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Gender Disorder as Gender Oppression: A Transfeminist Approach to Rethinking the Pathologization of Gender Non-Conformity

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The existence of Gender Identity Disorder (GID) in the Diagnostic and Statistical Manual of Mental Disorders (DSM) represents a highly controversial issue. This paper examines recent arguments that champion retaining GID in the DSM due to its perceived advantages and arguments that call for the removal of GID. By connecting these contentions with historical ideologies held by liberal feminist theorists and gender activists, I assert a more just model for treatment designated the Transfeminist Approach. To aid therapists in this approach I offer the Transfeminist Qualitative Assessment Tool, the Allyship Practice Model, and an identity continuums graph.

KEYWORDS Allyship Practice Model, feminist therapy, Gender Identity Disorder, transfeminist qualitative assessment tool, transfeminist therapeutic approach, transgender

> [T]he stakes of this debate are high since it would seem, in the end, to be a matter of life or death, and for some the (GID) diagnosis seems to mean life, and for others, the diagnosis seems to mean death. For others too, it may well seem to be an ambivalent blessing or, indeed, an ambivalent curse. (Judith Butler, 2004)

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The controversy surrounding the diagnosis of Gender Identity Disorder (GID) in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychological Association, 2000), is multifaceted and complex. The issue of GID reform has been a topic of debate amongst advocates and activist, queer and feminist theorists, as well as mental and physical health providers. It is clear that the cross pollination of concerns in these varied disciplines has been largely due to a shared understanding of what social and political gender policing has led to in the past, and, the effects of continued oppression of individuals, based on their gender, in present day cultures worldwide.

In this paper I assert that there is an intrinsic link between the century long oppression of women's mental wellbeing within the psycho-medical industrial complex and the pathologization of gender non-conformity through the psychiatric classification and treatment of GID. I explore various contiguous positions concerned with the elimination of GID from the DSM, and, seek to illuminate arguments, both for and against eradication, which claim to originate from feminist theory and social justice frameworks. I believe that arguments for the removal of GID from the DSM have roots in both feminist theories and social justice frameworks. Liberal feminist theory and therapeutic practice provide the foundation for most movements to end inequality between men and women in the context of a medical and mental health discourse. However, the liberal feminist perspective has been critiqued because it does not require a re-thinking of societal assumptions and values of the partriarical Western norms from which psychotherapy was born (Brown, 2010; Enns, 2004). Also absent from liberal feminist theories of psychotherapy is an awareness of the sex and gender *continuums*, and, the clinical implications of not acknowledging that there is an endless amount gender difference in people of the 21st century.

I will offer a new transfeminist therapeutic approach, an alternative therapeutic reconceptualization of feminist therapy based on the weaving of liberal feminist thought, social justice frameworks, and principles of allyship. Building from the liberal feminist base, the addition of a social justice lens illuminates the inequities that face individuals, families, communities, and larger social group systems founded solely on the basis of membership to a specific political or social group. I believe that this transfeminist approach is a forward step in feminist therapy, and the principles of this approach are a natural evolution in gender-aware and gender affirming therapy with people who are gender non-conforming and their families and partners. I have also created a Transfeminist Qualitative Assessment Tool (TQAT) and an Allyship Practice Model (APM), to be used in therapeutic consultations with individuals who are trans or gender non-conforming, and their families and partners.

THE CONTROVERSY OF GENDER IDENTITY DISORDER

The history of controversies surrounding GID originates in psychomedical discourse. As agents of social control, patriarchal psychomedical institutions have diagnosed gender differences to ensure sociopolitical homeostasis and maintain disciplinary authority (Butler, 2004). Psychiatrists attributed the first official classification of *disordered* gender expressions and behaviors to children. In 1980, Gender Identity Disorder in Children (GIDC) was introduced in the third edition of the DSM (American Psychological Association, 1980). Although diagnosing children with mental illness has elicited contentious debate among mental health providers, the classification of GIDC demonstrated sociocultural intolerance for gender nonconformity among children. For adults, the DSM-III introduced the category of *Transsexualism* under the broader category of *Gender Identity Disorders* (Butler, 2004). This classification represented the premiere of *Transsexualism* as an official disorder (Stone, 1991). These diagnoses reified socially constructed sex and gender binaries of male/female, man/woman, and masculine/feminine. In addition, psychomedical professionals gained authority and interdisciplinary respect for treating the conditions, and the terms legitimized all those who suffered from gender dysphoria (King, 1993).

In 1994, the DSM-IV was published (American Psychological Association), wherein Gender Identity Disorder became diagnosable in both children and adults. The DSM-IV diagnostic criteria (Appendix A) are currently used, and so are worth examining closely. Relaying the criteria for GID is important because much of the controversy that surrounds the pathologization of gender nonconformity concerns language.

First, the DSM does not account for the difference between distress or impairment that is inherent to the psychology of an individual and that which is a result of oppressive sociocultural structures. Critics question whether a person with atypical gender expressions would feel distressed or impaired if transphobia did not exist and gender affirming body modifications were easily accessible. In addition, scholars, providers, and activists who oppose the diagnosis assert that the language used in identifying GID is sexist. A GID diagnosis relies on stereotypes about men and masculinity and women and femininity. It ignores the last 40 years of feminist advances in gender liberation (Langer & Martin, 2004). Some critics also assert that GID was added to the DSM when homosexuality was removed as a way to continue policing atypical gender expressions (Ault & Brzuzy, 2009; Manners, 2009; Lev, 2009; Lev, 2005, Langer & Martin, 2004). These critiques assert that the coded language of GID diagnoses promotes a social and political agenda where disturbances produced through gender nonconforming behavior in families, communities, and institutions are justifiably mitigated through assigning mental illness (Langer & Martin, 2004). Since its inception, the institution of

Western psychiatric medicine has policed gender in women by diagnosing physical and psychic responses to oppression (Manners, 2009; Lev, 2005; Langer & Martin, 2004), associating mental illness with femininity for over a century (Ussher, 1991). Given this legacy, the continued pathologization of gender nonconformity is not surprising.

Similar to these feminist arguments, one of the strongest arguments for the removal of GID from the DSM is based on the premise that gender-atypicality has been observed throughout history and across cultures. Although it would be ethnocentric and inaccurate to impose the label transgender onto people who predated the term, contemporary scholars offer vast evidence of gender-bending behaviors and practices (Blackwood & Wieringa, 1999; Cromwell, 1999; Murray & Roscoe, 1998; Feinberg, 1996). This research suggests that cross-gender practices may not indicate dysfunction, even if they are statistically uncommon (Lev, 2009; Lev, 2005; Langer & Martin, 2004). As gender is a socially enforced and regulated construct that lacks precision, clinicians face an ethical dilemma in differentiating between *inappropriate* and *acceptable* gender variance (Langer & Martin, 2004). The GID diagnosis does not allow for these distinctions. Instead, it conflates gender nonconforming people who lack dysfunction and seek medical transition as a mentally healthy choice with those who may suffer from dysphoria (Lev, 2009). Some critics further assert that it is the diagnosis itself, once given, could be the cause of the *disorder*, as mental illness labeling carries tremendous stigma in contemporary Western societies (Bolin, 1988). When a person is stigmatized in a society, that person becomes discreditable (Goffman, 1963) and so loses autonomy.

On the other hand, some providers, advocates, and gender nonconforming people argue that maintaining GID in the upcoming DSM-V affords transgender people access to insurance coverage for gender-affirming treatments. A widely held belief, or perhaps an assumption, is that without an Axis I diagnosis of GID, the few American insurance companies that cover gender-affirming treatments would no longer have reason to honor the diagnostically assessed services (Gorton, 2006; Wilson, 1997; Nangeroni, 1996). Manners (2009) flips this logic, questioning why the consistently recommended treatment for a psychiatric diagnosis includes surgical body modifications. Many of these advocates suggest reclassifying gender-atypicality as a medical condition recorded on Axis III, just as high blood pressure or pregnancy are, to facilitate insurance coverage (Ehrbar, Winters & Gorton, 2009). Transferring gender nonconformity from a psychiatric disorder to a medical condition may preserve treatment coverage without sacrificing personal integrity. Lev (2005) imagines this next best scenario as reforming the diagnosis within the DSM to retain insurance coverage and access treatments. According to Lev (2005), reforms could include:

> The depathologizing of cross-gender experience; the recognition of transsexual trajectories based in mental health rather than on distress

> or dysfunction; the broadening of eligibility for medical referral to include those with non-transsexual gender variant experiences; attention to the role of heterosexism and sexism in generating the diagnostic criteria; and preventing the misuse of GID to treat alternative sexual orientations and gender expressions in children and youth. (p. 58)

This proposal widens the definition of what is diagnosable, or considered *disordered*. Broader eligibility criteria ultimately mean that more people become pathologized. Conversely, by taking a *least of all evils* approach, this model appeases activists and providers who work from a social justice framework by acknowledging heterogeneity in gender identity and expression. This model may alleviate some effects of the inherent pathologization and consequent stigmatization of gender differences by making inroads to more comprehensive and competent physical and mental health care.

The politics of pathologized identities and access to gender affirming treatments make arguments around GID difficult to untangle. Even critics who call for the eradication of GID from the DSM acknowledge the implications of losing coverage for transgender healthcare. Thus, with the impending DSM-V, advocates must weigh the advantages and disadvantages of retaining, reforming, or removing GID. The connection between feminist ideologies and arguments for GID reform are most salient when considering overlaps in legislative changes that have influenced both movements over the last four decades. The increase in access to gender affirming treatments, coupled with federal and state rights granted by the Gender Recognition Act (2004), the legislation protecting transgender individuals' right to treatment (Ault & Brzuzy, 2009), the 1969 Family Law Reform Act that allows adolescents to consent to treatment, and the Gillick competence ruling, have created a more comprehensive lens through which to critique the diagnosing of gender differences (Manners, 2009).

As a gender justice activist, I believe it is necessary to immerse oneself in the transgender community to make informed decisions about future directions for GID. Although many advocates active in the GID debates are trans-identified or avowed allies, understanding GID politics as they are articulated in trans and gender non-conforming spaces illuminates perspectives that may be more in touch with transgender lived experiences. With this in mind, I turn my attention to issues presented through transgender protests, at transgender conferences, and in essays published by established transgender leaders and feminist theorists who have written about the controversy of GID and gender difference. Although these forums represent a small and class-privileged fraction of the transgender community, they offer insight into the status of GID debates among transgender communities.

At the 2009 symposium of the World Professional Association of Transgender Health, two renowned transgender advocates, Kelley Winters and Nicholas Gorton, presented a session with psychologist Randall Ehrbar.

All three specialize in transgender health issues. Although Winters and Gorton had published opposing perspectives, they collaborated to produce a session that proposed shared visions for changes to GID classifications. They positioned ideologies about GID in the DSM along a continuum. On one extreme end are those advocates who believe there should be no diagnosis for transgender people in the DSM or the International Classification of Diseases (ICD). On the other are advocates who believe the existing GID diagnosis is perfectly fine. Ehrbar, Winters, and Gorton (2009) summarized GID thought communities into three primary groups along this continuum. The first group, on the left end of the continuum, includes advocates who believe gender nonconformity is not a mental illness and who want GID removed from the DSM and reclassified as a medical condition in the ICD. The group in the middle of the continuum includes those who believe GID is a mental illness, or may feel ambivalent about its status, but want to reform GID in the DSM to better help transgender people. The third group, on the right end of the continuum, includes those who view GID or gender dysphoria as a mental illness but want to reform the diagnosis to aid transgender people (Ehrbar et al., 2009).

When learning about the transgender community as it exists through conferences and protests, it becomes clear that GID remains a contentious issue. But it seems that trans politics most closely situate within the left-center position on the aforementioned continuum. Recent protests and conferences offer a gauge for assessing this climate. At the 2009 meeting of the American Psychiatric Association, transgender activists and allies protested against the continued pathologization of normal gender variations (Berman, 2009). This activism was reminiscent of early 1970s activism against the inclusion of homosexuality in the DSM (Kirk & Kutchins, 1992). Now, it is mostly transgender people who challenge prevalent psychiatric ideologies that classify their experiences as disordered.

Discussions about GID reform also exist within transgender conferences, especially those geared toward healthcare issues. In the past year, only a few conference presenters appear to take GID for granted, using it uncritically in titles and seminar descriptions (Burnett, 2009; Tunis, 2009). Far more presenters conduct seminars that challenge GID classifications. Some presenters consider how the GID diagnosis affects the efficacy of transgender politics (Bacon, 2009; Bockting, 2009), while advocates experienced with transgender litigation hesitate to reject GID due to its legal utility (Levasseur, 2009; Thaler, 2009). Other presenters use the conference forum to explicitly challenge the pathologization of gender non-conforming behavior and propose entirely new models for providing transgender-specific care (Douglass, 2009; Riverstone, 2009; Serano, Ryan & Winters, 2009). Although these presentations indicate a lack of consensus on GID reform within transgender communities, tendencies to support depathologization appear to be gaining popularity.

Despite this trend, a few prominent trans advocates have resisted depathologization models. One powerful argument worth exploring more in depth is that posed by Nicholas Gorton, a gay transman and physician. Unlike advocates who cite legal benefits of retaining GID in the DSM, Gorton (2005, 2006) challenges GID critiques on multiple levels. He argues for the continued classification of *transgenderism* as a disease and dispels arguments that attribute the pathologization of transgender identity to a transphobic society. Gorton likens GID to diabetes—a condition that also manifests differently depending on environmental factors (Gorton, 2005). Gorton accuses critics who link transgender struggles with rights obtained by gays, lesbians, and bisexuals as committing logistical errors. He argues that they cannot assert that lesbians and gays gained political acceptance after homosexuality was removed from the DSM. Gorton also takes issue with critics who want to shed the stigma of mental illness applied through a GID diagnosis and chastises them for being immoral bystanders to marginalization. He recommends that they instead ally themselves with the plights of the mentally ill. By presenting detailed information about nosological techniques, Gorton (2006) dismisses critics who cite misdirected scientific classifications as justifiable reasons for reforming GID. Ultimately, he reinforces a model that views transgender experiences within a psychiatric pathology model.

Gorton inaccurately implements the social justice concept of *coalition building* when he argues that to call for the eradication of GID for the purpose of de-stigmatization of gender atypicality is to undermine the fight to de-stigmatize *all* mental illness, and thus break coalitions between marginalized groups of individuals. Firstly, Gorton operates on the assumption that GID is in fact a mental illness, so of course it would follow in his argument that those who wish to destigmatize it as a mental disorder are activating from an amoral desire to disassociate *them* (all other diagnosis in the DSM) from *us* (GID). Gorton's essentialist argument for de-stigmatizing mental illness would only be feasible if the DSM contained a diagnosis for all variations of gender identity, including those that *conform* to the socially enforced gender/sex/sexuality categories. Gorton fails to recognize that to categorically pathologize gender difference but not gender conformity is to socially and politically police and stigmatize a person's mental status as well as their gender expressions, roles, and behaviors, in a way that diagnosing depression, anxiety, and schizophrenia does not.

Secondly, Gorton's argument to focus on the de-stigmatization of all mental illness instead of fighting for the removal of GID runs the risk of essentializing the argument to a point where the movement to end gender oppression is so diluted it can no longer be legitimately connected to its feminist tradition and roots. There are numerous funding streams that feed organizations fighting for the de-stigmatization of mental illness, but

the foundation of this activist platform is rarely that mental illness is not *pathological*. The arguments that call for the removal of GID from the DSM based on de-stigmatization are founded on the feminist principles that in a socially-just world, gender of any kind will not be pathologized.

Lastly, in acknowledging stigma as an enemy of social justice and feminist frameworks, it is important to remember the too often unquestioned privilege and safety that people with mental illness, be it depression, anxiety, schizophrenia, or bipolar, experience if they also happen to fall into a socially acceptable gender identity category of the binary. Unlike gender nonconforming people, the stigma that gender *conforming* individuals with mental illness are subject to is rarely a result of extreme and unexplainable hate in other people which can commonly lead to, in the worst cases, horrifying crimes including murder, and in the best cases, insidious violence(s) of social ostracization and rejection. Postmodern and transnational feminist practices are more able to incorporate the matrix of micro-oppressions that individuals with mental illness and gender non-conforming presentations are likely to experience (Grewal & Kaplan, 1994), however, until now with the transfeminist approach, there has not been a feminist therapeutic model that specifically identifies best practices in working with clients who are differently gendered and their partners and families.

Feminist theorist Bernice Hausman (2001) suggests that the abundance of scholarship related to transgender theory has become *decidedl*y queer, including transgender advocacy texts, scholarly texts, and texts that combine advocacy and scholarship. Hausman parallels the emerging interest in the specific gender concerns of trans people to the historical analysis that the *woman* underwent during first-wave feminist movements, calling the latter a problem characterized by feminism as the *woman question* and the former a question of sexual difference, *in the guise of transgender*. Hausman does not conceive of both movements to eradicate gender oppression as sharing a common social justice foundation in a field model of development. Instead she implies that transgender scholarship is replacing, even commandeering, feminist study and theory, in a linear model of development. Hausman (2001) bases this belief on an assertion that there is an "essential difference in the conceptualization of gender as an analytic category" between queer (transgender) theory and feminist theory (p. 465).

The rigidity of Hausman's assertion of essential difference in conceptions of gender categories does not allow for the intersection of other oppressed and privileged identities *with* the category of gender identity. Hausman's argument does not include awareness that an individual's gender is by no means a singular category existing untouched by the influences of that person's race, ethnicity, ability, sexual orientation, class, size and location. Hausman (2001) defines *queer* theoretical perspectives as including

an "attack on heteronormativity; emphasis on performativity over essence; insistent denaturalization of sexuality" (p. 467). However, these defining characteristics are also applicable to the arguments against GID that utilize a social justice framework and are founded on feminist ideologies and principles.

The arguments against GID that are founded in a social justice framework and are strongly influenced by feminist theory acknowledge the matrix of intersecting identities which one individual holds. Feminist movements have brought forth the *activity* and *practice* of self-determination and self-identification of gender presentations and expressions in contemporary Western culture. For critics of GID to risk undermining these fundamental principles of freedom and autonomy for the sake of a theoretical *undoing* of socially constructed binaries of sex and gender would be, in itself, othering and oppressive to gender non-conforming people. Hausman fails to recognize in her either/or stance of queer and feminist theory that transgender advocacy, activism, scholarship, and theory are intrinsically linked to the fundamental principles of feminist thought.

A shared foundational concept in feminist theory and social justice activism is the application of autonomy in the lives of oppressed populations. In analyzing arguments both for and against the eradication of GID, Butler (2004) identifies both a need for, and a problem with, the notion of autonomy:

> [T]he debate is a very complex one, and that, in a way, those who want to keep the diagnosis want to do so because it helps them achieve their aims and, in that sense, realize their autonomy. And those who want to do away with the diagnosis want to do so because it might make for a world in which they might be regarded and treated in non-pathological ways, therefore enhancing their autonomy in important ways. I think we see here the concrete limits to any notion of autonomy that establishes the individual as alone, free of social conditions, without dependency on social instruments of various kinds. Autonomy is a socially conditioned way of living in the world. Those instruments, such as the diagnosis, can be enabling, but they can also be restrictive and often they can function as both at the same time. (p. 77)

Butler (2004) cautions that autonomy is dependent on sociocultural arenas. Furthermore, the narratives and lived experiences of gender non-conforming individuals are numerous and heterogeneous and reflect the complex circumstances of an infinite expanse of social, cultural, political, and biological landscapes. In this way, GID hinders the autonomy of gender non-conforming persons who are positioned in a postmodern perspective and do not feel impairment or distress due to their gender identification. Often, these unimpaired differently gendered identities which are emerging in the 21st century do not wish to 'transition" from one end of the gender

binary to the other, rather, their transitional position on the gender identity continuum is the objective and is where they feel the most psychologically comfortable. Without the confines of the gender binary as a guide for providers, how can therapists and others ethically and competently work with gender non-conforming people and their families and partners, without pathologizing them or expecting them to want to fit into the socially constructed and condoned gender binary?

THE TRANSFEMINIST THERAPEUTIC APPROACH

The transfeminist therapeutic approach is an alternative therapeutic re-conceptualization of feminist therapy based on the weaving of feminist thought, social justice frameworks, and principles of allyship. The transfeminist approach is the next step in feminist therapy, and the principles of this approach are a natural evolution in gender affirming practice with people who are gender non-conforming and their families and partners. The foundational principles of the transfeminist therapeutic approach are: 1) There does not exist a hierarchy of authentic lived experience for women; 2) To privilege one *type* of womanhood or femaleness over another is inherently anti-feminist; 3) No one individual, group, or type of woman is permitted to define what it means to *be* a woman; and 4) Most trans and/or gender non-conforming individuals have had lived experience, either past or present, 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 require the therapist 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.

Before the ideological foundations of gender liberation were built during various feminist movements, mental health providers were trained to pathologize people who did not subscribe to criteria and restrictions of the gender binary. The edifying awareness that the gender binary is a socio-political 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. Historically, much of feminist therapy practice has been based on the belief that gender roles and expressions are fluid and unfixed, but there is still a conflation of designated sex (male/female) with gender identity (man/woman) in early liberal feminist therapy theory.

The conflation of designated sex and gender can lead to a lack of awareness about one's own gender conforming privilege. While the concept of

gender as a social construct has proven to be a powerful tool in shifting traditional attitudes toward women's capabilities, it still leaves space for one to justify certain discriminatory policies or structures as having a biological basis. Trans and gender non-conforming people are commonly described as those whose physical sex does not match the gender of their mind or soul, "She's a woman, trapped in a man's body." This explanation might make sense intuitively, but this is because the sex/gender binary is so assumed that it becomes a privileged invisible identity. The privileged invisible identities are those that are unquestioned and unpathologized in present day society, namely, a person who is designated female at birth, grows up to be a woman, expresses her gender with feminine characteristics, and is attracted to a designated male at birth, man, who exhibits a masculine gender expression.

To say that one has a female mind or soul would mean there are male and female minds that are different from each other in some identifiable way, which in turn may be used to justify discrimination against women. Essentializing our gender identity can be just as dangerous as resorting to biological essentialism. The transfeminist approach operates with the understanding that we construct our own gender identities based on what feels genuine, comfortable, and sincere to us as we live and relate to others within given social and cultural constraints. The transfeminist therapist 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. The transfeminist approach couples an awareness of the designated sex, gender identity, gender expression, and sexual orientation continuums with attentiveness to the multiple intersecting marginalized and privileged identities that an individual also carries. These other intersecting identities include, but are not limited to, race, class, citizenship, education, age, ability, religion, size, and ethnicity. These intersecting identities inform the way that a person experiences and actualizes their gender identity. One might imagine these multiple social and personal identities as constantly changing and shifting throughout a person's lifetime, like a pinwheel turning, always shaping and informing the sex and gender identity continuums (Appendix C). In this way, the transfeminist model moves away from the liberal feminist tradition toward radical feminism, social constructivism, and postmodern traditions.

To aid therapists in shifting their theoretical lens to a transfeminist approach I created the Transfeminist Qualitative Assessment Tool (TQAT) to be used in the beginning stages of therapeutic consultation with individuals who are trans and/or gender non-conforming, their families and partners. The purpose of the TQAT is to explore individual and family constructs

and constraints in the gender non-conforming person and to examine definitions of behaviors and feelings within family systems (Appendix B). The TQAT was inspired by the Ackerman Institute's *Gender Questions* (Sheinberg & Penn, 1991), a forum 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 encourage individuals to reflect on how their behaviors are constrained and constructed to be in concurrence with specific societal definitions.

The TQAT utilizes a narrative approach interviewing style with individuals in consultation. The questions asked in the TQAT are designed to explore and articulate the identity landscapes of past, present, and future understandings of gender roles, expressions, and identities of gender non-conforming individuals. This style of questioning is specifically developed to obtain narrative information that illuminates unexplored territories of an individual's gender landscape and to highlight the development of these territories through the double binds of a family system. The unspoken assumptions, roles, and norms within a family system are given language through the use of the TQAT, which creates new articulations of thoughts and different meta-communications related to gender. The TQAT starts with expressions of the historic gender norms of a family system, then excavates through ideas about the relational consequences that the presence of a gender non-conforming member creates *inside* the system. The third thread, after the family can consider different possibilities in gender behaviors, involves the manufacturing of alternative communications to give meaning to not yet identified norms. It could be speculated that the newly articulated norms achieved through the use of the TQAT would allow for the development of more complete gender identifications for the membership of the entire family system.

I have also created the Allyship Practice Model (APM) of guidelines for therapists to follow when considering and practicing the principles of the transfeminist approach (Appendix D). The APM provides detailed practice guidelines to follow when working therapeutically with gender non-conforming people and their families and partners. These guidelines are partially derived from curriculum I developed in collaboration with other members of Translate Gender, Inc., a collective-based, consensus-run, non-profit organization that works to generate community accountability for individuals to self-determine their own genders and gender expressions, providing workshops, consultation, mediation, and facilitation focused on gender oppression and concerns specific to trans and/or gender non-conforming individuals. The APM is meant to assist providers in working responsibly and competently with differently gender individuals while simultaneously considering one's own privilege and position within the therapeutic relationship.

A Call to Action: Becoming a Transfeminist Therapist

The existence of Gender Identity Disorder in the Diagnostic and Statistical Manual of Mental Disorders represents a highly controversial issue. Advocates, both inside and outside of the transgender community, maintain varying perspectives on the inclusion of GID in the DSM. Some providers and activists would like to retain an unaltered diagnosis, others want to revise the diagnosis to make it more affirming, and some want to see GID removed from the DSM altogether. These divergent viewpoints have sparked considerable debate in anticipation of the upcoming fifth edition of the DSM, and, have brought to light the pathologizing nature of many current therapeutic treatment models for gender non-conforming people and their families and partners.

I believe that a transfeminist approach is a forward step in feminist activism for therapists, and the ethics and principles of this approach are a natural evolution in gender-aware and gender affirming therapeutic practice with people who are gender non-conforming, their families, and their partners. Creating a commitment to self-reflection and community accountability within the context of feminist therapeutic relationships is the creation of what I term a transfeminist consciousness. Those who practice all types of feminist therapy must reconfigure their understanding of gender justice and feminism; adopting a transfeminist approach to their work with clients, to anti-discrimination policies in their agencies, to their administrating roles, and to their community landscapes. Feminist communities have set a precedent for gender equality within psychotherapy over this past century and they are now faced with the socially just obligation to do so again. Let us not shrink from the call to action.

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APPENDIX A
DSM-IV (2000) DIAGNOSTIC CRITERIA FOR GID IN ADULTS AND ADOLESCENTS

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children the disturbance is manifested by four (or more) of the following:

1. repeatedly stated desire to be, or insistence that he or she is, the other sex
2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4. intense desire to participate in the stereotypical games and pastimes of the other sex
5. strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex

characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (p. 581).

APPENDIX B
TRANSFEMINIST QUALITATIVE ASSESSMENT TOOL

Norms and Perceptions of Masculinity and Femininity

The first category of questions in the face-to-face interview examines the "norms" that gender non-conforming persons aspire to, and the possible relational consequences of changing or shifting perceptions. These questions ask what an individual's "ideas" are about masculinity and femininity.

1. What are your ideas about masculinity? About femininity? As a gender non-conforming individual, how do you believe you should behave toward men/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 questioning asks participants to speak to their personal experiences and emotional understandings of how they, as gender non-conforming individuals, have learned to metabolize emotions in light of their perceptions of masculinity and femininity.

4. If you were to show anger that you may feel, 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 Non-Conforming Members

This section of questions is aimed at identifying the norms to which the gender non-conforming individual's parents aspired and how the norms affected both the individual and their parents.

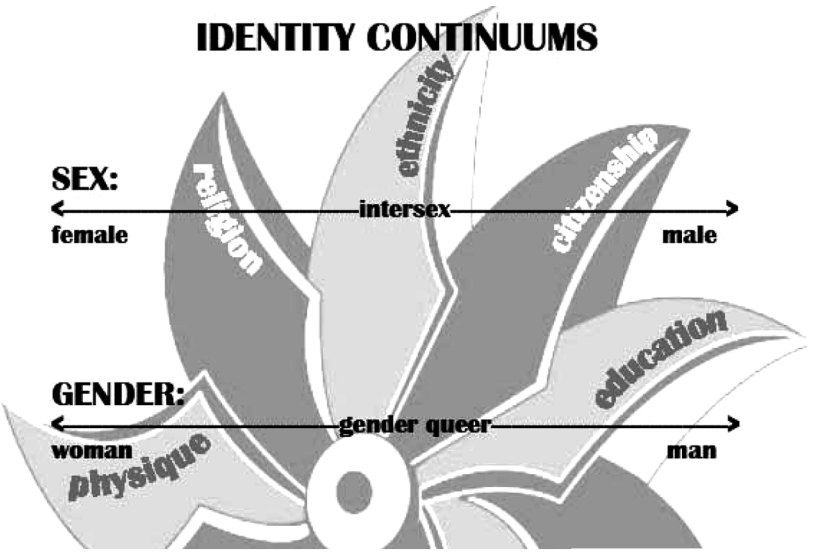
8. Did either one of your parents have a hard time meeting their parents' expectations about femininity/masculinity?
9. If your parents had different ideas about male/female behavior, how might it have changed their relationship?
10. What effects did your parents' norms and values have on your ideas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

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 how problems might continue. This section asks participants to project into the future and imagine how they might influence their own children, as well as, how might their parents perceive and interpret these influences.

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

APPENDIX C



APPENDIX D

The Allyship Practice Model for the Transfeminist Therapeutic Approach

Transfeminist therapists DO. . .

- Understand that everyone, regardless of their gender identity or expression, can be an activist and ally in the movement resisting 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, mysogony, homophobia, transphobia);
- Acknowledge how gender privilege and oppression have and continue to operate in their own lives;
- Recognize that trans and/or gender non-conforming 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/pronoun in some, or all, settings and to respect this confidentiality. Some people might prefer you use a certain pronoun at home, but not in the workplace, etc.;
- Mirror back language, especially self-identification;
- Expect to make some mistakes – but never use this as an excuse for not acting;
- Acknowledge having made a mistake (e.g., mispronouncing someone), apologize, correct themselves, and move on;
- Work to create inclusive non-discrimination 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 DON'T. . ..

- 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 and/or presentation;
- "Out" a trans and/or gender non-conforming (or lesbian, gay, bisexual, queer, intersex, or questioning) person without their explicit consent;

- Place the name, pronouns, or self-identification of a trans and/or gender non-conforming person in quotation marks;
- Ask people about their bodies, genitalia, or sex lives;
- Assume that there are no trans and/or gender non-conforming people present;
- Assume that anyone knows what a trans and/or gender non-conforming person "looks like";
- Question a trans and/or gender non-conforming person's assessment of their identity or experience;
- Question anyone's assessment of whether an incident was transphobic;
- Deny their 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.