

“Gender dysphoria”: Therapist negotiations of oppressive practices

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Introduction

It has long been demonstrated that psychological and psychiatric fields pathologise and discipline certain bodies and identities. However, fewer have explored practitioners' resistance to gender oppressive practices. By reporting empirical data gathered from semi-structured interviews with six therapists in Sydney, Australia, this study explores possibilities of anti-oppressive transgender and gender diverse (TGD) mental health care in practice. Case studies demonstrate how practitioners understood the experiences and heterogeneity of their TGD clients and enacted gatekeeping discourses, including diagnostic categories informed by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 2013). Thematic analysis of therapist case studies demonstrated how notions of “allyship” often fail to problematise power dynamics, including binary gender and cisgenderism¹, with some clinicians engaged in deeply problematic discourses and practices in relation to their TGD clients. The research makes clear that frameworks for challenging oppression in the lives of clients are essential to ethical, client-centred work. To contextualise the case study analysis, a brief introduction to historically oppressive therapeutic practice with TGD clients (drawing from theoretical frameworks of queer theory and transgender studies) is given below, as is an introduction to anti-oppressive practice principles.

Oppressive Diagnoses

A large body of work has critiqued the pathologising effects of diagnostic categories, particularly in relation to LGBTIQ+² folk (e.g., Ansara & Hegarty, 2012; Butler 2004; Foucault, 1986; Namaste, 2000; Serano, 2007; Spade, 2003; Tosh, 2016). Many have demonstrated how diagnostic categories codified in the DSM framework “erroneously pathologize natural variants of human behaviour” (Kamens, 2011, p. 40). For example, in *The History of Sexuality* Michel Foucault (1986) analysed how the *psy-sciences* (i.e., disciplines in which judgments are made about people's mental health, behaviour, cognition, personalities and social functionality) “are built upon the derogation of some groups in relation to the social order—the mad, the perverse, the unproductive” (Race, 2008, p. 418). Foucault demonstrated that the expert categories of the *psy-sciences* are not only historically contingent, nor merely descriptive, but produce and order the identities they pathologise. Transgender studies developed these critiques in specific

reference to sexual and gender identity “disorders”. For example, seminal trans theorist Sandy Stone (2006) explored how the medical establishment’s creation of the identifiable figure of “the transsexual” restricted TGD people seeking bodily adjustments into “norm-abiding gendered subjects” (p. 316). The construction of “disorder” and associated therapeutic interventions naturalised and institutionalised binary gender while regulating gender performances³.

The clinical process of professional gatekeepers identifying “true transsexuals” medicalised diverse trans experience into categories (Coleman et al., 2011). This gatekeeping model was “saturated... in the trappings of modalities which did not recognise diversity in gender” (Richards, 2017, p. 148), where lengthy assessment processes focused primarily on people “proving” their gender expressions/identity (Coleman et al, 2011; Richards, 2017; Serano 2007). TGD people were required to comply with professionals’ perceptions of “real masculinity” and “real femininity” (Spade, 2003, p. 29). This actively erased the multiplicity of TGD experience, as demands to “prove” one’s gender identity or gender “distress” resulted in the codification of a “born in the wrong body” narrative. The “born in the wrong body” narrative became the medical yardstick by which the legitimacy of “trans-ness” was measured (Barker & Iantaffi, 2017; Ellis, Riggs, & Peel, 2020; Schulz, 2018).

Within this model, there has been a well-documented history of strategic uptake of diagnostic categories by TGD people in order to advocate for the medical care they may desire (such as hormone therapy or surgery) (Bolin, 1988; Namaste, 2000; Serano, 2007; Spade, 2006). Many TGD people strategically negotiated psy-disciplinary spaces, training themselves in diagnostic language so as to effectively perform a particular narrative to gatekeepers, often to the detriment of the “emergent polyvocalities of lived experience” (Bolin, 1988; Cromwell, 2006; Namaste, 2000; Stone, 2006, p. 229). Regulators of the gatekeeper model have historically insisted that gatekeeping is based on client safety (Lev, 2004). Whereas critics have described the paradigm as a way of “inserting a paternalistic structure” (Butler, 2004, p. 83) that codifies particular experiences over others, enforces oppositional gender, and fails to support client autonomy, identity, and expression (Richards, 2017; Serano, 2007; Spade, 2015; Tosh, 2016).

Discursive variations to DSM diagnoses demonstrate the social embeddedness of psy-science, where professional manuals represent a canonisation of certain psychological discourses at the expense of others (Drescher, 2010; Mol 2002; Race, 2008; Tosh, 2016). Due to the continued clinical monopoly of the DSM, various voices imbricated in the convoluted process of diagnostic revision have direct consequences on the lived experience of that which is diagnosed as “gender dysphoria”. The struggle of the gay rights movement to petition DSM changes (leading to the 1973 retraction of homosexuality as a mental “disorder” provided a model for subsequent forms of gender and sexuality activism converging on the DSM. For some, the change between gender identity disorder (GID) in DSM-IV (APA, 1994) to the current diagnosis of gender dysphoria (GD) in DSM-5 (APA, 2013) demonstrated a small step away from stigmatising, oppressive practice (Schulz, 2018 p. 77). Rather than labelling gender diversity itself as a

“disorder,” GD attempted to codify distress associated with “misaligned” gender (Beek, Cohen-Kettenis, & Kreukels, 2016; Drescher, 2010; Kamens, 2011). However, the GD diagnosis continues to be “at a cataclysm of numerous debates and disagreements” (Tosh, 2016, p. 2), where mainstream psychotherapeutic practice for TGD people continues to reinforce “oppressive confines of sexism, cisgenderism, heterosexism and sanism” (Tosh, 2016, p. 12). The revised diagnosis continues to position “non-normative” conceptions of gender as pathological and practitioners as powerful “experts” (Schulz, 2018 Tosh, 2016).

Anti-Oppressive Practice

An understanding of the gatekeeper model and how it has reinforced a “legacy of distrust” (Murjan & Bouman, 2017, p. 126) with TGD folk, elicits questions of how therapists can problematise oppressive forces and work towards social justice. One such way is through anti-oppressive practice (AOP). Anti-oppressive counselling conceptualises “personal problems as social problems” (Brown, 2019, p. 24), where therapists seek to be critically aware of the intersectional ways in which heteronormativity, cisgenderism, patriarchy, white privilege, and classism operate, as well as their own assumptions, biases, and privileges (Brown, 2019; Baines, 2011; Crenshaw, 1989; Larson, 2008). AOP reorients traditionally oppressive practice with TGD people away from diagnostic tendencies to individualise and internalise distress. It locates “dysphoria” as a response to a sociocultural matrix continually steeped in binary gender and cisgenderism (Ansara & Hegarty, 2012). Incorporating understandings of cultural humility, it compels therapists to ongoing education, self-critique, and active engagement with inequalities (Fisher-Borne, Cain, & Martin, 2015; Tervalon & Murray-Garcia, 1998). Whereas cultural competence has focused on understanding and a sense of “comfort” in working with a collective sense of “them” or “Other,” cultural humility highlights a need for ongoing critical reflection (Fisher-Borne et al., 2015). It encourages an active, humble, and life-long engagement with power differentials within therapeutic relationships and broader contexts (Fisher-Borne, et al., 2015; Larson, 2008; Tervalon & Murray-Garcia, 1998).

So, what does a “safe professional” look like for TGD clients? Perhaps it is a therapist who is capable of holding space for their distress, someone who does not conflate “dysphoria” with “illness”—but rather contextualises responses and experiences. It may be a professional who does not rely on their clients to educate them on the realities of gender diversity, but who also resists making assumptions—who aims to understand each client, their context and meaning making systems (Barker & Iantaffi, 2017; Twist, Barker, Pieter, & Horley, 2017).

The Current Study

The current study sought to explore the inconsistencies, opportunities, and compromises that emerge within therapeutic practice by interviewing six professionals working in Sydney-based private practices. Participants (who have been given pseudonyms for confidentiality purposes) were found via their own internet-advertised expertise in working with gender diversity. Participants included three psychologists (John, Lisa and Susan),

one counsellor (Adrienne), one psychodynamic psychotherapist (Tom), and one psychoanalytic psychotherapist (Ellie). Qualitative data was gathered through fifty-minute semi-structured interviews. Questions were designed to explore participant understandings of TGD experiences and negotiations or implementations of their roles as gatekeepers. Interviews were transcribed and coded for emergent themes including their client base, theoretical orientations to working with TGD people, knowledge of gender diversity, and “treatment” style. Theoretical frameworks of seminal queer theory and transgender studies which disrupt uniform, pathologising psy-disciplinary work, framed the critical thematic analysis and assemblage into case study (Bolin, 1988; Cromwell, 2006; Namaste, 2000; Serano, 2007; Spade 2003, 2006, 2015). The study’s engagement with psychotherapy-in-practice demonstrates a move beyond the recourse of critiques to analytic binaries such as hegemonic/deviant, medicalised/de-medicalised, normative/pathological (Foucault, 1986; Spade, 2015). These case studies unearth some of the tactical and heterogeneous elements of TGD mental healthcare in practice. By doing so, the project produces a more nuanced understanding of how therapists enact and/or negotiate oppressive practice.

Therapist Understanding of TGD Narratives

Dominant Discourses

During his clinical psychology training, John had worked in a psychiatric hospital where he clinically assessed people designated male at birth for what was then referred to as sex reassignment surgery (SRS). Although over time his work and client group changed, his experience with TGD clients remained consistent, where he described working predominantly with older trans women who he often referred to as “biological males”. John described these clients as “always very distressed,” where John was most familiar with the “wrong body” narrative:

The amount of times I’ve heard how awful and distressing it is to be born in the wrong body. I mainly see biological males—[I] have men of 50, 60 telling me what it’s been like to live a whole life of being a woman in a man’s body and begin to recount their hardships.

John described how the outcome of working through experience, asking clients “what they want[ed] to do to live more in harmony with how they feel,” varied greatly: “Some I know have gone to Thailand for SRS, another has chosen to not go down that route, and is basically a woman in the privacy of their own home and a man in public”. Though there was a recognition of differing needs and outcomes of TGD clients, when discussing the experience of the client who was “a woman in their own home,” John enacted a traditional gender dichotomous psy-professional gaze as well as gender essentialist conceptions of masculinity and femininity:

I still think of him as a male as I have never seen him as a woman, dressed as a woman, so unfortunately, I am still seeing him in my mind’s eye as a man. Had archetypal male interests in racing cars, football... and now lives in a fluid situation... He hasn’t had

hormones but has had body hair removed. From my perspective... doesn't look very feminine. But then again, I haven't seen her, with makeup and clothing on, as she would be in her own house.

John acknowledged the possibility of gender fluidity, however he did so while mispronouncing his client and perpetuating stereotypes of what it meant to be a man (liking football and cars) and a woman (be hairless and wear make-up). This approach perhaps perpetuated the historical need for TGD people to perform gender in binarised ways to cisgender practitioners. The need for "passing" is well documented in the history of trans mental health care, where numerous trans scholars have described how clients would "dress up" for mental health professionals to enhance the reality of GD for gatekeepers (Bolin, 1988; Namaste, 2000). For example, Bolin (1988) recounted how "You must conform to a doctor's idea of a woman, not necessarily yours" (p. 108). Thus, it may be inferred that the history of obscuring diverse TGD experience is extended, with clients still required to perform their "trans-ness" in particular ways for gatekeepers such as John. Though John deeply cared about his clients and their experiences of suffering in silence, he primarily continued to operate in an inadvertently oppressive way. This stresses the importance of upskilling and critically reflective work when approaching therapy through an anti-oppressive lens.

Paradoxical Positions

Ellie described herself as a psychoanalytic psychotherapist whose clients approached her specifically for her therapeutic style and engagement with unconscious motivations and dream material. On Ellie's account her client base tended to have crises with identity, sometimes manifesting as gender or sexuality issues. In reference to these experiences, Ellie stated:

I am really comfortable working with them... there is a natural curiosity and an ability to sit with some very unusual material, and I think they at an unconscious level know that... I will be okay with whatever they bring in.

The material clients brought to therapy differed. Some came to sessions knowing they wanted to transition, while others were questioning and sought therapy to work through gender issues. However, due to her psychoanalytic style, Ellie said that mostly clients did not come wanting referrals to transitional medical care "but rather to understand" any confusion around their gender, "to get a sense of feeling comfortable in whatever gender or configuration they want to call it".

Ellie described herself as being open to diversity, relaying how she had attended a presentation which showed "compelling research" on the existence of diverse genders and the impact of cisgenderism and cissexism on society. Ellie said learning that there were "more than two genders...just made total sense to me!". However, at times, Ellie's account reinforced aspects of binary gender or a dominant "wrong body" interpretation of TGD experience. For example, Ellie gave an account of how a client who was assigned male at birth "was quite confused," wanting to wear breast inserts. She explained that

once they began to “sit with the possibility of being both [genders],” the client no longer “needed” to use breast inserts—“the more it was brought out, explored, unpacked, allowed, the cross-dressing tapered off”. Ellie justified this in terms of her commitment to focusing on the material clients bring to therapy and slowly working through and uncovering meaning in their experiences. Ellie clarified that stopping “cross-dressing” behaviour was not an aim of therapy, instead arguing that “by allowing that space, things shift and behaviours change”. Her therapeutic aims centred around clients attaining “an acceptance of who one is... to feel comfortable in one’s skin”.

When considered in the context of her hesitancy to facilitate transition and infer possible meaning behind gendered distress, Ellie’s vague term “one’s skin” perhaps suggests reluctance on her part in allowing clients to “pass through the gate”. For example, Ellie had suggested that “One of the questions I hold in mind when someone presents is... whether they actually want to change gender or is the desire to change gender a way to get something. Is it a solution to something unconscious and unknown?”. Such an explanation reinforces Ellie’s political and therapeutic orientation, where client and therapist would attempt to understand the significance of a desire to change gender. Ellie described an openness to diversity, albeit within the context of a psychoanalytic therapeutic intention to explain distress and explore what issues gendered anxiety potentially obscured. This perhaps does a disservice to the realities of gender exploration. It positions therapists as powerful experts who somewhat collaboratively (or not) analyse what ‘lays behind’ gender distress, positioning gender distress and associated constructs of cissexism, cisgenderism, and heteropatriarchy as not the “real issue”.

Paradoxical orientations were similarly enacted by Tom, a psychodynamic therapist working in private practice. He too engaged in long-term work with clients who sought his practice specifically because of its “openness to the complexity of life”. Tom described his client base as generally involving “people who have an underlying desire to address their own desires,” which sometimes manifested in a gender exploration. Tom described working with TGD clients to be “tricky because biology is changing, and decisions have to be made, legal things...out of my domain”. Tom discussed how advising clients about gender diversity and options for transition was beyond his capabilities, characterising himself as “certainly not an advocate of any law or medical matters”. Tom responded to clients’ desire to transition with some hesitancy: “It’s tricky because there is a mixed desire to change one’s physiology to suit the desires or felt gender, but that is a matter of exploration for me”. This orientation was extended as he described himself to be “no advocate” of hormonal or surgical intervention:

Some go down path of hormones, changing physiology. But personally, I am no advocate of that as the answer. I am an advocate of the experience and believing that their coming to grips and celebrate their actual experience, their lived life is fundamental before they move anywhere in a determined sense.

In reference to client narratives, Tom adopted a level of scepticism about the need or desire to transition, similar to Ellie’s therapeutic insistence that clients “feel comfortable in their own skin”. He did acknowledge that transition was sometimes “obviously needed,”

but that this was to be approached with caution. This demonstrates a paradoxical position without clear intentions of dismantling oppressive forces or an intentional disruption of a claim that psychodynamic approaches may be “the most explicit in their binary conceptualisations of gender” (Barker & Iantaffi, 2017, p. 109).

Diverse Narratives

In her private practice Addison primarily supported gender variant children, adolescents, and their families. With training in TGD mental health, Addison recognised the diversity of gender variant experiences and identities: “I always say there are as many ways of being trans as there is trans people”. Addison’s therapeutic interactions with children and adolescents varied. Sometimes she used clinical, standardised GD assessments (so as to advocate for hormone blockers or court reports required for hormones), but she also sought to educate parents, families, schools, and communities about the reality of gender diversity. Addison discussed how she refused to pathologise young children and “hated” the terminology of GD due to the way it conceptualised and limited TGD experience.

Addison believed that diversity was becoming better recognised by mental health practitioners and institutions such as The World Professional Association for Transgender Health⁴ (WPATH) because

15 years ago, it was “Does this person have Gender Identity Disorder? Let’s go by the criteria”. Now there seemed to be a better recognition that the “wrong body” narrative isn’t helpful to a lot of people... there has been a big shift towards “Hang on, who are we to judge this person and what their needs are?”

Addison demonstrated anti-oppressive practice in that she critically utilised approaches to advocate for and support her clients while participating in broader social change.

Susan and Lisa were psychologists who worked in a centre specialising in gender and sexual diversity. They worked with a variety of clients, including clients with non-binary identities and clients who had a “very gendered experience” (Lisa). Both Susan and Lisa recounted clients coming prepared to deliver a normative “wrong body” narrative, but who would reveal over time that this was a safety mechanism designed to negotiate access to the care they desired. Susan described how “a lot of non-binary clients say ‘Oh, I was going to come in and say I’m male, when I’m not’, just to get the testosterone”. Lisa described someone who wanted their breasts removed, however they

...did not have dysphoria, but it was something they felt would match more closely with their gender identity. They said that a health professional would not remove their breasts or give them [any] surgery without them experiencing dysphoria. So [the client] said they were then stuck in a position where they had to lie and say they experienced dysphoria or be in a body they didn’t feel was authentic to them.

Extending the history of trans people performing a particular experience to negotiate the psy-professional gaze, Lisa described how clients in the first few sessions tended to “check us out”. Clients tried to ascertain a therapist’s level of openness to gender diversity

and determine what they would need to articulate “in order to get [their] needs met” (Lisa). Lisa explained how clients would often

...probe to see what our attitudes are, while presenting a context of “Yes, I am definitely transgender, yes I definitely want to go forward” [with transition]. Once they determine it is something safe to explore and they are not going to be denied any access to anything, they will normally open up that their narrative doesn’t fit.

Both Susan and Lisa acknowledged and understood why clients would feel the need to perform their gender identity in such ways, due to the possibility of “risk[ing] rejection from the mental health professional if they tell the truth about their lives” (Lev, 2004, p. 49).

Lisa reflected on the importance of facilitating open and anti-oppressive therapeutic environments that held space for diverse identities and experiences, as clients often were “very wary about revealing anything because they [were] very concerned about being pathologised or laughed at”. This is suggestive of a reflective practice that tried to account for, and problematise, historically oppressive models. For example, Susan critiqued the gatekeeper model arguing “people who get nose jobs, boob jobs, take drugs, don’t have to see a psychologist to do that, while people who are assigned male at birth and want a boob job have to go through all this just because it’s non-normative?... It’s...really absurd”.

Anti-Oppressive Strategies

In the case of Addison, Lisa, and Susan, the creation of a therapeutic environment that openly discussed varied TGD narratives was often facilitated through the use of psychoeducation. Psychoeducation is frequently located as a first stage in “treatment” for mental health issues where psy-professionals are positioned as “experts” in conveying to clients key information about their “illness” or presenting issue (APS, 2010). Given the legacy of pathologisation within psy-sciences, it may be inferred that these practitioners employed a more subversive or anti-oppressive form of psychoeducation. Rather than discussing GD as a classified mental “illness,” these therapists aimed to educate clients about gender diversity and sexuality to empower clients with language that may better capture their experiences. Rather than speaking on behalf of clients, when working with adolescents Addison sought to help “them understand what’s going on, without putting any words in their mouth”—to introduce them to a language through which they may understand their lived experiences.

These practitioners employed psychoeducation as a liberatory psychotherapeutic intervention through which they could extrapolate the diversity of TGD identities. The use of this mainstream psychological “technique” is interesting given that these professionals at times attempted to distance themselves from much of mainstream psychology and questioned automatic connections between gender diversity, diagnosis, and gatekeeping. These practitioners intentionally separated gender diversity from diagnostic language and drew on sociological and gender knowledge to enable a strategic distance from the strict

requirements of diagnostic categories. They critically adapted psychoeducation to empower and collaborate with clients (which is in line with AOP), rather than paternalistically speaking *for* or *at*.

Practitioners had varying experiences of client narratives—ranging from the dominant “wrong body” trope, to clients performing a narrative that may not be their own to negotiate gatekeeper protocols. Differing client bases often led to divergent understandings of gender embodiment and therefore practitioners’ “treatment” of distress. For some practitioners, their experience of clients led them to develop a critique of normative discourses on GD, indicative of anti-oppressive principles. Some practitioners enacted a critically informed position and attempted to empower clients with language to explore their lived experience. The following discussion will expand this analysis by exploring how practitioners differentially “assessed” and “treated” gender diversity and/or dysphoria.

Therapeutic Assessment

Informed by their client bases, therapists expressed varying degrees of comfort and investment in gatekeeping. Two main assessment modes were identified, which will be discussed below:

1. A *procedural* (sometimes collaborative) approach, centred on the urgency of alleviating dysphoria; and,
2. A *relational* style, which sought to “deepen the experience” of the client, resulting in more conservative positions on transition services.

Mode 1: Procedural

Traditional Approaches

In the past John had worked in a psychiatric hospital where he was involved in the psychiatric clinical assessment of patients assigned male at birth who sought gender affirming medical interventions. John was trained in modes of assessing, report writing, and preparing people for surgery—procedural processes that he described as “fundamentally to do with making some judgement”. John contrasted clinical assessments to the role he now had as a “supportive therapist”:

I don’t think I would call it formal assessment really... I don’t really work that way... if someone is distressed, and they want my help to reduce that distress, live more authentically, that’s what I do.

This change to John’s therapeutic intention and style led him to work in a more reflexive way, compared to the structured and more overtly oppressive past assessment practices. Although he did not subscribe to explicitly procedural terminology, John did describe the therapeutic process he followed when working with “biological males” seeking to transition. John’s assessment centred on engaging with the client, enquiring into their unique experience, and exploring how they wanted to live more harmoniously with their

gender identity. These conversations had differing outcomes—sometimes John would refer clients to an endocrinologist or surgeon, however that was not an explicit goal or treatment focus. In this sense he described himself to be “quite eclectic,” where his client-centred therapy style aimed to “provide a space where people can really reflect and share... their experiences”.

Though this seems reflexive and openly engaging, John’s use of GD as a diagnosis is worth noting. John described how using the DSM to diagnose clients was an inevitable result of being a Medicare-funded psychologist. John did not have any qualms with using the GD label because he understood diagnosing clients to be necessary: “If you are using Medicare you have to have a diagnosis; it’s the law, it’s just the way it works”. This revealed how clinical decisions are mediated by administrative constraints and bureaucratic requirements. When questioned about the use of the GD diagnosis (for example, if it conflated gender diversity with “mental disorder”), John argued that the diagnostic language had changed and significantly improved. He stated that “cross-gender distress” codified in a GD diagnosis accurately represented the experiences of his client base, and thus he did not have reservations about using it as the official diagnosis for Medicare: “GID implies they’ve made a mistake... Dysphoria is what it is, it’s unhappiness, and people I meet with are unhappy”. John’s adherence to diagnostic language positions him within the bureaucratic modes of assessment and mental health care that he otherwise critiqued, while also enacting a strong relationship (or even conflation) between TGD identities and mental health issues. His commitment to diagnostic modes due to Medicare bulk billing brings important reflection for psychotherapists and counsellors who do not have to be as limited by bureaucratic functions. Perhaps there is particular potential for Australian psychotherapists engaging in AOP to seize the benefits of not currently being recognised as a registered field with Medicare funding.

Exploring Diversity

Susan and Lisa worked somewhat similarly to John, yet also sought direction from WPATH’s *Standards of Care* guidelines. Susan described herself as being relatively new to the field and so chose to trust the experience of a body that produced international standards. She used the guidelines in a “flexible” way where she created

...a space where the client can say, ‘I have uncertainties around this’ and for me to say ‘That’s ok, we can talk about that’, is actually much more helpful than ‘No, you have to be 100 percent gender dysphoric otherwise I won’t give you these hormones’.

As previously mentioned, Lisa and Susan had experience with clients presenting a particular TGD narrative in order to get access to referrals. As such, Susan employed flexibility in negotiating diagnostic procedures—particularly in terms of client’s reported “symptom” timelines. Susan used the GD criteria with discretion, stating a reluctance to withhold referrals if a client did not officially meet the DSM-5 six-month “symptom” timeframe. Susan’s deployment of some fluidity when enacting gatekeeper models reflected the ways in which neat categories purported by mainstream psychology proved

profoundly inadequate given the complexity of TGD lived experience. This is indicative of anti-oppressive work, in that Susan attempted to cultivate therapeutic spaces where non-normative narratives were welcomed and understood.

Similarly, Lisa sought to use diagnostic language in a collaborative way. She relayed that most of the time people are fine to have the [GD] diagnosis as long as we explain to them that we don't think they are mentally ill. It is just describing an incongruence between their identified gender and their gender assigned at birth.

Lisa sought to frame diagnostic language not as a means of pathologising clients but a tool to get the care desired. She described some of her therapeutic work in terms of advocacy rather than as an explicit gatekeeper: "We would frame it in terms of their health and their care... We are here to help you decide what is the best option for you to go forward".

Lisa frequently reflected on the difficulties of being limited to gatekeeper functions within the current system, but also believed that protocols were at some levels "logical" and necessary to ensure the safety and care of clients. This included her suggestion that assessment provided an opportunity to screen for "comorbid" mental health concerns, in line with WPATH guidelines which state that if left unaddressed other mental health issues "can complicate the process of gender identity exploration and resolution of gender dysphoria" (Coleman et al., 2011, p. 181). This approach continues to individualise client distress and rely on diagnostic categories. Effective AOP would highlight the highly contextual nature of a client's experience—problematizing questions of "what is wrong with this person" to "what has happened to this person, what systems and structures do they exist within and how does that impact their experience?" (Johnstone & Boyle, 2018).

Due to Lisa's agreement with the guidelines to assess for other mental health concerns, it is unsurprising that she justified her role as a gatekeeper within WPATH's bureaucratic management discourse, which remained fraught with fear:

There are actually some very good reasons for the gatekeeper model, but you need to know quite a lot about mental health and about gender issues... there are some mental health conditions which mean that people will show up at your office and say 'I have gender dysphoria, I want to be the opposite gender,' when what is actually happening is that they are going through a period of psychosis, or they have a disorder that means that they don't have a stable sense of self... To say [to clients] that 'What we are trying to do is just check that you are aware of the future implications and to also check that there are also no other signs of mental health issues that could preclude you from being able to make an informed decision'.

Perhaps Lisa's statement continues the long history of psy-professionals using "risk" as a justification for oppressive practice (Ellis et al., 2020; Spade, 2003). Though she also argued that ensuring "good mental health" was indicative of the double standard implicit in much of the gatekeeper discourse:

Nobody would say well this person needs a heart transplant but they have depression so they need to go and have counselling for six months to make sure their depression is treated before they then go and have the surgery. We would actually say this person is very sad, it's not precluding their ability/capabilities and we would refer them to the surgery they needed.

Lisa and Susan operated well within the dictated procedures of the gatekeeper model as codified by WPATH, but also tried to negotiate the model by strategically and flexibly using diagnostic language to their diverse client group. Their practice enacted a distinction between mental health problems and the desire to transition, rather than conflating them etiologically, which has historically been the norm. Though many would argue a GD diagnosis is inherently oppressive, Lisa and Susan's reflexive use of diagnosis demonstrates the more nuanced ways in which bureaucratic constraints can be negotiated in practice. While holding tenants of anti-oppressive work, this process certainly still bears traces of their role as a gatekeeper—mediators between the needs and desires of TGD clients, and the surgeons and endocrinologists who have the power to provide medical intervention. It also speaks to the bureaucratic limitations afforded particularly to psychologists in Australia, potentially in opposition to unregulated fields of psychotherapy and counselling. In rudimentary ways this may be indicative of anti-oppressive principles, in that it separates gender diverse identities from “pathology,” however AOP should call us far beyond the “bare minimum”.

Reflexive Work

Addison also used psychological language strategically. She had a thorough understanding of the gatekeeper model's pathologising history, the way it codified experiences and privileged particular forms of evidence over others. Addison positioned herself as a therapeutic supporter, an advocate for people's needs:

I don't have any agenda about how you turn out or what you call yourself or what your needs are regarding gender or sexuality, it's just about working out what they are—you don't even have to have a name for it... I just try to get away from any hard or fast criteria or boxes to put people in, and just give them the freedom to work out who the hell they are, what works for them, why, how that will impact their life, what they can do about it.

In separating herself from explicit criteria, Addison stated that she “hate[d] the word [gender dysphoria] really. It's only a diagnosis.” For Addison, a GD diagnosis was “a tool... to get people the treatment they need”. It was used in court reports (for adolescents to get hormones), referral letters, and diagnosis explanations some schools require for students who are transitioning—all documents Addison would formulate collaboratively with clients.

Although frustrated by the realities of the gatekeeper model and the processes she had to follow when working with gender diverse adolescents and children, Addison acknowledged that the model was improving. She commended WPATH's *Standards of Care* for “becoming more and more inclusive and flexible” and reflected how in her

experience the “gatekeeper element... is falling away, at least for me. I mean the only gatekeeping I need to do really is writing those darn reports to get people’s needs met, or surgery letters”. When working with adults, Addison argued that gatekeeping had changed significantly as “now it is fairly much...give them the name of someone who prescribes hormones and then it is up to them to decide”. Therefore, compared to Lisa and Susan’s liberal apologist approach to gatekeeping, Addison expressed a more explicit critique of the model. She knew and understood WPATH’s guidelines, but attempted to separate herself from clear-cut diagnoses, labels, and bureaucratic processes. She recognised the variety of client needs given the multiplicitous reality of TGD experience and approached diagnostic language and protocols as a means to an end.

Mode 2: Relational

Client-Led Approach

Tom and Ellie’s practice largely rejected mainstream psy-discourse surrounding gender dysphoria. This was in part a product of their scepticism toward much of mainstream psychology, as they both critiqued its insistence on diagnosing and pathologising individuals, and they were sensitive to the impact of these practices on certain communities. In line with their psychodynamic and psychoanalytic training, their approaches aimed to focus on the individual and what they described as the reality of their unique experiences. Tom did not subscribe to diagnostic language or dominant psychology’s therapeutic aims. He sought to engage with a client’s distress purely by listening to their experience. He described himself to be “totally against pathologising as far as that’s possible,” which resulted in a therapy style focused on unpacking the needs and life experiences of the client. In this he would

...show intrigue, curiosity into their experience... What has happened, how are you making sense of this, when did the trouble start to happen for you... I try to get to the experience underlying and look at it from different perspectives, without evaluation.

In contrast to the first style of assessment, which focused on external influences such as psychological strategies and hormonal intervention to alleviate dysphoria, an orientation of deepening the experience meant that therapy was not structured by definitive goals or timelines. Tom expressed how he did not have a “set [therapeutic] pathway,” but rather a “guarantee that I will work with them and listen very carefully to their experience and trust that will assist them in helping themselves... I encourage the person to trust their own resources”. On his account, the commitment to client experience mostly resulted in a “settling down” of depressive and anxious “symptoms”.

Similarly, Ellie’s approach, which steered clear from “strategies, interventions,” meant her TGD clients did not tend to come to the practice to “decide whether to transition or not but rather to understand it. To get a sense of feeling comfortable in whatever gender or configuration they want to call it”. Ellie relayed how she would help clients unpack their distress or gender diversity: “I don’t tick boxes, the individual is core. They direct the

work; they direct what we do in here". Ellie's client-led style sought to focus exclusively on the experience of the individual, with the added objective of attempting to understand or assign meaning behind their distress or gender fluidity. The focus on meaning differentiated Ellie's practice from the assessment modes of mainstream psychology as she focused on "sitting with", "unpacking", and "allowing" distress, rather than seeking to "defend against it and make it all ok".

Diagnostic Orientations

This mode took distance from what Tom and Ellie described as mainstream psychology's imperative to diagnose. Tom expressed disbelief as to how and why the DSM and many strands of psychotherapeutic practice had become narrow and privileged. For Tom, the development of psychotherapy as an "industry... creates authoritarian attitudes, absolutist positions," where the dominant paradigm continued to be "very clinical...very medical... very limiting". He argued that the model drew on limited forms of evidence to devise mandates that converted symptom clusters into distinct diagnosable categories, including TGD experiences:

The dysphoria, it's a label, and my bias is to hate labels. All the time I have to say 'Yes, I know what the books say, but is that... the experience of my clients?'... it doesn't match up... Part of human nature is to want finality, certainty, and ambivalence is distressing. But, actually, that's the reality, and it needn't be distressing... This thing of not getting caught up in the wave of the moment. To value the deeper understanding of embracing ambivalence and uncertainty.

Tom's critiques are interesting in that they separate dysphoria and/or mental health issues from gender diversity by openly characterising diagnoses as entities open to societal influence. In his analysis, diagnoses were not universal descriptors, but a product of a human need to name and categorise, to "define a problem, and inevitably construct a solution". When working with TGD clients Tom attempted to "stay open to the individual as an individual, always sacrosanct". Though at face value this may seem indicative of AOP, Tom continued to utilise language of "the individual". This is in opposition to AOP principles which highlight the importance of contextualising clients within their socio-cultural contexts. AOP holds that if not actively scrutinised or problematised, the microcosm of therapy holds the same prejudices and dangers for LGBTIQ+ clients as the broader context (Brown, 2019).

Ellie's approach was similar to Tom's:

As a therapist, you expect me to say, "I'm here to heal," but really, can we actually do that? ...there is this real drive to make it all okay, which is what we sit with and what we hope for, but we can't assume that.

Ellie suggested that psychotherapeutic focus on cognition and "fixing" was inadequate in the therapeutic assessment and "treatment" of gendered distress, because "If we are looking at someone who is confused about their gender, that is a bodily issue". Ellie was intent on understanding the possible meanings of distress and desires among her clients

rather than negotiating gatekeeper protocols and using diagnostic language. However, this orientation perhaps ran the risk of inferring gender diversity or experienced dysphoria is not the “real” issue, which may dismiss TGD experiences.

Referral and Advocacy

In relation to their duty of care towards clients, practitioners of this persuasion described their attempts to “de-energise the moment of catastrophe” (Tom). This involved efforts to “slow down” the sense of panic or urgency in clients’ gendered distress and/or desire to transition. Tom intentionally sought to decelerate distress/dysphoria, to “not be caught up in the drama” of the imperative to act quickly when confronted by a distressed client seeking medical transition:

My task is “Yes, I understand, let’s now look at the experience, let’s deepen, amplify the experience”... De-energise the moment of catastrophe. Because often that’s how individuals go into some sort of dramatic event: “I need to act quickly, I’ve always felt this way, now I have to act”... I say, “let’s look at your experience”.

Ellie expressed a similar orientation in her suggestion that therapy involved “allowing a space where people are free to bring in anything they wish to discuss, not directing it, not trying to tie up ends too quickly... You have to be patient”. Though perhaps seeming intuitively anti-oppressive in terms of holding space rather than a rush to diagnose, this could be seen as a particular inhabitation of the gatekeeper position. These therapists remained in a position of authority, with the therapeutic power to “slow a client down” in their desire to undergo transitional procedures, or “pass through the gate”.

These practitioners expressed hesitation when referring clients on to hormone therapy or surgery, as they sought to delay any sense of urgency or panic among their clients and instead unpack the meaning of experienced distress. Ellie and Tom were not advocates, but aimed to deepen a discussion of how their clients wanted to live (though this did not exclude the possibility of medical intervention in some instances). Tom identified that he was not “an advocate of that as the answer”—instead he sought to facilitate clients to “com[e] to grips and celebrat[e] their actual experience, their lived life”. Therefore, “slowing down” clients’ imperatives to act is a form of gatekeeping. It may be indicative of oppressive practice as these practitioners potentially unwittingly restricted access to services through a paternalistic adaptation of therapeutic power, whereby they subtly managed clients’ affect. This is important to note given the mounting evidence indicating “that waiting for assessment increases mental health issues, distress, and suicidality” (Murjan & Bouman, 2017, p. 134) for TGD folk.

For all their criticism of diagnoses and pathology, this mode presumed that gender diverse clients required a certain sort of therapeutic attention and expert handling—that is, de-escalation, slowing down, and deflation. This is interesting when one considers how WPATH’s *Standards of Care* and the DSM-5 diagnosis have changed over time, whereby a period of psychotherapy is no longer mandated for TGD clients, only evaluation or assessment is needed for medical transition services (which could occur in a one-off

session) (Coleman et al., 2011; Lev 2004). These practitioners enacted a subtler but perhaps more duplicitous mode of gatekeeping, focused on de-escalating the time-conscious imperatives of clients who are wanting to transition. In this way, Ellie and Tom's theoretical opposition to oppressive modes of diagnostic-based practice gets lost in their inability to account for the legitimate urgency for some clients in receiving medical services or explicitly affirming psychotherapeutic care. While psychoanalytic and psychodynamic approaches profess a more relational understanding of the human subject and a more complex appreciation of the ambivalence of self-experience, the hermeneutics of the subject it enacts may be more pathologising than it claims to be.

Implications for Anti-Oppressive Therapists

These case studies demonstrate how psy-professionals differentially perform tenants of AOP or gatekeeping/pathologising discourses. For some therapists, gender diversity was subsumed within "mental illness" and its "treatment". Some extricated gender diversity from questions of mental health, precipitating a strategic use of the GD diagnosis. Other therapists considered the assessment irrelevant due to their commitment to psychodynamic processes. Some therapists use of diagnostic discourse may reinforce their very power as a mode of pathologising gender diversity and reifying the role of diagnoses in therapeutic settings. Tom and Ellie attempted to critique an oppressive impetus to diagnose and inability to "sit with ambivalence". Yet such critiques were enacted somewhat paradoxically in perhaps a more subtle application of the gatekeeper role. These therapists somewhat paternalistically attempted to slow the urgency of some clients' desire to transition as they wanted to explore client experience and assign meaning to distress. Thus, while modes of inhabiting oppressive practice were varied and diffuse, practitioners still enacted some version of the gatekeeper role. As Ansara (2010) has argued, therapists that are better regarded by TGD people are acutely aware of "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" (p. 179).

The case studies provide unique insight into opportunities to incorporate anti-oppressive work with TGD clients. The differential focus on diagnostic principles elicits important reflections on the productive capacities of psychotherapy and counselling in Australia. As we are currently an "unregulated" field, for the most part we stand outside key bureaucratic constraints (e.g., those mandated by Medicare). Though organisations such as the Psychotherapy and Counselling Federation of Australia (PACFA) continue to advocate for our field, I propose that particularly when working with TGD clients, our position holds potential in facilitating critically reflective and anti-oppressive work. We possess a unique space within the psy-disciplines, where we can (and should) step beyond the confines of a gatekeeper model and respond effectively to clients without being intimately connected to oppressive practices such as GD diagnosis. The *WPATH Standards of Care* (Coleman et al., 2011) explicitly outline a range of disciplines, including family therapy and counselling, as appropriate in writing referral letters for hormones or surgery. However, within Australia professionals must be psychiatrists or psychologists.

This is incongruent with WPATH's guidelines, and perhaps demonstrates a form of professional discrimination within the field of counselling and psychotherapy within Australia. This poses an ethical issue in promoting/reinstating structural access barriers for people seeking medical transition support.

It is also important to note the *informed consent model* (Schulz, 2018) as an alternative to the gatekeeping model. Gatekeeper models root experiences of gender diversity in a “narrative of distress”, overlooking the “importance of authenticity in the therapeutic alliance” and the intersectional effects of financial burdens (Schulz, 2018 p. 73). The informed consent model allows accessibility to hormonal treatments and surgery without mental health assessment or referral. It removes gatekeeper requirements, where professionals equip those seeking medical support with information regarding costs, risks, and side effects. This practice positions TGD folk as experts in their own lives, where healing occurs in the context of safe, collaborative relationships—relationships in which therapists and other practitioners are embedded in AOP and cultural humility principles of ongoing reflexive work (Fisher-Borne et al., 2015; Schulz, 2018). Under the model, the role of therapists is to enhance client capacities for “self determination”—freeing them from confines of a gatekeeper role (Schulz, 2018, p. 86). Future research could continue to explore Australian professionals' negotiations of informed consent as an anti-oppressive approach to working with TGD mental health.

What can our different location within the “psy” field offer in terms of liberatory, affirmative care for TGD clients? What can AOP and an inquiry of gender teach us about ourselves as practitioners? What does it show us about the world we currently live and work within, and what questions does it ask about what kind of field we want to be? This research indicates there is inherent potential within our burgeoning field in Australia for supporting TGD clients⁵. We should seize the value and flexibility permitted of not currently being a registered field so we can subvert the constraints of bureaucracy and historically oppressive modalities. This will only be effective if we are willing to do the hard work of problematising our therapeutic power as “experts”, confront our biases and lack of knowledge, as well as actively re-work our privilege (Brown, 2019). We must be critical of the risks in “giving lip service to client empowerment while simultaneously defending a system that undercuts client autonomy and self-actualisation” (Ansara, 2010, p. 179). This is what we must be journeying towards as ethical practitioners informed by AOP—we must “undertake reflexive work around your own gender identity, experience, and assumptions” (Barker & Iantaffi, 2017, p. 120), honour the complex and oppressive history of psy-disciplines and TGD people. For when we view psychotherapy through lenses of heteropatriarchy, cisgenderism, white supremacy, and classism, questions appear that deeply “challenge our beliefs and change our professional practice to bring it in line with our social justice values” (Ansara, 2010, p. 190). It is inadequate to intellectually align with social justice (Larson, 2008). These values stem from an ethical responsibility which requires deliberate, ongoing action (Ansara, 2010; Raj, 2007).

This study investigated psy-professional's enactments of, or resistance to, gatekeeper constraints and highlighted key opportunities for counsellors and psychotherapists within Australia to incorporate AOP in their work with TGD people. The multiplicity of client narratives and the ways in which these were interpreted by therapists illustrated the embeddedness of psy-discourse and practice in social forces, local conditions, and disciplinary commitments. Thematic analysis of therapist case studies demonstrated how intentions of "allyship" can prove inadequate for problematising power dynamics and pathologising discourses, including conceptions of binary gender, diagnostic language, and ideologies such as cisgenderism. The research highlights ways in which frameworks for problematising oppression in the lives of our clients are fundamental to ethical, client-focused work.

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Endnotes

1. *Cisgenderism* is the sociocultural ideology which “denies, denigrates, or pathologises” (Lennon & Mistler, 2014, p. 63) gender identities that do not align with assigned gender at birth (Ansara & Hegarty, 2012). The ideology perpetuates the idea that cisgender identities are default, “normal” or of more value than TGD experiences (Lennon & Mistler, 2014). This is encoded within social norms, law, and language, sustaining a powerful nexus of power, privilege, prejudice, and discrimination (Spade, 2015). Cisgenderism differs from transphobia (an attitude of an individual) to the broader ideologies embedded in socio-cultural discourse (Ansara & Hegarty, 2012). Ultimately, language and practice rooted in cisgenderism functions to “dehumanise, silence and erase” (Ansara & Hegarty, 2012, p. 16).

2. There are varied arguments exploring the usefulness and/or appropriateness of terminology such as “LGBTIQ+”. LGBTIQ+ is often used as an umbrella term, however many argue it “conflates gender identity with sexual orientation and in doing so obscures LGB complicity in widespread discrimination and exclusion against people of trans experience” (Ansara, 2010, p. 187). Therapists, activists, and academics often adopt these terms uncritically, positioning TGD people as a unified group (Ansara, 2010). This does a great disservice to the lived pluralities of a varied collection of people and situates a cohesive “them” as “Other” (Ansara, 2010; hooks, 2015). This paper does not purport a homogeneity within “*the trans community*” nor broader “queer” networks/communities – it seeks to disrupt this, locating difference and heterogeneity as key. However, throughout this article the term transgender and gender diverse (TGD) is used as a collective term to include those whose gender identity is understood not to correspond with their assigned gender at birth (Pyne, 2011).

3. Judith Butler’s seminal theory of performativity conceptualises how gender comes into being through “a stylized repetition of acts” (Butler, 1990, p. 33). Rather than existing a-priori, Butler (1988, 1990) posited that gender *comes into being* through its enactment. A “gendered” sense of self arrives *through* language, through repetition (Butler, 1990; Ellis, Riggs, & Peel, 2020; Finlay, 2017; Namaste, 2009). However, many trans theorists/activists have questioned Butler’s concepts. For example, Namaste (2009) argued Butler’s analyses require “the existence of violence against trans bodies but largely decontextualis[e] this violence in the pursuit of her theoretical objectives” (Finlay, 2017, p. 60). Performativity’s questioning of “stable” identity has been received as invalidating capacity for self-determination—as some TGD folk seek stable identity to be recognised, to be safe (Finlay, 2017; Prosser, 1998).

4. WPATH is an interdisciplinary association aiming to promote care of TGD people through “evidence-based research” (Coleman et al., 2011, p. 166), education, advocacy, and public policy. The organisation produces *Standards of Care* and *Ethical Guidelines*, “which articulate a professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria” (WPATH, 2020, para. 6). WPATH aim to standardise the abilities and roles of practitioners. However, the managerial and paternalistic language used by WPATH can infer that gender difference is something to be handled, organised, structured. As Ellis, et al. (2020) suggest, WPATH’s Standards of Care “are widely considered to be the most supportive treatment guidelines, though they are not without their problems” (p. 46).

5. That is, if we are to risk rendering TGD people as a cohesive “whole” at all, as this comes with clear risks in making finite, defining, limiting. If implementing AOP, we must be aware of risks in replicating the pathologising practice of privileging particular narratives and ways of being over others.

