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### Translating the Sex and Gender Continuums in Mental Health: A Transfeminist Approach to Client and Clinician Fears

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## **Translating the Sex and Gender Continuums in Mental Health: A Transfeminist Approach to Client and Clinician Fears**

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*This paper expounds on the training developed for the GLAP Trans Symposium by Shannon Sennott and Tones Smith. This article addresses the stigmatization and pathologization of trans- and gender-nonconforming people by medical providers and therapists (Sennott, 2011). It is intended to aid in the development of personal best practices for clinicians who work with trans- and gender-nonconforming individuals. The authors introduce the transfeminist therapeutic approach, the Identity Continuums, the Transfeminist Qualitative Assessment Tool (TQAT) (Sennott, 2011), and the Allyship Practice Model (APM) (Sennott, 2011). The article explores countertransference, fears, and concerns of clinicians who provide physical and mental health services to differently gendered people. It also examines transphobia, misogyny, and homophobia, which can create barriers in a therapeutic relationship.*

**KEYWORDS** *transfeminist therapeutic approach, transfeminist qualitative assessment tool, identity continuums, allyship practice model, transgender, translate gender*

### **INTRODUCTION**

The training developed by Shannon Sennott and Tones Smith for the 2010 GLAP Trans Symposium, entitled “Translating the Gender and Sex Continuums in Mental Health: A Transfeminist Approach to Client and Clinician

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Fears,” was created in response to the stigmatization and pathologization of trans- and gender-nonconforming people by their medical providers and therapists throughout their course of physical and therapeutic treatments (Sennott, 2011). The training content is based on Shannon Sennott’s article “Gender Disorder as Gender Oppression: A Transfeminist Approach to Rethinking the Pathologization of Gender Non-Conformity” (Sennott, 2011).

This workshop explored the relationship between mental health professionals and gender-nonconforming clients, with the goal that participants develop personal best practices for working therapeutically and medically with trans- and gender-nonconforming individuals. To aid workshop participants in the development of personal best practices, they are introduced to the transfeminist therapeutic approach (Sennott, 2011), the Identity Continuums (Translate Gender, 2009), the Transfeminist Qualitative Assessment Tool (TQAT) (Sennott, 2011), and the Allyship Practice Model (APM) (Sennott, 2011). The client and clinician fears training utilizes experiential group exercises to explore countertransference, fears, and concerns of clinicians providing physical and mental health services to trans- and gender-nonconforming individuals, as well as to examine transphobia, misogyny, and homophobia that can create barriers in a therapeutic relationship. This workshop is structured to help health care professionals understand some fears that a gender-nonconforming client may have when entering a therapeutic setting. Self-identification and self-determination of gender are emphasized, with a focus on the creation of supportive communities and environments to best serve the needs of gender-nonconforming clients.

## TRANSLATING THE SEX AND GENDER CONTINUUMS

### Translate Gender, Inc., and the Inclusion Initiative

The distressing increase in gender discrimination within women’s college communities prompted the initial founding of the nonprofit called Translate Gender, Inc. Translate Gender is an advocacy and education organization that provides training and support to address the specific concerns of trans- and gender-nonconforming individuals. Currently, Translate Gender offers a particular focus on gender concerns within intentional women’s spaces, women’s college communities, and physical and mental health agencies through a program called the Inclusion Initiative. The Inclusion Initiative offers consultation, workshops, trainings, resources, and mediation to aid communities to be more accountable to individuals regardless of their gender identities and expressions. Most recently, Translate Gender contracted with Bryn Mawr College for a three-year community collaboration committed to working toward the full inclusion of gender-nonconforming individuals

on its campus. As part of the work with Bryn Mawr, Translate Gender collective members have designed a multilevel awareness and advocacy training for administrators, faculty, staff, and therapists on women's college campuses that specifically addresses the mental health issues of gender-nonconforming individuals and students.

Translate Gender (Translate) is a collective-based, consensus-run non-profit that works to generate community accountability for individuals to determine their own gender and gender expression. Their work is based upon the principles of self-determination and informed consent and recognizes the unique role that medical and mental health providers have in the lives of trans- and gender-nonconforming individuals. Translate's Inclusion Initiative not only works to educate medical and mental health providers around trans- and gender-nonconforming identities and issues but also acknowledges the need for a broader education and examination of medical and mental health providers own biases, assumptions, and practices when working with trans- and gender-nonconforming individuals.

Translate uses the term *gender-nonconforming* to describe the self-identification of a spectrum of individuals. This term illuminates the sociopolitical position of *conforming* to the gender binary and highlights the concept that "*all* people are oppressed by the socially sanctioned and imposed requirement to fit into one category or the other, not just those who are differently gendered" (Sennott, 2011). The term includes a spectrum of differently gendered people while acknowledging that not every person who is differently gendered identifies as trans, transgender, or transsexual, and not every trans, transgender, or transsexual person identifies as differently gendered.

Translate Gender's collective membership includes psychotherapists who are also gender justice activists and are faced with the unique challenge of using and promoting language and therapeutic approaches that are nonpathologizing to differently gendered individuals. Over the last two decades, language which developed to describe trans lived experiences has found its roots in a medically constructed discourse "that can be limiting and categorical at best, and pathologizing and emotionally violent in the wors[t] cases" (Sennott, 2011). Mental and physical health providers might label a gender-nonconforming person as having gender identity disorder (GID); however, a more sophisticated awareness of gender nonconformity acknowledges that within the continuum of nonconformity are an infinite number of identities ranging from more feminine to more masculine. Furthermore, one's identity can only be named by the person claiming the identity. It is critical to clinical competency with gender-nonconforming clients that therapists and providers have an awareness of their own use of institutionalized language regarding gender difference and that they understand the notions of socially constructed binaries within sex, gender identity, gender expression/impression, and sexuality.

## The Translate Gender Identity Continuums

The client and clinician fears training for therapists and providers begins with the introduction of the tool created by Translate Gender called the Identity Continuums (Figure 1).

This tool is designed to help participants understand the differences between designated sex, gender identity, gender expression/impression, and sexuality/sexual practices. We believe that awareness of these differences is fundamental for culturally competent providers working with trans- and gender-nonconforming individuals (Sennott, 2011; Translate Gender, 2010). More importantly, this tool allows participants to consider *themselves* in relation to their own gender expression and gender identity.

Translate Gender posits that the most effective way to combat oppression, transphobia, and other micro-aggressions in the therapeutic relationship is to have intimate and thorough knowledge of one's own gender identity, gender expression, and sexuality in relation to the identity continuum (Sennott, 2008; Sennott, 2011; Translate Gender, 2010). The more comfortable clinicians are with themselves, the less likely they are to be bothered by

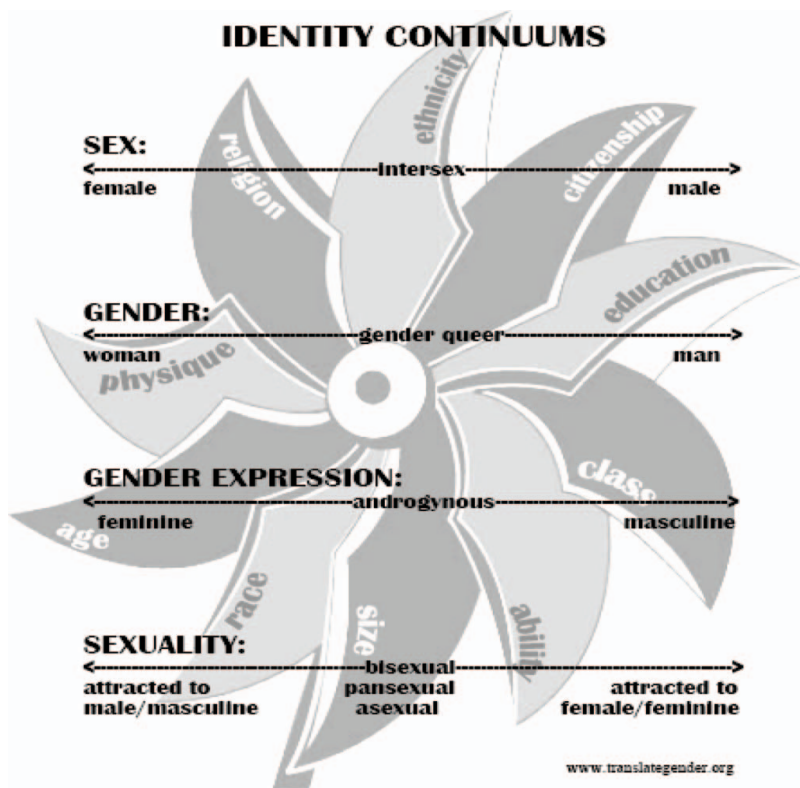


FIGURE 1 Identity continuums.

dissimilar expressions of gender or sexuality in others. Many gender-conforming therapists have never been asked to consider their gender and gender expression because their gender identity is socially assumed and therefore invisible. Translate encourages gender-conforming therapists to conceptualize themselves on these various continuums by examining their own expressions and impressions of femininity and/or masculinity. This in-depth assessment of oneself helps a provider realize that other people's gender identities are also self-identified and self-determined and that a therapist's role is not to name or legitimize a client's gender identity (Sennott, 2011; Istar Lev & Sennott, 2011, Translate Gender, 2010).

In Translate's Identity Continuums tool (Figure 1) the first identity is the *designated sex* continuum. The understanding that designated sex is a socially constructed binary is critical to the process of building therapeutic awareness with differently gendered clients (Sennott, 2011). At birth, an infant is assigned a sex of either male or female based on the deliverer's visual assessment of the baby's genital presentation. More than 40 different intersex conditions exist, but only seven are visible to the naked eye. The remaining three-fourths of intersex conditions are determinable only through genetic, chromosomal, and hormonal testing (Intersex Society of North America, 2010). Statistically, this means that up to three-fourths of infants born with differently sexed bodies are forced into the sex binary of male or female, without regard for where they may actually fall on the designated sex *continuum*. Having a clinical awareness of the vast continuum of sexed bodies is fundamental to understanding the conflation of the socio-politically constructed sex and gender binaries (Translate Gender, 2010).

Next on the Identity Continuums tool is the *gender continuum*. Gender is separate and distinct from designated sex at birth in that gender is not assigned from an outside force or agent but can only be felt and expressed by oneself. In the client and clinician fears training we introduce gender as being characterized as a mental or emotional state; therefore, there is no "real" or "true" gender but only the gender we experience ourselves to have. No one can tell another person what his or her gender is; only an individual can know this. We advise clinicians to consistently recognize that when clients state their gender identity there should be no argument, no question, and no doubt as to whether or not this is the person's "real" gender identity. It is the responsibility and obligation of mental health providers to realize this and recognize that they *do not* hold the responsibility of deciding a person's gender identity. That is for the person to decide and the therapist to mirror and affirm. It is a personal identification, not something that can be assigned, diagnosed or pathologized.

The next continuum is *gender expression*, which is not conceived of as a binary of feminine and masculine but rather lies on a continuum that may shape and shift over the course of one's lifetime. Gender expression is the outward appearance of gender. This is normally conveyed and expressed and

read by others through clothes, mannerisms, speech, expressions, and body language. Gender expression can vary immensely for people, regardless of their gender identity or designated sex at birth. For some people, trans identified or not, gender impression (how one's gender is interpreted by others) can shift from one moment to the next; for instance, someone may be "sir'ed" at the door entering a store and then be "ma'am'ed" by the cashier in the checkout line. For many differently gendered people, careful consideration not only of gender expression but also of gender impression is part of everyday reality and relates to both aesthetic as well as safety concerns.

A trans identified person may dress very differently while traveling or visiting parents than when in more familiar, queer-friendly spaces. This process can be anxiety provoking and unnerving for some due to real concerns around safety, discrimination, violence, and trauma. For those who feel comfortable in fluid gender presentations, it can be a source of joy and expression, as they embrace challenging preconceived notions of gender. For many, it is both: joy of expression of self and painful awareness of the real and lived oppression and trauma that attend non-normative gender expressions and impressions.

Traditionally, societal norms allow us to choose from two gender expressions, masculine and feminine, and these norms expect men to be masculine and women to be feminine. The gender expression binary is restrictive, and the socially sanctioned reinforcement of it oppresses everyone, not just trans- and gender-nonconforming people, by limiting the gender expressions of all people. The diagnosis of GID also tends to reify this binary. GID does not allow for diversity of experience. For example, many transpeople identify as genderqueer or bi-gendered. "The medical approach to our gender identities forces us to rigidly conform ourselves to medical providers' opinions about what "real masculinity" and "real femininity" mean, and to produce narratives of struggle around those identities that mirror the diagnostic criteria of GID" (Spade, 2003, p. 28). GID is the medicalization and pathologization of gender identity and limits the expressions of self and narratives of experience, thereby imposing society's patriarchal and heterosexual norms and values onto transpeople's bodies and lives. What most people view as homophobia in the form of hate crimes perpetrated against LGBTQ people are usually based in some form of gender phobia, that is, that violence and discrimination is based on fear of gender expressions and impressions. After all, one's sexual orientation is not visible but one's gender expression is, making masculine women and feminine men targets of hate crimes.

The final continuum on the Translate Identity Continuums is *sexuality*. An individual's sexuality may change over time and may not be fixed. Sexuality has long been conflated with gender identity and gender expression. A person's sexual orientation and sexual practices, however, are separate from gender identity and expression and may not align with binary expectations.

A clinical awareness of the distinctions between sexuality and gender identity are valuable when working with differently gendered people because there are trans narratives which are mired in medical discourse and are often not an accurate examination of identity. These narratives require the conflation of sexual orientation with gender identity in order to be seen as legitimately trans by health care providers.

We cannot consider the implications of designated sex, gender identity, gender expression/impression, and sexuality without considering the ways in which other aspects of our identity affect our sex, gender, and sexuality. Differences in race, class, size, ability, national origin, religion, first language, and citizenship all play roles in how we may or may not express our gender, how we have come to understand ourselves and our gender roles, and the ways in which our genders are perceived by communities and society. This intersectional approach to mapping identities is crucial in any social justice movement and to the larger understanding of our positions and beliefs in the discourse of gender. By recognizing our social location within our gender identity, we are able to continue conversations concerning how we are affected by issues of privilege and oppression, as well as the ways in which we have been socialized to maintain these privileges and oppressions. For example, a person may be designated female at birth and identify as a woman, but if she is also African-American she may experience her gender and gender impression differently than a person who is designated female at birth, identifies as a woman, and is white. A poor trans person living in the rural South may have a very different experience than a middle-class trans person in a major city in the Northeast. The manners in which we are able to express our gender, as well as the ways in which our communities support or reject us, inform the ways in which trans people, as well as cisgendered people, express their gender.

We encourage clinicians to be careful not to make assumptions, similar to those made by early waves of feminism and, in so doing, neglect the important differences that exist in our gendered selves. Feminism began as a movement for white women with class and economic privilege. Differences concerning class and race were ignored, leaving entire communities of women without a place in feminism. The history of feminism has taught us that there are as many ways to be a woman as there are women. Furthermore, trans rights are women's rights, which are also reproductive justice rights. This is evident in trans people's fight for fair and affirming medical and mental health treatment and the basic right for control and autonomy over their bodies, including access to gender-affirming hormones, surgery, and other gender-affirming treatment. We advocate a transfeminist approach to gender justice that does not privilege the experience of one type of woman over another and that similarly recognizes that there are as many different ways to express gender as there are people. The vast difference in the makeup of our intersecting identities is a critical component of the

conversation around gender and the gender justice movement. Translate Gender emphasizes the importance of recognizing our social location, our privilege, and oppression, and working with this understanding for a more gender-just and socially just world.

## THE TRANSFEMINIST APPROACH TO CLINICAL COMPETENCY

### What Is the Transfeminist Approach?

Creating a commitment to self-reflection and community accountability within the context of the therapeutic relationship is transfeminist consciousness (Sennott, 2011). The transfeminist approach is “an alternative re-conceptualization of feminist theory based on the weaving of feminist thought, social justice frameworks, and principles of allyship” (Sennott, 2011). The principles of this therapeutic approach are a natural evolution in gender-affirming practice with individuals who are gender nonconforming. The foundational principles of the transfeminist approach are:

1. A hierarchy of authentic, lived experience for women does not exist.
2. To privilege one *type* of womanhood or femaleness over another is inherently anti-feminist.
3. No one individual, group, or type of woman can define what it means to *be* a woman.
4. Most trans- and/or gender-nonconforming individuals have had lived experience as a girl or woman and have suffered the direct repercussions of socially condoned misogyny and systemic gender-based oppression.

These four principles are critical to a transfeminist therapeutic approach because they challenge clinicians to acknowledge the matrix of intersecting oppressions that shape the lived experience of all individuals designated female at birth and all people who identify as women (Sennott, 2011).

The transfeminist therapeutic approach assumes that we construct our own gender identity based on what feels authentic, ego-syntonic, and sincere to us as we live and relate to others within given social and cultural constraints. A therapist who adopts the transfeminist approach works to “disassemble the essentialist assumption of the normativity of the sex/gender congruence and acknowledges that those who do not fit neatly into one sex/gender/gender expression category or another can still feel as though they belong inside a gender identity and expression continuum that is not confined within the binary” (Sennott, 2011). The transfeminist approach couples an awareness of the designated sex, gender identity, gender expression, and sexual orientation continuums with consideration of the matrix of intersecting marginalized and privileged identities that an individual also carries. Special attention is paid to these intersecting identities because

they inform the ways in which a person experiences and actualizes gender identity.

The awareness that the gender binary is a sociopolitical construct is founded on the decoding of gender roles and expressions by feminist principles and traditions. However, this decoding of identities, roles, and expressions was still founded on an essentialist perspective that conflates designated sex, gender identity, gender expression, and sexual orientation. The conflation of designated sex and gender can lead to a lack of awareness about one's own gender-*conforming* privilege. Often, trans- and gender-nonconforming individuals within a clinical setting are described as those whose physical sex does not match the gender of the mind or soul: "She's a woman trapped in a man's body." This explanation may make sense intuitively, but only because the sex/gender binary is so assumed that it becomes a privileged invisible identity.

To say that one has a woman's mind or soul trapped in a man's body would presuppose that male and female minds are different from each other in some identifiable way, which in turn may be used to justify discrimination against female-bodied individuals or women. Essentializing a client's gender identity can be just as dangerous as resorting to biological essentialism. This is the identity narrative that a gender-nonconforming person is often forced to adopt in order to be seen as legitimate in the eyes of physical and mental health providers. Similarly, with this binary constraint to one's identity narrative, a gender-nonconforming person is immediately compromised by a pathologizing discourse and rhetoric that does not allow for the development of more subtle, complex, and individualized expressions of gender identity. With a transfeminist consciousness, clinicians have the opportunity to acknowledge the micro-diversities of gender identity and expression because they are able to provide a protective and nurturing environment in which people can explore aspects of themselves and have these manifestations of self-awareness mirrored back to them (Sennott, 2011).

### The Transfeminist Qualitative Assessment Tool and the Allyship Practice Model

To aid therapists in shifting their theoretical lens to a transfeminist approach, Shannon Sennott has created the Transfeminist Qualitative Assessment Tool (TQAT) (Appendix A) for use in the beginning stages of therapeutic consultation with individuals who are trans- and/or gender-nonconforming, their families, and their partners. The purpose of the TQAT is to explore individual and family emotional structures and to examine definitions of behaviors and feelings within family systems. The TQAT was inspired by the Ackerman Institute's *Gender Questions* (Sheinberg & Penn, 1991), a tool for men

and women to process the most unacknowledged societal gender assumptions. The gender questions compare the gender relationships within family systems to the ideologies of gender in a cultural context. They also serve to identify interpersonal definitions and norms of gender and to encourage individuals to reflect upon the ways in which their behaviors are constrained and constructed so as to be in concordance with specific societal definitions (Sennott, 2011).

Sennott has also created the Allyship Practice Model (APM) (Appendix B) of guidelines for therapists to follow when considering and practicing the principles of the transfeminist approach. The APM provides detailed practice guidelines to follow when working therapeutically with gender-nonconforming people and their families and partners. These guidelines are derived partly from a curriculum developed in collaboration with other members of Translate Gender. The APM is meant to assist providers in working responsibly and competently with differently gendered individuals while simultaneously considering our own privilege and position within the therapeutic relationship (Sennott, 2011).

### Clinician's Fears: Navigating New Territories of Sex, Gender, and Sexuality

Over the past three years of conducting Translate Gender trainings for clinicians and providers, we have asked therapists and doctors to be candid about their countertransference, prejudices, assumptions, phobias, and fears. We have found it helpful for health professionals to learn that many others share their fears and concerns, and that there are ways to navigate through these therapeutic obstacles in order to provide supportive, affirming, and competent care for gender-nonconforming clients. This can be done through the use of the TQAT, APM, and the adoption of a transfeminist therapeutic approach when working clinically with gender-nonconforming clients.

The greatest fear that clinicians have in working with differently gendered clients is that they are not properly educated and trained to work with a differently gendered population. This includes therapist's concerns about "blind spots" in treatment, fear of "saying the wrong thing" or "messing up a person's pronouns," "over thinking" instead of being present and mindful with a client, and not having the resources and knowledge to effectively advocate for a client. If therapists feels this way about their level of understanding about gender related issues, then it is likely true and it is critical that they begin the process of self-education and self-awareness before working therapeutically with gender-nonconforming individuals. This action can include, but is not limited to, taking responsibility for continuing one's education through research and study, trainings and workshops, and accessing online resources. We also recommend that therapists seek

supervision with a peer group or a therapist knowledgeable in areas of gender and sexuality to allow for the exploration of one's own assumptions, stereotypes, and countertransference in working with differently gendered clients.

Another common concern of therapists is that they will unconsciously perpetuate the systems of oppression within the therapeutic relationship and fall into the trap of conflating marginalized identities (e.g., queerness, gender, race, class) and recreating exclusion and stigmatization in the therapeutic context. Acknowledging and navigating multiple identities without reinforcing socially constructed binaries takes self-awareness and practice. Therapist will often make mistakes in this work, but it is critical that they acknowledge it, apologize, and repair any damage to the therapeutic connection. If therapists are able to take responsibility for a mistaken pronoun or gender assumption, they model affirming communication with a client. We encourage clinicians to recognize the mistake, acknowledge it, hold themselves accountable, and move forward. Feelings of guilt around mistakes are not useful to the client; modeling reparative experiences of communication can be.

Utilizing the transfeminist approach and the allyship practice model will inevitably aid clinicians in more competently serving their gender-nonconforming clients' needs. The key to beginning therapeutic work with differently gendered people is continued practice and reliable clinical supervision by a therapist properly trained in gender and sexuality concerns. With practice and supervision, a therapist new to gender concerns will be able to anticipate some client fears and create a strong connection with individuals, their partners, and their families.

### Client's Fears: Collective Trauma of Pathologization in Clinical Settings

Trans- and gender-nonconforming people have reported myriad mistreatments within the medical and mental health communities over the course of history. These real experiences range from devaluation and pathologization to forced hospitalization and forced medication. Historically, the medical establishment has supported both physical and psychological trauma to trans- and gender-nonconforming people. While it is beyond the scope of this paper to outline the real and lived traumas that trans- and gender-nonconforming people have experienced within the medical and mental health establishment, it is important to acknowledge the collective multigenerational trauma that has been experienced by the trans community.

While it is highly likely that trans- and gender-nonconforming people have lived through some form of maltreatment by medical and mental health professionals, those who have not are often aware of the history that the

medical-industrial complex has played in the lives of other trans community members. As a result, members of the community may be quite wary of medical professionals before ever setting foot inside the office door. The Internet allows access to others' lived experiences, and often it is through remote connection that community members inform one another of injustices and particularly triggering or traumatizing experiences with health care providers. As a result, it is likely that a gender-nonconforming person sitting in the office of a mental health professional may be weary and guarded due to either lived experiences or vicarious experience of collective trauma. For this reason, trans- and gender-nonconforming people may not enter treatment with the same ideas of mutuality, trust, and helping relationship of other clients. They may be guarded and worried, hypervigilant, and reluctant. Therefore, it is crucial to consider some of the fears that a trans- and gender-nonconforming client may have when beginning work with a therapist.

The most valuable first question a therapist can ask a client may be, "Do you have any reluctance or fears concerning the work we may begin doing together?" Concerns and fears should be acknowledged, validated, and normalized through recognition of the harms that the medical establishment has perpetrated against members of the trans- and gender-nonconforming community. It is also imperative to note that this question does not relate singularly to gender issues but also to fears in general. It is important to acknowledge fears or concerns without directly relating these fears to gender, as one common concern among gender-nonconforming clients is that anything the client brings into the room will automatically be related back to that individual's gender identity. This is a common practice for clinicians working with trans clients. A client may want to discuss relationships at work, the recent loss of a relative, or their fears around an upcoming trip and may not see these issues as directly related to gender. Clinicians ought not to conceptualize every issue as being related to gender, unless clients specifically make the connection themselves.

Similarly, clients fear therapists' assumptions about their gender identity. Common fears about therapists' assumptions are that a therapist will view a client's gender identity as stemming from abuse; that a client's gender identity will be seen as a "phase" that the client will pass through; and that the person's gender identity is a "problem," when in fact the person is quite happy as a trans- or gender-nonconforming person. Another common fear among trans people seeking therapy is that they will have to spend much time educating the therapist about basic issues concerning their identities. Often, clients feel as though they are unable to speak freely about their experiences because they have to stop and explain words and concepts to the therapist. It is the clinician's obligation to educate himself or herself on trans issues and a variety of trans experiences prior to working with clients. Questions ought to come from a place of exploring a client's feelings and motivations rather than from a desire for self-education. In other words,

therapists should not ask clients to “define” words and terminology; rather, they should research terms or concepts outside of therapeutic sessions.

One of the primary fears trans- and gender-nonconforming people have is not being believed and validated in their assertions of their gender identity or expression. This is particularly true for people in the early stages of their transidentity development. It is critical for clinicians to listen to clients and to mirror back their identities. When clients say who they are, the therapists must listen and protect that identity within the therapeutic relationship. It is not for the clinician to decide if a person is “truly” trans. It is the job of the clinician to affirm identity and mirror back language. Members of the trans community have also reported concerns that clinicians may attempt to fit them into binary gender roles and expressions that may not allow them to explore their gender identities in more subtle and complex ways. For example, therapists may believe they are providing positive mirroring of gender expression to transwomen clients when they reinforce typically feminine stereotypes with them. However, they may be missing or suppressing an entire segment of a person’s gender expression and identity by confining them to binary gender roles.

Often, trans- and gender-nonconforming individuals come to therapy seeking letters of recommendation in order to access gender-affirming treatments. Many fear that they will not receive a letter because they are not “trans” enough or because the therapist may have other ideas about the best interests of the client. It is important for clinicians to think about their policy about writing letters of recommendation for gender-affirming treatments *before* meeting with clients. Does the therapist write such letters? If not, why not? If so, for whom and when? When clients come to therapy for a letter, it is important for therapists to review their policy about letters with the clients in the initial meetings and not to use the provision of a letter as the carrot to keep clients in therapy in order to assess their trans-ness.

We advocate a model of transparency and co-authorship around letters for gender-affirming treatments. Clinicians are encouraged to depathologize the letter by avoiding the use of GID, by explaining the use of the TQAT and the APM, and by offering to write letters that clients can review and to which they can make changes, if necessary. We encourage therapists to be aware of resources in the community that do not require a letter but rely on models of informed consent to obtain gender-affirming treatments. By addressing these issues as soon as possible, both client and clinician are free to explore other aspects of the therapeutic relationship, and the client is granted agency to decide whether or not to use a letter or utilized an informed-consent model of treatment.

## SUMMARY

The client and clinician fears training asks clinicians to explore their fears, concerns, and countertransference in working therapeutically with differently

gendered clients. In the workshop, clinicians examine transphobia, misogyny, and homophobia, which can act as obstacles to the development of a gender-affirming therapeutic relationship. Through the use of a transfeminist therapeutic approach, participants develop personal best practices for working therapeutically and medically with trans- and gender-nonconforming individuals. This workshop helps health care professionals to understand fears that a gender-nonconforming client may have when entering a therapeutic setting as well as educate providers about what they can do to combat the extensive collective trauma that differently gendered clients experience when entering into a therapeutic relationship.

## REFERENCES

- Intersex Society of North America. (2010). FAQ's page. Retrieved from <http://www.isna.org/faq/conditions>
- Istar Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-varient people and their families*. Hawthorne Clinical Practice Press: New York.
- Istar Lev, A. I., & Sennott, S. (forthcoming). Trans-sexual desire in differently gendered bodies. In *Handbook of LGBT-affirmative couple and family therapy*. New York, NY: Routledge.
- Sennott, S. L. (2011). Gender disorder as gender oppression: A transfeminist approach to rethinking the pathologization of gender non-conformity. *Women & Therapy*, 34(1/2), 93–113.
- Sennott, S. (unpublished paper). The task of gender inclusion on women's college campuses: A transfeminist landscape.
- Sennott, S. (2008). *The double bind theory and gender nonconforming identity development*. Retrieved from [http://fcaw.library.umass.edu:80/F/7K846UX1EILNS6GAJA337F7PU9BHCRC6UIQNI57J997NF5I6TN-29020?func=item-global&doc\\_library=FCL01&doc\\_number=010126708&year=&volume=&sub\\_library=](http://fcaw.library.umass.edu:80/F/7K846UX1EILNS6GAJA337F7PU9BHCRC6UIQNI57J997NF5I6TN-29020?func=item-global&doc_library=FCL01&doc_number=010126708&year=&volume=&sub_library=)
- Sheinberg, M., & Penn, P. (1991). Gender dilemmas, gender questions and the gender mantra. *Journal of Marital and Family Therapy*, 17, 33–44.
- Spade, D. (2003). Resisting medicine, re/modeling gender. *Berkeley Women's Law Journal*, 18, 15–37.

## APPENDIX A: TRANSFEMINIST QUALITATIVE ASSESSMENT TOOL (TQAT)

### Norms and Perceptions of Masculinity and Femininity

The first category of questions in the face-to-face interview examines the “norms” to which gender-nonconforming persons aspire and the possible relational consequences of changing or shifting perceptions. These questions inquire into an individual's “ideas” about masculinity and femininity.

1. What are your ideas about masculinity? About femininity? As a gender-nonconforming individual, how do you believe you should behave toward men and women? How do you expect them to behave toward you?
2. Do you believe that men should feel sad? Afraid? Worried? Unsure? In need of approval? Dependent on their partners for comfort?
3. Do you believe women should feel angry? Assertive? Entitled to put themselves first? Competitive?

### Relational Consequences of Differences in Norms

This section of questions asks participants to speak about their personal experiences and emotional understandings of how they, as gender-nonconforming individuals, have learned to metabolize emotions in light of their perceptions of masculinity and femininity.

4. If you were to show anger, how do you think those close to you would feel and react?
5. If you were to show a need or desire for protection, how do you think those close to you would feel or react?
6. If you are frightened or dependent, can you show it to those close to you without risking a loss of self-esteem? What does that look like?
7. If you show feelings you keep silent, what do you think those close to you might think of you?

### Parental Norms and the Effects of Family-System Functions on Gender-Nonconforming Members

This section of questions attempts to identify the norms to which the gender-nonconforming individual's parents aspired and how the norms affected both the individual and the parents.

8. Did your parents have a hard time meeting their parents' expectations about femininity/masculinity?
9. If your parents had had different ideas about male and female behavior, how might it have changed their relationship?
10. What effects did your parents' norms and values have on your ideas of masculinity and femininity?
11. If either of your parents had disapproved of the manner in which you are a gender-nonconforming person, how would you have known that growing up?
12. What is your earliest memory of being acknowledged by your parent(s) as gender nonconforming?

## Establishing New Norms for Future Integration

Once consideration of the different possibilities of gender behaviors have been explored, questions about the future address the potential for establishing new norms, as well as altering the ways in which problems might continue. This section asks participants to look into the future and imagine how they might influence their own children, as well as how their parents might perceive and interpret these influences.

14. If you have a child, would you like that child to feel differently than you do about their masculinity and femininity?
15. Would your parents disapprove if you raised your children with different ideas from theirs about being a man or a woman in the world?
16. 15. Were (are) there people in your life that affirmed your gender identification growing up, even in subtle ways?

## APPENDIX B: THE ALLYSHIP PRACTICE MODEL (APM)

Transfeminist therapists *do*. . .

- Understand that everyone, regardless of gender identity or expression, can be an activist and ally in the movement against gender oppression;
- Recognize the intersections of trans/gender justice with reproductive justice, the women's movement, and other justice movements;
- Recognize the intersections of gender with other *systems of oppression* (including, but not limited to, racism, classism, sexism, ageism, ableism, heterosexism, misogyny, homophobia, and transphobia);
- Acknowledge the ways in which gender privilege and oppression have and continue to operate in their own lives;
- Recognize that trans- and/or gender-nonconforming people need allies, just as all oppressed and marginalized people need allies;
- Provide space for people to self-identify their gender and provide space for people to self-identify the pronouns they use to describe or identify themselves;
- Use gender-neutral language until preferred pronouns are established. This sometimes means asking what pronoun(s) and/or name a person uses (e.g. "What name do you use?" or, "What pronouns do you use?"). It is also important to receive consent to use this name or pronoun in some, or all, settings and to respect this confidentiality. Some people might prefer to use a certain pronoun at home, but not in the workplace, and so forth;
- Mirror back language, especially self-identificatory language;
- Expect to make some mistakes but never use this as an excuse for not acting;

- Acknowledge having made a mistake (e.g., mispronouncing a name), apologize, correct themselves, and move on;
- Work to create inclusive nondiscrimination policies in their schools, institutions, organizations, and communities;
- Work to create and maintain accountable spaces (e.g., encourage transparent communication, obtain consent, take ownership of personal actions);
- Challenge oppressive language and behaviors in themselves and those around them;
- Avoid and challenge gender assumptions and stereotyping;
- Ask questions respectfully and understand when someone elects not to respond if the question makes them feel uncomfortable.

Transfeminist therapists **do not** . . .

- Believe that resisting oppression only benefits targets of oppression;
- Accept the status quo (e.g., the gender binary);
- Believe themselves to be experts on any person's identity other than their own;
- Assume an individual's sex, sexuality, or gender based upon the individual's appearance or presentation;
- "Out" a trans- and/or gender-nonconforming (or lesbian, gay, bisexual, queer, intersex, or questioning) person without that person's explicit consent;
- Place the name, pronouns, or self-identification of a trans- and/or gender-nonconforming person in quotation marks;
- Ask people about their bodies, genitalia, or sex lives;
- Assume that no trans and/or gender-nonconforming people are present;
- Assume that anyone knows what a trans- and/or gender-nonconforming person "looks like";
- Question a trans- and/or gender-nonconforming person's assessment of identity or experience;
- Question anyone's assessment of whether or not an incident was transphobic;
- Deny their own privilege;
- Assume that everyone has equal rights;
- Ignore acts of discrimination and oppression without taking action;
- Show pity and sympathy for targets of oppression;
- Use guilt for one's personal and/or a group's actions, past or present, as a reason not to act.