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COMMENTARY

# Culturally Competent Evidence-Based Behavioral Health Services for the Transgender Community: Progress and Challenges

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The presence of individuals who identify as transgender has emerged into public awareness in the United States in recent years. Celebrities who publicly transition have expanded the national conversation about gender variation beyond gender and women's studies classrooms and certain specialty health and mental health services. This increased public visibility has been accompanied by increased visibility in the mental health literature, including the publishing of competencies or guidelines for working with clients who identify as transgender by various professional organizations. However, rapid societal changes and increased understanding of the experience of being transgender in our society means literature can rapidly become dated. This commentary identifies key points that will move forward professional competency, both of the field and of individual practitioners, in the provision of psychological services for individuals who identify as transgender.

Before proceeding further, it is necessary to clarify the terminology that is used. For purposes of this commentary, *transgender* refers to gender identity and is an umbrella term for anyone who identifies outside of the male–female gender binary as assigned at birth. This includes people who self-identify as gender queer, transman, transwoman, gender nonconforming, or claim any gender identify that differs from the one they were assigned as birth. *Trans* is used as the adjective form for transgender to facilitate expression. Also, it is important to note the diversity of transition journeys. Much of the literature on trans care focuses on medical transition (hormones, gender confirmation surgeries, etc.). Not all trans people seek a medical transition and there are many paths for transitioning. Also the term *trans community* can mask the diversity of people and experiences that fall under the umbrella term *transgender*.

## How Mental Health Has Contributed to Trans Stigma

The extensive stigma and discrimination experienced by the trans community is well documented. In the aptly titled report *Injustice at Every Turn*, Grant, Mottet, and Tanis (2011) described high rates of discrimination and bias in employment, housing, and education. Even in health care, 19% of respondents were refused treatment, and nearly one in three had experienced violence or verbal harassment in a health care setting.

The mental health establishment has a long history of contributing to the stigmatization of trans identities. Psychoanalysis treated gender dysphoria as a pathology in the individual who was unable to conform to societal expectations based on the sex assigned as birth. Behavior therapists applied their technology to try to decrease gender nonconforming behavior and desires. Even after homosexuality was removed from the psychiatric nomenclature, classification of gender nonconforming behavior and gender dysphoria as mental disorders has contributed to professional and public views that variations in presentation of one's gender is a sign of mental illness rather than a normal variation of the human experience.

The professional mental health community has, however, made progress in recent years in decreasing the stigmatization of trans identities. For example, the *DSM–5* (American Psychiatric Association, 2013) has shifted from a focus on gender nonconforming behavior to the individual's experience of distress in gender dysphoria. This change is important because it does not pathologize one's failure to adhere to certain societal gender norms and emphasizes the experience of the person. It does, however, fail to acknowledge the extent to which dysphoria is driven in part by recognition of societal disapproval of gender variation, as was argued about same-sex sexuality by psychologist Gerald Davidson 40 years ago.

## More Than Good Intentions Are Needed

The proliferation of position statements and guidelines affirming the need to provide adequate services to trans clients from various professional organizations suggests that

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the broader mental health field has recognized the history of care that has been at best poor, and at worse, overtly harmful to trans people. This represents an important shift of intention. However, intention is necessary but not sufficient, and there continue to be important barriers to optimal, trans affirmative mental health services, including lack of research and lack of training.

High-quality research that focuses on topics of particular relevance to transgender persons is greatly needed. As reviewers like Benson (2013) stated, most of the very limited scientific literature uses small samples, poor methodologies, or consists of case reports or clinical observations from experienced providers. If we, as a field, are serious about providing the best services to this community, we need to invest in sophisticated research that will give us a deep understanding of gender identity. This research needs to occur at all levels, from neuroscience to societal influences, and should include intersections across all of one's identities (e.g., trans people of color and different social and economic groups). Trans participants should be included broadly in research both by letting them identify themselves on appropriately worded demographic forms and by not excluding their participation in final samples because their numbers were insufficient to form a separate group in the analyses. Research on psychopathology needs to clearly distinguish among the normal variations in gender identity and expression, pathology brought on by stigma and discrimination, and dysfunctional emotional and psychological processes that could be present in anyone. Clinical services research needs to use the best methodologies and samples to ensure the most useful outcomes. It is not acceptable to resign ourselves to acting as if the best research to identify effective interventions will never be done because of insurmountable barriers, as suggested in the Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder (Byne et al., 2012).

The mental health field also continues to be part of the problem of stigmatizing trans identities by how we handle diversity training around trans issues. It is well documented that most currently practicing providers have had little or no training on provision of services to trans clients. Even if trans topics are included in current training programs, they are likely to be folded into a general discussion of lesbian, gay, bisexual, trans (LGBT) issues. This merger is problematic because issues faced by lesbian, gay, and bisexual individuals differ substantially from those faced by trans individuals. Intersectionality between trans and other social groups (e.g., ethnic minorities) may also be ignored. Here again, research is needed to inform diversity training in terms of content and on which models of training are most effective in producing competent clinicians and researchers.

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Although the World Professional Association of Transgender Health Standards of Care (WPATH Standards) have become more flexible in recent versions, many medical providers continue to require letters from a mental health provider to certify that a trans individual is ready for a medical intervention they have been pursuing. Some mental health providers require a certain number of contacts before such a gatekeeper letter is provided. This is a complex issue with competing agendas. Physicians want to avoid regret for irreversible medical procedures. It is within the scope of practice for psychologists and psychiatrists to determine whether someone is capable of making informed decisions about their health care, so clinicians may feel prepared to take on this responsibility to some extent. However, it is also a stigmatizing process in which the trans client must prove they are prepared for the medical transition, harkening back to models in which deviations from gender identity norms were defined as mental illness and its associated incapacity. There is also a tension between needing to prove one is healthy enough for the letter while at the same time being able to fully participate in any needed treatment for mental health problems that may be present or obtain support for the social transition. Research is desperately needed to guide this process and to objectively determine what, if any, psychological services are needed to ascertain readiness and the ability to give informed consent for medical transition when so desired.

Furthermore, much of the guidance detailing working with trans patients centers on traditionally defined trans individuals or those who wish to conform to the hegemonic gender binary through gender-confirming procedures. Left out are other communities of trans individuals—those who identify as gender-nonconforming or gender creative and are not seeking any sort of medical procedure to align with binary gender norms.

## Moving From Good Intentions to Competence

Mental health providers who wish to provide services for individuals who identify as transgender can turn to a number of models and guidelines for transgender care, such as the practice guidelines that Wylie and colleagues (2014) proposed. Many of these models can be quite helpful by offering specific recommendations, with some even including suggested questions to ask during assessment. The published models and guidelines are good resources for basic "trans 101" information such as pronoun usage and variations in gender presentation and the desired outcome for any social or medical transition. All of the models discuss the importance of recognizing the impact of stigma and discrimination on mental health. Furthermore, Ehrbar and Gorton (2010) discussed applications of the WPATH Standards of Care, and Wylie and colleagues (2014) provided an example of coordinating treatment across providers in different disciplines.

One recent positive development in the field is the distinction between therapeutic services focused on transition versus adapting treatment for various disorders to individuals who identify as trans. These are two separate issues, and it is crucial to recognize that there may be special considerations in using standard interventions for *DSM–5* disorders when the person receiving the services identifies as transgender, as demonstrated in Nuttbrock's (2012) treatment for

substance abuse and Collazo, Austin, and Craig's (2013) treatment for adolescent depression and anxiety. This territory is familiar in the sense that there is a tradition of research adapting commonly used interventions to various groups defined by age, primary language, nationality, ethnicity, and so forth. On the other hand, treatment of gender dysphoria and supporting an individual's legal, medical, and social transition to their desired gender represents its own area of expertise.

*The needed scientific literature is very limited for behavioral health services for trans individuals*

*Evidence-based intervention* is a common buzzword across the health care system in recent years. For this discussion, *evidence-based* loosely follows the American Psychological Association definition, which includes using the scientific literature to guide selection of assessment and intervention procedures combined with characteristics and preferences of patients and clinical judgment. It also includes ongoing objective assessment to guide treatment decisions whenever possible. For the most part, the needed scientific literature is very limited for behavioral health services for trans individuals. Furthermore, the usual approach of randomized controlled trials to compare interventions for specific diagnoses with little consideration of cultural context may not be an adequate approach for this community.

A model of evidence-based behavioral health care for individuals who identify as transgender may need to challenge our basic assumptions about interventions and clinical services. As we cease labeling a transgender identity as a clinical problem and start focusing on gender dysphoria, we are moving in the right direction. However, it is a mistake to think of gender dysphoria as a disorder or symptom in the way we think about depression or panic attacks as psychopathology. We need sophisticated research on gender dysphoria to help distinguish aspects that are internal to the individual from reactions to societal stigma for not fitting a rigid binary gender identity. As we design and test interventions, we need to ask to what extent is gender dysphoria a problem of person-societal fit rather than a dysfunctional process within the individual and/or a combination of both cultural and internal processes. We also need sophisticated research to better understand how gender manifests in the brain and endocrine system and how this manifestation interacts with environmental influences. It seems possible that hormone therapy and surgical interventions are the actual treatment for the underlying problem in some patients' presentation of gender dysphoria. For some individuals, psychological interventions may be most useful in combating the impact of stigma and discrimination.

An evidence-based model of behavioral health care should describe the appropriate role for the clinician when working with trans patients, perhaps challenging the traditional role of the clinician as an expert who wields power, even in the most collaborative therapeutic relationships. A *cisgender* (i.e., someone who has a gender identity that aligns with what they were assigned at birth) clinician may best aid a trans client to overcome the poisonous effects of stigma by standing aside and empowering the client and supporting the client's decision making. Clinicians may also have to step outside of their usual therapeutic role to serve the client as an advocate or caseworker. To be able to do this, the clinician must have a deep understanding of trans stigma, including their own implicit assumptions about gender, recognition of the privilege that comes with meeting societal expectations about gender, and the powerful influence of cultural messages about how our bodies are gendered.

## Research Agenda

Development of high-quality evidence-based behavioral health care for the trans community will require a rigorous research agenda including the following:

1. A sophisticated understanding of gender from neuroscience to society. This includes not just transgender but gender in all of its myriad manifestations and interaction with other identities.
2. Interdisciplinary research on trans stigma and discrimination, including the health and mental health impacts of negative cultural messages, personal experience with stigma, and the indirect effects such as reduced access to resources (e.g., unemployment, poverty).
3. Continued high-quality research on adaptation of the best evidence-based treatment for various disorders for trans individuals to reduce barriers to successful treatment of common mental health problems.
4. Specific research on the best way to support an individualized transition process, including what services are needed and when, and who best to provide them. Assessment measures to evaluate these services as they are identified are also needed.
5. Research on the gatekeeper function that mental health providers are often asked to provide. This research should include

**Table 1.** *Selected Recent Models of Trans Care*

Walter O. Bockting, Gail Knudson, and Joshua M. Goldberg (2006). Counseling and Mental Health Care for Transgender Adults and Loved Ones, *International Journal of Transgenderism, 9,* 35–82. http://dx.doi.org/10.1300/J485v09n03_03

Aiden Collazo, Ashley Austin, and Shelley L. Craig (2013). Facilitating Transition Among Transgender Clients: Components of Effective Clinical Practice. *Clinical Social Work Journal, 41,* 228–237. http://dx.doi.org/10.1007/s10615-013-0436-3

Melissa K. Cousino, Ajuah Davis, Henry Ng, and Terry Stancin (2014). An Emerging Opportunity for Pediatric Psychologists: Our Role in a Multidisciplinary Clinic for Youth with Gender Dysphoria. *Clinical Practice in Pediatric Psychology, 2,* 400–411.

Annelou L. C. de Vries, Peggy T. Cohen-Kettenis and Henriette Delemarre-van de Waal (2006). Clinical Management of Gender Dysphoria in Adolescents. *International Journal of Transgenderism, 9,* 83–94, http://dx.doi.org/10.1300/J485v09n03_04

Nicholas C. Heck, Leslie C. Croot, and Jennifer S. Robohm (2015). Piloting a Psychotherapy Group for Transgender Clients: Description and Clinical Considerations for Practitioners. *Professional Psychology: Research and Practice, 46,* 30–36. http://dx.doi.org/10.1037/a0033134

the informed consent process and what, if any, requirements are appropriate before initiation of hormone therapy, surgery, or other procedures for those who seek a medical transition.

6. Research on training, dissemination, and implementation to make the best services available to trans individuals, including those who have limited access to health care. The larger literature on training and dissemination of evidence-based practices may be useful but strategies for overcoming trans stigma and discrimination within the behavioral health care system are also be needed.

## Clinician Recommendations

A research agenda highlights what we do not know, which is rarely helpful for the clinician who desires to provide the best possible services now. Following are some recommendations for behavioral health practitioners who have trans clients seeking services.

1. Be familiar with the most recent models of trans care that are provided by individuals with extensive experience serving the community. A selected list of models appears in Table 1. Even if these are based more on clinical experience than on traditional research, they are a good place to start.
2. Learn as much as possible about the subjective experience of trans individuals, including their varied journeys and multiple possible paths for social, legal, and medical transition.
3. Be familiar with local, state, and federal laws, including nondiscrimination protections (if any), requirements and procedures for legal transition, trans support resources online and in the local community, and trans-affirmative medical providers. Be familiar with trans-friendly employers as employment discrimination is a significant challenge for many in the trans community.
4. Recognize one's own implicit assumptions about gender and gender roles and be open to how they may impact clinical services. Work to use de-stigmatizing language and make the setting trans-affirmative, from intake paperwork that includes all gender expressions to the use of preferred name and pronouns in medical records and/or interactions with the client.
5. Support the trans community through attendance at community events and advocacy. This is an excellent way to support trans clients and to gain familiarity with the experience of being trans in a particular community.

### Suggestions for Further Reading


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## A Multi-Faceted Challenge: A Moving Target

The recent increase in trans awareness has been staggering. In an article titled, "Transgender Representation in Offline and Online Media: LGBTQ Youth Perspectives," McInroy and Craig (2015) detailed how over the last 5 years, trans representation in media has gone from almost zero to include award-winning TV shows and movies and sports stars and popular culture icons. This representation, on the surface, is great for trans communities, as it allows a common understanding of what it means to be trans. However, it also creates challenges, because the representations seen on the screen and in tabloids are far from that of the typical trans person. For example, Caitlyn Jenner documenting her experience as trans through her transition created an opportunity for the nation to better understand gender. Through Jenner, traditional gender roles were questioned, as a key masculine sex symbol of the 80s transitioned while remaining strong and confident—in "opposition to the feminized superficiality of Kris Jenner and her daughters" (Brady, 2016, p. 115). On the surface, this challenging of gender roles seems positive, and could be thought to reduce stigma. However, as has been seen with other stigmatized groups as they become more visible, often these representations, while shiny on the outside, create unrealistic expectations for the group at large. In the case of Jenner, her trans experience is not the same as the average trans person because of her fiscal and social resources and her platform to self-promote. Despite

these advantages, she becomes a normative version of trans, is now the face (or one of the faces) of trans in America, and can be thought of as a transnormative icon, to which many will compare all other trans persons. Making such a comparison can lead to different types of stigma for those trans individuals who do not present in the same manner as Jenner.

As stated, it is possible to conceive of a world where gender dysphoria is a thing of the past as a result of the complete and total societal acceptance of any and all gender presentations. Although this thought is clearly optimistic, and distant at best, it becomes less possible when powerful media representations reinforce limited or binary gender representations. Therefore, it is imperative that research and work be done on the influence of media representations on gender presentations and understandings. Furthermore, research needs to be done on how these representations manifest into stigma and, in turn, how this stigma informs and influences trans individuals. Last, clinicians must be aware of these representations to be self-reflexive in their own conceptions of gender. Such self-reflection will allow for an open-mindedness that will promote better service and will be an important step toward a world with no need for a gender dysphoria classification.

## A Final Word

Every client and every research participant has a gender identity and gender expression. As researchers and clinicians, we tend not to think about gender unless it is a specific focus of the work, such as when thinking about the trans community, or research on gender effects in a particular arena (e.g., the gender effect in anxiety). We could best de-stigmatize variations in the expression of gender identity if we begin to regularly incorporate it into all of our conceptualizations, not just when it presents as an exception. As we gain a deeper understanding of what gender means, we could incorporate it into our research and clinical practice on almost any topic. How does one's gender affect the development of substance misuse or an anxiety disorder? How does the perception of one's gender identity impact interpersonal relationships or the employer–employee relationship? Moving beyond a binary understanding of gender can enrich all of our research and clinical work as we start to incorporate a more complete understanding of gender as a potentially influential variable for everyone, not just those perceived to be the exception or the other. In the meantime, the mental health provider community is engaging in some much needed self-examination to move away from a history of stigmatizing variations in gender identity and expression. Many trans individuals may be understandably cautious. Ideally, we can partner together to move toward trans affirmative behavioral health care models that are substantially informed by the best scientific research.

**Keywords:** transgender; mental health services

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