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Psychology

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Introduction

What is reality? How do we divide up the world into what is real and what is not? How do we measure what we find? In some sense, these questions have been key to psychology since its inception. We recognise the soul, the psy, at the heart of our science—but also strive for the rigour and the power which flow from the natural sciences; we try to weigh sadness on scales which would better measure out the nature of the planets, glaciers, or the flow of the oceans. Only at the sub-atomic scale do we have closer parity—a closer metaphor—with the human reality which concerns psychology; with things which may be both this and that, which may apprehend time in strange and unusual ways; which may bear ever closer scrutiny and yet still yield up insight into deeper complexity which is yet recognisable and representative of the greater whole.

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This paradox between the measurement of things with edges and those without sits at the heart of modern psychology and so inflects psychological understandings of non-binary and genderqueer people, as well as much else besides. How, for example, should we consider the ontology of non-binary people? As variation within either masculinity or femininity? On a spectrum between two 'poles' of male or female? As something entirely aside from the gender dichotomy? While our client's understandings are paramount and such considerations should be subsumed to them; the very work may consist of their seeking understanding alongside us. Indeed, the foundation of our approach, whatever it is, rests on an understanding of the nature of the presenting issue. For example, Cognitive Behavioral Therapy rests on a logical positivist assumption that *this* can be measured and that *that* intervention may change it by such a [Likert] degree. Phenomenological approaches, however—and especially existential ones—often frown upon fixed notions of identity; indeed fixed notions of anything aside from a very few existential givens such as Death; and yet many non-binary people do identify *as* such. Whether CBT, phenomenology, or any of the panoply of other modalities; it is the approach which invites the measurement, and so the understanding. Yet the measurement only captures a limited aspect of the phenomena in hand and so determines in that limited manner how it is apprehended.

Psychology then, as it relates to non-binary identities (as other identities), is in a bit of a pickle. So let's retreat from the swirl, ebb, and flow of the stranger tides of philosophy and onto the twin eminences of ethics and pragmatics—what are we actually talking about here?

Who non-binary people are has been eloquently discussed elsewhere in this volume, so we will not trouble ourselves to needlessly repeat that; suffice to say that there are many different sorts of folk—some who may identify as a static point on a notional gender spectrum; some who identify as a range upon that spectrum (gender fluid); some who have no gender (neutrois); and some who say Mu! (or *fuck you*) to the very question of gender (genderqueer or genderfuck people). The difficulty with the notion of a gender spectrum at all, of course, is that it assumes that the more masculine you are, the less feminine and vice versa. However, when you map traits or behaviours onto that, dyad things become more complex—if one is more aggressive, one is more masculine; less so, more

feminine; but what of the mother defending her children? The father holding his new-born child? Aggression itself does not neatly correlate with gender, nor, indeed, does anything else. The gender binary and the gender spectrum become suspect.

And yet, and yet, we *do* have something called gender—we can perform the thought experiment in which we remove it from the world and see if the world remains the same: Remove jazz-loving penguins in fedoras from the world and it changes not a whit[1]; remove the internal combustion engine and it is unrecognisable—the former does not exist and the latter must do—even if we have no knowledge of what an internal combustion engine is or how it works. Therefore, we have *something* called gender; however, what it is, is complex and does not easily bottom out. But such is the case with something like music—for what makes music music? The Chinese peoples used to carry crickets in cages to sing to them as they walked—is that music to the [Western] modern ear, plugged in as it is to the electronic waveforms of recent music production? Those very waveforms too are a [binary] digital approximation of an analogue human vocal reality—the sweep and dip of the sine clipped to utilitarian ends.

But surely men and women are qualitatively, *quantitatively*, different—with different capacities and desires? This once seemed obvious, so obvious that women did not have the capacity to be educated; to vote; to undertake physical work; to be in the military; to be military auxiliaries; to be soldiers; to be front line soldiers; and so on. As we try to separate 'the sexes' to say nothing of 'the genders', we have to caveat more and more to retain the edifice we have built. We might consider giving birth to a child as a divider—but then there are trans men who have done so. Let us, as a thought experiment, exclude them for the moment: There are cisgender[2] women who have had a hysterectomy—are they female in this two-sex system? (Of course)—but let us exclude them too for now. Pre-pubescent girls—naturally they too are female, so let us exclude them as well in our ever-growing set of people who can give birth but who aren't female; or who can't but are. Those people who do not know if they can give birth? Those who opt not to? We must caveat and caveat to link being female solely with childbirth. What seemed simple is anything but. And we can do this with literally any trait: breasts? Mastectomy. Penis? Penectomy.

Consider chromosomes: We 'know' men are XY and women XX, yet ignore the fact that genes are expressed in complex ways—for the loss of function of RSPO and WNT4 genes causes sex reversal of an XX genotype to a male phenotype (without an SRY gene); indeed, overexpression of WNT4 or DAX1 also induces sex reversal. Additionally, changes in SRY and SOX 9 expression cause XY sex reversal (Whitehead & Miell, 2013). This is to say nothing of the role of post-partum environmental factors and epigenetic expression giving rise to a variety of body and neurological forms aside from a strict sex dichotomy (cf Joel et al., 2015; Joel & Fausto-Sterling, 2016). Even such things as strength which might seem self-evidently sex-linked are not always so; with right-hand average grip strength of people aged 30 to 34 not significantly differing between men and women[3] (Fain & Weatherford, 2017). Men do seem to do better athletically than women however; and yet take the best women rock climbers of today—send them back just 30 years and they will beat the best men—far too short a time to be an evolved difference. This is not to say that there is not a complex interplay of culture, genetics, neurology, and biology which give rise to some differences (as seen in the fact that women who inhibit expressed emotion score as well as men on that bastion of sex difference research, mental rotation tasks; Fladung & Kiefer, 2015)—but that these differences are far less robust than one might assume.

This complexity around strict binary sex differentiation troubles the traditional notions in psychology that men and women think differently as well as have different brains (cf Fine, 2011). There are, indeed, *no* psychological differences between women and men where the results are discreet. The overlap is vastly greater than any differences (when found, and as seen above that may be explained as an interaction in certain instances) and even then the effect size is minimal. Further, we know also that most psychological studies purporting to have generalisability to the [adult] population utilise a convenience sample of university undergraduates who are mostly between the ages of 18 and 22. While in most countries these people have reached majority and so are legally classified as adults, their neurological development has still not fully matured. Consequently, their brains are best characterised as 'late adolescent' rather than 'adult' as there is a deficit (compared to adults) in fronto-parietal activation

implicated in control; and an increase (compared to adults) in ventromedial prefrontal cortex activation involved in emotional responses (Cohen et al., 2016). We also know that adolescents stereotype gender more than adults, both for themselves and for others (Alfieri, Ruble, & Higgins, 1996). Given there are observable brain differences between adolescents and adults, it is not unreasonable to assume that neurologically late adolescent college students may also have different responses compared to adults on [neural-implicated] tasks designed to discriminate between genders, especially those including stress, social behaviours, and inhibition—that is, many of those given to undergraduates. That is to say that adolescent-brained college students may be demonstrating larger gender differences in tasks than an adult cohort would. Given the marginal power and effect sizes in many of the studies which purport to demonstrate gender 'differences', this calls into question the degree to which the adult population's performance on psychological tasks is actually split along gender lines.[4]

So, the emperor's clothes are looking rather thin, but we live in a world where most people do see them. Indeed, while we can reasonably confidently decouple gender from [biological] sex; and certainly challenge the notion of only a binary-sexed and a binary-gendered world; there does seem to be something called gender which is important to people and may have a neural substrate (Bao & Swaab, 2011). Note this is not about cognitive capacity differences, but about identity—which of course is inflected epistemically by social and psychological processes (cf. Richards 2017a). Consequently, there are people who have a certain birth-assigned sex and who feel their gender (for whatever that means to them) does not align with that sex; and further that their gender is neither male nor female. We might say that they are seeking certain bodily and psychic configurations which feel congruent. Some of these groups of people may be struggling to position their identity; some may have a firm idea of their identity but be subject to social pressures which cause distress; and some may wish to change their physical appearance though apparel and possibly also via hormones and surgeries. While the vast majority of these groups of people will not seek psychological assistance as they will be getting on with the quotidian realities of living; some will, and it is this group which we turn to now.

Clinical Considerations

As we have seen elsewhere, the evidence for the mental health of non-binary people is mixed, with some suggesting that non-binary people have raised levels of mental health difficulties (Harrison, Grant, & Herman, 2012) and some suggesting that the levels are the same as the binary trans population (which is still raised compared to the cisgender population—McNeil, Bailey, Ellis, Morton, & Regan, 2012; see also the introduction to this volume) and some suggesting it is less (Warren, Smalley, & Barefoot, 2016). Of course, mental distress in these groups is likely to be caused by minority or marginalisation stress—stress which is itself caused by social opprobrium and prejudice. Devoid of such opprobrium, it is likely that non-binary people would have the same rates of psychopathology as cisgender people—just as trans people do under those circumstances (Robles et al., 2016). Indeed, it is possible that non-binary people who are able to deal with external opprobrium may have the potential for better mental health than binary trans people as they must necessarily not have an identity which is compared against a [cisgender] norm—either by themselves or others.

Very often in my clinical practice I have a trans person, not uncommonly a trans man, who is determined that masculinising hormones will make them indistinguishable from a cisgender man. When I gently suggest to them that there may always be people who are aware of their trans status, they can be most discomforted by this. The difficulty is that they are trying to be something they can never be—a cisgender man. Note that I have not said they can never be a *man*—evidently they *are* a man, but they are a trans one rather than a cisgender one. Why should it be that cisgender is held as the standard of what a man, or a woman, is? As we have seen, these categories are broad enough to include [cisgender] older people; younger people; fertile people; infertile people; women with mastectomies and hysterectomies; men who have had penectomies due to cancer, and so on. Surely, they can encompass trans men and women too without breaking at the seams? Until trans men and women measure their gender by their identity, rather than an external cisgender [cultural] norm—which is often unattainable for many cisgender people too—there will always be the potential for mental health problems as trans people measure themselves and find themselves lacking. If non-

binary people are able to ignore cisgender cultural norms as they necessarily identify outside of one side of the gender binary of male or female, there may be the option to avoid this stress altogether.

One may assume that it follows from this argument that it is therefore unnecessary for people to be trans or non-binary as the categories of male or female are wide enough to encompass a variety of gender identities and presentations. But I am not arguing that at all—quite the contrary. If we accept as axiomatic that there are two genders—male and female—(and as an aside this is, of course extremely open to debate) then it follows that there are people who feel they fit within them and those who don't. There are also those people who have bodily configurations they feel fit within them and those who feel they don't. There are those fortunate few—content cisgender people—whose bodies, identities, and cultural roles all accord and who do not need to do work to fit these together. However, these people are not the gold standard of gender configuration—they are simply a group of people who need to do less work to fit their gender configuration together.

Where non-binary people are especially at risk, however, is that their gender may be socially unintelligible (cf. Richards, 2017a) and so people find themselves in the trap of either seeming to be what they aren't and so being accepted, or seeming to be what they are and so facing opprobrium—a stressful situation felt by all minority groups with the option of concealing their identity down through the millennia. It follows therefore that any clinical approach used with non-binary people must not act like Procrustes, chopping and chopping until the client fits our, or our modality's, quaint notions of what people should be. We need to develop words and clinical frameworks beyond a gender binary or spectrum and beyond theoretical or modality stances if we are to respect non-binary people's identities and lives. In the meantime, ethics must trump philosophy (Richards, 2017a). Psychologists, scientist-practitioners as we are, can be overly theory-driven; while the theories we have are inadequate as they do not allow for an understanding of fluidity and fixity simultaneously and consecutively (cf Richards, 2017a). Be ware of the safety you find in your modality—while there may be dragons in the unknown; there have always been far more evil things lurking in the banal light of unthinking adherence (cf Richards, 2017b). What then

are we to do clinically with our non-binary clients? Naturally, it depends on the understanding of the client and on their needs and capacities. Psychotherapy has been expertly covered here by Barker and Iantaffi, so I will not reiterate that here and I shall consequently focus on formal assessment of non-binary people, whether for referral for hormones[5] or surgeries; or for other purposes.

At the time of writing, determining the viability of a person for hormones and/or surgeries is often down to a mental health professional such as a psychologist. Historically, this gatekeeping role was fraught with difficulty, saturated as it was, in the trappings of modalities which did not recognise diversity in gender, or which pathologised it when they did. Consequently, assessments were lengthy and arduous as much attention was given to a person 'proving' their gender identity. Naturally from a psychological perspective, this sits uneasily as it disallows respect for the patient's autonomy and identity. We could argue (as many do) that any assessment of viability for physical interventions represents an undue imposition, but this extremely right-wing approach sits uneasily within nationalised healthcare—suggesting as it does that the Devil may take the hindmost—where the mistaken most vulnerable are seen as a sort of collateral damage to the easier path of the less vulnerable.

Having said that, there is of course an argument that this is just what we do with regards to pregnancy, where anyone may have a biologically related child—but there is far more screening for adoption. Further, we require crash helmets for motorcyclists, but smoking is legal. Our ethics relating to policy and law are not coherent and will doubtless be subject to change. Indeed, this relaxing of state imposition is often correlated with wider societal attitudes—just as with same-sex relationships, and then adoption and reproductive rights, things become easier as society progresses. That which was 'bizarre' becomes commonplace and no-doubt will continue to do so. One cannot help wonder what is next—perhaps trans-species where people identify as non-human animals? And recall that any negative gut reaction one may have will have been had in the past concerning other marginalised groups also. Ultimately, we need to respect autonomy and protect the vulnerable.

At least for now, given psychologists are required to make these decisions; how do we make them? The formal assessment given below gives

basic information and a range of possible differentials. However, essentially an assessment of the viability of a certain person for hormones and/or surgeries consists of determining just two elements which, if you will forgive the idiomatic phrasing, can be summed up in just six words:

1. Is it non-binary?
2. Will it work?

This basically means determining (1) if there is some differential formulation or diagnosis which better accounts for the presenting factors, and (2) whether the proposed treatment is likely to be both benign and of some actual benefit to the client. Note that it's not about 'proving' gender—it's about matching the idea to the reality.

I hope that the future reader will forgive this focus on assessment—I believe such things as assessment (certainly as it is outlined here) will become an anachronism as the process of being comfortable in one's gender becomes a part of the ordinary flow of things. It would be nice if we could accept someone's gender much as we do their relationships—remarkable perhaps, but in the everyday sense of the word. If people want surgeries, then perhaps a greetings card?—as with a marriage or significant birthday—again notable, but as a part of the sort of things people *do*. Indeed, I'm sure my language will become archaic before a decade has passed. Please know then that the intent is noble—even if the sound to your future ears makes you wince occasionally.

Assessment then. A good basic assessment is below. Of course, first you will need a decent referral and will need to take account of any capacity and communication issues—certainly you'll need to tailor both the process and the content to the client and the degree of rapport. Remember some clients may well have had bad experiences with mental health professionals in the past and you may be starting in deficit as it were. Do also adapt it if you are not assessing for hormones and/or surgeries, although it can still be useful to find out about those things even if you are not—without focusing on them unnecessarily of course.

Ideally you should see the clients individually as they may be unwilling to answer questions about sexuality, money, and health with an

intimate person present. If they ask for, or need the support of, another person present, then of course this must be respected. Under these circumstances, I sometimes say "I'm going to ask you about sex now. Are you still OK to have someone with you?", and if a good rapport has been established, they may ask their family member or friend to step out. Given the nature of the interview, I do not think it appropriate to have children present.

Assessment

Introduction

- What does the client want?

This can take some finding out, and a good answer is often "I don't know". Do get specifics—many clients assume everyone wants the same thing, when, of course, they don't.

- What is their gender identity?

Here, the heuristic of the gender spectrum can be useful (I often use birth-assigned gender as the 0 and the 'other' gender as 100)—is it a fixed point on a line from 0 to 100?; Is their gender a range on that line?; Something else? As stated above, the line itself is nonsense, but it gives a rough feel in the way a whale is 'big' and a mouse 'small'—even if they are not when compared to a planet or an atom. Having established what the person's gender is on this scale then, of course, you then need to find out what that actually *means*.

- What are their preferred pronouns?

Most people prefer *they*, but other options include xe/xyr/xem/xyrself, Sie/hir/hirs/hirself, and Per/per/pers/perself. Do respect this.

- Have they taken any steps to align their presentation with their gender identity?

This might include such things as identification documents with Mx instead of Ms, Miss, Mrs, or Mr; apparel; hormones; surgeries; and any change of name.

If people have made a change of name, it can be useful to find out why they chose that particular name.

If people are concerned about presentation, then graduated exposure can be useful. When people are catastrophising, it can be useful to bottom out the fear. “Everyone gets attacked and murdered” may change to “I always get attacked” to “I haven’t been attacked, but my friend has, and I’ve been abused” to “I read about a person online being attacked and I think the people were shouting at me”. This is not to say that non-binary people do not get abused—sadly it is all too often the case. But that there is a salience effect where people who are abused tell others; whereas people who have ordinary days don’t—it’s a bit like plane crashes; they happen, but only tragedies are reported and those tragedies unduly influence those who are prone to such influence—especially if that’s all the exposure they have had to the phenomenon.

- Have they told anyone?

The most difficult people to tell can vary a great deal—some people’s parents are very accepting, some less so; some children are fine, some less so. Work or education establishments can seem daunting, although increasingly have positive policies in place. Grandparents can be especially concerning as there may be ageist assumptions, but are often underestimated.

Younger non-binary people may not be taken seriously if they are not acting as adults in other areas—if their mum is still cooking, cleaning, washing up, and paying for everything while they play on their computer in their bedroom; then their mum may be more inclined to see it as a ‘phase’ than if the person is independent. In this case, the usual process of individuation as an adult may need to be managed alongside the process of coming out around gender; Some find a conversation to be a useful method to start the process of telling people, but this can be difficult between people with high expressed emotion; some find a letter where both parties have time to consider to be useful.

Of course, there are circumstances where one cannot tell certain people if there is a history of violence, for example. In these circumstances,

families of choice and friendship networks will be vital. Do note that fear of violence can be as a result of tragic history and risk; or may be as a result of unfounded fear which can benefit from unpicking.

If they haven't told certain people there needs to be a plan—will they never see them again, ever? (What about religious ceremonies; birthdays; illnesses; funerals?) What would happen if their worst fears were realised? Their best hopes? That last is important too so as not to negatively bias the interview. It is extremely important for psychologists not to assume that living as a non-binary person is awful—it isn't. One can have a very happy life with a good career, children, partners, and so on (assuming one wants those things). It's not a matter of "well, you are this way, so you'll have to make the best of it"—there is much joy to be found.

Gender History

- How old when first disquiet or unease?

This gives a rough history, but people who have come to their gender later in life also go on to do quite well if they take things carefully and they rearrange their life gently and sensibly—without an undue assumption that surgeries and hormones will solve everything.

- How old were they when they first wore clothes not normally worn by that birth-assigned sex?
- When did they decide to change their body?
- When did they come out?
- Why come to me now?

Not uncommonly a life event has occurred such as leaving school; the death of a parent; retirement, a decade birthday, or the like.

Sexual History

- Have they ever had a sexual encounter?
- How old on the first occasion?

This can be useful to pick up any sexual abuse history—see below. It is also worth asking if they have had sexual encounters with people of different sexes—don't assume all partners will be binary or cisgender.

- Get a rough history of significant partners, including marriages/civil partnerships and the conception of any children.
- How does the person identify now in terms of sexuality?

I sometimes say—"How would you tick a box on a government form?"

- Are they using a body part they wish to alter currently?

If this is the case, then it is important that they consider the risks and benefits as well as just the benefits.

- Is there fetishism?

See *Differentials* below.

Family History

- Are they adopted?

This is needed to determine if there are any familial risk factors.

- Draw a genogram
- Physical and mental health of immediate family
- Any trans or non-binary family members?

As with friends, these people are usually (but not always) a helpful means of support.

- What was childhood like?

I usually ask this as "In a sentence or phrase describe your childhood"—otherwise, you may get the whole thing in a detail which is not wholly helpful.

- Any sexual or physical abuse?

I ask this separately and clearly, and very often get an answer that there was abuse even when told that the childhood was 'fine'. It should go without saying that there is no evidence that abuse 'causes' gender diversity; although it may inflect gender expression in some, extremely rare, cases. This should *not* be your first assumption (as you will likely be wrong).

Remember your duty to report if people are at risk. Remember you have a human in front of you who really, really needs you to be a decent human being at that moment.

Physical History

- Do they have any allergies?

If they want medical interventions, this is useful information.

- Do they take any medications?

It's worth asking about self-medication separately; as well as over-the-counter medications; and birth control as people don't tend to see these as 'medications'.

- Do they have any diagnoses?

I usually ask this as well as "Anything you see the doc for" as people with ongoing conditions sometimes miss things. I also ask it after medications as they remember those better than the diagnoses they are prescribed for. Pay attention to developmental conditions such as Autistic Spectrum Disorders (ASD); as well as strokes, clotting disorders, migraines, and psychiatric issues.

- Have they had any operations in the past?
- Do they have any Sexually Transmitted Infections (STIs)?

These may affect certain surgeries.

- Do they smoke?

This raises thromboembolic risk and can be a contraindication to some hormones and surgeries. People very often lie about how much they smoke. It's as well to explain the reasoning and to have some assistance available if they want to stop. Don't forget quitting is extremely hard and many people also enjoy smoking.

- Do they drink alcohol?

Aside from the physical factors, if people are having to drink a lot to mask their feelings, it can be difficult to get a read on how the transition is working out for them. The usual assistance should be offered if people are drinking to excess.

- Do they take illicit substances?

Similarly, if people are using recreational drugs, take whatever view you will. But if people need to mask their feelings that may need addressing, some people may have been using drugs to mask gender dysphoria—in this case, they should be assisted to move away from this coping mechanism when they are transitioning as the transition should act as a coping mechanism in itself (if carefully done) as the person comes to live in a way which is more personally congruent.

- How tall are they? How heavy?

A body mass index (BMI) over 30 can be a contraindication to some medical interventions. It can be extremely hard for people to lose weight—especially if they are using it as a means of masking a gendered body shape. I find it useful to encourage them to see it as part of a trajectory

towards their goal—just as surgery is for some people—a painful interlude for a vastly longer benefit.

Mental Health History

- First contact with mental health services

Finding out if they have had contact with mental health services is useful—asking about counsellors specifically here can be helpful as people often think mental health means psychiatrists only.

- Get any diagnoses or medications not mentioned above.
- Self-harm and suicide attempts

Getting a rough history including deliberate self-harm and suicide attempts with predisposing factors and triggers is vital. Crucially, getting the date of last attempts is important as helping people is key. Also most important is assisting people to deal with triggers if they are stressed by, and during, a transition process. Remember, though, that you have a human in front of you—not a computer to be downloaded in the allotted hour.

- Get a mood score

I find a general mood score from 0% "The worst you've ever felt" to 100% "The best you've ever felt" to be useful to track progress. Note that this scale is relative to the person and not absolute.

Forensic History

- Get the index offence.

It is beyond the scope of this chapter to go into this in depth. Suffice to say sexual offences particularly complicate matters as the psychosexual process of the offender may affect their approach to gender. Of course,

this is not invariably the case—offenders may be just as non-binary as anyone else.

- Get the sentence and (if in prison) tariff and likelihood of parole.

Again, this is complicated as there may be secondary gain in transition for people on long or indeterminate sentences. Some may feel that hormones or surgeries would appear to lessen their risk to the parole board (the risk is generally not lessened and may in fact be increased); Some may use it as a means of absolving themselves of blame: "I was only looking/touching the child to explore my own gender"—the criminal faulty problem-solving would still need to be addressed; and so on.

- Get key workers names.
- Assess risk.

The vast majority of non-binary people have never committed an offence. However, just as with any population—especially cisgender heterosexual males—some do perform criminal acts and should be treated accordingly.

Social Situation

- Find out where they live and if they are likely to be made homeless.
- Do they have any debt or savings?

You don't need to know how much—just if they have a means of support during transition or an additional stressor.

- Do they have supportive friends? Do the friends know about the person's gender?

For some non-binary people, as with some trans men and women, and especially when disowned or estranged from their blood relations—friends become a form of family sometimes called *framily*. This should be respected.

Educational and Occupational History

- Did they go to school?
- Were they bullied?

School bullying can greatly influence how people respond to the notion of transition, whether in school, just after, or far into adult life. If the person is in school, then they should be supported to get the school and carers to address the matter. Some schools are excellent at this; all should be. Just because it is in school does not make it acceptable—if you would not accept a work colleague doing it, then it is not acceptable in a school either.

If the person has left school, they should be assisted to recognise the differences in their adult life and to test out new responses to perceived threats.

- Did they graduate?
- What next? (University? Work?)
- Work history

This can be a useful marker of how chaotic people's lives are. They may need extra assistance with letters and appointments for example.

Formulation/Impression

This can include a diagnosis (BPS, 2012) such as gender dysphoria in the *Diagnostic and Statistical Manual* version 5 of the American Psychiatric Association (APA, 2013a) which specifically includes non-binary genders and recognises that they are not a mental disorder (APA, 2013b). However, this should only be used if absolutely necessary and for pragmatic ends. In terms of benefit to the client, my experience is that (aside from access to interventions) diagnosis does not assist.

Instead formulation is usually better employed (BPS, 2011), which succinctly identifies the client's current situation; desired direction and destination; and the strengths towards, as well as the blocks to, this

occurring—whether psychological, practical, or both. Note, it's important not to confuse psychological and practical blocks—"Of course I can't tell my grandmother" might seem practical, but is likely psychological in nature. Similarly, "I'll be fired if I come out at work" may be entirely practical; but may be psychological—the more intelligent the client, the more intelligent their very sensible reason for not doing what they fear to do. Identifying the fear as well as the seemingly practical concerns can be very useful.

Plan

- Further sessions?
- Referral?
- Physical interventions?

Remember above all that this person is a human, a human who is suffering (thus they come to you—non-binary people doing all right won't be seeing you), and is a person who has likely suffered (or is certainly part of a group who have suffered) at the hands of mental health professionals. We need to be skilled, caring, and compassionate.

Considerations and Differentials

In the past, things were so wretched for trans people that only those who had literally no other option[6] came out—those people whose feelings were so strong and whose identity was so at odds with their birth-assigned sex had no choice. This group consequently opened themselves up to the travails being an out trans person entailed. This meant that many of those people were binary (they had travelled too far from their birth-assigned sex to hide it as 'tomboy' or 'effeminate') or if they were queer, they were so much so they too had no option but to be out. They were pioneers and we owe them an extraordinary debt for forging a path.

Things are still wretched in many parts of the world; but in some areas of the high-GDP West, there are spaces opening up for people to live outside of their birth-assigned gender which was not previously available. This means that people who may have previously felt they had to stay safe

by nominally staying within their birth-assigned gender role are now able to come out. Thus, there is more of a mix of people with a range of degrees of gender dysphoria and a range of identities who are in the public, and clinical, eye. Similarly, there are differing amounts of bodily dysphoria becoming visible; and differing amounts of treatment seeking. These things are highly correlated—but not perfectly.[7] For example, you might have a person who is greatly distressed about their birth-assigned gender, but who does not desire physical interventions to change their body. Or a person with a mild dysphoria about their gender, but who especially dislikes their breasts. There are many non-binary people who have high dysphoria in all areas; but there are also people who have some aspect of dysphoria which is milder than that of the [mostly binary] people forced to come out who were referred to above. This is not to invalidate their identity—we none of us only do, and are, things we burn for—but it does make treatment decisions more difficult; and perhaps especially so when nationalised healthcare is involved in which psychologists must determine not only that the treatment is not harmful, but that it is of clear benefit.

In terms of determining likely benefit, differentials are, of course, vital in that physical or major social changes—if instigated for another reason than identity—may not turn out well. There are actually relatively few differentials one comes across in the general run of things. Far more often non-binary people are just that—non-binary—and should be assumed to be so. The differentials should be considered of course, but the non-binary person should only be considered not to be non-binary as a last resort. The main differentials are:

- Psychosis

This is easily addressed as those people who still have a gender identity which differs from their birth-assigned gender when their psychosis abates are like trans or non-binary and those who do not are likely not.

- Autistic special interest

There is a much higher rate of non-binary and trans identities among people on the autistic spectrum (ASD people; Glidden, Bouman, Jones, &

Arcelus, 2016), who will need the usual assistance afforded to neurotypical non-binary people but with appropriate accommodations being made. One key difficulty non-binary ASD people face is that they struggle with theory of mind. This means that they struggle to recognise that, while they understand they have a certain gender, if they do not communicate that fact to others—whether through apparel or other means—those others will not realise what the ASD person's gender is.

In addition to this group, there are a group of people, who are not trans or non-binary in the usual sense, but who have a special interest in gender and can become confused into thinking that they too are non-binary—especially if they have found a supportive (often online) group which encourages them in this belief.

- Fetishism

Many people feel more sexy in their [non-binary] gender of identity, rather than their birth-assigned gender, because they naturally feel more able to be sexual with an identity and/or body which reflects them appropriately. If there is fetishism or an interest in some aspects of BDSM as part of that, it may be that this is a safe place to explore gender.

Alternatively, there are those people for whom body alterations are a direct part of the fetishism (this is rare, but does happen). This can be a problem as once body alteration in permanent, the day-to-day familiarity removes the erotic charge leaving the person with no sexual motivation for the change; no identity motivation for the change; and an irreparably changed body.

- Forensic secondary gain

See *Forensic history* above.

- Immaturity

Some people who have yet to form a complete sense of themselves will try out identities to see if they fit. Thus, non-binary people may try out binary identities before settling on [a non-binary] one which fits.

Very often younger people will understandably look to their immediate social circle to try out identities. This is a natural part of adolescence and will include things such as sexuality and gender. There is no reason why a person should not try out such things if they include non-cisgender and non-heterosexual identities and practices as there is nothing wrong with a non-binary identity (or being same-sex attracted for that matter). It is not that there is nothing wrong (but being cisgender is preferred). There is simply nothing wrong. Period.

Having said that, it would be foolish to make permanent bodily changes which may be regretted under these circumstances, and so it is important to make sure the person is clear before making such changes. This is not to say children cannot be non-binary—they can—we just need to make sure that the identity is likely to be permanent before making permanent changes.

And:

- Non-binary identity as a path to a binary trans identity

This last is separated out as it is not really a differential by virtue of being something else entirely from non-binary; but more of a step on the way which is increasingly being seen as non-binary identities becomes more accepted. In this case, some people believe it is easier if they do not 'go the whole hog' and so they tell people that they are non-binary instead of transitioning into another [binary] gender entirely. Thus, if their name is John Doe, they may change to Jamie Doe and so avoid parental opprobrium as the parents can still think of them as Jamie (male) while their friends think of them as Jamie (non-binary). If they feel more binary gendered, this will not be entirely satisfactory for them and they then make a further change to a (in this case female) gender which feels more comfortable and so change again to Jane Doe and deal with any parental opprobrium. Unfortunately, and ironically, some people who opt for a non-binary identity as a means of avoiding opprobrium in fact find more—as at present many people expect a binary world even if some people have 'crossed the floor' between the genders. This can be the case even if the viewer thinks the person they are interacting with was assigned another gender at birth—it is still explicable within a binary worldview;

Whereas these viewers with a binary worldview can be more disquieted by people who appear to be neither male nor female.

Naturally, there are also some people for whom a binary trans identity is a step on a path to a non-binary identity also.

Psychologists may be especially well placed to undertake such assessments and consideration of differentials, given that they sit at the nexus of meaning, law, physicality, mental processes, and much else besides, and so may be more able to get to the heart of the individual in all their liminal, interstitial, psychically iridescent beauty. As we marshall this movement beyond the binary, however, we need to be mindful that clients may act as signifiers for a breakdown of social order linked to heteronormativity. When societies, institutions, and laws require a gender binary—in the form of single-sex prisons and changing rooms, for example—the political loading for societal change can rest on the shoulders of our clients, who may be especially vulnerable (cf Richards in Barker & Scheele, 2016). It behoves us therefore to advocate on our client's behalf, not only within the safe confines of our therapy rooms, but also in wider political arenas where our power may be brought to bear to affect societal change, rather than centring the need for such change within our clients and expecting them to carry the burden into the body politic.

We need to be especially aware here, as elsewhere, of the place of intersectionality. Where clients have multiple areas of discrimination or challenge, it is important not to silo each of these. What is true for a white middle-class heterosexual non-binary person may not be so for a working-class non-binary person of colour—there are very few matters which sit in isolation as 'non-binary matters' (or other matters for that matter—cf. Iantaffi & Barker, 2017). Consequently, advocacy might need to be in regard to social welfare, adequate housing, or the like, in order that the person can safely express their gender—to say it is not our business as "It's not psychology" or "It's not about gender" is to fundamentally misunderstand the interconnected nature of people's lives; and to abrogate the responsibility which comes with our roles as psychologists.

We need too to be aware of the role that gender is playing out in society—the meanings loaded upon it which it struggles to bear about power, possibilities, love, rights, sex, death—the stuff of life. We need to think about how people, including ourselves, may be policing one

another's gender, and how we police our own as a sort of internalised panopticon with the inhered society always looking, pointing, criticising, and stopping who we might be were we to release ourselves. We need to strive to be all we can be; whether we identify within the binary or without, and to be kind and a source of strength for those around us who are similarly fighting that good fight.

Summary

- Reality is not binary—neither should our practice be.
- Be mindful of differentials while also supporting client's self-determination.
- Do use the person's preferred pronouns and name.
- The usual psychological assistance with anxiety; phobias; depression; relationships; bullying; and so on, can pay dividends with this client group too—even when the matter is apparently about gender.
- Be reflexively aware of what your own assumptions about gender are—whether you are trans, cisgender, non-binary/genderqueer, or anything else.

Notes

1. Sadly.
2. A cisgender person is a person who is content to remain the gender they were assigned at birth.
3. While other groups in the study did differ, this shows it is not *invariably* so.
4. I fear I shall have my psychology department tweed jacket's elbow patches ceremoniously stripped off for this heresy. Nonetheless, orthodoxies must be overturned if we are truly to be scientists.
5. As seen in in the endocrine chapters, a difficulty with hormone treatment at present, which may need addressing within the psychological consultation, is that, biologically sex development is 'opposite' for males and females to some degree; or Y shaped with divergent paths. There is complexity and variation, but one hormone or set of hormones often blocks

the expression of the other, thus a pure choice of body types is not currently endocrinologically possible. Consequently, attention must be paid to attributing comfortable meanings to extant body parts (body parts don't have inherent meanings) if they cannot be changed without a less desired change accompanying it.
6. Mostly, some of us were up for the fight to be ourselves too of course.
7. As a side note, this is the rebuttal to the incorrect assertion by some radical feminists and psychoanalysists that bodily changes would be unnecessary were trans and non-binary people to simply widen their understandings of gender. It is not that people are overly eliding physicality with gender—it is that people have a certain gender, and (independently and interrelatedly) wish to have a certain body.

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