MAINSTREAM ISSUES: MINORITY CLIENTS

TINA LIVINGSTONE OFFERS A PERSPECTIVE ON COUNSELLING TRANS-IDENTIFIED AND TRANS-HISTORIED CLIENTS

Abuse, anxiety, bereavement, cancer, career counselling, debt management, disability, relationship issues, work-related stress – any of the human issues you can think of – may affect the lives of trans-identified and trans-historied people as much as the lives of anyone else. Trans-identity offers no immunity to the other truck of life, thus the human issues that affect us all may occur prior to, alongside, or post gender reassignment. Moreover my master's research showed that trans-identified and trans-historied (trans) clients find talking therapies, in the main, helpful – 79 per cent of respondents returned ratings of very or fairly helpful. This indicates that the population value talking therapies, and are therefore likely to seek them out.

However, where minority populations are concerned, it is often only a minority of professionals who take interest, despite the fact that all human issues can affect all human beings. It is, perhaps, a reflection of the way minorities tend to get segregated in society; a parallel process to the way minority groups are sidelined from the mainstream – as though owning some diversity nullifies the rest of one's humanity. As part of the presenting panel of the Gender Symposium at the 8th PCE (Person-centred and Experiential Psychotherapy and Counselling) Conference in 2008, I proposed: 'There can be no greater alienation than to be deemed an inauthentic human being.' Those words still ring true – it is my hope that in writing them again, more therapists will hear the call to become actively 'anti-sectarian' and, perhaps, in reading on, become inspired to open their counselling room doors more comfortably to gender diversity.

Setting trans-specific counselling issues aside, one might argue that if the issues are mainstream, there's no need for further discussion. However, all diversities 'have their own "languages", knowledge and models of being'[1] The need for culture-specific awareness and understanding may seem obvious where race and faith are concerned, but can be overlooked, if not resisted, when diversity concerns sex and/or gender. It has been suggested that this may be due to our existing in a 'cultural matrix that sustains the illusion of two coherent gender identities' and 'prohibits and pathologises any gender-incongruent act, state, impulse, or mood, as well as any "identity structure" in which gender or sexuality is not congruent with biological sex'[2]. Where gender and sexuality comprise socially instituted, normative ideals, variation from the norm has been perceived at best as choice, and at worst deviant, and what emerges is alienation. My research indicated that lack of relevant knowledge had a strong effect on the risk of therapy being found unhelpful; moreover, within client comments, knowledge of trans issues was the most frequently mentioned positive practice.

TRANS SUBCULTURE

It has been my privilege to be involved with trans subculture, personally and professionally, for over 20 years. I say 'subculture' rather than 'community' because the diverse individuals who comprise this population do not necessarily participate in, or identify with, each other or any trans-specific groups. Community requires communication, whereas subculture, though defined by shared characteristics, may not only be widespread, but its members may also be utterly unconnected.

Wikipedia defines subculture as 'a group of people within a culture that differentiates themselves from the larger culture to which they belong'[3]. In the case of trans-identified and trans-historied people, I suggest it is the larger culture that tends to do the differentiation. Like most other groups of people, trans people are often quite ordinary in themselves; it is society at large that persists in out-grouping them. Moreover, whilst other minorities derive some benefit from grouping regarding identity and relationship, many trans people regard themselves as being part of the heterosexual majority; they are therefore more likely to come into mainstream counselling.

Since assignment of atypical sex and gender development remains in the realms of psychopathology, it is small wonder that society's morbid curiosity continues, and reluctance to engage with the trans population is perpetuated. Despite the American Psychiatric Association (APA) acknowledging that 'how mental disorders are defined and diagnosed... impacts how people see themselves and how we see each other'[4] (trans-identity remains in the DSM V Gender Identity Disorder. Being retitled Gender Dysphoria, and Transvestic Fetishism, renamed Transvestic Disorder, does little to remove the stigma of psychiatric diagnosis, the power of which disarms both mainstream and minority concerned with anxious notions of abnormality).

THE MEDICALISATION OF DIVERSITY

In parallel to this, the continuance of medicalisation of trans' diversity, originally propounded by Dr Harry Benjamin and his contemporaries in the 1950s[5,6] focused attention on the physical process of realignment. This propagated numerous studies into physical outcomes rather than quality of life, and such regulatory discourse, medically normalising diversity, can distract us from engaging with those concerned, as people. Consequently, BACP's systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people 'found very few papers focusing on psychotherapy for transgender people that were not solely concerned with preparing them for gender reassignment'[7]. This 'de-personing' of diversities through medicalisation not only leads to misattribution of client issues[7] but can effectively exclude people from relevant mainstream services.

The following example appears in Izzard, Quantick and Double's *Dress to kill*[8].

'I went to see the Doctor wearing make-up:
"I've got a cough."
"You've got a what?"
"I've got a cough."
''You're a transvestite?"
"No. I've got a cough. I am a transvestite, but I've got a cough."
"Well, I'd better sort the transvestite thing out. Have to refer you for that."
"No, that's not the problem. Just the cough, thanks.""

Being part of a stigmatised subculture is a tough place to be, and not one any human being would take from choice. In order to understand where this weight of social stigma comes from, we need to spin the wheel of time back around 150 years – when the lesbian, gay, bisexual and trans people of today simply did not exist; that is to say that the labels currently applied to those populations did not exist. Diversities of

human sex and gender were evident but perceived somewhat differently: 'Untainted man will never become sexually inverted... The tainted individual, however, whose psycho-sexual centre is originally weak, is in a different position ... evil influences may render him furthermost psychically bisexual, then invertedly mono-sexual, and eventually may even effect castration.' (Richard Freiherr von Krafft-Ebing, 1886).

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The regulatory function of medical discourse was thus transparent at that time – anything outside the heterosexual norm was simply taken to be downright sinful, a notion that pervades some people's consciousness even today.

Within my lifetime, behaviourists have aligned transvestism with paedophilia and sadomasochism, and treated all similarly through olfactory and faradic conditioning (noxious smell and electric shock)[9]. Studies that explored and expounded such treatments were generated from the notion of sexual deviance, and focused on aversion therapies[10-12]. Indeed, *A Comparison of Pharmacological and Electrical Aversion Techniques*[9] listed eight 'advantages of faradic aversion conditioning over the conventional pharmacological type of behaviour therapy'. Three times I have knowingly worked with people who have previously suffered such therapies in their youth; it is such experience that fires my passion to contribute to better treatment now and in the future.

Words can harm as well as heal, and how one is addressed matters. Using generic terms can be received at best as inappropriate, at worst as insulting, and a specific term that doesn't fit may be equally uncomfortable. Catalano, McCarthy and Shlasko[13] acknowledged the importance of distinguishing between transgender as a descriptive term and transgender as an identity, noting that many people who fit the 'broad definition of transgender may not claim a transgender identity'. The umbrella term 'transgender' is actually considered inappropriate by some who seek, or have undertaken, sexual reassignment because the term 'transgenderist' was coined by Virginia Prince 'to refer to those people like herself who, though male, elected to live full time as women while retaining male genitalia'[14]. Additionally, subculture often mirrors mainstream; thus trans subculture can be very hierarchical – with those participating in cross-gender expression part time deemed somewhat less than those who have undergone clinical realignment. Consequently I use the term 'trans-identified' to refer to the combined populations of people currently labelled transvestite, transgender and transsexual, as I perceive them all equally, and respect the fluidity of personal journeys; while the word 'trans-historied' is designed to offer respectful inclusion to those who have completed transition/hold a Gender Recognition Certificate (GRC)/ have changed their birth certificate, and no longer consider themselves trans.

COUNSELLING PRACTICE WITH TRANS PEOPLE

The body of knowledge on which recommended counselling practice with trans people currently rests comprises the following factors: clinical opinion[15,16]; account of therapists' experiences based on vignette[18]; and transgender youth accounts of upbringing[19]. Despite a lack of field studies, there is a clear emphasis on humanistic approaches, with recommendations focusing on the person rather than their diversity. Vitale[20] reported being a 'strong advocate of empowering the individual by using a supportive, responsible, down-to-earth existential-humanistic approach'. Ettner[14] wrote in favour of 'those practitioners who are humanistically or existentially orientated' as having 'advantage in that they are accustomed to acknowledging and affirming phenomenological and experiential states'. Lev[17] stated that therapists 'must have a humanistic perspective that supports the empowerment of client self-identification'. This emphasis on respect and relationship is perhaps understandable against the previous focus on psychological abnormality and aversion therapies. It certainly aligns with counselling and psychotherapy research indicating the contribution of facilitative attributes of counsellors to successful therapeutic relationship[21-23].

However, as Glasser[24] observed: 'Virtually anyone can be helpful some of the time, but when we are talking in terms of viable therapeutic outcome criteria, vague allusions to generalised helpfulness are entirely insufficient.' Twenty-one per cent of respondents to my survey indicated therapy had been unhelpful. Quantitative analyses undertaken with the data showed that therapists' practices toward trans-identified and trans-historied clients had the strongest effect on clients' perceptions of helpfulness of therapy. Inappropriate practices, indicating prejudice or lack of understanding, increased the risk of therapy being found unhelpful by trans-identified and trans-historied clients up to 11 times.

Societal prejudice is not always communicated with malicious intent; indeed the communication of bias and discriminatory behaviours can be 'unconsciously communicated by well-meaning and kind-hearted individuals,'[24] therapists included. This underlines the importance of identifying what clients experience as negative, since we cannot correct what we simply don't recognise. Defined as 'communications of prejudice and discrimination expressed through seemingly meaningless and unharmful tactics', Shelton and Delgado-Romero[25] identified seven themes of micro-aggression. These included therapists' assumptions that the clients' diversity caused all their problems, heteronormative bias, and warnings about the dangers of identifying as lesbian, gay, bisexual or queer. They further reported that, 'micro-aggressions within the individual therapeutic environment had a negative impact on the therapeutic process... in the form of participants' emotive reactions, attitudinal changes regarding therapy and therapists, and diminished help-seeking behaviours'. Appreciating this 'unconscious' aspect to negative practices highlights the importance of identifying what clients from stigmatised subcultures find helpful and unhelpful in counselling practice.

INTERNALISED OPPRESSION

Whatever the issues a trans-identified or trans-historied client brings to counselling, one theme likely to be present across the board is internalised oppression. This is the manner in which members of an oppressed group come to accept and collude with the oppressive attitudes of others toward them.

We learn about ourselves through others' actions and reactions toward us; our interactions with the world around us inform us about who we are. Moreover, we are all raised within culture, and become subject to it from an early age. It is, therefore, not unusual for members of marginalised groups to believe in the negative stereotypes embedded in their own culture, or even hold an oppressive view toward their own group. Trans-identified and trans-historied people thus often have huge struggles simply coming to terms with being themselves. A culturally embedded concept of disorder is difficult to override, especially for the people themselves. Consequently, first awareness of trans diversity is often alarming for the person concerned. Trans-identity has been so powerfully dehumanised that those who experience it frequently struggle to regard themselves as 'proper' people, and often see this aspect of themselves as some heinous attachment or curse.

Remembering the tendency for fight, flight, and freeze when sensing threat, the scene is set for interesting and sometimes challenging encounters, not simply in the wider world but actually within the self. Aside from lack of self-esteem and self-worth, a sense of profound vulnerability often precipitates and propagates huge anxieties, and it follows that hypervigilance is high.

Becoming comfortable within oneself is a huge task when one believes the world at large is extremely uncomfortable with you. Notions of 'same' and 'equal' are often conflated in our society. We are not all born the same but we are all equally valid human beings. Unfortunately, the existence of equalities legislation indicates that this is not a universally held principle but one that needs to be enforced.

TO CONCLUDE

When I began my journeys alongside differently gendered people, I had no personal experience of 'feeling like a woman' or 'thinking like a man'; I only knew my own experience of being – as a person. I am still no closer to resonating with gender stereotypes, yet through hearing the stories of trans-identified and trans-historied people, I have come to understand the frustration of 'living life behind frosted glass so that nobody can really see me nor know who I truly am', and can imagine the discomfort of feeling 'like living with your clothes on backwards; it's doable but uncomfortable and exhausting, and sometimes really chafes'. Similarly, I have never contemplated gender transition, but like most human beings who are a tad long in the tooth, I have experienced numerous life transitions, from the first day at school to the onset of old age, and therefore have some understanding of the mix of emotions that change can evoke.

Trans-identified and trans-historied people are still subject to prejudice; hold in awareness that those connecting with them may be doing so out of political correctness or out of curiosity (rather than genuine interest). Trans-identified and trans-historied people are aware of tokenism, and want to be met as people, not as novelties.

The world of work and relationships can consequently feel like a minefield – superficially ordinary, with explosions waiting to happen. We have the ability to make the world of counselling what it should be – non-judgmental, respectful of self-governance, and enabling. ■

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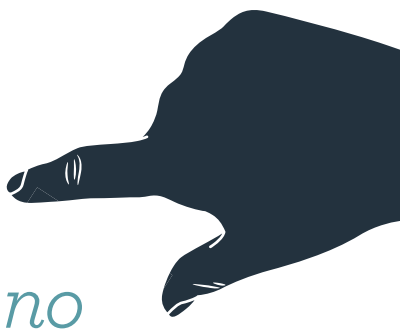

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PROFESSIONAL DEVELOPMENT DAY

Tina Livingstone will be facilitating the following upcoming BACP professional development day:

Working with Trans-identified and Trans-historied clients in your own practice – 27 October – Birmingham

The session will explore what it means to be trans-identified or trans-historied and will use Tina's research as a starting point from which to discover what specifically detracts from helpfulness of therapy when working with trans clients, and what practices optimise helpfulness. Participants will also explore some of the culture-specific issues commonly raised in counselling with trans-identified and trans-historied clients. By the end of the day, it is intended that those attending will feel more able to meet any trans clients who present for counselling with best practice.

BACP's series of PDDs are designed to deliver CPD opportunities that will develop skills in specified areas. For more information, please see *BACP Healthcare round-up*, page 47. For details of all PDDs, please visit www.bacp.co.uk/events.

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We have the ability to make the world of counselling what it should be – non-judgmental, respectful of self governance, and enabling