

Problems with binary gender discourse: Using context to promote flexibility and connection in gender identity

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Abstract

Western society recognises male and female sex from physiological attributes, such as genitals and chromosomes. 'Gender' is the social and cultural expectation of how males and females should think, behave and how they should be treated by others (Diamond, 2002). Some children and adolescents experience distress, marginalization, and abuse associated with their gender identifications, preferences and behaviours, which are inconsistent with those expected of their biological sex. Often their families and society find gender non-conformity at best difficult, at worst offensive, distressing and intolerable. There is increasing focus on how mental health professionals work with difference in gender and sexual identity and recent publications highlight the shift from pathologizing transgender to a more 'identity-based' perspective, focussing more on the stigmatizing affects of the environment and the impact on the individual (Bockting, 2009). This article describes the challenges of binary gender discourse for young people and their wider contexts and considers how clinicians may more helpfully respond to avoid unhelpful binaries and so keep the young person in mind. The therapeutic aims of the UK Gender Identity Development Service (GIDS) for children and young people are considered and examples of our work provided.

Keywords

children and young people, gender development, gender discourse, gender identity disorder, systemic

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Binary gender discourse

In western contexts, those who present to mental health services with (i) a strong and persistent cross gender identification, (ii) persistent discomfort or sense of inappropriateness with his/her sex

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or the gender role of that sex, and (iii) are in significant distress or impaired in functioning, all in the absence of a physical intersex condition, may receive the diagnosis of Gender Identity Disorder (GID: Diagnostic and Statistical Manual of Mental Disorders (DSM - IV), American Psychiatric Association, 1994). Receiving a diagnosis of GID is the only method in the UK of receiving physical interventions such as cross sex hormones or surgery related to 'gender reassignment'. It is also through diagnosis as well as indicators of persistence, such as living in 'role', that adults can be recognized legally in the UK under the Gender Recognition Act 2004 as their chosen gender (HMSO, 2004).

Currently, the diagnostic criteria for GID are being reviewed as part of the consultation for the next volume of the Diagnostic and Statistical Manual (APA, 1994). Wilson, Griffin and Wren (2002) in their review of this diagnostic category argue that there are many concerns about its validity. They highlight the reification of gender related distress as a disorder as well as the assumption of normality inherent in this. They stress the link between psychiatric diagnosis and treatment of childhood cross-gender behaviour as essentially to prevent adult homosexuality, which is not pathological. They question the research on the DSM-IV criteria, especially the small quantity and the focus on male cross-gender behaviour. They also argue that gender identity is culturally constructed, and experienced differently in non-western societies. Despite this critique, consideration of the alternatives such as excluding GID from future volumes of the DSM may lead to a reduction in legal protection for 'transsexuals' and access to surgery or hormone treatments to those who desire them (Meyer-Bahlburg, 2010). It is with these challenges in mind, that clinicians must work to support young people who experience distress associated with their gender identities; avoiding unhelpful binaries while facilitating access to services. One of the ways clinicians can do this is through the development of alternative discourses which attend to the young person's different contexts and experiences within these. These are discussed next.

Developing an alternative discourse

There are variations in sex and gender expression that challenge the male/female, masculine/feminine dichotomy. Diamond (2002) helpfully distinguishes the variations in the complex area of gender and sexual expression and defines the realms of gender and sexual identity. He argues that usually sex and gender concord, that a 'typical' female/male acts in a feminine/masculine way and prefers males/females as sexual partners. In this respect he argues that there is no conflict between sexual and gender expression, and that sex and gender as terms are conflated. Where there is discord between sex and gender identities and expression, conflict is apparent.

Gender is therefore a variable and socially constructed phenomenon (Newman, 2002). Newman (2002) in a review of sex, gender and culture, argues that 'gender-aberrant' behaviour is seen as pathological, and is diagnosed as a disorder, which reinforces the binary gender model. For western contexts, gender expression is binary as well as temporally and contextually fixed, with prescribed forms of expression—one is born as female/male, behaves in a feminine/masculine way at all times throughout one's life. This conflation of biological terms and the use of masculine/feminine language associates gender expression with a natural phenomenon that appears to obviate the social construction of gender expression. This naturalistic discourse divides the world into masculine and feminine roles without exploration or critique, and makes unacceptable, even unnatural, other forms of gender expression.

Lefrance (2005) explores the power and confessional nature of the interaction between transsexual patient and psychiatrist in GID diagnoses. She argues that while it is imperative for the transsexual person to receive the diagnosis, and therefore recognition of his or her distress, through

the act of 'confessing' to the psychiatrist, only particular discourses are heard while others are subjugated. She focuses on the subjugated discourses of grief, uncertainty and ambiguity about ones gender and sexual expression, and how diagnosis negates these in favour of certainty and polarisation.

If the transsexual were to speak the manifold fears, confusions and bereavements that frequently accompany sex change, then on some very basic level the idea that all human beings are fundamentally and unequivocally male or female—with no mess, spillage or overlap between the two categories—becomes suspect (Lafrance, 2005).

Therefore, a binary discourse of sex and gender provides concrete predictability where there may be a great deal of uncertainty and fluidity, both temporal and contextual.

There are three main difficulties of this binary discourse and its operation for young people who experience their gender as inconsistent with their biological sex. Firstly, the binary discourse artificially divides acceptable expression of gender to masculine or feminine. These have a range of social role expectations, seen as natural to that biological sex, such as appearance, sports/hobbies/interests, toys-play, needs/services and employment, friendship groups, behaviours, attitudes and beliefs. Deviations from these expectations may lead to abuse or social isolation as well as attempts from others to encourage conformity. This polarization encourages some young people to conform rigidly to extreme masculine or feminine roles, without considering alternative forms of gender expression. For some young people this may lead them to seek to alter their bodies to appear more in line with their internal sense of their gender, perhaps making their preferences seem 'natural' to themselves or others.

Secondly, highlighted above, is the need to be certain about one's gender identification and its permanence, while silencing grief and uncertainty both to oneself and to others. This is part of the discourse of identity formation generally. Erikson's (1968) stage theory of personality development is an example of the expectation of western young people to 'discover' who they are as part of their adolescence, as if their identity was thereafter fixed, enduring and essential to their being. Many young people struggle with this challenge to differing degrees. Particular difficulties face young people who identify with a marginalized group or feel that they cannot identify with those around them (Di Ceglie, 2000). There are different levels of knowledge associated with external context and awareness about one's own identity. The contexts we find ourselves in construct how we experience ourselves and our identities. Where identity is socially marginalized our awareness of our identity and its marginalization engenders secrecy and shame leading to difficulties in exploration of the emergent qualities of a sense of self. This can lead to extreme, fluctuating and unyielding attitudes and beliefs about ones gender identity and its expression as well as confusion and difficult feelings about oneself.

Thirdly, deviation from the typical expression of gender for one's biological sex necessitates disclosures and explanations, or what Foucault described as 'confessing', to one's self, family, friends, strangers, professionals and the Law, in order to make gender identification and distress related to it 'true' (Lefrance, 2005). Given the difficulties detailed above, it is hard for young people to disclose their thoughts and feelings about gender and have their difference from the norm examined and evaluated by those close to them as well as strangers. It poses challenges to those who choose not to disclose their feelings to others, yet still wish to identify with roles and expectations inconsistent with their biological sex. Awareness and understanding of emerging gender identity may also be complicated by questions about other aspects of identity such as race, sexuality and culture. Decisions about disclosure can affect intimate relationships and cause stress for the

young person on a daily basis as their thoughts and feelings about their gender are questioned or important aspects of their identity are hidden or treated negatively by themselves and/or others.

These three areas of difficulty might be more or less important at different times, given a young person's developmental history, life-stage, family context, socio-economic background, race, culture and social/political context. Carter and McGoldrick (2006) provide a useful framework for incorporating the multiple contexts of such difficulties. The Expanded Family Lifecycle model (Carter & McGoldrick, 2006) embeds the individual within the significant relationships of their family and community, highlighting the temporal and developmental elements of the family life cycle. Families and the individuals within them are seen as undertaking a range of developmental transitions, such as increasing independence. Transitions are often associated with stress and are usually managed through the resources and relationships within the community and family. Families who experience contextual stress (relational, cultural, political or biological stress) may have more difficulties managing developmental or unpredictable stressors and may have trouble at that time, or at a later developmental transition.

This way of understanding an individual within their multiple contexts highlights the profound effect of an atypical gender identity on a young person and their family. The young person's feelings and preferences may impact on their family's expected development and transitions, such as leaving home, getting married and having children. There could be considerable conflict within the family regarding the acceptance of the young person's gender feelings, affecting relationships and available sources of support. In a wider context, the young person's gender identity may impact on how the family are seen within their community or by the professionals who work with them. If these are experienced as difficulties and are combined with historical or current stressors, such as illness, deprivation or abuse, the resilience of an individual and family may be seriously challenged resulting in significant distress.

Within this framework it is useful to consider how individuals and families find meaningful identities and negotiate these across contexts. Co-ordinated Management of Meaning (Cronen & Pearce, 1982) is useful here as it considers how social realities are constructed and made meaningful through stories that are told and subjugated and how these stories are co-ordinated across contexts. This enables the exploration of the stories that individuals and families bring as well as those they construct with others; which can be important in understanding how gender identity development is influenced in different contexts. It also allows all parties to make explicit and understand some of their assumptions relevant to gender identity development and the experience of various contexts on these understandings.

Ideas from Narrative Therapy are useful in exploring and ameliorating the impact of problem-saturated, marginalized and narrow focussed or 'thin' narratives of the identities of young people with gender difficulties (White & Epstom, 1990). In conjunction with the other theories it is useful to consider the impact of discourse and the 'thickening' narratives around identity to encompass various aspects of personality and expressions of gender and sexuality. Queer Theory in therapy, with its focus on deconstructing heteronormative discourse and critique of identity, is a useful adjunct to the above approaches as it challenges the established norms and assumptions of gender and sexuality, which are often biased toward heterosexuality and binary gender, and promotes 'alternatives' to these ways of thinking and doing (Nylund, 2007). It makes use of concepts such as 'performing' identity (Butler, 2000) through speech and action as well as providing ways of interrogating gender and sexuality. This approach is useful to clinicians working with people with marginalized gender and sexual identities aiding them to recognise their own assumptions and biases. Professionals are thus enabled to explore and manage the flexibility and uncertainty in gender expression and to co-construct with young people meaningful and rewarding identities.

1. To foster recognition and non-judgemental acceptance of the gender identity problem.
2. To ameliorate associated emotional, behavioural, and relationship difficulties
3. To break the cycle of secrecy.
4. To activate interest and curiosity by exploring the impediments to them.
5. To encourage exploration of mind-body relationship by promoting close collaboration among professionals with a different focus in their work, including a paediatric endocrinologist.
6. To allow mourning process to occur
7. To enable the capacity for symbol formation and symbolic thinking
8. To promote separation and differentiation
9. To enable the child/adolescent and the family to tolerate uncertainty in the area of gender identity development.
10. To sustain hope

Figure 1. Primary Therapeutic Aims of Working with Atypical Gender Identification Organization (De Cegli, 1998b, pp. 187).

The Gender Identity Development Service diagnoses and provides access to relevant medical treatment within the NHS for children and young people in the UK who experience difficulties associated with GID. GIDS also provides ongoing support and consultation to families and other groups, such as schools and community groups, in supporting and working with young people diagnosed with GID. An audit of the referrals to GIDS found that the most associated features with gender identity problems were difficulties in relationships with parents/carers and peers as well as the young person's experience of depression/misery (Di Ceglie, Freedman, McPherson & Richards, 2002). Di Cegli (1998b) describes 10 therapeutic aims of working with young people with gender identity difficulties and their families that focus on exploration and acceptance rather than treatment for GID (see Figure 1).

Diagnosis, utilizing binary concepts of sex and gender, and contextual approaches described here provokes a dilemma for clinicians working with GID. For example, using the borrowed authority of the medical model through assessment and diagnosis to promote acceptance of gender difference perpetuates the use of binary gender discourse as well as associating gender difference with the stigma associated with mental illness.

Given the difficulties related to GID diagnosis, Wilson et al. (2002) argue that clinicians working with families should focus on the distress associated with problems of gender identity without labelling gender identity difficulties as pathological. It is proposed that the above therapeutic aims are adopted in association with a contextualized approach, such as those proposed by Carter and McGoldrick (2006) and the critique of heteronormativity offered by Queer Theory. In understanding gender identity related distress in context is important to consider individual,

family, community and socio-political factors in any assessment and their interconnectedness with the young person and their families' experiences. These will need to be addressed according to the priorities of the young person and their family. Safety must be prioritized, including addressing the presence of suicidal ideation and self-harm.

With the family's consent, professionals need to be engaged with local health, education and social services and any voluntary/community agencies who may be involved, in order to facilitate understanding, reduce stigma and prejudice and identify alternatives which promote flexibility and acknowledgement (Eracleous & Davidson 2009). Examples of how such work may be conducted will now be discussed from the experiences of the authors work at the UK's Gender Identity Development Service. In order to demonstrate a range of approaches and maintain confidentiality and anonymity, the following examples are composites from the authors' experiences. The pronouns adopted for each example are consistent with the young person's chosen identity. However, these may change according to the young person's preferences and the degree of support given by those closest to them.

Case examples

Jo was a 15-year-old biological female who found communication of his gender feelings almost impossible with certain members of his family, causing conflict and distress for all of them. His family were shocked by his recent disclosure of his feelings because they experienced their relationships as close and supportive and felt that they should have known before. In order to engage and hear from as many of the important people in Jo's life, as many different members of his family as possible, including his parents, grandparents, aunts, uncles and siblings, as well as his friends and partners, attended meetings. Conversations promoted curiosity and connectedness and included invitations to adopt different positions and perspectives in relation to Jo's experiences. We thought about where the family's stories about gender came from and how they were reinforced by society and their community (e.g. the influence of groups such as the Women's Institute, Scouts/Girl Guides, Young Farmers and Working Men's Clubs). We aimed to support non-judgemental openness throughout in order to facilitate acceptance of Jo's dynamic choices.

Jo wished to attend college in a male role, but was anxious about people at the college he attended finding out about his gender feelings. With Jo's permission, we contacted staff and held meetings at the college he attended in order to promote acceptance of his chosen identity and to reduce stigma. Local meetings were arranged which could be attended by those peers whom Jo wanted to be involved. The conversations we involved them in aimed to provide Jo with further support and facilitate greater understanding and openness.

With Jo's family, we considered the options that Jo faced currently and was likely to face in the future. Considering issues of privacy and autonomy, we created spaces for them to talk separately about their hopes and fears. Jo's parents wanted to protect Jo's fertility and ensure that he could choose to have children later, if he wanted: their grandchildren, when Jo rejected a referral to fertility specialists. We supported them with a private space to express their grief at not becoming grandparents, and helped them to hear Jo's voice, about his wishes and decisions. We met with Jo on his own to consider his choices and focus on his own concerns, which were how to manage what to disclose to current and future friends and partners. These meetings were conducted in parallel and involved different people over time, to bear witness, share in his narratives and support both Jo and his parents (White & Epstom, 1990).

Reece was a biological male, aged nine at the time of referral to us. At the beginning of our work we liaised with social services following child protection concerns involving his biological father

and possible others. Interagency liaison included the local Child and Adolescent Mental Health Services and his school, who were also concerned about several inappropriate behaviours involving Reece and other children. Important in this work was the observation of boundaries—who knew what and why. The child protection concerns at the beginning of our work had meant that many professionals had to be involved, making it important to decide with Reece and Reece's mother the limits of confidentiality with each professional as we continued with our discussions. We therefore spent much time and effort in thinking with them about the process and timings of disclosures. Fears that Reece had been sexually abused by his father and/or others, gave this work around personal boundaries, including those relating to the body, greater weight and significance.

The family trauma of alleged abuse and Reece's behaviour at school seemed to be affecting how the family and professionals saw Reece, with the narrative surrounding his identity becoming increasingly focussed on abuse and gender with an increasing wish for clarity, predictability and certainty. Reece from a young age had believed he was a girl and often dressed and acted in role as a 'fairytale princess'. His family assumed that he would go on to receive hormones and surgery to 'become female'. However, we kept in mind the potential for any number of outcomes, given that of the children who present with atypical gender identity (GID) about 80% find a solution other than gender transition (Carmichael & Davidson, 2009, p. 916).

We therefore provided space for uncertainty, curiosity and openness so that Reece and his family could explore identities and not form rigid identity conclusions too soon. Not everyone was able to attend our meetings and we thought about why this was and how we could promote their voices being heard. We explored with whoever came to the sessions how they had come to know their identities and how the contexts that they had experienced shaped these (for example school family and work). We acknowledged the stories and beliefs held by each (as reported by others when they were not able to join us), including the stories of the parents and grandparents gender identities. To encourage the 'thickening' of Reece's identity, we considered Reece and others' identities within the home, within the neighbourhood and in the community, including for Reece, at school.

We thought with Reece how he could safely express his gender identity and the links he made with feeling ashamed and misunderstood, with a tendency to withdraw from others in such situations. He was able to access weekly individual sessions at the local CAMHS to reflect on the multiple aspects of his identity and work on developing safe boundaries and resilience. We considered Reece's impending transition to secondary school and how this might be best supported. With the support of school staff, Reece and Reece's mother agreed which teachers should be told and how Reece and school staff should manage any incidents of bullying. We anticipated with Reece and the new school the distress Reece might experience with the school uniform, where girls and boys wore different coloured tracksuits for PE. Additionally we considered Reece's difficulty using gender segregated toilets and, not identifying as disabled, not wishing to use facilities labelled 'disabled'. The school were able to identify a staff toilet that Reece could use and allow Reece to wear the tracksuit he preferred. The school later considered a change to their uniform policy to require all pupils to wear the same colour PE kit.

Alex was a 14-year-old biological female with who was part of a large family in a deprived area which had lost its major industry over the past two decades. His emotional needs struggled to be met amongst the family's impoverished and chaotic lifestyle, where he and each of his siblings required significant support from his parents day-to-day. Alex's gender feelings had been recognised and acknowledged by the family at a young age, but Alex became increasingly distressed at the physical developments of puberty and had no outlet or support with this. Various members of the family experienced verbal and physical abuse from their neighbours as a result of Alex's outward appearance. His behaviour deteriorated at school and he expressed suicidal ideation, each of

these putting additional strains on parents who already struggled to manage. Alex's siblings had been involved with the local CAMHS and Youth Offending Team for a number of years, but they believed that Alex's needs could only be met by GIDS. As a national service GIDS required the local services to provide more accessible support and respond in case of a crisis. Here, the aim of our work was to alert the community and local services to the difficulties faced by the family as a whole and mobilize support locally for Alex to reduce distress. We thought with the family about further support and arranged local meetings at the school between us, the family, school staff (including the nurse, Special Needs Co-ordinator and school counsellor), CAMHS and GP to promote consistency, acceptance of Alex's needs and wishes and to promote openness about the next steps. Over time we noticed that Alex became increasingly focussed on other areas of his identity rather than gender, such as friendship groups, interests and more intimate relationships. Alex's father had been particularly against the possibility of Alex being gay. We worked with different people in Alex's life who were significant to him to encourage openness to the possibility of different outcomes. At the time of writing Alex no longer wished to transition his gender, but is experimenting with his own gender identity definition, alongside other facets of his identity. Alex, now 17, increasingly refuses to be defined as male or female, but prefers more simply to be referred to as Alex.

Lou, a 17-year-old biological male was referred to the GIDS following years of distress and was at risk of suicide. She wished to commence cross sex hormone (oestrogen) treatment immediately and expressed a wish to withdraw from education, employment and social activities until she could 'pass' as female without being asked questions. We liaised with the adult gender identity services about the transition to them given her age. However, for Lou her wish for physical treatment overshadowed anything else and it became difficult to sustain hope while she had to wait for the treatments she wanted. This frustration increased her desperation and correspondingly her risk to herself. Bearing frustration became a theme that we were all engaged with; trying to find ways to maintain reflection and thought, while facilitating her transitions was a continual balancing act. We supported her to identify further resources within her community and with the process of applying for jobs so that her life could develop further meaning in addition to her desire to transition her gender as well as sustain her through the long process of gender reassignment. As her appointment for the adult service came closer, Lou's mood stabilized and became more hopeful, bringing with it the possibility of the surgery she wished for.

Discussion

The case studies highlight many of the difficulties of using binary gender discourses for young people and consider the contextual factors that contribute to the distress experienced by young people and how they can begin to be addressed. Further thoughts are now offered regarding the dilemmas inherent in undertaking this work in a mental health setting and the difficulties for clinicians working in this area, as well as implications for practice.

It may be that binary discourse is deep rooted within western society and affects nearly all aspects of life, including professionals and the systems they learn, work and socialize in. Wilson et al. (2002) have alluded to this in their critique of the DSM diagnosis of GID. Their comment on the research related to DSM diagnosis and GID is significant in the consideration of the impact of binary discourse on clinical practise. There is an inextricable link between social values and expectations and the interests of research and the subsequent knowledge and practise (Foucault, 1980, 1988). Wilson et al. (2002) have highlighted that research on GID is focussed on male cross gender behaviour within a medical context of this being disordered. While it is accepted that sex and

gender is binary, research focuses on the differences and similarities between males and females, and so develops knowledge and truth related to what it is to be male and female (Foucault, 1980, 1988). Such focus can only serve to reinforce the system supporting binary gender and increase the rigidity inherent in such knowledge about the nature of males and females. An example of this is the recent exploration of 'masculine' and 'feminine' brains and the links with Autism Spectrum Disorder (ASD: Baron-Cohen, 2004). Through focussing on correlations made with the functioning of brains of people biologically described as male and female, an 'essential difference' is assumed between males and females (Baron-Cohen, 2004). Evidence is provided for the binary naturalistic discourses related to gender and its expression, where some behaviours are essentially male and others essentially female regardless of the identity of the person expressing them. Social practices and knowledge of them are therefore mutually reinforcing, creating truth about sex, gender and its expression (Foucault, 1980, 1988).

Truth and ways of questioning it then filters through to the teaching, thinking and practise of professionals. It then becomes difficult to think outside of this frame, when thinking is so embedded within it. Clinicians learn a lot from their training and experience about the similarities and differences between males and females, their difficulties and expression of them. Of course, that is not to suggest that differences do not exist in our experiences of males and females, as there are different biological, psychological and social expectations for each. It is in fact the conflation of the natural and the social aspects as well as the rigidity of the binary discourse surrounding sex and gender that cause these difficulties for young people as well as the knowledge and experience of the professionals who work with them (in schools, health services and communities).

This poses professional and ethical questions about how to approach work with this marginalized group, who are also embedded within these systems. There is a tension between recognising the difficult to change social and contextual pressure on individuals and families and the distress that this causes on a daily basis. The multiple contextualized approaches described above go some way to addressing the rigidity and polarity experienced as a result of focussing on single contexts, such as gender. This was particularly prominent in the case of Alex, where local services struggled to see the multiple ways Alex and his family needed support beyond his gender feelings. We suggest that there are benefits to raising awareness and reducing stigma across various contexts such as the media and schools so that young people like Alex and those around them can recognise difficulties, access understanding and support at an earlier stage of distress.

Where flexibility in reflection is limited, narratives of people become thin and focussed on single contexts as in the case of Lou. Here members from the GIDS, the local network, Lou's family and Lou herself struggled to contain and support Lou in managing the aspects of her life that caused her distress—Lou seeing that the only solution was physical intervention and the only alternative to this possibility was suicide. From this binary position it was difficult to move beyond crisis management to greater stability and reflection. The referral to adult services provided a way that Lou's wishes could be explicitly acknowledged and validated so that Lou's attention could shift to overcoming other difficulties and planning for the future.

We are challenged as professionals to continually reflect and discuss the multiplicity that is possible within human experience, recognising the ways of thinking and knowing that we are embedded in. We have highlighted how it can be unhelpful to reach a more binary, problem saturated and individualistic formulation, such as provided by a diagnosis of GID; but it can also be detrimental to pay inadequate attention to the strong wishes of those who present it as unhappy with their gender. Invariably a balancing act is required, where difficulties are acknowledged and frustration tolerated: where curiosity can be stimulated and additional ideas and perspectives considered. In the GIDS, we believe it is imperative to share experiences of our work within a

multidisciplinary team to maximize reflection on these difficult issues and incorporate multiple ways of thinking and working. Where we are able to facilitate support and sustain hope, young people are able to achieve different outcomes and flexibility in thinking and expression. They are then able to access and explore many possible selves without having to rigidly conform to extremes of gender or sexuality, amongst other facets of their identity.

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