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Beyond Cisgenderism, Counselling People with Non-Assigned Gender Identities

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Introduction: Why Equal Treatment Isn't Enough

As the Founding Director of Lifelines Rhode Island/Cuerdas de Salvamento, a regional non-profit organisation focused on meeting the needs of individuals with *non-assigned gender identities*,¹ I provided advocacy, support, referrals, and crisis intervention services to hundreds of individuals with extremely diverse demographic characteristics and needs. My position also involved conducting professional training programmes and offering consulting services for physicians, psychologists, educators, clergy, and other human service providers. This position gave me intimate views into the daily lives of many individuals and the myriad elements affecting their lives. During this time, my other day job involved working in the editorial office of an internationally recognised, peer-reviewed psychology journal. The stark contrast between the understandings I gained during my work at Lifelines and the inaccurate, disparaging

Comment [YGA1]: 06.09.11 My updated definition of cisgenderism: discriminatory ideology and behaviour regarding people whose assigned genders differ from their self-designated genders and people whose assumed biological 'sex' characteristics differ from their actual bodies.

Comment [YGA2]: 28.08.11 Note that I now say 'self-designated gender' instead. In my recent work, I have also critiqued how the concept of 'gender identity' enacts a linguistic shift that positions people's self-designated gender as intrapsychic 'identity' while treating 'gender' (unqualified and unmarked) determined by other people as an authoritative 'natural fact'. See Ansara & Hegarty, 2011 for updated writing on cisgenderism. Thanks! ☺

¹ People whose gender identities differ from those they were assigned; often termed people with affirmed genders or people of trans, intersex, and/or non-binary gender experience, e.g., a person with an *assigned* gender identity as a man who identifies as a woman can be described as a *woman with a non-assigned gender identity* or an *affirmed woman*.

depictions of our constituents² in psychological literature that I encountered at the journal revealed a wide gap between clinician awareness and service user experiences.

During an interactive component of a Continuing Education training exercise that I was conducting with a group of mental health professionals, one woman was brave enough to raise a question that echoed concerns others later said they had felt uncomfortable asking aloud: ‘I treat all of my clients equally and like human beings. Why do I have to know how to treat trans and gender variant clients? I just treat everyone the same; I respect and understand them. Why do I need this training?’

I discovered that the ‘Why is this necessary, anyway?’ sentiment was widespread among participants in my trainings. This also included staff at nominally gay, lesbian, and bisexual agencies, who felt that the mere addition of a ‘T’ to their identifying acronym in the form of ‘LGBT’ prepared them sufficiently for responding to individuals with trans-related concerns.³ I also encountered counsellors of trans experience who felt that their personal experiences enabled them to utter authoritative pronouncements to their colleagues about ideal professional responses to All Trans People Everywhere.

Numerous texts aspire to be complete reference guides on this topic or offer monolithic guidelines for counselling trans and non-binary gender clients. Yet psychological texts and training manuals rarely consider the tremendous variety of situational permutations that affect the daily lives of individuals with non-assigned gender identities. I say ‘individuals’ because neither my personal experience of gender affirmation nor my extensive involvement in trans-

² During my tenure, Lifelines used the term ‘constituents’ to emphasise that persons served were stakeholders whose lived experiences and feedback motivated frequent revisions of our policies, procedures, and informational materials. *Constituent* implies civic engagement rather than consumerism.

³ The terms ‘gay’, ‘lesbian’, and ‘bisexual’ describe sexual orientation, not gender identity. Sexual orientation, sometimes termed affectional orientation, refers to people’s erotic attractions, romantic partner preferences, and/or kinship ties.

only social networks prepared me sufficiently for the dazzling array of perspectives and experiences that I encountered during my tenure as Lifelines director.

This chapter addresses the question ‘Why is this necessary?’ in a manner that I hope will initiate meaningful critical dialogue and reflexivity for counsellors regarding their clinical judgements and service delivery, a point of departure for future insights. The tendency of many authors in this field to impose academic and theoretical viewpoints that ignore or negate the complexities and incongruities of actual people’s lives is one reason I have chosen to focus on the individuals whose lives touched mine when making conceptual points in this chapter.

In this chapter, I will use the term *cisgenderism*⁴ to describe the individual, social, and institutional attitudes, policies, and practices that assume people with non-assigned gender identities are inferior, ‘unnatural’ or disordered and which construct people with non-assigned gender identities as ‘the effect to be explained’.⁵ This definition of *cisgenderism* offers a new paradigm for understanding currents that run through the vignettes that follow. My theoretical framework has been placed in the concluding section rather than at the beginning of this chapter because I believe that meaningful theory must emerge from the front lines of the people it claims to represent rather than from within clinical or ivory tower academic disciplinary boundaries.

I have selected merely a small sample of situations out of the hundreds of situations that I encountered. Rather than issue blanket pronouncements or propose a single method for streamlining counselling responses to people of trans experience, I have chosen to illustrate absurdities and inadequacies of current policies and practice—indeed, of any attempt to impose a normative policy or practice in this field—and to share an array of techniques that my volunteers

⁴ Originally from *cisgender* (Buijs, 1996), but see Serano, 2007 for an examination of *cisgenderism*. The prefix *cis-* is derived from Latin, meaning “on the same side”. For example, in organic chemistry, the phrase *cis-trans* isomerism is used to designate contrasting structural formulas in compounds with identical molecular formulae.

⁵ See Hegarty and Pratto, 2001 for an explanation of norms and ‘the effect to be explained’.

and I found effective and beneficial. This chapter is my attempt to answer the aforementioned ‘Why is this necessary?’ question in a manner that will initiate meaningful critical dialogue for counsellors regarding their clinical judgements and service delivery. Numerous relevant topics have been omitted or only minimally addressed by this chapter and by available literature. Yet my intention is to provide a point of departure rather than the detrimental illusion of fluency that predominates in our field.

Beyond What Meets the Eye

I first encountered Danielle⁶ on the telephone. She was afraid to meet in person. After several phone calls, her voice trembled as she agreed to meet with me and one of my Peer Advocates in the office space Lifelines had just acquired in the back room of a local print shop. Extremely concerned about her privacy, she insisted upon changing out of her flannel lumberjack shirt in the tiny bathroom beside the back entrance before meeting with us. She emerged wearing a modest peach pantsuit and low heels, her pink lipstick matching the smile that hovered uncertainly at the corners of her mouth. Her gaze flitted briefly from the floor to our staff and then back down, her hands shaking as she smoothed her hands across the hem of her blouse. The peer advocate and I smiled encouragingly, honoured to bear witness to her as she presented herself as she wished to be seen by others for the first time in over fifty years. Unfortunately, the owner of the print shop picked that moment to allow a 12 year old boy into the back room. The multiple conversations with me and my clinical supervisor about the extreme privacy needs of our constituents and the importance of not allowing his customers into our space while we were in meetings had failed. The boy glared at Danielle for several long moments, while her hands

⁶ Names and identifying details of all individuals mentioned in this chapter have been altered to the extent necessary to protect their privacy.

shook with increasing rapidity, her smile faltering as I began collecting Lifelines' newly placed office supplies for removal in front of her to reassure her that we would not retain office space in a hostile environment, a tangible assurance that her safety was more important to us than this particular office space. My willingness to relinquish an asset as vital as office space when retaining that asset became incompatible with Danielle's best interests highlights the secondary marginalisation and sacrifices that counsellors may face while trying to maintain ethical practices.

As Danielle invited us into her life, she taught me that, despite my own experience of having a non-assigned gender identity and the fact that local professionals were beginning to consider me an expert in All Things Trans, all of us had a lot to learn. One of the first insights most people gain when working with people who are exploring non-assigned gender identities is the importance of pronouns; 'she' or 'he', 'him or her'. Typically, ideas about appropriate pronoun usage are limited to identifying a person who appears visually ambiguous to the viewer and either assiduously avoiding gendered pronoun usage or asking which pronoun the person prefers. The former is frequently experienced as degrading or insulting by individuals with a clear pronoun preference, while the latter can often attract the unwanted attention of others who are present, and both cases can result in a sense of social exclusion. Nonetheless, assigning a pronoun based on social categorisation of visual appearance is risky—risky in the sense that an incorrect assignment can damage client trust. Constituents like Danielle provided me with the insight to see that the usage of pronouns and gendered terminology was even more complex than I had anticipated. This complexity also extends to matters of attire and visual presentation.

The single parent of a young child, Danielle struggled with the competing demands of caring for her terminally ill spouse, finding safe ways to simultaneously express her gender

identity and maintain her family. Since her wardrobe of women's clothes had been discovered, Danielle's strict Christian relatives had threatened to seek full custody of her child if she demonstrated any signs of continuing to express her gender as a woman, an expression that they considered psychologically abnormal, dangerous, and deviant.

After hearing about her extreme isolation, I invited her to attend the support group that I facilitated for people articulating, exploring, or affirming non-assigned gender identities. She stressed that if we encountered her outside of the group, we must address her as Jack and use male pronouns. This was not due to gender ambiguity or hesitation on her part; she was petrified that someone from her insular, rural community might discover her identity and try to destroy her family. It was a learning experience for the members of the group to witness Danielle attending the group with the thick, coarse arm hair, stubble, and flannel shirts typically associated with men, looking every bit the part of the robust lumberjack she had to be to sustain her home life, while being referred to consistently as Danielle and 'she'. Danielle's presence reminded all of us that the freedom to present as a member of the gender with which one identifies—*despite* one's attire, hair, voice, or mannerisms—was a basic human right denied to many others in similarly repressive situations. For other group members, fear of governmental and police oppression deterred them from exercising this right; despite the inclusion of trans individuals in local equal protection legislation, these laws were rarely known or observed by local police, who routinely harassed and arrested numerous women from our group for illegal sex work solely because they did not 'pass'⁷ as female when wearing women's clothes in public.

⁷ To be perceived as the gender with which one identifies; 'passing privilege' means being accorded the respect of acceptance as one's gender identity- this privilege is often taken for granted by people whose gender identities match their assigned genders, while being considered 'deception' in the context of 'trans' individuals. See Speer and Green, 2007 regarding the implications of 'passing' in psychiatric assessment. See Roen, 2002, for a discussion of debates on 'passing' within networks of individuals with non-assigned gender identities.

For Danielle, the group was a respite from the oppressive act she was compelled to play in daily life, the stress of a role that did not match her inner longings. Sometimes, I would arrive early enough to unlock the door in time for her to change into comfortable women's clothing prior to the meeting. At other times, she was barely able to abscond from the responsibilities of home and family for long enough to slip inside the building before our meetings were over. Yet each time she joined us, Danielle expressed relief that she had one safe place in which to explore what it felt like to be herself. Consequently, group sessions take on a critical role—they are perhaps the only setting in which some people experience the liberation of being 'seen' and 'heard', essential components of trauma recovery and transcending marginalisation. During the check-in period at the beginning of each meeting, after the ground rules were recited aloud by the group, each participant was encouraged to state one or more desired gender pronouns. On multiple occasions, Danielle expressed her gratitude for the rule that required participants to respect desired pronouns, regardless of visual appearance or passing ability. Her presence reminded others that visual cues provide limited and sometimes misleading information about gender identity.

Staff at clinics where I conducted site assessments often described cases of clients whose legal documentation listed them as 'male' and who alternated between overt visual presentation as women and standard men's attire. The consensus among clinic staff was that such individuals could be unhesitatingly addressed and treated as men, since these clients had neither asserted identities as women, nor corrected staff on pronoun usage. The staff sobered when I raised questions inspired by Danielle's presence in the group. Did these individuals wish to be considered women in the private confines of the clinical office, but to have their privacy preserved to safeguard their livelihoods, as in Danielle's case? Were they in the process of

articulating a gender as women, bi-gender, or genderqueer while being unsure of how to explain their situation to staff or advocate for themselves? Were they trying to communicate their feelings and preferences passively or non-verbally? By examining these questions, we learned that consulting with clients and confirming their pronoun preferences is a vital first step in creating safe environments.

I was surprised to discover that many counsellors and clinic staff held the belief that their clients were 'regular people' (not of trans experience) unless otherwise specified, an assumption that placed the burden of advocacy solely upon constituents. The fact that few staff had been exposed to people of non-assigned gender identities outside of media images exacerbated this problem. Women like Danielle, who did not fit the popular stereotype of the transsexual sex worker were often assumed to be 'transactivists', a mysterious single word utterance. These articulate and highly functional individuals were assumed to participate in an elusive and widespread network of others 'like themselves'. Many counsellors with whom I conversed were shocked to discover that many of our constituents were not activists; many of our support group members were not involved in any trans-related political action and many had never even met another person with an affirmed gender identity before attending the group. While the Internet does provide significant opportunities for interpersonal connection, many of our constituents either lacked home Internet access or were unable to gain the privacy required to engage in gender-related conversations online.

In Danielle's case, prior to the formation of our support group, she sought resources in multiple locations where she was unlikely to be recognised by people from her hometown. She told me that she had been rudely escorted from the women's changing facilities at an urban multi-service health centre on multiple occasions when she arrived for counselling sessions

directly from her job as a manual labourer, and that she felt despondent about enduring counselling in an environment where she lacked the freedom to be herself. I wondered: Had the staff paid attention to when their clients' gender-related needs might change, and had they taken the initiative to enquire? Had they considered that their clients might have come directly from work on the occasions when they wore attire typically associated with men and therefore they were unable to wear women's clothing? Had anyone offered these clients the option of separate pronouns within the private confines of the exam and counselling rooms, regardless of whether they occasionally wore men's clothing? Had anyone provided options that might address the kinds of dilemmas faced by Danielle and others, rather than assuming that their lack of complaint ensured that their needs had been met adequately?

These questions barely skim the surface of the concerns that Danielle and those in similar situations needed their counsellors to address. To return to the question of why it is vital for counsellors to educate themselves about the intricate dynamics of people with affirmed gender identities, it is evident from the experiences that Danielle and others shared with me that without specific awareness of the situations faced by these individuals, even the most skilled therapist will be unable to provide quality care. A therapist should expect to expend some effort toward equality of service before these individuals perceive the same level of respect and feel the same level of comfort typically enjoyed by people with assigned gender identities (i.e. people whose gender identities match the ones they were assigned).

Pronoun Cueing and Mispronouncing

The first person to assign a pronoun to another person in a social situation plays a pivotal role in establishing the person's gender identity and pronoun to those present. On a superficial

level, pronoun usage may appear to be a social pleasantry that has little impact on service delivery. In fact, *pronoun cueing* is a fundamental component of social interactions that has the power to effectively challenge systemic inequities or to construct formidable access barriers.

Consider the case of Tara, a 19 year old woman who did not ‘pass’ visually as female. After her domestic partner physically assaulted her, Tara was referred through several agencies. Based on both her visual appearance and identity documents that listed her as male, her caseworker at a human services programme consistently referred to her as ‘he’ while otherwise helpfully attempting to get her a bed at a local women’s shelter. This *mispronouncing*—usage of a pronoun that inaccurately depicted Tara’s articulated gender identity—exacerbated the access barriers that she faced when attempting to access shelter resources. Staff at the women’s shelter had difficulty understanding why someone referred to as ‘he’ needed to be housed in their women-only facility. Her caseworker was unable to advocate successfully for her with shelter staff that had a reputation (according to numerous affirmed women) of discriminating against them, in violation of local laws.

After being denied access, at least partly due to the incorrect pronoun cueing of her caseworker, Tara was placed in a mixed-gender homeless shelter. This shelter lacked the domestic violence services that Tara needed to cope with the domestic abuse that had caused her fresh bruises. Far more troubling was the fact that Tara, a young woman in crisis, was an easy target for bullying by men in the mixed shelter. Mere hours after surviving her partner’s violent assault, Tara was sexually assaulted in the place she had gone for help. This time, her caseworker turned to a local organisation that focused on gay and lesbian clients. Despite their altruistic intentions, this organisation’s staff had such a rudimentary grasp of ‘trans’ issues that their response to a traumatised, understandably suspicious Tara was to have her admitted to a

psychiatric ward. While gay and lesbian clients served by this organisation had often reported positive experiences in this particular ward, which was known to have several nominally ‘LGBT-friendly’ clinicians on staff, women with Tara’s gender history had disclosed overwhelmingly negative experiences with this unit to Lifelines. In Tara’s case, while multiple factors contributed to the unfortunate outcome, mispronouncing was a key element.

Many of the caring therapists whom I encountered were unaware of their intermittent pronoun slips until these slips were mentioned by me or by one of our constituents. While some therapists were embarrassed and troubled by their unintended errors, an alarming number of therapists initially attempted to justify this as client-specific, as a reflection on their client’s level of success in appropriating the normative gendered behaviour of their non-assigned gender. One gay holistic mental health counsellor had the audacity to tell a client struggling to gain respect as a man that ‘it’s my psychic vibe telling me that I’m just not sure how deep this “being a man thing” really goes with you.’ Another therapist told a constituent in the process of affirming his identity as a man that ‘I only have trouble with your pronouns, because you don’t really have guy mannerisms; my other clients seem more authentically male.’ Counsellors attempting to justify or explain their mispronouncing are misguided at best, destructive and counter-therapeutic at worst. It is important for therapists to remember that mispronouncing is a form of verbal and psychological abuse. A wrong pronoun can wound as deeply as an ethnic or racial slur. The therapist has a moral obligation to be aware of this potential for injury and to make a concerted effort to avoid inflicting it. The emotional impact of mispronouncing not only erodes a developing therapeutic relationship but also can have a dehumanising effect, as it denies recognition of the identity-related aspect of personhood and coerces the client into an ill-fitting gender straightjacket.

Another common problem for people early in the process of *gender identity actualisation*⁸ is the provider expectation that they would complain or notify the counsellor if the pronoun, given name, or gender identity that they were assigned did not work for them. During a site assessment at a local mental health clinic, staff assured me vehemently that none of their trans clients had ever objected to their system of colour-coding patient files by assigned gender category (rather than by affirmed gender identity). A crucial fact to consider is that silence does not automatically mean approval or comfort. At almost every one of our support group meetings, participants would describe situations in which they experienced discomfort with therapists and other service providers. In the vast majority of cases, they did not feel secure enough to voice their discomfort to the providers themselves. This was particularly noticeable among constituents who were in the first few years of affirming non-assigned gender identities and those from historically underserved ethnicities.

Many people in our group commenced the expression of their pronoun preferences tentatively, asserting that we could ‘use whatever pronoun we wanted’, claiming that they didn’t mind. However, in almost all cases, after further conversation in which I- as facilitator- and other group members asked what they would *prefer*, these superficially ambivalent attendees expressed clear and unambiguous pronoun preferences. For counsellors who wish to support the gender affirmation process, this means taking the initiative to ask detailed follow-up questions designed to encourage clients who have not yet articulated the belief that they are entitled to their preferred pronouns. Many people in our group described the sentiment that they were inconveniencing others or making outlandish demands when explaining why they had chosen not to correct authority figures or friends who mispronounced them. For many of those who did not

⁸ A non-pathologising alternative to terms like ‘gender transition’ or ‘sex change’, *gender identity actualisation* (Vanderburgh 2009) acknowledges that people who affirm their gender identities do not suddenly become a new gender, but instead actualise who they already know themselves to be.

‘pass’ visually based on normative stereotypes about gender in the dominant mainstream culture, advocating for themselves in this manner felt belligerent and aggressive. While this kind of self-advocacy came more naturally to the minority of the group with backgrounds in activism, members of the group typically spent several meetings encouraging some participants before they felt liberated enough to accept our respect as their basic right.

The sense of liberation that the group provided for people initiating the process of gender identity actualisation was enhanced by the peer nature of our group. Yet this kind of life-affirming environment is one of the components of a safe, welcoming counselling relationship. By taking responsibility for asking detailed questions of clients, by offering a lavish banquet of choices rather than waiting for clients to pick the cheapest item on the menu (i.e., the pronouns and gender-associated name least likely to require effort or encounter resistance), counsellors demonstrate their willingness to take the journey of discovery with their clients, and to embrace new insights and the self-respect that is essential to thriving rather than merely surviving.

The need for providers to ask rather than to assume that lack of complaint translated into satisfaction was illustrated for one local clinician when he consulted with me on ways to help one of his long-term patients. A specialist in the field of communicable diseases, this caring provider had shared the joys and struggles of the Santiago family for five years. They had bonded closely during this time and seemed to have excellent communication.

When I spoke with Juan, my initial questions were about preferred pronouns and name. I knew from previous experience that I had to actively solicit this information by offering possible options in an encouraging and persistent manner. The first response was the predictable ‘I don’t want to inconvenience or challenge anyone’ response I had heard from so many of our constituents: ‘Whatever you want is fine.’ Then, after it was clear that I was sincere and willing

to treat her requests seriously, ‘Well, I sometimes go by ‘she’, but it’s okay to call me whatever you feel comfortable.’ I persisted, ‘What would be the *best* and most comfortable for *you*? Would you like me to call you by Juan or by another name?’ In fact, after further conversation, it turned out that ‘Juan’ was actually Maria, whose experiences as a low income immigrant with limited employment background and difficulty expressing her emotions in English—despite her extensive practical vocabulary in daily life situations—made her hesitant to risk alienating her provider with what she considered might be, or might come across as, an ungrateful demand.

After five years of working with Maria’s family, it had simply not occurred to her talented and responsive provider to investigate and solicit her pronoun preference and gender identity. It took fewer than five minutes for me to elicit this information from Maria during our initial phone conversation, because I knew which questions to ask and to pre-emptively address Maria’s unspoken questions about how far I was willing to go toward taking her gender identity seriously. I found that this kind of advanced notification of provider attitude transforms the therapeutic relationship by meeting the client halfway in the communication process. Most people are not activists, and may simply be unable, unaccustomed, or unwilling to assert themselves before being provided with unsolicited supportive information from their providers. For many clients, gender identity affirmation may reveal itself in subtle hints and gestures, rather than in spoken form. One of the more widely praised counsellors among our support group members was appreciated for, in the words of one affirmed man, ‘putting it all out there on the table for you as something on the menu before you even get up the courage to ask if you can add it in.’ Maria’s ability to get appropriate care improved as a result of sharing her information with her provider; the validation she received from her provider after he began treating her as a woman made her feel safe enough to disclose other details relevant to her wellbeing.

Even counsellors who express generally supportive attitudes toward trans youth may hinder their gender identity actualisation process by demonstrating less than full support for their affirmed genders with parents. For youth whose parents have not accepted their gender identities, counsellors have the potential to bridge parent-child communication gaps in their capacity as youth advocates. I was disappointed to discover that a counsellor working with vulnerable youth made the clinical judgement to use the name and pronouns with which the parent was most comfortable, rather than to use those asserted by Matthew, the 16 year old affirmed man who was supposed to be her client. This counsellor mispronounced Matthew during our treatment team meetings and failed to use his preferred name and pronouns when he was not present, instead of setting an example of respect for other staff and Matthew's parents to emulate. Had this counsellor treated Matthew's gender identity as genuine and not a costume to be discarded at will when it was inconvenient or met resistance, his mother may well have felt motivated to consider offering similar acceptance.

From 'Gender Identity Disorder' to 'Gender Specialist Identity Disorder'

At a collaborative training for staff at a local hospital, Maria's provider commenced his presentation with an anecdote about the aforementioned experience, as a reminder to the medical and mental health specialists and department heads present that the best clinical training and experience in other areas do not necessarily prepare a provider to handle these kinds of situations effectively. The wisdom and humility of this realisation are crucial to providers who work with people of non-assigned gender identities. While providers who have significant experience with this population often take the presumptuous title of 'gender specialist' or 'gender expert', this grandiose nomenclature obscures the reality that there are as many gender identities, gender

histories, and gender trajectories as there are individuals to claim them. One might easily become a celebrated ‘gender specialist’ or prolific author of ‘gender therapy’ guidelines, yet find oneself stumped when the responses that might have seemed beneficial and prudent in one case yield disastrous results in another. The ‘gender specialist’ mentality is dangerous because it presupposes a common link between people with affirmed gender identities, an ill-fitting set of blanket guidelines and prescriptions to govern something that is far less tangible and quantitatively structured than heart rate or body mass.

My position at Lifelines introduced me to people with gender identities that remain virtually unacknowledged in psychological texts, including genderqueer, kathoey, third gender, Two Spirit, agender, gender-free, bi-gender, tri-gender, androgyne, and macha, to name a few. Few providers are versed in counselling these individuals. As a result many people with gender identities outside the binary have difficulty finding appropriate psychotherapy, even from binary-gendered therapists of trans experience or therapists with extensive trans experience.

A transmasculine genderqueer individual whose assigned gender was that of a woman, Judah (who prefers male pronouns) shared his own challenges in seeking care:

I was depressed when I graduated from college, probably because I had no idea what I was doing with my life and couldn't see any future for myself, so I went to get therapy. The first place I went was covered by my insurance and had some therapists. Just a luck of the draw kind of thing. I wanted to talk about how I had no friends and no direction and was miserable and what could I do? The therapist seemed fascinated mostly by my transmasculine gender, my relationship with my cross-dressing boyfriend, and other things of that nature. I left after one session because I felt like her entertainment -- but I was supposed to be paying her!

My next therapist was at (a popular clinic), which is supposed to know a lot about GLBT people, so I figured there was more of a chance she'd be cool. I mentioned my gender issues during my intake but also said I was not there for gender therapy. So I was assigned to a therapist who focused on helping me with my negative thoughts,

increasing my self-esteem, finding a direction, and so on. It was great. But sometimes gender did become an issue, and at those times my new therapist became very confused. She would always point out when I contradicted myself instead of respecting that I had contradictory feelings, and no, it wasn't coherent and didn't make sense; why yes, I noticed that! I wanted a butch community but also sometimes wanted to transition (to being viewed as a man socially). Eventually I got frustrated with this because I felt that she just didn't understand me, so I left and went to a genderqueer therapist someone else had recommended to me.

Unlike most genderqueer individuals who contacted me, Judah eventually managed to locate a counsellor who was both comfortable with and aware of his needs. Praising his genderqueer counsellor, Judah states:

This therapist understands -- and actually had first-hand experience regarding some aspects of -- my gender experience. *Ze*⁹ is able to acknowledge the complexity and contradictions of my experience, to focus on gender when appropriate, or bring it in when it is relevant, without either ignoring it or making it the entire reason for all of my troubles.

The sensitivity that Judah's counsellor brings to their therapeutic relationship has translated into reduced access barriers. While most genderqueer individuals are unable to access hormones and surgery during gender identity actualisation, Judah's therapist assisted him in acquiring testosterone, something many 'gender specialists' routinely deny to people outside the binary. Since starting testosterone, Judah's self esteem and comfort with his body have increased significantly.

Counsellors are often stunned to learn that a high percentage of the unofficial provider complaints we received were about therapists who identified themselves as 'gender specialists', some of whom were among the most widely recognised names in the field. Since few of our constituents were willing to file official complaints, most of these concerns were addressed

⁹One of several 'third gender' English pronoun options (often used in conjunction with the gender neutral possessive pronoun 'hir') preferred by some genderqueer and non-binary-gendered individuals. (See Bornstein, 1994, and Feinberg, 1998.)

through cautionary anecdotes in our trainings or by advocacy meetings with individual providers. The rarity of formal complaints was an unfortunate consequence of the tremendous control that the widely used (though not, as many mistakenly believe, obligatory) *World Professional Association for Trans Health* (WPATH, formerly Harry Benjamin International ‘Gender Dysphoria’ [sic] Association [HBIGDA]) *Standards of Care* (Meyer et al 2001)¹⁰ gives to therapists of people seeking access to hormones and surgery related to gender identity affirmation. These complaints ranged from simple disrespect to clear violations of client autonomy to ethical misconduct and abuse.

Consistently, the counsellors who garnered praise in our confidential support group, where attendees felt safe enough to warn against or recommend providers without fear of retaliation, were those who maintained modest perspectives about their ‘gender expertise’ and the needs of people with non-assigned gender identities. The few counsellors about whom I heard frequent praise were those who did not support the belief that people with affirmed gender identities had ‘Gender Identity Disorder’ (GID), who recognised the inequity of a system that forced ‘trans’ clients to jump through hoops to prove their validity in hopes of being accorded the same rights as other individuals, who understood the dangers of accepting the role of judge and jury in the psycho-medical gatekeeping system, and who forged therapeutic alliances with their clients to navigate the dictates of existing professional standards.

If trendy professional phrasing is considered necessary, the terms *gender advocate* and *gender affirmation counsellor* seem far more client centred and empowering. These terms

¹⁰ At this time, the 2001 WPATH guidelines are the most updated version available. While a newer version is imminently due for publication, it is worth noting that most clinics I encountered were still using outdated Standards of Care that dated as far back as the 1990s and few recognised the need to remain current. (See Lev, 2009 for recent recommendations for revisions to the current standard.) The contrast between updated standards and versions applied in clinical settings underscores the ethical obligation for authoring bodies to provide outreach and oversight to clinical settings that are ignorant of or resistant to employing the most recent standards.

emphasise the necessity for counsellors to address the extreme societal inequities facing people with non-assigned gender identities, while avoiding the hierarchical authoritarianism and arrogance of assuming the therapist as expert about something with which the client has far more intimate, daily experience. When I hear counsellors who market themselves as ‘trans allies’ make well-intentioned statements about the importance of clinical evaluation in determining whether someone ‘really knows what they want’, whether ‘gender transition is right for them’, whether the client is ‘really transsexual’ or ‘should be allowed to get hormones or surgery’, I wonder if they understand the paternalism and condescension of their approach.

While licensed therapists working within professional guidelines may often find themselves struggling to balance their ethical commitment to social justice with the dictates of a system that may inhibit this commitment, I still find myself surprised by the numbers of ‘trans ally’ therapists who do not engage in critical scrutiny of the institutional structures to which they contribute or of the discrepancy between giving lip service to client empowerment while simultaneously defending a system that undercuts client autonomy and self-actualisation. It is possible to work within the system without adopting its pathologising, dismissive mentality, as some fine strategic counsellors demonstrated in their conduct with our service recipients.

Dis-abling

I first learned about Jason’s case from fellow trans activists when he was a teenager, years before we first met. An outgoing, active young man who was involved in various artistic, athletic, and community service activities, Jason had been trying to affirm his gender and obtain a prescription for testosterone for over six years. Several activists informed me that his numerous attempts had been consistently blocked through a combination of subtle manipulation

and overt denials orchestrated by the host of providers who had ‘cared’ for him. The only counsellor who understood Jason and his needs well enough to give approval for him to begin ‘T’ (the vernacular term for testosterone commonly used by affirmed men) had stopped seeing him after questionable tactics by well-intentioned staff at a local organisation, who felt that he could not possibly know what he wanted. His large chest and high voice meant that he would be unable to pass visually as male in daily life without T. The discrimination Jason encountered was largely due to his having been diagnosed with a cognitive disability that accounted for his primary school reading level.

The moment I heard Jason’s story from veteran activists, I vowed that if I were ever in a position to assist him, I would do so. I was delighted when Jason began attending our support group. I waited for him to share his experiences in the group before offering to help him speak effectively for himself with his providers, who had discounted his wishes in the past due to his inability to use collegiate language or grasp technical jargon. My desire was to give him a platform to express his needs by bridging communication gaps rather than speaking for him. Jason became despondent after watching his peers acquire hormones, while he had been seeking a prescription for years. By this time, I had booking privileges at the clinic of a local physician who had begun working collaboratively with Lifelines in some aspects of service provision. This physician was aware of the ease with which many people frustrated with rigid gatekeeping were able to obtain black market hormones and the perils to which that commerce exposed our constituents. He operated on a *harm reduction* standard that acknowledged the detrimental effect of service denial. As with other referrals, we exchanged disclosure of information forms from constituents, I briefed the physician on Jason’s history, and I explained some of the access barriers that he had encountered due to his disability.

During the appointment, the physician patiently explained the informed consent document in language that Jason could understand, discussing sexuality, genital changes caused by testosterone, and other issues with admirable sensitivity. While Jason often found technical medical language daunting and unintelligible, this adept provider was able to translate the information into simple terms and check to make sure that Jason had grasped the message. Jason left the appointment with renewed hope and excitement about his future.

Unfortunately, within a few days, my voicemail was filled with intimidating, hostile messages from various professionals who had been working with Jason. Only one of these was a licensed provider, with whom I agreed to meet for conversation after exchanging the requisite disclosure forms from Jason. The others were from staff affiliated with a disability service agency charged with overseeing Jason's housing. It is relevant to note that Jason did not have a legal guardian and that he had the legal status of being mentally competent to make his own decisions about his care. One voicemail from a senior staff member at the service agency mispronounced Jason repeatedly, expressed alarm at the fact that he had been attending our support group, and contained vague threats about my being 'in trouble' for assisting Jason in affirming his gender identity.

I was unable to guess how inviting a vulnerable young man to attend a peer support group with others who shared some pivotal aspects of his history and needs was worthy of criticism. When I returned the phone call, the woman sputtered when I corrected her pronouns and used Jason's preferred name—a name that he legally made his official name years before he ever encountered this agency. I calmly explained the basics of gender affirmation to this woman and the fact that the physician and I were both in contact with his therapist. She seemed unable to articulate the source of her distress, resorting to repetitions of stock lines like 'but he has a

disability!’—as if people with cognitive disabilities lack the ability to know their own gender identities or the human right to affirm that ability.

At our initial conversation, Jason’s therapist was equally anxious. While she seemed far more aware of ‘trans issues’ and used the correct name and pronouns, she explained his trauma history and past suicidal ideation as definitive reasons why he should under no circumstances be permitted to access testosterone. She also expressed misinformation about numerous aspects of gender identity actualisation. As Jason was her first and only client of trans experience, she did not have past cases to challenge these inaccurate ideas. I explained that the denial of hormones to people with sexual abuse and trauma histories exacerbates their survivor issues by forcing them to continue having unwanted, intimate kinaesthetic experiences like menstruation or beard growth. Many of our group members had disclosed past genital mutilation and suicide attempts from the acute distress of this kind of kinaesthetic contrast. Several experienced physicians with whom I had presented had shared their insights about working with trans patients at our trainings, marvelling at the dramatic and sudden improvement in patient mental wellbeing caused by hormones alone, in the absence of any psychological therapeutic interventions. After describing these cases and explaining the distress that denial of T was causing to Jason, his therapist quickly became my ally in supporting him to get T.

Jason continued to face resistance and even derision from disability services employees who were afraid of his foray into a process about which they neither had nor desired basic knowledge. Yet despite these obstacles, he began to blossom after he acquired T. His therapist and even some of the staff who had been his detractors marvelled at his transformation—not the gender aspects, but the dramatic increase in his self esteem, confidence, and life satisfaction. Jason surprised many people by enrolling in courses at a local community college and obtaining

assignment accommodations for his disability; the day he smiled and flashed his campus identification card at me to show that he had succeeded was one of the most rewarding moments of my life. After years of multiple psychiatric hospitalisations per year, Jason did not have a single hospitalisation after starting T.

At that moment, I recalled the agonising nights that I had lain awake replaying those hostile voicemails from ignorant staff in my head. What gave me the right to think that I knew best? These people were older and more experienced professionals than I, and in some cases had more extensive clinical training than I. Was I doing the right thing or leading Jason down a disastrous path with a catastrophic conclusion that everyone but me could see? As with many other complex moral dilemmas I faced during those three years, I sought the counsel of the retired marriage and family therapist who had agreed to be my clinical supervisor so that I could benefit from his wisdom and insight in just this kind of predicament. His response was characteristic of the astute perception that he graciously lent to our organisation. ‘Gavi,’ he said in his quiet, compelling voice. ‘You aren’t the one making the decisions. It’s not *your* decision to make any more than it is theirs. This is Jason’s decision. Our only obligation is to support Jason in making *his own* decisions.’ I realised that despite my moral convictions and ironclad resolve, the formidable pressure against my efforts to help Jason had caused even me to waver. I can only imagine how difficult it would be for an inexperienced counsellor or for someone in the same situation as Jason. Yet maintaining ethical integrity in response to institutional bullying and prejudice is one of the few effective ways to surmount these barriers. The therapist for whom the principle of client autonomy is foremost in the clinical judgement process is best poised to promote successful gender identity actualisation and prevent the potentially catastrophic impact of unwanted delays.

The Gatekeeping Industry and Standards of (Unequal) Care

Jason's case exemplifies the conflicts that can result when stakeholders in service professions feel that client needs threaten their livelihood or their authority. I discovered months later that at least part of the sentiment behind the intimidating phone calls stemmed from fear that Jason might move out of the programme's housing and services if their inability to address 'trans issues' was revealed, thus removing a lucrative source of income for the agency. As parties with financial, professional, and ego-based stakes in client outcomes, therapists must evaluate their motives very carefully when providing services or making clinical judgements. Whether therapists work for nationally funded public service agencies (like the NHS in the UK) or an international equivalent, private clinics, community health centres, or as independent providers, the fact that they receive a paycheque for their services is not a trivial detail. Therapists who defend their role as gatekeepers for access to hormones and surgeries related to gender identity actualisation may have consciously altruistic motives, but the severe risks inherent in playing judge and jury over whose gender identities are permitted actualisation and whose are deemed unauthorised outweigh the putative benefits.

My direct service experiences included hundreds of people who were harmed by well-meaning but misguided 'trans allies' and 'gender specialists' who blocked them from vital steps toward self actualisation. Several of the most widely used standards for dealing with trans clients seem to favour those who are financially independent, able-bodied, articulate, college educated, versed in theoretical jargon, and native speakers of the national languages in their countries. Even among therapists known for challenging racism, classism, ageism, ableism, sexism, heterosexism, and other forms of discrimination, these prejudices often emerged in their work with clients of trans experience.

DeShawn and Lakesha were among many Black-identified affirmed women who complained to me about being denied approval for hormones and surgery by non-Black counsellors of various ethnicities who considered them 'too masculine' to be women according to non-Black cultural gender norms. Lakesha's identity as a butch lesbian further challenged the prejudices of the therapeutic team that administered her mental health services, one of whom asked her during an evaluation meeting why she 'wanted to be a woman, when you can just be a straight man and have a normal dating life.' The fact that one of her providers was herself an out butch lesbian did not prevent the team from applying unequal standards to Lakesha; while her provider's status as an assigned woman apparently entitled her to deviate from normative straight femininity without endangering the legitimacy of her gender identity, Lakesha's butch lesbian identity was viewed as disqualifying her identity as a woman. The denial of medical resources to both DeShawn and Lakesha had severe negative repercussions that affected their abilities to gain legal employment, avoid police harassment, and access basic health care.

Similar discrimination delayed Hassan, an affirmed man whose penchant for wearing brightly coloured scarves and kohl eyeliner prompted his counsellor to speculate on the authenticity of his affirmed gender identity. Hassan was one of several affirmed men from Asian and Middle Eastern cultures who sought assistance from Lifelines in their efforts to obtain hormones or surgery, after having been informed by their therapists that they were considered unsuitable candidates because these affirmed men's traditional ethnic attire and cultural mannerisms read as 'feminine' or 'girly' to counsellors who lacked awareness of cultural differences in gender norms.

Professional assumptions about the appropriate ages for trans individuals to affirm their gender identities also clash with human actualities. One conventional paradigm classifies

individuals as either ‘primary or secondary transsexuals’, with the latter referring to individuals who affirm their gender identities later in life. These ‘secondary’ trans individuals are depicted as having less authentic affirmed gender identities and less suitability for hormones and surgery. The underlying assumption is that a ‘true’ gender identity would have asserted itself at an earlier chronological age rather than after they had built families and functioned efficiently in their assigned genders. Marquetta’s path to gender affirmation reveals the inherent classism and ethnocentrism of this notion.

An affirmed woman refugee from a Spanish-speaking nation, Marquetta had lived in her assigned gender as a man for decades, working 16-hour shifts in blistering heat during several decades as a migrant farm worker before she learned enough English to secure steady employment at a company that provided excellent retirement benefits. The eldest child in a large family, she was obligated to provide financial support for her younger siblings, and had limited educational opportunities. In her early sixties, Marquetta had only begun to have time and space to consider her own needs in the last few years and quickly realised that she wanted to affirm her gender as a woman. Although the decision to have genital and other surgeries has no bearing on the legitimacy of someone’s gender identity, Marquetta chose to travel to Thailand for one of several possible genital surgeries as part of her gender identity actualisation process after she located a Thai surgeon who did not require therapist approval. Despite receiving full medical clearance that surgery was safe, she was denied approval by a therapist who considered her ‘a poor candidate for surgery’ due to the age at which she affirmed her gender. Prior to retirement, Marquetta lacked not only the financial resources to obtain surgery, but the time to contemplate matters beyond her material needs for basic subsistence. In this case, the only discernible

difference between a ‘primary’ and ‘secondary transsexual’ was socioeconomic status and self-reflective leisure time associated with class privilege.

The many children and adolescents who sought assistance from Lifelines in their efforts toward gender identity actualisation were typically less fortunate than Marquetta, whose legal status as an adult gave her greater freedom to make decisions about her own body. It is comforting for those of us dedicated to our work as counsellors to dismiss examples of blatant discrimination encountered by DeShawn, Lakesha, Hassan, Jason, Marquetta, and countless others as mere ‘exceptions’, as atypical or as the fault of individual therapists. However, these inequities are a direct result of institutional discrimination enshrined in the *WPATH Standards of Care*. The unexamined assumption that only individuals with the social status to present pristine (and normative) textbook examples of ‘genuine trans people’ are worthy of the right to gender identity actualisation underlies many current policies and practises in psychological counselling.

The vast majority of the hundreds of people who either attended our support group or who contacted me individually for assistance shared horror stories of service denial and mistreatment by providers who insisted that they were merely following approved ‘Standards of Care’. Many of these individuals—particularly those who were discriminated against in seeking hormones and surgery because of their non-binary gender identities—found ways to acquire hormones through unofficial channels in efforts at self-preservation that would not have been necessary if their providers had been actual rather than nominal allies. The most widely used versions of the ‘Standards of Care’ contain a ‘Real Life Test’ component. This ‘Test’ requires individuals to live ‘full time’ asserting their gender identity to the world prior to accessing gender affirmation-related surgeries that permit them to change sex markers on identity documents or use changing rooms at athletic facilities without trans-related harassment. Rigid

provider adherence to these guidelines was directly responsible for severe physical safety hazards for our constituents.

Andrea, the desperate mother of a 17 year old affirmed woman named Rochelle who used a wheelchair and suffered from chronic illness, was referred to me by her therapist after previous contacts failed to assist her. Andrea begged me to help her to save her daughter's life. They lived in a rural village where residents knew each other intimately, with little opportunity to maintain privacy or keep secrets. There were several counsellors in the village, but their connections with Andrea's employer and her church meant that she could not confide in them about Rochelle without risking her job or her social standing in the tiny community.

For several years, Rochelle had been desperate to obtain hormones or the fully reversible hormone blockers like Lupron Depot that prevent the trauma of 'the wrong puberty' in people under 16 years old. Unfortunately, due to extreme political backlash against some providers willing to assist people less than 18 years old with *kinaesthetic identity actualisation*¹¹, all of the medical providers whom Andrea consulted adhered to rigid Standards of Care. These Standards required that Rochelle either undergo months of counselling or meet the aforementioned criteria known as the 'Real Life Test'.¹² Her physical condition made travel to a therapist's office precarious and her attempt at meeting the Real Life Test requirement was thwarted by a violent assault she experienced the first time she attempted to use the handicapped stall situated in the women's bathroom at her local community centre. Far from being an exception, Rochelle's predicament typified the unequal access caused by lingering inflexibilities in current Standards of Care.

¹¹ The process of acquiring hormones, hormone blockers, and various genital and secondary 'sex' characteristic-related surgeries to make one's embodiment match one's sense of self; often but not always part of the process of affirming one's gender identity.

¹² For an ethical critique of these Standards of Care, see Hale, 2007. See Giordano, 2008, for an ethical critique focused on treatment protocols for adolescents.

On a weekly basis, I heard reports from affirmed men and women who were harassed and assaulted at banks, clubs, and routine traffic stops when presenting identity documents that did not match their visual appearance. One affirmed woman dropped out of a prestigious nursing programme after being repeatedly beaten in the face on her evening bus rides to and from classes. She had wanted to wait to live 'full time' as a woman until she could afford to move to a new city where people would not recognise her from her past public role as a man, but she was barred from getting surgery until she took this risk.

My past experience as a multilingual psychiatric caseworker prompted a local physician to refer an affirmed woman who had been unable to locate a counsellor fluent in her native language. Her patient Nasreen had a history of past suicide attempts that were prompted by her extensive trauma history. Concerned about the possible emotional fluctuations she might experience in the initial period of adjustment to oestrogen, Nasreen's health care team was unwilling to prescribe hormones without an agreement that she would attend regular counselling sessions to monitor her moods. At first glance, this safety precaution seems reasonable, prudent, and even requisite. Unfortunately, there were no counsellors who spoke her native language registered at the local centre and her providers had searched the entire region to no avail. She was seeing an English-speaking counsellor who was trying her best to meet her needs, while recognising that Nasreen didn't feel comfortable sharing the personal information required for psychological assessment with her counsellor due to their cultural and linguistic communication gaps.

Nasreen waited many months before we were able to locate a therapist who spoke her native language, during which time her well being deteriorated as a result of acute distress regarding the delay in acquiring hormones. Nasreen eventually decided to obtain hormones

through unofficial channels, rather than continue to wait indefinitely. Any evaluation of the benefits and drawbacks of providing hormones to Nasreen given her history must also consider that blocking her access to a hormone prescription had a detrimental rather than neutral effect; in cases like Nasreen's, the medical dictate to 'Do No Harm' may provide compelling ethical justification for action.

Nasreen's situation illustrates the critical role that awareness and knowledge of a client's language and culture has in establishing therapeutic relationships. Simply being from the same cultural background or identity category as one's client does not in itself grant a counsellor a better ability to meet client needs; some clients of trans experience even found that trans therapists assumed far too much commonality or imposed their personal politics in unhelpful ways. Yet the frequency with which trans individuals from historically underserved ethnicities complained about analogous access barriers highlights one of the many flaws in placing therapists in gatekeeping roles. In addition, the combative nature of the gatekeeper-suppliant dynamic precludes the basic trust, respect, and encouragement of autonomy that are fundamental to therapeutic relationships.

The *WPATH/HBIGDA Standards of Care* may have become less stringent over the past two decades, but the popular requirement of either a 'Real Life Test' or several months of therapy is a formidable obstacle to many already marginalised people. Some people of trans experience who conduct provider trainings or who are employed by gender clinics defend the 'Real Life Test' as an essential and beneficial requirement before obtaining permission to access medical resources. Yet the suffering this requirement causes many disenfranchised individuals challenges the ethics of such an assertion.

When speaking with counsellors whose support for the current gatekeeping system and restrictive ‘Standards of Care’ stems from claims by trans presenters that these systems were helpful and necessary in their own gender affirmation journeys, I am quick to enquire about the backgrounds of these educators. With few exceptions, people with affirmed gender identities who support the current system have ‘passing privilege’, come from dominant cultural backgrounds, are above poverty level, are citizens by birth rather than immigrants, and/or do not have physical disabilities that would hinder travel to counselling appointments. Among these apologists, those who are employed at gender clinics and other gatekeeping institutions have a clear conflict of interest in the related debate, as their continued employment depends upon their willingness to abide by workplace policies. It seems disingenuous to use the existence of a few privileged trans individuals who defend and promote the current system as proof that the ‘Real Life Test’, specifically, and gatekeeping, generally, are beneficial and ethical, when the system continues to fail the most vulnerable among us. The therapist who wishes to avoid becoming an inadvertent oppressor should fearlessly interrogate *hir*¹³/her/his relative resistance and compliance to gatekeeping within the scope of *hir*/her/his professional practise.

Don’t Drink the Alphabet Soup

The popular acronym ‘LGBT’ (lesbian, gay, bisexual, and transgender) conflates gender identity with sexual orientation and in so doing obscures LGB complicity in widespread discrimination and exclusion against people of trans experience.¹⁴ The term ‘queer’ is often used

¹³ A ‘third gender’ possessive pronoun preferred by some genderqueer and non-binary-gendered individuals.

¹⁴ While some cultures and gender identities (i.e., kathoey in Thailand, kinnar in India, and Two-Spirit in North America) have historically integrated notions of sexual orientation and gender identity, the concept of ‘LGBT communities’ that is now internationally known and used in multiple languages has its roots in the emergent identity politics of mid-1960s civil rights struggles that informed AIDS activism in the wake of the 1980s HIV epidemic (p 24, Grover, 1991).

interchangeably with 'LGBT' in counselling and outreach work, despite its divergent possible meanings. The uncritical inclusion of 'trans' in the 'LGBT' or 'queer' community umbrella masks the inequities faced by people with affirmed genders in 'LGBT' environments.¹⁵

Eric, an affirmed gay man who had donated hundreds of volunteer hours to a local queer organisation, expressed dismay when several fellow members of the organisation consistently mispronounced him at public venues. When Eric began passing as a man after several months on testosterone, he became increasingly frustrated with the inability of fellow volunteers to respect his affirmed name and gender pronouns. After several events hosted by this organisation during which his assigned gender was disclosed without his consent, Eric left the group and sought other social environments in the general community, where few people knew his history.

Negative experiences like those that Eric shared with me are regrettably commonplace in ostensibly LGBT environments. A shy affirmed woman in her mid-forties who had lived in her assigned gender until her recent birthday, Molly spent several weeks selecting an outfit to wear for her first time wearing clothing that matched her style. Molly selected tailored blue jeans and a royal blue cardigan that accentuated her warm blue eyes. She pulled her hair into an elegant bun and added a hint of clear lip gloss. The style suited her modest personality and those of us from the support group who had chosen to accompany her to the café on this momentous occasion basked in the glow of her happiness as she began to relax and enjoy the evening. Shortly after she arrived, the evening took a decidedly unpleasant turn when several gay men from a local LGBT group arrived in drag and began taunting her for not looking 'feminine' enough. They insulted her hair, her outfit, and her lack of makeup before walking away to accost someone else. Frequent reports of equally hostile and ignorant behaviour against people with affirmed gender identities in nominally queer environments are of particular concern to me given

¹⁵ See Weiss, 2004, for a discussion of this phenomenon in the US.

the widespread tendency for social service agencies to refer individuals of trans experience to queer organisations with the assumption that these organisations are poised to meet their needs.

Affirmed men who identify as gay and affirmed women who identify as lesbian often face derision or disrespect in ‘LGB’ environments; some lesbian and gay ‘community’ events even bar trans participants from attendance. In addition, many of our constituents identified as straight or heterosexual in their affirmed genders. While some of these individuals identified as LGB allies and were regular participants in LGB-themed events, many others expressed reactions of alienation in response to what I term *coercive queering*, the act of automatically lumping people of trans experience into the category ‘queer’ without bothering to investigate accuracy or issues of consent. (This kind of ‘trans as trope’ mentality abounds in queer theory and gender studies.¹⁶)

The aspiration of trans inclusion may prompt an increasing number of organisations to add what many trans activists consider tokenistic mention on their masthead, but the achievement of this goal is rare. As an incoming member of a regional task force that focused on ‘LGBT’, queer and questioning youth issues, I worked collaboratively with service providers to refine measurement tools for assessing ‘LGBT’ awareness in counselling and therapeutic settings. I quickly discovered that our printed materials mentioned ‘transgender’ but omitted any mention of trans-specific prejudice or discrimination. Instead, our materials stated the goal of challenging ‘homophobia’ to improve educational safety for ‘LGBT’ youth. The ‘LGBT inclusion and awareness’ assessment tool designed by the task force did not contain any mention of ‘trans’ aside from the ever-present ‘LGBT’ acronym.

¹⁶ I have frequently attended ‘queer’ and ‘LGBT’ conferences where the only individuals of trans experience in attendance were the presenters, and these were seldom more than one or two individuals among dozens of speakers. Some colleagues of trans experience challenging inaccuracies in gender theories have even been publicly dismissed by gender theorists with assigned gender identities for ‘not knowing enough about it’!

Some aspects of the assessment tool reflected awkward attempts to take language and concepts popular in sexual orientation contexts and graft a letter 'T' onto them. The youth survey questionnaire contained the item 'have you been discriminated against for your LGBT sexuality?' inviting the question of why trans was being considered a 'sexuality' rather than a gender identity, gender expression, or process of gender affirmation. The architects of this document had also not considered the difficulty that a gay, lesbian, or bisexual respondent who was also of trans experience might face when answering this unintentionally convoluted question. Survey questionnaire items that dealt with 'coming out' demonstrated a similar lack of consideration for conceptual fit that made the 'T' seem even more haphazardly plastered onto the acronym.

The question 'to whom are you out about your sexual identity?' may have appeared straightforward to the authors. However, even if we overlook the fact that many trans individuals would bristle at having their gender assignment history considered a 'sexual identity', how would someone with an affirmed gender identity be expected to interpret the intent of this question? To whom are you known as your affirmed gender? Who knows that your affirmed gender is not the same one you were previously assigned? 'Do you have images of LGBT reading materials clearly visible in your clinic waiting room?' one item asked. Usage of the acronym meant that clinics were able to respond affirmatively and rate as welcoming without necessarily having any trans-related material. The unexamined assumption evident from the wording of this question was that LGB inclusion automatically implies trans inclusion despite the fact that many of our service requests were from trans individuals who felt they had received unequal treatment at agencies with reputations for satisfying gay, lesbian, or bisexual services users with assigned gender identities.

This Alphabet Soup approach is prevalent in psychological research to such an extent that several task force therapists seeking statistics on trans youth had difficulty locating studies that even bothered to delineate trans from LGB and many of the citations they found used the four letter acronym despite their failure to include a single trans participant. In such a climate of erasure and invisibility, how can task forces and governmental bodies hope to develop policies that address the needs of trans youth adequately? The attainment of trans awareness and inclusion requires far more finesse than that evinced by a crude ‘cut and paste’ mentality.

Some nominally LGBT organisations attempt to remedy trans exclusion and ignorance by appointing people of trans experience to leadership positions. While integrating people with affirmed gender identities into management structures is an essential step toward the achievement of genuine inclusion, the logic behind this tokenistic manoeuvre configures an imagined and homogeneous ‘Trans Community’. Predictably, these purported leaders are rarely selected from among the most disenfranchised and often gain acclaim in queer circles while simultaneously garnering negative reputations in trans only social networks for their complicity in the oppression of those whose backgrounds differ from their own. These externally or self-appointed authorities can become apologists for the gatekeeping system and for systemic inequities faced by less institutionally privileged trans individuals.

A trans educator who attended a town hall style meeting at a health conference with prominent providers was appalled by the efforts of several ‘trans leaders’ to impose restrictions against people under 18 seeking hormone blockers and hormone therapy. None of these purported trans leaders was a licensed medical provider or endocrinologist, yet their input might have contributed to increasing rather than decreasing access barriers for youth. These ‘trans leaders’ had not questioned their assigned gender identities prior to adulthood; they lacked

personal experience with the intimate and constant violation of a puberty that clashed with their kinaesthetic identities.

If the Alphabet Soup approach is an ineffective and precarious method of challenging trans exclusion, counsellors may well ask which options exist for reducing exclusion and increasing awareness. The answer is that inclusion requires input from a multiplicity of perspectives, particularly from those whose extent of marginalisation precludes leadership roles. In specific instances, there may be strategic advantages to collective activism that integrates G, L, and B with T, while in other instances a kind of dilution effect seems to occur. For example, numerous ‘LGBT’ educators with limited presentation time choose to tack on cursory and superficial mention of ‘T’ in the concluding five to ten minutes of a one hour presentation slot, rather than integrate substantive trans-related material throughout their presentations.

Organisations that include the ‘T’ should recognise that doing so is likely to increase the difficulty that current and future trans-led, trans-focused initiatives will face in securing funding, as LGB-based organisations tend to be more well-established, less politically controversial, and more palatable to mainstream donors. While many of the local organisations that focused on gay and lesbian concerns were able to gain funding for office space, their addition of the ‘T’ meant that Lifelines had difficulty securing local funding. During our efforts to secure financial assistance, my volunteers and I repeatedly heard from potential funders that other organisations ‘had it covered’ when it came to trans-related work, one negative consequence of the current trend for ‘gay, lesbian, and bisexual’ (GLB) organisations to add what many consider a tokenistic ‘T’ to their acronym. Unfortunately, these were also the same organisations that called us in—usually without paying us—to help them even begin to learn how to address the needs of their trans clients. Even in the provision of services, Lifelines staff and volunteers felt the

disenfranchisement on an organisational level to which those of us with affirmed gender identities are subjected in our daily lives.

Beyond Cisgenderism

I have chosen to conclude rather than commence with a discussion of cisgenderism—and what it means for counselling psychology to move beyond it—because cisgenderist privilege and passing privilege typically render cisgenderism elusive in the absence of the concrete examples provided in this chapter. To restate the definition provided at the beginning of this chapter, my working definition classifies cisgenderism as the individual, social, or institutional attitudes, policies, and practises that assume people with non-assigned gender identities are inferior, 'unnatural' or disordered and which construct people with non-assigned gender identities as 'the effect to be explained'¹⁷. The 'everyday cisgenderism' encountered by Lifelines service users reflects a broader 'systemic cisgenderism'. Institutional and social systems are designed with the expectation that people needing to access them will match their assigned genders, and therefore provide services less effectively for people of trans experience. When we view psychotherapeutic and counselling practise through the lens of cisgenderism, questions emerge that allow us to challenge our beliefs and change our professional practice to bring it in line with our social justice values.

Far too often, counsellors and activists alike depict 'Trans People' as a cohesive demographic group, an 'Other' species that occupies a distinct social class and genus¹⁸; this portrayal condenses individual variations into oversimplified, formulaic notions that bear little

¹⁷ Hegarty and Pratto, 2001.

¹⁸ The ideological assumption that people with non-assigned gender identities constitute a distinct class of person or homogeneous 'community' may be a form of Othering used to maintain or justify institutional cisgenderism, a strategic activist response to cisgenderism, or a form of internalised cisgenderism among people with non-assigned gender identities.

resemblance to the lived experiences of thousands of individuals, morphing them into a conceptually cohesive theoretical unit presumed to share membership in some secret and mysterious ‘community’. The assumption of ‘community’ among disenfranchised groups affects our ability to meet people’s needs, since this generalised terminology swallows individual identities, as Jan Zita Grover explains:

Whether used by spokespersons for (the gay community) or by its enemies, the people characterised as the *gay/homosexual community* are too diverse politically, economically, demographically to be described meaningfully by such a term. (One only has to attempt its opposite, *the heterosexual community*...for the full absurdity of the term to become clear...)...the great diversity of humankind is reduced by means of the term to a single stereotype. (Grover, p. 24)

Grover’s astute observation about ‘the gay community’ compels us to cease thinking and speaking of people with affirmed gender identities as a ‘community’ for similar reasons. While clusters of ‘trans activists’ in some regions may constitute a community, the vast majority of clients with affirmed genders are likely to fall outside this demographic. When we begin thinking of clients with non-assigned genders as individuals rather than as part of a homogeneous group, important questions will organically emerge from this realisation.

Consider the psychotherapeutic implications of cisgenderist language. Terms popular even among people of trans experience reinforce cisgenderist assumptions. For example, the term ‘FTM’, an acronym for ‘female-to-male’, reifies biological designations, placing a bureaucratic category as a salient element of identity and denies unqualified inclusion in an affirmed gender. ‘Bioguy’, a word used for assigned rather than affirmed men, contains the subtle implication that affirmed men are less authentically male due to a perceived lack of physical authenticity as male. The term ‘gender variant’ is problematic, because it assumes a social norm and vantage point from which to measure such variance: ‘Variant’ from *what* and

according to *whom*? Even the term ‘trans’, used reluctantly throughout this chapter, is a norm-referencing descriptor that configures people with affirmed gender identities as ‘the effect to be explained’¹⁹. While I have used ‘affirmed man’ and ‘affirmed woman’ for clarity, the need for the qualifier signifies the current climate of cisgenderism.

Notions of biology are inextricably bound up in concepts of gender identity in the field of psychology. Consider the current usage of ‘gender’ to refer to gender assignments, while the qualified term ‘gender *identity*’ is used to refer to the subjective sense of gender held by individuals. This usage reflects the ultimate subjugation of self-designated genders to the authoritative force of external gender designations in normative counselling ideologies. I have intentionally avoided discussing ‘sex’ because ‘biological’ sex designations involve taking a limited number of hundreds of biological dimensions, constructing two profiles based on these dimensions, and labelling the profiles ‘male’ and ‘female’; the dominance of this taxonomy persists, despite extensive medical evidence documenting that many existing biological profiles do not fit neatly into either of these binary categories.²⁰

In her critique of how academic psychologists’ treatment of ‘sex’ as ‘an ahistorical, pretheoretical notion’ negates understandings of gender-associated embodiment and gender identities outside the binary, Mary Brown Parlee notes that trans activists ‘have found it necessary to move beyond such bedrock concepts of common-sense and scientific discourses as ‘woman’, ‘man’, ‘female’, ‘male’... simply in order to take into account the empirical variety of

¹⁹ See Hegarty and Pratto 2001 for an explanation of norms and ‘the effect to be explained’.

²⁰ See MacKenzie, Huntington, and Gilmour, 2009, for one recent exploration of exclusion and forced normalisation of individuals who do not fit a ‘male’ or ‘female’ biological profile; while this study was limited to only a few participants, the authors provide useful historical background and raise important practical concerns, without constructing human biological variation as inherently pathological.

actual persons' embodied subjectivities.²¹ While Parlee's point may seem overly technical and unrelated to psychotherapy, it has relevance for counselling practise. Just as many people are born with biological profiles that do not neatly match 'male' or 'female', many people's gender identities do not graft onto their kinaesthetic identities in a normative manner. Take the example of Charlotte Karlsdotter, a Swedish affirmed woman with a beard who has been denied approval for surgery to give her a vagina²² based on cisgenderist concepts about 'woman', 'man', 'female', and 'male'. While history contains numerous examples of bearded women, Charlotte has been discriminated against by providers who refused to consider the legitimacy of her embodied gender expression. Moving beyond cisgenderism in psychotherapeutic responses to Charlotte and others who transcend the bounds of scientific discourse means recognising their equal right to hormones and surgery for gender identity actualisation, thereby challenging the normativity project in which many 'gender specialists' are engaged. Confronting cisgenderism means asking our colleagues aloud why intersex babies' genitals are still being surgically altered at birth far below the age of informed consent, while women like Charlotte are routinely denied these surgeries.

Transcending cisgenderism means asking tough questions and initiating swift action, rather than becoming mired in theoretical discussions that exclude practical applications or evaluating policies without first having re-evaluated their problematic underlying conceptual frameworks. The terms that I have used are expendable; the critical enquiry behind them is not. Words like 'trans' and 'gender identity actualisation' are temporary placeholders to be replaced

²¹ Parlee, 1996.

²² Volcano and Dahl, 2008.

with newer concepts in the process of moving beyond 'cisgenderism'—another placeholder. For these reasons, instead of recommended reading, the endemic cisgenderism in psychology suggests that counsellors might be better served by recommended *thinking*, by seeking out new sources of knowledge production and new ways of viewing the world.

Challenging cisgenderism means more than being willing to switch pronouns depending upon whether you are alone with your client or addressing them in front of others, if they wish to keep their gender identity private. Moving beyond cisgenderism means more than merely providing clients with safe spaces to change and dress in clothing that reflects their gender identities. In the UK, eliminating the current requirement that service users seeking approval for hormones and surgery from Charing Cross Gender Clinic in London must 'dress in role' at clinical sessions would be a promising development for individuals facing Danielle's challenges; yet this improvement would do little to help those like Charlotte Karlsdotter, whose ability to give informed consent would remain subjugated to normativity under current clinic policies.

Transcending cisgenderism involves recognising the counsellor's ethical responsibility to challenge injustice, the 'activism as therapy' approach advocated by therapist-activist Rupert Raj (Raj 2007). This 'therapeutic activism' is not a substitute for other forms of therapeutic services, but a complementary technique which frees space for therapists to address topics best suited to the therapeutic environment, including the creation of safe contexts for exploring the potential impact of medical and social gender affirmation decisions on employment, romantic relationships, parenting and child custody, and other major life domains. As many community

psychologists have long argued, providing beneficial services to meet people's mental health needs is impossible unless their societal oppressions are confronted directly by clinicians.

In her recommendations for revisions to the 2001 WPATH SOC, therapist Arlene Istar Lev (2009) offers a responsible and humane approach to counselling people with non-assigned gender identities. Some elements of Lev's (2009) recommendations that seem particularly worthwhile are her explicit acknowledgement of the potential harm caused by mental health provider gatekeeping; her recognition of the need to develop harm-reduction approaches 'to assist marginalized populations in gaining access to trans-specific and general medical needs, regardless of whether they have been previously assessed using the SOC' (Lev, Table 1, p 82); and her recommendation to 'remove the necessity to diagnose utilizing the DSM...' , asserting that 'referral for medical services should not rely on meeting the diagnostic criteria of GID...' (Lev, Table 1, p 82).

Lev contends:

...The educated and informed transgender or transsexual client who is not suffering from mental illness or addiction, and is relatively stable socially and vocationally, and who has the support of loved ones, should be able to undergo a psychosocial assessment and referral process within a few sessions, typically between two and six hour-long appointments... (Lev, p. 80)

While the revisions proposed by Lev would constitute a vast improvement to existing WPATH/HBIGDA SOC, these proposed criteria would still favour college-educated, financially secure clients with dominant culture ethnic and religious affiliations.

Lev follows this recommendation with a thoughtful discussion of the support counsellors should offer to individuals who do not meet the criteria excerpted above, such as those who have

lost jobs or loved ones due to economic recession or disclosure of non-assigned gender identities; those with pre-existing mental health and self-harm issues unrelated to ‘trans status’; or those who have developed psychiatric symptoms or addiction in response to past trauma or anti-trans brutality. When considering these support needs, it is vital for therapists to remember that denial of hormones and surgery often translates into denial of passing privilege; in the context of widespread employment discrimination and harassment of trans individuals in academic settings, failure to pass creates insurmountable barriers to vocational and financial stability for many individuals. For these reasons, while stability and sufficiency are clearly desirable for those in the midst of gender affirmation, requiring individuals to achieve vocational and financial stability prior to acquiring hormones may place them in an untenable predicament.

While some therapists routinely deny hormones to sexual abuse survivors who have not ‘worked through their issues’ beforehand, many Lifelines constituents like Jason found that they were unable to begin addressing their past trauma and truly thrive until they were liberated from the triggering and traumatic daily experience of existing in their bodies. Indeed, few among hundreds of Lifelines constituents met all of Lev’s (2009) criteria, and many showed clear signs of relief from existing psychiatric symptoms and distress within weeks of starting hormones or acquiring surgery. It is axiomatic among trauma recovery professionals that genuine healing typically begins only after survivors are removed from abusive environments. The positive results of our constituents strongly suggest that the long-term process of trauma recovery may be aided significantly by providing hormones to some individuals, given that relief from the acute

oppression of unwanted menstruation or beard growth may free emotional energy for vital recovery work.

While many Lifelines constituents who acquired hormones did not meet Lev's criteria, they did receive information about the medical and psychosocial risks and benefits of hormones from their medical providers sufficient to constitute 'informed consent' and those fortunate enough to have supportive therapists also discussed issues of disclosure management and social support with these therapists. Therefore, educational barriers and lack of family support may be issues for therapeutic discussion at the same time that acute needs for hormones or surgery are met, rather than automatic disqualifiers. When individuals share living space, parenting duties, or legal relationships like marriage or civil partnership, issues of disclosure become more complex and some interpretations of professional ethics may require client disclosure to spouses or parents; however, it is important to note that any ethical requirement for disclosure and spousal agreement should not be greater in this situation than in equivalent medical situations with major, irreversible consequences, as in the case of pregnancy or bariatric surgery.

Lev's (2009) assertion that clients may present with genuine mental health concerns unrelated to gender identity is an important one. Merely handing vulnerable clients a prescription for hormones out of a misguided notion that this 'magic bullet' will 'cure' their problems can be irresponsible and disastrous. The urgent need for hormones articulated by many clients must be accompanied by assistance that addresses their basic need for social support; subsistence level food and housing; freedom from domestic, workplace and public harassment and abuse; and opportunities for spiritual, intellectual, and creative growth. While several

primary care providers from local community health clinics noted drastic reductions in psychiatric symptoms merely from the administration of hormones, independent of any other ‘therapeutic’ interventions (as occurred for both Jason and Judah), trans individuals often face greater risks of trauma-related concerns than those without the severe daily stress and abuse commonly reported by these individuals²³. In many cases, assistance with acquiring hormones is insufficient to promote mental wellbeing in the absence of therapeutic support that addresses existing mental health concerns or the gender affirmation process itself- an ordeal that even those with substantial privilege and social resources often find daunting. Therefore, ethical practise requires therapists to explore which concerns are influenced by systemic inequities and therefore subject to improvement through activism, and which are best addressed through other therapeutic modalities; however, sometimes clients are the best judges of which modalities will work for them and therapy is not necessary or helpful for all individuals.

A therapist with an extensive background as an advocate on behalf of trans individuals, Lev’s (2009) recommended revisions nevertheless fall within the scope of existing diagnostic frameworks rather than transcending the diagnostic lens. In an earlier piece, Lev herself raises ethical and practical concerns about the limitations of this lens:

The utilization of GID to confer eligibility for gender variant people who need medical treatments serves as a confirmation that transsexual and transgender people are suffering from disorder and dysfunction and invites questions about the ability of the DSM to distinguish between mental illness and social non-conformity. If the person does not exhibit distress or dysfunction, are they therefore ineligible for treatments they are requesting? If the person exhibits significant distress and dysfunction are they then too unstable to receive treatment? What are the ethical implications of labeling gender variant people who are mentally sound with a psychiatric diagnosis to justify their receiving medical treatments?

²³ For an examination of trauma among individuals with non-assigned gender identities, see Lev, 2004.

Can a diagnosis of a mental illness do anything but set the stage for protocols designed to repair a dysfunction? (Lev, p 57)

These dilemmas and those addressed by Lev's (2009) recommendations exemplify the thorny issues encountered by therapists thrust into the role of gatekeepers. Given Lev's explicit caution regarding the tremendous damage therapists can cause through service delay or denial, coupled with the need for prudent deliberation to avoid the potential liability of licentiousness, one may question whether it is appropriate or ethical to place therapists in this vulnerable position with even more vulnerable clients.

Lev offers one possible solution to this dilemma within existing diagnostic frameworks:

An additional suggestion is to remove GID from the psychiatric nosology and use the already extant diagnosis of Transsexualism—described in the International Classification of Diseases, Tenth Edition (ICD-10), an Axis III medical condition—for medical treatments and reimbursement.

The ICD diagnostic criteria would need to be revised and updated since they are based in a narrow view of transsexualism, but utilizing a diagnosis from a manual of physical ailments would validate the need for medical treatment without inferring a mental health diagnosis. Thus, gender transition would be an insurance reimbursable medical condition similar to pregnancy. Any mental health issues would be noted on Axis I or II as they would for any other psychological disorder, without mentioning the gender issues per se. A black person with an anxiety disorder does not receive a racially identifying diagnosis, nor does a gay man with alcoholism receive a diagnosis highlighting his sexual orientation. This is not to say that race or sexual orientation do not impact anxiety or alcoholism, or even in some cases explain or justify these symptoms; it is not, however, part of the diagnostic label. (Lev, p 59)

While Lev's suggestion is a viable solution that would drastically reduce pathologising of trans individuals and which is certainly among the most enlightened views within the diagnostic lens, her mention of pregnancy raises questions about the extent to which counsellors should be involved in assessment and evaluation of trans individuals when people seeking equally

‘irreversible medical procedures’ (e.g. surgical abortion, bariatric surgery, or designer labioplasty) with predictable psychosocial impact are not held to an equal standard of engagement with therapeutic counselling. To what extent does the assumption that service users seeking hormones and surgeries need therapeutic screening at all construct people of trans experience as a distinct class of person with diminished capacity for informed consent? How might counsellors react differently to assessment procedures that regulate medical access of other historically marginalised populations (e.g. women or indigenous populations) whose systemic oppression is addressed in an increasing number of counsellor training programmes?

Counsellors who balk at the notion that women seeking surgical abortions should be required to undergo pre-surgical counselling to ‘make sure they are making the right decision’ and ‘really know what they want’ (popular phrasings used by many self-styled ‘gender specialists’), viewing the imposition of mental health assessment in the absence of overt psychiatric symptoms as a form of benevolent sexism²⁴, seem hesitant to apply this discrimination lens to the treatment of trans individuals seeking hormones or surgery. Does the pervasive silence about paternalistic cisgenderism in normative counselling ideologies account for this discrepancy?

In her concluding remarks, Lev (2009) laments the current ‘dearth of scientific evidence backing up much of the current SOC’ (p 95), stressing the need for ‘evidence-based research’ (ibid) and ‘SOC...with substantial guidance in the treatment of complex clinical cases’ (p 82) including expanded discussion on ‘issues related to assessment, treatment, and comorbid mental health issues.’ (ibid) Yet the potential benefits of ‘evidence-based research’ are mediated by the manner in which the evidence is collected, the assumptions underlying the research

²⁴ See Moya, Glick, Expósito, de Lemus, and Hart, 2007, for a study of protective paternalism and the role of benevolent sexism in women’s acceptance of protectively-justified restrictions.

methodology, and the ideological lens through which the research questions are formulated. Given the institutional cisgenderism endemic to normative counselling ideologies, 'evidence' that transcends the limitation of disciplinary prejudices and offers new insights to challenge pathologising or paternalistic views may prove elusive. Guidance regarding clinical treatment of complex cases may impose further rigidity on a system that already seems insular, rigid, and unresponsive to many service users. The ostensible neutrality of the term 'assessment' is counteracted by its linkage with 'treatment' and 'comorbidity' both terms that denote an underlying pathology or disorder; Lev's apparent objectives, to reduce pathologising of trans individuals solely on the basis of their non-assigned gender identities and to normalise trans experiences, are thwarted by the conflicting implications of these terms.

If one accepts the notion that therapists have a potentially appropriate function in the assessment process at all- that individuals of trans experience seeking medical resources should not be presumed mentally competent until proven otherwise (as is typically the case with individuals whose identities and expressions are socially normative) - one must grapple with the question of which training these therapists would require to provide helpful services. Curricula developed by those responsible for pathologising people with non-assigned gender identities may facilitate a decline in provider awareness, rather than serving its intended purpose. The 'substantial guidance' that Lev contends therapists desperately need is most likely to emerge when clients perceive themselves encouraged to give critical feedback to therapists and SOC-authoring bodies, without fear of retaliation or the expectation that their contributions will be dismissed. My work at Lifelines permitted me to engage in these kinds of dialogues with clinics and therapists and to ensure that our constituents felt comfortable contributing their experiences to training curricula. Yet I frequently hear from service users at Charing Cross Gender Clinic

and other ‘gender specialist’ settings that they are too concerned about service denial or negative repercussions to launch formal complaints. As long as professional guidance remains disconnected from this essential client feedback on the outcomes of its application, training programmes will fail to provide meaningful insights for mental health clinicians.

A local counsellor of trans experience who was held in high regard by many of our support group participants told me that the most valuable insight she gained from her professional training was the view of therapy as ‘a form of social justice activism that empowers disenfranchised people to tell their own stories rather than having others speak for them.’ The ‘telling’ may take the form of words, while others may ‘speak’ through activism, dance, or various forms of radical theatre that enable individuals of all literacy levels to share and transcend oppression.²⁵ To reach beyond cisgenderism, we must move beyond the confines of the counselling session into the institutions and professional associations within which we practise, and gain an intimate understanding of the systems that impact our clients’ lives. In addition to offering new ‘transpositive’ therapeutic models like the aforementioned approaches by Raj (2007) and Vanderburgh (2009) (both experienced therapists with non-assigned gender identities), Lev’s (2004) narrative approach, or Fraser’s (2009) depth psychotherapy practise, counsellors should examine the culturally-specific assumptions of the 50-minute talk therapy model and be willing to offer non-verbal or solitary formats (i.e. meditation or home yoga) that match client needs.

Many experiences were omitted from this piece. These tableaux are intended to provide only rudimentary foundations for transcending cisgenderism. If these abridged portraits have demonstrated the nuances and intricacy of providing counselling that both challenges

²⁵ For information about the usage of theatre as a therapeutic modality and/or as a form of client empowerment, see Boal, 1995, and other work by Augusto Boal.

cisgenderism and transcends it; if you are motivated to confront cherished professional convictions and to interrogate your clinical judgements rather than to adhere perfunctorily to guidelines that promote normativity; if you are moved to critically evaluate the unexamined assumptions that underlie your counselling ideology, then I urge you to join the small but dedicated ranks of your fellow counsellors who are dedicated to advancing the psychological wellbeing, autonomy, and equal rights of people with non-assigned gender identities.

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