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The gender affirmative lifespan approach (GALA): A framework for competent clinical care with nonbinary clients

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ABSTRACT

Background: The limited research on nonbinary individuals suggests that this community experiences significant health disparities. Compared to binary transgender individuals, research suggests that nonbinary individuals are at elevated risk for discrimination and negative mental health outcomes, including depression, anxiety, traumatic stress, and suicidality. Even mental health providers who work with binary transgender individuals often lack knowledge of and training to work competently with nonbinary individuals.

Methods: The authors of this conceptual article present the Gender Affirmative Lifespan Approach (GALA), a psychotherapy framework based in health disparities theory and research, which asserts that therapeutic interventions combating internalized oppression have the potential to improve mental health symptomatology resulting in improved overall health and well-being for gender diverse clients. GALA's therapeutic interventions are designed to promote positive gender identity development through five core components: (1) building resiliency; (2) developing gender literacy; (3) moving beyond the binary; 4) promoting positive sexuality; and (5) facilitating empowering connections to medical interventions (if desired).

Results: The core components of the GALA model are individualized to each client's unique needs, while taking into consideration age and acknowledging developmental shifts in, or fluidity of, gender across the lifespan. This model represents an inclusive, trans-affirmative approach to competent clinical care with nonbinary individuals.

Discussion: Application of the GALA model with nonbinary clients is discussed, including one clinical case vignette.

KEYWORDS

Genderqueer; nonbinary; transgender; transgender health; LGBT health; gender affirming psychotherapy

Transgender identities are gaining visibility in research and scholarship; however, this scholarly work often perpetuates a narrow view of gender diversity by focusing primarily on binary gender identities, which categorize people as exclusively male/man or female/woman (Richards et al., 2016). This binary gender framework has been developed and reinforced over many years through colonization and systemic oppressions, and continues to be reflected in status quo approaches to transgender health care (Richards et al., 2016; Webb, Matsuno, Budge, Krishnan, & Balsam, 2017). For example, a colonized understanding of gender, derived from biological sex only referring to male (XY) versus female (XX), means that those assigned male at birth are socialized to behave in culturally masculine ways and those assigned female at birth are socialized to behave in culturally feminine ways (Crouch & David, 2017).

In considering how to rectify the narrow view of the gender binary, it is critically important to consider how historical subjugation and oppression affect our own conceptualization and engagement in research and clinical work (Bouman et al., 2017). The more dominant cisnormative and patriarchal binary gender framework is situated within a social hierarchy in which men, European race/ethnicity, and heterosexuality are often considered superior (Crouch & David, 2017; Hwahng & Lin, 2009; Martins, 2016). The impact of this

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framework has been upheld and reinforced through systemic hierarchies, including in health care settings. For example, historical discrimination and silencing of transgender and gender diverse people in research and health care settings has led to mistrust and a reluctance to engage in such services, resulting in delayed access to both physical and mental health care for many transgender people (Rider, McMorris, Gower, Coleman, & Eisenberg, 2018; Spencer & Vencill, 2017).

Further, cisgender perspectives tend to dominate research (Galupo, 2017), which may, and often do, exclude and erase transgender and gender diverse voices. When representing transgender and gender diverse individuals, it is crucial to work alongside while uplifting the voices of those who identify within this community (Erickson-Schroth, 2014; Galupo, 2017). Clinicians are in a unique position to invite and welcome input from their clients (e.g., asking about name, pronouns, and gender-related terminology clients use and would like avoided in discussions) in order to provide affirming services. Discussions about how a client defines particular identity labels or experiences their gender may be warranted; however, this is not the same as asking a client to educate their clinician on transgender and gender diverse issues, which should be avoided (American Psychological Association, 2015).

Using resources created and maintained by transgender and gender diverse individuals is another way of centering this community in clinical contexts while obtaining information for educational purposes (American Psychological Association, 2015; Erickson-Schroth, 2014). For example, the Trans Student Education Resources (TSER), a national organization led by transgender and gender diverse youth whose mission is to educate the public, provides materials including a list of LGBTQ+ terms and definitions. According to TSER (n.d.), nonbinary is an umbrella term for individuals who express their gender or identify with a gender other than (or not exclusively as) female/woman or male/man and who may or may not also identify as part of the transgender community. Genderqueer individuals are those who identify as neither, both, somewhere between, or outside a spectrum of masculine and feminine (TSER, n.d.). While some individuals use the terms nonbinary and genderqueer interchangeably, others who identify as genderqueer may not consider themselves transgender or nonbinary. Some people may also choose other labels such as third- and fourth-gender, which are terms that create overlap between non-Western and non-white indigenous conceptualizations of sex and gender systems, as opposed to the European American paradigm of sexual orientation and gender as distinct categories (Hwahng & Lin, 2009). For the purposes of this article, authors primarily use the term nonbinary; however, the term genderqueer is incorporated at times to be consistent with the language researchers have used in prior publications.

Stigma and mental health

Nonbinary individuals face stigma and discrimination both from the larger society and within the transgender community, as stereotypes exist that a lack of binary gender identification means that one is not "really" transgender (National LGBT Health Education Center, 2017). For example, Wyss (2004) documented numerous experiences of physical and sexual violence faced by genderqueer and gender nonconforming youth in their American high schools; data that have been supported by additional work on perceived safety in schools for gender diverse youth (e.g., Toomey, McGuire, & Russell, 2012). Results from the 2015 U.S. Transgender Survey (USTS; $N = 27{,}715$, 35% identified as nonbinary) indicated that a majority of nonbinary participants reported that they tend not to tell others about identifying as nonbinary or correct assumptions about their gender, particularly because others historically did not understand and it felt "easier" not to mention it. Forty-three percent of nonbinary participants reported fear of violence if they were to tell others about their gender (James et al., 2016). Similarly, the European Union Agency for Fundamental Rights (2014) conducted an internet-based, quantitative study with 6,579 transgender people from 28 countries in the European Union and found that their sample of gender variant individuals (11% of total sample) tended not to be "out" or to disclose their identities to others in settings such as work or school. Forty-two percent of gender variant participants in this study reported harassment or discrimination in the

past year, ranging from name calling and ridiculing to isolation and physical assault. Almost two-thirds of the gender variant sample reported avoiding expressions of their gender or going to certain places for fear of threat or assault (European Union Agency for Fundamental Rights, 2014).

Research also suggests that although transgender individuals experience health disparities compared to their cisgender peers, nonbinary youth and adults experience elevated disparities including negative mental health outcomes compared to both binary transgender and cisgender people (Harrison, Grant, & Herman, 2012; James et al., 2016; Tabaac, Perrin, & Benotsch, 2017; Toomey et al., 2012; Veale, Watson, Peter, & Saewyc, 2017; Wyss, 2004). In a quantitative study using a convenience sample of 64 genderqueer-identified adults who completed an online survey, over half of participants endorsed clinical level depressive symptoms, and another one third of participants reported anxiety symptoms that reached a clinically significant level (Budge, Rossman, & Howard, 2014). Results from the 2015 USTS indicated that 49% of nonbinary participants reported current psychological distress, compared to 35% of transgender men and women and 5% of the overall U.S. population (James et al., 2016). Clark, Veale, Townsend, Frohard-Dourlent, and Saewyc (2018) found that nonbinary transgender Canadian youth demonstrated lower rates of overall mental health and higher rates of nonsuicidal self-harm than binary youth. Nonbinary youth assigned male at birth reported greater use of marijuana and tobacco than other groups. This study replicated findings that nonbinary Canadian youth reported lower levels of mental health and greater incidence of self-harm than their binary peers (Veale et al., 2017).

Despite these risks documented in U.S. and Canadian samples, European gender variant participants were among the most likely to report that they did not want or need psychological or medical care related to gender (European Union Agency for Fundamental Rights, 2014). In an online quantitative study using a convenience sample of 677 binary and nonbinary transgender youth in the United Kingdom, Rimes, Goodship, Ussher, Baker, and West (2017) found that nonbinary participants assigned male at birth were less likely than binary and nonbinary youth assigned female at birth to seek mental health services. Unexpectedly, nonbinary participants reported higher levels of life satisfaction than binary participants, though the researchers note that life satisfaction ratings across all transgender groups were significantly lower than those found in general population research. Clark et al. (2018) found that nonbinary transgender Canadian youth were less likely than their binary peers to desire hormone therapy, however, were more likely to report barriers to accessing such gender affirming care when hormone therapy was needed.

The need for the Gender Affirmative Lifespan Approach (GALA) as a psychotherapy framework

Arguments of biological sex have been used to pathologize and undermine gender diversity and nonconformity, as well as maintain and reinforce binary gender norms, stereotypes, power differentials, and disparities in access to resources (Crouch & David, 2017; Serano, 2007; TSER, n.d.). This perpetuation of oppression has also contributed to silencing, discrimination, marginalization, and erasure of transgender and gender diverse individuals and radically changed understanding of gender identity and expression (Martins, 2016). Given that research often informs clinical work, it is important to understand the cultural ramifications and implications of historically published empirical work, particularly as health-related studies are often informed by European American LGBTQ frameworks (Hwahng & Lin, 2009).

While there has been increased attention to mental health concerns, stigma, and minority stress related to the larger transgender community, there remains little awareness of or knowledge about nonbinary identities and experiences (Matsuno & Budge, 2017), including how to competently and affirmatively work with this community in clinical settings. Notably, mental health clinicians are tasked with the responsibility to assess readiness for gender affirming interventions and make referrals for access to medically necessary treatments (Coleman et al., 2012). Mental health clinicians thus are often in a gatekeeper role when helping transgender and

nonbinary clients with the process of medical transition (Budge, 2015). Transgender clients participate in therapy services for multiple reasons, including personal growth, gender transition assistance, and coping with stigma, prejudice, and discrimination (Bess & Stabb, 2009 ; Budge, 2015; Rachlin, 2002). For those who are seeking therapy, the gatekeeper model can undermine the meaningful and transformational role that psychotherapy can play in transgender people's lives due to fear that they will be denied access to medically necessary gender affirming treatments (Budge, 2015). Competent and affirmative clinical work involves explicitly addressing and countering the gatekeeper model in therapeutic work, and acknowledging the unique challenges, barriers, and supports of those who identify within sub-communities of the transgender population.

Even clinicians who work with binary transgender individuals may lack knowledge of and training to work competently with nonbinary and genderqueer individuals (Budge et al., 2016; Hendricks & Testa, 2012). For example, although there are now several professional documents that guide mental health practice with transgender clients, few mention clinical care for nonbinary people. The American Psychological Association's (2015) *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* notes that a "nonbinary understanding of gender is fundamental to the provision of affirmative care," highlighting the potential for gender to be fluid and widely diverse (p. 835). Unfortunately, this set of guidelines does not address differences that may arise when working with binary and nonbinary clients, or the unique needs of nonbinary clients. Likewise, both the American Counseling Association's (2010) list of clinical competencies and the World Professional Association for Transgender Health's (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (Coleman et al., 2012) acknowledge a lack of (but need for) differentiation between the many diverse gender identities, including nonbinary and genderqueer-identified people. Lack of training and experience in transgender health in general, and with nonbinary clients in particular, put clinicians at a distinct disadvantage in their ability to fully assist gender diverse clients.

Recently, two resources were published that begin to highlight the unique needs of, and clinical recommendations for working with, nonbinary and genderqueer clients. The American Psychological Association's Society for the Psychology of Sexual Orientation and Gender Diversity produced the first fact sheet on nonbinary gender identity, including clinical recommendations for mental health providers (Webb et al., 2017). Additionally, the National LGBT Health Education Center (2017) published an introductory guide to providing affirmative health care to nonbinary individuals. Comprehensive models for clinical work that are inclusive of nonbinary and genderqueer individuals are lacking and are critical for developing appropriate, culturally competent intervention strategies with this population. The Gender Affirmative Lifespan Approach (GALA; Berg et al., 2017, described in Spencer & Vencill, 2017) was developed as a trans-affirmative psychotherapy framework that is explicitly inclusive of nonbinary people and values nonbinary identities as central to the overall approach. The authors aimed to create an evidenced-based, integrative psychotherapy approach to challenge the historical binary cis- and heteronormative models of transgender health care.

Methods

Brief overview of the GALA model

The authors of this conceptual article present GALA, a psychotherapy framework based in health disparities theory and research, which asserts that therapeutic interventions combating internalized oppression have the potential to improve mental health symptomatology resulting in improved overall health and well-being for gender diverse clients. The GALA model is comprised of five philosophical foundations, as well as five core components. In promoting healthy gender development, the five core components of GALA are defined as the practical application areas in which clinical interventions are focused. These interventions are tailored to the developmental phase of each client to create an

individualized treatment approach. The five philosophical foundations are the main conceptual values on which these interventions are based.

The five GALA philosophical foundations

The philosophical foundations of GALA include the values of: (1) trans-affirmative care; (2) intersectionality; (3) transparency; (4) developmental differences in care across the lifespan; and (5) an interdisciplinary approach (Berg et al., 2017; Spencer & Vencill, 2017).

GALA counters gatekeeping models of transgender care through a *trans-affirmative* approach that centers transgender voices and experiences, and asserts that being transgender is an identity, not a disorder (Carroll & Mizock, 2017; Hidalgo et al., 2013). The value of *intersectionality* requires that, when addressing an individual's gender, clinicians recognize and acknowledge that the cultural contexts of race, class, sexual orientation, ability status, and other important identities are inextricably linked and interwoven into a person's lived experience (Crenshaw, 1991; Nadal, 2013). Additionally, GALA promotes *transparency* (Brown, 1994) as a critical practice to subvert processes of oppression in gender health care. Specifically, this involves intentional information sharing between clinician and client, and breaking down difficult-to-access or -interpret concepts and procedures (Singh & Burnes, 2010). Transparency is important in countering the opacity of systems of power (e.g., accessing health care in a historically transphobic culture and environment) that serve to perpetuate pathologizing narratives of gender diverse, nonbinary, and transgender bodies and sexualities (Spencer & Vencill, 2017). The GALA model emphasizes attention to *generational and developmental differences across the lifespan* with regard to gender identity and expression over time (Berg et al., 2017). Therapeutic approaches are tailored based on whether the client is a child, adolescent, emerging adult, elder, and so on, and incorporate attention to generational differences that shape gender exploration and identity development. Finally, *interdisciplinary* approaches are central to GALA and critical to informing competent practice with gender diverse clients, who often interact with multiple providers from a range of disciplines (Ettner, Monstrey, & Coleman, 2016). These philosophical foundations are the framework of GALA and inform the process of applying the five core components of the model in clinical work.

The five GALA core components

As previously mentioned, the GALA core components are the main overarching topics for clinical application and intervention. The five core components of GALA include: (1) developing gender literacy; (2) building resiliency; (3) moving beyond the binary; (4) exploring pleasure-oriented positive sexuality; and (5) making positive connections to medical interventions (Berg et al., 2017; Spencer & Vencill, 2017). *Developing gender literacy* is the process of identifying and naming oppressive practices within a society shaped by the binary gender paradigm. Gender literacy also involves understanding that one's body does not define their gender identity or expression (Berg & Edwards-Leeper, 2018). *Building resiliency* involves learning how to overcome adversity and effectively cope with challenging situations in life (Jew, Green, & Kroger, 1999; Singh, Hays, & Watson, 2011). Resiliency building also involves finding and creating safe places (e.g., with family, friends, community groups) to share these difficulties and to gain support (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; McCann & Brown, 2017; Singh et al., 2011; Testa, Jimenez, & Rankin, 2014). Gender and sexual binaries pathologize nonconformity and can limit healthy gender and sexual expression (Burdge, 2007; Saewyc, 2017). Thus, *moving beyond the binary* allows for the inclusion and affirmation of all gender identities and expressions (Berg et al., 2017; Burdge, 2007). Research and practice in the past have focused largely on negative sexual outcomes for transgender and gender diverse people (Spencer & Vencill, 2017), and little attention has been paid to how dysphoria, stigma, and relational experiences shape sexual and gender health (Glynn et al., 2016). Since gender identity and affirmation can play such a critical role in healthy sexuality (Hill-

Meyer & Scarborough, 2014; Spencer, Iantaffi,& Bockting, 2017), developmentally appropriate psychotherapy aimed at exploring *pleasure-oriented positive sexuality* is extremely important to fostering healthy gender and sexual development (Spencer & Vencill, 2017; Spencer et al., 2017). Lastly, gender competent clinicians need to facilitate *referrals for appropriate medical interventions*, including knowledge of the full spectrum of gender care, not just binary-focused interventions (Coleman et al., 2012; Lev, 2004; National LGBT Health Education Center, 2017).

The GALA model was developed to assist with facilitating gender health as well as improving overall health and well-being for gender diverse clients. As previously mentioned, professional education and training opportunities for working with nonbinary individuals are lacking (Budge et al., 2016; Hendricks & Testa, 2012; Matsuno & Budge, 2017). Furthermore, there is limited published guidance for facilitating affirming interventions with nonbinary individuals at different developmental stages in clinical settings. As such, the authors of this article have provided key recommendations for clinical work with nonbinary clients using GALA. These recommendations are based both on existing scholarly work as well as on the work of the authors, who are all mental health providers and gender specialists with experience providing clinical services to nonbinary clients. Note: two of the authors also identify as nonbinary people of color.

Results

Key GALA recommendations for clinical work with nonbinary clients

Developing Gender Literacy

In applying GALA with nonbinary clients, the first core component, *gender literacy,* is highly useful in disrupting binary gender assumptions. Gender literacy involves identifying and externalizing oppressive gender narratives that have become invisible (Berg & Edwards-Leeper, 2018). A key role clinicians can play is to validate the client's gendered experience and support them in developing an ability to critique and externalize the embedded binary messaging pervasive in dominant culture (Berg et al., 2017). Many nonbinary clients are apprehensive about accessing clinical services, anticipating clinicians' lack of knowledge about nonbinary identities and a medical system that is based in reinforcing a binary gender paradigm (National LGBT Health Education Center, 2017). Clinicians have the opportunity to be transparent about the binary medical system while also serving as an advocate for nonbinary clients within the system.

Moving Beyond the Binary

Another value of GALA is the concept of *moving beyond the binary* to a gender spectrum approach. The history of transgender health care is mired in heteronormative, cisnormative, binary-enforcing gender assumptions (Burke, 2011; Davy, 2015; Nieder & Richter-Appelt, 2011). Early treatment protocols for transgender care were deeply embedded in the colonized framework of heterosexuality and accompanying gender binary assumptions of patriarchal femininity and masculinity (Butler, 2004, pp. 75–101; Johnson, 2007). The unexamined norm guiding transgender health care was that of compulsory heterosexuality (Rich, 1980), with its assumption of femaleness mapping onto stereotypical femininity and maleness (when even considered, since most of early transgender health care focused on transgender women) assuming stereotypical masculinity (Burke, 2011; Davy, 2015; Nieder & Richter-Appelt, 2011). The enforcement of binary genders within transgender health care served to regulate what gender identities and expressions were deemed "legitimate," which further operated to label as deviant and oppress gender expressions and sexual desires that did not fit within a heteronormative, cisnormative framework. For example, binary transgender identities are often seen as valid based on medicalized standards; however, nonbinary identities are often perceived as deviant or nonexistent and thus invalidated, ignored, or rendered invisible. As a result, nonbinary individuals who are interested in medical interventions may present themselves as identifying with singular, binary gender stereotypes in order to access care. This process results in perpetuation of oppression and invisibilizing of nonbinary individuals. Shifting to move beyond the

binary is essential in shattering the ties between, and challenging frameworks centered on, transnegativity, misogyny, homonegativity, and colonization (Hendricks & Testa, 2012). Applying this in clinical work is to not only elucidate the history of how a binary gender paradigm serves as an underpinning to heteronormativity, cisnormativity and patriarchal gender norms, but to also actively validate nonbinary identities and expressions (Berg et al., 2017).

Building Resiliency

An important task of psychotherapy is to support a client's resilience to stigma, discrimination, and stress (Hendricks & Testa, 2012). In working with nonbinary clients, *building resiliency* includes addressing the specific stressors of living as a nonbinary person in a binary world (Berg et al., 2017; National LGBT Health Education Center, 2017). One potential clinical intervention to utilize for building resiliency is through supporting nonbinary clients in connecting with resources online, in communities, and via other social outlets. Connecting to social supports and sharing experiences of stigma with similar others has been shown to improve mental health outcomes in coping with minority stress (Bockting et al., 2013; Budge, Adelson, & Howard, 2013). Additionally, finding role models and other nonbinary people in the community are important components of building resilience (Craig, McInroy, McCready, & Alaggia, 2015). Learning how to self-advocate in social situations, as suggested in cognitive behavioral therapy models of trans-affirmative therapy (Austin & Craig, 2015) and enrolling the support of allies in challenging stigma (Harper & Schneider, 2003), can be another boost to building client resiliency.

Exploring Pleasure-Oriented Positive Sexuality

As noted above, compulsory heterosexuality and concordant normativity in sexuality is resultant in the rigidity of the gender binary, in that it assumes mapping of heteronormative desire onto binary gender categories (Butler, 2004; Rich, 1980; Serano, 2007). Nonbinary, genderqueer, and gender nonconforming people have long been seen as deviant in their variance from conformity to these sexual and gender norms (Richards et al., 2016). Nonbinary bodies and sexualities have been pathologized, ignored, and misunderstood, leading to a lack of competent resources for promoting sex positive pleasure, satisfaction, and healthy sexual functioning (Hill-Meyer & Scarborough, 2014; Richards et al., 2016). As such, a core component of GALA is pleasure-oriented positive sexuality; that is, prioritizing pleasure and satisfaction for all bodies across the gender spectrum. Existing models of sexual functioning and related sexual health interventions are aimed at cisgender, and primarily heterosexual, clients (Spencer et al., 2017). Missing from the literature are descriptions of effective clinical strategies based on transgender, and specifically nonbinary, individuals' common presenting concerns. Scholarly literature addressing the specific concerns of transgender clients is slowly increasing (Baral et al., 2013; Garcia, Christopher, De Luca, Spilotros, & Ralph, 2014; Gooren & Asscheman, 2014), but only recently have sex therapy interventions been discussed to address topics beyond a diagnosis of gender dysphoria, STI prevention, or medical transition-related concerns (Spencer & Vencill, 2017). Pleasure-oriented positive sexuality, as a core component of GALA, calls for a paradigm shift and centers the rights of all individuals across the gender spectrum to sexual empowerment and pleasure. In practice, this may include assisting clients in identifying gender congruent language for their bodies and learning how to negotiate sexual situations in ways that feel gender affirming (Spencer & Vencill, 2017; Spencer et al., 2017). Gendered language for body parts can be dysphoria inducing, and finding gender neutral terms or creating language that feels more congruent can be an empowering way to feel more at home in one's body (Bouman et al., 2017; Spencer et al., 2017). Identifying empowering (versus fetishizing) resources that show nonbinary people in relationships and being sexual validates nonbinary sexuality in a culture that routinely erases such individuals (Hill-Meyer & Scarborough, 2014).

Making Positive Connections to Medical Interventions

A challenge for many nonbinary clients is finding knowledgeable medical providers (National LGBT Health Education Center, 2017). A critical

component of GALA is the facilitation of connections to medical interventions, as clinicians are often a referral point for clients seeking such access. When appropriate, finding competent providers for nonbinary clients includes identifying those who are knowledgeable about hormone protocols that support the transition goals of nonbinary clients and accessing surgeons who are familiar with and supportive of a range of surgical interventions (that may not include a binary outcome). Clinicians can play an important role in advocating for nonbinary clients as well as educating other providers about gender diversity (Wylie et al., 2016). Since medical interventions have historically focused on binary outcomes (Nieder & Richter-Appelt, 2011), providers can utilize emerging resources, such as those cited above, to encourage providers toward culturally competent care where medical interventions match clients' desired outcomes, rather than a predetermined binary approach.

Discussion

Little scholarly work focuses on practical applications of conceptual frameworks and guidelines with nonbinary clients in clinical settings. A complicating factor is that existing identity development models focus on binary transgender individuals (e.g., Bockting et al., 2016; Devor, 2004; Gagné, Tewksbury, & McGaughey, 1997). Such models – linear in nature and based on a binary gender paradigm – often lack validity for nonbinary people and can contribute to the ongoing erasure of this community. Indeed, approximately two-thirds of nonbinary participants in the most recent USTS reported that others often dismiss their identity as not being legitimate or "just a phase" en route to a binary transgender identity (James et al., 2016). This dynamic can make identity exploration and development more stressful for nonbinary people, given the often constant and repeated need to come out and/or to confront and correct others' binary gender assumptions. Clinicians are in the unique position to support and affirm nonbinary clients in their gender identity exploration and development.

The case study below helps to illustrate how GALA can be applied in clinical work with a nonbinary client. Readers are encouraged to take note of the application of the five core components as clinical interventions to promote gender health. Consider also adjustments to the interventions (aligning with each GALA core component) in order to individualize care to fit a client's age and developmental level.

Applying GALA to clinical work: A case study

Jay is a 21-year-old, Hispanic, bicultural, bilingual (Spanish and English) person assigned female at birth, who identifies as nonbinary and uses they/them/their pronouns. Jay was born and raised until the age of 6 in a middle class, urban area in Puerto Rico. Jay and their parents then moved to a rural community in the midwest region of the United States. Jay described a history of gender nonconformity in expression since childhood and a notable preference for stereotypically masculine to gender neutral dress, play, and interests that continued into adulthood. Jay recognized feelings of being *diferente or creativo* as a child, yet did not have the words to express this until adolescence. Due to fears of family disownment and rejection from friends, they did not openly identify as nonbinary until age 20. Importantly, Jay initially communicated concerns regarding their nonbinary gender identity in English. It wasn't until they began to talk with their parents about gender that Jay began to recognize that they did not know how to communicate their nonbinary identity in Spanish.

Prior to seeking therapy, Jay established a social network within the queer community who they called their chosen family. They continued to struggle with acceptance and affirmation of their gender identity from their family of origin. Jay described overwhelming concern about being disrespectful toward their family due to being a reflection of the family unit (*la familia*). This, coupled with a fear of being disowned, resulted in Jay distancing themself from family and looking to their chosen family for support. Jay also experienced work-related stress due to fear of disclosing their gender identity in the workplace. Therapy began with identifying and processing the impact of family isolation and Jay's fear of rejection and erasure of their gender identity.

Developing Gender Literacy. Jay came to recognize how gender roles and family expectations that accompanied such roles reinforced how they were viewed within their family system. As a child and adolescent, Jay was actively involved in theatre, which stemmed from an affection for costume design. Jay spent significant time with their mother seeking guidance on sewing and stitching techniques – interests that were viewed as strongly feminine within the family and had become the scapegoat that Jay's parents used to invalidate Jay's gender identity. Jay came to understand how the feminine associations of clothing design, embraced within both their family and the larger culture, had stifled their dreams of pursuing this career path. Through negotiation of how restrictive gender norms may continue to emerge within their family and while pursuing career goals, Jay began to realize that their gender identity was valid despite the binary nature of their family's views and the greater cultural stereotyping of their interests.

Moving Beyond the Binary. Through Jay's individual therapy, *familismo* (the views of the immediate and extended family as more important and valid than the individual's views) emerged as a central theme. They recognized the emotional benefit of working toward relational repair with their parents and extended family, setting goals of utilizing family therapy as a safe space to share thoughts and feelings with parents and to discuss their family's assumptions of Jay's identity. At the start of family therapy, Jay's parents expressed their care and concern for Jay's well-being, disclosing fears that Jay's "lifestyle choices" would inevitably make Jay more vulnerable to harm and disownment from la familia. Jay's parents equally expressed confusion regarding how in English the grammatical use of they/them/their as plural elicited cognitive dissonance for them when considering a singular alternative use. Additionally, Jay's parents expressed the inability to translate gender neutral pronouns when speaking Spanish. Jay's mother argued that Jay's history of dating both men and women might suggest that Jay's nonbinary identity was better explained by sexuality confusion. Jay's father focused on Jay's gender expression, highlighting some of Jay's interest in stereotypically feminine activities (i.e., sewing and clothing design) as evidence that Jay's nonbinary identity was invalid.

In an effort to develop a common language and lessen the divide in perspective, family therapy focused on psychoeducation. Through explanation of identity characteristics existing on a continuum, Jay and their parents were guided in an exploration of the various ways sex assigned at birth, gender identity, gender expression, and attraction uniquely come together within themselves and one another. Jay's mother recognized her own gender identity as "not completely female" and her gender expression as fluid. Jay's father, who self-identified on the far masculine end of a continuum, showed recognition of the possibility of different combinations of gender identity and expression. Through further discussion Jay's parents, who grew up in the 1960's in Puerto Rico, processed the impact of generational cultural ideals on their own conceptualization of gender identity and expression. While Jay's parents continued to maintain their binary view of gender, they demonstrated openness to considering alternative perspectives and this opened the door to relational repair with Jay.

Building Resiliency. Family therapy provided Jay with a safe space to develop skills for having sensitive and difficult conversations with their parents regarding differing perspectives of gender. Jay began to self-advocate by correcting their parents' use of incorrect pronouns in English. Due to the lack of gender neutrality available in Spanish, Jay and their parents mutually agreed to use masculine language when referencing Jay in Spanish. Jay and their parents also decided to approach their extended family to discuss Jay's gender identity and ways to reference Jay in Spanish.

Though Jay's resilience for managing adversity within their family had strengthened, they continued to struggle within the workplace. While the few coworkers that Jay had come out to were supportive of their gender identity, Jay was fearful of losing their job if they were to initiate a full workplace disclosure of their identity. During therapy, Jay developed a plan to learn about state employment laws and rights in order to ensure protection of their identity. They contacted a local LGBTQ advocacy organization that provided pro bono legal counsel, which encouraged

them to address the issue with their workplace human resource department. After 3 months of research, planning, and processing the risks and benefits of the planned disclosure, Jay successfully came out at work as nonbinary.

Exploring Pleasure-Oriented Positive Sexuality. Jay identified as queer and pansexual, describing their attraction as romantically and physically influenced by an emotional connection rather than by gender or body parts. Upon starting therapy, Jay had been in a polyamorous relationship for several months. Jay felt safe and comfortable sexually with their primary partner, yet feared that they would become "overly dependent" and subsequently viewed as "unfit" for polyamory. Jay recognized feelings of insecurity related to a fear of rejection and anxiety about sex. Jay also experienced dysphoria about being thin and was self-conscious about being naked. Therapy focused on exploring Jay's sexual insecurities and finding outlets for challenging their fears in positive and healthy ways. Jay's interest in the kink community became the conduit by which Jay began confronting these insecurities. For example, Jay befriended several people after exploring a local kink community group recommended by the therapist. Jay and group members regularly discussed sexual and relationship insecurities and the impact of exotification in relation to racial identity, as well as offered support to one another. The group organized small play parties where Jay could explore sexual interests, work through anxiety about being naked, and learn skills for asserting sexual boundaries. Through the group experience, Jay gained confidence that enhanced their sexuality and relationships.

Making Positive Connections to Medical Interventions. As Jay's comfort in their sexuality improved, they became more aware of how significantly body dysphoria impacted their sense of self. Jay desired menstrual suppression, voice deepening, and lean muscle mass gain, yet did not desire significant masculinization. Through psychoeducation about masculinizing hormone therapy, Jay explored the potential impact of hormones on their body and fertility. Given the importance of their family's understanding of their gender identity, Jay did not wish to pursue gender affirming medical interventions without first discussing it with their immediate and extended family. Afterwards, Jay made an informed decision to consult with a medical doctor regarding low-dose approaches to hormone therapy.

Limitations and future directions

GALA is a psychotherapy framework developed from integrated research within the fields of transgender health, psychology, sex therapy, and family social science, as well as from the clinical experience of the authors. GALA was developed within a gender and sexual health clinic primarily composed of gender specialists who are sex therapists as well as licensed psychologists. As such, the model is limited in broad applications to specific fields outside of psychotherapy. In particular, some clinicians without psychotherapeutic training may find aspects of GALA difficult to implement in practice, given the assumption of time (length of sessions) and rapport (development of a therapeutic relationship over time). Additionally, as an integrative framework, GALA requires a broad knowledge and skill base of practitioners.

Implementation of GALA requires clinicians to move beyond gender specialization skills (difficult enough to attain) to include developmental and sex therapy approaches, as well as knowledge of navigating medical systems, into their approach. Indeed, this may exceed the role and training of many providers. In addition, although GALA does not appear to have any contraindications as a therapeutic framework and approach, it may prove difficult to apply in some settings and providers should consider their scope of practice before attempting certain interventions (e.g., Spencer & Vencill, 2017) derived from the GALA core components. These limitations reflect the potential strength of GALA as an interdisciplinary gender health specific model. Instead of adapting existing models of psychology or development or gender or sex therapy, GALA applies these frameworks in a truly integrative manner to address the complexity of gender health across the lifespan.

GALA is early in its development and therefore requires empirical testing. GALA is derived from clinical experience and existing scholarly literature, and the effectiveness of the proposed interventions, particularly with nonbinary clients, have not yet been empirically tested. Questions that should be addressed in future research include whether interventions grounded in GALA improve therapeutic working alliance, rapport, and relational factors for nonbinary clients, as relational factors have been shown to be key in improving mental health outcomes in psychotherapy (Lambert & Barley, 2001).

Conclusion

Research suggests that nonbinary individuals experience significant health disparities and are at elevated risk for discrimination and negative mental health outcomes, including depression, anxiety, traumatic stress, and suicidality. Gender health is a clinical specialty and even mental health providers who work with binary transgender individuals often lack the knowledge to work competently with nonbinary individuals. The Gender Affirmative Lifespan Approach (GALA), introduced here, is a psychotherapy framework meant to be individualized to a client's unique needs and gender-related goals. Based in health disparities theory and research, GALA asserts that therapeutic interventions combating internalized oppression and transnegativity have the potential to improve mental health and overall well-being for gender diverse clients. In addition, GALA promotes teaching a gender spectrum as a natural expression of the diversity of gender to allow all clients the freedom to find themselves in all of the gender possibilities, rather than choosing from a narrow two option category. GALA represents an inclusive, transaffirmative approach to competent clinical care with nonbinary individuals.

Conflict of interest

The authors declare that they have no conflict of interest.

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