Are Mental Health Professionals Prepared to Work with Transgender Clients?

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This article introduces mental health professionals to the issues, practices, research and resources, including the World Professional Association for Transgender Health (WPATH), for working with transgender clients.

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Equal Rights Protection

In early 2009 the Lawrence-Douglas County Chapter of the Kansas Equality Coalition sent a letter asking commissioners to include transgender protection as part of the city's human rights ordinance. The change would make it illegal for landlords and employers to deny someone housing or a job based on their transgender identity. Similarly, North Dakota's state Senate voted 27-19 to pass Senate Bill 2278, which would bar discrimination on the basis of sexual orientation and gender identity in matters of employment, public accommodations, housing, state and local government services, insurance and credit transactions. Nationwide, 13 states, i.e., California, Colorado, Hawaii, Illinois, Iowa, Maine, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington plus Washington D.C. include gender identity in their antidiscrimination laws.

In addition to the above, the Transgender Law and Policy Institute has verified that 92 jurisdictions have a transgender inclusive non-discrimination law and has on file either the passed ordinance or bill, or the relevant sections of the municipal or state code. Other sources count at least 108 counties and cities that have passed legislation to ban this discrimination in their communities. This trend is also evident in corporate America which has been known to extend fair policies and benefits to lesbian, gay, bisexual and transgender (lgbt) workers (Fidas, 2009.)

In the Media

Yes, transgender equality is progressing and, simultaneously, transgender people are becoming increasingly more visible in our culture: Dr. Tania Israel, University of California, Santa Barbara, states, "There definitely is greater awareness, allowing more opportunity for people to express themselves more broadly." This includes prime time television where a beautiful transsexual actress, Candis Cayne, stars in "Dirty Sexy Money," and plays the role of a transsexual character (Seabaugh, 2009).

With the production of the movie, "TANSAMERICA," Duncan Tucker and the Weinstein Company provide an opportunity for mainstream audiences to learn about the process and experiences of transitioning from one gender to another. The film demonstrates this process and the issues and struggles faced by the people who experience it, including the families and friends of transgender individuals. From within the transgender community the National Center for Transgender Equality (NCTE) offered its congratulations to Felicity Huffman on her Oscar nomination for Best Actress in a Leading Role. Huffman portrays Bree, a transwoman traveling across the country with her son. "All across America, folks are talking about transgender people because of Felicity Huffman's

portrayal of Bree," commented NCTE's Executive Director, Mara Keisling. "It helps raise consciousness that trans people exist, that we are parents, that we face the same joys and troubles as other people. This is the portrayal of one trans woman's story and we're glad it is out there." NCTE also reports that Huffman received a Golden Globe award for her role in this critically acclaimed movie. In her acceptance speech, Huffman said, "I know as actors our job is usually to shed our skins but I think as people our job is to become who we really are. So I would like to salute the men and women who brave ostracization, alienation and a life lived on the margins to become who they really are" (NCTE, 2006).

Through "Sex Change Hospital," a six-part cable television series, WE tv introduces and educates the public about gender reassignment surgery (GRS), also known as sexual reassignment surgery (SRS), and its related issues. It is a reality series that follows patients - from retired grandfathers to construction workers, businessman and office managers – as they undergo surgery to transition from one gender to another and confront their related unique social struggles. These are patients of Dr. Marci Bowers, who is also a transgender woman. Dr. Bowers has a clinic in Trinidad, Colorado, where she performs these surgeries. With the broadcast of this reality series Dr. Bowers hopes to clear up a lingering misconception that transgenderism is psychological or that transgender people are mentally ill. The series provides the opportunity to see and hear from transgender people and learn that they have felt their gender identity from their very earliest memories. They share that their experience is not about how they were parented, or their choice, and that it is certainly not psychological. Their feeling is that their gender identity was established prenatally and that their experience is an overwhelming sense of relief after surgery. The message conveyed by the series is that these are interesting, normal, productive people who happen to be transgender. Their stories are real. They're just looking for acceptance and continuity between their spirits and their bodies (DiNunno, 2008).

On the MSNBC documentary series "Born in the Wrong Body," (July 27, 2009) one episode titled "All in the Family," demonstrates the progress that has been made by transgender people by, yet again, explaining that some, if not many transgender people know at a very early age about their transgenderism. Thus, much emotional pain and isolation can be averted with an early transition and, with the guidance of a mentor. The documentary features a 16 year old transboy, Jake, who has known he was born in the wrong body as far back as age four. He was fortunate to have a mother that appreciated his struggles and researched his options. She realized that her choice was to let her female child transition to a male or to have a dead child, probably by suicide. Therefore, she allowed her child to transition at age 15. The mother's support for the transition included an active role in working with school personnel on Jake's behalf, etc. In addition to the support of his mother and the school personnel, Jake's ability to sort out and deal with the challenges of transgenderism was further enhanced by a mentor, a

middle-aged transman who, because he was born a generation earlier, had to suffer in the wrong body for more than 50 years before he realized it was possible to live in his desired body.

ABC's "Primetime: Family Secrets" (July 21, 2009) documents a family negotiating the uncharted world of gender transition when a husband and father of two very young children transitions to a woman. In addressing multiple issues, the documentary demonstrates that young children are well able to deal with the transition of a parent as long as they know they will be loved and cared for and that, if and when they wish, they will be able to talk about the issue.

Mistrust of Providers

Many mental health clinicians may believe that, based on their experience, the likelihood that they will see a transgender client in their practice is quite small. However, for many reasons discussed above and for the many reasons that the incidence and prevalence of gender-variant persons is difficult to measure, including reasons like, such behavior is private and often viewed as shameful; that it is shrouded in guilt and secrecy; that data can be collected for those who apply for SRS but not all gender-variant people seek SRS; and that in the United States private mental health practitioners see as many, if not more, individuals who are transgender than gender clinics per se, yet those numbers are not included in the incidence reports in the literature, the need may be greater than most believe. Dr. Randi Ettner (1999), therapist, transgender specialist and expert author states that the prevalence of gender dysphoria is grossly underreported. However, it can be reported that transgender people inhabit every nation of the world, come from all walks of life, and occupy all socioeconomic strata. Gender conditions do not discriminate on the basis of race or religion.

The Human Rights Campaign (HRC), the largest lgbt civil rights group, notes that many transgender people are generally mistrustful of health care, as well as social and public services. They are frequently mistrustful of local law enforcement authorities because the authorities often lack training and understanding of transgender people and often exhibit intolerance or fail to investigate or prosecute cases of transgender hate crimes. Likewise, transgender people have frequently suffered discrimination in health care. For example female-to-male transsexual Robert Eads of rural Georgia developed cervical cancer but could not find a doctor to treat him. Twenty physicians simply refused. He eventually found one who was located more than 130 miles from home, but by then, Eads partner said, it was "just too late," and Eads died. Anti-transgender discrimination also occurs in housing, credit and public accommodations (HRC, 2009.)

Goldberg (2009) has concerns within mental health care, as well. In the American Counseling Association's (ACA) monthly publication (April, 2009), the

"From the President" column was titled, "I am an asterisk." The president at the time, who was open about being a lesbian and belonging to a sexual minority, called for action among ACA members to include sexual minorities in their advocacy work along with their advocacy for ethnic minorities and the differently abled. Although she advocated for these groups, she did not advocate for the rights and service needs of the transgender community per se. The article lacked any message of inclusion or welcome to the transgender community. Perhaps her intention was to include the transgender community in her use of the umbrella term of "sexual minority". However, since transgenderism is not about sexuality, many transgender individuals do not see themselves as part of a sexual minority. Rather, they see themselves as gender variant individuals with a variety of issues that are unique and discrete from sexual minorities. Unfortunately, the column reinforces that which is documented in the transgender literature, i.e., that clinicians and facilities are not sensitive to this community and that transgender people are not acceptable or visible in many treatment settings. The then ACA president missed the opportunity to communicate to counselors that gender variance is a legitimate issue, relevant, unique and important to a transgender individual's identity. Since lgbt people are generally grouped together, many mental health clinicians feel that their experience working with clients from the lgbt community has prepared them for work with transgender clients. In fact, there are a few overlapping issues among these groups, but there are many unique issues that transgender individuals face (Goldberg, 2009). Just as unfortunate is the fact that the transgender community receives little, if any, support from the lesbian and gay communities (Goldberg, 2008).

Current Research and Practice

Although this short e-book is not a comprehensive treatment and resource guide for working with transgender clients, it provides a sampling of information and issues, as well as recommendations for areas of knowledge that mental health professionals will find helpful.

Recently, at the World Professional Association for Transgender Health (WPATH) 2009 XXI Biennial Symposium, titled "Childhood – Adulthood, Culture and Brain" much data were presented and shared for and by mental health professionals, in the areas such as:

- Medical Ethics, Culture and Youth: Henriksson Bendiksby (2009), shared that there are vast cultural differences in expressing and handling gender roles, as well as their content and significance. These differences pose particular problems for immigrant children and youth growing up with the difficulties of living with an internal split in their cultural identity. This may present struggles in handling important life-choices related to gender and sexuality, especially when the split identities have opposing views. It must

be determined what might be culturally adequate and what might be pathological.

- Gynecology, Urology and Endocrinology: Gómez-Gil, Toquero, Esteva de Antonio, Almaraz, Godás, López, , Yahyaoui, and Salamero (2009) reported from their study in Spain of patients who had SRS that none of the participants voiced regret for having received the surgery. Social and sexual satisfaction after SRS was considered to have much improved in the majority of participants. None reported more negative social or sexual relationships. SRS had a positive effect on different aspects of the patients´ lives. These data agree with those of previous studies showing the beneficial effects of SRS.

  Deutsch (2009) reviewed the methods, safety, efficacy and outcomes of informed consent based cross gender hormone therapy programs at selected health clinics in the United States. She found that the WPATH Standards Of Care (SOC) are frequently misinterpreted as mandating twelve sessions of psychotherapy for a minimum of three months prior to referring a client for cross-gender hormone therapy. The SOC actually allows for case-by-case clinical decisions, including an allowance for some transgender individuals who might not need psychotherapy at all. Rigid adherence to these misinterpreted guidelines may lead to increased barriers to optimal care for the maximum number of transgender persons; interference with harm reduction; and the stigmatization of the useful role of supportive psychotherapy as merely another gate keeping and/or financial hurdle to be overcome in the process of gender transition.

- Public Health: Bauer, Hammond, Travers, Kaay, and Boyce (2009) demonstrated how certain processes may work in a mutually reinforcing manner to produce a system where the appearance of a trans person is seen as an anomaly. Thus, the impetus may fall on trans individuals to remedy systematic deficiencies and policies, and to acquire the knowledge necessary to address their own needs. Interventions at the institutional policy, information and community levels were identified as strategies for improvement in such social determinants of health.

  Burnett (2009) described a model project that has enabled impoverished transsexual (TS) patients to not only obtain TS (and other) medical care but also receive a high-quality hormone regimen, all at a cost below what they were paying annually for their illicit meds which many feel are sought through the “black market”. The use of “black market” medications is dangerous as the users have little or no understanding of what type(s) or dosages they are giving themselves.

- Psychological Adjustment: Rodrigues-Molina, Asenjo, Becerra and Lucio (2009b) reported their findings from a Spanish study in which there were

no significant differences between transgender individuals and the general population in depression, psychopathology and emotional competition. There are significant differences in stress, quality of life and well-being. There is not a definite psychological profile of transgender people. However, regarding certain bio-social variables such as genetic sex, chosen sex, receiving hormone therapy, receiving surgical treatment, family support, educational level, employment status and sexual activity, their findings indicate that a relationship exists between certain biological or social variables and the psychological state of transgender people (Rodrigues-Molina, Asenjo, Becerra and Lucio, 2009a).

Norman (2009) reported that a suitable methodology and design is being developed for a research program to measure interpersonal skills that affect the social and cultural integration of transsexual people. Thus, such skills can be, (1) linked with other factors which also affect the social acceptance of reassigned transsexuals; (2) create a better understanding of which skills might assist TS individuals who wish to better adapt to and integrate within their reassigned gender role; (3) reflect on how some language and behavior based interpersonal social factors might affect the development of social attitudes towards this minority group; and (4) how transphobic attitudes and behaviors may be formed. The target audience for the research will be broad based, from an academic to a wider, non specialist, audience, including, of course, those people who are transsexual themselves, and their families.

Brown and McDuffie (2009) presented a descriptive study of 70 U.S. veterans with gender identity disturbances. The modal veteran with gender identity disturbance was a natal male (91%) identifying as female, less than 40 years of age, Caucasian, employed, with less than12 years of education. Fifty-seven per cent were parents with a history of sexual involvement with opposite sex individuals. Histories of autogynephilia were not elicited in veterans interviewed since 1997. Classic "flight into hypermasculinity" was described by a majority of the natal male veterans as an understanding of why they joined the military. Psychiatric comorbidities (43%) included post traumatic stress disorder (PTSD), depression, schizophrenia (N=1), substance use disorders (17%), dissociative identity disorder (N=1), and personality disorders (11%). Ninety-three per cent were diagnosed as meeting criteria for the diagnosis of GID or GID NOS. Suicidal ideation was reported by 61%, and suicide attempt(s) by 11% of 56 responding. Four per cent reported genital self-mutilation, although 11% expressed active thoughts of surgical self-treatment; most expressed a desire for physician-performed SRS. Cross-dressing behaviors were common; currently reported arousal with cross-dressing was reported by 13%, 63% of whom were not diagnosed with GID.

Yüksel, Aslantas, Öztürk, Bikmaz and Oglagu (2009) investigated transgender individuals in Istanbul who received both individual and group psychotherapy for two years plus family counseling meetings conducted twice per year. The participants had high rates of life time suicidal thoughts (53.7%), and attempts (28.5%) had been reported. In some cases suicide attempts were the reason of their application to the clinic and can be seen as a help seeking behavior. Most of them attempted suicide before the age of 21. Except for two cases, no suicide attempts were reported within the two year treatment period and after the SRS. It appears to the investigators that in societies where sexuality is still a taboo, transgender people are being exposed to discrimination. These conditions may cause isolation, a reason to estrange themselves from social life and suicide attempts. Interactions between participants and active participation to the group process were especially encouraged and during the therapy period they found functional and mental improvements in social, work and private lives. Thus, the investigators believe that such a program may help prevent suicide attempts and suicidal thoughts. They suggest that data are needed to better plan prevention strategies for youth suicide.

Sargent (2009) discussed that the 60+ phase of life may socially allow more freedom for gender transition due to the freedom of retirement, children reaching adult age, etc., but there are unique challenges. If one chooses a medical transition, health issues may influence whether one is a candidate for surgery or hormone therapy. When seeking a part-time job, one may face not only age discrimination, but also gender discrimination. If assistance from adult children for physical or financial care is needed, the opinions of the children about the transition may influence how far one is able to move toward transition. However, a late life transition may extend life because living as the desired gender may reduce stress and depression. Psychotherapy has a role in assisting the older transgender client.

Hotimsky (2009) discussed issues facing transgender people who have aging parents. Specific issues can include:

- Legal issues such as a will in which the transgender person is referred to as a different sex and name,
- The humiliation of the transgender person who must explain, clarify and fight to resolve the legal matter.
- Psychosocial issues such as in Alzheimer's disease in which the older parents may not recognize the transgender person, especially if the parent never accepted the transition.
- The trans person may be quite unprepared to deal with the extended family or may be ostracized by the parent's health care staff.

Thus, interventions for the transgender person should include strategies to manage conflicting or ludicrous types of situations that can be generated between family members, among hospital staff or in a retirement home.

- Gender Transition in Childhood: Brill (2009) discussed a growing number of boys who are verbalizing their interest in wearing attire that society has primarily considered to be within the female-only domain. This stereotypically feminine expression is not exclusively limited to clothing but can extend to hair length, jewelry, and other accessories. If these boys are supported and/or tolerated in this expression, much of society will perceive them as girls. However, a number of these boys are comfortable in their male gender identity and do not feel themselves to be girls. They are not transgender; rather, these children are boys with what society views as a feminine gender expression. To better understand this one can look at the progressive work in this area that has been done for females. When we consider a girl who wears pants, or other clothes previously viewed as male-only, we think of that intolerant view as outdated and narrow. Unfortunately, clinicians often have a mistaken understanding of what is going on for little boys in the above situation which leads to a quick and inaccurate diagnosis of gender identity disorder, when, in fact, the child does not have a fixed identity of the gender of the opposite anatomical gender. For those who are transgender, e.g., those who do have a fixed identity of the opposite anatomical gender, once this identity is certain, that is when the transition should begin. The younger this occurs, the better as there are better outcomes.

  Möller, Gjergji and Schreier (2009) analyzed interviews with experts to determine current understanding and treatment of children with GID. They found that it has changed over the last decades and is controversial until today. Various centers use different treatment approaches ranging from deleting or changing cross gender behavior to hormone treatment of young adolescent patients. However, due to the small number of centers and patients, no large comparative study has been published yet.

- Issues in Therapy with Transgender Clients : Wojdowski (2009) recommends that clinicians:

  - Watch for depression, substance use disorders and anxiety in addition to exploring issues related to transgenderism.
  - Explore transgenderism with clients who present with depression, substance use disorders and anxiety symptoms since clients may not bring up transgender issues when they present with these symptoms.
  - Identify support and non-support networks, including attitudes, religion, children, and spouse/partner.
  - Enable client to make decisions as to what will work as the clinician may be the only support. .

- Discuss probable future issues they may face as a result of transition, such as the increased probability that the client will be alone, issues related to future income, cost of treatment and surgeries.
- Explore what learning has occurred from the internet. Many transgender people play out their desired gender at web sites like "Games of Life". Since this is fantasy, require clients to meet at least one other transgender person face to face in order to confront any issues of homophobia/transphobia and any other issues of shame and guilt.
- Dispel unrealistic fantasies. Encourage sexual experimentation to experience reality rather than fantasy.
- Provide psychoeducation about relevant issues including hormone and surgical treatment, resources, etc.
- Make certain that any family anger is not mistakenly seen as lack of support. There will be issues of loss, particularly for the spouse/partner even if the transgenderism was previously revealed. Families have to grieve, even if they are supportive.
- Include stigma management, sexual decision making in the chosen gender role and any disappointment with post surgical results or lifestyle, especially during the termination phase of therapy.
- Check counter transference, i.e., does the clinician resist or need to grieve the client's transition?

Diagnostic Controversy

At the symposium Ehrbar, Winters and Gorton (2009) discussed the current controversies surrounding the DSM-IV-TR GID diagnosis and offered revision suggestions for gender related diagnoses in the DSM and ICD. They presented varied viewpoints differing on whether there should be a diagnosis at all or what kind of diagnosis it should be, such as:

- The mentally disordered label in the DMS-IV-TR inflicts harmful social stigma and barriers to transition care.
- Practically, diagnosis is needed for access. Conceptually, it makes sense to categorize gender dysphoria as a mental health disorder.
- GID by any name belongs in DSM-V. Revisions can foster acceptance among consumers without compromising scientific accuracy. Diagnosis facilitates insurance coverage and disability protection.

They communicate the fear that the choice is between the stigma of mental illness and sexual deviance or there will be loss of access to hormonal and surgical procedures as well as disability protections. From the viewpoint of harm reduction, since there will almost definitely be a diagnosis in the DSM-V and the ICD-11 which will affect medical access and the civil rights of transgender people for many years, the immediate issue is to improve the diagnosis so that it better

reflects the experience of transgender people and is more useful in supporting their access to care and civil rights rather than undermining them.

As such, Ehrbar, Winters and Gorton (2009) propose a diagnosis in which the focus of pathology is on gender dysphoria (GD), i.e., persistent distress with physical sex characteristics, or ascribed social gender role, that is incongruent with persistent gender identity rather than focusing on gender identity since the latter is not a symptom; actions taken to resolve dysphoria are removed from the criteria (i.e., presenting in the desired gender role); nonconformity to assigned birth sex is removed from diagnostic criteria; distress of GD, with physical sex characteristics or ascribed social gender role, is distinguished from distress caused externally by societal or family intolerance and the latter is excluded from clinical significance criterion; GD in remission exists for those whose treatment has helped to resolve GD; an option exists for those who no longer meet criteria but need treatment to remain in remission; and an 'exit clause' exists for those who no longer meet criteria and do not need treatment to maintain remission. Regarding GD in children, they propose the reduction of psychosexual pathology for gender expression differing from assigned birth-sex role; reduction of false positive diagnoses of gender nonconforming children who were never gender dysphoric; the removal of all references to gender nonconforming expression in diagnostic criteria and supporting text; and the removal of archaic "aversion" clauses in diagnostic criteria regarding "rough and tumble play" and normative feminine clothing."

Additional issues addressed by Ehrbar, Winters and Gorton (2009) include DSM diagnostic location and the diagnosis of transvestic fetishism. Regarding location they state that the GID diagnosis is neither clinically accurate nor palatable to many transgender people in its current location in the sexual and gender identity disorders section. They argue the pros and cons of relocating it to (1) a separate section within Axis I, (2) the section for the disorders generally first diagnosed in infancy, childhood or adolescence; and (3) the section for the anxieties disorders. Regarding the diagnosis of transvestic fetishism they encourage its removal from the paraphilias section so that cross-dressing and expression of femininity by birth-assigned males will no longer be equated with sexual deviance.

Issues to Consider

Thus, for mental health clinicians to be prepared they must be familiar with:

- The definition of transgender, i.e., there are multiple categories of gender-variant people, each with unique needs;

- The SOC and Ethical Guidelines, which articulate a professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders, and to help professionals

understand the parameters within which they may offer assistance to those with these conditions (WPATH, 2007.) The SOC are clinical guidelines that are intended to provide flexible directions for treatment with eligibility requirements that are meant to be minimum requirements. They include standards for professional involvement with patients; the roles of the mental health professionals with the gender patient; standards for the training of mental health professionals; the differences between eligibility and readiness criteria for hormones or surgery; the mental health professional's documentation requirements for the differing letters for hormones or for surgery; standards for children with GID; standards for treatment of adolescents; standards for psychotherapy with adults; standards for the real-life experience; and requirements for genital reconstructive and breast surgery (Ettner, 1999, pp. 139-150.)

- The transition process, i.e. the required elements, the differences in the process among individuals, the differences in support, the challenges, and more;

- SRS, and the differences for male to female (MTF) individuals and female to male (FTM) individuals, as well as the various emotional issues and "catch 22" issues that present financial obstacles for making SRS possible;

- Assessment and diagnostic issues, as well as controversies regarding DSM IV-TR's GID;

- Transgenderism and substance abuse and how the disease of substance abuse and the assault of transphobia intermingle and intensify each other;

- Issues for transgender children, including gender development, suicidality, and parental response;

- Issues for children of transgender parents, including disclosure, emotional struggles of the children, the transgender parent and the non-transgender parent;

- Family therapy issues and interventions;

- Disclosure and passing;

- Unemployment, underemployment and employment discrimination;

- Issues of legal I.D. and health insurance;

- The role, obligations and responsibilities of clinicians;

- Theoretical ideologies and psychotherapeutic interventions;

Professional Resources

Accordingly, given that for transgender people there is the seemingly steady increase of equality legislation, the increasing visibility and opportunities for more broadly based expression, the incidence and prevalence of gender-variant persons across nations, socioeconomic strata, race and religion, it appears that there is good reason for mental health professionals to prepare for clinical work with this population. Listed below are three professional resources that may be helpful to begin such preparation.

The American Library Association published a transgender bibliography in 2005. http://isd.usc.edu/~trimmer/glbtrt/bibtransgender.pdf

World Professional Association for Transgender Health, Inc. (WPATH) http://www.wpath.org/

CE-credit.com offers a 7 hour home study continuing education course, "Transgenderism: A Case Study of the Movie TRANSAMERICA," which addresses the points mentioned immediately above.

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