's desire and the medical profession's ability to transform the individual from one gender to the other. In the case of the male to female or "M to F" transsexual, the term denotes an individual whose natal sex is male (born with a penis) but who seeks to live in the female gender role and who identifies as either "female" or a "transsexual woman" (Lev, 2004). In this view, the male to female transsexual thus would seek to reduce primary and secondary sex characteristics associated with the category male and

to acquire the secondary and primary sex characteristics associated with the category female. Here the transsexual identity is characterized as being highly dependent on the degree of success in which the individual transforms from one gender to the other. A degree of invisibility is implied in that successful transformation means the ability to blend into society as a “proper” man or woman. It should be noted that while some transsexual individuals seek to be perceived by others as the gender of their choice, not all transsexuals are intent on becoming “invisible” (Bornstein, 1994; Roen, 2002).

The term “passing” denotes the ability of the transsexual individual to perform the gender role of the “opposite sex” in public. It may also refer to the extent to which the transsexual physically resembles a member of the “opposite sex” (opposite of the natal sex). Successful passing means being identified by others as the gender with which the transsexual identifies. Again, the effort to pass may involve medical interventions such as hormone therapy, cosmetic surgery, and gender reassignment surgery. Individuals who do not “successfully” pass are frequently denigrated as they are perceived to transgress stereotypical gender roles. Thus, a male to female transsexual who “passes” is perceived by others as female without questioning her gender identity or expression (Lev, 2004).

The term “sex reassignment surgery,” also referred to as “SRS” or alternately as “gender confirmation surgery” or “gender reassignment surgery,” denotes the surgical procedures whereby genitals are altered (i.e., penis and testes removal, construction of a vagina, breast removal, construction of a phallus). Historically, the medical narrative

viewed hormonal treatment and SRS as the solution to psychological distress (gender dysphoria) that would permit the transsexual individual to reintegrate into society as a proper man or woman. Documents such as the DSM-IV and the WPATH *Standards of Care* potentiate the narrative by imbuing mental health professionals and physicians with the authority to regulate and facilitate the rite of passage for the transsexual from one sex to the other.

Therefore, individuals seeking out SRS were put in the position of potentially distorting their life story so as to be labeled a true transsexual to obtain permission to proceed with surgery. While the SOC have evolved since the initial inception (WPATH, 2001, WPATH, 2011), it should be noted that mental health professionals continue to be positioned in the role of 'gatekeepers' via authority to bestow the diagnosis of GID and ability to determine an individual's eligibility and readiness for surgery. As previously mentioned, the gate keeping function of the mental health professional can be detrimental to the ability to establish a therapeutic alliance with the transsexual client.

While many individuals who self-identify as transsexual do seek out sex reassignment surgery, some do not. The term "transition" or "transitioning" is used to describe the process by which a transsexual individual begins to self-define a gender identity and adopt gender roles that are congruent with the subjectively felt gendered sense of self as opposed to the natal sex. This may involve a public "coming out" process whereby the individual reveals one's identification as a transsexual and pursues a path of living in the new gender role, initiating hormone therapy, cosmetic surgery

and/or gender reassignment surgery. The transition is both a psychological and social phenomenon as it involves embracing and confirming an aspect of self and adopting social behaviors denoting the evolution of the individual's identity. Coping with the reaction of the environment (i.e., family, friends, employer, etc) to this process might also be included in the individual's journey to claim their true self (Lev, 2004).

It has been argued that the term "transgender" arose as a reaction to the medically pathologized identity of the transsexual (Coolhart et al., 2008; Roen, 2002). Historically permission to proceed with sex reassignment surgery depended on being diagnosed as a "true transsexual" as opposed to being labeled a transvestite or effeminate homosexual (Lev, 2004). The term "transvestite" is a psychiatric classification used to denote a heterosexual man who experiences intense fantasies or behaviors involving cross dressing (APA, 2000). The term "cross dresser" is used to denote an individual who wears clothing typically associated with the opposite sex.

In the past, transvestites or cross dressers were typically excluded from the possibility of medical or surgical intervention designed to more fully express their gender identity (Lev, 2004). Also, currently, many individuals do not seek out complete sex reassignment surgery; some are satisfied with access to hormonal treatment, some pursue only "top surgery" (surgery to create or remove breasts), some pursue only facial cosmetic surgery (surgery designed to "maculinize" or feminize" facial features) with the intent of a more convincing gender presentation. Additionally, some individuals describe a gender identity divergent from their natal sex but elect not to pursue any

hormonal or surgical alteration of their bodies. The current SOC acknowledges that enforcing a rigid approach to who might benefit from surgical or hormonal intervention is no longer viable as increasingly there is a recognition that gender can be conceptualized from a narrative, self-definitive perspective in which the individual may experience gender identity on a continuum or spectrum rather than dichotomously. This does not eliminate the need for sex reassignment surgery as some individuals, frequently those who self-identify as transsexual, continue to request confirmation of their gender that includes the alteration of genitals. Rather, it creates the possibility of complexity with regards to the number of possible gender variant identities (Lev, 2004).

Given the spectrum of possible identities that are not encapsulated by the term “transsexual,” the term “trans” or “transgender” denotes individuals whose gender identity and behavior is considered gender variant in comparison to typical cultural expectations. Categories subsumed under the term transgender might include transvestites, cross dressers, transsexuals, bi-gender, and gender queer, and intersexed individuals. For many, transgenderism opens up the possibility of less of an emphasis on “passing” or becoming “invisible,” but instead positioning as an alternative gender identity or expression to the strict patriarchal binary of male and female. This stance generates controversy as to whether the transsexual and transgender identities are at odds with each other given the typical association or depiction of the transsexual being exclusively concerned with “passing” in their performance of gender (Coolhart et al., 2008; Roen, 2002).

Goals of the transgender model include challenging the gender dichotomy, making space for all diverse genders, depathologizing gender variance and deemphasizing the need for trans-people to pass as a certain gender (Coolhart et al., 2008, p. 304).

While some view the models or paradigms of transsexualism and transgenderism as mutually exclusive, many see transgenderism as subsuming the identity of the transsexual as part of the diverse spectrum of gender identity and gender variant behavior. The desire to “pass” accomplished through surgical intervention can be seen as one option amongst many for gender expression of the gender variant individual (Coolhart et al., 2008; Lev, 2004). Sensitivity to the multitude of possibilities for the expression of gender variance highlights the importance of the mental health professional’s conceptualization of gender and gender expression. Allowing the individual to self-identify and affirming the individual’s narrative regarding the process of identification demonstrates a supportive, therapeutic atmosphere. However, the question again is raised as to what the limits of support and empathy for the individual’s expression of identity might entail if that includes behavior that involves self-mutilation?

Finally, the question arises as to why the proposed research chooses to focus on individuals who self-identify as transsexual as opposed to the broader category of transgender. While not all transsexual individuals seek out sex reassignment surgery, many do and this requires interface with the mental health professional. If one possibility of interaction with a mental health professional is to obtain authorization to

proceed with sex reassignment surgery, behavior or thoughts regarding self genital mutilation represents a potential confound for the mental health clinician. The desire to change one's genitals to bring congruence about between the body and gender identity is a feature of how the professional literature and the DSM envision as inherent to the phenomenon of transsexualism (APA, 2000). If this is true, would self-mutilative thoughts or behavior of the transsexual be viewed as atypical and worthy of clinical intervention or a crisis response or would it be viewed as "normal" for the person identified as transsexual and not necessarily worthy of clinical attention?

Thus for the purposes of this research, the transsexual will be defined as an individual who desires to pursue sex reassignment surgery. As this paper focuses on male to female transsexuals, the term genitals will be used to refer to the whole or any part of the testes, scrotum, glans, and meatus of the penis. The term "pre-operative" is used to denote the presence of the penis on the male to female transsexual's body despite having adopted the gender role and the appearance of the female gender. The term "post-operative" refers to the individual's completion of gender reassignment surgery whereby the penis is removed and a vagina is constructed through surgical means. The term "castration" will refer to the act, self induced or surgically performed of removing the testes.

Controversy Regarding the Differentiation of the Terms Self-Injury vs. Self-Mutilation

Another term requiring clarification for the purposes of this research is self-mutilation. The choice of language to describe self-generated acts resulting in injury to

one's body is somewhat controversial. Various authors report that the term self-mutilation has been replaced with the term self-injury due to derogatory implications associated with the word mutilation (Connors, 2000; Favazza, 2011; Walsh 2006). Walsh in particular believes that the term self-mutilation sensationalizes the behavior and predisposes mental health professionals as well as the public at large to view individuals who engage in such behavior in less than humane terms. This may in turn compromise the quality of care offered by health professionals (Young & Feinsilver, 1986). Walsh acknowledges that individuals who engage in self-injury rely on the behavior as a psychological coping mechanism and believes in that sense that the behavior may in some ways be construed as adaptive (Walsh, 2006).

Both Favazza (2011) and Walsh (2006) advocate a nuanced system of classifying self-injury based on several dimensions include severity (extent and location of tissue damage), frequency, degree of awareness of the behavior (i.e., intoxicated at the time of injury, compulsive vs. impulsive self-injury), and intent (i.e., suicidal vs. non suicidal, direct vs. indirect). Walsh differentiates self- injurious intent from suicidal intent asserting that self-injury is designed to reduce psychological pain via modifying the body, and that suicidal actions are planned with the intent of finally eliminating pain that is perceived to be catastrophic and inescapable. Thus, the person who self-injures has a mechanism for regulating affect, the suicidal individual does not. Walsh uses the term "common self-injury" to refer to acts such as cutting, scratching, not allowing a wound to heal, hitting, burning, head banging, biting, piercing, hair pulling, or inserting

objects into the skin. Additional common forms of self-injury include eating disordered behavior such as purging, ingesting laxatives, and self-starvation (Walsh, 2006).

Despite Walsh's attempt to create distinction between the terms self-injury and self-mutilation, he acknowledges equivalence between his construction of the term "major self-injury" and "self-mutilation."

Favazza stated that 'major self-injury refers to infrequent acts - such as eye enucleation, castration, and limb amputation - that result in destruction of significant body tissue. This type of self-injury can properly be referred to as 'self-mutilation' because it meets Webster's definition for the word 'mutilate', meaning 'to cut up or alter radically so as to make imperfect' and 'to maim, cripple'.... The terms 'major self-injury' and 'self-mutilation' are used interchangeably.... Although major self-injury, by definition, involves significant tissue damage, such behavior usually does not involve suicidal intent. Persons who perform major self-injury are generally in very acute distress, and/or states of intoxication. The extreme behavior often indicates that they are trying to solve a major life problem, transform themselves, or are following perceived instructions from a powerful external force. Noticeably absent in the intent of these self-injurers is a desire to die. (Walsh, 2006, pp. 255-256)

A question raised by this classification system is what language a therapist might use to describe this phenomenon. Do they see a difference between self-injury and self-mutilation when the target of the attack is the genitals, particularly by an individual who identifies as transsexual? Additionally, what language would the transsexual individual herself use to describe such behavior? The majority of the peer reviewed literature refers to acts of self-mutilation involving self-castration and auto-penectomy (removal of the testes, removal of the meatus and glans of the penis), which implies substantial tissue damage and loss to the physical body. As will be discussed further in the

literature review portion of this study, the incidence of genital self-mutilation appears to be a relatively rare phenomenon.

As such, I am electing to maintain the term self-mutilation as a means of differentiating between behavior that results in superficial wounds versus behavior designed with the intent to permanently alter the appearance and function of the genitals. Given the emergent nature of the data to be generated in the current proposed study, it is possible that participants may identify a range of severity of self-injurious behavior in clients ranging from thoughts of wanting to remove the genitals, to scratching or hitting or inserting objects into the penis, to actual self-castration or autopenectomy. As such, it will be necessary to clarify with participants specifically what type of behavior they are referring to when the idea of genital self-mutilation is discussed.

Rationale for the Study/Significance to the Social Work Profession

A readily identifiable gap in research literature regarding the professional social work perspective of the behavior of an oppressed and underserved population exists. Given the importance of establishing a therapeutic alliance based on competence and empathy, academic research on this phenomenon can contribute to the knowledge base of the social work profession. Ultimately, this may aid the clinician who encounters such behavior amongst this population.

The push for evidence based treatment models within the profession of social work implies that researchers generate knowledge of populations and behaviors that

can be implemented practically in clinical settings. The phenomenon of self genital mutilation amongst male to female transsexual individuals is a poorly understood issue in that it is a rare occurrence among a population has historically been pathologized (Hill, 2007). Thus, the behavior runs the risk of being sensationalized as “exotic” and the fullness of the client’s person being reduced to a single behavior rather than promoting a fuller, nuanced and empathic understanding of the person and the environments behind the behavior.

Additionally, the proposed research may capture clinical practices that are already employed and yet have not been made overt in terms of clinical wisdom for the profession, particularly for clinicians working with transgender and transsexual individuals. For example, the importance of capturing whether clinicians currently interacting with this population employ a particular theoretical perspective in formulating conceptualization and intervention stages of treatment and whether that theoretical perspective is consonant with social work values promotes scrutiny of what entails best practice with the population.

Questions to consider in the push to make clinical practice overt in connection with this phenomenon include examining whether a clinician relies on a particular theoretical approach, such as psychodynamic, cognitive or strengths based theory, in addressing this behavior while intervening with this client?; how does the clinician view the power distribution of the therapeutic relationship with such an individual?; does the worker conceptualize the client’s behavior as a subjectively felt necessary step towards

becoming female?; to what degree if any does the clinician encourage the client to reflect on whether the behavior is driven by societal standards to conform to the Western prejudice towards binary definition of gender roles and expression?; to what extent does the client's identification as transgendered or transsexual impact the therapist's conceptualization of the client's behavior as pathological versus attempts at self-affirmation?

Self-reflexive awareness is crucial to competent practice for the clinical social worker and the proposed study may highlight potential clinical 'blindspots' in terms of countertransference and clinician bias. If the clinician defines the client's behavior as foreign and disturbing without the capacity to empathically analyze the intrapsychic motivations and environmental transactions contributing to the behavior, it increases the chances of impeding the development of a strong therapeutic alliance. Thus, the proposed study may uncover particular clinician reactions to 'in vivo' client behavior and promote better management of countertransference responses, as well as pointing to conditions within the environment contributing to the behavior which require macro-level intervention through community empowerment and policy advocacy.

Additionally, it becomes important to gain a sense of the degree to which a clinician confronted with such behavior might turn to other clinicians for help in conceptualizing the behavior or even emotional support. To what degree does an intersubjective agreement exist between therapists with regards to how such behavior is to be addressed? Does the clinician take into consideration how other therapists

might react to such behavior? Is the clinician aware of whether best practice standards exist regarding such behavior and to what extent if any are guidelines for managing such behavior to be followed?

These unanswered questions again raise the specter of DSM terminology and the clinician's relationship to the transsexual seeking gender reassignment surgery in general. Currently, the WPATH *Standards of Care*, the document establishing best practice guidelines for health professionals working with transsexual patients, recommends that the individual obtain two letters from different clinicians affirming that the individual is a suitable candidate for surgery (WPATH, 2011). Again, this puts the clinician in the role of a "gatekeeper" and thus sets up a potentially adversarial relationship between the divergent views of the prospective patient and the cautious psychotherapist. How likely is a clinician who is already confronted with multiple challenges to recommend gender reassignment surgery for someone who has engaged self genital mutilation? Would such an individual be viewed as pathological or as self-affirming and, would there be any ethical concerns either for or against in terms of the ultimate recommendation of such an individual for gender reassignment surgery?

As the clinician helps the client to navigate the tension between adaptation to a potentially hostile environment and the thrust towards claiming the identity that resonates with the client's sense of self, it is possible that the clinician may experience internal conflict between affirming behavior that consolidates the client's identity and challenging behavior that is detrimental to the client's safety and well being (for

example, some literature indicates that clients may label the behavior as self-surgery vs. self-harm) (Brown, 2010). The behavior of the population under discussion may fall into the category of ethical conflict between a client's right to self-determination versus the worker's duty to prevent harm to self (NASW Code of Ethics, 1996). Understanding the means by which a worker may resolve internal conflict and this potential ethical dilemma with regards to this behavior serves the purpose of strengthening integrity of practitioners serving this population.

Finally, the proposed study may shed light on factors that may facilitate building alliance with the members of the community that the clinical social worker seeks to serve. Being mindful of various clinicians' perspectives in working with this population demonstrates interest in understanding the conditions which add to or detract from compassionate treatment of the male to female transsexual population. Compassionate treatment that assists the client in promoting functioning and achieving goals may further the chances that potential clients at large will perceive clinical social workers as allies rather than oppressors and work to counteract barriers to entering treatment that is affirmative and supportive of the transgender or transsexual identity.

Researchers working with trans people should remember that trans communities are often marginalized and historically disenfranchised communities. Although there is no shortage of successful trans-identified people, sometimes trans people are isolated, attacked, discriminated against, or simply excluded. As a result, trans communities are arguably in need of good research to alleviate the oppression

they experience. Thus, it seems logical that researchers should try to empower these communities through research (Hill 2007).

CHAPTER II

LITERATURE REVIEW

Having previously defined the term genital self-mutilation for the purposes of this study, it remains necessary to examine the peer reviewed literature that researchers and clinicians cite as support for the assertion that the behavior occurs amongst the male to female transsexual population. This will also provide a point of comparison for how this behavior is framed and described from the perspective of multiple observers across time. This will also allow for an examination of what actions researchers specifically describe as representative of genital self-mutilation and the means used in the execution of such actions.

Additional points of interest relevant to the current study to be revealed through reviewing available literature include who the researchers observe as typically engaging in such behavior. For example, has a sociodemographic profile of the “typical” transsexual self-mutilator been established, and has a prevalence and frequency of the behavior been determined? How does this profile compare with the researchers observations of similar actions in other populations? Are there confounding psychiatric diagnoses or labels that are attributed to the individual engaging in genital self-mutilation and what is the typical psychological state of the individual who engages in such actions? Is this type of classification in addressing etiology of the behavior useful?

In what context does the behavior occur? Do the authors observe health risks inherent in such behavior and do they believe it is a behavior that should be prevented? What motivations are put forth as explanations for such behavior? Finally, what models of psychological treatment are put forth as useful in addressing this phenomenon?

Throughout the summary of the literature, it will be necessary to be critical of author assumptions regarding the constructed category “transsexual” as well as pointing out strengths and weaknesses in their research design and conclusions. Additionally, where gaps in the literature occur, it will be necessary to supplement the available knowledge with comparable studies on similar phenomenon or populations. Thus, the purpose of this literature review is threefold: to describe what is known of the phenomenon amongst this population, to summarize proposed motivations asserted by the authors for such behavior, and to describe specific relevant psychological assessment and treatment models that directly pertain to the phenomenon. Ultimately, it is believed that this will be useful in determining whether such knowledge influences or is representative of the beliefs, attitudes and clinical practices of the participants of the current proposed research investigation in terms of how they understand such a phenomenon.

The Behavioral Phenomenon Including Descriptions of the Behavior and the Clinical Population*

Single Case Reports

Searches of PsycInfo and Medline databases revealed examples of single case reports that elaborate on how specific individuals have self-mutilated citing means used, extent of damage to the body, and assessment of the individuals psychological functioning within the existent literature. Haberman (1979) describes a 25 year old biological male requesting hormone treatment in preparation for eventual gender reassignment surgery. He depicts this individual's gender dysphoria as resistant to interventions of either medication or participation in psychotherapy of one year duration. From Haberman's perspective, he did not consider the client to be experiencing a psychotic thought process and noted that his patient felt unable to engage in relationships due to the presence of male genitalia. Haberman notes that the individual reacted to the process of facilitating hormone treatment by warning the physician that: He might castrate himself because he felt we were proceeding too slowly but said that he could control the impulse since such an act might jeopardize subsequent genital surgery (p. 348).

Haberman (1979) reports that the individual eventually castrated himself by going to the bathroom of a hospital, injecting an anesthetic into his scrotum, cutting out his testes and flushing them down the toilet. He notes the planned nature of the act,

*Please note, the pronoun "he" will be utilized when discussing case subjects in reflection of the authors' original use of the language.

stating the patient had studied anatomy and remarking on his surgical skill. At the time of his treatment in the emergency room, Haberman reports that the patient was not assessed as psychotic, did not experience remorse for his actions, and did not experience further urges to self-injure or to commit suicide. Haberman notes that gender reassignment surgery was performed on this individual two years later.

McGovern (1995) describes a patient who was evaluated through the emergency room after he cut off his testes. McGovern reports that the reasoning the patient asserted for his action was the length of wait for gender reassignment surgery. Per McGovern, the patient had been presenting as a female in public for five years, had recently initiated hormone treatment, and stated that he had been waiting for gender reassignment surgery for five years. Additionally, McGovern points out that the patient refused to give permission for the surgical repair of his genitals. McGovern states that the patient voiced that he threw away his testicles specifically so that surgical repair would not happen.

Murphy et al. (2001) report on a patient who presented to the emergency room after having cut out his right testis with a razor blade and flushing it down the toilet. Murphy et al. provide background information regarding the patient's psychological state in the months leading up to the act of self-mutilation. Per Murphy et al., the patient experienced depressed mood due to the realization of the wait involved in obtaining gender reassignment surgery which Murphy et al. report may take up to five years in the United Kingdom (the author is based in Dublin, Ireland). Murphy et al.

report that the patient made a suicide attempt prior to the act of self-mutilation via overdose on medication. Murphy et al. also note that the patient had been seeing a psychiatrist and participating in a support group for transsexuals prior to self mutilating. Murphy et al. warn that cases have been observed where the individual utilizes such implements as varied as razor blades, axes, and a chain saw to accomplish genital self-mutilation.

Russell, McGovern, and Hartre (2005) described a patient labeled as transgender who utilized radio frequency energy derived from an amplifier aimed at destroying the testicles. He reports that the patient devised this method of self-mutilation after being unable to obtain assistance from her general practitioner to address a long standing history of gender dysphoria. The patient was able to convert a homemade radio into a device that delivered radio frequency to the testes. The device had a heating effect and resulted in burns and nerve damage for the patient to the scrotal area. The patient applied this device approximately four times per week for a period of two months before presenting for medical treatment.

The case reports raise relevant points to discuss with clinicians including whether they have an awareness of how patients fantasize or enact genital self-mutilation. For example, does the client consider use of cutting implements or other means? Another relevant question from an assessment perspective includes whether clinicians have prior warning, i.e., an expressed plan, to the act of genital self-mutilation? More specifically, have the clinicians experienced individuals disclosing the urge to self-mutilate in the

context of the psychotherapeutic encounter? Do the clinicians find that the disclosure is overt or covert? Does disclosure occur in the actual psychotherapy session or outside of session? Finally, do clinicians associate any particular psychological state with this type of behavior? A critical perspective regarding themes evident in these case studies will be discussed in a later section of this review.

Multiple Attempts at Genital Self-mutilation, Progression in Level of Severity

From a clinical assessment perspective, psychotherapists often try to determine the frequency and intensity of a behavior that is deemed as symptomatic or indicative of psychopathology. Thus, the idea of managing further impulses towards self-harm is relevant to the mental health clinician who seeks to promote the client's safety. Case reports do exist which warn against the transsexual patient engaging in more than one attempt at genital self-mutilation.

Rana (1993) presented a case of a transsexual who engaged in self-castration due to the despair associated with the waitlist to obtain gender reassignment surgery. The patient sequentially injured his genitals by first removing one testicle, then the other and finally self-amputated his penis. These actions occurred separately over the course of several months. The authors speculate that the patient's subsequent actions following the initial self-castration were motivated by the disappointment that self-injury did not decrease the waiting time to receive gender reassignment surgery.

Catalano, Catalano, and Carroll (2002) examine the phenomenon of genital mutilation from the standpoint of repeated acts of self-inflicted injury versus a one time

occurrence. They present a case of a 49 year old male who sought out emergency treatment as he had initially removed his right testicle. The patient verbalized that he had a sexual problem and wished to eliminate his sexual desire. Further assessment revealed that the patient experienced some degree of gender dysphoria which manifested as the wish that he had been born a female. The patient denied that he desired sex reassignment surgery or a desire to become a woman. Following his discharge from the inpatient psychiatric unit, the patient successfully castrated his other testicle approximately three weeks post discharge. The patient verbalized that he felt that castration would prevent erections which would in turn eliminate sexual frustration. While this individual might be considered transgender instead of transsexual, the issue of self-mutilation occurring post discharge and whether psychotherapy might have prevented or impacted on such an outcome seems pertinent.

Examining the theme of multiple attempts at self-mutilation, Catalano et al. (2002) suggest that it is vital for attending physicians to be able to discern whether patients who have engaged in genital mutilation are at risk for further attempts. The authors went on to perform a literature review regarding repetitive genital self-mutilation and found 12 cases within the professional literature. Of the cases reviewed, the authors asserted that 8 of the 13 patients (including their case) could be conceptualized as experiencing conflict regarding gender identity. Additionally, the authors indicate that of the patient cases reviewed, self-mutilative behavior usually progressed in level of intensity beginning with scratching or cutting resulting in

superficial wounds to more severe behavior over time (as observed in 6 out of the 13 cases). The authors conclude based on their review of cases that the patient with the highest risk of repeated genital self-mutilation is one for whom gender identity issues are paramount. Additional risk factors per the author's review include masturbation practices that involve intentional injury to the penis progressing in severity of injury over time.

Relevant points to explore with clinicians experienced working with this population include whether they are aware of a progression in severity of repetitive self-mutilative behavior and how the clinician gauges whether the risk of further, serious self-harm exists. Additionally, from a countertransference perspective, what feelings might be provoked in the clinician who works with a client who engages in multiple attempts at genital self-mutilation?

Themes Emerging Across Case Studies and Critical Discussion

Common themes emerge when comparing the details of the aforementioned case reports. They include the context of interaction with medical professionals occurring in an emergency room, the psychological state of the patient being described not as psychotic but depressed, the authors' report of the patient's justification of the action as being due to the wait to obtain gender reassignment surgery, the patient's removal of the testes in such a manner as to prevent the possibility of repair, multiple attempts at self-mutilation, and contact with psychiatrist or physician when initiating hormone treatment prior to the act of self-mutilation.

From a critical perspective, as these are individual cases, the conclusions of the authors cannot be generalized as representative of the circumstances and motives of all transsexuals who self-mutilate. More than likely, there are cases of less dramatic self-injury or individuals who did not self-mutilate at all who did not come to the attention of Emergency Medical Room personnel. Additionally, given the amount of time elapsed between publication date of each case, there is a curious lack of variation in the ascribed motive for self-mutilation. Each author suggests that the length of wait time for the gender dysphoric surgical candidate as a motivating factor in the behavior. However, this represents a foregone conclusion that the motivation for self-mutilation is the result of the patient's inability to access surgery in a timely fashion. What needs further discussion and exploration is the psychological and sociological factors that may or may not coincide with the conscious rationalization that self-mutilation is necessary given the length of wait for surgery.

So the question remains, how might psychotherapy clinicians differentiate the individuals depicted in the case reports from individuals who were able to avoid self-mutilation if they do make such a distinction as the authors of the case reports seem to do? In the clinicians' mind, is length of wait time the only influencing variant between mutilators and non-mutilators? Again, this raises the point of avoiding reductionist views of behavior as solely caused by biological, psychological or social factors. How the clinician balances these units of analysis in working with clients engaging in such

behavior is a question that this study seeks to explore. Discussion of motivations for such behavior will be examined in further depth at a later point in this literature review.

Meta-Case Reviews Comparing Multiple Cases

Given the limitations of the single case study in developing theoretical understanding and practical intervention models of genital self-mutilation, the question arises whether literature exists that views the phenomenon from a more cumulative perspective that compares multiple case data across time. Ira Pauly's work (1965) may represent one of the first systematic descriptions of genital self-mutilation in the male to female transsexual population. In an attempt to elucidate what he terms as a "dramatic psychiatric syndrome," Pauly reviewed published medical case literature available regarding transsexualism from a period spanning the years of 1916 to 1965. While the purpose of his case review may have been to raise awareness of transsexualism amongst psychiatrists, Pauly highlights the actions of genital self-mutilation as indicative of the forceful nature of the transsexual subjects' wish to alter their gender. Of the 100 cases reviewed, Pauly noted 18 individuals who had engaged in self genital mutilation behavior. Per Pauly, he describes self genital mutilation for these individuals as involving either castration, autopenectomy, or both.

It is important to note that Pauly (1965) distinguishes self genital mutilation from other types of self-injury, stating that genital self-mutilation amongst the transsexual population represents a different psychological motivation than other types of self-injury. These dramatic acts illustrate the intense abhorrence of their genitalia, and the

desperate need to rid themselves of these organs (p. 176). He describes an additional motivation behind self-mutilation as the individual's attempt to persuade a surgeon to provide surgery to alter the genitals.

Based on his case review data, Pauly (1965) describes the individual labeled as transsexual utilizing a variety of psychiatric adjectives including depressed, suicidal, grandiose, exhibitionistic, disorganized, and for a small portion, psychotic. A criticism of Pauly's review is his reliance on these adjectives to characterize the transsexual identity when he fails to compare the percentage of individuals that display these psychological characteristics in the larger non-transsexual population with his sample. Had he made this comparison, it is highly likely he might have found proportionate psychopathology present in individuals who do not experience gender dysphoria.

Additionally, scarce mention is made of the psychological impact of coping with both internal and external pressures to adhere to a cultural standard of binary gender expression. Instead, the transsexual's suffering is posed as largely an intrapsychic phenomenon resulting in covert and overt demands on the medical professional to alleviate that suffering. Thus environmental context of the subject depicted in these case reports is ignored in favor of intrapsychic dynamics. Ultimately, the underlying theme of this characterization is the view of such an individual as manipulative and dramatic. The bias towards the transsexual subject is evident in the narrative and thus may undermine the applicability of such conclusions for the modern day clinician.

The biopsychosocial demographic data presented by Greilsheimer and Groves (1979) regarding individuals engaging in genital self-mutilation provide a somewhat more detailed background information than Pauly's review of medical case reports. Greilsheimer and Groves reviewed 53 cases available in the medical literature regarding genital self-mutilation and reported some interesting statistics. Their sample was not limited to solely individuals categorized as male to female transsexuals, overall it examined natal males who engage in the behavior in general. Per their report, the typical self-mutilator was a white, single biological natal male between the age of 20 to 29 with no children and a diagnosis of schizophrenia whose severity of the act of self-mutilation included the removal of both testicles. However, they also noted that of the patients considered nonpsychotic in the reviewed cases, approximately 6% were transsexual and of those patients, approximately 67% had made a previous attempt at genital self-mutilation prior to the current incident. Other diagnoses of individuals outside of the researcher assigned transsexual category engaging in such behavior included manic depression, psychotic depression, and alcoholic psychosis.

Of note, Greilsheimer and Groves (1979) indicated that regardless of whether the genital self-mutilation was premeditated or not, of the individual cases classified as transsexual, subjects were observed doing as much damage to their genitals as psychotics whose act appeared as an impulsive response to a psychotic thought process. They also provided specific examples of how the self-mutilation was carried out. For example, individuals utilized razors or butcher knives to accomplish the act. Level of

severity of the injury ranged from complete removal of one testicle to complete amputation of the both the penis and testicles.

From a critical standpoint, Greilzheimer and Groves meticulous review of cases highlights the current lack of knowledge regarding the average demographics of the transsexual patient who engages in genital self-mutilation. Current literature does not provide a statistically derived demographic profile of the transsexual at risk to engage in such behavior. Per their summary of cases, it is also important to note the small percentage of individuals categorized as transsexual who engage in such behavior when compared to the larger sample. Additionally, it raises the question of whether clinician's are cognizant of the possibility of multiple attempts at self-mutilation, and if they are aware of the repetitive nature of the phenomenon, how does that impact on the therapeutic alliance and goals? If the assumption is that this is an infrequent occurrence amongst a small subset of a larger clinical population, it is likely that many clinicians have not encountered this phenomenon firsthand. Thus, it is vital to encourage clinicians who have experience working with this phenomenon to share their expertise.

Limitations of Classification Efforts

Another critical point to be raised is that the classification efforts to differentiate etiology or psychopathology in connection with this behavior may be reductionistic given the complexity of the phenomenon and population, ignoring environmental factors that might impact the behavior. Greilzheimer and Groves (1979) review establishes a precedent theme which resurfaces throughout the literature on self-

mutilation which compares the subject categorized as “transsexual” with the subject categorized as “psychotic” in connection with the behavior of genital self-mutilation. This renders the motives of the transsexual subject engaging in such behavior as deriving from a different etiology from that of the psychotic. The individual categorized as psychotic is viewed as impulsive, obeying command hallucinations or succumbing to a delusional system which concretizes the genitals as a source of sin. The individual categorized as transsexual is viewed as premeditating their actions in a deliberate manner, so as to either accelerate the gender transition process or out of frustration with the wait for gender reassignment surgery.

From a critical standpoint, however, there is no explanation regarding how the distinguishing diagnoses were made. What questions or specific behavior did the author observe to be able to make this distinction? It also raises the question of whether an a priori distinction between the categories transsexual and psychotic predetermined the researchers’ conclusions regarding motivation for genital self-mutilation in that the individual must be assigned to one or the other category.

In contrast to Greilsheimer and Groves, Money and DePriest (1976) discussed the possibility of transsexualism and psychosis being coexistent influences on self genital mutilation. While the authors concluded that the cases represented varying degrees of compulsive action based on the attempt to manage anxiety associated with gender identity issues, they admitted that it was not possible to make definitive conclusions regarding the etiology of such behavior based on retrospective medical

records and recalled memories of the patients. Money and DePriest, speculated that patients engage in self-surgery because of shame involved in revealing gender identity issues to prospective surgeons and the fear of being mocked or ridiculed because of such a request.

Outside of the possibility that an individual might fall into more than one category (see also Mellon et al., 1989) (i.e., psychotic and transsexual) based on the vantage point of the observer, and the issue of whether genital self-mutilation amongst transsexuals is always premeditated, *it is striking that the distinction in etiology with regards to the behavior does not carry over into treatment discussions*. In the available literature, the needs of the transsexual client are typically overshadowed by the discussion of stabilizing psychosis in order to prevent further injury. Transsexual self-mutilators who seek out outpatient psychotherapy are omitted due to this emphasis leaving little guidance as to how these individuals were treated following the injury.

Given the distinction made in the literature between the categories “psychotic” and “transsexual,” the question arises whether the treating clinician might view genital self-mutilation as representative of an encapsulated psychotic thought process despite the individual’s level of reality testing and functioning in other domains? It should be noted that the WPATH SOC recommends that mental health professionals treat psychosis before recommending surgical intervention (WPATH, 2011). Other than the SOC, professional literature geared towards complex understanding of the behavior in terms of contradictory or coexistent etiological categories seems to be sparse. One

exception is Mellon's case report. Mellon et al. (1989) discuss a case in which the patient was dually diagnosed as both schizophrenic and transsexual. They assert based on their case description that dual diagnosis such as this heightens the risk for genital self-mutilation dramatically.

While this example is extreme, it does highlight the possibility of client experience that is not easily rendered cleanly according to the distinctions made in the literature. Clinical situations do not always lend themselves to neat, mutually exclusive categories and this makes the assessment and intervention process more complex for the clinician. In the context of outpatient psychotherapy, it is also possible that some transsexual clients may self-mutilate in an impulsive fashion rather than the described planned manner in the case reports. Thus, the distinction in etiology and expression of such behavior amongst the transsexual population needs to be explored more deeply.

Attempts to Establish Comorbidity

From a clinical assessment standpoint, the issue of comorbidity might begin to offer a more complex picture of the phenomenon. In other words, are there additional diagnoses beyond gender identity disorder that might be influencing such behavior? While no studies explicitly seek to assess comorbidity of diagnoses connected to genital self-mutilation amongst transsexuals, there are a few studies that include data assessing the presence of genital self-mutilation amongst the population. Dixen, Maddever, Van Maasdam, and Edwards (1984) utilized a standardized questionnaire to assess the psychosocial characteristic of a sample of transsexuals applying for gender reassignment

surgery at a gender dysphoria clinic in Palo Alto, CA. One of the behavioral categories assessed by the questionnaire under the category of psychological history indicated attempts at self-mutilation of the genitals (including breasts). Responses indicated that 2.4% of biological females and 9.4% of biological males reported engaging in self-mutilation of the genitals. Limitations of this statistic include a lack of discussion regarding how this question was worded and how the term mutilation was defined. Additionally, the data depended on self-report and could be distorted by a client's wish to hide such behavior out of fear of how this might impact on their request for sexual reassignment surgery.

Cole, O'Boyle, Emory, and Meyer (1997) conducted a research study to determine the extent of comorbidity of gender dysphoria with psychiatric diagnoses among a sample of transsexual patients applying for gender reassignment surgery. While not specifically geared towards the topic of genital self-mutilation, the construct is included in their survey assessment tool. In addition to undergoing two hour clinical interviews and completing MMPI testing at the time of application for surgery, patients completed an extensive medical questionnaire assessing factors considered relevant to the request for gender reassignment surgery. One of the factors assessed in the medical questionnaire included genital self-mutilation behavior. The specific question posed to respondents was as follows: "Have you ever attempted to cause damage to your genitals? Breasts?"

The authors of the study observed that 8% of male to female patients and 1% of female to male patients reported genital self-mutilation behavior. The behavior reported included “taping, hitting or squeezing the genitals out of intense frustration.” The authors also noted “Only a few individuals had cut their genitals with a knife or other object.” The authors did not specifically isolate the psychiatric diagnoses of any the patients who engaged in this particular behavior or whether a relationship existed between this behavior and a psychiatric diagnosis. The authors did state that a theme that emerged in the clinical interviews with patients was the lessening of self-destructive behavior (including suicide attempts and genital mutilation) as a result of beginning to receive treatment for gender dysphoria.

An interesting point is that the authors of this study include actions such as taping, hitting or squeezing the genitals as noteworthy in assessing the individual. This opens the possibility for inclusion of less dramatic forms of self-injury to the genitals being of concern to the clinician working with the individual in the context of psychotherapy. It may also open the possibility that clinicians elicit information from clients that represents a range of severity of self-injury, from thoughts, wishes and fantasies to actual cutting of the genitals.

Lobato et al. (2007) presented data accumulated from 1997 to present on transsexuals presenting to their outpatient clinic between the years of 1998 and 2005. Patients were interviewed using semi-structured interviews, and each patient was interviewed separately by three mental health professionals so as to triangulate the

assessment process. These clinical interviews assessed comorbidity for psychiatric diagnosis in addition to gender identity disorder. Based on a sample of 138 patients, approximately 5.2% were classified as having engaged in self-mutilation behavior. However, mirroring the flaws of previously mentioned studies, the term self-mutilation was neither specified nor defined and as such it is difficult to determine if such behavior includes genital self-mutilation.

It should be pointed out that in Lobato's sample, only male to female transsexuals were indicated as engaging in self-mutilation behavior. Additionally, it should be noted that individuals diagnosed with psychotic disorders were excluded from this sample. The diagnoses of highest comorbidity found within the sample included Mood Disorders and Personality Disorders. The authors report that the individuals within their sample who did engage in self-mutilation could be considered "impulsive." This seems to contradict previous impressions of the transsexual self-mutilator as discussed in earlier case report accounts. Lobato et al.'s (2007) characterization differs from the transsexual who is seen as engaging in planned, deliberate actions in mutilating the genitals. Additionally, the authors did not specify which diagnostic categories (i.e., mood disorder, etc.) were representative of the individuals who engaged in self-mutilation. Thus, future studies assessing this behavior must be highly specific in defining what behavior constitutes the variable of genital self-mutilation, and which comorbid diagnoses if any might accompany such behavior so as to accurately capture the breadth of the phenomenon.

Attempts to Establish Prevalence

Case reports indicate that the behavior of genital self-mutilation appears to occur in a small subset of the population. Again, a pertinent question to consider is whether clinicians are aware of the frequency with which the phenomenon presents itself in clients seeking psychotherapy treatment. To what extent have researchers been successful in obtaining reliable data regarding the prevalence of the phenomenon? Nakaya's (1996) review of medical cases of genital self-mutilation contributes further information of interest in the depiction of the transsexual genital self-mutilator. Nakaya examined medical literature of cases involving genital self-mutilation since 1901, building on Greilheimer and Groves' (1979) data. Nakaya (1996) compared cases across dimensions deemed relevant to the phenomenon based on case reports and previous literature and was able to categorize cases according to the dimensions of clinical diagnosis, religious psychotic experiences, preceding alcohol dependence, guilt feelings around sexual conflict, loss of the father (prior to age 16), and disturbance of sexual identity. Case characteristics that qualify classification according to the dimension of disturbance of sexual identity include feelings of femaleness, homosexual desires, rejection of masculinity, strong feminine identification, transvestism, and incapacity to establish a stable heterosexual relationship (p. 245).

Of the sample of 110 cases, 9% of genital self-mutilators were classified as transsexual. This contrasts with diagnostic categories of psychotic disorders (55%) mood disorders (9%), organic or substance induced psychoses (13%) and personality

disordered (14%). Of the cases classified as transsexual, Nakaya (1996) finds no evidence of those individuals experiencing religious psychotic delusions, or evidence of alcohol dependence prior to the act. He does assert that 30% of the cases classified as transsexual had a history of previous self-injury. However, he does not specify if that represents previous self-injury to the genitals or to other parts of the body.

Additionally, he does not find evidence of feelings of guilt around sexual conflict or early loss of father in any of the transsexual cases. He does find evidence of disturbance of sexual identity in 100% of the cases designated as transsexual.

Per his analysis, Nakaya (1996) rejected the proposition that early loss of father was more evident in patients who experienced sexual identity conflict. By contrast, the reader cannot help but notice the small sample composing the meta-review. From a critical perspective, Nakaya's review does not allow the reader to make a determination regarding the overall prevalence of the behavior amongst the transsexual population at large. It is interesting to note Nakaya's usage of the term "disturbance of sexual identity" to characterize the transsexual subject. This terminology represents outdated assumptions regarding gender identity in that sexual distress is not the core issue regarding the "transsexual dilemma." Gender is differentiated from sexual orientation and a presupposition of a homosexual orientation in the transsexual subject is unwarranted.

Putting aside the assumptions inherent to Nakaya's assertions, it should be noted that further efforts to elucidate the demographics of individuals engaging in

genital self-mutilation seems to be a worthwhile endeavor from the point of view of understanding the phenomenon of genital self-mutilation. Unfortunately, within the peer reviewed literature, many studies attempting to create a picture of the population involved rely on meta-analyses of medical case literature for their sample. Again, from a critical perspective, this fails to capture less dramatic instances of the behavior, i.e., behavior that does not result in an emergency room visit or that comes to the attention of medical professionals. Also, outpatient mental health clinicians must find ways to translate findings within the medical literature so as to make them applicable and useful in the context of outpatient psychotherapy treatment.

Eke (2000) may be the first author to attempt to address the epidemiological aspect of the behavior via establishing prevalence of genital self-mutilation amongst the general population. Eke performed a literature review regarding genital self-mutilation via examining the available medical literature on the subject published between 1900 and 2000. He reports that reviewing the number of cases discussed in the literature, it was determined that the incidence of genital self-mutilation could be calculated as a mean score of 3.1 cases per year occurring from 1900 to 2000. Eke asserts that the behavior is observed cross culturally although he does not utilize specific statistics but rather anecdotal case reports to support this assertion. He reports that the age range of patients engaging in such behavior based on his review of the literature falls between 6 to 66 and that the highest rate of the behavior is found amongst males between 30 and 50 years old. Additionally, in his estimate of prevalence, he does not further specify the

prevalence amongst the male to female transsexual population. An obvious limitation of Eke's estimate is the reliance on a sample derived from case literature rather than a survey of the general population.

Eke (2000) asserts that motivation for the behavior may include intended suicide (based on an estimate of 10% of the cases reviewed in the literature). He also attributes other motivations to attempts by the patient to gain sympathy for loss, sexual conflict, and for transsexual patients in particular perceived length of time to sex reassignment surgery. Additionally, Eke describes the extent and severity of the injury inflicted on the genitals as being proportional to the intrapsychic conflict the patient experiences over feelings of guilt or gender identification. Eke also reports that in the majority of cases based on his literature review, patients demonstrated low motivation to have their genitals reconstructed and frequently actively disposed of the amputated parts (i.e., flushing testicles down the toilet).

While case reviews and studies including survey questions which address genital self-mutilation amongst transsexuals might be a starting point for developing a beginning understanding of the phenomenon, it is evident that the state of knowledge is lackluster and further inquiry is necessary to develop useful clinical assessment and intervention models. In particular, more quantitative studies utilizing survey methodology which sensitively engages the target population may be necessary to more actually capture the essence of the phenomenon. While the proposed study does not utilize this methodology, a qualitative in depth understanding of current clinicians

attempts to understand the phenomenon addresses whether the client is being treated with sensitivity and awareness of the complexity of the issue.

Medical Risks

In reviewing the phenomenon, the question arises why physicians or psychotherapists would be concerned with genital self-mutilation. Why are they focused on treating or preventing such behavior? Does it stem from concern regarding danger to the patient? From the standpoint of the medical perspective, the published literature strikes an odd balance between fascinated observer and expressing misgivings about the physical risks to the patient's health as a result of the behavior. While there might be secondary gain for the researchers in publishing information on a phenomenon that is deemed by the larger culture to be unique and freakish, it is important to understand the risks that the patient might incur in engaging in such behavior.

Again referencing the aforementioned study by Eke (2000), he discusses health risks posed by such behavior. Based on case reports, these risks include fatal hemorrhaging, impotence, loss of sensation, urinary fistulae, urethral stricture, and suicide. Eke reports goals of medical treatment include successful replantation of the penis to testicles utilizing microsurgical techniques, restoration of erectile function, and successful testicular reimplantation. Eke does not believe that genital self-mutilation rules out the possibility of genital reconstructive surgery. However, he does not address issues of repetitive genital self-mutilation nor the potential disconnect between body

image/psychological sense of self that transsexuals endure. He does not discuss whether a conflict of interest exists between the physician's wish to heal by reattaching severed genitalia versus the individual's wish to avoid repair. He believes more effort should be paid to psychotherapeutic attempts to engage transsexual clients in order to prevent genital self-mutilation.

Stunell, Power, Floyd, and Quinlan (2006) outline the case of a 53 year old male diagnosed with schizophrenia who utilized a bread knife to cut off his testicles and penis. She goes on to describe the phenomenon of genital self-mutilation in general and thus includes in her discussion reference to transsexuals who are faced with a lengthy wait time to obtain gender reassignment surgery. Stunell et al. report that medical treatment of the injury depends on its severity. Superficial scratches might be sutured while self amputation requires surgical intervention. Stunell et al. describe complications due to genital self-mutilation including:

erectile dysfunction, urethral stricture or urinary fistula formation, sloughing of the distal urethra and penile skin, and abnormal sensation distal to the anastomosis. Unfortunately, a significant minority will repeat their act, and a proportion will die as a result of hemorrhage from the injuries inflicted. A minority, estimated at 1 in 6, intend suicide and a small number will go on to completed suicide.... (p. 1360)

Stunell et al. points out that treatment of patients who self-mutilate their genitals requires an interdisciplinary approach and specifically cites the necessary cooperation of urologists, psychiatrists, and primary care physicians. It is curious that social workers are not mentioned as a potentially useful resource in assisting these patients.

These reports raise the question whether both the client and psychotherapist are aware of the potential health risks of such behavior. From a harm reduction perspective, might a psychotherapist advocate for medical intervention so as to prevent self-mutilation? Have any clinicians worked with clients who have suffered health complications as a result of genital self-mutilation? These unanswered questions again point to the necessity of the current proposed research.

Countertransference Issues/Beliefs Regarding Efficacy of Psychotherapy

How do clinicians react to this behavior? What feelings regarding the phenomenon or the population are noticeable for the clinician? Are those feelings acted upon to the benefit or detriment of the client? How confident is the clinician regarding the utility and efficacy of psychotherapy in addressing this behavior? While much of the literature regarding genital self-mutilation amongst male to female transsexuals originates from the medical perspective, it is worth exploring available references to determine if adequate information is available on this topic.

While Greilsheimer and Groves (1979) did not address the countertransference of the treating clinician, they did discuss the psychiatric consultant's role in managing the crisis of genital self-mutilation. In their opinion, this extended not only to stabilizing the patient's psychosis but also to managing the strong feelings, including fear, hopelessness, anger and disgust, provoked amongst healthcare workers on the unit to which the patient is admitted. In their discussion of a specific case, Greilsheimer and Groves indicated that significant reluctance was expressed amongst hospital staff

regarding the utility of reattaching the patient's severed penis. The consensus was that this behavior is indicative of either future attempts to remove the genitals and/or suicide potential. Healthcare workers were observed to actively avoid the patient or to treat him as a curious specimen. The consulting psychiatrist in the reported case was able to counteract, per Greilsheimer and Groves report, the strong affects amongst the staff by challenging non-evidence based statements (i.e., refuting statistical claims of lack of success of surgical replantation of the penis when no such evidence existed) and highlighting that the staff's ambivalence mirrored the client's ambivalence as the patient did not dispose of his genitals but brought his severed penis with him to the emergency room.

It should be noted that the patient in the case discussed was not diagnosed as a transsexual but rather as a schizophrenic. Given the healthcare workers reactions to this phenomenon, the question persists regarding how an outpatient clinician manages potential countertransference to such phenomenon and whether reactions might differ with the client who identifies or is perceived as transsexual. The healthcare workers' reactions illustrate the risk of negative impact on quality of care on the patient. Do the clinician's feelings mirror larger societal attitudes that oppress the transgender individual? What personal vulnerabilities of the clinician might be stimulated by the nature of the act?

Young and Feinsilver's (1986) discussion focused on the triage and stabilization of patients who present through the emergency room from a psychiatric and genital

reconstruction perspective. It should be noted that the cases described by the authors involved individuals diagnosed as schizophrenic as opposed to gender identity disorder. While their discussion is not specifically geared towards the population of interest in this study, some comparisons might be drawn regarding reactions of healthcare workers to the act of genital self-mutilation.

Young and Feinsilver (1986) asserted that once the psychosis is stabilized, they believed that these patients were unlikely to attempt further genital mutilation and as such they recommended that the psychiatrist advocate for genital reattachment/reconstruction for such patients. They contrasted this clinical decision with an assertion that the probability of a male to female transsexual will engage in repeated genital self-mutilation in an attempt to correct a perceived flaw. The authors evade the question of whether surgical repair/reattachment should be attempted with the transsexual individual engaging in this behavior.

Young and Feinsilver (1986) advocated the psychiatrist role in managing the cases presenting through the emergency room should entail establishing an accurate diagnosis, making recommendations to the surgical team, engaging the client's support system to further clarify diagnosis and establish support, hospitalizing the patient following surgery in an inpatient psychiatric setting, stabilizing the patient through frequent contact and monitoring while on the psychiatric unit, and making discharge planning decisions based on psychodynamic material that emerges over the course of the hospitalization. Interestingly, the authors devote significant portion of the article to

suggesting how the psychiatrist might manage the reactions of the attending nurses and surgical physicians who they state frequently express disgust and cynicism regarding the outcome of repairing the patient's genitals.

This type of reaction is indicative of the potential risk a transsexual patient incurs in interacting with healthcare providers. If the healthcare provider experiences the patient's presentation as alienating, the patient may be shamed or discriminated against in terms of accessing compassionate, competent healthcare. Again, this points to the need of understanding how mental health clinicians working with this particular population manage countertransference feelings and at the same time create a supportive environment that detoxifies shame or transphobia. Additionally, the study's focus on the inpatient setting highlights the need to understand what happens to these individuals beyond discharge? Of those who do participate in outpatient psychotherapy, do the clinicians serving them feel adequately prepared to address the phenomenon?

Lobato et al. (2007) assert that the individuals in their sample who engaged in self-mutilation had difficulty engaging with the therapist or were aggressive towards the therapist. Lobato et al. report that these individuals dropped out of treatment. Criticisms of Lobato et al.'s observations include failure to specify what factors may have contributed to difficulty in establishing the therapeutic alliance. Lobato et al. infer that it is the impulsive, aggressive nature of these clients that prevents psychotherapeutic treatment. However, from a relational standpoint, the psychotherapists' reactions to

the client represent an equally valid possibility in terms of obstacle to treatment. Additionally, Lobato et al. fail to specify how many sessions the client and therapist attempted before engagement was considered unsuccessful. Finally, Lobato et al. do not specify what the purpose of the psychotherapy was. For example, was the therapy geared to provide positive psychological support of the transsexual identity? Might these patients been wary of the potential gatekeeper role that mental health professionals play in terms of assessing one's suitability for gender reassignment surgery? A higher level of transparency regarding Lobato et al.'s assertions is necessary in order to deconstruct his statement regarding the lack of benefit of psychotherapy for transsexual self-mutilators.

In considering the assertions of these authors, further questions regarding potential countertransference issues on behalf of the treating clinician take on significance. For example, what might the clinician see as the intent behind the patient's verbalization of desires or acts of genital self-mutilation. Does the clinician experience this behavior as manipulative or with the need to "save" the client?

Guralnick and Simeon (2001) references a range of potential feelings evoked in the clinician by self-mutilative behavior. These range from feelings of helplessness, rage at the client, feeling shut out, fear, and difficulty understanding the symbolic intent or communicative functions behind the client's disclosure or actions. Given the potential of the client's disclosure to evoke strong emotion in the clinician, is there any point at

which the clinician experiences the client's story or actions as difficult to bear or to listen to?

In the work with self-mutilating patients, intense countertransference issues threaten to overwhelm the treatment and pose challenges for the therapist. These reactions make it difficult for the clinician to remain clear minded and respond to self-mutilation as if to any other clinical matter... Clinicians may feel guilt and shame in their inability to stop their patient from destructively acting out as though this behavior implies something about their own competence as clinicians.... The feelings of helplessness, incompetence, shame and guilt may lead the clinician to pull away and avoid the patient or refrain from inquiring further into his or her self-destructive behaviors and may evoke an urge to retaliate or behave sadistically towards patients. (Guralnick & Simeon, 2001, pp. 191-192)

It remains to be seen whether interviewing the current research subjects reveals a different opinion on the matter of the utility of psychotherapy in addressing this phenomenon. Additionally, exploring the manifestations of countertransference seems to be crucial as emotional reactions to this phenomenon might impede the building of a therapeutic alliance as well as contributing to further rejection and stigmatization of this type of client. Determining clinician's attitudes regarding the likelihood of this population seeking out or maintaining psychotherapeutic support contributes to knowledge of whether these attitudes are evidence based or derived from countertransference issues.

Alternative Definitions Regarding the Phenomenon

It is important for clinicians to be aware of the contrasts in how the phenomenon is framed based on the vantage point of the subject. For example, the medical establishment refers to self-cutting behavior as self-harm or self-mutilation. It

is possible that the transsexual population views this behavior not as self-harm but a necessary physical self-alteration akin to a cosmetic surgery. A question arises whether clinicians who work regularly with this population or advocate for this population might call for a view divergent from the perspective which constructs this behavior as self-damaging? Additionally, another question of interest is why knowledge of potential health issues such as pain or blood loss does not serve as an internal deterrent for the individual engaging in such behavior. Psychotherapists might explore the meaning of those health issues with clients and the reasons the client provides as to why those issues may or may not impact the actual behavior.

A clinician who offers an alternative definition of the phenomenon is Brown (2010). Brown argues that the phenomenon of genital self-mutilation amongst male to female transgender individuals should be reframed as “surgical self-treatment” in the context of those individuals who are incarcerated. He asserts that transgender prisoners are routinely denied access to hormones and medical support that would otherwise constitute continuity of care for those individuals who are in the process of transitioning at the time of their incarceration in the prison system. The author states that the motivation for the behavior is not derived from psychotic thought processes nor attempts to manipulate attention from the penal system in such individuals. Additionally, he states that the behavior is not spontaneous in his opinion as he reports that from his observations the surgical self-treatment is preceded by attempts to communicate with prison staff and garner the necessary services.

Brown (2010) concludes that the behavior is motivated by the psychological urgency and desperation the individual experiences in the desire to reduce the impact of testosterone on the body (i.e., production of secondary sex characteristics so as to reduce the incongruity between their experience of gender and their physical body). He asserts that the self-surgery would be unnecessary should prisoners be given access to hormonal treatment, medical care, or sex reassignment surgery and that the lack of such access to treatment is indicative of a systemic bias which deprives transgender prisoners of humane access to medical care. Per the author's case observations, individuals who engaged in surgical self-treatment did not experience regret over their actions nor did they wish to have their genitals reconstructed following the act.

It should be pointed out that the author does suggest that Gender Identity Disorder and a Psychotic Disorder can be comorbid. The author makes the distinction between an individual who displays gender dysphoric behavior while psychotic and an individual with comorbid diagnoses of gender identity disorder and psychosis. He believes that if gender dysphoric behavior persists when the psychotic process is in remission, this is indicative of a more intense level of psychological conflict regarding gender identity. He also believes that comorbid diagnoses of gender identity and psychosis increase the risk that the individual will engage in surgical self-treatment. However, the author also admits that there is no formal data to support his hypothesis beyond anecdotal case reports. It is interesting that the author continues to utilize the

term surgical self-treatment considering the mental state of the individual involved even if there is a comorbid diagnosis of Gender Identity Disorder and Psychosis.

Brown's (2010) willingness to initiate a discussion on reframing behavior in terms that might counter pejorative or sensationalistic definitions of such actions ultimately contributes to a dialogue on empowering the male to female transsexual population. However, unanswered questions remain including whether the term "self- surgery" would be used in conjunction with attempts to alter the genitals outside of the context of prison? The current proposed study may determine whether clinicians experienced in working with male to female transsexuals who engage in genital self-mutilation share Brown's vision. For example, would a therapist reframe genital self-mutilation as genital self-surgery in the case of the transsexual? If so, how might the clinician articulate the understanding that allows them to assert such a perspective? The current proposed research endeavors to capture the clinician's thought process on such a subject.

Echoing Brown's sentiment regarding the construction of the narrative defining the phenomenon and the connection to the subject's voice, Connors (2000), another author who has written about working with clients who self-injure, is careful to point out that self-injurious behavior must be viewed as a complex phenomenon and that the context in which the behavior occurs and the meaning attributed to the behavior makes a fundamental difference in how the clinician ultimately understands the phenomenon. Connors summarizes it best:

The broad continuum of self-harming behavior incorporates many different kind of actions or (inaction). Whether a certain act is perceived as self-harming is

partly determined by social norms, the actor's intent, the psychological state accompanying the behavior, and how the act impacts the body/self. Any particular form of behavior can be viewed in different lights, depending on the social and personal context within which it occurs. For example, cutting or piercing one's skin may constitute self-injury, or it may be an act done to allow one to wear earrings within certain cultural contexts, or it may be part of an initiation rite in a particular culture. Any exploration of meaning of a particular behavior needs to be grounded in the surrounding details....In short, we need to exercise caution as we attempt to define self-injury, given the impact of context and individual perceptions in categorizing behavior. Particular care needs to be taken regarding attributions of meaning and function. A certain behavior may constitute self-injury for one person but not another.

While both Brown (2010) and Connors (2000) raise important points in raising the clinician's awareness regarding how the act of genital self-harm might be framed, the issue remains regarding potential risk of harm due to medical complications and the individual's psychological functioning following such an act. Again, this raises the question of whether clinicians view such behavior as something to be prevented? Does framing the behavior as self-surgery vs. self-mutilation make a difference to the clinician in terms of whether they would attempt to influence an individual to refrain or alternatively pursue such an act? If the male to female transsexual client had raised the fantasy or discussed a specific plan with intent to engage in self modification of the genitals, how would the outpatient clinician react? What might the clinician's goals be in such a situation?

This points to the necessity of examining the experience of clinicians who have worked with male to female transsexual clients who have contemplated or engaged in genital self-mutilation. The more that attitudes, actions and clinical thought processes of these clinicians can be articulated, the hope is that a deeper understanding of the

phenomenon as well as a reservoir of clinical expertise can be brought to light and disseminated to allies of the transsexual population.

Motivation

In considering the motivation behind the act of genital self-mutilation amongst male to female transsexuals, heterogeneous explanations are put forth by various authors to reveal why individuals engage in such behavior. The motivations range from a psychoanalytically informed understanding of the individual's psychology, to environmental transactions that induce psychopathological behavior due to the difficulty adapting to a hostile society. Additionally, postmodern critical theorists posit explanations for self-injury that may bear relevance to how clinicians understand the phenomenon. Given that the phenomenon of genital self-mutilation is rare, in order to provide a sufficient exploration of the topic, it is necessary to include within the review the work of some authors who write about self-mutilation although not specifically in the context of the male to female transsexual population. This promotes the ability to extrapolate relevant information from those discussions to the study of the population at hand. Throughout this process, critical commentary will address how the postulated motivations might need to be reconsidered or modified in order to sensitively and comprehensively explain this phenomenon.

Psychoanalytic conceptualizations. An author that is frequently cited within the existent literature on the phenomenon of self-mutilation as the clinician who conducted the first serious clinical and theoretical inquiry into the behavior is Karl Menninger

(1938). Karl Menninger conceptualized self-mutilation behavior as an act of 'focal suicide'. By this he meant that the behavior could be considered to be arising from an impulse towards suicide. However, he asserted that this impulse was targeted towards a specific body part rather than the entire organism. Menninger drew from psychoanalytic drive theory to propose that the intrapsychic motivation of such behavior derived from multiple wishes. Primarily, Menninger felt that the individual engaging in such behavior resolved tension between aggression towards others, aggression towards the self in the form of a desire to be punished, and the fear of being trapped in a situation that was psychologically intolerable to the self via enacting suicidal intention in a symbolic manner. The end result satisfies the wish to cause harm to the other through the distress the behavior provokes in observers, satisfies the drive to punish the self through the harm inflicted, and helps the individual to triumph over the fear of being trapped through the demonstration of masochistic power. Menninger felt that the intensity of the behavior corresponded to the degree of ego functioning of the individual; thus, the neurotic demonstrated less severe self-harm behavior than the psychotic whose behavior could be categorized as extreme.

Menninger's (1938) formulation of the meaning of self-mutilation derives from the metapsychological framework of psychoanalytic drive theory. His formulation has been challenged by more recent investigators of self-mutilation (Favazza, 2011) who contest the idea of 'focal suicide'. The value of including Menninger's ideas in the review of extent literature on self-mutilation is to demonstrate the dilemma a clinician

faces in assigning psychological motivation to the act of self-mutilation. The theoretical orientation of the therapist and the most current available scientific knowledge are highly influential in making sense of the behavior. However, paradigm shifts do occur and understanding of the phenomenon may evolve over time. Current expertise on the phenomenon of self-injury/self-mutilation distinguishes the behavior from suicidal intent (Favazza, 2011; Walsh, 2006).

Nevertheless, for the purpose of this study, it may be important to determine whether the clinician can articulate what separates the boundary between an unconscious covert attempt to harm oneself and conscious behavior intended to alter the emotional state of the self, confirm identity, and/or elicit reactions in the client's interpersonal environment? Clinicians must make the distinction for the purposes of safety planning for the individual affected. Thus, attribution of motives regarding this behavior takes on significance for both the client and the clinician from the start.

Additionally, perhaps the value of Menninger's (1938) formulation lies in his recognition that the clinician must be mindful of whether reality impairment influences the behavior. The fact that an individual who is labeled transsexual has engaged in genital self-mutilation does not necessarily preclude the possibility that the client may have a psychotic thought process. Alternatively, a transsexual whose ego functioning is classified as neurotic might do as much damage to the genital organ as someone classified as psychotic and perhaps without experiencing any emotional distress at the contemplation or execution of the act.

Blacker and Wong (1963) discussed four cases of psychiatric patients who self-castrated. Their cases focused on patients who were labeled as psychotic. A summary of themes apparent in the four cases caused Blacker and Wong to propose a combination of factors leading to self-castration. They asserted that primary amongst potential causative factors would be neglect and isolation endured in the patient's childhood environment. Per Blacker and Wong's observations, the male child raised in this environment resolved sexual confusion and anxiety regarding separation from the mother via identification with the female gender. Additionally, they pointed out that these individuals acted out internalized object relations via masochistic subjugation of the self to female others. The self-castration appeared to be a concrete means of eliminating the anxiety associated with "male" expression of sexual desire or identification with the male gender.

Blacker and Wong (1963) proposed that individuals engaging in self-castration could be considered to be schizophrenic and that the concrete enactment of castration resolved psychological conflict for these individuals. Concrete enactment refers to the expression or resolution of psychic conflict/psychological processes/fantasy in the individual's tangible actions within the physical world. Psychoanalytic influences in their conceptualization of the case derive from an object relations perspective which emphasizes the difficulty in separation and individuation for the child from the mother. Expression of "masculine" identification, wishes or behavior is suppressed, avoided, or

punished for fear of loss of the mother and perpetuated in adult relationships defensively via continued identification with the female gender.

Blacker and Wong's (1963) discussion of "concrete enactment" raises the question of whether transsexuals also engage in "concrete enactment" when they injure their genitals. Does the difference between concrete enactment by a schizophrenic and self-castration by a transsexual reside in the intention of the individual, the diagnostic category, or the resulting impact on the sense of self? Does it represent the psychological identification of the "male" as exclusively resting within the genitals? Again, an idea such as "concretization of psychological conflict" highlights the impact of the vantage point of the clinician in describing the behavior and how mental functions may be ascribed to one population but not another. Thus, the clinician's perspective plays a paramount role in comprehending the phenomenon. It is essential to gain an understanding of how the clinician's perspective ultimately depicts the client's struggles.

Robert Fisch (1987) utilized the psychoanalytic case study method to explore in depth the genital mutilation (involving an autopenectomy and cutting open of the scrotum) of an individual male patient in connection with his psychotic thought process from a psychodynamic point of view. Fisch reports that the patient's first sexual experience with a woman resulted in a fear that he was harming his partner. The patient reported ongoing homosexual contacts but associated this sexual activity with further rejection and guilt. His most longstanding relationship lasted approximately one year with a man, the loss of which occurred shortly before he engaged in self-mutilation.

Following the loss of his relationship, the patient came to believe that his penis was the source of his trouble in maintaining relationships. He also experienced hallucinations in which his mother told him how much trouble he had caused her as a child. At this time he conceived of the idea of cutting off his penis in order to die and rejoin with his mother. Fisch (1987) asserts that the details of the patient's case are not unlike previous cases of male genital self-mutilation found in the literature. Common themes include the rejection of the penis due to association of the genitals with aggression towards women. The patient concretized his psychological pain and difficulty maintaining relationships via making his penis bear the "bad" parts of him, i.e., the homosexual part, the unwanted child, the lonely man without a family.

Fisch (1987) does not observe that the client specifically identifies with the mother in terms of gender identity, however, his hallucinations indicate the intrusive presence of a negative introject within his psyche. Fisch asserts that the act of genital mutilation for this individual represented a fulfillment of the wish to be reunited symbiotically with his mother and to be punished for his self perceived inherent lack of worth.

Fisch's (1987) conceptualization of the case mirrors Menninger's concept of the focal suicide to relieve guilt associated with rejection by his mother while at the same time punishing and eliminating his sexuality altogether. The author observes that once the act of self-mutilation was committed, the patient did not "regret the loss of his genitals" and experienced a remission of psychotic symptoms.

From a critical perspective, the patient described by Fisch (1987) does not classify for the diagnosis of Gender Identity Disorder as described in the DSM-IV TR (APA, 2000). It is possible to conclude based on Fisch's description that the client's conflict regarding gender derived from psychotic thought process rather than a longstanding wish to be perceived as the opposite gender. Additionally, understanding of transgender identity as a normal psychosocial developmental outcome (Lev, 2004) is not accounted for in psychoanalytic theory. Thus, while this case report provides an example of an attempt to appreciate the complexity of the client's behavior through the intersection of intrapsychic structure and environmental stressors, it does not provide a narrative that depicts a transsexual protagonist and might not provide the clinician working with the transgender patient a familiar insight into client motivation.

From a psychoanalytic developmental perspective, Lothstein (1992) highlights the behavior of genital self-mutilation emerging in childhood amongst male children who experience gender dysphoria. Lothstein attributes genital mutilation in all subtypes of patients including those who are psychotic as well as transsexuals to ongoing feelings of gender dysphoria which he believes originate in the childhood matrix of the relationship with the parents. He asserts that genital self-mutilation most frequently appears in male children who meet the DSM criteria for Gender Identity Disorder. Lothstein believes that this behavior often goes unnoticed amongst children because clinicians do not purposefully screen for it through clinical interview questions with the child or his family. Lothstein describes children's varying attempts at self-mutilation

including attempting to cut off the penis, hiding the penis and testicles between the legs, and beating the penis with the intent of injury.

Lothstein (1992) attributes the attempted genital harm to the child's unconscious anxiety regarding messages communicated from the parents regarding his unacceptable maleness. Lothstein observes that the cognitive capabilities of the child cause him to reduce and equate the idea of "maleness" to his penis. Ultimately, Lothstein believes that the child fears abandonment by the parents for expression of anger or aggression (maleness) and wishes to "sacrifice" the symbol of those qualities so as to retain ties to the parents. Lothstein relies heavily on psychodynamic theory incorporating both object relations and self psychology to conceptualize the child's psychological experience of internalized images of good vs. bad along gender lines as well as the distorted mirroring that gives rise to an inability to soothe the self without the presence of the mother and to denigrate the male aspect of the self. Lothstein proposes both psychotherapy with the child as well as separate psychotherapy with the parents with the aim of utilizing empathy to counteract the urge to harm the genitals and the shift of family focus on what he sees as the symptom (the genital dysphoric behavior) to the resolution of conflict within the child and the family system. Therapy with these children should not be based on biases regarding their future gender identity or sexual orientation. What is critical is that these boys be provided the necessary self structures with which to negotiate the complex realities they have yet to experience (p. 103).

While it is admirable that Lothstein (1992) implores clinicians to set aside prejudice towards how the child's developing psychology might impact future self expression through identity, it should be noted that traditional psychoanalytic theory regarding the development of gender identity has been historically criticized for making patriarchal assumptions regarding transgender identity. For example, the postulation that healthy gender development rests on successful resolution of oedipal struggles, and that healthy gender identity necessitates the individual identifying with the parent of the same biological sex (Lev, 2004; Pfafflin, 2006). This assumes that individuals who identify with the parent opposite of their natal sex are psychopathological. Clinicians' preconceptions regarding whether a transsexual's sense of gender identity represents a delusion or a variant of a natural developmental psychosexual outcome, is highly relevant here, and thus potentially influences intervention decisions (Chiland, 2000; Limentani, 1979). For the purposes of the proposed study, this raises the question of how the clinician balances the perspective of the professional observer who brings classification schemes and theoretical constructs to bear on phenomenon with the empathic understanding of the client's subjectivity in conceptualizing such behavior?

This developmental account of the etiology of childhood gender identity disorder has also been criticized on the grounds that all children exhibiting gender nonconforming behavior do not automatically experience psychological distress, nor do all families present with the dynamics described by Lothstein in his attempts to formulate the clinical picture of the origins of gender identity issues (Corbett, 2009).

Additionally, as there are no research studies assessing the prevalence of genital self-mutilation amongst gender non conforming children, the assertions put forth by Lothstein (1992) lack a rigorous empirical base to support his position. Nevertheless, Lothstein's call to clinicians to consider treating the family system in addition to the individual patient reveals a willingness to consider the impact of the client's environment on their behavior.

Ultimately, however, the question arises whether Lothstein and potentially other clinicians confound theoretical explanation of the etiology of gender identity disorder with behaviors that are not limited solely to the transsexual population. How might Lothstein's (1992) conceptualization be modified in order to avoid perpetuating oppression and to be sensitive to the differences between the realities of the gender identity disordered child and the transsexual/transgendered adult? Again, theoretical orientation of the clinician working with a client who engages in self genital mutilation bears relevance here. Are therapists cognizant of potentially oppressive aspects of using any particular theoretical lens to understand this population and this behavior? How might clinicians modify their theoretical knowledge base when designing interventions with this population?

Environmental transactions/social factors. In contrast to a focus on the behavior as motivated by intrapsychic dynamics, some authors avoid psychological theory as a motivation for behavior and instead highlight the social context in which the behavior occurs. This implies social factors as having determining influence on the

behavior. Baltieri and de Andrade's (2005) case description and discussion is representative of this perspective. Baltieri and de Andrade discuss the case of a 24 year old natal male who cut out his testes using a stiletto. They identify the patient as a transsexual with a history of gender dysphoria evident since age 4.

Baltieri and de Andrade (2005) reference the nature of the Brazilian legal code (where the authors are based) which permits gender reassignment surgery to be conducted only through university based medical clinics which regulate the individual's request for surgery. They cite gaps in the legal code which perpetuate transphobia including the individual's inability to get married, employment discrimination, and difficulty in collecting appropriate social security benefits as indicative of a society that has not taken into consideration the impact of a binary gender code on individuals who identify as transsexual. They assert that forces such as these result in higher risk of suicide and self-mutilation for the transsexual subject as they seek out covert means of attempting to alter their genitals, i.e. through secret clinics. The authors recommend that Brazilian physicians advocate changing the legal code to be more sensitive to the needs of the transsexual individual.

Referring again to Lobato et al.'s (2007) research, the authors voice concerns regarding the social conditions of their patients in that the majority of their sample had dropped out of high school. They cite a host of social stressors that potentially impede providing effective treatment of any form for the patients including hormone treatment or psychotherapy due to lack of access to income. The authors report that the majority

of participants in their sample rely on prostitution to generate money to survive. They acknowledge the multiple social barriers that are connected to the patients attempt to change gender, namely obtaining legal documents, name change, voting, and obtaining a job. The authors recommend that Brazilian health services do more to provide information regarding the disorder of transsexualism in order to counter social prejudice. They authors believe that earlier diagnosis (for example in childhood) might allow healthcare professionals to prevent outcomes such as school dropout and resorting to prostitution

From a critical perspective, it bears mentioning that the regulation of gender reassignment surgery through university sponsored clinics and the WPATH *Standards of Care* raises the issue of the psychotherapist acting in a “gatekeeper” (see Ehrbar & Gorton, 2010) role with regards to the individual’s ability to access surgery. While the domination of the gender transition industry by University based clinics may no longer be as prevalent in the United States, issues such as the prerequisites and cost of the surgery represent a similar hurdle in the effort towards self-actualization.

Additionally, the recommendations of the WPATH *Standards of Care* continue to indicate the necessity of interfacing with mental health professionals so as to obtain surgery. WPATH has recently revised its requirements regarding approval for surgery based on their passing a real life test and obtaining two letters from two separate clinicians testifying to their mental health and appropriateness for surgery (see WPATH revision to *Standards of Care*). Nevertheless, the question remains whether individuals

who engage in genital self-mutilation fear rejection by therapists or healthcare workers in their bid to obtain gender reassignment surgery. It is difficult to establish a trusting relationship with a therapist if one fears the shame and frustration of disapproval. The current study might elicit clinician opinions as to whether WPATH *Standards of Care* are considered to be a relevant factor contributing to the phenomenon.

Despite the value judgments regarding level of education and reliance on prostitution as a means of survival as discussed by Lobato et al. (2007), the value of the aforementioned studies is that they acknowledges the multiple challenges the transgender/transsexual individual must cope with as they attempt to negotiate the often competing demands of self-actualization of gender identity vs. participation in a society's institutions which are based on binary conceptions of gender. While both of the aforementioned studies were conducted in Brazil, the social conditions described mirror difficulties for the transsexual subject in the United States. There is currently no federal legislation protecting these individuals from employment discrimination which sets the stage for marginalization and oppression. The clinician must be aware of these pressures as they attempt to assist the patient who has engaged in genital self-mutilation. Lack of access to income, healthcare, and fear of rejection by healthcare professionals for the transsexual subject, are potent forces to consider from a systemic perspective in attributing motivation for the behavior. Might interventions at the macro systemic level impact the manifestation of such behavior? The current study seeks to

explore whether clinicians consider these factors to be pertinent in understanding the behavior of genital self-mutilation amongst this population.

Postmodern/feminist views. A postmodern view of this phenomenon reveals that the “discourse” on genital self-mutilation is framed and dominated by the medical profession rather than from the point of view of the patient subject. Crowe (1996), in her discussion of self-harm amongst female trauma survivors, points out how the medical perspective places the problem within the individual through pathologizing it and simultaneously reinforces the position of the medical provider as an expert who regulates the subject through diagnosis. From Crowe’s point of view, this ignores social conditions which contribute to such behavior.

In her analysis of the discourse that influences descriptions of self-mutilation, Crowe (1996) reframes the act of self-mutilation as resolving a “tension” between the public self and the private self played out on the body of the individual. Crowe summarizes one feminist view that the body can serve as a discursive site where the relationship between private and public can be displayed and inscribed via acts of self-injury. Identity for the individual is viewed as achieved through the act of self-cutting in that marks on the body are used to symbolize a separation/individuation process from the “dominant group.” This simultaneously allows the subject control over the public’s perception of the self and expresses internal subjective experience. However, this process can be fraught with struggle for the subject as subjective experience competes with desires and to integrate and conform to larger social values.

While this construct of establishing identity through self-harm for the female trauma survivor does not specifically reference the transsexual subject, certain parallels might be drawn. For example, does the act of self genital mutilation both express a privately felt sense of gender while at the same time attempting to navigate the binary patriarchal construction of gender within the larger culture? Is gender identity consolidated through injuring the genitals by simultaneously resisting cultural pressure to claim the natal sex of one's body while pursuing the wish to be "read" as female by others? For the purposes of this research, it will be necessary to explore whether clinicians consider the constructs of private and public self and self-mutilation as resolving the tension between them as useful concepts in understanding the phenomenon of interest or if these are seen as irrelevant assumptions that fail to add to the clinician's attempt to develop a helping stance towards the client?

Sullivan (2006) raises similar criticisms regarding the influence of discourse on how body modification is conceptualized. In her argument, Sullivan explores whether a similarity exists between body modification practices such as tattooing, piercing, branding, and cosmetic surgery with practices that are thought to be solely representative of the transsexual subject, i.e., hormone treatment and gender reassignment surgery. Sullivan points out that while both cultural practices such as tattooing, etc and gender modification practices are referred to by some as self-mutilation, there exists a tendency within the discourse to set up a dichotomy between "good" and "bad" forms of body modification. The "bad" forms of body modification,

per Sullivan are often defined by various professions according to their discipline. The cumulative effect of this regulatory practice per Sullivan is that particularly amongst social science disciplines, body modification is interpreted as: 'self-mutilation' and thus a symptom of a mental health problem, and/or of self-loathing associated with a history of abuse...the person who participates in practices which mark, wound, open, the body is often represented as a victim, as someone who is in need of being healed (p. 559).

Thus, according to this discourse, the transsexual who engages in genital self-mutilation would of course be viewed as a pathological individual whose actions imply mental illness. The professions (i.e., medicine, psychology, etc) which make such a determination perpetuate their power by framing the phenomenon in this manner. This precludes the possibility of viewing the practice of genital self-mutilation as "good" albeit complicated or problematic. The ability to define some forms of body modification as "bad" according to Sullivan (2006) detracts from the possibility of viewing all such practices as means of transforming being and understanding them in depth. Rather, in Sullivan's opinion, the discourse equates "bad" with "monstrous" and succeeds in scapegoating certain practices based on value judgments as to what constitutes "normality." Perhaps at bottom, what procedures as diverse as mastectomies, penectomies, hormone treatments, tattooing, breast enhancement, implants, corsetry, rhinoplasty, scarification, branding, and so on, have in common, is that they all function, in varying ways and to varying degrees, to explicitly transform bodily being - they are all, in one sense at least, 'trans' practices (p. 552).

Rather than succumb to this binary mode of conceptualizing body modification practices, Sullivan (2006) introduces the concept of “transmogrification” which she defines as a mode of becoming that encompasses the “strange” element of transformation of being and combats the urge to project onto certain practices the quality of the monstrous “other.” From this perspective, the transsexual who engages in self-mutilation of the genitals might not be considered dangerous or freakish, “bad” but rather as a subject who is seeking to transform being in a manner that might not be sanctioned by the culture at large. Sullivan urges the reader to approach body transformative practices from a standpoint of appreciating the desire of the subject to transform some aspect of their being through material means.

Finally, in the review of available literature on the phenomenon, one cannot but help notice the gendered aspect of the discourse. Putting aside for the moment the assertion that genital self-mutilation occurs more frequently amongst male to female transsexuals rather than female to male, the preoccupation within the existent literature is on the male to female subject. Does this focus represent an attempt to regulate gender via describing the removal of male genitalia as pathological? Questions regarding control over one’s body and the ability to self actualize gender identity seem compromised by a perspective which advocates medical intervention so as to ensure proper treatment and outcome.

Nevertheless, despite the valid insights offered by the postmodern perspective on the phenomenon of genital self-mutilation, it remains to be seen whether clinicians

who work with such individuals actually rely on this framework in understanding motivation behind the behavior. Additionally, the postmodern perspective, while empowering in many aspects, seems to neglect the potential of medical complications that might place the individual's health in jeopardy. This points to the complex nature of the phenomenon in that issues of self determination and self-definition might conflict with social prejudice as well as ethical issues involving safety and professional conduct. As such, the current proposed research seems necessary to shed light on how clinicians negotiate these tensions.

Assessment and Treatment Models

The quantitative research and case studies discussed in the previous section are heavily influenced by the medical paradigm of differential diagnosis, epidemiology, descriptive statistics, triage, and stabilization of symptomatic behavior. Some of the authors do acknowledge the importance of awareness of the sociocultural factors that may contribute to the phenomenon of genital self-mutilation. Reference to a therapeutic relationship with an individual client are largely absent from the discussion. Thus, it is important to include perspectives in the review of literature for the proposed study that are resonant with the clinical social worker's value of utilizing the working alliance as a tool for therapeutic intervention (Saari, 1986).

While their work has not been solely specific to the description of working with transsexual individuals who self-mutilate, two authors who are extensively cited throughout the professional peer reviewed literature as experts in the field of self-

injury/self-mutilation are Walsh (2006) and Favazza (2011). The value of examining the writings of both of these authors is that they provide a more in depth discussion of assessment, the cultivation of a therapeutic relationship with the self mutilating client, and potentially helpful interventions in addressing self-mutilation behavior. Insights culled from their work might be extrapolated to the male to female transsexual population. At the same time, it is important to be mindful of how their theoretical assumptions and approaches would potentially need to be modified so as to sensitively and respectfully address the needs of the self mutilating transsexual client.

Additionally, another author's contribution to the discussion of assessment and treatment is highly relevant in that the author focuses explicitly on the transgender population (which is inclusive of the transsexual identity). Israel (1997) puts forth a crisis intervention model in conceptualizing and responding to the phenomenon of genital self-mutilation. The value of including Israel's work in this discussion includes the perspective of a psychotherapist who self identifies as a "gender specialist." A gender specialist specifically trains to develop expertise in understanding and treating transgender individuals in the context of both assessment for readiness for gender reassignment surgery as well as providing outpatient psychotherapy that is supportive of the transgender identity. Therefore, Israel's extensive experience working with the transgender community serves as an asset to understanding the phenomenon of genital self-mutilation from the perspective of a psychotherapist who has encountered the phenomenon first hand.

The following discussion seeks to examine the applicability of these three author's models to the therapist responsibility of assessing and treating genital self-mutilation in the context of outpatient psychotherapy.

Walsh's Model

The value of Walsh's model (2006) is the holistic approach to assessment of self-injury and the necessity of tracking the multiple factors that contribute to the phenomenon. He puts forth a biopsychosocial perspective regarding assessment of self-injury, delineating the importance of examining five dimensions which he asserts interact to produce self-injurious behavior. Those dimensions include the behavioral, cognitive, affective, biological and environmental. Walsh reports that the mental health practitioner must be able to trace the genesis of the self-injurious behavior through each of these dimensions if the clinician is to fully understand the complexity of the phenomenon. For the purposes of the proposed study, Walsh's emphasis on multidimensional assessment resonates with person in environment paradigm that the social work profession applies to understanding human behavior. In this way, intrapsychic, interpersonal, and systemic environmental conditions might be considered relevant contributing factors to the phenomenon of genital self-mutilation.

Walsh's (2006) inclusion of the impact of invalidating or hostile environments within the client's family or larger social groups that contribute to vulnerability to self-injurious behavior demonstrates an understanding of the phenomenon of self-injury that encompasses negative social transactions for the client. Additionally, he asserts

that negative core beliefs activated by construction of one's reality, thoughts of self-injury being the only solution to psychological pain, difficulty regulating affect or dissociative processes, isolation, and planned preparation for where, when and how the self-injury will take place are particularly salient factors in assessing risk for the individual of self-mutilation.

Walsh (2006) also provides a protocol with questions specific to assessing someone at risk of engaging in genital self-mutilation. This process includes obtaining a thorough history of the individual's previous attempts at self-injury, whether a trauma history is evident, recent loss of someone important to the client, sudden dramatic changes in appearance or dress of the individual, examining mental status for the existence of command hallucinations, ideation including plans or preoccupations with self-injury, substance usage, fixation on tools or methods of self-injury, rituals centering on self-injury, and dissociation resulting in lack of pain when engaging in self-injury. Walsh also specifically notes that the clinician should be mindful of "preoccupation with transgender issues, (especially the desire for a sex change)" (p. 259).

This aspect of Walsh's (2006) protocol seems to mirror the trend amongst the previously discussed writers on the phenomenon of self-mutilation that the clinician should be aware that individuals who desire gender reassignment deserve special attention when considering the possibility of genital self-mutilation. While it is questionable whether Walsh's assessment questions geared towards psychotic self-injurers might provide a parallel assessment tool to be used by clinicians working with

non psychotic male to female transsexuals, it does provide a touchstone for comparison.

In particular Walsh's questions aimed at assessing for urges towards genital self-

mutilation might be relevant for the purposes of this study. They include the following:

Do you experience any sexual thoughts or feelings that bother you? Do you believe it is wrong or sinful to have these thoughts and feelings? Are you comfortable with your sexual or gender identity? Do you feel that your dissatisfaction with being a male (female) may cause you to injure yourself? How will this injury help you with your feeling about being a male or female? (Walsh & Rosen, 1988, p. 127)

In terms of the behavioral dimension of assessment, Walsh (2006) proposes a yardstick by which to measure the severity of the behavior in the service of determining whether the patient needs to be protected from themselves in some fashion.

The general rule of thumb as to what defines 'serious' is the need for suturing or other professional medical intervention. Another rule of thumb is the inflicting of many cuts or burns suggesting considerable emotional agitation and distress... Extent of physical damage can also provide important information about escalation of psychological distress. For example, if an individual usually scratches her arm with a paper clip, barely breaking the skin, and she shifts to using a razor blade and inflicting deeper cuts, this is an important development... The modest increase in physical damage should be explored in detail as part of the behavioral analysis. When individuals self-inflict massive trauma or disfigurement they are usually floridly psychotic or in a manic state. In these cases the individuals have passed over from self-injury into self-mutilation. (p. 86)

Walsh's (2006) attempts to differentiate clinician response to self-injury based on severity may provide the therapist with an initial guideline in addressing the behavior of self genital mutilation. It seems fair to inquire of clinicians participating in the proposed research what criteria they might use to classify the severity of self-injuring behavior of the male to female transsexual population. At what point from the

perspective of the therapist regarding the client's behavior cross a line (if at all)? Can behavior that is innocuous, but perhaps indicative of environmental stress and psychological conflict be compared to behavior that is considered dangerous or life threatening with respect to the client's relationship to their genitals? At what point might a therapist become uncomfortable (if at all), addressing self-injurious behavior of this population in an outpatient setting? What questions does the clinician use when engaging and assessing such behavior and how does this compare to those put forth by Walsh?

For Walsh (2006), the boundary is clear; his model assumes injury to the genital region as a crisis demanding intervention by the clinician. Once the threshold has been crossed from thought or fantasy regarding genital mutilation to concrete enactment, the client's safety is jeopardized.

In my experience, injury to any of four areas of the body is cause for special concern. These are face, eyes, breasts (in females) and genitals (in either gender). ... Harming the breasts and genitals is cause for concern for different reasons. These parts of the body usually remain hidden from public view, so social repercussions for the injuries may be less of an issue. Nonetheless, the symbolic meaning of breast or genital self-harm, and the level of distress it implies, is cause for special alarm. Breasts and genitals are sensitive regions with nerve endings that are very responsive to stimulation and pain. To deliberately harm these areas, the person has to have somehow 'turned off' the normal physiological pain responses. Intense distress or dissociation may neutralize pain responses, enabling people to harm these body locations. There is also the symbolic significance of harming these areas. Extreme distress about sexuality is usually indicated. Psychotic decompensation or primitive trauma reenactment may be involved in such self-injury.... In general, when persons injure the face, eyes, breasts or genitals, an emergency psychiatric evaluation should be considered. The level of distress accompanying such behavior is often considerable, meriting protective intervention and close supervision. (Walsh, 2006, p. 89)

Note the contrast between Walsh's perspective on genital self-mutilation and the previously discussed perspective of Brown (2010) who refers to the act as surgical self-treatment in reference to self genital mutilation amongst transsexuals. Walsh views genital self-mutilation as a behavior to be prevented. Interestingly enough, he highlights the increased risk of self-injury amongst LGBT youth. He also asserts that non-psychotic individuals may engage in genital self-injury. However, it is unclear if his aforementioned warnings regarding the urgency of treating genital self-mutilation apply equally to the transsexual subject.

With regards to possible psychological motivations for such behavior amongst LGBT youth or non psychotic self-injurers, Walsh (2006) puts forth the construct of "body alienation." Walsh defines body alienation as feelings of disconnection from one's body, and feelings of dissatisfaction/discomfort with one's embodied form. It may manifest in states of dissociation or feelings of being "at war" with one's own body. While Walsh's primary exploration of the construct of body alienation occurs in the context of links with trauma and sexual abuse, he reiterates that these are not the only sources of body alienation for the self-injuring individual and thus references the LGBT youth population. From an environmental perspective, he proposes that the degree to which an LGBT adolescent is supported in being "out" bears relevance to risk for engaging in self-injurious behavior and the extent of body alienation.

In the process of garnering information from the client to perform a thorough assessment of self-injurious behavior, Walsh (2006) also proposes means by which the

clinician may cultivate a therapeutic relationship with such an individual. Walsh enjoins the clinician working with the client to avoid attributing motives of suicide to self-injury, even in the case of self-mutilation. Instead, Walsh proposes that the clinician attempt to build a working alliance through use of language that is non-offensive and if at all possible utilizes the client's own behaviorally descriptive language with reference to the act. Walsh proposes close monitoring of the clinician's countertransference responses, including avoiding displaying reactions of shock or withdrawal from the client.

However, he cautions that the clinician should not be overly demonstrative of concern with the client as the positive reaction the client elicits from the clinician may serve as a partial reinforcer of the behavior. Walsh advocates that the clinician utilize a stance of nonjudgmental compassion while demonstrating a subdued, non-reactionary demeanor towards the client. These assertions seem relevant to the proposed research in that assessing clinician's reactions and therapeutic stance towards the client who engages in genital self-mutilation is essential to the proposed research.

Once the clinician has performed an assessment and set the foundations for a therapeutic relationship, Walsh's model of treatment relies on cognitive behavioral interventions including tracking the antecedents and context of the behavior through the use of self-monitoring logs, modifying cognitive distortions that precede and trigger the behavior, use of replacement skills such as breathing and visualization techniques as a means of self-regulating affect, substituting forms of body touch that does not result in tissue damage (i.e., use of ice cubes instead of razors on skin), exercise, writing, artistic

expression, communication skills, and distraction techniques to reduce psychological distress.

With regards to individuals coping with body alienation, Walsh (2006) proposes the use of exercises to promote what he refers to as “body integrity.” Body integrity is qualitatively different than body alienation in that it encourages gentle connection with the body in a nonjudgmental manner that allows the individual to be fully present and refraining from self-harm. Walsh proposes exercises such as a body scan meditation, massage, engaging in activities that involve full body coordination to increase mindfulness/connection, taking a bubble bath, mindful walking concentrating on the breath, and viewing oneself in a mirror with an emphasis on nonjudgmental observation as means by which the individual might begin to circumvent the dissociative or self critical stance towards the body.

The question remains whether these interventions are effective in addressing genital self-mutilation amongst non psychotic, male to female transsexuals. Additionally, the interventions may not be specific enough to the population as use of mindfulness, replacement techniques, and exercises countering body alienation bear similarity to approaches designed to treat other populations (Linehan, 1993). Nevertheless, Walsh’s (2006) construction of a protocol to assess risk of self-mutilation represents a potentially useful comparison point for the proposed study in terms of examining the actual practices of therapists who work with this population.

Favazza's Conceptualization

In contrast to Walsh, Favazza (2011) provides a detailed analysis of the varying cultural contexts in which self-mutilation occurs and demonstrates that dependent on the culture, some of these practices are socially condoned; they represent symbolic functions communicating cultural beliefs regarding sexuality, gender, promoting cohesion within group membership, etc. Favazza's anthropological examination of the phenomenon reduces sensationalism regarding self-mutilative behavior through tracing historical and cultural precedents and highlights the importance of the influence of the cultural context on the manifestation of the phenomenon. It also avoids reducing discussion of the behavior to purely the psychological dimension through acknowledging that culture ultimately determines what is considered pathological vs. non-pathological behavior.

The individual human body mirrors the collective social body, and each continually creates and sustains the other. Misperceptions of reality, feelings of guilt, negative self images, antisocial acts, and all other symptoms we associate with personal mental illness defy understanding without reference to the psychological, social, cultural, and physical integrity of the communal "body" ... Self-injury cannot be understood and dealt with without recourse to psychology, biology, and culture. When dealing with patients, I recognize self-injury not only as a pathological behavior but also as an expression of a struggle to reenter 'normal' life and achieve psychophysiological homeostasis. (Favazza, 2011, p. 277)

Perhaps the value of Favazza's (2011) observations is that it highlights the challenge for a gender non-conforming individual of navigating a culture that emphasizes a dichotomous, binary construction of gender (versus a culture that might be more tolerant of gender diversity). From this perspective, one might ask whether

cultural pathology rather than psychiatric diagnosis is warranted when considering this phenomenon. More specifically, if gender is defined by anatomy according to the prevalent cultural belief, then what does the act of genital self-mutilation communicate to oneself and others? What rituals, if any might be culturally sanctioned in attempting to cope with binary gender expectation regarding gender expression? Why might the culture sanction gender reassignment surgery and view attempts to auto-modify the genitals as transgressive behavior? For the purpose of the proposed study, what is the clinician's understanding of how cultural expectations regarding gender expression influence such behavior?

It should be noted that Favazza's (2011) analysis of self-mutilation is not limited to cross cultural comparison, however. He does discuss the emergence of genital self-mutilation in connection with individuals with psychiatric diagnoses. Mirroring the discourse promoted in the previously reviewed literature on the subject, Favazza points out that the phenomenon is rare, most commonly occurs in psychotic individuals, and points out that frequently non-psychotic genital self-mutilators are individuals who might qualify for the diagnosis of gender identity disorder. He believes it is important to determine the diagnosis of the individual through examining mental status, motivation and circumstances surrounding the act of genital self-mutilation. Belief by men that they are really women and who castrate themselves out of desperation because they have been refused gender reassignment surgery, cannot afford the surgery, or are frustrated by the long preoperative process (p. 210).

Favazza (2011) asserts that in contrast to the individual who is psychotic at the time of genital self-mutilation, transsexuals typically plan the act in advance. He asserts that they may complete the act with surgical precision despite having made the cut themselves. Interestingly enough, he also believes that the behavior might actually result in the transsexual individual receiving medical and psychological care that had previously been difficult to access or was denied.

Favazza (2011) also raises the issue of gender with regards to genital self-mutilation. He asserts that natal males are more likely to engage in genital self-mutilation as he believes that males are more likely to concretize and project meanings regarding gender and sexuality onto their penises either consciously or unconsciously when compared to women by virtue of the fact that their penises are visible and external to their body. He refers to this psychological process as "localization." The person encapsulates the "bad" or conflicted part of themselves within the genitals and then removes it thereby retaining a sense of oneself as "good." Based on his review of the literature, Favazza states that genital self-mutilation allows the male subject to rid himself of psychological conflicts regarding sexual urges, failure to live up to male gender roles, anger or aggression towards women, and may allow for the wish to emulate the female body. Favazza states that there are few examples of women who engage in genital self-mutilation when compared with men. It should be noted that this perhaps is a biased assumption, containing vestiges of the binary construction of gender which inadvertently reinforces the idea that genitals can be equated with gender.

Nevertheless, Favazza asserts that psychological conflict seems to be assuaged for the individual engaging in genital self-mutilation.

In terms of treatment, Favazza (2011) believes this alliance is heavily influenced by how the clinician manages countertransference feelings regarding the client's actions and that the clinician makes the attempt to understand the behavior as the client's means of reducing psychological tension. While he asserts that CBT, Psychodynamic, or DBT might be theoretical orientations appropriate for addressing self-injury, he advocates for a behavioral analysis known as the "four function model" (Nock & Prinstein, 2005, as cited in Favazza, 2011) as a means of understanding the function that self-injury serves for the individual and beginning to plan individualized treatment. This entails the clinician scrutinizing the circumstances (psychological and social) that precede and follow the act of self-injury. This model postulates that the four possible functions of the self-injury include the following: automatic negative reinforcement (the act removes the negative psychological state), automatic positive reinforcement (the act brings relief by inducing feelings contrary to depersonalization, numbness), social negative reinforcement (the act serves to isolate the individual by evoking disgust, withdrawal by others), and social positive reinforcement (the act serves to gain the desired individual attention or nurturance from others).

Once the function of the self mutilating behavior is understood, the clinician may move to provide specialized treatment. While Favazza (2011) discusses CBT, DBT, and Psychodynamic therapies as potential interventions, he does outline a general approach

utilized by Hawton (1990), which he believes is comprehensive. Relevant questions the clinician considers according to this model include the following list:

1. Did an argument or experience of rejection precede the act?
2. What self critical thoughts and accompanying or subsequent mood states occurred?
3. Did the individual isolate from others and/or seek out cutting instruments? Where did the individual retreat to?
4. Was substance use involved?
5. Were there any means of preventing or delaying the act (i.e. calling a friend, using distraction techniques)
6. What was the extent of the injury and the goal of the individual in committing the act? Were there positive or negative consequences associated with the behavior?

Treatment according to this model includes the following:

1. How might environmental triggers or escalating factors be avoided or reduced?
2. How might the individual build their coping mechanisms? i.e. use of medication, ventilation of emotions, contact with a friend
3. Address the underlying issues driving the behavior including a focus on mood regulation, self esteem, and communication difficulties.

It should be noted that Favazza (2011) also advocates for the use of medication, particularly in the case of genital self-mutilation when there is evidence of major depression, mania, or psychosis. Despite the detailed model of assessment and treatment that Favazza provides, it is evident that they may need to be significantly

modified for the transsexual subject as he depicts them. If the transsexual subject per his experience plans the act in advance, does not experience distress, feels relief, and gets further attention that was previously denied from medical and psychosocial resources, what specifically might the clinician have to change in order to provide sensitive, competent, individualized treatment for the male to female transsexual genital self-mutilator? Again, the proposed study may illuminate how psychotherapists currently working with this issue provide tailored assessment and treatment.

Israel's Model

A therapist who explicitly addresses the clinician's responsibilities towards the transgender client who engages in genital injury is Gianna Israel (Israel & Tarver, 1997). From the conceptualization standpoint, Israel links the behavior to a perceived lack of resources and support in the environment regarding the expression of gender identity as well as a sense of hopelessness that help exists to address gender non-conforming feelings. Israel believes that the behavior represents an attempt at communication by the individual, albeit a desperate one. Israel characterizes the individual who contemplates or engages in such an act as experiencing an intolerably high level of emotional pain as well as being socially isolated. Israel asserts that it is essential for the clinician to assess for co-existent suicidal ideation. Perhaps the most severe transgender crisis is that of an attempted, or completed, auto-castration or genital mutilation (p. 34).

Israel (1997) also details how the client who engages in such behavior might relate to healthcare providers. Israel advocates for sensitivity on the part of the clinician to the likelihood that the individual experiences a high level of shame and embarrassment regarding the behavior and may fear potential psychiatric hospitalization. Israel cautions that care providers unempathic to gender identity issues raise the risk of further shaming and alienating the client.

Dependent on the clinician's determination of the severity, Israel asserts that it is possible that behavioral "no self-harm" contracts established between the clinician and the client might allow for outpatient management of the behavior. For behavior, that is more severe (including auto-castration that has been enacted by the individual), Israel (1997) advocates for short term hospitalization with the psychiatric team consulting with a therapist who specializes in Gender Identity issues. Discharge planning should include further consult with a therapist with specialty in working with transgender individuals. In either inpatient or outpatient settings, Israel advocates that the clinician assist the client in regulating feelings of hopelessness via raising awareness of existent resources, support and options regarding gender expression.

Israel's (1997) willingness to explicitly address the issue of genital self-mutilation demonstrates a concern regarding delivering competent, sensitive care to the individual. Framing the behavior of genital self-mutilation as a crisis represents a perspective of a psychotherapist who views the phenomenon as damaging both psychologically and potentially physically to the individual.

While clinicians may read such behavior as an indication of mental distress, it should be noted that this is an interpretative act on the part of the clinician. The voice of the client regarding their perspective on the behavior remains muted. This points to a need for future research which highlights the client's own view of the phenomenon. Additionally, it is possible that Israel's assertion regarding the use of no self-harm behavioral contracts as a possible intervention can be tested empirically. While the proposed research does not purport to pursue these inquiries, it does bring attention to the need for building a database that is sufficiently theoretically complex, explicitly acknowledges the influence of gender and cultural biases in examining the phenomenon, and emphasizes the value of the inclusion of client understanding of the phenomenon.

Conclusion of Literature Review

The aforementioned literature review raises more questions than it answers regarding the phenomenon of genital self-mutilation amongst male to female transsexuals and therapist conceptualization of such behavior. Again, the lack of epidemiological studies as well as cases that never make it to the attention of healthcare professionals might minimize the prevalence of the behavior and prevents generalizations based on evidence. More than likely, the male to female transsexual population is neither homogenous with regards to the behavior nor completely without contact with mental healthcare providers who might have a unique perspective regarding the individual's motivations. The discourse on the phenomenon reveals

generalizations that are not necessarily helpful to the clinician, including simple categorizations of the behavior by population, i.e., “psychotic” vs. “transsexual” and lack of attention to the non-inpatient transsexual subject.

From a postmodern perspective, it is evident that the domination of literature on the phenomenon from the medical standpoint reinforces a view of the individual engaging in genital self-mutilation as pathological rather than considering whether such actions represent an attempt at self-definition. The dearth of evidence based literature on the subject puts the clinician in the position of relying on a patchwork of anecdotal discussions, outdated meta-reviews of the topic which do not discuss the possibility of psychotherapy as being useful to the individual self-mutilator, and research that is infused with cultural bias regarding the construct of gender when discussing the transsexual identity.

Additionally, discourse that generalizes that the behavior is simply motivated by economic factors, lack of access to medical technology, or denied bids for gender reassignment surgery seems to simplify a complex behavior that is multi-factorially determined. It does not clarify why some transsexual individuals in the same circumstance or environment might refrain from engaging in such behavior when compared to those who do. Additionally, the question arises whether all transsexuals who engage in such behavior exhibit lack of distress with regards to the consequences of such an act as the discourse suggests? While an experience of psychological relief following the act is postulated for the genital self-mutilator by many authors, this

observation seems to be limited to the context immediately following the action. What might be useful is to have a long term perspective on the individual's understanding of the act and how they interpret the act as impacting on their life course.

Another perspective to consider might emphasize that the behavior reveals the importance of subjective, psychological factors in terms of motivation in addition to the sociological factors. Individuals construct unique meanings for themselves regarding their environment and their actions, and those unique meanings are equally influential determinants of behavior along with interpersonal and social systemic forces.

Psychotherapists are privy to the world of subjective meaning of the client and how it influences behavioral expression. The proposed study thus may begin to illuminate the subjective factors that specific psychotherapists identify that differentiate the self-mutilating individual from the non-self mutilating peer. The issue remains whether the conceptualization of the phenomenon displays a level of complexity worthy of the issue and the individual client.

CHAPTER III

METHODOLOGY

This chapter describes the research design and methodology utilized by the investigator to conduct the study. Included in the discussion are summaries of the theoretical foundation for the study, the research design, the specifics of the sampling recruitment procedure, ethical concerns, data collection procedure, data interpretation procedure, and description of the method for ensuring the credibility and trustworthiness of the study.

Theoretical Framework

The investigator of this study relied on an Interpretative Phenomenological theoretical framework in articulating the research question, the means of gathering data, and the overall data analysis (Smith, 2009). Interpretative Phenomenology utilizes qualitative inquiry to access the research participant's subjective experience in connection with the question of interest so as to explore how the participant makes meaning of their particular lived experience. From the interpretative phenomenological perspective, lived experience includes the individual's understanding of their personal and social world. The phenomenological aspect of this theoretical framework seeks an "experience near" articulation of the individual's process of meaning making.

However, it is acknowledged that the researcher did not approach the phenomenon of study without his own subjectivity. Language and culture also impact the investigator's interpretation process. Through a process of bracketing, the investigator was able to acknowledge preconceptions, assumptions and biases that detract from an ability to empathize with, describe and interpret how the individual makes sense of his world (Tufford & Newman, 2010). The term bracketing refers to the researcher's efforts to suspend judgment regarding phenomena; or to suspend the "natural attitude" (Schwandt, 2007, p. 24) which accepts phenomena at face value. This is accomplished via first identifying one's own assumptions and preconceptions and "setting them aside" (p. 24). The use of bracketing within a qualitative format implies that the investigator is engaged in a process of explicit self-questioning so as to shift attention onto the process of how a lived experience becomes meaningful for an individual.

It should be noted that Interpretative Phenomenology assumes that the researcher, by virtue of his separate subjectivity, cannot fully apprehend the research participant's meaning making process. The research strives to grasp how the phenomenon of study becomes an "experience of importance" (Smith, 2009) to the individual. This entails making explicit the mental activity or concepts the individual relies on to create meaning so that the phenomenon moves from an experience which happens automatically (something that is lived) to one the individual interprets as significant. Thus, Interpretative Phenomenology assumes that mental operations

mediate between raw experience and meaningful awareness for the individual and seeks to explore that process of mediating operations/factors.

The researcher attempts to accomplish the goal of articulating the process of how an experience takes on meaning for the individual through approaching the subject in an empathic, experience near fashion. The researcher tries to understand how the research subject understands phenomena. However, the researcher, by virtue of their own meaning making process, can never fully comprehend how another makes meaning. The researcher utilizes description and interpretation to approximate the other's process of meaning making. Thus, the researcher oscillates between "a midpoint between a hermeneutic of understanding and a hermeneutic of suspicion" (Smith, 2009) in analyzing emergent themes culled from the participant's responses to interview questions. Ultimately, this oscillation promotes the ability of the researcher to appreciate how the participants perceive their world while at the same time comparing this description to the investigator's personal and professional knowledge so as to generate a rich, critically informed data analysis.

IPA also allows a hermeneutics of questioning, of critical engagement, as the reader may well ask questions and posit readings which the participants would be unlikely, unable or unwilling to see or acknowledge themselves. Both stances can be seen to contribute to a more complete understanding of the participants' lived experience. Within such an analysis, the empathic reading is likely to come first and may then be qualified by a more critical and speculative reflection. (Smith, 2004)

From a methodological research design perspective, the question arises as to how the interpretative phenomenological approach differs from other forms of inquiry

such as grounded theory. More specifically, why the investigator for this study chose to utilize Interpretative Methodology versus a Grounded Theoretical approach to research design and data analysis? The investigator sought to understand the experience and meaning making process of psychotherapists who worked with male to female transsexual clients who exhibit thoughts, feelings, fantasies or actions related to genital self-mutilation. As so little is understood regarding both genital self-mutilation amongst male to female transsexuals and how psychotherapists in general handle this phenomenon, it was the investigator's belief that approaching individual psychotherapists with the intent of exploring, describing and interpreting their particular lived experience will provide a starting point for future research which may build on individual characteristics and experience in the service of exploring group characteristics and experience.

The researcher's intent then highlights some of the primary differences between Interpretative Phenomenological analysis and Grounded Theory. This centers around the scope of what research inquiry seeks to accomplish. Interpretative Phenomenology tends to utilize smaller samples and to focus on comparisons between individual subject cases. Interpretative Phenomenology does not seek to make claims regarding a general theory that applies across cases that is representative of a general meaning making process.

Clearly there is considerable overlap between IPA and what grounded theory can do, and both have a broadly inductivist approach to inquiry. On the whole, however, an IPA study is likely to offer a more detailed and nuanced analysis of the lived experience of a small number of participants with an emphasis on the

convergence and divergence between participants. By contrast, a grounded theory study of the same broad topic is likely to wish to push towards a more conceptual explanatory level based on a larger sample and where the individual accounts can be drawn on to illustrate the resultant theoretical claim...it is possible that an IPA study could lead onto a subsequent grounded theory study.... IPA is concerned with the micro analysis of individual experience, with the texture and nuance arising from the detailed exploration and presentation of actual slices of human life. It is partly about degree of focus and speed of generalization. IPA is not opposed to more macro level claims but it steadfastly asserts the value of complementary micro analyses, analyses which may enrich the development of more macro accounts. (Smith, 2009, p. 202)

Again, the investigator believes that the current investigation may serve as a foundation for future research perhaps utilizing grounded theory methodology that can make broader claims concerning the phenomenon of psychotherapist understanding of genital self-mutilation amongst male to female transsexuals.

Research Design

The purpose of this study was to explore the lived experience of a small group of mental health clinicians who work with a particular type of client who engage in a rare behavior. A qualitative exploratory research design was appropriate to accomplish the aims of this study given the lack of peer reviewed literature on how psychotherapists experience working with male to female transsexual clients who engage in self-mutilative behavior targeted towards the genitals. Additionally, the investigator sought to capture in depth accounts of the participants' clinical experience with this particular population. The primary interest in conducting this research was exploring how each particular clinician made sense of the phenomenon of genital self-mutilation amongst their male to female transsexual clients.

In order to accomplish this goal, the investigator asked participants to share their experiences of grappling with male to female transsexual client's thoughts, feelings, fantasies, or actual behaviors around the act of genital self-mutilation. The participants' answers to the investigators inquiry represented their clinical and personal impressions of the phenomenon. How the clinicians experienced and made sense of this behavior and the challenges and needs of their particular client became evident in their verbalized descriptions of their feelings about interactions with such clients. The hermeneutic element of this study derived from the investigator's thematic analysis of the participants' described accounts of attempts to make sense of their client's behavior. It should be noted that the investigator did not seek to make claims regarding how all psychotherapists who encounter the phenomenon of genital self-mutilation amongst male to female transsexuals in their practice make clinical sense of what they are experiencing. Rather, the focus of this research was to begin to explore individual psychotherapist's meaning making process regarding this phenomenon.

Qualitative analysis was accomplished via generating data obtained through semi-structured interviews. Semi-structured interviews promoted a freedom of thought process for participants and as such allowed for the possibility of unexpected responses to questions posed. Ultimately, the goal of utilizing semi-structured interviews was to obtain a thick, rich description of the phenomenon of interest that lends itself to interpretation through thematic analysis.

Sampling and Recruitment Strategies

Interpretative Phenomenological research design utilizes purposive sampling to gather research participants (Smith, 2009). As such, the participants represented a sample of convenience. The investigator initially aimed to recruit five participants to the study. However, after an exhaustive attempt at locating willing and interested subjects, the investigator was unable to recruit more than four participants. The recruitment strategy is outlined in detail in the following discussion. It is believed that the limitation of the sample to four participants did not impact the quality of the subsequent data analysis as the methodology encourages small sample size and the number of participants was within the permissible number of subjects. In terms of sample size, limiting participation to four to five participants allows for an in depth analysis of transcripts to occur. This is within the recommended sample size of three to six participants suggested by the interpretative phenomenological theoretical framework (Smith, 2009).

Recruitment Strategies

Given the rarity of this phenomenon and the limited number of clinicians who encounter the phenomenon in practice, the investigator utilized multiple recruitment strategies to generate interest in participation. The strategies and procedure for each strategy were as follows:

Strategy 1. The first strategy involved approaching psychotherapists who are members of WPATH (World Professional Association for Transgender Health) to

ascertain their interest in participation. The mission of WPATH as excerpted from their website is as follows:

The World Professional Association for Transgender Health (WPATH), formerly known as the (Harry Benjamin International Gender Dysphoria Association, HBGDA), is a professional organization devoted to the understanding and treatment of gender identity disorders. WPATH Mission Statement. As an international multidisciplinary professional Association the mission of WPATH is to promote evidence based care, education, research, advocacy, public policy and respect in transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transgender, transsexual, and gender-variant people in all cultural settings. (wpath.org, retrieved 08/10/11)

WPATH is responsible for developing and disseminating the *Standards of Care* for Treatment of Gender Identity Disorders regarding best practices for healthcare professionals working with transgender and transsexual individuals. They provide a membership directory of healthcare providers for a nominal fee. This was obtained by the investigator upon written request. The investigator identified psychotherapists per their listed credential on the mailing list and an invitation to participate in the study was mailed to 50 members. Follow up phone calls were placed to targeted mailing list participants, however, phone messages were not returned or the target of interest declined to participate. Simultaneously, the investigator contacted the administrator of the WPATH health professionals' listserv which is a national listserv and requested permission to post a general recruitment request on the listserv. The listserv administrator indicated that the investigator was not allowed to post to the listserv directly but volunteered to post announcement of the research along with the

investigators contact information on behalf of the investigator. Unfortunately, neither of these strategies yielded any potential participants.

Strategy 2. The investigator posted recruitment announcements for the study on the following listservs: the Chicago Therapist listserv, the Illinois Sex Therapist listserv, and a national listserv hosted on the linkedin.com network Mental Health Networking which is a national listserv posting board for mental health clinicians for professional networking purposes. This strategy resulted in the recruitment of one participant.

Strategy 3. The final strategy involved the author seeking out psychotherapists identified as having experience providing services to the LGBT community. This involved the investigator researching postings on the Psychotherapy Networker directory online and mailing letters announcing recruitment for the study to identified clinicians who advertised experience or training in conducting psychotherapy with clients with gender identity issues. The investigator identified 67 clinicians to whom letters were mailed. From this strategy, two participants were recruited. Simultaneously, the investigator utilized referral by word of mouth from these recruited participants to approach other psychotherapists who might be interested in participation. Through referral by word of mouth, the last participant was recruited. This is representative of "snowballing" which means that once a participant is identified and recruited, that participant may refer or suggest to the investigator other participants who may have experience with the phenomenon or interest in the investigation.

Inclusionary/Exclusionary Criteria

The initial goals of the investigator to qualify participants for the study, was that the subject should be a psychotherapist with a master's level or doctoral level degree in an appropriate academic discipline such as counseling, psychology, psychiatry or social work. The subject should be licensed to practice psychotherapy as required by the mandates of their professional organization and state regulations. The subject should practice primarily in an outpatient setting such as private practice.

However, as the previous discussion regarding recruitment strategies demonstrates, it was difficult to exclude participants based solely on this criteria. Thus, one participant was recruited who had worked with the phenomenon in the context of a social service agency and not in the context of a private psychotherapy practice and did not have licensure for independent psychotherapy practice at the time of encounter with the phenomenon. This participant's role with the client was not exclusively as a psychotherapist, but involved case management functions as well. The investigator made the decision to include this participant due to the low recruitment rate for the study.

Another hoped for specification for participation in the study was that the psychotherapist should have conducted psychotherapy with at least one self-identified male to female transsexual client for a period of at least 21 sessions during which time the client expressed thoughts, feelings, or fantasies regarding genital self-mutilation or engaged in actual self-mutilation of the genitals. This criterion was felt to be important

at the time of the proposal of the research in that a salient issue to consider in terms of screening potential candidates for participation in the study is the minimum number of sessions of conducted psychotherapy necessary to qualify the therapist's interaction with the client as a therapeutic relationship.

As clients were not participating in the current study, variables such as strength of the therapeutic alliance and perception of therapist empathy could not be accurately utilized to define contact between the client and psychotherapist as therapeutic. Additionally, it was assumed that the detailed narrative provided by the participant in response to the semi-structured interview questions would provide some idea of the quality of the relationship that existed between that particular participant and client.

Therefore, the issue remained that the author must rely on other data to justify the assertion of the 21 session minimum requirement as representative of a psychotherapeutic relationship. The investigator believed that one potential characteristic of a therapeutic relationship might rest on how the construct of outcome success is measured. An aspect of measuring success can be the amount of time required to bring about demonstrable change in the client's thoughts, feelings and behavior.

The figure of 21 sessions was not an arbitrary number chosen by the investigator but rather derives from Lambert's (2004) summary of meta-analyses conducted on the dosage of psychotherapy necessary to demonstrate clinically significant change. Lambert explored research geared towards determining how much psychotherapy is

necessary for the client to make change. In his review of meta-analyses, Lambert cites studies supporting change for 50% of clients in a range from 7 sessions to 21 sessions (Barkham et al., 1991; Carlson & Hoyle, 1993; Kadera, Lambert & Andrews, 1996; Kopta, Howard, Lowry, & Beutler, 1994; Lambert, Hansen, & Finch, 2001; Maling, Gurtman, & Howard, 1995; McNeilly & Howard, 1991; Thase et al., 1997). Lambert (2004) goes on to make his own assertion stating that:

We now have better estimates of the amount of therapy needed in order to bring about clinically meaningful change. For patients who begin therapy in the dysfunctional range, 50% can be expected to achieve clinically significant change following 21 sessions of psychotherapy...Patients should be encouraged to anticipate a course of therapy that is sufficient to provide meaningful change. (p. 180)

Thus, the investigator believed that the twenty-one session minimum stipulation would be representative of a short term psychotherapy engagement. The investigator modified this criterion to allow therapists to participate who have worked with a client over the course of 21 sessions that are non-concurrent. For example, one of the therapists treated a client over a long period of time but not in concurrent sessions. The investigator made this decision based on the low recruitment rate.

Finally, another important qualifier for participation in the study was that the therapist should have worked with a client who self identified as “transsexual.” In particular, the client should have expressed to the therapist intentions of pursuing hormonal or surgical treatment in order to confirm gender identity or to cope with feelings of gender dysphoria. Additionally, during the time that thoughts, fantasies, feelings, or actions regarding genital self-mutilation emerged in the course of the

therapeutic relationship, the client would not have yet engaged in gender reassignment surgery delivered by a physician designed to modify the penis or testes. All participants met these criteria for inclusion within the study.

Ethical Concerns

Given that the phenomenon of study is a rare behavior among a small minority of individuals within a minority population, the investigator strove to preserve the confidentiality of the participants. Participants were asked to disguise their client identity in the semi-structured interview via refraining from divulging client name, date of birth, or other identifying demographic information. Additionally, participants were instructed to disguise any information regarding their interaction with the client or unique aspects of the case that could potentially reveal the client's identity.

The investigator obtained permission from Loyola University Chicago Institutional Review Board to proceed with the proposed research. All participants were informed of the purpose of the study and the requirements for participation. The concept of informed consent was reviewed with all participants. All participants were made aware of the time commitment, and the risks and benefits of participation were explained. It was assumed that participation in the study will pose minimal risks for participants. All participants were given the option to stop the interview, decline to answer a specific question, or to withdraw from the study altogether. All participants provided informed consent to participate in the research as well as to have their interview audio-recorded by the investigator. Further efforts to preserve participant

confidentiality were made in the data collection aspect of the investigation as the author removed any further identifying information regarding cases such as locations, dates, and ages of clients.

Data Collection Procedure

The goal of interviewing participants was to enable them to freely discuss their experience of the research phenomenon so as to capture the participants' meaning making process that can subsequently be analyzed for emergent themes. Data was gathered through audio-taping the interviews via an electronic recording device. Interviews were conducted face to face in the offices of the participants. Subjects were offered the opportunity to review the list of the general questions in advance of the actual interview; however, none of the participants requested this option. Field notes were written following each interview so that the investigator could record initial impressions regarding the interview and the respondent.

Transcription of the recorded interview material was done personally by the investigator utilizing Microsoft word. In terms of the generated transcript and final written analysis, the participants were given pseudonyms to protect their confidentiality.

Notes on the Interview Questions

The investigator modified the schedule of interview questions from the initial proposed list after conducting the first interview with the first research subject. The time allotted to conduct the investigation did not allow for all of the questions to be

covered in detail. After reviewing the initial interview transcript, the investigator opted to eliminate questions 4 and 9 (please refer to Appendix C) in the interest of not obstructing the participants' thought process and sharing of experiences and opinions that were felt to be essential to obtaining an experience near account of the lived experience of the participants in dealing with clients who engaged in genital self-mutilation. Thus, going forward, all further interviews included the following questions: (The full interview schedule along with accompanying probes is included in Appendix C of this document.)

1. Could you share your definition of the terms "transsexual" and "transgender" and your opinions regarding these terms?
2. Could you describe the work you do with client or clients who self-identify as transsexual and are male to female in your psychotherapy practice?
3. Based on your experience could you describe some of the concerns this client or clients bring to therapy?
4. Could you share your definitions of the terms "self-injury" and "self-mutilation" and your opinions regarding these terms?
5. Could you share your experience of working with a case or cases in which a client who self-identifies as transsexual and could be considered male to female expressed fantasies, thoughts, feelings or engaged in actions that represented self-mutilation of the genital region?

6. Looking back on this case, what factors if any in your opinion regarding the client and the situation or their environment were important to be aware of in assessing these thoughts, feelings or behavior?
7. Looking back on this case, what goals or interventions for treatment were relevant, changed, or remained the same, or were instituted as a result of the client's thoughts, feelings or behavior?
8. Is there anything else you can think of that I may have missed regarding the topic of our conversation that you think is important to add to the discussion?

Focus of Data Analysis

Table 1. Summary of Steps in Data Analysis

Data Analysis Activity performed by Researcher	Definition of Activity
1. Transcription	Converting audio recorded activity to written format to allow reader to identify specific quotes with interview subject
2. Exploratory Noting <i>a. Descriptive commentary</i> <i>b. Linguistic commentary</i> <i>c. Conceptual commentary</i> <i>d. Bracketing</i>	<p>Investigator reviews transcript in depth, jotting down reactions to subject's responses, seeking to understand the subject's meaning making process keeping in mind how the phenomenon being investigated becomes significant to the subject. Investigator comments on material from three perspectives while noting his own preconceptions.</p> <p><i>Descriptive commentary-</i> describes what is occurring, summarizes the content of the subject's response</p> <p><i>Linguistic commentary-</i> highlighting language subject utilizes such as key phrases, metaphors in connection with how the subject understands the phenomenon</p> <p><i>Conceptual Commentary-</i> investigator notes questions that begin to dialogue with the subject's responses utilizing professional knowledge, knowledge derived from literature review, abstract concepts. Questions are interpretative in nature as they represent the investigator's perspective. Questions begin to address</p>

	<p>subject motivation, how and why the phenomenon is of interest to the subject.</p> <p><i>Bracketing</i> – investigator highlights personal experience, preconceptions or emotional reactions to interview content so as to maintain self reflexive stance towards material</p>
3. Open Coding , saturation of transcript, memoing	Initial coding of commentary generated in exploratory noting. Codes are simple phrases capturing what's important in the data. Codes are supported by quotes associated with coded commentary and subject responses. Transcript is coded until codes being generated become redundant. Memos capture investigator's thought process in creating code, continues memoing process through data analysis
4. Constant Comparative Method, reduction of codes	Number of open codes is reduced and distilled through comparing codes to each other and to the transcript , condensation occurs through eliminating overlapping codes.
5. Developing emergent subthemes through abstraction, distillation to themes representing case	Codes are combined into emergent subthemes via an overarching concept through the process of abstraction. Abstraction involves searching for patterns amongst codes by grouping similar ideas together and naming the overarching concept or pattern that ties the ideas together. Investigator returns to transcript to code using emergent subthemes. Subthemes are then distilled to non overlapping concepts.
6. Repetition Across Cases	The steps outlined previously are repeated individually on a case by case basis
7. Comparison of emergent subthemes across cases, development of supraordinate themes	Emergent subthemes are compared across cases looking for similarities and differences. Supraordinate themes are developed through abstraction process. Transcript is recoded using supraordinate themes to test accuracy.

Following transcription of the interviews to a written format, the first step in data analysis involved the investigator immersing himself in the interview content. This was accomplished through several readings and re-readings of the interview itself. Once this was accomplished, the investigator divided the pages containing the content of the interview into two divisions, the left side contained the questions and answers of the interview content, the right side consisted of the exploratory notes in reaction to

the content of the interview. In accordance with Interpretative Methodological Analysis, exploratory notes were based on free association to the interview content and then developed further into three dimensions of commentary review. The three dimensions of commentary included descriptive commentary aimed at summarizing the participants' actions and thought processes from an experience near perspective. The second dimension of commentary involved making note of the participants' use of language in the form of keywords or metaphors that might provide further information regarding how the participant made sense of the phenomenon. The third dimension of commentary involved asking conceptual questions generated from the investigator's understanding of the material. Finally, bracketing of the investigators personal feelings and reactions were recorded as a means of tracking a self reflexive process. Examples of this type of exploratory noting are provided in the tables below.

Table 2. Example of Exploratory Noting

Therapist A: whereas those people who are more disassociated and I think have a more difficult time, really hold a lot of animosity and ... rigidity around the fact that because they have these parts	The individuals in the dissociated group deal with more intense challenge psychologically or socially or both? . Other factors characteristics of individuals in this group, rigidity, animosity. <i>Dissociated</i> . How are they rigid? Does psychological rigidity contribute to chances or ideation or tendency to self mutilate? What psychological or social factors would contribute to a person needing to be rigid? (I agree with her assessment that psychological rigidity may make life difficult for the individual. My experience in working with clients mirrors her experience here. My experience is that it also makes it more difficult for the therapist to help the client to a certain extent) Does this connect with the concept of being "concrete" vs. "psychologically minded"?
I: uh huh	
Therapist A: that is what is wrong with them	<i>Use of term What's wrong with them.</i> Does she mean wrong/pathology from her perspective or from the client's perspective or both?
I: ok	

Therapist A:and then you know for people who are not like that they seem more able to, they have better they have better relationships ,	Those who are less dissociated from their body, trans that do not fall into category of disconnection from their body have better quality of relationships. How are their relationships better?
I: uh huh	
Therapist A: they have better better ...like sexual health in terms of being able to experience themselves as a sexual being	Trans in the less dissociated category have better sexual health, more access, more connection to a physical, sexual experience of their body. <i>Use of language Sexual being.</i> Less dissociation means fuller experience of life, more access to different parts of self? Flexibility, psychological health equals better quality of life? Rigidity as psychologically cutting off parts of self? Parallel process: rigidity cuts off aspects of experience, rigid trans cuts off genitals. How does this close off experience for the trans individual? (I'm making an assumption here regarding rigidity cutting off experience instead of opening up experience.) For the "rigid" trans the question is rigid from whose perspective? IMPORTANCE OF PERSPECTIVE. WHAT'S RIGID TO ONE PERSON OR GROUP MAY NOT BE TO ANOTHER. DIFFERENCE BETWEEN PROFESSIONAL PERSPECTIVE AND THE CLIENT PERSPECTIVE? Also, perhaps it helps liberate new experiences rather than shut down or close down experience?).

Note: Descriptive comments are in regular type, *linguistic comments are italicized*, **conceptual comments are in bold type**, and (bracketed material is placed in parentheses).

Once exploratory commentary was completed for the entire length of the transcript, the process of open coding was initiated. This was accomplished by importing the notated document into NVivo. From there open codes were generated by reading through the commentary and the accompanying portion of the interview text. Open codes captured ideas and patterns found in the commentary and were checked against the accompanying interview text to verify the accuracy of the categorization. This process was exhaustive, the transcript was coded until saturation of concepts was met and new codes could no longer be generated.

Table 3. The Summary of Open Codes Generated for Each Interview Transcript

Therapist Interview	Number of Open Codes
Therapist A, interview 1	398
Therapist A, interview 2	285
Therapist B	377
Therapist C	378
Therapist D	364

Table 4. Example of Open Coding

Therapist B: so by the time she was a teenager she was sneaking away to crossdress	Gender expression manifesting as crossdressing. Performing gender requires crossdressing. Gender as female clothing. Sneaking away. Use of this language implies that the client knew that he was doing something wrong, potential experience of fear of being exposed or shamed. Societal expectations of gender. What social forces would necessitate a teen boy having to “sneak away” to crossdress. (I can identify and empathize with the client’s experience of having to hide, to be sneaky, to risk to be oneself based on my experiences growing up).
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Note: Wwith accompanying text and commentary, excerpt from interview with Therapist B, codes are highlighted to match accompanying content. Generated codes: **performing gender via clothing**, **fear of exposure**, **cultural regulation of gender expression**. **Interview text corroborating codes.**

The investigator also initiated a process of memoing as an accompaniment to the generated codes so as to articulate the rationale for categorizing the data and continued the memoing process throughout the data analysis. From the open coding phase, data analysis proceeded to discovery of initial emergent themes that were generated through the process of abstraction. Abstraction involved themes of similar concepts being grouped together by an overarching concept such as a pattern or relationship that

connected the themes together. Abstraction was used to begin to reduce the volume of open codes to more general themes. The investigator then returned to the original transcript and recoded utilizing the distilled themes. This method was repeated until a group of themes representing the essential interpretation of concepts regarding the case emerged from the data analysis process. The process of abstraction and distillation of subthemes was completed for one interview transcript before proceeding to the next case. In other words, transcripts were analyzed independently of each other on a case by case basis before proceeding to cross case comparison.

Cross case comparison involved a similar process of abstraction to yield a further set of subthemes which then were abstracted to yield master supraordinate themes. The investigator utilized the subthemes and master supraordinate themes to recode across cases so as to support the emergence of the final concepts discussed in the findings section of this investigation. The subthemes and master supraordinate themes were mapped onto domains that summarized the aspect of the phenomenon being described in terms of therapist activity in interacting with the phenomenon. Therefore, themes were grouped according to the following domains: conceptualization, treatment, and impact of the phenomenon on the self of the therapist.

It should be noted that in accordance with the interpretative methodological framework of the study, the investigator's method of data interpretation evolved over the course of the data analysis phases, moving from a more descriptive, phenomenological stance towards a more interpretative stance that critically evaluated

the participants meaning making process. This included an effort to discern the participants' motivation, i.e. what the participant may be trying to achieve, in interacting with the phenomenon, and whether more than one level of meaning/intention could be ascribed to the participant's actions, the participant's level of awareness of different motivations/intentions and how these connect to the context of the therapeutic relationship and participant understanding of the phenomenon. Memos incorporated the connections of the investigators critical interpretation to constructs within the peer reviewed literature so as to develop a full understanding of the relevance of the emergent themes.

Credibility and Trustworthiness

In any qualitative research study, it is essential that the "trustworthiness" or rigor of the research design be explicitly addressed (Merriam, 2009). In particular, in order to maximize "credibility" (Merriam, 2009), it is incumbent upon the researcher to strategize the means by which the conclusions arrived at are evident to the reader. In the qualitative paradigm, one means of demonstrating credibility is through respondent validation of generated data. This is accomplished through engaging in member checking of emergent themes culled from the interview data (Merriam, 2009).

Member Checking

This was accomplished in the current study via the author contacting the participants for follow up to obtain feedback regarding their experience of the research and their opinions regarding the investigators preliminary data analysis. Excerpts of the

interview transcript along with a sample of emergent themes culled from the interview data were provided to all participants. All four of the participants were invited to comment on the themes as to whether they were representative of the participants intended meaning in comparison to the supporting quotations from the interview transcript. Three of the participants responded to the investigators request for feedback. These three participants were provided with samples of emergent themes along with the supporting text from the interview. Two of the participants posed questions to the investigator as to how he selected these particular themes. The investigator explained the connection that he perceived between the categorized interview text and the theme. In the end, the three participants who provided member checking indicated agreement with the initial conclusions of the investigator in terms of the emergent themes and also provided feedback regarding their overall experience in the study.

Independent Audit

Additional means of maximizing both credibility and consistency of the conclusions arrived at by the researcher involved producing an audit trail which incorporated the memos/field notes into a diary that is easily accessible, saturating the observation of the phenomenon via repeated analysis, and reliance on an ongoing self-reflexive stance towards data interpretation (Merriam, 2009). It should be noted the Interpretative Phenomenological Method does not recommend inter-rater reliability as a method of assuring the quality of the study (Smith, 2009). Rather, the method of

independent audit of the research process by an individual not affiliated with the project is recommended. This auditor follows the investigator's thought process from the exploratory noting, to open coding, to memoing to the emergent code and checks to see that the investigators conclusions are logical and the connections between interpretation and the interview text are sound. The auditor also offers feedback regarding their own reactions to the generated data which the investigator can then use to accomplish further analysis.

An independent audit is not at all the same thing as inter-rater reliability, commonly used when quantifying the analysis of open-ended material. The independent auditor is attempting to ensure that the account produced is a credible one, not that it is the only credible one. This speaks to the particular nature of qualitative inquiry. The aim of an independent audit is not to produce a single report which claims to represent the 'truth', nor necessarily to reach a consensus. Instead the independent audit allows for the possibility of a number of legitimate accounts and the concern therefore is with how systematically and transparently this particular account has been produced. (Smith, 2009, p. 183)

Therefore, the investigator triangulated the analysis by selecting three peers of the research investigator to review the translation of raw interview material to the interpreted emergent themes. Two of the peers are licensed psychotherapists with several years in practice, one of whom also has experience working with the LGBT population. The third peer is a colleague from the investigator's doctoral program who had experience conducting qualitative research. Each peer was provided with a different interview transcript so as to maximize the material subjected to audit. Each peer was also provided with the exploratory notes, memo/field notes, and corresponding identified themes along with the excerpts of interview text connected to

the themes. The peers reviewed the provided material, and submitted written feedback to the investigator. All three of the auditors found the conclusions of the investigator to be logical. One of the peers provided such useful feedback that the investigator was able to incorporate new ideas into the final analysis.

Additional Means of Assuring Credibility and Trustworthiness

Additional means of ensuring the quality of the current study involve further efforts at transparency. Extended verbatim quotes extracted from the participant interviews are offered to the reader so as to permit the reader to judge the investigator's thematic conclusions.

Because such care is taken with the collecting of data from participants and with grounding analytic claims in the data obtained, a strong IPA study will thereby be demonstrating a sensitivity to the raw material being worked with. So a good IPA study will always have a considerable number of verbatim extracts from the participants' material to support the argument being made, thus giving participants a voice in the project and allowing the reader to check the interpretations being made. And good IPA is written carefully, making claims appropriate to the sample which has been analyzed. Interpretations are presented as possible readings and more general claims are offered cautiously. (Smith, 2009)

The investigator endeavored to create a thick description of the participants' experience of the phenomenon of genital self-mutilation amongst their clients. Conclusions drawn from the data represent the investigator's "reading" of the participants meaning making process.

Subjectivity of the Investigator

Finally, as previously mentioned, the research author's subjectivity is inescapable and an ongoing self-reflexive stance towards the phenomenon observed necessitated

the use of bracketing to encapsulate and suspend the author's assumptions and beliefs in the initial phenomenological analysis. The subsequent interpretative process allowed the author's experiences both personal and professional to contribute to an informed comparison of the phenomenological themes to relevant constructs from the literature review. The personal experience of the investigator with the phenomenon of study will be discussed in Chapter V of this study.

CHAPTER IV

FINDINGS

The aim of this study is to explore the lived experience of psychotherapists who work with clients who self-identity as male to female transsexual and who engage in genital self-mutilation. The findings of this study are based on the transcript analysis of semi-structured interviews with psychotherapist participants. In order to provide a rich, thick description of the therapist experience of this phenomenon, verbatim quotes from the interview transcripts will be provided so as to demonstrate the support of the emergent themes derived from the data analysis. It is hoped that this will provide the reader with an in depth understanding of how participants generated meaning of the phenomenon in discussion with the investigator.

Participant Profiles

Four clinicians chose to participate in the research. Their names and identifying information have been changed in order to preserve confidentiality.

Sally

Sally is a clinical social worker who has been practicing for over 30 years. She describes herself as having a lot of experience in providing psychotherapy to the transgender population. She shared her experience of working with a male to female

transsexual client who self mutilated approximately six months into their work together. Sally's interview lasted one hour and 41 minutes.

Robert

Robert is a clinical social worker who has been practicing for over 13 years. He characterized himself as familiar with the transgender population but stated that his experience of providing direct psychotherapy services to this population was minimal. He did share a case of working with a male to female transsexual client who self-mutilated approximately nine months into their work together. The context of their relationship was a social service agency in a large metropolitan area whose mission is to serve the LGBT population. Robert provided both case management and psychotherapy to his client. Robert's interview lasted one hour and 16 minutes.

Katy

Katy is a clinical social worker who has been practicing for over 15 years. She characterized herself as specializing in providing psychotherapy to gender variant individuals. Katy shared two experiences that she had with clients who were male to female transsexuals who engaged in genital self-mutilation. Katy's first experience took place in the context of an emergency room where she was the attending social worker. In this experience, she witnessed firsthand the aftermath of the client's attempt to remove the genitals. Katy's second experience was in the context of her private psychotherapy practice where she reported working with a male to female transsexual client for several years who chronically resorted to thoughts and fantasies regarding self

mutilation and then at times would injure the genitals in various ways; for example by constricting blood flow using rubber bands. Katy requested to participate in a second interview following the first interview with the investigator. She found it useful to talk about her experiences and wished to share more. Katy's first interview lasted 55 minutes, her second interview lasted one hour and six minutes.

Elaine

Elaine is a licensed clinical professional counselor and a certified sex therapist. Elaine has been practicing for over 30 years. Elaine characterizes herself as a trans advocate and she reports that she's had experience providing psychotherapy to approximately five transsexual or transgender individuals. Elaine shared her experience of working with a male to female transsexual who attempted self castration on multiple occasions. Elaine reports the client's first attempt at self castration took place immediately prior to their beginning a psychotherapy relationship and that further attempts took place soon after the therapy was initiated. Elaine reports that she worked with this client in therapy for several years. Elaine's interview lasted one hour and five minutes.

All participants discussed their clinical understanding of the behavior of genital self- mutilation, what factors they believe are relevant to understanding the roots of the behavior with their particular clients or the male to female transsexual population in general, the characteristics of the person who engages in such behavior, the interpersonal context of the behavior and the relevant social conditions which they

consider to influence the manifestation of the behavior. The following discussion explores the subthemes contributing to the supraordinate themes emerging from the data analysis. Supraordinate themes represent the common concept abstracted from the connection between sub-themes. Through the process of data analysis, supraordinate and sub-themes were mapped onto three general domains constituting different aspects of the participants lived experience of the phenomenon of interest.

Domain 1: Themes Related to Conceptualization

The following themes can be mapped onto a larger construct of “conceptualization.” In other words, the themes discussed represent the factors participants deemed salient to understanding how they clinically conceptualize the phenomenon of self-mutilation. Table 5 presents a visual display of the supraordinate and corresponding sub-themes associated with this domain. So as to facilitate the reader’s understanding of the connection between subthemes and the supraordinate theme, the excerpts supporting the theme definition will focus first on discussion of the subthemes and then conclude with the explication of the abstracted supraordinate theme.

Emergent Sub-Themes Supporting Concept of Client Experience of Psychological Pressure

Conceptualization emergent sub-theme 1: Female gender identity as the client’s authentic self. Participants made reference to the felt sense of urgency clients experienced in relation to a growing awareness of gender variant feelings and a desire

to publicly express those feelings. Gender identity was described as a force emanating from within that was irresistible and would ultimately overpower the client. The conceptualized understanding of this client experience was the sense that female gender identification was essential to one's core sense of self. So essential, in fact, that participants believed it would inevitably surface within the clients' consciousness and behavior despite social stigma and internalized transphobia.

Table 5. Domain 1: Conceptualization

Subthemes	Supraordinate Theme
<ol style="list-style-type: none"> 1. Female gender identity as the client's authentic self 2. Toxic Shame 3. Double Bind 	Client experience of psychological pressure
<ol style="list-style-type: none"> 4. Social Obstacles to Self-Actualization 5. Insufficient Coping Mechanisms 	Constraints on Client Sense of Agency
<ol style="list-style-type: none"> 6. Self-Mutilation as harmful physical action 7. Self-Mutilation as attempt to problem solve 	Protecting the Self through Action

In this excerpt, Katy discusses her sense of the futility of suppressing one's basic identity:

if what you're telling me is can you ignore it, will it go away, will you feel better about not doing anything about it, no, you won't, eventually our identities come knocking, who we are always comes knocking, we can never, it's the only thing we can't get away from, we can ignore everything in our lives, we can ignore all kinds of things, but who we are at our core we cannot ignore.

Elaine emphasized how difficult it is for the client that has been hiding for so long to continue to restrain female gender expression. She describes the factor of time as pressing on the client's awareness in different excerpts throughout her interview:

they can't contain it anymore...there's an analogy for the developmental person...comes a point where my insides and outsides have to match.

remember she was developmental, remember? So it comes to a point where I've got to take some action.

but but there's something that they get to, the developmental point of awareness that you have to do something.

there are some people who know something is wrong, something is not matching from as far as they can remember, and there are some that become aware as they start growing.

Robert referenced his sense that gender identity is even a more essential part of self-experience than sexuality, speaking to the sense of gender as a building block of the mind. In his opinion, such a fundamental piece of self could not be suppressed.

and I've thought about it in the sense that it seems like a sense of gender or one's own identity predates sexuality in terms of how own identifies with their sexual attraction, it's pretty elemental to who one is.

its subjectively set in stone. And so because it's someone's fundamental understanding of themselves, and because it's so early, it's not something that can be tinkered with.

Similarly to Robert, Sally shared her client's experience of gender identity as a constant mental presence informing self- experience in different excerpts within her interview:

and you know for years and years and years and years...she said that she was always a girl in her dreams. Like in her dreams at night or in her fantasies, she's always a girl, but she started to feel like I'm always hiding tremendous shame.

Here Sally references her sense of gender identity as closely connected to self concept.

because to me the essence of this whole process is about identity, it is about sense of self. It is about sense of self in a very core fundamental way and parts of identity and the essence of one's identity. And language has meaning...and that particularly with this language in terms of gender, it's such a core sense of people's self.

From a general perspective, participants viewed repression or suppression of gender identity as deleterious to the self and creating a vulnerability to psychopathology. Participants contrasted the clients' experience of their female gender identity with their experience of male embodiment. A common theme in reviewing participants understanding of the client's relationship to their body was the feeling of being trapped or hating the body.

Here Katy describes the intense self-hatred her client experienced that made looking in the mirror emotionally painful. She characterizes her client's sense of self as being violated by her physicality:

she hated her body...she hated how she looked, every time she looked in the mirror all she saw was this guy and she wasn't a guy. Like your body betrays you, right? It's a betrayal of I think just such a primal thing...that when you look in the mirror who you are is not who you see.

Elaine shared her sense of the distancing or disavowing of the genitals as representative of the client's antagonistic relationship with her body. The genitals are experienced as foreign to the self and cannot even be named by the client.

Here Elaine quotes her client directly: the feeling of being a female incarcerated in a male body was very painful, I tried to remove that part of my body that shouldn't belong to me.

Again quoting the client directly: I tried to remove my unwanted organ (Elaine's comment on client's quote) that's a threat, it's so disconnected, an unwanted organ doesn't even have a name, the body part you know.

Robert discussed how in listening to the client in the course of their interaction the issue of body hatred emerged and how he expressed his understanding of her negative relationship with her body through validating her pain:

well the first thing that came to my mind was self-hating, that was just where my mind went.

but in terms of hating her body, that had come up. And I remember validating, 'well I understand that that makes sense to me'.

Sally described the psychological crisis her client experienced at the onset of puberty which intensified her disgust with her body and how this disgust persisted into her adult life:

you know right when puberty started, like panic, just when her body was starting to change, just out of her mind beside herself. Panic, and I mean a lot of confusion. I mean she had no idea and had nobody to talk to, and this is what people describe, just a lot of self-hate.

so not feeling ok with her body since 7. Feeling really disgusted, and wanting to disconnect from it, from puberty even in a very more conscious intense way.

Conceptualization emergent sub-theme 2: Toxic shame. According to participants, female gender identity as a vital part of self-experience conflicted with feelings of self-hatred. Additionally, from the therapist perspective, feelings of shame and feeling like they were hiding something shameful were perceived to be common to

all clients. The experience of shame was perceived as having a toxic effect on the self of the client.

Katy's point illustrates the opinion common to all participants, seeing shame as fundamental to their sense of self:

I think the biggest, the overarching thing that people bring is shame. Shame is at the core of all of it, and it's the thing that's hardest to work out, I think that's true for most things that we deal with in therapy though is that core of shame.

Robert referenced the heightened sense of self-consciousness that accompanies feelings of shame; his client felt negatively scrutinized by others and this predisposed her to intense shame reactions:

and I remember the phrase it's not really paranoia if people are really out to get you. I wouldn't consider it a thought disorder if she thought everyone was judging her....that's projection based on her reality.

Elaine points out her client's fear of exposure of gender variance:

so by the time she was a teenager she was sneaking away to cross-dress and you know it was developmentally that way. She got married and was still sneaking around cross-dressing until she was discovered cross-dressing and of course that causes chaos, especially when there's been total secrecy.

Here Elaine shares her client's efforts to conceal her female gender identification from her wife. Even when the client's secret was revealed, she attempted to convince her partner that she would not transition:

(Elaine quotes the client here), I kept this from partner since I didn't want her to worry about...

(Again quoting the client directly) after I shared with her my secret and tried to reassure her that I was not going through with the gender change

Sally depicted the connection of feeling different to her transgender clients' experience of shame:

so they all talked about feeling different, they all felt like something wasn't right, or that they wanted to hang with the girls, or they wanted to wear girls' clothing, or they just didn't feel right.

that act of feeling like they had a secret was very shaming, and so this is what I've seen across the board. And that has that impact, feeling like there's something different, that they had to hide.

Therapists connected feelings of shame to a variety of sources including the clients' negative relationship with their body, the sense of being different and less than in comparison to others, and experiences of interpersonal rejection. Shame was perceived as toxic in that it was regarded as interfering with psychological development by diminishing the clients' self-esteem and relational capacities.

Here Katy discusses the messages that the client internalized that negate the gender variant identity and negatively impact self-esteem:

And then it's likely that you grew up hearing that you should not feel the way that you should. So you have a person that grew up hearing that you can't feel that way, like that's actually not right, no you're a boy, you know. So you have this person who already mistrusts themselves, who already has been taught that you can't feel how you feel, and that you really need to change that because it's not ok if you do feel that way. So they're already starting from kind of behind the 8 ball, in terms of their development, and their psyche, and you know how they feel about themselves in the world. I mean it's unfortunately...too rare that trans people have decent self-esteem. That they feel like they, you know like who they are.

Robert discussed how his clients experience within her environment of bullying around gender variance resulted in a defensive posture to protect a fragile self-esteem, her shame in essence warping her self-presentation.

I know that it's very true that kids can be enormously cruel and I imagine that grade school, middle school, high school was tormenting. And so for all of those reasons, I think about the flat affect almost being an extension of a sense of herself which was very small, almost like the core of her personality was deep inside, and the rest was armor, there was a lot of armor there....

Elaine remarked on her client's difficulty empathizing with others in connection with a history of non-empathic responses to her own transsexual identity:

on the negative side...she...suffers, I don't know, she has indications of some real strong narcissism and she felt quite entitled.

Throughout her interview, Sally referenced her client's struggle to manage self-care and relationships due to an inadequately developed sense of self.

I mean there's a lot of adult growing up developmental stuff that hadn't happened the way it needed to happen. And I connect that to the gender issue in the sense of having to hide and all the things that interfered with her own development. I mean some of that maybe would have happened with her no matter what just from her family of origin issues, but it was dramatically exacerbated by substance abuse and the gender identity stuff.

that they had to hide interfered with the formation of friendships and relationships. That was the permeating factor that I've seen in everybody with kind of gender identity issues at the core.

Sally describes her client's porous boundaries; the client's conscious access to her own feelings and needs is impaired by a history of others not recognizing those needs:

not doing street drugs but drinking tons of soda and sugar, bad eating habits. Very disrupted sleep... a lot of self-judgment, a lot of rescuing activities with the girlfriend, a very difficult time setting boundaries in terms of even identifying her own needs or taking care of them, and then, yeah, feeling really disgusted.

In particular, therapists likened the impact of shame on their clients in terms of a developmental arrest. In the therapists' opinion, skills such as affect regulation and the ability to engage in self-care were negatively impacted by the clients' efforts to cope with overwhelming shame. Thus, participants described clients' vulnerability to psychopathology such as states of depression, substance use, impulsivity, or poor self-care habits. They viewed their clients as adapting to their life circumstances to the best of their ability despite painful experiences of shame.

Conceptualization emergent sub-theme 3: The double bind. Participants described the dilemma that the drive to claim and express identity created for the clients. From the therapist perspective, clients coped with negative reactions to their wish to transition from significant others in their environment. Just as gender identity was experienced as a vital component of self, so too were relationships with significant others and/or members of the family of origin. From the therapist perspective, the competition between these aspects of self was experienced by clients as creating an impossible double bind. Yearnings for self-expression collided with the risk of rejection and the pain of loss of significant others. Thus, congruence between private and public self was conceptualized by participants to come at a high price for the individual. According to participants, they believed that clients perceived this as a no win situation

in which part of the self would need to be sacrificed to ensure the other part could continue to exist. In other words, in the therapist's understanding, expression of female gender identity and maintaining relationships with loved ones were mutually exclusive propositions for their clients. Therapists believed to make either choice meant pain for the client.

Katy described the sense of a no win choice for her client:

there was a thought that she didn't want to be male, like she didn't want her body to be male, that's what she didn't want...she, she very specifically, not he, she wanted to live...but no one in her life was allowing her to live, they all expected her to be him...if he had to live, she couldn't right?

and so who are you gonna choose, you or everybody else?....and so to choose you is almost impossible, like you know if who you are going to be is going to disappoint every single person and you could lose everybody, to choose yourself is huge.

Here she describes the client's rejection by her family of origin based on her female gender presentation:

they continually refuse to call her by her legal name, which is a female name now, has been for years. They refuse to call her by her legal name. They call her by her given male name. They will only refer to her as male. They keep talking about it as if this is just some kind of scatterbrained, harebrained idea that she has that she's female. There's not any acknowledgement that she is who she is, nor any respect around that. So what will happen is if she has a lot of contact with them, in between the time I see her, then it's likely she's going to wind up feeling horrible about herself and hurt herself in some way.

Robert details the negative consequences of his client's gender expression on her family and her romantic relationship:

her family was awful towards her and so she felt basically discarded ...quoting the family 'when you change your mind and accept the fact that you're a man you're welcome back'.

but in her case I do recall that she started seeing someone... and she did not disclose her gender, and so when they became intimate, obviously the guy found out and was furious, and kind of pushed her away, but that level of rejection compounded other kinds of rejection...and it's kind of that if 'if I didn't have a dick this relationship would have worked'.

Elaine talked about her client's intense fear of losing her marriage based on her gender expression:

or the partner wouldn't stay with her, so I think for her in the desperateness that comes, the only way to survive this was to keep it secret, the conflict inside was horrific.

all of this was building up, but then she had these restrictions, 'I don't want to lose the marriage, I don't want to lose the legal situation', so it distorted her thinking.

Sally discussed her client's feelings of rejection in relation to her girlfriend's negative feelings regarding her transition:

feeling rejected because the girlfriend doesn't accept that I'm transitioning. The conflict was very specifically, or at least in my client's mind, with the girlfriend, the alcoholic girlfriend, related to you know her transitioning, and who she was, and feeling tremendously, completely rejected. It really brought all that stuff to the surface.

Participants conceptualized the intensity of the affect associated with such a double bind as experienced by the client as tantamount to annihilation anxiety as the authentic self of the client was threatened with extinction by social expectations. From the therapists' perspective this pressure was untenable and unsustainable for a client

who was already hyper-vigilant to rejection. Participants also described the pressure of the double bind as being amplified by the client sense of isolation and secrecy.

Conceptualization Supraordinate Theme: Client Experience of Psychological Pressure

In deconstructing the therapist understanding of the motivation of their clients behavior, therapists' discussed the forces they believed impacted the client's decision to engage in genital self-mutilation. One of the explanations participants relied upon characterized their clients as experiencing significant conflicts at both the intrapsychic and interpersonal level. As clients sought to confirm a gendered sense of self, these conflicts were seen to contribute to a sense of psychological pressure that threatened to overwhelm the vulnerable self of the client. Participants describe their clients frequent experience of fear of exposure connected to internalized shame and rejection connected to the expectations imposed on them by others who could not accept their female gender identification. What this meant for the client in search of validation was a continual risk of collapse under the prohibitions around self expression.

Katy summarizes the theme common to all participants understanding of their clients' psychological experience that coping with their conflicts was like waiting for a bomb to go off:

I think it's that internal loathing that builds a pressure so much that it feels like it's going to explode.

Emergent Sub-Themes Supporting Concept of Constraints on Client Sense of Agency

Conceptualization emergent sub-theme 4: Social obstacles to self-actualization.

In addition to experiencing the double bind of choosing between gender identities or

significant others, participants assigned significance to their clients struggling with feelings of powerlessness in relation to the institutions with which they interacted and with society in general. According to the therapists, clients' ability to enact their transition process was hampered by lack of access to resources such as hormones, supportive medical providers, obtaining or maintaining employment, obtaining permission from health insurance to reimburse gender transition procedures, or fears of the impact of transition on legal battles

In discussing her client's experience of powerlessness, Katy referenced her client's struggles with insurance authorization and reimbursement for transition procedures:

she had said that she was a decorated military veteran, and that she had been in X war. And she had spent many years in the military forces, and she was...you know really successful in her life...but she she had retired from the military forces, and she was trying to transition because she knew that she was female, and that she wanted to transition physically. She had X benefits and she had good healthcare at the time, but they would continually deny her. They would not allow her to do anything related to her transition and she felt very stuck. She had continually tried to get help through her healthcare and tried to get things done and tried to do all of this, and continually she was denied. They wouldn't do it because they didn't consider it relevant or preferable in terms of her insurance.

Robert believed his client's socioeconomic status and her limited financial resources necessitated turning to black market hormones to facilitate her transition. He points out how in her mind, gender confirmation surgery was experienced as beyond her reach given the struggle just to obtain hormone treatment:

I do remember that she couldn't afford hormone treatment. And so she kind of got street versions of it which I think compromised her health because of how illegitimate they were. They're not exactly monitored by the FDA...but I think that had an effect on her...everything, I mean physically as well. I think the psychological piece would be recognizing that the only path to hormones was the street, and I think that fueled her sense that she didn't have the resources. She didn't have the resources to get them from her doctor, how is she gonna have a gender reassignment surgery?

Elaine pointed out the challenges her client coped with fighting a legal case and how a gender transition was perceived as jeopardizing the chances of a successful outcome:

she was keeping everything so secret. She wasn't pursuing anything because her family did not have (explains legal situation here) yet they were (legal status), ...they didn't want to do anything that could interfere with them getting (explains legal situation) so that was that was kind of a unique thing that doesn't happen with everybody. That was one of the elements.

Sally described her client's despair following her job loss which threatened her financial and healthcare resources to enact her transition:

she lost the job she had right away after we got together. And then was terrified. She was unemployed for awhile, and when she got the next job, there was like no way that she could do that right away (referring to transitioning, because there was a lot of financial issues. This is the other thing, when you work with people you're not dealing with just one issue with anybody. She had maybe a few more layers somewhat than other people, but I've never had somebody who just had one issue you know what I mean? There's medical, there's financial, I mean you're balancing all of these factors that people are bringing, along with the transition issue. And they all interact and are connected in different ways. You know, do you have insurance? And can you afford what you need including my services?

In the therapist's opinion, these social impediments to the self-actualization of gender identity resulted in clients feeling a lack of control over their ability to manage their bodily transformation. The road to transition was perceived as longer and more difficult given the challenges in navigating these social obstacles. According to participants, this left clients feeling frustrated and hopeless. Therapists conceptualized this feeling state to be one of intense desperation.

Katy discussed how devastating the client's lack of control was and how this predisposed the client to desperate action to regain a sense of control:

but if you are so desperate, if that is the piece that you see, like that's the only thing keeping you, that that's the one thing that you want and you haven't been able to do, that there's a desperation in that because there's nothing else to do.

Robert likened his client's emotional state to hitting rock bottom. The pain associated with a lack of control could not get any worse and called for drastic measures to rectify it:

at the time I didn't, the word that came to mind for me was desperate. And not desperation to die but desperation to change....just an absolute fatigue with it. In a very different way like from a recovery perspective it's when people say sick and tired of being sick and tired, kind of a bottom.

Throughout her interview, Elaine described the intensity of her client's desperation as exceeding containment even by inpatient hospitalization:

so just to show how desperate they get, even though he was hospitalized.. He tried it again you know what I mean? That doesn't make sense to many people. This is how desperate they get.

the last hospitalization, yeah those are factors. Now you may talk with other professionals who work with self- mutilators who wouldn't have

the same set of circumstances, but this self-mutilation is desperate if you ask me.

I think self-mutilation is a very desperate...it's hard to comprehend, a desperate measure, you know.

Sally felt that her client's emotional state of desperation was unbearable to the point of thinking becoming painful to the client and setting the foundations for the use of action to solve emotional pain:

I think all of those factors led to that behavior. Kind of really a lot of self-hate, a lot of desperation, a lot of overwhelm, for all those things set her up, for that.

Conceptualization emergent sub-theme 5: Insufficient coping mechanisms. Just as client's experienced their transactions with the institutions in their environment as punitive or non-supportive, therapists described clients experiencing a lack of choice with regards to the defenses they used to protect themselves from emotional pain. More specifically, participants described clients feeling powerless in regards to coping with the waves of strong emotion connected to experiences of rejection or shame. Participants viewed clients as relying on rigid coping mechanisms by which they diminished awareness of their self or their environment. Participants believed this was representative of the client's limited psychological repertoire for solving emotional pain.

In Katy's understanding, in a general sense, she differentiated the transsexual client who self-mutilates from the transsexual client who does not by virtue of the degree of defensive dissociation from their body:

and it's those that are kind of more disassociated from their bodies, and then those that are not, and the more disassociation from their body and

their body parts, the more that they are not connected to themselves as a physical being, or the more that they have a lot of self-loathing around how the body looks and their experience of their body, they're more likely to self-mutilate.

versus somebody who is more dissociated from their body, you know from people who have a hard time. The classic 'I can't look at myself in the mirror'...who won't talk about their genitals. They sort of talk about it as 'down there'. They won't talk about it. It's very removed, it's very dissociated, and that seems to be one of the primary things I see, so it's like if there's more dissociation they're more likely to harm themselves.

Katy then described her specific client's negative relationship to her body and her lack of impulse control as contributing to self-mutilating behavior:

having gender difficulties which meant that she had no ability to be able to sort of manage the overwhelming feelings that would happen by her body betraying her, which would then ultimately make her injure herself, because she didn't have any other coping skill right? She just wasn't mentally, emotionally capable of having another coping skill, so she injured herself...I mean the difficulty with her would be that she has poor impulse control.

Elaine viewed the intensity of her client's fear causing distortions in her thinking and problem solving capacities. At different points in her interview, she shared her belief that the client's fear constricted the ability to think through solutions to his conflicts that did not involve self-harm:

and anxiety works physiologically as well as emotionally, so I think the body and the emotions go well together. The cognitive part is where my client was distorted because all of this was building up, but then she had these restrictions, 'I don't want to lose the marriage and I don't want to lose the (legal situation)' so it distorted her thinking because there were too many impediments. She was bumping up against these impediments" "I think the reality of losing the marriage and losing the legal situation is founded. I think where the distortion came out is how to resolve those two factors. That's where I think the distortion came out...that's why she chose to do it herself.

It was her secretness and her desperateness to stay married and be (names legal situation here). Those issues were blocking her thinking sometimes because she could not see her way out of this.

Robert discussed how his client cut off feeling entirely and at times engaged in substance use as a means of managing pain:

I remember how likeable she was, but frequently how flat or blunted she was as well. And I don't recall psychotropics, what she was on and not on...but when I reflect on it now, I would see some of the blunted affect as a defense against spontaneity, kind of holding things together out of a fear of judgment.

I think more in terms of self-medication, and certainly the more drastic versions are also self-medication...an experience of intolerable pain that someone doesn't have the appropriate tools to manage.

and so we can go on the wild goose chase of why, and so I think at the time I could say 'well no wonder she abused' which on some level makes sense.

Sally found a connection between her client's impulsivity and difficulty tolerating painful feeling:

I think some of the self-mutilation had to do with just impulsivity. I mean kind of like dry drunk, like not using. She had come to me when she wasn't using substances, but she also hadn't learned self-management skills in terms of tolerating frustration, delayed gratification. Tolerating sadness, affect management, which there's a lot of here and so she was missing all these good coping skills.

Here Sally points out the client's survival mechanism of dissociation, substance use, and avoiding her own emotional turmoil through a compulsive focus on others' predicaments as no longer working to block out intolerable affect:

had she learned to disconnect from her body and her feelings to try to cope, oh yeah. She probably wouldn't have made it to see me if she

hadn't learned how to kind of numb some stuff out right? And she did it with drugs and alcohol, and then sometimes she even did it with just staying super busy with work, rescuing other people and staying all focused on them. Just disconnecting from her feelings, shutting them down, a lot of compartmentalizing because she didn't have any other skills. Really what happened I think that there were so many things going on that paradoxically those weren't working. In other words, it's like that fear of abandonment, and rage and shame, she couldn't tap all of that down in that moment. There were too many things going on at once, and so I mean I think that set her up to look to a behavior that she had not done before.

Interestingly enough, despite the intensity of the feelings and the lack of coping mechanisms, participants did not characterize their clients behavior of genital self-mutilation as being motivated by psychotic process or by suicidal ideation.

Conceptualization Supraordinate Theme: Constraints on Client Sense of Agency

Participants discussed their sense that clients felt themselves to be at the mercy of an environment indifferent to an urgent need to transform the self and simultaneously overwhelmed by feelings of disgust and shame regarding their physicality and being different. According to participants, clients experienced a psychological state of overwhelm brought on by factors that detracted from an ability to enact self-actualization. In other words, participants described constraints on the client's sense of agency; the self was hampered in carrying out wishes vital to expressing core identity. In the participants' opinion, powerlessness was connected to the clients reduced access to social resources necessary to facilitate a gender transition process. Additionally, from a psychological standpoint, participants felt that the clients coping mechanisms for managing the stress of frustration related to the challenges in their

environment as well as to be able to withstand the critical feelings of self-hate from within were not adequate to contain the depths of pain associated with the marginalization of the transsexual identity.

Participants felt clients were unable to regulate feelings of shame without turning to means of coping that placed them at a disadvantage in strengthening their efforts to transform themselves. Dissociation, impulsivity, substance use, codependent relating, and constricted thought process were representative of the clients' best effort to manage emotional pain. While these defenses may have temporarily helped the client to survive, ultimately participants felt that the clients experienced themselves as being victimized by a storm of emotions with little chance of redressing the factors contributing to the power of those emotions.

Katy's opinion reflects the common opinion of all participants that the constraints on the client's sense of agency amplify frustration and the need to find a solution to an unbearable sense of powerlessness:

how long they have to deal with having the body that they don't want, so I mean, if you think about it in terms of sort of a level of frustration or a building right? Of feelings, like this one person, when she had tried to cut off her penis, she had been trying for years to get surgery, that's all she wanted, and she had been trying, and had been denied over and over and over right? So in some ways it was like a tipping point. Would she have self-mutilated if 10 years prior they had granted surgery?

Subthemes Supporting the Concept of Protecting the Self through Action

Conceptualization emergent sub-theme 6: Defining self-mutilation as harmful physical action. Self-mutilation was defined by all participants as a direct act of physical

harm deliberately self-inflicted on the body. Self-mutilation was differentiated from a broader concept of self-injury which was viewed as including behavior that indirectly harmed the self, for example neglecting health care or engaging in substance use. The participants also described self-mutilation as harm resulting in tissue damage or blood loss.

Sally notes the active nature of harm directed at the body as constituting self-mutilation and contrasts this with self-injury which she sees as a more passive, indirect form of harm:

let me say that I probably used to think of self-mutilation more specifically as cutting because I was introduced to that term working with clients. Seeing clients that have done something like burned themselves or other kinds of things...It's evolved, my understanding. I think of self-mutilation in terms of the physical body, and self-injury I used to think of it as pretty much the same as that, but really now I hold that term self-injury in a little broader way. For example, you're sick and you don't go to the doctor and now you have bronchitis.

Here Sally describes the variety of tools that an individual might utilize to enact self-mutilation:

so I've seen people use exacto knives. I've seen people use razor blades. I've seen people use pieces of glass. I've seen people use knives. I've seen people use things that burn like cigarettes. Pens, oh my gosh...somebody used sandpaper once. Oh it was bad, what else? Gosh in terms of this, and this is really, I'm talking in terms of bodily injury now, I'm thinking in terms of bodily injury.

Robert discusses self-mutilation as going beyond just cutting:

Well that's not the only thing, I mean I would say knives. When I hear mutilation I hear tearing apart. Sometimes people might take an object and slam it into their genitals...I'd consider that mutilation. And that's

just from the vantage point of if something could rupture and there could be internal bleeding, there could be other damage.

Elaine used examples of quotations from the Bible to illustrate her notions of the actions defining self-mutilation:

I don't know if you're you're Christian or not, it doesn't have to be. I can't quote scripture like some people do ...in the old testament you know if your eye has offended you pluck it out, if your finger has ...well, however the thing goes. You cut it off, you know what I mean, that kind of stuff. That's what I put in the self-mutilation category...when you get to my transsexuals or transgendered people...my transsexuals especially, not my TG's cause they often stay pre-op for the rest of their life, but for my TS's ...they do try to cut off the penis or the testicles or somehow get rid of them, or intense pain for the binding you know the the female to male, the binding the breasts they can hardly breathe, I mean that to me is beyond just self-injury.

Katy distinguished between self-injury and self-mutilation by the degree of client awareness of their actions:

you can be self-injurious by eating McDonalds if you have it too much... in terms of self-mutilation it's usually more deliberate. I can say self-injury sometimes is maybe more of an unconscious thing, and not something that people feel like they consciously choose.

Katy also described physical harm as representative of self-mutilation:

I suppose that the more typical, traditional ways of looking at it would be cutting, burning, or branding...self-mutilation would be more physical acts...physical ways of harming the body.

All participants described working with clients who engaged in self-mutilation on the genitals. Clients' targeted areas included the testicles and/or meatus of the penis; and in all cases resulted in significant blood loss for the individual.

Sally explained the damage the client did to her genitals with a razor:

She cut, she cut with a razor. She almost needed to go to the hospital because she cut on the edge of the skin, like kind of close to her body, her testicles and she cut right at the edge, right close to a little bit above her pubic area, and right at the beginning of where her penis was. She made these cuts and those would be on the top part. I mean they bled obviously, but where she cut closer to the bottom where her testicles were, cause the thinner skin there that made her stop because there was more blood, and yeah she was bleeding.

Robert described his client as cutting while intoxicated to the point of causing significant blood loss:

I can't imagine how desperate it felt, but one night when she had a lot of vodka, she took out a knife and tried to do it. And I think it was, I don't know the extent of the injury, but obviously it was a tremendous amount of blood, and I think at that point she called 911.

Elaine referenced the multiple times that her client attempted to castrate herself and requiring hospitalization as a result:

I'd say unfortunate case, I mean is that I know it doesn't have to be that way ...she tried several times to remove her testicles and ...castration is what the medical term would be, causing great...pain...infections and even needing one hospitalization.

In her interview, Katy described her client's intent to remove her penis and testicles:

her main intent was to cut off her penis and testicles...which she pretty much succeeded in doing. They were still somewhat attached but...more unattached than not... and then she had started cutting on herself. And she did, she just sliced, there was cuts everywhere. She was bleeding everywhere.

Conceptualization emergent sub-theme 7: Self-mutilation as attempt to problem solve. Participants conceptualized the combination of psychological pressure and constraints at both the social and psychological level on the client's sense of agency

as laying a foundation for self-mutilating behavior. Driven by intense feelings of shame and desperation, clients coped with increasing levels of unbearable levels of anxiety. Poor coping mechanisms failed to stabilize the anxiety to a manageable degree. This contributed to a sense of powerlessness to manage their fate. Thus, in the participants' opinion, clients turned to harmful physical actions to restore a sense of control. In essence, genital self-mutilation served to either regulate overwhelming feelings or to communicate to others that which was not permitted to be spoken, namely the wish to be affirmed as female. Thus, the client attempted to transform a negative relationship to the self through an act that was motivated to serve as a release of toxic affect. Alternatively, the client attempted to transform her relationship to others by allowing the self-mutilation to speak for her.

Participants understood their clients' actions to represent a form of problem solving. For instance, self-mutilation might represent the client's attempt to solve "being torn apart" by strong feelings, a solution to coping with the pressure of hiding a female gender identity, a communication of the pain of living in a male body, or completely eliminating the torturous experience of self reflection.

While empathizing and applauding their clients efforts to manage an overwhelming situations, participants opinion was that given the intensity of the desperation, lack of resources, and lack of environmental responsiveness to the need to establish and consolidate gender identity, this particular form of problem solving was understandable but involved a high cost to the client. More specifically, participants

were concerned with the client's physical safety and the sense that the client felt they had no other option but to resolve their issues through self-harm. Additionally, participants were skeptical regarding whether the act actually transformed the client's sense of powerlessness.

Katy puts herself in the mind of her client as she attempts to explain how genital self-mutilation rids the self of a burden:

it's a complete violation, and you have no other way to get out, right? Like the only way to get out would be to literally try and tear off what's there.

Here Katy shares her sense that genital self-mutilation does not fully alleviate the client's struggles as a trans identified individual:

I don't think that it does. See that's the thing right? Like we think that it will. We think that we will feel better, it's like people who try suicide and kill themselves and they think that they just want the pain to go away, and then they do something and then they think I didn't really want to die...like that wasn't what I wanted. And they can kind of see in hindsight how that was a bad decision. But they couldn't see it beforehand. I think that people think that's gonna solve it, but it doesn't. You still have all the other things. Because ultimately we walk around in the world and nobody knows if we have penises or not....It's an assumption. So if they cut off their penis they really haven't done anything, because the assumption is that they're still male. Like now they don't have a penis but everything is still there, people still respond to them as male, people still expect them to be male, now they're just a guy who's been in a horrible accident. That doesn't really solve anything.

Katy pointed out that the client's pain of being perceived as male by others, despite her client's female gender identification as oppressive to the client's sense of self. She believed the action of self-mutilation served to visually express this inner turmoil while at the same time represented a solution to self-loathing.

and knowing that the world reacts to your body but you are inside going 'hello?' Like that's not me right? So there's the body and who everybody reacts to and everyone has expectations of and who you are as this person with a penis and there there is who you are! ...you know which is very different.

(referencing her sense of genital self-mutilation)...you know in order to give a visual to internalized pain.

Here Katy discusses how the cultural equation of gender with the genitals plays out for the client who rejects the male gender. Again, she sees the client's thought process as the pain associated with being perceived as male can be eliminated through self-mutilation.

You know for mtf into visuals everything that they get taught, that everything that we all get taught is that it's about the penis. So it seems to make sense that well, you know if a equals b and b equals c then a equals c, so let's just get rid of the penis. And then cut out the middleman and everything is fine, and the self-loathing goes away.

Elaine talked about her client's mounting sense of internal tension and the self-mutilation as a solution when cross-dressing no longer succeeded in reducing that tension:

Elaine quoting the client directly: from time to time I needed to release the inner pressure that was built up by the attempt to hide my feelings, usually I could satisfy my inner desire by cross-dressing for a short period of time without anybody noticing it...my partner has always been very insensitive, she didn't take it seriously until she found out my secret in Y month of a X year. I was hospitalized because I attempted to remove my testicles I called her from the hospital after surgery, she was shocked initially after I shared with her my secret.

Robert viewed self-mutilation as additional evidence of the cognitive dissonance created by the disconnect between a female self-concept and the presence of male

genitalia. He likened the experience of this dissonance to one of psychological exhaustion:

But with someone who's transgendered and self-mutilating, it's obviously an extension of self-identity that their penis or vagina is something that feels so foreign. I mean it's the biggest example physiologically of the differences between men and women. That there's something about it which represents a kind of emotional and psychological fatigue of living in their body, within their body.

Here Robert asserts that the intent behind the client's act of self-mutilation was to communicate the state of the client's self to others. In his opinion, her actions expressed what words could not capture:

because I think as horrifying as it was it was a very powerful communication to her doctor and to me, that this was desperate...I think it's a cry for help. A kind of parasuicidal act. For instance I recall a case, my first job out of grad school, where I was very stiff and not fully in myself with clients because I was very clinical. And there was someone who was Axis II, probably schizoid or schizotypal and ...I don't use this word a lot but very, very sick. And during one session he took his head and banged it against the desk, with blood pouring down his face and he said 'now do you understand how much pain I'm in?' ...But in some ways it was a communication of how much pain she was in. Not a direct communication from her to us, but more a representation. A very physical and graphic representation that was self-evident to us of how much pain she was in. Like a demonstration, yeah.

In a similar fashion, Elaine also talked about her client's action of self-mutilation as an attempt to communicate. One of the intentions behind her act is to make her wife understand the gravity of her wish to live as the female gender.

and I guess, well even in the two things I read, the partner just kind of minimized it or ignored it or was disgusted or something, you know what I mean? To get her to hear her, I think that was the intent, but I think it

was just one....I think self -mutilation is really; here's my solution I'll just cut it off.

Sally also felt that there was a communicative aspect to her client's behavior of genital self-mutilation. Again, action demonstrated the anger that words could not express.

Well she was thinking she was accepting, but then of course they had this big fight, and the woman got drunk. She was saying all these things like 'I don't know if I can go through this with you and I don't know if I really want this' and 'I don't think I can do this' and you know she's gonna leave, abandonment stuff....I means her first piece of it was really just feeling like screw you to the girlfriend in a way. I mean she was feeling a lot of self- hate. I mean some of that was on the surface, but she was really hurt and really angry. Like 'fine you don't want me have it then fuck you, fuck you, you know I'll show you'.

Conceptualization Supraordinate Theme: Protecting the Self through Action

Participants experienced their clients as coping with intrapsychic and interpersonal assaults on their basic sense of self-worth. Participants also believed that their clients had little in the means of social capital to protect themselves from psychological damage of correlated shame. As such, participants noted how their clients continually had to adapt to their circumstances through a variety of means so as to keep the self from crumbling under pressure. Over time, the participants believed that the clients' reached a tipping point as their already inadequate coping mechanisms were worn down in terms of exhaustion with fighting with their body and with others in their environment. Participants felt, to the clients' credit, that the behavior of genital self-mutilation did not represent a suicide attempt. Rather, participants felt that the

action of self-mutilation served a defensive function, which was restoring a sense of the self's capacity to endure that which had become unworkable.

Participants felt that the physicality of the act was in direct proportion to the client felt sense of extreme measures necessary to survive psychologically. Concrete, harmful, physical force pushed back against powers that intended the demise of the client female gender identification. Painful feelings of shame could be placed outside of the self via concretization and then managed by harming the dissociated body part that was perceived as 'not me'. A fantasy of being able to make the pain disappear could be carried out by physical means.

Simultaneously, participants' believed the client attempted to reclaim some power by demonstrating the ability to define the body rather than being defined by others. In other words, as the clients bids to influence the environment regarding their gender identity failed, the client could preserve some sense of agency through communicating to others both the wish to alter the body as well as demonstrating through literal means the emotional pain of being forced to do this singlehandedly due to lack of environmental support.

Sally's quote summarizes the participants understanding of the mental state of their clients in motivating the behavior of genital self-mutilation. The assertion is that in the client's mind, the cessation of suffering was equated with the removal of the genitals. This also served the function of precluding the need for self-reflection; anxiety could be evacuated through action rather than grappled with through thought:

(describing the mental state of her client) I can't stand this and just like I don't want to have to think about this. Like I'm gonna gonna cut this. I'm gonna be done with these testicles, these genitals and it's like that's gonna fix it. I don't have to think about it. You know I just can't stand this anymore. It's too much. I can't deal with this too. I don't have to think. You know like somehow their genitals came to symbolize all the shame, cause of rejection, cause of hurt, cause of the emotional pain. Like if I could just cut these off then I would not hurt anymore. I won't get rejected, I won't hurt...it was somehow, now I'm gonna be like freed from... It really was in some ways almost like her mindset when she was a teenager with the drugs, I'm gonna take this and I won't feel any pain, like I won't have to be in this pain.

Domain 2: Themes Related to Treatment

While the aforementioned discussion provides a sense of how participants understood the meaning of the behavior of genital self-mutilation, the following themes emerging from the data analysis mapped onto the broader concept of treatment.

During the course of their interviews, all participants addressed both how they specifically worked with their clients and hypothetically how they might work with a client who has engaged in genital self-mutilation in the context of a psychotherapy relationship. These themes revealed the participants experience and understanding of the goals and interventions in treating a transsexual client who engages in genital self-mutilation.

Emergent Sub-Themes Supporting Concept of Affirming Female Gender Identity

Treatment emergent sub-theme 1: Supporting client self-definition. All participants described witnessing their clients' confusion and panic regarding understanding their female gender identification. Participants actively encouraged clients to explore their feelings and thoughts regarding their gender identity and

developmental experience as a means of assisting the client to begin to self-label in a manner that felt authentic to their deeper sense of self. Therapists were mindful of the fact that clients had been coping with the social expectations associated with male gender, and how these expectations imposed a sense of being defined from the outside in rather than from the inside out adding to a false self presentation. For participants, this mindfulness resonated with a deeper sense of their role in therapy as assisting the client to reflect on their experience rather than defining it for them.

Table 6. Domain 2: Treatment Themes

Emergent Sub-themes	Supraordinate Theme
<ol style="list-style-type: none"> 1. Supporting Client Self-Definition 2. Cultivating Compassionate Stance towards the Self 	Affirming Female Gender Identity
<ol style="list-style-type: none"> 3. Connection to Support Resources 4. Negotiating roles and relationships in new identity 	Mediating Vulnerability of the Coming out Process
<ol style="list-style-type: none"> 5. Establishing links between thoughts, feelings and behavior 6. Practicing Harm Reduction 	Safety Planning supports Client Self Reflective Capacity

Katy talked about educating clients on the process of therapy as one that entails supporting the client's own decision making capabilities rather than advancing the therapist's agenda:

Typically people call, and they're calling because they want something. They want to explore something around transitioning, around the transitioning process. I think a lot of people have sort of a notion that there is one way to transition. That they have to do particular things. It's kind of that view of us being gatekeepers in the community which I deal

with a lot. But I don't really agree with that, so I wouldn't necessarily see myself as a gatekeeper, nor do I put myself in the position to be a gatekeeper. I don't tell somebody whether they're male or female. I help them figure that out for themselves, and help them figure out what they want to do with that related to kind of how they want their process to be.

Throughout Sally's interview, she stressed the importance mindfulness of language as a factor in creating a safe space for the client to self-define:

I really, what I feel like is important to me, is that people tell me how they identify and use those terms. I feel like that you have to be really careful with language and nomenclature that people don't get put in a box. If people consider themselves, whether they use transgender, transsexual, queer, gender variant, I've heard a lot of different terms, and the people that use those terms are in a huge spectrum of places. I always ask people. I ask the clients what language do you feel fits? And I don't ever even use a term before that, before I have a conversation with them, and I wanna know what it means to them. Sometimes they're in that same evolution process with language, because language is so connected to identity. I ask the clients...and I wanna understand what they understand, and their experience and the meanings to them, and then kind of be on that journey that evolves with them without imposing. And I also wanna create a space that allows for them to safely explore that, without any prejudice. And to see where they wanna go with it, in terms of language and also in terms of their physical and emotional and spiritual process. It's a really big deal.

Elaine revealed her stance towards normalizing and affirming her client's trans identity through explicitly positioning herself as an advocate despite her lack of specialization in working with the trans population at large. Thus, Elaine's client could rely on her for ongoing support in self-defining:

because you're listed as a sex counselor or sex therapist and somebody's desperate, looking for help, it's a very logical place to turn to. I don't specialize in it but I certainly am a TS or TG advocate.

Throughout Robert's interview, he discussed creating a holding environment which promoted his client's ability to engage in self-exploration and clarifying a gendered sense of self.

It's ultimately about creating a very safe environment where people can talk about anything, absolutely anything.

It's about creating more and more space for clients to find their way, and I do that in general with people. Where I have a balance between how active I am in session and allowing for a lot of silence. And if it's clear to me that someone is actively working or thinking or you know doing something, I allow them a lot of space to kind of do that, but if they're anxious I step in.

Additionally, from Robert's point of view, monitoring his own countertransference and refraining from the need to explain his client's gender variant identity was key to supporting client self-definition:

In working with the transgendered population for myself, it's certainly is paying very close attention to my own countertransference and I think keeping that at bay.

and that's the countertransference piece, and I think that it's important for me to...hold on to the not knowing piece, holding onto the waiting and seeing piece. And that's where I keep my own countertransference in check in terms of working with those, and so that's one thing that I look out for and moderate itself.

Treatment emergent sub-theme 2: Cultivating a compassionate stance towards the self. Another means that therapists utilized to affirm female gender identity was to address the client's manner of relating to their own experience. A client pattern of harmful relating to the self either in terms of self-judgment, self-hatred, or actual physical harm was apparent to all participants. Recognizing this as connected to

internalized messages from the client's environment, participants sought to increase the clients' awareness of this pattern. Participants believed that by assisting the client to accept their female gender identification while simultaneously adopting a non-punitive stance towards the body and the self promoted a means of relating to self that was both nourishing and supportive. Again, participants believed this might reduce the chances of utilizing self-mutilation as a means of coping with gender dissonance.

Throughout her interview, Katy discussed how assisting the client to shift from a concrete to a psychological understanding of gender promoted self-acceptance. For Katy, this entailed helping clients to deconstruct the cultural message that the presence of a penis is equated with maleness. In Katy's opinion identifying as a woman and the presence of a penis were not mutually exclusive propositions:

You know ultimately it's about coming to an awareness that the parts they have have nothing to do with them being female. That who they are as a woman is irrelevant to the body parts that they have. And you just have to be with them long enough to get them to see the way that I do.

And so even if they wish that they had a vagina and not a penis, that they're still able to utilize the penis for what it's worth, to have a relationship, to feel ok about being sexual, it might not be exactly what they want but it's kind of, it's what they have now and it's gonna be ok.

You know whether or not they have a penis is not indicative of how they see themselves as a male or female you know.

But then a lot of what I end up talking to people about in an ongoing way is...to begin to allow them the idea that they could have a level of acceptance with their bodies that doesn't have to mean that they are male. Accepting your penis, recognizing it, that it's a part of your body and that it can bring you pleasure. It has a function, does not mean that you don't identify as female and that it can be ok. It can be ok to have relationships with people. It can be ok to masturbate. It can be ok to

allow that part to exist. That it is not an affront to your femininity to have an erection.

Robert demonstrated a modeling of compassion by avoiding negative reactions to client feelings and behavior and instead joining with the client to comprehend the needs behind such feelings or actions. Robert's attitude was apparent throughout his interview and served as an invitation to clients to approach their experience with curiosity rather than judgment:

well I think the one thing is to understand very fully what the intent was. And...and if they say 'I hate my body' or 'I just want to be rid of it or anything like that' I would still explore it further. And where I would go with it is how much do you hate your body?

There's very little behavior now in my career that I consider sick... and I wouldn't consider it sick now.

And so my mind would go to the that that place, as opposed to 'I don't understand how she could possibly do that'...I think what has settled inside of me is a deeper and deeper appreciation and understanding for people who are transgendered or are transsexual.

My reaction would be deep empathy for the pain she's in emotionally.

At different points in her interview, Elaine described helping her client to grieve her losses as a means of cultivating compassion towards the self:

Of course we talked about that in session when we first got together. Once I was fairly certain, if anybody can be certain in therapy, that their the marriage was not going to last, I think my getting her to that point of acceptance precluded that she had no reason now, to to hide.

There's a whole lot of depression that goes with the whole changing system you know. There's a lot of grieving and adjustments and...because with that depression comes a loss of power.

What happens in all those situations if they get desperate about losing the marriage, well I mean that's what we focus on. Or if they have a barrier at work, I've had guys lose their jobs because of the transition they're making.

Sally described reframing her client's revelation that she had engaged in genital self-mutilation as an opportunity to demonstrate a non-punitive reaction to the client, thus modeling a non-judgmental stance towards the self:

it was just what I got. First of all that it meant a lot that she told me, and I think her seeing...yes, I mean first of all, that was such a huge act of trust and I think and testing, in an appropriate way, to see how I would react and if I would be angry or judge her. I mean she was just like always waiting to be judged. I mean like her filter to the world was just waiting to be judged. And waiting to be told something was wrong with her. So you know I made a big deal out of that. And I and I asked her, what do you want? What I did with that was look at what the real need was and how are we going to help you meet that need in a way that you're taking really good care of yourself because that's what our work is about.

Treatment Supraordinate Theme: Affirming Female Gender Identity

Participants perceived clients to be in a precarious relationship with both themselves via internalized shame and their environment by virtue of the stigma associated with their female gender identification. Thus, clients were perceived to be continually battling with forces that denigrated the transsexual identity. Participants believed that this damaged client self-esteem and heightened the possibility of resorting to the behavior of genital self-mutilation. Participants sought to counterbalance the clients' experiences of rejection via normalizing the transsexual identity as non-pathological. Participants believed that it was essential to demonstrate to the client a recognition of the pain associated with hiding one's true self. Instead of shaming the

client's self-expression, participants sought to strengthen their clients self through acknowledging the clients subjective sense of being female. This was felt to reduce the pull towards genital self-mutilation as a means for regulating emotional pain.

Participants accomplished this goal through various means including supporting the client's efforts to self-identify and assisting the client to cultivate a compassionate stance towards the client's experience.

Here, Sally's discussion of a non pathological approach to understanding transsexual identity is representative of all participants' feelings regarding the necessity of validating their clients' sense of themselves as female and the struggle of having a gender variant identity in a patriarchal culture:

A lot of education. Education and normalizing which go together. Normalizing about well of course you felt that way, of course this was hard for you. And compassion right? Because a lot of time people have had a lot of judgment with themselves versus like some compassion for their own experience. So really trying to reinforce that very compassionate voice, and really try to deal with that self-judgment and shame.

Emergent Subthemes Supporting Concept of Mediating Vulnerability of the Coming

Out Process

Treatment emergent sub-theme 3: Connection to support resources.

Participants were largely aware of the multitude of social challenges that accompanied their clients' desire to publicly embrace their female gender identity. As such, all participants described working on behalf of their clients to assist them in accessing resources that were previously not available to the client. These resources were

perceived by the participants as helpful in furthering the clients' goal of transition as well as supporting their ability to function socially. Participants intervened typically by recommending the benefit of accessing a particular service, for example, hormone treatment. Participants then took an additional step of facilitating referrals to services or providers they perceived to be affirming of the transsexual identity. Participants described the sense of hope that these actions instilled in clients who they characterized as isolated and fearful of further rejection in their efforts to transform their bodies. A sense of hope and decreased isolation were considered by participants to be factors that alleviated the urgency associated with genital self-mutilation.

Katy discussed how discussing the idea of hormone therapy with her client alleviated depressive feelings and reduces anxiety around gender dysphoria to within manageable limits:

One of the primary things I think is so important is hormones, being hormonally balanced. And being able to identify as female, being able to be hormonally female is such a key piece. It typically keeps people from going off the ledge. That's one of the very first things that I talk to people about is how comfortable they are with hormones. Particularly if they feel like that they're really unstable, because antidepressants and anti-anxietys don't work, people tend to self-medicate with drugs and alcohol, pot...because they're trying to remove themselves. But if they can go on hormones it really goes away in a lot of ways, a lot of the physical self-hatred goes away. It's almost as if hormonally when the mind and the body are in balance, when those things are in sync, even if they have the wrong body parts, that's enough to sort of keep it at bay. So that would be the first thing.

Elaine also discussed facilitating referrals to trusted surgeons and medical providers that could assist with her clients' gender transition as her client was unaware of existing services:

So we got in touch with Dr. Y., he used to be the ts surgeon. Made the connections, and the hormone doctor, but anyway we got the right things going and the right plan and process.

Additionally, throughout her interview, Elaine discussed her belief that connecting the client to a support group would be helpful:

Here's all the resources. Here's what pre-op requires. Here's what post-op looks like. Here are the routes...therapy, medication, hormones, possible surgery, I mean just the psychoeducation, I think getting them in with a group, a support group I think.

To yeah get into a support group, to normalize their feelings and behavior.

Well if they're involved in a support group, like at X agency. Or they're involved in therapy and they have psychoeducation. That is part of what happens in all those situations.

Robert shared the benefit he perceived of connecting his client to a transsexual support group, reducing her sense of isolation and exposing her to peer influence:

but I do believe...that I know that this is the case, is that I did refer her to a support group at the agency which really I think helped....helped to kind of patch her up and that was following the injury. There was some difference in her from participating in the support group. There was a little less flat affect and especially because again a number of the people in this support group were (mentions minority status), and so that was a further identification which I think really helped.

Sally talked about connecting her client to a physician who would help her client manage hormone treatment in a safe fashion after discovering that her client had been utilizing street hormones:

She had seen a doctor that she wasn't that crazy about, about a little over a year before she'd come to see me. He had started her on some hormones, but she hadn't gone back to do any follow up, and this was like 14 months. She had continued to take stuff and plus had supplemented that with stuff she'd gotten on the street. And we had a really big conversation about this is not the way to do it. And that to me that ends up a lot of the time being a form of self-injury. I don't shame people around that. I understand. But because it is so dangerous you don't always know what you're gonna get. I've seen people end up in the hospital. And just not getting the effects they want. And so I got her connected up with one of the doctors I really like and she did go.

Treatment emergent sub-theme 4: Negotiating roles and relationships in new identity. Another means by which participants acted to buffer the stresses associated with the public coming out process was to assist clients in managing relationships in their newfound identity. All participants described how clients interpersonal challenges connected to the upheaval of reaction to their female gender identification contributed to the client's experience of psychological turmoil. Participants believed that by processing with clients strategies for managing loved one's reactions, or by directly intervening with the client family system, stress for the client could be reduced. Additionally, participants felt that assisting clients to negotiate their relationships was a means of demonstrating to clients that living in the role of the female gender was possible. The reduction of stress and the installation of hope regarding being able to

function in relationships and the environment as a woman was believed to decrease the internal tensions contributing to the need to engage in genital self-mutilation.

Therapists also described more concrete, behavioral means of assisting clients to feel confident in a public female gender role. This involved creating a safe space for clients to practice female gender expression without negative judgment from others. In the safety of the therapist's office, clients could experiment with female gender expression via clothing, makeup, and body language. This provided an experiential means of reinforcing client attempts at self-expression and building the client's confidence.

Elaine described how she intervened with her client's family by working with her children. Helping the children to process their feelings and providing psychoeducation related to their father's transition served to reduce the level of stress on both the client and the client's family system:

I worked with her for a number of years with the kids. Coming out to the kids... for the first time they went on vacation at the X location with daddy in a female swimming suit. I mean that's a lot of stuff we had to work with.

In working with the children, especially the oldest child who's a gem...the child read everything it could to fully understand daddy. It was admirable. The child didn't have to take sides, the child could support mother and accept father. It was really encouraging for me to see.

She also described how her client used therapy to practice female gender presentation:

As they begin transitioning or they begin more risk taking.. and it could be also in this hallway out here I practice how to walk, and how to cross your legs, that's behavioral too...to dress in your gender of self. There's a lot of behavioral things that go along with that.

Sally talked about how her client waivered in her faith that she could manage the reaction of other people to her transition process. Her interventions included processing with the client how to manage feelings connected to perceptions of rejection as well as to suggest activities such as participating in support group or cultivating a network of supportive friends as a means of building the client's confidence:

We would get to the other stuff, so we could talk about down the road building the self-confidenc. See that's the thing. She used these words, she said 'I don't have any confidence'. And when I asked her what she wanted, she said that 'I wanna be where I don't care so much about what other people think...I wanna feel like I have the confidence, like I have the strength to make it through transitioning and particularly a work environment'.

Katy discussed taking on the role of a teacher or mentor via concrete behavioral interventions assisted the client to feel confident in moving through the world in the female gender:

They needed someplace to be able to say that. A safe place, and I was gonna be that person. Like I wasn't gonna, I couldn't couldn't not be that, right?...Like now I mean now I size people for bras. I've done so many things in therapy that I never would have thought I would do...like who else are they gonna do that with right? I've given more make up tips to clients that I have to people in my own life. And I am not particularly saddled with being feminine in some way. But if you're working with someone who they are feminine, and they are female, and they identify that way, and no one else in their world has ever taught them how to be that way, then of course it's gonna be about that because it needs to be about that, that's where they're at.

Robert discussed how his relationship with the client and the context of where the therapy took place provided a sense of sanctuary where even the

physical space demonstrated respect for the client's gender variance and thus encouraged expression and presentation in the female role, this along with the access facilitated to a peer support group served to build client confidence:

If anything I think she experienced the agency as a safe haven, because her world was so isolative. It was a place she could be herself, gender neutral bathrooms and everything and so I think she experienced some safety there.

Treatment Supraordinate Them: Mediating Vulnerability of the Coming Out

Process

In addition to supporting clients attempts to claim their own identity as well as to develop a more compassionate relationship with the self, analysis of the data revealed that participants played an active role in assisting clients to manage the stresses associated with the public identification and expression of female gender identity. This was seen as another form of intervention that served to strengthen the clients' capacity to function as the authentic self within their environment to the best of their ability. Therapist intervention helped to maximize the chances that the transsexual identity would be workable within society as opposed to unsustainable given the multiple challenges of coping with a transphobic culture. Participants believed this reduced client stress levels, and as such had an impact on the likelihood of a recurrence of genital self-mutilation. Participants enacted this role via multiple means including connecting the client to resources that were supportive of the client's transition efforts as well as

assisting the client to negotiate relationships in their new identity or coaching the client on successful presentation in the female gender role.

The following excerpt from Sally's interview describes a common perception amongst all participants of the state of vulnerability of the client who sought help from them. The client is confused and worried, needing help in developing an understanding of self. Participants interventions sought to address this vulnerability.

I mean this is how people come sometimes right? In this very circuitous way. But she had been thinking about this, she said, that in terms of transition she really was struggling with is this the right thing? am I gonna get accepted? Who am I? The gender identity issues in terms of male/female all of that, were very of course mixed in with just like who am I in terms of as a person? Because, well, all the pieces that had gotten impaired or limited in different ways in her development.

Emergent Subthemes Supporting the Concept of Safety Planning Supports Client Self-Reflective Capacity

Treatment emergent sub-theme 5: Establishing links between thoughts, feelings, and behavior. In working with clients, all participants sought to elicit the narrative from the client as to how the act of genital self-mutilation took place. From the participants' perspective, this served a therapeutic aim which was to assist the client in making sense of the behavior. In having the client recount the story of the behavior, participants aimed to develop self-understanding within the client regarding the connections between intrapsychic and interpersonal stress and to more fully explore the potential motivations behind the behavior. The understandings developed through this process were then generalized to either anticipate future episodes of self-mutilation or

to help the client develop a means of weighing the value of particular choices or behaviors in terms of their likely outcomes.

Elaine described the use what she called “decision sheet” in working with her client towards being able to predict the outcomes associated with particular thoughts, feelings and behavior:

One way when we come up to barriers, what are our options? I have a sheet that I used to call a decision sheet, and it’s a very detailed process. So if this happens, if this happens what do we do? I use that like a decision tree to think through options...mutilation by itself, these are the consequences: see a psychiatrist, go inpatient, these are the consequences, to face reality and to break through my own denial system here are the consequences...it’s it’s a whole form like that, then we get down and here’s my decision and those consequences are a doozy, it brings some relief and all that kind of stuff.

Katy discussed jointly exploring her client’s decision making process and through her in depth questioning, making her clients thought process more explicit:

well...I talk to them about why they made that decision. I wanna know how they came to that decision. Were they thinking around how they were gonna do this? Why would they feel like this is the only thing they could do? Like why this option versus any other?

So you wanna keep talking to them. Do they see how down the road this could end up being a negative option for them?

Robert shared how his exploration of the intent behind his client’s behavior lent itself to an investigation of the risks associated with particular chains of action:

The other thing I certainly would kind of explore the pros and cons, not to be too graphic about it. But to understand the intent, and what would be lost if she did that? What’s a possible risk? The fact that it really wouldn’t give you a vagina. You know, it would make you more like Hedwig...and

so kind of exploring some of those things, and saying 'well you know we're working together'.

Throughout her interview, Sally expressed how she might make interpretations or point out patterns of behavior that connected the various aspects of the client's concerns. In essence, Sally lent a bird's eye perspective to the variety of the client's thoughts and feelings:

I mean not that they might come in and talk about whatever, but my job is to hold that picture of where they say they wanna go, and link things and come back and check in about it, in terms of what they say they want. And I think that really creates a structure that people feel very supported by. And at their pace pace you know?

Part of my job then is to do that reality check. To look at, 'well you know you say you're struggling with this. You're here so I kind of wonder what stops you from going to get some support with that? Let's talk about that'...and say 'you know you've brought that up before and and what's your thought? And kind of what makes you hesitate because I think you could really get some support with that here. And let's talk about what's getting in the way'.

Treatment emergent sub-theme 6: Practicing harm reduction. In addition to assisting participants to make sense of the connections between thoughts, feelings and behaviors that contributed to the act of genital self-mutilation, another common theme emerging from the data analysis revealed participants implementing a harm reduction approach to working with the client to be a valid goal of treatment. Participants discussed assessing their client's level of knowledge regarding the danger associated with a particular behavior. Additionally, they discussed making active concrete recommendations to the client in the attempt to generate alternatives to unsafe behavior. This modeled for the clients problem solving that reinforced a less physically

damaging means of handling the self and reduced the chances of a more disastrous outcome associated with the behavior.

Here Katy discusses how she feels it is unrealistic to expect the client to refrain from self-mutilation altogether:

So many times the choice is to do nothing. The choice is to try to try and do damage control. I mean in some ways it's almost like a harm reduction approach that you would do with someone rather than an AA approach.

Here Katy talks about helping the client to generate safer alternatives to cutting behavior:

Are you using using razor blades instead of an edge of a can? Are you doing things that are safer? Are you cutting in a place that you're not gonna cut an artery or vein? You know...that there is harm reduction that has happen.

Well like could you cut somewhere else? I know that sounds strange, but I mean there's a lot of times, that you can't tell people to not cut, they're gonna cut.

Katy also talks about assessing her client's meanings around what is considered safe behavior and how the client might actively implement those safer alternatives:

I'd really wanna know whether or not it seems like they had done enough research to be safe about it. I know that sounds strange, but you actually can castrate yourself safely. Now, some people don't believe in home birth, right? So there's a line for everybody. But you can, there are things you can do. So I guess I would wanna know like how much research have they done?

You know like... 'you recognize that when you drink this much you tend to get into this space? How can we make sure that you don't drink that much? Who could you be around? Who could you you call? You know what would you do if this did happen?' Like those types of things to

do some sort of safety checks. And an ability to see where you could help a little bit.

Sally shared a creative aspect of what she considered to qualify as a harm reduction intervention involving encouraging the client to give the tool used for self-mutilation to her for safe keeping. In her opinion, not only was this a concrete step towards establishing safety, but it symbolized to her the quality of the trust within the psychotherapeutic relationship:

In this case she had you know... I mean sometimes I actually have people bring me implements they've used. And have them leave them with me. I've had that happen. Now with her that wasn't so much the case, but I have had people bring me in the tools they've used. It's this ritual of being willing to bring something they used to therapy, and say I'm gonna leave this with you, knowing that if they want it back, they're gonna get it...it's a way, it's very powerful when people are willing to do that.

or especially if they're on their own, or if they're living with a supportive person, to get certain things out of their physical environment, so they're not easily accessible. You know even though you can't get rid of everything. Again there is a symbolism to that.

Here Sally discusses harm reduction as working with the client to establish a series of obstacles in the behavioral chain that might result in genital self-mutilation.

Sally believes that utilizing the ER as a contingency plan is a viable option for promoting safety.

And if somebody had cut, I mean again worse where they ended up in the hospital. It'd be that next level, kind of calling before. A safety plan very much like you would do with suicide prevention. What are things that are gonna interfere before you get to that point? Calling me and a backup if you don't get me. What are these other things you can do, including going to the ER.

Robert emphasizes the importance of being able to communicate with emergency medical personnel in the event of the behavior happening:

It would also be harm reduction. In other words are there towels nearby? Do you have your cellphone with you, in case you need to call 911? ...that kind of a thing, that last resort. So I don't want to pin down something that's that dangerous to someone, but that's kind of how how I would work with them.

Elaine used the analogy of suicide prevention when comparing it to safety planning and harm reduction around genital self mutilation:

You and I can't say that someone is never gonna suicide again for instance. Just as an analogy, but if we know that a person understands that there's a likelihood of finding at least three alternatives to suicide then we can say with some surety we don't have to worry about suicide, you know what I mean? So if there's an alternative to self mutilation...

Treatment Supraordinate Theme: Safety Planning Promotes Self-Reflective Capacity

Data analysis revealed another supraordinate theme around therapist activity of safety planning with their clients. Given the nature of the clients' self-mutilative behavior, all participants felt that addressing safety issues with the client was an important piece of treatment. Although they empathized with their clients' emotional pain, therapists sought to avoid a recurrence of the behavior, and to reduce the factors they felt contributed to the emergence of such behavior. They sought to work with the client to problem solve in a fashion that did not necessitate harm to the self. Alternative problem solving took different forms. Therapists sought to make explicit their clients triggers, feelings and actions as a means of increasing client awareness of the signs that self-mutilation was imminent. Additionally, exploring the client decision making process

through analyzing outcomes associated with a particular choice or behavior served to assist clients in understanding the causal links in a chain of events that resulted in self-harm. Ultimately, participants believed this approach decreased client impulsivity, increased affect regulation, and led to greater self-understanding with a sense of increased choices regarding healthy coping mechanisms. In essence, participants demonstrated that through their interventions, they developed an aspect of the client's observing self that had previously been stunted or missing.

From a more concrete perspective, from the participants' perspective, a vital component of the safety planning process involved working with the client around harm reduction. Participants did not place ultimatums on their clients in terms of stating that the client must not engage in genital self-mutilation whatsoever. However, they invited the client to consider ways to reduce the degree of harm done to the self in the event that genital self-mutilation was to occur again. Participants believed this served a dual purpose of increasing the client's behavioral repertoire of coping mechanisms and inducing the client to get in the habit of considering their overall safety when making decisions related to their health and well-being. Again, participants believed that this process cultivated the client's self-reflective capacities.

A quote from Sally's interview illustrates this common theme amongst all participants. Active safety planning contributes to a deeper self understanding regarding how to manage the behavior of genital self-mutilation:

So noticing, identifying that cycle that set up the overwhelm, and helping her being able to start to learn to try to identify. And actually wrote

things out where when this concrete thing happened, how she could use some of those self- regulation techniques like tapping, breathing, imagery or reaching out to someone or going for a walk. I mean we built all these you know self regulation things in there.

Domain 3: Themes Related to Impact of Phenomenon on Self of the Therapist

Data analysis of participant interview transcript yielded a group of themes that can be mapped to the domain of how the phenomenon of genital self-mutilation impacts the self of the therapist. The following themes are representative of the emotional and professional demands participants found to be inherent in working with the phenomenon of genital self-mutilation amongst their male to female transsexual clients. Again excerpts of participant interviews supporting the sub-themes are explored first so as to provide the reader as sense of the connections behind the abstracted supraordinate themes.

Table 7. Domain 3: Impact of Phenomenon on Self of the Therapist

Emergent Sub-Theme	Supraordinate Theme
Therapist feeling overwhelmed Boundary challenges Vicarious marginalization	Countertransference parallels to client experience
Practices defining incompetence to work with trans population Tensions around predicting client safety	Competent Practice in the Context of Emotional Stress
Turning to others for support Practices promoting stress management	Therapist Active Coping

Emergent Subthemes Supporting Concept of Countertransference Parallels to Client Experience

Impact of phenomenon on self of the therapist emergent sub-theme 1:

Therapist feeling overwhelmed. In the course of data analysis, an emergent sub-theme revealed participants struggling with the shock of discovering that their clients had engaged in genital self-mutilative behavior. The discovery provoked a range of emotional reactions that posed a challenge to the therapists' ability to remain present to the client within the psychotherapeutic relationship. As the initial shock of learning of the client's behavior subsided, participants described feelings ranging from anger and sadness to fear concerning the client's safety and a heightened sense of responsibility for managing what the participant experienced as a client crisis. All participants described attempts to manage their anxiety concerning the clients' safety via re-assessing the client's thoughts, feelings and behaviors in an attempt to identify whether further threat of harm was imminent. It should be noted, however, that these reactions provoked intrapsychic conflict for the participants as they remained devoted to attempting to empathize with their clients emotional pain while discerning and assessing the motivations informing the behavior. Participants worked to contain their own emotional reactions so as not to injure the client in a manner reminiscent of the rejection that was so prominent within the clients' environment.

Katy describes the emotional impact of witnessing her client's self mutilation in the context of the emergency room as unique compared to other overwhelming

experiences in her life. Katy describes her senses being filled with sights and smells that compete with her therapeutic intent of connecting with the client:

You know it was difficult at the time. At the time I knew it was difficult but you do what you do. I mean, I've been held at gunpoint, I've seen a lot of stuff, but I think that what was...the memory for me was that blood has a smell. And that's all I could smell. Like there was so much blood, that's all I could smell. When I was talking to her there was all this blood. And they're working on her, trying to get a catheter in her, which is impossible when you have a detached penis, but they're trying to get a catheter in her, and they're trying to do all these things and I'm trying to just pay attention to her, to just talk to her and look at her face which is also sliced open. And ...it was overwhelming from a sensory standpoint. It was really overwhelming.

Katy references the traumatic quality of the experience given her proximity to the client:

And to sort of hold it as something that you know happened vicariously to you ...so I had more emotion about it than I thought that I would.

Katy talks about her feelings of guilt regarding an emotional reaction. Her desire was to be emotionally available for her client but her inexperience made it difficult to contain her feelings.

And he really needed to show up that day and not have it be about who was in the room, it needed to be about him.

Robert reported feelings of horror upon learning of his client's actions:

and I was horrified. And when I met with her we talked about it. I was still horrified.

Here Robert describes being overwhelmed by visual images of the client's behavior:

Where it instantly goes to is a very visual place. And in my mind I get very, yeah, I'm very visual, and especially when there's narratives, and

then my mind is going to different places, and so I can imagine what that would look like, more in terms of the blood than anything else.

Robert experienced his client's actions as "other" in that he could not feel himself into the client's motivations. He describes his own gender identity and his own experience of male embodiment as part of the obstacle in relating to the client's experience. Again, this posed a challenge for him in empathizing with the client's suffering.

Well I think, on one level, it's an inability to relate. And oh my god, but on another level I mean, I played baseball and some groundballs hit me right in the crotch and the thought of the pain involved. That's another thing, where I was just like 'oh my god, why would you want to do that? Why would you wanna do that? Again because since I identify as male to me it would be horrifying that happening to him.

Here Robert talks about how experiencing the client as an "other" predisposed him to view her psychopathologically. It took some time before Robert was able to regain a view of his client's frailty and humanness:

Yeah. And so...and there was a little part of me which kind of went to the sick place with her too. 'My god' and 'She's really kind of screwed up' this client.

Elaine discussed a shift from an initial empathic stance towards her client to feelings of frustration and irritation with her client's actions. She experienced his behavior as a crisis that demanded response on her part.

You know it really was difficult, so in that sense...I moved from total empathy to this what she was trying to do, to some problem solving and crisis intervention.

Elaine also talked about feeling the weight of being the sole individual the client relied on for emotional support at this time. Her feeling of responsibility towards assisting the client in his crisis competes with the awareness of her duties to her other clients.

I think it was more out of her desperation than who else was going to help her. So I had, to set some limits you know. I just can't drop four hours of clients to make sure I can deal with her without notice so I can rearrange clients...so there was a little negative feelings on my part for some of her demands. On occasion this was difficult at times.

Her demand of my time and attention, I should drop everything for her that could have been defused you know.

Sally talked about being overcome with a feeling of sadness regarding her client's self-mutilative behavior.

I mean when she you know, did that, I mean in a way it just like broke my heart.

Sally's initial reaction of sadness evolved to frustration and anger with her client. Sally talked about self blame, worries of having failed the client in some way in addition to her searching for answers to the question "why"? However, she works to contain her feelings and reorient herself to being emotionally present to the client. She characterized these conflicting feelings and desire to serve the client as resulting in stress for her. Sally also references struggling with a feeling of whether she can trust the client given a concern about the potential for recurrence of the behavior.

And wanting to keep an eye on it. And it's a trust issue too with both of us, right? Cause you don't know if somebody's telling you everything, and they don't, people don't always.

Impact of phenomenon on self of the therapist emergent sub-theme 2:

Boundary challenges. The client behavior of genital self mutilation challenged the therapeutic frame in various ways for participants. While none of the participants described abandoning or rejecting their clients based on the behavior of genital self-mutilation, the clients' actions necessitated a response, either overt or covert, on the part of the therapist in determining what constituted acceptable versus unacceptable behavior within the therapeutic relationship. All participants were forced to grapple with where they "drew the line" regarding their comfort level with the client's self-threatening behavior. Overt boundary setting might include informing the client of the therapist willingness to call 911 as an emergency response or considering the use of a behavioral contract to induce the client to buy into the need to pay attention to safety issues. Covert boundary setting was more subtle and took place in the internal mental space of the participants with regards to how they viewed how to handle unsafe behavior within the therapeutic relationship. This might entail accepting the therapist's limitations with regards to the ability to influence the client's decisions. While this wasn't always communicated directly to the client, it represented an internal boundary set by the therapists' attitudes and treatment philosophies that allowed the therapist to be functional and helpful within the therapeutic relationship.

Katy's covert boundary setting manifested in her sense that engaging in a power struggle with her client over the client's cutting behavior was ultimately futile. So instead of making the therapeutic relationship contingent on the client not harming

themselves, Katy balanced her concerns regarding the client safety with her sense that the client required contact with an emotionally supportive mental health professional:

But with her I couldn't. I mean if I told her she couldn't cut, if I told her that I wouldn't work with her if she cut, she could likely kill herself or she would just not go into treatment because her only avenue is cutting so it's not going anywhere. The cutting is gonna win. So if the cutting is gonna win how can you cut safely?

Robert discussed his sense that the client testing the therapist boundaries is not unusual behavior. Robert was concerned with surviving the client's testing behavior and maintaining a non-judgmental stance towards the client:

And another thing that is very parallel to all clients is that sometimes eventually, everyone pretty much, for the most part tests the boundaries and tests the shock value because people are looking for evidence that their therapist is gonna judge.

However, Robert displayed more of a tendency towards overt boundary setting in the analogy he drew between coping with client genital self-mutilation and dealing with a client who is chronically suicidal:

That if it was manipulative with suicidal acts to get my attention for more time, in that case I'd be more like I would say 'let's call 911 then' and I've done that before and people are like 'oh no no no I mean I really have no plan'.

Elaine's interview revealed a more covert form of boundary setting manifesting in regards to her attitudes towards the gender transition process in general. While Elaine describes herself as a trans advocate, she also holds tightly to the sense that there is a "right" way to transition. This seems to stem from a desire to keep the client safe and achieve a satisfactory outcome in terms of eventual gender reassignment

surgery. However, her sense of what constitutes legitimate transition versus illegitimate transition, demonstrates to the client a value regarding how claiming one's gender identity should proceed.

Once it became clear that the marriage was not gonna survive...help the client engage in planning and connecting to resources to make the transition the right way, the right way.

Here she refers to her client transitioning, The legal situation resolved so she was free to do the right way.

Again referring to her client transitioning, But anyway we got the right things going, and the right plan and process.

Elaine also contrasted her client's attitude towards the process of transitioning with other transsexual clients she had worked with. Again, this sends a subtle message regarding how she believes transition should proceed.

Right, right, the things is that I had that one case...but I was thinking a couple of my other people ...they...look forward if they can afford it to... sexual reassignment surgery or gender reassignment surgery, it goes by SRS or GRS, ...but they plan for it. They save money for whatever else. The person who is self-mutilating is in a different state of mind. They don't want to go through the channels.

Elaine again contrasts her experience of working with transsexual clients who do not self mutilate in this excerpt:

My other cases, my other ts's, they cooperated whoever I wanted them to see for hormones or whatever I wanted to talk about, the partners at the time came in and we worked through the grieving and all that you know what I mean.

Sally admitted to struggling with the need to contain feelings around the client not responding to her advice. The means she used to prevent the client's actions from

threatening the therapeutic frame took place in a dialogue within her mind regarding actively affirming her client's right to choose their own behavior. Sally ultimately sought to avoid a power struggle with her client which she felt would be more damaging than empowering her client to find safer ways to cut if the urge was irresistible to the client:

I don't control what people do and it is always hard to see that, and I have to, it's really I think I have to...really hold that space of reminding myself of you know self-determination.

And to not you know...you know get angry, like you know 'well you're not doing what I suggested', because people don't.

Impact of the phenomenon on the self of the therapist emergent sub-theme 3:

Vicarious marginalization. All of the participants described the challenges of working with a disenfranchised and stigmatized population of clients that lacks environmental supports that assist in facilitating transition efforts. By virtue of the intimate association with their clients' experiences, a theme evident for all participants was the isolating nature of the work and the frustrations of a sense of powerlessness in being caught between an effort to help the client while at the same time wrestling with a transphobic culture. In a sense, the participants were privy to the experience of isolation and helplessness of their clients particularly as they went about attempting to procure resources for the client.

Throughout her interview Sally discussed her feelings of powerlessness in helping her trans identified clients access proper medical care and peer support. While she is highly affirmative of gender variant identity, Sally describes feelings of being overwhelmed by the attempts to procure services for her clients.

Huge frustration in general with, the lack of resources.

You know all the prejudice that people have, and so even being able to access medical care if they don't have insurance or pay for drug., I mean, yeah, it just sometimes I feel very powerless sometimes in the face of that. Yeah, I mean frustrated, powerless.

And then the frustration, yeah sometimes I feel very powerless, sometimes I feel frustrated, not necessarily directly with the client but with the situation... and sad.

First of all you know to find this is overwhelmingly frustrating and difficult for me because half the time people don't have decent insurance.

In her interview, Elaine discussed the pressure of having to work with her client and her client's family as both individual and family therapist given the lack of transgender sensitive clinicians at the time that she worked with the client. Elaine felt obligated to work with both the client and his family in that there were few trans affirmative clinicians that she could refer to at that time. She felt that this created stress for both herself and her clients in some ways in that they family system was highly dependent on her to manage their emotions. She referenced her desire to have shared the burden with a qualified family therapist:

If I could redo ... About x number of (referring to case) of years ago, I'd I would have gotten more people involved in the treatment to handle the then wife, the kids separately from me, because I was working with daddy. They trusted me because I was working with daddy, but also I think they were afraid to say some things, maybe I'd tell daddy, you know.

Yeah, well in today's world it's easier than it wouldn't be x number of years ago.

I think that would be important...and a family therapist if there was a family therapist involved or another therapist if there was gonna be an

issue with the marriage you know what I mean as opposed to just a person working with all the family.

In her interview, Katy expressed concern regarding the lack of resources available to what she perceived to be complex cases involving trans identified individuals coping with multiple challenges similar to those of her client that self-mutilated. While she did not characterize her client specifically as severely mentally ill, she did use the point to illustrate the challenge of working with transgender clients who cope with multiple mental health stressors.

If you have gender issues and you have anything else wrong with you, you're in trouble.

because even so many private practice therapists don't deal with people who have severe mental illness.

Even X agency won't work with people who have severe mental illnesses. You know and they're sort of the go to for people who don't have money and have trans issues.

Katy also discussed the frustration of feeling the lack of therapists knowledgeable and affirmative of trans identity that she could refer cases to. Instead, Katy shared how she often is faced with undoing the damage on trans identified clients done by other therapists.

I would say I'm pretty extensively experienced...yeah ...cause I don't have very many people I can refer to I guess.. So I would say I have pretty extensive experience with it...Yeah it's really frustrating. I think it's difficult because usually people have come to me and they've already had really bad experiences in therapy, really wrong experiences in therapy that make me cringe as a therapist that people actually said that, and did that.

Robert talked about the extra mile he was willing to go for his client given the lack of trans affirmative resources and the client's previous experiences with non affirming trans providers. While this demonstrated a high level of support to his client, it also added an extra duty to working with a client who had multiple needs:

It would be making sure that she sought medical care. For whatever reason if she didn't have medical care I would work closely with her. And so I know some LGBT physicians.... A couple in particular who are very warm and accepting, and I would offer to do it. There are times when I still accompany people to go to an appointment...and ...so I do that...and I would do that with her. Especially given just the level of fear.

Impact of the Phenomenon on the Self of the Therapist Supraordinate Theme:

Countertransference Parallels to Client Experience

The similarities between the participants' feelings and their descriptions of their understanding of the clients' experiences are striking. The connection appears on many levels. One parallel process developed for participants with regards to experiencing intrapsychic conflict regarding an authentic reaction of the self to their clients behavior, for example strong feelings of sadness, anger or horror and their wish to suppress or hide such reactions for fear of alienating clients who were in a vulnerable state. This is reminiscent of their clients' challenge in that clients also experienced a split between authentic self expression and a fear of alienating the other. Participants were sensitive to the possibility of damaging the client through unintentionally duplicating the hostility of their environments regarding behavior that was deemed repulsive. Thus, participants found themselves in the position of having to balance strong affect with their sense of duty to remain present and emotionally available to the client. This represented an

emotional pressure that participants had to adapt to in the course of their work with their clients.

Sally summarizes the feelings experienced by all participants regarding sitting with the client while simultaneously battling with personal feelings about genital self-mutilation:

Well I think I just go back in terms of my own feelings, I mean when people harm themselves in any way, whatever term you use, I mean it's always frustrating for me. I think about what I could have done differently, and what more does this person need. Well I feel both frustrated and angry with them like, 'why did you do that that way?' You know that's not what I say to them. I am concerned and self-questioning, and also just really committed to sit with them to see how it can be different, but it is so stressful.

Additional elements of parallel process with client experience could be found in how participants dealt with their clients' unsafe behavior. In essence, the participants were faced with the conundrum of a potential power struggle with the person they most wanted to help. Participants had to decide whether the behavior of genital self-mutilation would imply the termination of the psychotherapeutic relationship. While none of the participants actually rejected their clients for engaging in such behavior, the concerns regarding client safety certainly intensified the possibility of an all or nothing stance with regards to willingness to work with such high risk clients. Participants had to find a compromise that might allow them to manage feelings of powerlessness induced by the behavior of genital self-mutilation while at the same time exerting their own influence so as to enact their psychotherapeutic interventions and maintain the frame of treatment. Although the intensity of the participants' dilemma did not reach

the level of the clients' double bind scenario, it did lend itself to the sense of a power struggle between self and other, an experience that their clients were familiar with in their efforts to self-define.

Finally, participants experienced a taste of the marginalization that their clients coped with in daily society in the form of the effort to obtain fair and adequate resources to meet the needs of their clients. Just as clients struggled with issues of isolation and blocked access to a healthcare system that might support their efforts to transition, so too did participants encounter frustration and feelings of powerlessness in their quest to connect clients to services. This resembled a constraint on the participants' sense of agency, as playing the role of intermediary between the client and the relevant institutions or systems was hampered by overall lack of access or dearth of resources. Despite these constraints, it is a testament to the creativity and persistence of the participants that they were able to eventually connect their clients to services such as support groups or hormone treatment.

As the excerpt from Sally's interview indicates, at one point or another in their work with these clients, all participants experience a sense of powerlessness of which they had to find a strategy to cope.

But especially like with this population resources and then the frustration. Yeah sometimes I feel very powerless.

Emergent Subthemes Supporting the Concept of Competent Practice in the Context of Emotional Distress

Impact of the phenomenon on the self of the therapist emergent theme

number 4: Practices defining incompetence to work with the trans population. Data analysis of participant interviews also revealed a theme related to the participants' definitions of what constitutes professionally incompetent practices in connection with working with the transgender population in general. In essence, participants were describing professional "good" versus "bad" ways of intervening and relating when addressing clients who brought issues related to gender identification to either the psychotherapeutic or medical encounter. Participants discussed how they believed therapists or medical professionals without training or experience working with the transgender population caused psychological damage to their clients, frequently by reinforcing cultural stereotypes around gender expression, failing to distinguish between sexuality and gender, denigrating the transgender identity, or misdiagnosing the client's difficulties as mental pathology, for example, confusing depression with gender dysphoria. Participants described feeling frustrated with witnessing how clients could be further victimized in the context of turning to an authority figure for help in coping with gender identity issues.

Sally talks about the insidious nature of incompetence in the form of practitioners who caused harm unintentionally by not being educated and connected to

a network of trans affirmative providers. An egregious offense in her opinion is the practitioners' lack of awareness of the psychological aspect of gender:

But then I've seen people that thought they understood and they meant well, but they didn't understand. They didn't refer appropriately. They didn't know how to educate the families. I've seen people go through horrible stuff with doctors that were trying to assign gender indiscriminately, or trying to get this person to do things that were more masculine, to make him more of a man, you know, just really ignoring the fact that that wasn't really their sense of identity.

Sally also talked about how a psychiatrist's ignorance of gender variant identity contributed to her client experiencing a sense of invisibility around understanding her own developing gender identity:

And she felt out of control, and I guess her mother did take her to the psychiatrist, and that's the one that just didn't get what she was going through at all....and said 'you should try to be really a man', but it was just that they missed it and they didn't get it at all...and then the person just like thought 'oh you know, just teenage stuff' and went to put her on Paxil which she didn't really end up taking for very long.

Elaine discussed how her client's legal case was negatively impacted by professionals who lacked awareness of gender variant identity. She references their feelings as influencing their professional judgment and the implications for her client's case:

We don't have enough professions, lawyers, judges, including with professionals such as psychiatrists who are appointed by the courts you know who do truly understand. I think they either get shocked or disgusted or something, cause the couple I talked to I know they didn't understand. That was very unfortunate. There's a lack of professionals that have an awareness. It's a true ignorance. It's a not knowing, the true ignorance, and that caused us some real difficult times.

Robert shared his client's fear of the medical profession in general and sees this fear as having some basis in reality given practices such as conversion therapy that actively pathologize LGBT identity. He references her experiences of coping with physicians who failed to realize the wounding impact of failing to recognize her female gender identification.

The genital mutilation, you talk about mistrust of medical establishment...much like therapists have all sorts of biases that are based in reality regarding any number of things. People still do conversion therapy for example. That's a very real thing. And she probably, I don't know for sure, met with other physicians maybe that were entirely disrespectful. Constantly referring to her by her birth name for instance. And using masculine pronouns, and so that's kind of what I think of in terms of her.

Katy shared her outrage regarding her client's being shamed by a previous therapist who equated gender with external behaviors and advised her client based on stereotypes of what constitutes proper gender expression:

She was seeing a therapist and she told this therapist how she felt and the therapist's response was that she thought....What he should do, she knew him as he, what he should do was...was try and forget about it, was throw himself into other hobbies and he really needed to find a girl to get married to, and it would be better if he just sort of focused on the sort of traditional things that he was kind of supposed to do in life. And try not to think about women's clothes or wanting to be a woman and just sort of ignore it...which...was appalling to me because what this did for this woman was it left her in a place of feeling like....you know what she was trying to do and explore who she was was wrong.

Impact of phenomenon on the self of the therapist emergent subtheme 5:

Tensions around predicting client safety. Another emergent theme derived from the data analysis of participants' interviews concerns the degree of stress or emotional

tension generated for the therapist in negotiating a felt sense of responsibility for weighing the safety implications of the client's behavior of self-mutilation in order to predict whether the client's risk of further harm might pose a more severe danger or even be lethal to the clients' well-being. This tension surfaced in a variety of contexts including making decisions whether or not the client should be hospitalized, and to what degree should the client history of self-mutilation be communicated to other treating professionals as a relevant piece of safety information. This created some ethical dilemmas for participants as they considered multiple factors relevant to being confident in making a prediction around the client's safety. Factors of relevance in the participants' minds included whether the resources available to protect the client were likely to exacerbate a dangerous situation through ignorance of gender identity issues, concerns regarding legal liabilities to the therapist, and discerning whether information regarding the client's history of genital self-mutilation might complicate the client's desire to obtain gender transition.

Sandy referred to the anxiety around deciding whether hospitalization is required to protect her client as having a nightmarish quality for her. Her commitment to serving her client to the best of her ability conflicted with concerns about her physical safety. She notes that although she felt her client should have gone to the emergency room due to the bleeding and possible infection as a result of the genital self-mutilation, she expressed concern that her client would be exposed to inferior treatment.

Throughout her interview, she expressed some doubt as to whether the hospital would serve as anything other than a holding compound for the client:

That's an ethical dilemma, and it is always one of the most stressful things in the world when that happens... When any client where they're really on edge, where I have to assess you know the severity of harm, and if it's really at the part where I need to either voluntarily or maybe potentially need to be hospitalized against their will....these are nightmares.

She should have probably gone to the ER but she didn't.

I don't really know a single inpatient unit where I trust that people are gonna necessarily know what the hell they are doing...but 98% of the time, you get people that just you just don't know if you're gonna get anybody that has any clue, so really all you're necessarily getting is containment.

It's not like the core issues are going to be addressed there, they're not.

Sally coped with this dilemma by becoming directive with the client. She pushed for the client to seek care on an outpatient basis with a trans affirmative physician, therefore removing her concerns about the potential damage that could be done to the client in an inpatient setting.

I wasn't going to obviously look at her genitals, but I wanted (names her physician referral source here) to. And I mean as much as I can insist from my seat, say 'you know you need to do this and are you willing to call (names physician here) and get in there right away? And will you call me tomorrow, and let me know that you called (names physician here)? And if she hadn't called me tomorrow or the next day, and let me know that she had called (names physician here), I would have called her and said you need to do this.

Katy expressed similar fears to Sally with regards to the concerns about placing her client in an inpatient unit. From a general perspective, she hypothesized that she

would cope with her conflict by defining the act of exposing a client to substandard care as inherently unethical:

...Yes...however I would say that I have a different (...long pause...) standard for trans clients than I do for other clients which would be that my duty to warn and my duty to ...to maybe hospitalize somebody ...involuntarily is different than is for trans clients than it would be for other people. Mainly because if I were to do that, ultimately they could end up getting worse care wherever they were hospitalized because there would not be a place they could go that would understand gender issues. So knowing that if you have a suicidal trans client and what you do, what your choice is is to involuntarily hospitalize them at a place that would give them unethical treatment...you don't do it.

Another means by which Katy speculated that she would reduce her anxiety around the client's safety is to actively discuss with the client that the client's behavior places her in a double bind and how might they jointly avoid this double bind so that the client could ultimately be safe.

I wouldn't tell them to go to the hospital, and I would talk to them about the reasons why. I would be very frank about the fact that normally I would want someone to go into the hospital but these are the reasons why you shouldn't, and why it could be bad which is why I need you to not harm yourself enough that you would need to go into the hospital. Like we need to figure out something that you can do, even if it's mutilation, something that you can do that will not require you to be hospitalized because if you are hospitalized it is going to be worse....and clients are usually responsive to that.

Elaine's feelings around predicting client safety were evident in her discussion regarding conflict in writing a letter supporting the client's bid for gender reassignment surgery. While wanting to support her client, Elaine felt that it was incumbent upon her to include in her letter the client's history of genital self-mutilative behavior. For Elaine, she refused to duplicate the client's experience of holding secrets or living a lie by hiding

what she perceived to be relevant information regarding making a prediction regarding the client's safety.

Oh well I would have to, even if...it seems negative cause...with this kind of work truth telling is the only thing we can do going forward, because they've lived a lie for how many years. Only truth telling.

Elaine countered her concerns regarding a negative impact on her client being approved for surgery by stating that she would also include in the letter the evidence of the stability in the client's growth in using coping mechanisms which to her were a strong indication of the client's ability to commit to safety and well-being.

So if there is a history of self-mutilation it has to be put in there. And here's where we are now, here's the growth, here's the changes....look, I think this is the path she's going to be taking. I think that that's realistic but I always believe I don't ...time ...I see change that lasts, that's the word I was looking for change that lasts.

Robert felt that unless there was clear evidence of a client's suicidal plan or intentions, that genital self- mutilative behavior in and of itself might not fall under an ethical duty to protect the client through involuntary hospitalization.

It would be...to be perfectly frank I mean if someone...if someone threatens to cut off their dick it's not mandated reporting, and so if someone, if it was clear that someone was going to do it I would say AMA (against medical advice).

This caused conflict for him in that his wish would be to prevent the client from engaging in self-harm. Robert relied on factors such as assessing suicidality and whether the behavior took place concurrently with substance use that increased the risk of fatal injury. The only assurance that Robert could give himself regarding predicting client safety was through the use of behavioral contracting. He also felt that consulting with

an attorney would be necessary to discern his legal liability should his attempt to predict client safety be faulty.

I think like to me that's something I would consult with. Consult with an attorney. If the attorney said yes there are risks I would have them sign a contract.

In a fashion similar to Katy, Robert also felt that it would be important to communicate the rationale for his having his client sign a contract as a means of disclosing the nature of his felt sense of tension to the client. He felt that this would be an effort to influence the client's decision making behavior and to communicate clearly how he not only cared for the client but wanted them to be safe.

And say you know 'this is not intended to be punitive but this is a serious issue and I deeply fear that you might die if you do this. And so this is a line that I just need to draw . And it's not punitive but it's important to know how risky this is and how scary this is'.

Supraordinate Theme: Competent Practice in the Context of Emotional Stress

Participants experienced emotional stress in the context of striving to provide what they defined as competent psychotherapy to their clients who engaged in genital self-mutilation. As participants worked to prevent trans negative cultural practices from invading the therapeutic alliance, they assumed a demanding level of responsibility for undoing wounds inflicted by other professionals. Had the participants not been keenly aware of relevant gender issues, for example the difference between sexuality and gender, it is likely that they would repeat the mistakes that cost the client so dearly in encounters with other health professionals. For the most part, participants welcomed

this responsibility; they had the chance to utilize their sensitivity in affirming the client's previously unrecognized identity.

A quote from Katy's interview reflects an attitude common to all the participants' which was a high level of respect for their client's vulnerability and how the participants wished to honor the clients' willingness to engage in treatment:

I do, I think that it's very difficult, but if they make the leap to actually call, they're at least hopeful that someone can be different right? So...in many ways I think we end up you know as therapists getting people who are resilient enough to at least do tha, it's all the people that don't call anyone else right? Like they're out there in therapy with somebody who they have no idea it could be any different, and that is where I'm like, I just... you know because that there are so many more, right? So the fact that they actually get to me and they will tell me that they've had this experience it...it makes me extremely hopeful because it's like 'ok we can undo that....like that fact that you're actually willing to tell me and that you want to talk about it we we can undo that', it's fixable then.

In some respects, participants were also highly aware of the discrepancy in the quality of services and emotional support they could provide to their client in the context of the therapeutic relationship and the forces outside of the therapeutic alliance both professional and cultural that could destroy the hard work of building the client's self-esteem. Knowing that for example, a referral to a physician whose insensitivity might intensify the client's already existent feelings of shame created a unique conundrum for participants. How could they provide care that was deemed competent if they were dependent upon adjunct treatments to actualize the client's self that were not to the participant standards in terms of their definitions of affirmative care?

Another quote from Katy's interview illustrates the level of emotional distress participants could experience in witnessing their clients' attempts at self- definition undermined through incompetent treatment:

and the thing about it was, what I thought was so appalling, there were so many appalling things about what was going on, but what I thought was so appalling was the conversation in the room with the doctors was about how to reattach her penis. That was the whole point of them getting her ready for surgery... she didn't want it. That was why she was there, that was why she did what she did right? But their protocol was they had to reattach her penis...according to their protocol...and I was like 'what in the world?' Like, how unbelievably just ironic...that she's going through all of this and they didn't bother asking her any of that... like this is the whole point, right? The whole point of what she went through and what you're going to do with this is undo it?

This awareness extended the participants sense of responsibility to their clients but also heightened their level of stress, particularly in situations in which the client's safety was in question. For example, what did it mean to the participant to be caught in a dilemma between sending the client to the Emergency Room versus not subjecting the client to the risk of further emotional damage by professionals ignorant of trans identity? The participants' definition of competent practice in these situations rested on their ability to negotiate a balance between supporting the client's self definition and protecting their well being.

For participants, competence was also contingent on their level of communication with clients. In essence, being able to convey the totality of their concerns both with regards to the clients safety and any ethical dilemmas that this

posed for the participant, helped to maintain a sense of the therapy as a partnership with the client's best interests at heart.

Another excerpt from Katy's interview illustrates how participants felt that self-disclosure was a part of competent practice and was a means of reducing emotional stress on the participant:

And so there you know it's something that I think you have to talk about. I think so often we can feel that maybe we shouldn't talk to the client about what it means to have to do that. About what our experience is like in that and how it would be. That we kind of keep it from them, rather than I feel like you know the therapy that I do with people is a partnership. And they need to know what I'm thinking in it.

And so I kind of put that to them in terms of trying to help them understand that I have this dilemma...what do you want me to do?

Emergent Subthemes Supporting the Concept of Therapist Active Coping

Impact of the phenomenon on the self of the therapist emergent sub-theme 6:

Turning to others for support. Data analysis of participant interviews revealed a theme connected to participants relying on others for professional and emotional support in dealing with the intense feelings and dilemmas provoked by working with these types of cases. Participants leaned on colleagues, friends, and significant others to stabilize their anxieties. This enabled them to continue to work with the client and to decrease the impact of their personal countertransference reactions from contaminating the therapeutic goals with the client. Ultimately, human contact for the therapist in the form of their own support was considered to be an invaluable resource in meeting the challenges of working with their clients.

Throughout her interview, Sally stressed the importance of both personal relationships that sustained her and the professional relationship of a colleague who played a mentor/consultant role for her. For Sally, her friend offered a safe emotional outlet to verbalize her stresses. Her consultant kept her informed and helped her contain anxieties around clinical decision making in working with her particular case:

But just being able to talk to a colleague. I have a friend who's also a social worker, who I know I just can vent to with no identification. 'Oh my god I have this client and then this is what happened' and you know, my friend has no just sense of who I'm talking about but...I just need to vent you know.

But I've done tons of trainings and consultation you know with the person that I feel is kind of like my mentor in this field.

Yes a lot of things, I mean I called (names therapist) who I use as a consultant, just like bouncing off of her was there anything else I could do?

I mean this is when you gotta use consultation right? And we have to support each other...and so could I do something different and you know what else do I need to do?

Robert discussed turning to both his supervisor and a physician involved in his client's case to manage a feeling of being overwhelmed by her actions of genital self-mutilation. He found this to be a comfort and it strengthened his commitment to continue working with his client:

I had an individual supervisor...there was someone else that I worked with on the medical side who is a fount of knowledge and humor and understanding that I also relied on....So I got clinical support...and the doctor I spoke to was very empathic too. I mean he could be kind of flip when it was just me and you know sort of the gallows type of humor. But deep down and you really talked on a very serious level how deeply concerned and caring we were for her.

Elaine talked about her relationship with her significant other as a sanctuary where she could discuss her troubling feelings. The outcome of being able to rely on the relationship in Elaine's mind was to be able to resist perseverating on thinking about the case:

I would debrief with (names person here) cause (names person here) understands cause sometimes I just go to this person and say 'honey just put your arms around me and just hold me'.

Otherwise you're up in the middle of the night, pacing the floor thinking about something you know that isn't good you know.

Katy shared that her inexperience at the time her client self mutilated was tempered by the ability to turn to a supervisor for guidance. She describes her supervisor as helping her to think clearly in an emergency situation:

When you're when you're new into working with people and I would say social work cause I'm a social worker but it counts for anybody, new doctors, new therapists, new nurse, whatever. You're more in your own head, right? It's more about you because you're worried about what you're doing.

What I did was bolt from the room, and dive into my supervisors office who was right next to me and she was on the phone and I started yelling you have to come in you have to come in right now.

She kind of takes control of the situation and she's like we all sit down.

Katy also shared how she utilizes personal therapy as a means of processing her feelings related to intense case material:

And so even though I I do process with people and you know I do my own therapy, it's interesting to talk about.

Impact of the phenomenon on the self of the therapist emergent sub-theme 7:

Practices promoting stress management. Participants supplemented turning to others for emotional support with other diverse forms of stress management. Participants discussed both specific practices and general ideas about how therapists in the position of working with transsexual clients who engage in genital self-mutilation might engage in self care that promotes the ability to engage with clients in a productive manner and at the same time tend to the self of the therapist. Participants drew strength from activities that nourished them both physically, intellectually and spiritually.

Katy discussed how she managed fear connected to client safety issues through her spirituality:

Honestly I pray a lot...I have a pretty strong faith and I pray a lot.

And now I breathe, it's like breathing and I just do it.

Robert sustained himself through a more intellectual approach. For Robert, up to date professional information, particularly if it was derived from individuals knowledgeable in working with the transgender population, gave him a sense of empowerment in tolerating making tough clinical decisions:

I consult with colleagues quite a bit and If I was really stuck I would reach out to...the therapists that have provided trainings in the past, given their vast expertise in working with people. It would be like relying on someone with a lot of d.v. (domestic violence) experience. In terms of how to work with someone.

I've done some training on the recipient side from some therapists who are very seasoned in the field...they're both therapists in the field.

Elaine talked about how a group approach to working with cases involving genital self-mutilation would help to promote an atmosphere of both support and continuity of care that she believes would be ultimately beneficial to a client. In particular, she felt that the exchange of ideas amongst different disciplines on the team would be helpful to the therapists' sense of efficacy:

See that's where I think a gender team could be helpful. To debrief a little bit. If that countertransference should happen, or something. I think that would be a real plus. For a gender team or to have some trusted person that you can vent to or dump on or something that keeps confidentiality.

So I think a treatment team or they call them nowadays a gender team.... I can see the value of that....the support... to be able to ask 'you gotta an idea what to on how to handle this?' The whole thing, the coordination of course.

Sally referenced a combination of relying on her spiritual beliefs and paying attention to her body's needs as essential aspects of her practice of stress management:

And then when people leave my office, when they walk out the door, I do a ritual. And I cut the cord. And I do a prayer that I like for them, and just like put them in the light. And I do that with everybody everyday and it's very helpful. Because it's really that you know they're kind of in the hands of the universe.

And just bigger things like how I take care of myself? Everything related to my support in general. Sleeping, eating, and going for a walk. All my self care I think is directly connected to managing cause it's a really stressful situation.

Impact of the Phenomenon on the Self of the Therapist Supraordinate Theme: Active Coping

The supraordinate theme revealed through the process of data analysis concerning participants management of stress related to working with cases of male to

female transsexual genital self-mutilation can be summarized as the necessity for participants to actively cope with a variety of stressors both emotional and professional inherent to managing a case that could by some standards be considered to be high risk. Participants did not have the luxury of leaving their self care to chance when confronted with strong emotions, client safety issues, and ethical dilemmas regarding the best way to proceed in terms of intervention. Without conscious attention paid to developing an awareness of how the intersection of client psychology, countertransference and systems inadequacies intersected and being mindful of how overwhelming this combination could be for the individual clinician, it is likely that participants would experience burnout in the face of the intense demands such as case could place on the therapist.

A quote from Sally's interview exemplifies the participants' sense that how they viewed their challenges was pertinent to their ability to manage them. Sally found a way to cope with situations in which she lacked control via reconciling her stress with her system of meaning:

But that framing you just said is hugely important, because part of what allows me to function is that I know that I cannot keep them. I can't. I don't have that kind of power. And so I mean that's where my own spiritual system comes into play, because, I besides all the clinical things that I do I put them in that light and I do all my own spiritual things, you know, because worrying about them isn't gonna help me or help them. And so I have developed my own good self-care skills to cope with those stresses because I think you just can't. I mean I think if you're gonna function as a therapist we have to practice what we preach.

Summary of Findings

Table 8 summarizes the findings of this study generated through coding to find emergent themes from the transcripts of participant interviews with the researcher. Findings are divided by domains which represent the broad aspects of the phenomenon onto which the supraordinate themes can be mapped. Subthemes are presented to establish support for the abstracted supraordinate theme and are displayed next to the supraordinate theme to which they correspond.

Table 8. Summary of Findings

Domain	Supraordinate Themes	Emergent Sub-themes
Conceptualization	Client experience of psychological pressure	<ol style="list-style-type: none"> 1. Gender Identity as Authentic Self 2. Toxic Shame 3. Double Bind
Conceptualization	Constraints on Client Sense of Agency	<ol style="list-style-type: none"> 4. Social Obstacles to Self-Actualization 5. Insufficient Coping Mechanisms
Conceptualization	Protecting the Self through Action	<ol style="list-style-type: none"> 6. Self Mutilation as Harmful Physical Action 7. Genital Self Mutilation as attempt to problem solve
Treatment	Affirming Female Gender Identity	<ol style="list-style-type: none"> 1. Supporting Client Self-Definition 2. Promoting Compassionate Stance towards the Self
Treatment	Mediating Vulnerability of the Coming out Process	<ol style="list-style-type: none"> 3. Connection to Support Resources 4. Negotiating roles and relationships in new identity
Treatment	Safety Planning promotes Self Reflective Capacity	<ol style="list-style-type: none"> 5. Establishing links between thoughts, feelings and behavior 6. Harm Reduction

Impact of the Phenomenon on the Self of the Therapist	Countertransference as Parallel Process	<ol style="list-style-type: none"> 1. Therapist Feeling Overwhelmed 2. Boundary Challenges 3. Vicarious Marginalization
Impact of the Phenomenon on the Self of the Therapist	Competent Practice in the Context of Emotional Stress	<ol style="list-style-type: none"> 4. Practices Defining Incompetence to Work with the Trans Population 5. Tensions around predicting client safety
Impact of the Phenomenon on the Self of the Therapist	Active Coping	<ol style="list-style-type: none"> 6. Turning to others for support 7. Practices promoting stress management

Data analysis yielded significant themes around multiple aspects of the lived experience of therapists understanding of the phenomenon of genital self mutilation amongst male to female transsexuals. Participants' clinical conceptualization of the motives for such behavior included the sense that female gender identity could not be suppressed despite the shame and interpersonal risks associated with its expression. From the participant perspective, clients experienced psychological pressure as their desire to explore a fundamental part of themselves and the internalized against doing so came into conflict. Participants believed that clients experienced themselves in a double bind where they felt they had to choose between either being themselves or losing their families. Social prejudice and habitual coping mechanisms constricted the clients' sense of any ability to influence their fate and resolve this conflict. A sense of desperation set in as participants felt that their client's could not see a way to solve this problem. The physical act of genital self mutilation then served a psychological function

for the client which was to restore some sense of control in a situation in which a lack of agency had become unbearable for the client. The client attempted through action to solve the problem of the true self being threatened with extinction by social expectations.

According to participants, treatment of clients engaging in genital self-mutilation involved restoring the client's sense of agency through non harmful means. This involved encouraging the client to begin to define themselves rather than to be defined solely by their environment or their shame. Participants sought to help clients relinquish negative patterns of coping through via helping the client to become more compassionate with themselves. Participants acted as mediators in the client's coming out process with the sense that it supported a public identification as female. Additionally, connecting clients to the needed resources to further their transition efforts and helping them to find ways to manage the reaction of their environment to their new identities were seen as means of empowering the client's self definition. Participants felt that validation and provision of resources both social and psychological reduced the need to rely on genital self mutilation to either regulate the state of the self or to communicate its needs and intentions. Participants provided clients with a deeper understanding of the precipitants to genital self mutilation and offered alternatives to this behavior by helping the client to use harm reduction. Ultimately, by assisting the client to organize their sense of how genital self mutilation occurred and creating a

safety plan to avoid further recurrence, the participants assisted clients to develop an observing self capacity.

Working with this phenomenon impacted the participants deeply. The feelings provoked in treating such cases paralleled the clients' experiences of being overwhelmed, feeling torn, and experiencing a sense of powerlessness. Participants were challenged to set boundaries that enabled treatment to occur; the boundaries were evident in both participant behavior towards the client and their philosophies of treatment around safe and unsafe client behavior. Participants were also given a firsthand experience of their clients' oppression in their efforts to secure resources for the clients. Thus, participants' countertransference paralleled the client's experiences on many levels. In their commitment to serving their clients competently, participants did experience some tension around confidently predicting their clients' ability to remain safe. Participants were highly aware of the professional practices they considered to be injurious to their clients' sense of self and strove to avoid duplicating those practices within the therapeutic relationship. However, this caused some emotional stress for the participants as the pressure of attempting to assure the client safety while at the same time respecting the client's newfound sense of self was a delicate balance to strike. Participants coped with their own stress in this process through relying on emotional support within their personal and professional networks as well as utilizing more specific techniques to actively cope with the demands of working with these cases.

CHAPTER V

DISCUSSION OF FINDINGS AND IMPLICATIONS

This study explored the lived experience of psychotherapists who work with male to female transsexual clients who engage in genital self-mutilation. Data analysis of semi-structured interviews with participants utilizing an interpretative phenomenological methodology yielded nine supraordinate themes which emerged across all participant interviews. These themes will be discussed with regards to their connection to the secondary research questions posed by the investigator as well as being compared to the relevant available peer reviewed literature regarding the phenomenon of genital self-mutilation amongst male to female transsexuals so as to further illuminate the significance of the results of the current study. It should be noted as this was an exploratory, qualitative study, the emergent data does not correspond directly in a one to one fashion with the posed secondary research questions. As such, the investigator will denote the discussion of the implications of the theme with the correlated secondary research question. In addition, the findings of this study will be discussed from the perspective of implications for micro and macro social work practice. The limitations of the study as well as the implications for future research regarding the phenomenon will be discussed. Finally, the investigator's personal experience with the phenomenon will be shared to demonstrate the author's self reflexive process.

Table 9. Supraordinate Themes and Corresponding Secondary Research Questions

Supraordinate Themes	Corresponding Secondary Research Questions
1. Client Experience of Psychological Pressure	Secondary question #1: How does the therapist conceptualize the phenomenon from a behavioral, intrapsychic and interpersonal perspective?
2. Constraints on Client Sense of Agency	<p>Secondary question #1: How does the therapist conceptualize the phenomenon from a behavioral, intrapsychic, and interpersonal perspective?</p> <p>Secondary question #7: How might the clinician understand whether the expression of such behavior is influenced by social conditions and how the client adapts to the challenges of their environment?</p>
3. Protecting the Self through Action	Secondary question #1: How does the therapist conceptualize the phenomenon from a behavioral, intrapsychic, and interpersonal perspective?
4. Affirming Female Gender Identity	<p>Secondary question #2: How might the therapist envision the goals of treatment with such an individual?</p> <p>Secondary question #5: How might the clinician's actions and thought process in working with such a client be influenced by various theoretical understandings of the motivation of such behavior?</p>
5. Mediating Vulnerability of the Coming Out Process	<p>Secondary question #2: How might the therapist envision the goals of treatment with such an individual?</p> <p>Secondary question # 4: How might a clinician ascertain the likelihood of a successful outcome of treatment in addressing the needs of this particular client and their behavior?</p>
6. Safety Planning Promotes Self-Reflective Capacity	<p>Secondary question #2: How might the therapist envision the goals of treatment with such an individual?</p> <p>Secondary question #3: How might the clinician consider such behavior as well as the client's opinions regarding the behavior in the context of establishing a therapeutic alliance</p> <p>Secondary question # 4: How might a clinician ascertain the likelihood of a successful outcome of treatment in addressing the needs of this particular client and their behavior?</p>

<p>7. Countertransference as Parallel Process</p>	<p>Secondary question #6: How might the clinician's actions and thought process be influenced by the client's goals as well as the ethical demands made on the therapist in the context of treating such a client?</p>
<p>8. Competent Practice in the Context of Emotional Stress</p>	<p>Secondary question # 6: How might the clinician's actions and thought process be influenced by the client's goals as well as the ethical demands made on the therapist in the context of treating such a client?</p>
<p>9. Active Coping</p>	<p>Secondary question #6: How might the clinicians actions and thought process be influenced by the client's goals as well as the ethical demands made on the therapist in the context of treating such a client?</p>

Discussion Theme 1: Client Experience of Psychological Pressure

This theme corresponds to the posed secondary research question, how does the therapist conceptualize the phenomenon from a behavioral, intrapsychic, and interpersonal perspective?

Genital self-mutilation occurs in the context of emotional distress for the individual. Participants in this study referenced the influence of the mind as an explanation for the manifestation of this behavior. In particular, a mind in conflict was attributed with laying the foundation for extreme action in the form of genital self-mutilation. From an intrapsychic perspective, participants understood their clients to be struggling with a conflict between their gendered sense of themselves as persons and a level of shame that was overwhelming. This finding is significant in that it implies that in order to understand or prevent the behavior, a unit of analysis that must be taken into consideration is the emotional state of the individual contemplating the behavior.

While access to needed resources and addressing stigma attached to gender variant identity within the culture are important remedies to consider, the participants experience with the phenomenon suggests that a critical element to pay attention to is the degree of emotional suffering that the individual endures. This also implies that psychotherapy may be a legitimate means of intervention to address the behavior of genital self-mutilation as it is suited to deepening client self understanding which reduces psychological conflict.

Participants' understanding of their clients' psychology was connected to their perception of the client experience of the emotional strain of managing conflicting feelings around gender identity, shame, and from an interpersonal perspective, fearing the loss of the individual's significant others. These may represent dimensions of psychological experience that clinicians could assess in addressing the potential for an individual to engage in genital self-mutilation. The intensity of these thoughts and feelings predominated the participants' understanding of their clients' motivation for the behavior. This attribution of motive to psychological conflict converges with other accounts of the behavior within the available literature.

A convergent formulation is evident in Menninger's writing (1938). His explanation of the behavior deserves reconsideration when compared to participants' depiction of the psychological forces at play within their clients' minds. Menninger conceptualizes the motivation of self-mutilation as connected to a fear of being trapped in a situation intolerable to the self. This resonates with the participants' perception of

their client's psychological experience of a double bind. Acceding to the environment's expectations of male gender identification was construed as antithetical to the client's deepest desires and according to participants provoked a sense of desperation amongst clients. Participants' descriptions of conflicting wishes of a desire to maintain connections to loved ones and to explore their female identities also corresponds to Menninger's proposal that the behavior represents a compromise formation amongst multiple competing wishes. Some divergence from Menninger's formulation can be observed in his ideas regarding why the genitals in particular are targeted for harm. In Menninger's depiction, consistent with his drive theory, the symbolization behind targeting the genitals is connected to a need to distance or disavow sexuality; the internal crisis is conflict over sexual wishes. From the participants' perspective, the client experience of psychological pressure is not connected to conflicts over sexuality but again the threat of annihilation by the expectations of the other.

The participants understanding of motivation being connected to an experience of psychological pressure is also revealed in their discussion of their clients' relationship to their bodies. Disgust with the body and the genitals was a common theme throughout the participant interviews. This coincides with Pauly's case review (1965) which attributes motivation for the behavior amongst the transsexual population to hatred targeted towards the genitals. Psychological pressure according to Pauly is experienced in the sense of desperation connected to the wish to be rid of the genitals and the reality of their being connected to one's physical being.

Walsh's (2006) concept of body alienation also supports the participants understanding of motivation. All participants noted the clients' antagonistic, oppositional relationship to their bodies. Male embodiment was humiliating and painful to the client. From the participant perspective, this contributed to a chronic dissatisfaction with the self manifesting as shame and self hatred. Walsh characterizes body alienation as an experience of being at war with the body. Participants understood part of their clients' symptomatology as an effort to cope with the dissonance between gender identity and the physical body and a sense of hopelessness regarding their ability to transform their bodies. By elevating the client relationship to the body as a target for psychological intervention when addressing self mutilation, Walsh seems to mirror the participants concerns regarding softening the stance towards the self.

While Lothstein's (1992) clinical population was that of children and not adults, his discussion of the impact on the child of mixed messages from caregivers regarding gender, and the unconscious sense that expressing male gender would be equated with abandonment by one or both of the caregivers can be contrasted with the participants understanding of their client's psychological conflicts. Lothstein's formulation is more an etiological account of how the transsexual identity develops and how genital self-mutilation eliminates both shame around being male and addresses the fear of abandonment by others for being male. Participants offered an inverse explanation of their clients' fears in comparison to Lothstein; potential abandonment was connected to

expression of female gender identity, not male gender identity. Participants' felt that the clients' fears were conscious, real and justified based on their experiences of hostility towards female gender expression within their environments. Participants characterized the sense of secrecy necessary for the clients to avoid exposure of their flaw as being female and not good enough for those around them. Again the psychological experience of pressure was connected by participants to the conflict between what made the client feel safe, which was hiding the true self versus the need to express the true self. More consistency with Lothstein's account can be found in his emphasis of the influence of the relational environment on the self conception and actions of the individual. Fear of abandonment exerts a powerful hold over the self.

An author not previously discussed in the literature review portion of this study and included in the discussion here is Arlene Lev (2004). Lev's work on psychotherapy with the transgender population resonates with the findings of the theme of client experience of psychological pressure as significant to understanding the behavior of genital self- mutilation amongst this population. Lev believes the clinician working with a transgendered individual in therapy needs to be familiar with the predominant feelings and thoughts coloring their experience of gender variant identity. Lev empathically points out that given the stigma associated with gender variant behavior, when a client begins to accept their sense of themselves as different from how society's binary construction of male or female gender, there is a potential for this awareness to disrupt the client's psychological equilibrium. The similarities between Lev's

understanding of the pressure of coming to accept and claim a gender variant identity is strikingly similar to the participants depiction of their clients being driven by a wish to claim the true self of their female gender identity.

Specifically, Lev's (2004) discussion of the emergence of gender variant identity within the consciousness of an individual is likened to the impact of high momentum force.

When transgenderism comes to the surface of conscious awareness, or intensifies and can no longer be suppressed or denied, a floodgate of emotions is thrown open. The shock of gender dysphoria surfaces like the intensity of sexual abuse or other traumatic events that have been buried under daily consciousness. The force of gender variance awareness can rise up like a tidal wave, threatening the entire foundation of one's life and identity. (p. 236)

Lev's aforementioned quote supports the participants' sense that their clients were in a state of psychological disequilibrium brought on by the conflict of the need to express the true self and the proscriptions against doing so.

Further support for the theme of client experience of psychological pressure is evident in Lev's (2004) writing. She utilizes the same construct of a 'double bind' when discussing the psychological pressure transgender individuals experience around their sense of the potential consequences of being open about their identity with loved ones. Lev describes the trans individual's sense of being torn between sharing their self discovery in their relationships versus the sense of fear around the other's potential disgust and rejection of their true self.

Transgendered people are placed in a class double bind. They have become aware of an essential part of themselves and have begun to normalize it through their process of gathering information and connecting with others who are also

dealing with gender issues. A part of them, long hidden and denied, is finally coming out, and they want to share it with others whom they love and are close with. Yet they are also aware of the impact this will have on their loved ones. They are fearful, and rightfully so, that others may not be as enthusiastic as they are....The pressure to come out and the (perceived) pressure outside to stay in, cause an emotional quagmire. It is precisely their intimacy with significant others that pushes them to want to disclose and it is this very quality that they risk by disclosing. (Lev, 2004, p. 248)

These accounts indicate a consensus that the transgender individual copes with an extraordinary amount of psychic pressure in consolidating and publicly expressing gender. This corresponds with the view of the participants of the current study who characterized their clients as enduring psychological conflict and stress which contributed to the ultimate behavior of genital self-mutilation. Thus, the current study indicates that participants utilized a framework to understand the phenomenon from both intrapsychic and interpersonal perspectives.

Discussion Theme 2: Constraints on Client Sense of Agency

This theme corresponds with the secondary research questions of how might the clinician understand whether the expression of such behavior is influenced by social conditions and how the client adapts to the challenges of their environment? This theme also corresponds with the secondary research question how does the therapist conceptualize the phenomenon from a behavioral, intrapsychic and interpersonal perspective?

Given the experience of psychological pressure that participants understood to be essential to the manifestation of genital self-mutilation, the limitations on the client's ability to rectify psychological disequilibrium was considered by participants to be

another critical factor in understanding this behavior. In essence, participants were deeply concerned with the factors that they believed prevented clients from changing a situation that was psychologically harmful. Participants strongly believed that social conditions, namely institutional discrimination that erased or negated the trans identity, restricted clients from accessing services that were essential to manifesting the gender expression of female gender identity. Participants were concerned with issues of power of their clients in regards to the ability to self actualize gender identity. Power could be defined as ability to access resources or to make the environment respond to the desire or wish to transform oneself.

Of interest, within the available literature, the motive most cited amongst researchers for the behavior is the wait the individual endures in accessing gender reassignment surgery. Haberman and Michael (1979), Murphy et al. (2001), McGovern (1995), Rana and Johnson (1993), and Stunell et al. (2006) all referenced such cases. While the participants experience did not necessarily contradict these reports, what participants seemed to emphasize was the oppressive combination of systemic issues of access to care influenced by social norms as well as the client difficulty in coping with the impact of this type of discrimination. For participants, while social conditions were a significant piece of the puzzle, the psychological defenses participants employed to cope with such circumstances also figured prominently in the participants understanding of the constraints on the clients' sense of agency. Thus, participants did not split the

constrictions clients experienced into an either/or conceptualization of social vs. psychological explanations for the behavior.

The participants' understanding of the relevant social conditions contributing to the sense of client powerlessness is mirrored by Baltieri and Andrade's (2005) discussion of how the Brazilian legal code erases the transsexual identity through failing to recognize the possibility of non binary gender in human experience. Their discussion of the case of their client who used what they characterized as covert means to enact gender transformation resonates with participants descriptions of clients who were rejected by the institutions they turned to in their quest for transition. Baltieri and Andrade's conclusion that the risk of the behavior of genital self-mutilation increases when social exclusionary practices disempower the transsexual individual supports the participants' understanding that their clients behavior was not solely driven by psychological motivation and that the behavior could not be understood by separating the transsexual client from their relationship to the environment.

Additional support for the theme of constraints on the clients' sense of agency can be found in Lobato et al.'s (2007) assertion that when basic social resources such as obtaining a job are denied, a source of income to enact transition is unavailable and may cause the individual to turn to prostitution in order to survive. Participants described their clients as being deprived of social resources such as jobs and access to sensitive healthcare which ultimately detracted from the clients' sense of an ability to influence their fate. Lobato et al.'s call for reform connected to recognition of the transsexual

identity mirrors participant understanding that clients' loss of hope was connected to their experience of an environment hostile to their wish to transform. Without environmental changes, the individual has limited choices regarding changing their physical body.

From the standpoint of insufficient psychological coping mechanisms also restricting client agency, the participants understanding that symptomatic behavior represented their clients best attempts to cope but that this form of coping tended to disenfranchise the client coincides with Connors (2000) sense that mutilative behavior represents the breakdown of the ability to access healthy means of regulating affect and the boundary of the self.

With an incomplete or inadequate self boundary, the repertoire of skills normally available to an adult to regulate internal sensations and mediate interactions with the external environment may be temporarily inaccessible. It is as if the combined intensity of past experiences and current events cannot be sorted effectively or contained. The self-boundary operates inadequately, as people struggle to find some method to ground, sort, hold, and understand their experiences. Avenues to less self-violent means of coping can short circuit, or become blocked, and self-injury becomes the regulator and the communicator.

The use of dissociative means of coping with strong affect predominated the participants' discussion of the types of coping mechanisms clients relied on to manage their emotional pain. Substance use, a depersonalized relationship to the body, and focusing on others at the expense of the self were prominent amongst client defensive maneuvers. The participants' experience was that while these defenses temporarily allayed emotional overwhelm, they failed to bolster the clients to navigate environmental challenges without hurting themselves in the process.

The predominance of these types of coping mechanisms for managing emotional stress corresponds largely to available literature on trauma victims (Briere, 1998; Linehan, 1993). Additionally, Lev (2004) points out that for the transgendered individual, the experience of a core part of self not being recognized and validated within the environment, but rather shamed and degraded, is tantamount to an experience of psychological trauma for the transgendered individual. Coping with trauma takes many forms and Lev asks practitioners working with this population to consider symptomatic behavior as evidence of clients' attempts to cope with the fragmentation of the self in the face of interpersonal onslaught on the trans identity.

...when examining lifelong gender dysphoria there is often no discernible traumatic event to focus on, but rather a series of smaller experiences that have culminated in years of denying one's essential sense of self. The fear of social punishment for transgressing social norms and the long-standing presentation of a false self can also create numerous mental health problems. The high incidence of mental illness among transgendered people noted in the literature might better be understood as reactive symptomatology and post traumatic sequelae. It is literally crazy making to live a false self. (Lev, 2004, p. 196)

The participant understanding of their clients demonstrates the toxic chronic frustration derived from social marginalization. Without a sense of agency, an individual is predisposed to feelings of hopelessness. The locus of control is external to the individual and beyond influence. If a sense of power is not forthcoming in terms of the ability to influence either the environment or one's feelings about the situation, then power may be sought out through physical action. As participants felt that their clients attempts to cope with the lack of power were ineffective in preventing further harm to

the client's self, it is obvious why participants understood their clients to feel hopeless and without recourse.

What should also be noted is that the participants' understanding of their clients' defensive structures means that it is not social obstacles impinging on one's sense of power alone. The individual's unique personality and coping style comes into play ambivalently as a protective and destructive factor in client functioning. It is difficult to challenge discriminatory practices or to confront one's environment when for example one's energy is drained by dissociative processes.

This seems significant from the perspective that this behavior amongst this population may be particularly suited for a clinical social work approach to assessment and intervention. The social workers focus on the person and their relationship to the environment creates many potential levels of intervention, either with the individual directly in terms of the client psychology or with the environment in terms of addressing issues of access, marginalization, and existence of needed services for minority populations. In essence both levels of intervention are geared towards empowering the client to reinvent the relationship to the environment in a way that promotes ability to participate and function. Addressing the obstacles that prevent a more benign interaction between the individual and the environment can restore a sense of hope and power to the individual. Instilling means of coping that offer alternatives to self harm also increases hope that one can manage in an effective manner.

Discussion Theme 3: Protecting the Self through Action

This theme corresponds to the secondary research question how does the therapist conceptualize the phenomenon from a behavioral, intrapsychic and interpersonal perspective?

As clients' emotional stress built over time and a continual experience of powerlessness interfered with the ability to resolve the sources of stress, participants understood the clients' action of genital self-mutilation as an attempt to protect the self from further overwhelm and annihilation. In the participants' experience, the function of genital self-mutilation lay in the clients' efforts to gird the self against further attack either from within the self or from the outside environment. Self-mutilation was defined by participants as a harmful physical act carried out on the individual's genitals. Physical action was understood to serve a psychological function, restoring a sense of control to the individual by removing that which was felt to be disgusting and communicating the forbidden to others, which was the clients' desire to embrace their female gender identity.

From a behavioral perspective, the participant's depiction of self-mutilation as physical wounds inflicted on the body are consistent with the descriptions of the behavior offered in the accounts of Rana and Johnson (1993), Catalano et al. (2002), Greilsheimer and Groves (1979), and Stunell et al. (2006). These authors share similar experiences of their clients' blood loss, damage to the testes, and actions such as slicing or cutting using knives or other sharp implements with the participants. Where the

participants differ from these authors is their deeper knowledge of the intent behind the behavior. The description of the individual's psychology does not cease with attribution of motive to frustration with a wait for reassignment surgery or the consequent medical risks associated with the behavior. Rather, participants see the behavior as purposeful and complex.

This is significant in that participants' construal of the behavior in this manner may be a less pathologizing means of understanding intent. Problem solving is a universal human tendency and participants positioning clients as seeking resolution to difficulty humanizes their actions to a certain degree. At the very least, participants ongoing relationship with their clients allowed for the possibility of empathetic identification as opposed to superficial attribution of motive. While participants felt the problem solving to be ultimately lacking in efficacy, they nevertheless did not fault their clients for protecting themselves against psychic breakdown.

Additionally, the participants' sense of their clients' behavior as an attempt at problem solving is somewhat consonant with Brown's (2010) construction of self mutilation as 'self-surgery'. Brown emphasizes the emotional distress of the individual in being deprived of access to means to transform the body by virtue of non recognition of gender dysphoria as a problem requiring medical intervention. In Brown's view, hormones are 'medicine' and if the individual does not have access to medicine, they will seek other means to 'cure' their illness. Mutilation is not mutilation in this understanding but rather a medical intervention one enacts on oneself in order to

survive psychologically. To Brown, these actions solve the individual's problem of not being heard and not being able to access care. Again, however, participants' understanding of the medical risks involved in attempting to regain a sense of control and their concerns about preventing recurrence of the behavior indicate that self-mutilation is not viewed as the most efficient means of empowering oneself.

Of note, participants' understanding of the mental process by which clients carried out their action of self-mutilation is also supported by a few of the authors within the literature. Participants described their clients as psychologically equating removal of the genitals with elimination of painful feelings and communicating in a symbolic fashion the desires of the self. Favazza's (2011) concept of "localization" resonates with the participants' sense that clients found a means to resolve shame and fear of their female gender identity being erased by others by displacing these feelings onto the genitals and believing that these feelings would cease to hold power over them once the genitals were removed. Participants' experience was that the clients sense of their genitals was akin to a cancerous growth; something that had to be removed in order for the self to survive. From the participant perspective, the irony of localizing shameful feelings to the genitals is that it fails to protect the client from further experiences of shame and rejection, particularly within a transphobic culture. Participants perceived the experience of clients coping with this type of culture as inherently damaging to the sense of self and attempts to exorcise this oppression

through violence directed against the self does not preclude the possibility of further disempowerment by others.

The point should be made however, the sense that the clients were communicating with others via their action of self mutilation is supported in Crowe's (1996) construction of the body as a site of discourse between the individual and society. Participants sense that clients' communication of emotional pain of being perceived by others as male and their wish to make their body congruent with their psyche via the action of genital self mutilation does resemble the wish to differentiate oneself from social norms governing identity discussed in Crowe's writing. If the transsexual cannot be permitted to develop an authentic identity as a result of marginalization and erasure, physical action may symbolize the individual's process of claiming their own identity. The wounds to the body speak the sense of being different, of not wanting to be labeled according to social convention, and attempting to control how the other perceives the self. In some sense, this is the challenge the participants believed their clients faced as they could not convince those around them to honor their female sense of self.

Finally, the theme of self-protection seems significant in that it translates behavior that initially can be viewed by others as pathological or shocking and connects it to subjective intention. Thus, behavior that is difficult to understand can be deconstructed and contextualized, which offers the possibility that alternatives to the behavior that carry out identical intentions for the subject can be imagined. Intentional

behavior is amenable to deconstruction within a purposeful dialogue with a concerned other. Thus, the behavior of genital self mutilation may be approachable through the person of the therapist who assists the individual in constructing the origins and functions of the behavior. A therapist who understands that genital self mutilation is functional from the standpoint of saving the self, but that it also risks the death of the self if the body is harmed extensively does the individual a service by offering complex interpretations of intentional behavior from an empathic standpoint.

Discussion Theme 4: Affirming Female Gender Identity

This theme corresponds to the secondary research question how might the therapist envision the goals of treatment with such an individual? This theme also corresponds with the secondary research question how might the clinician's actions and thought process in working with such a client be influenced by various theoretical understandings of motivation of such behavior?

The emergence of this theme raises the question of how affirmation of female gender identity is relevant to the behavior of genital self-mutilation? In the participant experience, affirmation was considered to be an essential element of both building a therapeutic relationship with the client and a psychological intervention in and of itself. Establishing a relationship with a vulnerable client traumatized by frequent experiences of rejection and fearful of having shameful secrets exposed necessitates an active demonstration of trust building on the part of the therapist. Affirmation of the client subjective sense of self was perceived by participants to be at the core of the

therapeutic endeavor. It was felt to undo toxicity of shame, and to counterbalance the experience of a non-responsive environment. From the participant perspective, this diminished the allure of reestablishing psychological homeostasis through acting out against the self. Instead, affirmation improved self-esteem and reduced the desperation of being unseen or rejected by others. In essence, the factors that might dispose the client towards acting out were depotentiated through the respect participants extended towards the client subjective sense of self.

Without question, this study demonstrates the participant experience of a desire to normalize and affirm the female gender identity of their clients. Being keenly aware of the psychological toll that clients bore in terms of having their experience labeled and defined by others resulting in shame and estrangement from the self, participants worked hard to create a safe space in which the client could begin to express feelings and thoughts around gender that were not permissible in other contexts. Participants believed this served to bolster client self-esteem in the face of being depicted by their environment as freakish or monstrous. The participant perception of a connection between having one's identity devalued, the experience of rejection as disempowerment, and the behavior of genital self-mutilation are significant in that it implied potential theoretical influences influencing the participant stance towards their clients' subjective experience and how they intervened. Primarily, the participant emphasis on the nourishing aspects of the therapeutic alliance in the forms of

promoting client self-definition and modeling compassionate relating to self are consistent with broad social work principles of valuing the human relationship.

While participants did not explicitly identify their interventions of supporting client self-definition and promoting a compassionate stance towards the self as aligned with a specific theoretical orientation, the action of affirmation corresponds to a number of theories that have been influential on social work practice in general. For example, the invitation to the client to behave authentically through encouraging honest disclosure of thoughts and feelings could be likened to the client centered philosophy of assisting the client to develop congruence with the self (Rogers, 1961), the object relations perspective of creating a holding environment which allows the client to relinquish a false self presentation in favor of the true self (Winnicott, 1965), or a self psychological perspective of viewing gender identity as a developmental aspect of the nuclear self which through proper mirroring could reignite development of self structure (Kohut, 1977). More specifically, however, the participants' affirmation of female gender identity corresponds to the treatment model expounded by Lev (2004) as a sensitive, competent approach to working with gender variant individuals.

According to Lev (2004), treatment with the gender variant individual is envisioned as a process of shepherding the client's burgeoning awareness of gender identity through a series of confirming therapeutic experiences with the ultimate goal of allowing the client to experience and express their gender identity as authentic self experience worthy of social dignity. Prime among the directives within these treatment

models is that the clinician creates the psychological space for the client to self-identify; gender identity is not imposed on the client by the clinician. The goal of therapy is to assist the client in greater self-knowledge so he or she can make informed decisions about his or her gender expression, self identity, body configuration, and ultimate direction of his or her life (p. 186).

Lev (2004) envisions treatment with the gender variant individual has having a developmental tilt, the therapist accompanies the client through stages of identity confirmation, and the therapist's role changes in accordance with the appropriate stage. In comparing Lev's model to the participants' intervention with clients, it is apparent that both participants and Lev share the sense that a foundation for therapeutic action rests on the conditions created in the therapeutic alliance. This is the first step towards building trust between the client and therapist that promotes a sense of safety for the client.

The clinician must create a 'holding environment', a safe space for repressed emotions and forbidden thoughts to emerge. This holding environment is a kind of 'container' that allows traumatic issues to surface. Issues of confidentiality are paramount, as is the client's commitment to his or her own physical safety. The therapist's relaxed comfort regarding gender issues, and referencing of others who are transgendered through examples and stories can ease the sense of shame and isolation for clients. The therapist brings with him or her an immense power of authority, and modeling acceptance, kindness and ease can help assuage the intensity of dysphoria (p. 239)

It is interesting to note, as the aforementioned quote illustrates, in Lev's opinion, the client's commitment to their own physical safety is an important aspect of building the holding environment that permits client self introspection. The question arises then

whether the act of affirmation of female gender identity entails condoning the client act of genital self mutilation. Lev's (2004) writing does not specifically address the behavior of genital self-mutilation nor the details of ensuring the physical safety of a client who is self harming. In the participant experience, this posed an ethical dilemma and a clinical decision regarding how treatment and the therapeutic relationship would operate.

These issues will be addressed in the discussion of themes 6, 7, and 8.

Discussion Theme 5: Mediating the Vulnerability of the Coming Out Process

This theme corresponds to the secondary research question how might the therapist envision the goals of treatment with such an individual? This theme also corresponds with the secondary research question of how might a clinician ascertain the likelihood of a successful outcome of treatment in addressing the needs of this particular client and their behavior?

While participants focused on establishing an affirming relationship with their clients, their actions demonstrated a belief that additional interventions beyond an accepting attitude towards the client's gender identity were necessary so as to fully address the contributing factors to the behavior of genital self-mutilation. Just as participants were concerned with building the client's self-esteem from within, they demonstrated an equal concern with the conditions of the client's environment. Participants understood that in order for the client to feel a sense of hope about their future, attention would need to be paid to the quality of the clients' relationships and the nature of the transactions with the systems and institutions that would allow the

client to function as a social being while expressing the female gender identity. More specifically, participants were aware that clients required assistance in managing the vulnerability associated with the coming out process.

This theme is significant in that it represents a sense of the shifting roles of the therapist in relation to addressing the behavior of genital self-mutilation. As this theme exemplifies, a combination of both direct and indirect interventions seems to characterize the experience of the participants as they worked with their clients towards addressing genital self-mutilation. The idea of shifting roles of the therapist operationalizes the participant understanding that the problem of self-mutilation is not solely an intrapsychic phenomenon but rather is also influenced by the clients' relationship to their environment.

The attention paid to the client coming out process and assisting the client to negotiate relationships while publicly identified as female seems to contrast with the attributed motivation within some of the literature on cases involving genital self-mutilation. If interventions were designed to assist these clients based solely on the case reports of Haberman and Michael (1979), McGovern (1995), Murphy et al. (2001), Rana and Johnson (1993), and Catalano et al. (2002), the focus might be on reducing the wait time between the recognition of transsexual identity and the execution of gender reassignment surgery. While this intervention might be helpful from the point of view of negotiating institutional discrimination, the participants experience highlights the client immediate relationship to significant others as an equally valid target for

intervention. Again, this seems to demonstrate that both the explanations and proposed remedies for the behavior cannot be reduced to single explanations within only one dimension of client experience. The participants' willingness to intervene within the client family system or to focus on enabling the client to manage fears related to loss of significant others demonstrates a more nuanced appreciation of the challenges the client faced in their environment.

With regards to the participant connecting their clients to resources that facilitated or supported the transition process, we see the participants' role towards the client shifting to encompass the activity of an advocate and go between. This intervention served both psychological and tangible aims; the client's sense that access to support was possible created a sense of hope and the access to actual services such as hormones or peer support groups doubled as material means of furthering the wish to transform the body. Hope and actual success in transformation efforts was perceived as a means of reducing the need to resort to genital self mutilation to accomplish one's goals.

The sense of the therapist working with the gender variant client as an advocate and go between expands the domain of therapist professional duty beyond the traditional notion of what activity defines the role of the psychotherapist. Participants' experience demonstrated that in order to be effective and therapeutic with their clients, concrete interventions outside of the therapy room were necessary to help the client. Providing referrals, interfacing with other medical providers, allowed participants to

challenge systems who unintentionally might not recognize gender variant identity or be sensitive to the needs of a gender variant client. The emergence of this theme within the data seems to correspond to the social work paradigm of the concern with the focus on the person in the environment. Advocacy and social transactions are seen as psychologically relevant to the individuals functioning and therefore within the purview of the psychotherapist. This theme is supported by the literature on social work with the LGBT population which calls for mezzo and macro level action in lessening the potential of a traumatic impact on the individual of a coming out process.

Morrow and Messinger (2006) enjoin the social work practitioner to consider the aforementioned principles in working with LGBT clients:

Approach cases from an ecological systems perspective. The social environment can be oppressive for GLBT people. Because social systems have such a significant impact on the treatment and civil rights of sexual minority populations, it is critical to consider their influence on clients' lives. It may be necessary to establish social supports to help clients cope with issues such as family rejection, workplace discrimination, and faith community marginalization. (p. 14)

Discussion Theme 6: Safety Planning Promotes Self-Reflective Capacity

This theme corresponds with the secondary research question how might the therapist envision the goals of treatment with such an individual? This theme also corresponds with the secondary research question how might the clinician consider such behavior as well as the client's opinions regarding the behavior in the context of establishing a therapeutic alliance? Finally, this theme corresponds with the secondary research question how might the clinician ascertain the likelihood of a successful

outcome of treatment in addressing the needs of this particular client and their behavior?

While affirming the client's female gender identification and mediating the vulnerability associated with the coming out process may represent indirect routes the participants utilized to reduce the behavior of genital self mutilation amongst clients, actual safety planning explicitly broached the participants' concerns with client safety. However, as discussion with the participants indicates, the goal of focusing on safety issues was not to impose standards on the client in an authoritarian manner. It was believed that creating a power struggle with client over the acceptability of genital self-mutilation would ultimately harm the therapeutic alliance and reduce the effectiveness of therapy.

One of the ways in which participants coped with this challenge was to invite the client to consider the behavior as a focus of curiosity. Clients were invited to join with them in deconstructing the act by making it a legitimate topic to be explored within the therapeutic encounter. Participants aided clients to unite thoughts, feelings and behaviors into a comprehensible and predictable narrative that provided a sense of control over something that previously had been perceived by the participant as a driven, desperate action.

Through the introduction of interruptions into the behavioral chain leading to self-mutilation, or the cognitive deliberation involved in anticipating the consequences associated with certain actions, participants could help the client invest in behavioral

alternatives to self harm. By planning for alternative behaviors or reducing the level of harm associated with self- injurious behavior, participants could create a sense of choice for their client where none existed before. The experience of choice cannot be overemphasized in its therapeutic potential for these clients whose histories reflected a distinct lack of choice with regards to self definition.

From a therapeutic standpoint, participants believed the experience of choice restored a sense of ownership to the self with regards to how stress was managed. This served a dual purpose in that by owning thoughts, feelings and behavior around genital self- mutilation, the participants simultaneously heightened the clients' awareness of themselves as a being with some agency and a capacity to relate to their bodies in a less punitive, more compassionate fashion.

In comparison with the literature on the subject of genital self-mutilation, the theme of safety planning promoting the self reflective capacity of the client most closely resembles the treatment model of Walsh (2006). Walsh's reliance on typical cognitive behavioral tools such as self-monitoring logs around triggers and thoughts connected to self harming behavior and second generation cognitive interventions such as mindfulness practice are both means of developing non-judgmental self-observation in clients. The use of substitution of less damaging forms of touch on the body in the place of utilizing harmful instruments represents a form of harm reduction. His instruction in behavioral coping methods such as breathing and visualization to regulate affect also

echoes the goals of the participants in creating choice for the client; namely, how to avoid use of defensive reactions in managing painful emotion.

It is interesting to note that participants utilized relational interventions such as building the therapeutic alliance through affirmation prior to introducing more specific cognitive or behavioral interventions such as harm reduction or cognitive decision trees. Some of the participants diverged from Walsh's (2006) approach in that explicit tools such as self-monitoring logs were not utilized, but rather the therapeutic dialogue itself served as a marker to build the clients' self awareness. Nevertheless, this seems to point to the issue that with a behavior and population as complex as the phenomenon presented, multiple theoretical positions may be brought to bear on different angles of the psychotherapeutic encounter. As participants did not explicitly identify their interventions as representative of a specific theoretical orientation, it is possible that the reality of practice with this phenomenon, particularly in a situation where the stakes are high as far as safety is concerned, may lend itself to eclectic or pragmatic focus from a theoretical standpoint. What is valued is what works with regards to cultivating client awareness and safety.

Discussion Theme 7: Countertransference as Parallel Process

This theme corresponds to the secondary research question how might the clinician's actions and thought process be influenced by the client's goals as well as the ethical demands made on the therapist in the context of treating such a client?

While participants strove to assist the client to develop an observant perspective towards themselves, client behavior did pose significant challenges in terms of impact on the self of the therapist. Countertransference feelings of helplessness, anger and horror were not uncommon for participants. The participants found themselves in the position of working to suppress their emotions for fear of injuring their clients' self-esteem further. Walsh (2006) discusses the need for the clinician to "unlearn" the natural human response to witnessing injury in the service of preserving the therapeutic alliance and suppressing non professional reactions to disturbing therapeutic material. Here he discusses typical reactions of the clinician to a behavior such as genital self-mutilation.

Encountering the wounds of self-injury often produces a visceral, automatic recoiling in others. To withdraw from or avoid those who have intentionally damaged their own bodies may be 'wired into' the human organism. The impulse to escape may be especially intense when the behavior is at the level of major self-injury or self-mutilation. When people disfigure their eyes, face, breasts or genitals, or cause themselves extensive physical damage that requires medical attention, almost any human being is likely to be shocked and want to withdraw at least temporarily. (Walsh, 2006, p. 223)

The safety concerns regarding their clients' behavior also presented a challenge to the frame of treatment in that participants had to decide how they would manage their feelings related to the client behavior and to what degree the behavior would be tolerated. Participants found ways to adapt to the accommodation of their clients. The sense was that outright condemnation of the behavior would fracture the therapeutic alliance. Participants also experienced feelings of helplessness as they attempted to advocate and connect client to necessary resources to facilitate transition and

emotional support. The feelings of helplessness, the pressure to suppress feeling for fear of injuring the other, and the power issues implied in drawing boundaries regarding client behavior all seemed to duplicate the emotional experience of the clients in some respects although perhaps not to the same degree or intensity.

The emergence of the theme of participant countertransference as parallel process to the experience of the clients is significant in that it speaks to the human vulnerabilities of the clinicians coping with the stress of determining how to be of help to their clients. Given the intensity of the emotions provoked in dealing with this phenomenon, participants struggled to maintain a sense of choice with regards to their own ability to reflect and intervene in a thoughtful manner just as their clients struggled to develop the capacity to understand themselves. Given the dramatic quality of the client behavior, a pull towards reactionary struggles for power, suppressing feelings of rage or disgust, and viewing the client as an "other" were forces that threatened to invade the well intentioned and best efforts of the therapist in creating a safe place for the client. Therapists were in essence challenged to regulate their own affect, and this was not done without struggle, just as clients wrestled with managing their own feelings. This challenged the participant in terms of finding a balance between their own need for control and allowing the client enough freedom for self exploration. Setting boundaries within the treatment therefore was the means by which participants established some modicum of control.

The participants' countertransference reactions converge and diverge with some of the available descriptions within the literature on the subject. Guralnick and Simeon (2001) reference the strong emotion that self-mutilative behavior can provoke in the clinician and the pressure this places on the therapeutic relationship. They emphasize the toxic nature of self-doubt regarding one's competence as a therapist and that clinicians may cope with this by withdrawing from the client. In the current study, participants did not overtly withdraw from clients either through ending the therapy relationship or distancing themselves from the desire to be of service to the client. Withdrawal was more subtle in terms of an inward preoccupation with the storm of feelings they struggled to cope with. It is unclear whether clients were cognizant of the emotional turmoil that participants were managing and whether they interpreted this inward focus as a rejection or withdrawal. Again, given participants desire to maintain professional stance towards the client, it is possible that participants were able to mask to a certain extent the reactions they experienced from the client.

Both Greilsheimer and Groves (1979), and Young and Fensilver (1986) discuss the reaction of healthcare workers to the behavior of self mutilation on the inpatient units in which they were treated. They seem to emphasize the feelings of disgust and a sense of futility in treating patients who were perceived to be highly likely to engage in the behavior again. These reactions seem to diverge somewhat from the participant experience of countertransference in reaction to the phenomenon. After the initial shock of learning of the client behavior diminished, participants were able to re-engage

the client and commit to treatment in the form of harm reduction. It is possible that their empathy was not completely obscured by the clients' actions because of the participant commitment to professionalism.

Discussion Theme 8: Competent Practice in the Context of Emotional Stress

This theme corresponds to the secondary research question how might the clinicians actions and thought process be influenced by the client's goals as well as the ethical demands made on the therapist in the context of treating such a client?

Ensuring that mental space was available for reflection in the face of emotional and ethical concerns regarding client safety was no simple task for participants. Another factor impinging on the participants' ability to remain present to the client was the degree of responsibility they assumed in rectifying what was perceived as harmful, incompetent treatment of transgendered clients. Participants' awareness of the psychological harm inflicted on clients by clinicians who were not educated about gender identity issues was troubling on several levels. Firstly, the sense of the client vulnerability in turning to an authority figure for help and being further victimized through ignorance violated the participants' sense of social justice. Participants defined professional incompetence as practices that reinforced gender stereotypes, erased the gender variant identity, or directly caused psychological harm to the client.

From this perspective, incompetence perpetuated harmful oppression and participants did not wish to participate in processes that contributed to further marginalization of their clients. It should be noted that participants themselves were in

a vulnerable position in terms of the ability to redress this form of social injustice. Given their sense of the lack of properly trained professionals to meet the needs of gender variant clients and their commitment to the clients' well being, participants were automatically consigned to a role of being a specialist where it is possible that the need for competent service outweighed the supply of specialist providers able to meet this need. Thus, participants were aware of how essential it was that they conduct themselves in a competent professional manner as they believed others would fail the client in this capacity.

Secondly, it is possible that participants' moral outrage regarding incompetent treatment caused them to overcompensate for this injustice through either believing they could protect their clients against further negative encounters with the healthcare system or by assuming some responsibility for predicting the client's future safety. This set up the participants to experience further emotional stress in working with these clients in that not only were they coping with their own countertransference reactions towards the client, additionally, they were managing the feelings of isolation and disappointment with the other social institutions that were supposed to be of service to the client.

The enormity of dealing with a transphobic culture contributed to feelings of being overwhelmed as participants in a sense were striving to carry out what they believed was the best level of care for their clients. Perhaps the greatest example of how the participants striving to avoid incompetent practice ironically created an ethical

dilemma for them is the opinions some of the participants shared regarding their reticence to hospitalize their patients in inpatient settings. Participants directly stated that they would have qualms about hospitalizing their client for genital self-mutilation that they perceived as dangerous.

The reticence to hospitalize diverges from the professional literature, for example in Israel's (1997) discussion of how to manage the genital self-mutilative behavior amongst transgendered individuals. Israel believes that emergency hospitalization is a necessity to address self-mutilative behavior that cannot be managed on an outpatient basis through behavioral contracting. While she agrees with the participants that clients are sensitive to rejection by unempathic, uninformed healthcare providers, this does not prevent her from recommending that hospitalization take place to assure the clients safety. She does recommend however, that best practice would entail a gender team that consults with the inpatient unit so as to provide the best quality of care possible.

It is possible that participants in this study have recognized the limited resources available to inpatient units in the "real world" based on their own experience and that being able to depend on a gender team to ensure quality care for the client may be wishful thinking. However, in their desire to protect their clients, there seemed to be a lack of conscious awareness of a willingness to deconstruct their own assumptions about the quality of care a client could receive on an inpatient unit. One can empathize with the position these participants find themselves in which making a choice between

the lesser of two evils in their perception, i.e., risk having the client seriously hurt themselves versus subjecting them to further humiliation and incompetence at the hands of untrained professionals.

Additionally, the tool of behavioral contracting seems insufficient to the task of addressing the ethical conflicts between the duty to keep the client safe versus the right to self determination for the practitioner. Behavioral contracting seems to be an individual solution to a collective problem which is whether inpatient units are in actuality able to sensitively provide care to clients who engage in genital self-mutilative behavior. Participants felt themselves to be in a unique position in that the impact of marginalization on their clients extended to the quality of resources available to support the client at times of danger to self. However, once access to a containing resource such as inpatient hospitalization is removed, participants were then put in the position of being able to predict client safety to a certain degree. While it is possible that the harm reduction approach to treatment may have assisted participants in managing anxiety around predicting safety, it appears that despite this it provoked considerable anxiety for practitioners. Again, these issues reflect the level of emotional pressure that participants coped with in agreeing to treat these cases. It is possible that particularly with regards to ideas or practices around hospitalization, participants might benefit from reflecting on the degree of responsibility they assume when the understanding is that other support resources are inadequate.

Discussion Theme 9: Active Coping

This theme corresponds to the secondary research question how might the clinician's actions and thought process be influenced by the client's goals as well as the ethical demands made on the therapist in the context of treating such a client?

Given the level of anxiety connected to working with this phenomenon, the emergence of the theme of active coping is not surprising. Participants coping efforts did not have a passive quality; they involved seeking out the comfort of others and implementing stress management practices that required some thought process regarding the larger phenomenon they were coping with. In turning to others for emotional support, either other therapists, friends or significant others, therapists were both cognizant of the distress they were experiencing and the need to replenish themselves so as to be able to continue their work. This seems significant for the simple fact that participants' self-awareness played a role in their ability to engage with this phenomenon and to remain committed to working with clients despite emotional risks and professional risks.

Turning to others for support as an active means of coping with the stress of working with a client who self mutilates is supported in the relevant peer reviewed literature. Both Linehan (1993) and Walsh (2006) urge therapists to rely on the support of a team approach or the use of consultation so as to avoid "compassion fatigue." Walsh asserts that while clinician emotional reactions to clients who self-mutilate are understandable and perhaps inevitable, he emphasizes that the client has a right to

expect that the clinician will manage their feelings in a professional manner. One way of doing this is by seeking out peer supervision or consultation as a means of venting frustration and receiving feedback as to how to effectively work with a difficult client.

It is interesting to note the particular stress management practices that participants relied on outside of the actual relationships they utilized to manage their countertransference. The use of spirituality, attending trainings, or envisioning the benefits of creating a gender treatment team, seems to represent a means of specifically attempting to regulate feelings of powerlessness by restoring a sense of control. Participants operated in an arena where lack of control either in the form of the ability to make the environment more responsive to the clients' needs or in coping with the clients' frightening behavior, threatened to overwhelm the therapist. The value of these practices is that participants were able to generate reassurance for themselves even if it was in an abstract manner. Reassurance distanced imminent hopelessness and created the vital mental space therapists required to avoid reactionary behavior towards their clients.

While Walsh (2006) would likely support the aforementioned means of coping for therapists if it enhanced their efficacy and responsiveness to clients, it is interesting to note that he recommended therapists engage in a parallel process of practicing the coping skills that they hoped to instill in their clients. For Walsh, coping skills involved the use of cognitive restructuring, breathwork, and utilizing countertransference in the service of therapeutic goals. To Walsh, the sign of active coping is that the clinician is

able to utilize these self-soothing mechanisms prior to actual behavior of frustration emerging towards the client in the context of session.

Implications of Findings for Micro and Macro Practice

Micro Level

The behavior of genital self-mutilation amongst male to female transsexuals is a phenomenon that has the potential to challenge the limits of a therapist's clinical skill, professional demeanor and compassionate nature. As such, the current investigation affords the opportunity to make recommendations based on observations of the lived experience of the participants at both the micro and macro level of social work practice so as to assist clinicians who might encounter this phenomenon in the field. While these recommendations are not based in controlled studies regarding best practice regarding the phenomenon, nevertheless, the participants who have shared their experience in this study offer a glimpse of what the "front line" might look like to an outside observer. It behooves us to consider the value of practice wisdom based on clinical experience and it is from this perspective that the following recommendations are offered. It is also important to note that these are general recommendations and they may need to be modified to fit the individual case. Additionally, practice literature already exists which describes gender variant affirmative practice (Lev, 2004; Morrow & Messinger, 2006). Therefore, recommendations are limited to working with trans clients who engage in genital self-mutilative behavior as opposed to therapy with the transgender population overall.

Assess the degree of hopelessness or desperation. There is a link between the client's emotional state and the behavior of genital self-mutilation. The therapist may ascertain the intensity of client feelings of powerlessness by asking questions related to the quality of the client's relationship to self and others as well as ideas regarding transitioning. For example, to what degree does the client feel self hatred or shame regarding either the body or gender identity? Is there a particular body part which the client feels is disgusting or wishes, was not part of them? What are the clients feelings regarding male embodiment, are there feelings of shame regarding appearance or the ability to pass? What have been the messages or reactions within the client's relationships to expressing the female gender role? To what degree does the client feel that it is necessary to hide gender identity or expression from others? What is the client's outlook on the transition process? To what degree does the client experience a sense of urgency regarding the desire to change the body? How does the client plan to change their body and will anyone assist in this process?

From a behavioral standpoint, feelings of desperation are represented in previous actions of mutilation and/or symptomatic defensive behavior. For example, has the client actually injured the genitals previously? If so, how was this accomplished? To what degree were the thoughts or feelings about injuring the genitals irresistible? At what point did the thoughts or feelings cross over into action? How has the client coped with either feelings related to gender identity, male embodiment or the transition process, or challenges in relationships as a result of gender variant feelings? For

example, does the client ever engage in substance use as a means of self soothing? Is the client depressed or anxious? How does the client manage feelings of rejection by others?

Why is genital mutilation the only solution to these problems? The therapist should seek to understand in as much depth as possible as to what problems the client believes the action of self mutilation will solve and how self mutilation will be helpful in addressing these problems. For example, does the client believe that genital self mutilation is the only avenue possible to changing the body because of financial difficulties? Does the action of self mutilation relieve psychological pressure? Does the client believe that engaging in this action will influence how others see her? How does the client think they will feel about themselves after engaging in such action? The therapist aims to validate and empathize with the feelings contributing to the construction of genital self-mutilation as a solution. However, the therapist might assist the client to avoid binary thinking or splitting when engaging in problem solving. It is possible that the client may construct the situation in all or nothing terms, for example, my options are remaining hopeless or taking control of my body. The therapist might invite the client to begin to make a habit of adopting the perspective that there is more than one solution to a problem and that together the client and therapist can consider whether there are means of addressing the problem driving the action of self mutilation that may not involve harm to the self or represent more of a middle ground solution.

Practices that promote compassionate stance towards self and regulate affect.

One of the underlying issues driving the behavior of genital self mutilation is a punitive pattern of relating to the self and the body. The client is unlikely to refrain from using genital self mutilation to problem solve if this initial aspect of their experience remains unaddressed. Raising the client's awareness regarding the impact of self denigration, how this may be connected to experiences of interpersonal stress or represent internalized transphobic attitudes, and how devaluing the body amplifies a sense of shame brings attention to the possibility that the client may substitute kinder ways of relating to the self. The goal is not to change the client's desire to transform their body, rather, it is to help the client extend acceptance to the body in transition. When feelings of disgust or shame arise, the therapist may help the client to utilize sensory mindfulness techniques as a means of regulating the intensity of the feeling. Additionally, encouraging the client to adapt self affirmations which might either include focusing on personal qualities the client values or parts of the body which the client is not disgusted by can shift the client attention to positive valuing of the self.

Supporting client self-definition and coming out. The benefits of affirming and acknowledging the client's gender identity cannot be underestimated in terms of demonstrating the therapists understanding of the client as well as strengthening the client's sense of self. If the client feels seen and deeply heard as an individual, it is possible that the therapists "getting" the client may preempt the communicative function of genital self mutilation behavior. Additionally, the therapist demonstrates

active respect for the client's self definition through a willingness to connect the client to proper supportive, adjunct services that facilitate the self actualization of gender identity. For example, connecting the client to the local social service agency that targets the LGBT population may serve as a useful resource for the client in the form of peer support groups or accessing trans affirmative healthcare. Also, the therapist can assist the client to plan the coming out process in a controlled fashion where the therapeutic space allows for role play of others reactions and how to manage these reactions. The client can derive a sense of hope regarding the transition process through both peer feedback and through therapist ability to help the client predict steps in the transition process. Again, this may reduce resorting to genital self mutilative behavior as the client learns that others are interested in supporting the client's sense of self and gender expression.

Harm reduction. The therapist and client can benefit from preparing in advance for the possibility of recurrence of the behavior. This lessens the likelihood that reactionary decisions are made in a crisis state and increases the chances that the outcome of the behavior will be less damaging to the self. Inviting the client's cooperation in this planning process can help the client invest in the goal of preventing harm to the self to the greatest extent possible. Outlining contingency plans involving specific alternatives such as which tools will be used, where and when cutting will take place, and whether relief can be achieved through less severe cutting helps the client put the plan into place at the time it is required. It is also important that the therapist

and client discuss how the client will discern when they may require emergency intervention to prevent blood loss or infection and to plan how the client will access medical assistance in a timely fashion. For example, the therapist and client can compare ideas regarding what the line is between safety and unhealthy or dangerous consequences to the cutting behavior. The therapist might ask the client to ask the therapist how the therapist reaches conclusions about safety and why those conclusions are viewed by the therapist as valid. In a sense, the therapist offers the client the chance to mentalize the therapist's perspective on what defines safety versus danger and in doing so offers the client a frame of reference for behavior that might otherwise be considered abstract or less real for the client.

Use of self disclosure in service of the therapy. The therapist should consider how to communicate concern regarding the client's safety or actions in a manner that furthers the goal of demonstrating that the therapist is interested in the client's well being. The intention in sharing thoughts or feelings regarding the client's behavior is not to shame or punish the client. Thus, feelings of disappointment or anger may be better processed in the context of consultation rather than directly with the client. However, disclosing feelings of being in a double bind with regards to wanting to be supportive to the client but at the same time feeling deeply worried that certain behaviors may increase the risk that the client will be seriously harmed communicates to the client that the therapist wants to remain connected to the client. The therapist can use self disclosure to invite the client to reflect on the purpose of the therapy and

encouraging the client to reflect on and share how the therapist's expression of concern impacts the client's thoughts and feelings concerning self and the therapeutic alliance. For example, the therapist might state: "you've been sharing with me how you plan to use a knife to remove your testicles. I find myself feeling torn between empathizing with your wish to be rid of a part of your body that disgusts you and being aware that carrying out this plan might put you in serious jeopardy of bleeding to death. The possibility of your losing a lot of blood is of great concern to me because I don't want to see you come to any harm and I value you as a person. How is it for you to know that I'm having these feelings about you?"

Practices that help the therapist maintain a therapeutic stance towards the client. The therapist should be aware of the emotional impact of witnessing someone who is victimized by society driven to extremes in the need to define and protect the self. The therapist can wind up sharing the burden of marginalization by proxy in the realization of the stark realities of inequality that trans people encounter in their daily lives. Additionally, the possibility of vicarious traumatization of the therapist in connection with the client's behavior of genital self mutilation is an ever present possibility. These are risks of practice that ultimately can detract from the therapist's ability to avoid burn out and to be of service to the client. Therefore, the therapist needs to actively engage in self care so as to conduct effective psychotherapy. Self care can take many forms but in particular with this phenomenon it may be important for the therapist to reflect on their comfort level with high risk behaviors and to have a clear

sense of what behaviors they can tolerate and work with and what behaviors are so frightening as to make therapy impossible. This determination is subjective to a certain extent and will vary from therapist to therapist. Some therapists may have more experience with crisis intervention or management and thus have a higher tolerance level for coping with the client risk of self harm. Additionally, the therapist is strongly encouraged to obtain consultation that addresses how the therapist formally resolves ethical conflicts regarding client behavior. Finally, the therapist is encouraged to rely on peer support, mentoring relationships with therapists who have experience working with the transgender population, and stress reduction practices that promote the ability to regulate strong affect. The benefit of taking these actions is that it maximizes the chances that the therapist is able to remain present to the client's needs and to intervene without countertransference threatening the therapeutic alliance.

Macro Level

In addressing potential macro level social work practice with the phenomenon of genital self mutilation amongst male to female transsexuals, the essential question that must be asked are what are the social conditions that contribute to the manifestation of this particular behavior within this population? It is understood that issues of social justice are in play when the transsexual individual is unable to obtain or maintain employment, access adequate healthcare, utilize health insurance to obtain hormone treatment or gender reassignment surgery, or depend on legal rights and protections afforded to other groups in society. While these issues negatively impact the ability to

self actualize gender identity, they take on additional significance when discriminatory practices contribute to the sense of powerlessness that accompanies the manifestation of the behavior of genital self mutilation. The social work practitioner needs to consider what circumstances detract from the individual's ability to reasonably expect that they can influence their own destiny and thus exacerbate a sense of hopelessness leading to defensive acting out behavior. What are the necessary conditions that must be met in order for the transsexual individual to have the chance to survive and flourish in society? Morrow and Messinger's (2006) discussion of the disproportionate impact on LGBT individuals with regards to how social discrimination interferes with psychological development highlights the importance of being aware of the connection between behavior that might be perceived as pathological but arises in reaction to frustration of unmet social needs.

Justice concerns the degree to which a society contains and supports the institutional conditions necessary for the realization of the values that constitute the good life- a society that supports the self-development and self-determination of its constituent individuals and community groups. Self development includes one's ability to meet basic needs, to use satisfying skills, and to have one's particular cultural modes of expression and ways of life recognized. The division of labor and the distribution of resources are central issues related to self-development. Self-development also raises questions about the institutional organization of power, status, cooperation, and communication in ways not reducible to resource distribution. Self-determination means being able to participate in determining one's actions and the conditions of one's actions. Individuals are optimally self-determining if they are able to pursue life in their own way. But self-determination is frequently restricted by other agents and institutional relations, including those that award differential power to some agents while constraining the choices and actions of others. (p. 375)

Suggestions for macro level practice then are likely to overlap with advocacy efforts already underway for the LGBT community, for example, passing legislation protecting the individual from discrimination based on sexual orientation or gender expression, the idea being that advocacy that increases the individual's ability to access institutional resources or participate in society will have a beneficial impact on the sense of self determination. Another example might be advocating for legislation that mandates gender reassignment surgery be covered by health insurance as a medically necessary procedure.

Where more specific recommendations regarding macro level intervention can be made in connection with this phenomenon of genital self mutilation are in the area of ensuring that adequately trained and sensitive social work clinicians are able to meet the demand for providing competent, trans affirmative psychotherapy. This could be enacted through lobbying the Council on Social Work Education to call for Schools of Social Work to incorporate courses or training into their curriculum designed to enhance practitioner awareness of the needs of transgender clients and what specific therapeutic conceptualizations and practices are appropriate to meet these needs. Increasing the number of trans affirmative social work clinicians maximizes the chances that the client, particularly the client who self mutilates, will be met with an empathic and effective caregiving response in the context of a supportive psychotherapy relationship. Additionally, these social work practitioners might represent a future influence as consultants or trainers to other healthcare disciplines in reviewing practices that

support rather than negate the transgender identity. Shifts in the overall healthcare culture that recognize that dignity and respect should be afforded to the transgender individual again maximizes the chances that the transgender client feels heard and understood and perhaps less likely to resort to genital self mutilation out of the desperation of dealing with a hostile environment.

Limitations of the Study and Directions for Future Research

A notable limitation of the investigation is that by design it failed to capture the voice of the transsexual client who engages in thoughts, feelings, or behavior related to genital self-mutilation. While the therapist conceptualization and experience of this phenomenon is vital to clarifying a professional perspective on the behavior, eventually, it will be crucial to articulate the client's experience and perspective and the client's sense of how this impacted on their relationship with their therapist. Due to limitations in time and resources, the current study could not explore both perspectives simultaneously. The benefit of conducting research that seeks to capture the perspective of transsexual clients who have engaged in genital self mutilation is that it would offer an opportunity for comparison to the findings of the current study. In particular, to explore how clients understand the motivation for their behavior may assist clinicians in continuing to refine an experience near understanding of the phenomenon that permits for more empathic and effective intervention.

Additionally, the current proposed study did not seek to examine issues such as race or culture in connection with the therapists' experience of the phenomenon of

interest. Social workers are well aware of how these factors influence the transactions the client carries out with their environment. Future research might aim to explore variables such as racial or cultural identity for both the therapist and the client and whether this influences understanding or expression of the behavior of genital self-mutilation. Additionally, further research is called for with regards to how the clinicians own gender identification might influence work with the transgender population in general. From a countertransference perspective, this seems essential given the likelihood of the clients struggles to accept or define their gender are likely to tap into the clinicians own preconceptions of what gender means.

As this is a study derived from the qualitative paradigm of research, it should be noted that no causal explanation is offered regarding the issue of genital self-injury amongst male to female transsexuals. Additionally, the study did not estimate the number of therapists encountering this phenomenon within their practice, nor the overall prevalence of genital self-mutilation amongst transsexuals. No statements can be generalized based on the data to how psychotherapists overall understand or interact with the phenomena of genital self-mutilation amongst male to female transsexuals.

Another limitation of the study is that the client population of interest is restricted to male to female transsexuals. This excludes female to male transsexuals as well as other distinct categories of psychosocial identity such as intersex, transvestite, or crossdresser. Future studies may explore therapists' experience of working with

individuals who self- identify in the aforementioned categories who engage in genital self-injury.

Finally, again it should be reiterated that the results of this study are not generalizable. While the qualitative research paradigm does not advocate generalizability of research results, the concept of transferability of particular contextual thematic conclusions to professional practice is incumbent on the audience. It is the reader who decides whether the information generated through the study is pertinent and applicable to similar problems or circumstances (Merriam, 2009). The quality of transferability of conclusions of this study depended on the author's ability to provide a thick, in depth description of the phenomenon of interest to enable the reader to compare similarities and differences to their own context. It is hoped that the author was able to meet this goal for the reader.

Self Reflexivity: The Author's Personal Experience with the Phenomenon

An essential aspect of the qualitative paradigm of research is the acknowledgement and deconstruction of the subjective perspective the investigator brings to bear on the phenomenon of study. As such, I seek to discuss my motivation for conducting this particular research and to illuminate the preconceptions that influence my understanding of the phenomenon of genital self-mutilation amongst male to female transsexuals.

The idea for this study came from an experience that I had as a psychotherapist. I worked with a client who presented for therapy wishing to discuss issues around

gender identity. I had previous experience working with clients who identify as transgender or transsexual and as such I believed I could be of service to this individual. Approximately three months into our work together, I received a call from an inpatient psychiatric unit indicating that the client had been hospitalized after being taken to the emergency room following the removal of one of the testes through cutting. The client had removed the teste but experienced blood loss that motivated the client to seek out a relative to assist in obtaining medical attention. The client spent a long time on the psychiatric unit and was discharged for follow up in individual therapy.

My countertransference upon learning of the client's actions was a mixture of feelings ranging from shock to fear to anger. My sense of shock emanated from the fact that the client had never discussed feelings around self mutilation or plans to self castrate nor had I intuited that this might be a possibility. My fear stemmed from concern that the client might have died in the attempt to modify the body and perhaps selfishly how this might reflect on the quality of my work with the client. My anger originated from a sense of betrayal; I felt as if the client had a hidden agenda and that the client had undone my efforts to create a safe and welcoming environment so that gender identity issues might be explored. I found myself doubting my capacity as a therapist, wondering what signs I must have missed along the way that indicated the threat of self mutilative behavior.

Upon the client's return to individual therapy, I found myself in the grip of an intense anxiety. I was scared that the behavior might recur and I was determined to

assist the client to remain physically safe. Having never had this experience before, I turned to other therapists to make sense of what was happening and how to manage the situation in a way that preserved the client's safety but did not disrupt the therapeutic relationship. Unfortunately, I could not find another therapist to consult with who had encountered this experience before and thus I had difficulty containing my anxiety about how to help both the client and myself maneuver through the consequences of the client's behavior.

I felt isolated and I coped with the anxiety by becoming directive with the client. I insisted that the client enter a partial hospitalization program to work on coping skills that would delay the impulse to self mutilate. The client agreed to participate in the program which I experienced as a relief. I felt that I could not offer this client the level of support and structure that was needed to develop an ability to resist the desire to self castrate in the context of individual therapy. Despite entering the partial program, the client ultimately made an attempt to self castrate again following discharge back to individual therapy. At this point I attempted to get the client to commit to personal safety either through agreeing to return to the partial program or utilizing a behavioral contract for safety. The client was not willing to engage in either option. At this point, I terminated the treatment stating that I could not be of help to the client without the client's commitment to promoting a safer relationship with the body. I experienced feelings of having failed the client in some respects as well as a sense of relief that I would no longer feel responsible for preventing the client from self castrating.

There are significant details regarding this case that have been omitted for the sake of client confidentiality. Nevertheless, the aforementioned description is offered for comparison to the results of the current study in terms of similarities and differences between my experience and that of the participants. It is obvious to the reader that I have an emotional investment in gathering knowledge on the subject of genital self mutilation amongst male to female transsexuals. Partially, this is connected to my memory seeking out therapists who had managed similar experience and being unable to find them. However, on a deeper level, it perhaps represents my wish to rectify a sense of guilt regarding what I perceived to be an unsuccessful outcome regarding my case.

Conducting this research has offered me the opportunity to reflect on my clinical understanding, decisions and feelings involved in working on this case. Hindsight and the participants' willingness to share their experiences have impacted how I think about how the case evolved and how it ended. I am cognizant of a sense of urgency that the client was communicating regarding a wish to begin expressing and identifying self in the female gender role and some opposition within the client's relationships regarding the client's wish. Initially the client did not express thoughts about a wish to undergo gender reassignment surgery but did express a desire to initiate hormone treatment. At the time, based on my understanding of additional mental health diagnoses that the individual was coping with, that initiating hormone treatment without a period of investigation and reflection might set the client up for failure in the environment with

regards to publicly expressing female gender identity. I believe that my hesitancy referring the individual for hormone treatment might have contributed to a sense of frustration in the client regarding my willingness to support a gender transition. While I affirmed the client in the desire to explore female gender expression, I recommended that changes that were made were small and reversible (for example, experimenting with wearing makeup or items of female clothing) at least initially as the client had not reported previous experience with expressing self in the female gender role prior to initiating therapy. My goal at the time was to help the client slowly explore what female gender identity and expression felt like and to do so in a manner that did not expose the client to rejection or unsafe situations within the environment too quickly. My feeling was that building the client sense of confidence regarding female gender expression in small doses and at a controlled pace would increase the chances that reactions within the environment would be more manageable to the client.

In comparison to the participants in the current study, I had not utilized referral for low dose hormone treatment as a potential intervention in helping this client address feelings of gender dysphoria. Perhaps unconsciously, I adopted the role of a “gatekeeper” which obscured the sense that one of the issues to consider regarding hormone treatment was the client’s ability to understand and give informed consent regarding the choice and consequences of initiating hormone treatment. It is possible that the client’s clinical presentation with regards to the additional mental health diagnoses influenced my decision making in a conservative direction. Regardless of

whether this was a good decision or not, what I failed to realize was that the client was withholding the feeling of disappointment and frustration from our conversations. This may have contributed to the client experiencing a feeling of being misunderstood not only in the environment but by the therapist and therefore potentiated a sense of desperation around wanting to change the body. If the therapist was non-responsive to the wish for body modification, it is possible that the client felt it necessary to take control of the transition effort through self- mutilation.

My countertransference reactions were similar to those described by the participants of this study in terms of feelings of horror, sadness, and fear. Where we differed was that I did not experience an ethical conflict with regards to the client being hospitalized on an inpatient unit. Although the hospitalization took place without my knowledge and I was informed after the fact of the client's behavior, I feel it is likely that I would have recommended or supported the attending physician's decision to hospitalize the client. From my perspective at the time, the client's actions represented a grave risk of harm to the self and therefore it appeared appropriate to me to contain the client in an environment that could guarantee that a repeat of the behavior would not occur at least for a short while. What is interesting having interviewed the participants in this study is that ideas regarding the client receiving a substandard level of care due to ignorance of transgender identity issues did not even cross my mind. I was so focused on worrying about the client's physical safety that I failed to take into consideration that the experience of hospitalization may have been humiliating to the

client. In hindsight, following discharge, I would have spent time exploring and processing the client's feelings regarding the hospitalization at a level of depth that I did not previously.

Other differences are apparent between my actions in the case and the participants' experiences. At the time this occurred, I would not have thought to use harm reduction as a means of intervention. I think in my mind that I was looking at the issue of safety in more black and white terms where the participants in this study found harm reduction to be a valid means of coping with the client behavior. My insistence on participation in the partial hospitalization program was my effort to establish a sense of control but this may have represented an assumption of responsibility for the client's actions that was overly ambitious. I was able to connect the client to a partial hospitalization program that was geared towards the LGBT population and in that respect I felt comfortable in the knowledge that other professionals would not seek to humiliate or reject my client based on gender expression.

It is possible that the participants in this study may have been able to maintain a therapeutic relationship with the client where I was unable to due to my fears concerning client safety. Again, it is possible that out of the anxiety to establish some control over the client's behavior, I presented an ultimatum to the client that was unreasonable from the client perspective. In hindsight, this rupture of the therapeutic alliance might have been avoided if I had been clearer on what my role was in working with this client. I assumed the responsibility of trying to protect the client from

themselves when a deeper understanding of the function of this behavior for the client in terms of the quest for self definition might have prevented the relationship from degenerating into a power struggle.

Ultimately, while the experience was difficult for me as a clinician, it also represented a learning opportunity. Thus, when I sought out accounts of how other clinicians managed this type of behavior in therapy and was unable to find enough literature specific to the phenomenon, it seemed a natural extension of a wish to be better prepared and more sensitive to the needs of future clients for me to construct this research study. I have been fortunate to expand my clinical knowledge and contrast my experience with those of the participants as it has afforded me a greater sense of confidence in my ability to work with this phenomenon in the future.

Conclusion

This study explored in depth how psychotherapists understand the phenomenon of genital self-mutilation amongst male to female clients. The author recruited four psychotherapists who participated in semi-structured interviews in which they were asked to respond to questions geared towards elaborating their experience working with transsexual clients who had engaged in genital self-mutilation during the course of the psychotherapeutic relationship. Analysis of the participant responses were carried out utilizing an interpretative phenomenological analytical framework. This entailed a detailed inquiry into the meaning making process of the therapists; the author sought to capture the mental constructs mediating the therapists' interaction with the

phenomenon of genital self-mutilation amongst this population. Themes were generated from interview transcripts via successive layers of coding, distillation and abstraction which highlighted descriptive, linguistic, and conceptual aspects of the participants' responses.

The analysis generated nine supraordinate themes which were mapped onto relevant domains of the therapist interaction with the phenomenon, including how the therapist conceptualizes the motivation for the behavior in connection with a client who identifies as transsexual, how the therapist intervenes with the behavior in the context of a psychotherapeutic relationship, and how the behavior of genital self-mutilation impacts on the self of the therapist from an emotional and countertransference standpoint. Within the domain of conceptualization, emergent supraordinate themes included the psychotherapist understanding of genital self mutilation as motivated by multiple factors. From their perspective, the behavior was understood as a means by which the client protected the psychological self from annihilation by the expectations or actions of others which denied the legitimacy of the client female gender identification. The participants felt that clients experienced a sense of desperation which arose from the intersection between social obstacles to self-actualizing the female gender identity as well as limited coping mechanisms to manage the psychological stress of being marginalized and rejected by a transphobic society.

Within the domain of treatment interventions, the therapist value and activity of explicitly affirming the client's sense of self as female as well as helping the client

manage the vulnerability associated with the coming out process served to detoxify shame and to strengthen the client capacity to manage living publicly while expressing female gender identity. From the participants' perspective, this lessened the urgency or desperation that might cause the client to act on thoughts or feelings related to genital self-mutilation. Additionally, the therapist intervention of safety planning served a dual purpose of reducing physical danger and cultivating a self reflective capacity within the client.

Within the domain of the impact of the client behavior of genital self mutilation on the psychological self of the therapist, emergent themes included the parallels between the clients' and therapists' emotional experience. The therapists' countertransference of struggling to manage strong affect, fear of losing or hurting the other by voicing authentic feelings, and the struggle to find adequate, sensitive resources to further their clients self actualization represented a microcosm of the daily experiences of their clients navigating a transphobic culture. Out of a wish to protect the client from further marginalization, participants inadvertently create an ethical dilemma where the need to ensure that the client who engages in self-mutilation receives healthcare that is sensitive to the transsexual identity competes with concerns regarding the client's safety due to bleeding or injury associated with the behavior. Ultimately, in order to work effectively with clients engaging in this behavior, active coping on the part of the therapist through activities which restored the therapist's

ability to self regulate and reflect represented an essential part of the work involved in assisting clients displaying this behavior.

Based on the findings of the research, several clinical recommendations for practice were recommended for social workers and psychotherapists who might encounter the phenomenon of genital self-mutilation amongst clients who identify as gender variant. Assessing the degree to which the client feels powerless or hopeless within their interpersonal environment is essential in discerning whether the client might resort to concrete action in an attempt to manage emotional pain. Additionally, a therapist can benefit from understanding why the client believes genital self-mutilation is the only viable solution to this emotional pain. Once the therapist has an empathic understanding of the client's experience, intervening through assisting the client to shift to a less punitive, more compassionate stance towards the body is warranted. The therapist can also instill hope, counteracting the client's pain by supporting the client's self definition regarding gender and acting as an advocate and intermediary in facilitating the client's coming out process. From a safety standpoint, preparation with the client in advance of crisis states utilizing harm reduction methods promotes alternative means of regulating strong affect and increasing the client sense of choice when dealing with feelings of hopelessness or desperation. The therapist might also amplify the client's self reflective capacity and ability to consider when behavior crosses the line into dangerous territory by using self disclosure at times when the client's behavior threatens their physical safety. Encouraging the client to engage in a process

of mentalization whereby the therapists concerns regarding client safety are offered as an object of curiosity for the client to ponder contributes to the client ability to flexibly consider multiple points of view in choosing a course of action. Finally, given the emotional intensity inherent to treating a client who engages in genital self-mutilation, the therapist's ability to maintain a professional, empathic, self-reflexive stance towards the client's behavior hinges on activities that counterbalance secondary trauma, and connects the therapist to an interpersonal support network, and replenishes the energy and faith necessary to preserve the ability to treat the client with dignity and compassion.

APPENDIX A

RECRUITMENT LETTER FOR PARTICIPANTS

Dear _____,

My name is Michael Kenney and I am a doctoral student in Loyola University Chicago School of Social Work. I am contacting you for the purpose of inquiring about your potential interest in participating in a research study which seeks to explore psychotherapist's understanding of genital self-mutilation amongst male to female transsexual clients. This is a rare phenomenon and as such I am conducting an exploratory, qualitative study to gain a deeper understanding of how clinicians conceptualize and make sense of this behavior.

Participants will be invited to engage in an in-depth interview which will last approximately 1 to 1 ½ hours. Participants will also have the opportunity to review excerpts of their interview responses and to comment on the quality of the themes that are culled from the data. Participant confidentiality will be preserved throughout the study.

Your time and your experience with this subject matter are highly valued. However, there is no financial compensation for participation in the study.

I am grateful that you might consider participation in the study. From my perspective, it represents a chance to begin to understand a subject on which little research has been conducted.

In order to qualify for participation in the study, you should meet the following pre-requisites:

- Be a psychotherapist with at least a master's level degree or a doctoral degree in a discipline that trains practitioners to conduct psychotherapy. (For example, counseling, social work, psychology, psychiatry, etc.) Be licensed to practice psychotherapy independently in accordance with the regulations of the state or region in which you work. Practice psychotherapy primarily in an outpatient private practice setting.
 - Have conducted psychotherapy with at least one client who self-identified as transsexual and is male to female. The client should have been in the pre-operative stage of transition and expressed an eventual desire to pursue gender reassignment surgery.
 - During the course of psychotherapy with the client, the client expressed thoughts, feelings, fantasies regarding genital self-mutilation or engaged in actual behavior of genital self-mutilation with the intent of inflicting damage, injury to the penis or testes or both (this may have been accomplished via such means as cutting, burning, shocking, hitting, etc.)
 - Have conducted psychotherapy for approximately 21 sessions with this particular client
- If you are interested in participation, please contact me via phone at (773)316-2477 or via email at michaelkenney@comcast.net. *Additionally, if you have had experience working with a case that seems similar to what has been described but you are concerned regarding whether you might not qualify for participation in the study, for example, the case does not meet the required number of sessions, please contact me so that we might discuss it.* Thank you in advance for your time and interest in this research.

Sincerely,

Michael Kenney, LCSW
 Doctoral candidate
 Loyola University Chicago
 School of Social Work

APPENDIX B

PRE-SCREEN SCRIPT FOR POTENTIAL PARTICIPANTS

I appreciate your willingness to take the time to inquire regarding my research study. As you may already be aware, I am a doctoral student in Loyola University Chicago School of Social Work. I am engaging in research for the purpose of completing my dissertation requirement and to explore a phenomenon of interest. Please let me tell you more about my research.

I am interested in understanding how psychotherapists who have experience working with male to female transsexual clients who engage in genital self-mutilation understand this particular behavior amongst this particular population. More specifically, because this is a rare phenomenon that occurs amongst a population that is frequently stigmatized, I am interested in how psychotherapists conceptualize, intervene, and manage countertransference in connection with this behavior. Additionally, I am interested in how this behavior might impact the therapeutic alliance with such a client and whether this has any implications for the client's overall goals for change. My study has been approved by the Institutional Review Board of Loyola University Chicago and my research is being supervised by Dr. Jim Marley, Director of the Doctoral Program at Loyola University Chicago School of Social Work.

Should you agree to participate in the study, I will seek to set up a time and meeting place that is convenient with your schedule and location so that I might interview you regarding your experience. During the interview, as we discuss your experience and thoughts, I will require that you disguise any information that might identify any of your clients to protect confidentiality. Additionally, your responses will be kept confidential, and referred to within the written analysis in an anonymous fashion. For example, you might be referred to as "Therapist A" within the write-up of the interview. Again, your name or identifying information will not be utilized in any transcripts, analyses or reports within the research. Additionally, your client's name and identifying information will not be used in any transcripts, analyses or reports within the research. Your contact information will be kept separate from the research material on a master list. This will be stored in a locked file cabinet in my office.

I will digitally record the interview and the interview should last approximately 1 to 1 ½ hours. The audio-recording of the interview will be kept in a locked drawer within my office and the recording will be destroyed within 2 years following the publication of the results of the research. I will be personally transcribing the results of the interview into a database on a secure computer that allows me to analyze responses for themes that may be useful in answering my particular research question.

In considering your decision whether or not to participate in the study, I'd like to remind you that participation is completely voluntary. Should you decide during the course of the interview that you do not want to be in the study, we may stop the interview and delete the audio-recording. You also have the option of not answering particular questions during the interview without penalty.

It's important to explain both the benefits and risks of participation in this study for you. Although there are no direct benefits to you in terms of participation, your contribution helps further knowledge of the topic within the profession of social work and in the community of psychotherapists who work with this particular phenomenon in general. Risks of participation are minimal. The only foreseen potential risk might be emotional discomfort that arises over

the course of or following the interview when discussing your case. Should your discomfort prove difficult, it is recommended that you seek out the resources of consultation or personal psychotherapy to be utilized at your discretion.

I appreciate the opportunity to explain the research and the conditions of participation. I'm happy to answer any questions that you might have regarding the project.

In order to ensure that you qualify as a participant for the study I need to ask you some questions.

1. What is your degree and training in conducting psychotherapy?
2. Do you have a license to conduct psychotherapy in your state?
3. Is the majority of time you devote to psychotherapy practice within an outpatient setting? For example, do you work in private practice or at an agency that provides outpatient psychotherapy?
4. Have you worked with a client in the past who self-identified as transsexual, was considered male to female and was in a pre-operative stage of transition?
5. Did this client verbalize the wish or intent to eventually undergo gender reassignment surgery?
6. Over the course of working with the client, did this client share thoughts, feelings, fantasies or engage in actual behavior with the intent of mutilating the penis, testes, or both?
7. How long did you work with this particular client?
8. How did you learn about this study?

APPENDIX C

SCHEDULE OF SEMI-STRUCTURED INTERVIEW QUESTIONS

1. Could you share the definition of the term “transsexual” and “transgender” and your opinion regarding these terms?
2. Could you describe the work you do with client or clients who self- identify as transsexual and are considered to be male to female in your psychotherapy practice?

Probe: What level of experience would you say you have in working with such a client/clients?

3. Based on your experience, could you describe some of the concerns this client or clients bring to therapy?
4. Could you describe how your theoretical orientation towards psychotherapy or your clinical experience helps you to understand these concerns and the individual?

Probe: Could you discuss any benefits or drawbacks to addressing these concerns in the context of psychotherapy?

5. Could you share the definition of the terms self-injury and self-mutilation and your opinion regarding these terms?
6. Could you share your experience of working with a case or cases in which a client who self-identifies as transsexual and could be considered male to female expressed thoughts, feelings, or fantasies or engaged in actions or behavior related to genital self-mutilation?

Probes: what specifically occurred? How did this impact you? How did this impact the client? Can you discuss how this experience may have impacted your understanding of the client’s concerns? Could you describe how this impacted the therapeutic alliance?

7. Looking back on this case/s, what factors if any in your opinion regarding the client and the situation and their environment were important to be aware of in assessing these thoughts, feelings, fantasies or behavior related to genital self-mutilation?

Probes: Could you discuss any ideas you have on what might have motivated or influenced these thoughts, feelings, fantasies or behavior ?

8. Looking back on this case/s, what goals or interventions for treatment were relevant, changed, remained the same, or instituted as a result of the client’s thoughts, feelings, fantasies or behavior?

Probes: What interventions if any do you believe were helpful or not helpful in addressing these thoughts, feelings, fantasies or behaviors? To what degree if any did your theoretical framework change or remain the same in understanding this particular case/s?

9. Could you discuss whether your experience of this case has impacted or changed how you understand, assess, or treat clients who self-identify as transsexual and are considered to be male to female in psychotherapy in general?

Probes: In your opinion, how might fantasies, thoughts, feelings, or behaviors of self genital mutilation impact the client's eventual goal of obtaining gender reassignment surgery?

10. Is there anything else you can think of that I may have missed regarding the topic of our conversation that you think is important to add to the discussion?

APPENDIX D

CONSENT TO PARTICIPATE IN RESEARCH

Project Title: Therapist Understanding of Genital Self-Mutilation amongst Male to Female Transsexual Clients

Researcher: Michael Kenney, Doctoral student Loyola University Chicago School of Social Work

Faculty Supervisor: Jim Marley, Ph.D.

Introduction:

You are being asked to participate in a research study being conducted by Michael Kenney for a dissertation completion requirement under the supervision of Dr. Jim Marley at Loyola University Chicago School of Social Work.

You are being asked to participate because of your experience in working with male to female transsexual clients who engage in thoughts, feelings, fantasies or behaviors related to genital self-mutilation.

Please take the time to read this consent and review it carefully. You are encouraged to ask any questions regarding the project before you consent to participate in the study.

Purpose:

The purpose of this study is to explore psychotherapist understanding of the phenomenon of genital self-mutilation in the context of work in psychotherapy with male to female transsexual clients.

Procedures:

If you agree to participate in this study, you will be asked to do the following:

1. Participate in an audio-recorded interview regarding your experience working in psychotherapy with a self-identified male to female transsexual client who expressed thoughts, feelings, or fantasies or engaged in actual behavior with the intent of mutilating the genital region of the body (the penis, testes or both).
2. You will be asked to disguise any identifying information regarding the client to preserve confidentiality.
3. The interview will last approximately 1 to 1 ½ hours. Within 3 months following the initial interview, you will be provided the opportunity to review excerpts of your interview transcript and to comment on the themes derived from the analysis of the interview responses so as to gauge whether the material is representative of your experience. This commentary may be provided either in written form or via phone to the researcher. Commentary is not expected to last more than 30 minutes if done over the phone for the follow-up review.

Risks/Benefits:

There is minimal risk in participating in this research project. The only foreseeable potential risk might involve the experience of uncomfortable emotions while sharing your case experience. Although there are no direct benefits to you, your participation may advance knowledge regarding the phenomenon within the social work profession and the community of psychotherapists who typically work with the male to female transsexual population.

Confidentiality:

All transcripts, field notes, memoing, and reporting of data will require that your name be replaced with a pseudonym (for example, "Therapist A") so as to protect confidentiality. You will be instructed to disguise any identifying information of cases during the interview. For example, you might refer to a client by using the term "client x" or "client y". You will be instructed to utilize pseudonyms when discussing other relevant participants in the case. For example, you might refer to another provider as "provider x" or to a hospital as "hospital y". Any identifying information that is mentioned in the interview will be omitted from the transcript of the audio-recording.

Audio-recorded material will be kept in a locked and secure file cabinet in the researcher's office and will be stored separately from the master list with your identifying contact information. All research materials will be destroyed approximately two years after the study is completed.

Voluntary Participation:

Please be advised that participation in this study is voluntary. If you do not want to be in this study, you do not need to participate. If you do decide to participate, you are not required to answer all questions and may withdraw from the study at any time without penalty. If you decide to withdraw from the study, the investigator will delete your audio-recorded interview responses.

Contacts and Questions:

If you have questions regarding this research study, please contact me at (773)316-2477 or via email at michaelkenney@comcast.net. You may also contact my faculty supervisor, Jim Marley at (312)915-7005.

Additionally, if you have any questions about your rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at (773)508-2689.

Statement of Consent:

Your signature below indicates that you have read and understood the information provided above, have had an opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form for your records.

Participant Signature

Date

Researcher's Signature

Date

Statement of Consent to have interview audio-recorded:

Your signature below indicates that you have agreed to have the content of the interview with the research investigator digitally audio-recorded. Please be aware that participation in this study does not require that you consent to have your responses audio-recorded.

Participant Signature/ Date

Researcher Signature/Date

APPENDIX E

FIELD NOTES FOLLOWING THE INTERVIEW

Interview Date:

Interview Time:

Location:

Length of Interview:

Initial Impressions:

Interferences/Disruptions, Unexpected Occurrences:

Mood/Tone of Interview:

Subjective Perception of Participant:

Personal Reactions to Interview Content:

APPENDIX F

FOLLOW UP TO INITIAL DATA COLLECTION, PARTICIPANT FEEDBACK

1. Excerpts of our interview and a summary of themes that emerged from analyzing your responses were forwarded to your attention. Have you had the opportunity to review this material?
2. What are your thoughts regarding what you've read so far?
3. Is there anything that concerns you or that you feel misrepresents your experience?
4. Are there any quotations or themes that you feel are particularly important in accurately representing your experience?
5. Do you have any further comments regarding the material or your participation in this study?

APPENDIX G

SAMPLE LETTER TO LISTSERV MODERATOR

Attn: listserv moderator name here
Mailing address
City, state zipcode
Email address:

Date:

Dear (listserv moderator name),

My name is Michael Kenney and I am a doctoral student in Loyola University Chicago School of Social Work. I've obtained your contact information with the purpose of requesting permission to post an announcement on your listserv regarding my desire to recruit participants for the research study I am conducting in connection with my dissertation requirement through my doctoral program. My research is being supervised by my dissertation chair, Dr. Jim Marley of the School of Social Work and I have obtained permission to conduct the research through Loyola University Chicago's Institutional Review Board. Please allow me to describe my research study and the reason I have approached your listserv as a means of gaining potential research subjects for my study.

I am conducting a qualitative study which seeks to explore how psychotherapists' understand and conceptualize thoughts, feelings, fantasies or behaviors related to genital self-mutilation amongst male to female transsexual clients. This is a poorly understood phenomenon that to date has not been discussed from a perspective which appreciates the complexity of issues involved. The existent peer-reviewed literature on the subject tends to emanate predominantly from the medical model perspective rather than a holistic, biopsychosocial point of view. Additionally there are controversies regarding the use of terms such as "transsexual" or "self-mutilation." In an effort to begin to address this gap in the peer-reviewed literature, I am seeking to gain an understanding of how clinicians who have encountered clients who self-identify as transsexual (and in particular those clients who might be considered male to female), who have expressed either thoughts, feelings, fantasies or actions or behavior related to genital self-mutilation make meaning around what they observe and experience clinically when working with such a client in psychotherapy.

I'm seeking to recruit approximately 5 psychotherapists to participate in an audio-recorded interview on this subject. I have taken steps to promote and protect the participants' confidentiality throughout the research process. I am approaching you in your capacity as the listserv moderator for permission to post the attached statement to your message board. As you can see per the statement I have prepared, potential participants will be instructed to contact me via phone or my email address if they are interested in participating in the research. I have chosen your listserv due to my perception that many of your members are practicing psychotherapists.

I appreciate your willingness to consider my request. If you have any questions regarding my research or you are willing to grant permission for me to post my invitation seeking research participants on your listserv, please contact me either by my office phone at (773)316-2477 or at my email address at michaelkenney@comcast.net.

Thank you in advance for your assistance and consideration.

Sincerely,

Michael Kenney, LCSW
Doctoral Student, Loyola University Chicago, School of Social Work

APPENDIX H

SAMPLE POSTING ANNOUNCEMENT TO LISTSERV

Michael Kenney, a doctoral student in Loyola University Chicago School of Social Work, is seeking participants for a research investigation on the topic of psychotherapist understanding of genital self-mutilation amongst male to female transsexual clients. The research being conducted is in connection with the dissertation completion requirement of Loyola's School of Social Work. This is an exploratory, qualitative study and the purpose of the research is to gain an in-depth, complex understanding of how psychotherapist clinicians conceptualize and make sense of client thoughts, feelings, fantasies, or behaviors related to genital self-mutilation amongst this population. Additionally, the research investigator is interested in the clinicians' opinions and ideas on the language used to describe either the population (male to female transsexual) or the behavior (genital self-mutilation). Participants in the study will be invited to engage in an in-depth interview with the investigator which will last approximately one to one and a half hours. The interviews will be audio-recorded and the participants will have the opportunity to review excerpts of the transcript of the interview in addition to being given the opportunity to comment and provide feedback on the initial themes generated from the data analysis. Participant confidentiality will be preserved throughout the study. Please note that your time and your experience with this subject matter are highly valued. However, there is no financial compensation for participation in this study. If you are interested in participation, please contact me via phone at (773)316-2477 or via email at michaelkenney@comcast.net to further discuss the prerequisites for participation and so that I might answer any questions that you have.

Thank you for your time and consideration.

Michael Kenney, LCSW
Doctoral Student
Loyola University Chicago
School of Social Work

APPENDIX I

SAMPLE LETTER TO POTENTIAL PARTICIPANTS REQUESTING A COPY OF THE SCHEDULE
OF SEMI-STRUCTURED INTERVIEW QUESTIONS IN ADVANCE OF PROVIDING INFORMED
CONSENT OR PARTICIPATING IN THE INTERVIEW

Psychotherapist Name
 Psychotherapist Office Address
 City, State Zipcode
 Psychotherapist email address

Date

Dear (Psychotherapist Name here),

Per your request, I am forwarding to your attention a list of the questions to be asked in the course of our interview together for my research project. Please note, this list represents the basic questions that I would like to discuss with you. It is possible, during the course of the interview, that I might ask additional questions requesting for you to elaborate on your responses.

1. **Could you share the definition of the term “transsexual” and “transgender” and your opinion regarding these terms?**
2. **Could you describe the work you do with client or clients who self- identify as transsexual and are considered to be male to female in your psychotherapy practice?**

Probe: What level of experience would you say you have in working with such a client/clients?

3. **Based on your experience, could you describe some of the concerns this client or clients bring to therapy?**
4. **Could you describe how your theoretical orientation towards psychotherapy or your clinical experience helps you to understand these concerns and the individual?**

Probe: Could you discuss any benefits or drawbacks to addressing these concerns in the context of psychotherapy?

5. **Could you share the definition of the terms self-injury and self-mutilation and your opinion regarding these terms?**
6. **Could you share your experience of working with a case or cases in which a client who self- identifies as transsexual and could be considered male to female expressed thoughts, feelings, or fantasies or engaged in actions or behavior related to genital self-mutilation?**

Probes: what specifically occurred? How did this impact you? How did this impact the client? Can you discuss how this experience may have impacted your understanding of the client’s concerns? Could you describe how this impacted the therapeutic alliance?

7. **Looking back on this case/s, what factors if any in your opinion regarding the client and the situation and their environment were important to be aware of in assessing these thoughts, feelings, fantasies or behavior related to genital self-mutilation?**

Probes: Could you discuss any ideas you have on what might have motivated or influenced these thoughts, feelings, fantasies or behavior ?

- 8. Looking back on this case/s, what goals or interventions for treatment were relevant, changed, remained the same, or instituted as a result of the client's thoughts, feelings, fantasies or behavior?**

Probes: What interventions if any do you believe were helpful or not helpful in addressing these thoughts, feelings, fantasies or behaviors? To what degree if any did your theoretical framework change or remain the same in understanding this particular case/s?

- 9. Could you discuss whether your experience of this case has impacted or changed how you understand, assess, or treat clients who self- identify as transsexual and are considered to be male to female in psychotherapy in general?**

Probes: In your opinion, how might fantasies, thoughts, feelings, or behaviors of self genital mutilation impact the client's eventual goal of obtaining gender reassignment surgery?

- 10. Is there anything else you can think of that I may have missed regarding the topic of our conversation that you think is important to add to the discussion?**

Please note that your receipt and review of this letter outlining the aforementioned questions **DOES NOT** indicate that you have provided informed consent to participate in my research study. This letter only serves to provide you further information regarding the nature of the questions to be asked during the research interview.

If you have any questions or concerns, please feel free to contact me at (773)316-2477 or via email at michaelkenney@comcast.net.

Thank you in advance for your time and consideration.

Sincerely,

Michael Kenney, LCSW
Doctoral Student,
Loyola University Chicago
School of Social Work

APPENDIX J

LETTER TO WPATH REQUESTING MEMBERSHIP DIRECTORY

Attn: Andrea Martin (USA)
Executive Administrator

Email: wpath@wpath.org

1300 South Second Street, Suite 180
Minneapolis, MN 55454

Dear Andrea Martin,

My name is Michael Kenney and I am a doctoral student in Loyola University Chicago's School of Social Work. I am seeking participants for a research study I am conducting in connection with my dissertation requirement. My research is being supervised by Jim Marley, Ph.D. of the School of Social Work and I have obtained permission from Loyola University Chicago's Institutional Review Board to recruit subjects for participation in my study.

My research investigation is a qualitative study aimed at exploring how psychotherapists who work with individuals who self-identify as transsexual and are considered to be MtoF understand client thoughts, feelings, fantasies or behaviors related to genital self-mutilation. This is a complex phenomenon that is poorly understood and is not without controversy regarding the language used to describe either the population or the behavior. I am interested in how therapists clinically conceptualize and understand this phenomenon.

Given that your organization's membership has many researchers and psychotherapists who are trans-affirmative and who work frequently with the trans community, I am requesting a copy of your membership directory. My intent is to submit letters to members who identify as psychotherapists announcing my research. The goal is to obtain a sample of psychotherapists who might be willing to participate in an audio-recorded interview discussing the research topic. I have enclosed a check of \$15 for the fee to obtain the membership directory list. Would you please be so kind as to email the list to my attention at michaelkenney@comcast.net or alternately to mail it to my home address at 7017 N. Greenview, Unit 2 Chicago, IL 60626. If you have any questions please feel free to contact me via phone at (773)316-2477 or again at the aforementioned email address.

I appreciate your assistance in this matter.

Sincerely,

Michael Kenney, LCSW
Doctoral Student
Loyola University Chicago
School of Social Work

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VITA

Michael Kenney received his Bachelor of Arts degree in Psychology from the University of Chicago, fulfilling a childhood dream of learning more about human behavior and the mind. During his studies at the University of Chicago, he completed a practicum in Client Centered Counseling with the Chicago Counseling and Psychotherapy Research Center. Following his graduation from college, for approximately two years, he worked as a casemanager in a nursing home serving clients who cope with chronic, severe mental illness including schizophrenia and schizoaffective disorder. This experience provided him with firsthand exposure to the operations of the mental health system in Chicago.

Michael Kenney had the good fortune of living nearby a social service agency, AidsCare, which allowed him to do volunteer work for five years. Additionally, concurrent with his volunteer work, he worked as an intake coordinator at two different private psychological practices. These practices specialized in providing psychological testing for the Illinois Department of Children and Family Services as well as other foster care agencies. Both volunteering and working as an intake coordinator further deepened his understanding of the mental health system in Chicago.

Realizing that a graduate degree was necessary to further his desire to work in the social service arena, Michael Kenney enrolled in Loyola University Chicago's School

of Social Work and successfully obtained his Masters Degree in Social Work in May of 2002. His area of concentration was adult mental health. He enjoyed his coursework, particularly classes that focused on human development and conducting psychotherapy with adults. During that time, he completed two social work internships. First, at the Illinois Masonic Wellington Center, a psychiatric partial hospitalization program, and second at Howard Brown Health Center, an LGBT affirmative health clinic.

Following his completion of his MSW degree, Michael Kenney was hired as a behavioral health specialist at Catholic Charities Archdiocese of Chicago. His duties included crisis intervention as well as triaging clients for referral to the appropriate level of mental health care. Michael Kenney passed his Clinical Social Work licensing exam and eventually began to work with clients in the capacity of individual and couples psychotherapy.

Michael Kenney's desire to learn more about psychotherapy theory resulted in his enrolling in Loyola University Chicago's School of Social Work's doctoral program in 2005. He has been heavily influenced by attachment theory, self psychology, and interpersonal neurobiological approaches to working with clients. He continues to work as a psychotherapist at Catholic Charities.

Michael Kenney enjoys the academic aspect of his professional discipline, and as such he has taught as an adjunct professor at the following universities: Aurora University, Loyola University Chicago, School of Social Work, and St. Augustine College. He has taught social work methods courses at both the undergraduate and graduate

level. He plans to continue a lifelong journey of learning more about human behavior and the mind.

