**CHAPTER 2**
**Revisioning Gender, Revisioning Power: Equity, Accountability, and Refusing to Silo**
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*Expanding Definitions of Gender?*

"Gender is a language, a system of meanings and symbols, along with the rules, privileges, and punishments pertaining to their use—for power and sexuality…" (Wilchins, 2004, p. 35). It is a powerful organizing principle that creates a hierarchy of power and places higher value on cisgender, White, heterosexual men. Gender is also at the center of multiple, intersecting systems of oppression: sexism, cisgenderism, and heterosexism, and is further complicated by race and class.

Historically, gender has been constructed as binary and biologically determined, but only based on observation of the external genitalia at birth. Among contemporary scholars (Nealy, 2008), gender is understood as being composed of 3 elements: 1) biological sex, 2) gender role, and 3) gender identity. Biological sex consists of external genitalia, internal reproductive organs, hormonal levels, and chromosomal markers creating a rich diversity in biological sex that transcends binary categories. Gender role is the socially constructed set of behaviors and expectations that is taught and imposed based on the biological sex assigned at birth. Gender identity is one's internal sense of self, how one conceptualizes their gender. Phillips and Stewart (2010) conceptualize gender not as a noun representing an aspect of identity, but as a fluid evolving verb that makes space for infinite ways of doing gender that changes across time and context.

The purpose of this chapter is daunting: To move family therapy beyond recognizing the overt and covert power inequities, to challenging insidious notions of therapeutic neutrality and relational equality, in an attempt to revise how to address gender in clinical practice. Despite the challenge, the saliency, in light of zeitgeist, this has never been more vital. In this chapter, we strive to deconstruct and give consideration to the way race and other aspects of social location inform gender, and the ways in which the curious exploration of gender in clinical practice can make space for relational healing, empowerment, and fulfillment. Family therapists identifying and understanding the intersections of their own identities, and their associated marginalizations and privileges, in preparation for doing the same with clients, is vital (Greenspan, 1986; Simi & Mahalik, 1997; Watts-Jones, 2010). We name that our perspectives about gender are informed by our lived experiences as mental health professionals of varying social locations. I, DA, am an African American, Black, married, lesbian, middle-class, ciswoman and licensed clinical social worker/therapist. I, CJ, am a White, European-American, partnered gay, middle-class, cisman, and licensed couple and family therapist, as well as a full-time academic. Naming our social locations is a way to actively consider their associated privilege and marginalization, present and historic, and its implications on the process.

*History of gender in family therapy*

During the early years of family therapy, gender was invisible, implicitly binary, sexist, and racist, as White cismen were made the measure of all others. In this era, healthy families were seen as White, middle-class, cisgender, and heterosexual. Family therapists only acknowledged generation as a fundamental principle of family organization (Goldner, 1988). Gender based

power differentials were frequently unnamed, unexamined, and taken for granted (Knudson-Martin & Laughlin 2005). Cismen were seen as the natural leaders of the family, charged with the instrumental tasks of providing for the family. Ciswomen, despite generational equality, were assumed to be subservient to men, and to take full responsibility for the emotional and domestic spheres of family life. Gender was weaponized, and women continue to be pathologized as the source of most family problems.

Beginning in the late 1970s, family therapy was re-visioned through a (White) feminist lens. (White) gender was made visible, from a binary perspective, and named as a fundamental organizing principal in White heterosexual family life (Goldner, 1988). The impact of patriarchy and sexism on family life and the discipline's approach to working with families was examined, without regard for race, class, or ethnicity. Inequality in family relationships was recognized and understood as being organized solely along gender lines. Because men held more power, it became impossible to view women as the sole source of family problems, or the sole source of resolution (Knudson & Laughlin, 2005). Following the feminist revision of family therapy, other dimensions of identity/social location, including race, class, sexual orientation, and culture, became more visible, but each dimension was viewed a-contextually and marginally. For example, gender was discussed without reference to class or race. White middle class cisgender heterosexual families remained central, and the standard by which all other families were assessed. As we entered the 21st century, (Knudson-Martin & Laughlin, 2005) proposed that we take a post-modern approach to gender and developed a model of CFT that focuses on the exploration and pursuit of gender equality. However, this approach upholds ideas of gender as a binary and biologically determined. Family therapy is stuck in revisioning relationships, families, and communities along the intersections of race and gender (McIntosh, 1990).

Family therapists working with trans/gender non-conforming/non-binary/gender expansive individuals, couples, and families invite individualized construction of gender that may be fluid and flexible, that include both binary and conventional ideas of gender and expansive ideas that are greater than two (Lev, 2004; Malpas, 2006; Giammattei, 2015). Individuals seeking therapy inform how they construct gender, e.g., binary, non-binary, expansive, and the affirming clinicians follow their lead (Malpas, 2006). This approach is also instructive for family therapists working with cisgender individuals of varying racial and cultural backgrounds, as it makes space for them to tell us who they are, and what is the best way they can do gender in the world, their communities, and relationships in the context of other intersecting social locations.

CFT has broadened its definitions of relationships and families, from White, cisgender, and heteronormative, over the decades since its inception, to include blended families and same-sex partnerships, among other relational systems, in keeping with sociocultural change. Sociocultural change has further assisted CFT in moving beyond absolute, fixed identity constructs, such as race, sexuality, or gender, to consider fluidity and intersectionality, and, more importantly, to view identities as being imbued with both places of privilege and subjugation which profoundly shape individual and group experience. CFT scholars have highlighted the relational power inequities associated with gender, the influence on romantic and familial relationships, as well as larger societies, and the need for greater consideration of effective, clinical-intervention strategies (Dickerson, 2013; Knudson-Martin, 2015). Generating new, effective clinical strategies for addressing gender inequities has not manifested. CFT, despite a shift in language among some professionals, remains gendered, a prisoner of its defining institution: Marriage.

*Gender and race*

People of color represent a range of racial/ethnic/cultural groups sharing some common values and beliefs regarding gender. With the exception of some indigenous peoples in the United States, the binary construction of gender, and the belief in power of men over women, are common themes, consistent with White, Eurocentric gender beliefs.

Racism imposes significant physical and mental healthcare risks for people of color (Karlsen & Nazroo, 2002; Williams, Neighbors, & Jackson, 2008). Further, racial dehumanization of people of color constrains and interferes with the process of performing gender, fulfilling conventional gender roles, and accessing gender affirmation. The additional marginalizing and oppressing forces that result in the intersections of race and cisgender are underexamined (Silverstein, 2006). Those who hold marginalized racial/cultural identities may experience a higher need for racial and gender affirmation that does not get met, as partners may find gender expansiveness threatening to the sense of self. Black (cis)women partners may privilege male power within the home, restraining female use of power, due to the intense devaluation experienced by Black cismen outside of the home (Cowdry et al., 2009). (Cis)women of color continue to experience more gender sexism (Beale, 1970; Chiang & Low, 2008; Sesko & Biernat, 2010), as compared to their white peers. Racism may serve as partial explanation for cisgenderism within some communities of color. It has been suggested that rather than being a static aspect of identity, gender expression and role, for people of color, it may be performance that shifts and evolves depending on context (Cowdry et al., 2009; Phillips & Stewart, 2010). However, racism constrains gender in ways that are not always easy to overcome and may result in personal and relational distress, and stricter adherence to binary, cisnormative ideas of gender. Gender expression beyond cisgenderism is inherently challenging. The opportunities for gender affirmation, and the achievement of satisfaction in gender expression, in light of social pressure and racism, is less available to people of color.

*Gender Nonconformance as Resilience*

"Labels can be reinforcing and dangerous" (Hardy & McGoldrick, 2008, p. 10). While resilient people of color have found creative ways of reclaiming their humanity, asserting their gender, and fulfilling gender roles in ways that promote survival and cultural resonance, gender nonconformance can put people of color in grave danger. Transpeople of color, specifically transwomen, experience the highest rates of violence and health disparities (Sevelius, 2013). Transgender persons of color further suffer the exponential effects of racism, sexism and transphobia, as evidenced by higher rates of unemployment, poverty, and health problems, than their white counterparts and the larger U.S. population (James et al., 2016). Gender differences in scripting, values, and experience, pervade, require nuanced assessment and consideration in addressing gender inequity clinically.

*Guidelines for Exploring Gender in Clinical Practice*

*The authors considered existing models, as well as their own clinical experience, in developing the following recommended guidelines for exploring gender in clinical practice:*

1. Self of the therapist: Family therapists, supervisors, and educators need to explore their own understanding of gender, their gender story over time, self-designations, relational

designations, gender role beliefs and assumptions, and the ways they participate in upholding cisgenderism (Malpas, 2006; Blumer, Ansara, & Watson, 2013). Gender exploration is to be done in the context of other social locations, with attention to the impact of other systems of oppression.

2. Locating the self: Family therapists should initiate the process of locating self with clients (Watts-Jones, 2010). The process of locating self may unfold over the course of the therapeutic relationship.
3. Locating the client: Support the client to engage in the process of thinking about and naming their social locations. The process may begin during the initial stages of therapy and continue throughout the therapeutic process.
4. Unpacking gender stories in context: Explore the client's understanding of gender, their gender story over time, self-designations, relational designations, gender role beliefs and assumptions, and the ways they participate in upholding cisgenderism. The exploration of gender is carried out in the context of other social locations and systems of oppression, with attention to how oppression constricts and how these locations may be sources of resilience.
5. Examining the use of power: Support the client (couple, family) to examine the ways in which power operates in the relationships by exploring questions such as whose needs and desires are attended to or are prioritized under what circumstances. How are decisions made? How did these processes come to be? Is the partner with more social power privileged in the relationship? (Knudson-Martin & Laughlin, 2005).
6. Seeking affirmation: Support clients in examining how the way they are doing gender fits/does not fit with family/community/cultural norms and values, identifying supports that are validating, and determining how they will negotiate relationships that are invalidating.
7. Reclaiming self and relationships: Support clients to identify and reclaim aspects of self and their relationships that have struggled to survive under the weight of patriarchy, sexism, cisgenderism, and other systems of oppression.

We will apply these guidelines to the case study below, as a demonstration.

*Case Study:*

Nasira and Charisse, an African American, Black, middle class, cisgender, lesbian couple in young adulthood, entered therapy with DA to address communication issues that resulted in cycles of conflict, physical separation (not relational), apology, and reunion. Charisse, a musician who suffered from depression, attributed some of their conflicts to Nasira's tendency to "act like a man." She defined acting like a man as Nasira's ability to lead, and to make decisions in a logical, emotionally detached, business-like manner, and lack of responsivity to some of Charisse's needs. Nasira saw herself as holding capacity to lead and to be emotionally present. In fact, she complained that Charisse's emotional needs took up most of the space in the relationship, leaving little room for her needs. Together, we explored each partner's understanding of ciswomanhood and what that meant for how they should be and act in the world and in relationship to each other. It became apparent that Charisse's ideas about gender were informed by her upbringing in a hetero/cis lead household with parents who were conservatively religious and enacted conventional gender roles in which her father led the family through provision of material support and spiritual guidance, and her mother provided domestic

care and emotional support. Charisse associated Nasira's behavior with her father and believed that Nasira held more power in the relationship. As a Black feminist, Nasira believed in the agency of women, rejecting the notion that leadership, logic, and decisiveness were the domain of men. In exploring her understanding of gender, Nasira believes that biology does not confer a set of attributes or abilities to individuals. She understands her story of becoming a leader as being rooted in her experiences of oppression as a Black ciswoman lesbian, rejected by her family of origin when she came out during adolescence; she taped into her capacity to lead in order to survive. As a student, she sought out/was drawn to Black women educators and peers who acted as role models, exposed her to Black feminist ideology, and shaped her gender story. Nasira learned to embrace and celebrate the leader part of herself that served her well, that she valued, and enjoyed. Expanding Nasira's gender story helped Charisse expand her idea of gender and to see the ways in which patriarchy and binary gender socialization limited her capacity to value and appreciate her partner, and aspects of her own abilities that she had previously disavowed as "manish." As she reclaimed these disavowed parts of self, she felt more empowered. We further explored how the couple could make space for the emotional needs of both partners and how they could be more responsive to one another. It became apparent that what seemed to be a lack of space for Nasira's needs was related to Nasira's inability to express her needs as her upbringing taught her that she could not rely on others. Some of Nasira's work focused on stating her needs, giving Charisse the opportunity to respond, and learning to trust that Charisse would respond. The couple continued in therapy addressing other issues related to their respective attachment needs.

| *Guideline:* | *Therapeutic Example:* |
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| 1. Self exploration | Through ongoing self-reflection and collegial consultation, I explore how I understand myself and my experiences as a Black, African American, ciswoman, lesbian. As we focused on gender, I specifically reflected on what I have learned, experienced, and believe about gender and race and how my thoughts and beliefs were shaping how I understood and related to the clients. |
| 2. Location of self | In the first meeting with Nasira and Charisse, as part of the overview of therapy and contracting process, I named my social location, specifically race, gender, sexual orientation, and spirituality. During the course of therapy, I disclosed more of my story regarding these locations and how my stories inform my thinking. |
| 3. Locating the client | During initial meetings, I used the cultural genogram (Hardy & Laszloffy, 1995) to elicit and support the client's reflection on social location. |
| 4. Unpacking gender stories in context | We explored how Charisse came to understand Nasira's behavior as "manish," and how this |

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| | "manish" behavior impacted her. We explored how Nasira understood her behaviors that Charisse named as manish. We explored (cis)womanhood, what they learned about gender, the source of the learning and their beliefs. We made the ways in which race informed their gender stories explicit. We questioned the ways that these gender narratives were limiting and liberating. |
| 5. Examining use of power in the relationship | We discovered how Charisse's description of Nasira's behavior as "manish" was code for saying that she thought Nasira was in charge. We discovered how Nasira experienced Charisse as being in charge of the relationship because of the emotional space taken by Charisse. |
| 6. Seeking affirmation | Conversations regarding validation came up as we discussed gender in context. The couple saw themselves as transgressive in larger society and among segments of their cultural communities because they were a same sex couple. They named Black queer community as a key source of affirmation and validation regarding their race, gender, and sexual orientation. Nasira also identified parts of her extended kin network as a source of gender affirmation. To manage the invalidation she experienced from her immediate family, she limited her contact with them, but when she did have contact it was in full authenticity. Charisse named her professional community as a place that offered gender validation. She named her family of origin as an unintentional source of invalidation and we struggled to develop coping strategies that she found useable. |
| 8. Reclaiming self and relationships | Each partner reclaimed disavowed parts of self and expanded how they understood the other in relationship. They were able to move forward in their relationship and address other issues. |

The aim of the aforementioned clinical example is to bring to life the application of the guidelines suggested by the authors. However, it should be noted that the process of exploring gender, and its implications, is not summative. It requires continual self-evaluation and work with clients. The literature review and case example highlight the continued vitality of exploring

gender in clinical work. Alternately, the manner in which it is done requires intentionality, to avoid microaggressions towards clients, or reinforcing cisgenderism that can have implications in the therapeutic relationship and beyond (Blumer et al., 2013).

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