

SEXUALITY & GENDER

FOR MENTAL HEALTH PROFESSIONALS

A PRACTICAL GUIDE

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TRANSGENDER (TRANS) – LIVING A DIFFERENT GENDER FROM THAT ASSIGNED AT BIRTH

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This chapter aims to:

- Examine the ways in which trans people who live in a gender not assigned at birth differ from those trans people who do so on a temporary basis.
- Consider the various ways in which being trans sometimes relates to discrimination, reproductive capacity and emotional experience.
- Briefly outline the various physiological interventions available to trans people.
- Consider when referral onwards is necessary and when trans is irrelevant.

INTRODUCTION

Some *trans* people *transition* into a role they were not assigned at birth on a temporary basis. This may be for reasons of personal comfort and congruence, for sexuality, or for some other reason. Some people who do so are called ‘dual role transvestites’ if there is no sexual component, or ‘fetishistic transvestites’ if there is, although these are medical terms which are often regarded as pejorative and so cross-dressing is preferred, although still problematic. These groups where transition is transient, and/or related to sexuality, are covered, in detail, in Chapter 11. People who transition into genders other than ‘man’ or ‘woman’ are covered in Chapter 5.

This chapter covers those people who wish to live full time in a male or female gender role other than the one they were assigned at birth. Individually, they are known, when it is pertinent, as a *trans man* or *man with a trans history* (people assigned female at birth who transition into a male role); and a *trans woman* or *woman with a trans history* (people assigned male at birth who transition into a female role). Collectively this group is often known as ‘transsexual’ people, although again this is a medical term with which some people feel uncomfortable. It should be noted that the people covered in this chapter are (perhaps somewhat arbitrarily given recent brain studies) not considered to be intersex or to have a DSD (see Chapter 3).

Trans is generally the safe term for the people considered in this chapter, although again only when it is pertinent that the person is trans. When a

person's trans status is not pertinent, trans men are simply men and trans women are simply women. Thus, if a trans woman is having her hormonal regimen adjusted she is a trans woman; whereas if she is in counselling for a recent bereavement she is simply a woman. For this reason the terms 'Male to Female' ('MtF') or 'Female to Male' ('FtM') should generally not be used (although they are occasionally used by trans people themselves) as the person may not be identifying with their past at the time, and indeed may never have identified as male or female respectively.

Trans people who have not transitioned have a sense of themselves as a man or a woman (their *gender identity*) which is at odds with both their birth-assigned gender and the way they present to society (their *gender role*). This may cause low mood, anxiety, and other difficulties which are known as *gender dysphoria* and has been linked with markedly increased rates of suicide and self-harm. Trans people who receive appropriate treatment and are able to live in a way which is comfortable to them, with a *gender presentation* (clothing, mannerisms, etc.) and gender role that are congruent with their gender identity, often do very well and have no higher rates of psychopathology than the general population (e.g. Hoshiai et al., 2010).

Trans people, both before and after transition, may feel an especial dislike, or even hatred, towards their bodies and may regard their DNA or endogenous hormones as poison. This hatred (as opposed to discomfort) can sometimes be addressed by a skilled practitioner through education regarding the wide variety of bodies in the general population and the effects of hormones and psychology – the former sometimes less powerful than many people think and the latter sometimes more powerful. In this way trans people may come to a place where their body is metaphorically like living in someone else's house – they are able to see it as reasonable – just not *theirs*. From this place physiological and psychological interventions effect far greater comfort in trans clients.¹

Trans people often, but by no means always, undergo treatments in order to physically alter their bodies such that their gender presentation more easily matches their gender identity (see Barratt, 2007, and Ettner, Monstrey & Eyler, 2007, for a full overview of physiological interventions available to trans people). Interventions are generally carried out after the trans person has made a full transition into their preferred gender role, including a formal change of name and identification documents (ID), telling friends and

¹ Those who are particularly body (but not necessarily role) dysphoric (sometimes referred to as dysmorphophobia) sometimes suffer poorer outcomes from interventions and often wish for further surgeries as their sense of unease shifts from one body part to the next. Trans people who are particularly *gender dysphoric*, however, seem to do very well if properly evaluated and supported.

family (covered below), and often gaining some form of occupation in that role appropriate to their ability level – for example, paid or voluntary work or study for those able to do these (people with learning disabilities, etc. will have commensurate requirements to their abilities). Hormones are often the first physiological intervention after transition, as they are, to some very small extent, reversible, although many changes, for example voice deepening, will be permanent. These may then be followed by surgeries which are quite irreversible (outlined below).

COMMON CONCERNS

There are several different reasons why a trans person may approach a counsellor, psychologist or other health professional. Broadly speaking they fall into four groups.

- Those for whom this is completely incidental to the reason that they are seeking help or support.
- Those who would like some assistance to transition gender role.
- Those who are experiencing problems related to other people's perceptions of their trans status or transition.
- Those who have some personal concern about being trans.

Those clients in the first group should be dealt with just as you would a cis-gender person (see Chapter 4), although with due regard for differing body morphology and trans-specific needs. In this way trans people are treated just as others are.

As the last three groups of people approaching a professional are so often intertwined we shall consider them together with much of the technical material concerning transition being included in the section on Key Practices below. Of note, however, is that some people can maintain concerns about being trans after transition, and of course other people's concerns about a person being trans may crop up at any time in a person's life. In these instances, and indeed when a person is transitioning, it is well to consider whether the matter is indeed trans-related, or a mask for some other difficulty. Is a relationship break-up due to the person being trans, or because one partner wanted to travel and the other to pursue their career? Is the weight gain hormonal or through lack of exercise? Are people commenting because the person is wearing female clothes, or because they are particularly erotic clothes? When seeing trans people professionally, not having a metaphorical neon sign saying 'TRANS', but rather a whispered hint behind one's shoulder that there may be a trans theme, is usually the best course of action.

AETIOLOGY AND BLAME

One common concern of trans people is “Why am I like this?”. This can stem from a feeling of guilt about being trans and a wish to avoid blame. It is important for practitioners to reinforce that there is no blame to be apportioned. Trans people seldom choose to be trans and, given that it is an innocuous identity and practice, there would be no need for blame if they did. Of course people do sometimes feel hurt when someone close to them transitions, but that does not mean that the trans person *made* them hurt as it is not inevitable that they will be so. It can be profitable to explore how all parties involved can take responsibility for their decisions and feelings.

One of the key ways of avoiding blame is to consider the ways in which a person became trans – however this should be avoided where possible as we seldom devote time to considering why people are heterosexual or cis-gender, for example. Nonetheless the empirical evidence suggests that being trans has nothing to do with rearing, as some psychodynamic theorists have suggested. Instead there is a suggestion that, at least for those who transition when young (sometimes called ‘primary’ trans people), there is a neurological difference – that their brains are literally hardwired to think like a gender different from the one they were assigned at birth (see Kruijver, 2004 – of note is the fact that all studies are post-mortem and so cannot be undertaken while the trans person is alive as a diagnostic test). In contrast those people who transition later (sometimes called ‘secondary’ trans people) – some of whom have often gone through a sexualised phase before wishing to transition – most likely have a multifactorial aetiology. Not all trans people will worry that being trans is problematic, and many younger people are becoming quite comfortable with their identities from an early age. This can be usefully accomplished by good social support including friends, family, community, etc.

TELLING OTHERS

If, after a period of time living in a male or a female role privately, a trans person determines to live full time in a gender role, then they will need to tell people about their decision to transition. In the first instance the person told is often a close friend or partner, or a professional, and it can be the most nerve-wracking event of the person’s life (if you are the first it is a great honour and should be treated as such). Support and acceptance are vital. The opening of conversational space, as well as provision of calm reassurance, can have implications which will stay with a person throughout their life. Some people, when told of a person’s intent to transition, may act in a negative manner, refusing to discuss it, being abusive, or even

violent. Often this will settle of its own accord once any shock has abated. It is not uncommon, however, for close friends, family, etc. to have an inkling, or even to know, and to have been waiting for the trans person to tell them in their own time.

For those trans people who do not receive an accepting response, extra support can be gained through the internet, support groups, face-to-face support, reading, etc., and this may also be helpful for the family, friends, etc. of trans people who do struggle to accept and respect it. It is vitally important that professionals do not suggest that there is an issue where there is none. Well-meaning professionals may think that 'of course' a partner, parent or child will be shocked and outraged, but in fact many are not and are very supportive. Suggesting to such people that there must be a problem may cause difficulties unduly. For some people, especially couples, the status quo provided by a partner not being happy with the transition can be comfortable for both parties. The trans person's partner (whether or not they themselves are trans) keeps their partner as they've always been, and the person who nominally seeks transition is prevented from the difficulties of doing so without having to bear the responsibility for this. In such cases it can be useful to unpack the motivations of all involved.

Similarly, people may say that they themselves are unconcerned, but their neighbours, children, elderly parents, etc. have a problem and so their partner, or they themselves, cannot transition. It is useful to enquire how they know this (have they had a conversation?) and how much say do they have over those people's lives given that they give them so much power over their own life? Why do others get to decide? Often such fears are predicated upon the notion that trans is not acceptable. Of course relationships will need to be negotiated and some people close to the transitioning person (and again not everyone by any means) may need to seek further support. Very often, however, people are unconcerned provided that the trans person fulfils their other roles adequately – be that darts captain, parent, drummer, foreperson on the factory floor or whatever else.

Employers, particularly, seem to most often be unconcerned when people have had a good working history and large companies and organisations especially seem well able to assist employees to transition with the minimum of fuss (although see below for situations where transphobia does occur). Trans people are protected by law against discrimination within the UK and several other countries (e.g. HMSO, 2010). Again, fears of discrimination should be attended to (and indeed some accommodation may unfortunately have to be made), and may be usefully explored in relation to their validity and to any purpose they may serve.

A further example of trans people being inappropriately influenced is that of children. Children should be cared for and informed at an appropriate level, but should have no greater say than in any other matter.

A parallel example might be moving house where a child would have their concerns listened to and reassurance given, but would nonetheless not be allowed to stop a necessary house move on the grounds that they didn't like it. Similarly, a partner or parent of an adult trans person should not expect to be able to put limits on the trans person's behaviours simply because they don't like it. A trans person should not automatically be expected to leave their home due to transition, and should not lose it, or children, in any separation simply because they are trans. Looking out for the terms 'of course ...' and 'should' can be useful in identifying and questioning assumptions here.

Some people continually put off their transition until after some future life event (for example, their children passing their exams, graduating college, getting married, having grandchildren; their grandchildren passing their exams, etc.). In such cases additional reasons for this will always be found, for such is the nature of life. Similarly, some clients delay transition as they feel that, were they to transition now it would demonstrate that they could have done in the past – a thought that is unconscionable – and so they delay (Richards, 2010). Consequently, some clients end up transitioning just before death in order to be buried in the gender they feel is correct for them. Making these processes explicit with clients, and discussing the pros and cons of choices, and the choice implicit in not choosing, are useful avenues of exploration.

PRESENTATION AND SECOND ADOLESCENCE

If accepting of the transition, friends and relatives, as well as some professionals, may very occasionally cautiously offer presentation tips early in transition, such as how a person might dress, speak or move. This can sometimes be helpful *if appropriate and accepted* (if the person has a learning disability, for example), as people will not have been socialised in their preferred gender and may have concerns about how others relate to them. However, it is important that people are able to portray themselves through their presentation and trans people will, of course, become offended if given unwanted or unwarranted advice. It is also worth noting that there will always be a tension between authentic personal expression of one's gender and the fact that gender presentation is socially constructed – consider the different modes of dress globally.

Cisgender people are taught how to do their gender from childhood and so it often appears 'natural' (although it would appear 'unnatural' in different cultural contexts and at different times). Trans people who transition after childhood must learn how to do their gender, often from stereotyped images from the media. This means that during a second

adolescence period trans people may need to take some time before their gender identity and gender presentation match. It is not uncommon for trans people who are transitioning to identify with a gender role which is much younger than their chronological age – perhaps teens or twenties. Again this can be a part of finding who their female or male identity is. A useful intervention may be to ask who their heroes are and why. This identity formation can also be complicated by the introduction of hormones and allowances should be made, while still expecting the client to remain the adult that they are. Blaming unacceptable behaviours on hormones does not render them acceptable. Once people have transitioned for any length of time all this will have settled down and they should not be advised on presentation as this is, of course, as offensive as with any cisgender person.

Professionals should advise clients to act in a considered manner as far as possible, as many trans people will wish to rush ahead as fast as possible having taken the plunge to transition. This can destroy relationships and others in the trans person's life may need independent support. However, there is nothing wrong with being trans – a point worth reiterating freely and often (as we have here) – and so trans people should not be unduly stymied by other people's opinions, or accept behaviours that would otherwise be unacceptable. It is not uncommon for professionals to unnecessarily ask of trans people "Have you had the operation yet?", for example. Do not do this! It is unnecessarily invasive and is very likely to cause offence. Unless it is your common practice to ask about genitalia you should treat your trans clients just as any other client – genitalia is generally irrelevant in day-to-day life after all.

SEX AND RELATIONSHIPS

Trans people are often worried that existing relationships may fail if and when they transition. In some cases they do fail almost because it is thought inevitable that they will, but in others things may change, or may remain much as they were before. Sometimes romantic relationships of long standing become more that of companions, not uncommonly sexuality has faded during the relationship as in many relationships between cisgender people. Trans people may have any of the sexualities included in this book and beyond, with the proportions being somewhat similar to the general population. Some trans people's sexualities change after transition, whereas some remain the same, but the name changes. For example, a trans woman who is attracted to women may be heterosexual ('male') before transition and lesbian afterwards. A trans man who is attracted to men may be heterosexual ('female') before transition and

gay afterwards. In contrast a trans man may be attracted to women before transition and men afterwards. Bisexual trans people may or may not remain bisexual, and so on.

SEX WORK

Some trans people are sex workers, and some are very successful at it. In the UK there are fewer trans sex workers than in other countries as the large amounts of money needed for surgery are paid for through taxation (and interestingly are most often recouped by the exchequer through increased taxation of the trans person as they become settled and therefore frequently earn more). A few trans people (especially some young trans women), however, feel that as a trans person they have to be a sex worker – of course they do not – and employment advice for a job which is comfortable (if sex work is not) for them can be useful. Similarly, some trans people feel a sense of validation of their identity through sex work (or indeed unpaid sex), and work on self-esteem and considering other ways of expression can be useful here. Unfortunately there is often increased risk of homelessness, especially among the young, when trans people leave, or are forced to leave, home as they transition. This can lead to unwanted sex work and support should be given, both in terms of finding other employment and also STI (sexually transmitted infection) prevention, etc.

One difficulty of sex work peculiar to trans people is that physiological body alterations can materially affect their work – with trans people trading on their trans status having to compete in a much larger (cisgender) market, and so sometimes less successfully, after hormones and surgeries.

DRUG USE

Some trans people misuse substances either as a means of avoiding transition or as a means of dealing with the stresses of transition. With the UK National Health Service drug and alcohol problems must be well managed before hormones and surgeries are considered. Elsewhere in the world rates of infections from shared needle use are strikingly high – again often because trans people cannot gain the emotional and financial support they need to transition and so endeavour to find other means of ameliorating their distress.

The usual procedures regarding drug and alcohol abuse can be employed, and should be considered for middle class clients drinking a great deal of wine, for example, as much as they are for groups who are more conventionally regarded as substance abusers. Care should be taken that trans-specific needs – such as being allocated the right facilities – are attended to.

KEY PRACTICES

This section covers coming out, interventions including hormones and surgeries, and issues around referral, names and trans youth.

COMING OUT

Trans people are often concerned when they first realise that they are trans due to the stigma associated with this. Things are somewhat easier now that the internet allows people to gain information and support easily and discretely and indeed this is often the appropriate first port of call for people considering transition (although some may need support gaining internet access in a safe location). However, clients and practitioners alike should utilise internet resources with a critical eye and due caution.

Trans people can be told that there is a 'right way' of being trans which may be at odds with their own identities and feelings (see Group Norms below). In addition, young and vulnerable people may be scared by negativity and horror stories on the internet and so not seek the help they need – with disastrous consequences. There can also often be a heavy emphasis of hormones and surgeries as well as the necessity of 'passing' as the gender one identifies with – see below. In addition, some unscrupulous people can play on some trans people's low self-esteem to make them have surgery they don't need, or that they are too early in their transition for, or that is of a poor quality. Similarly, trans people can be targeted for sex or unequal relationships to which they feel unable to say no.

Professionals should also be wary of supposed 'professional' information both online and in the research literature. Some people purporting to be expert in trans care have actually seen few trans people, seldom more than a couple of hundred and almost never more than a thousand. Of course this skews their notion of what trans people are like. In addition, some professionals, especially some academics, co-opt trans experiences by theorising them when they themselves are not trans, or, again, have seen few trans people and none clinically. One current debate is that of autogynephilia or autoandrophilia – the idea that trans women and men are erotically aroused at the thought of themselves as women and men respectively; and that this is the reason for their transition. Except in extraordinarily rare cases this is incorrect and in the UK is treated as such. However, professionals new to the literature could be forgiven for thinking otherwise due to the proportion of papers on this topic.

Early in the process most people experiment with wearing clothing not normally attributed to their birth-assigned gender (cross-dressing). This is usually much easier for trans men than for trans women as in many

cultures, especially those in the West there is little opprobrium attached to women wearing male attire, but much opprobrium, even violence, towards people perceived as male in female attire. Consequently, trans women often start to wear female clothes in secret and out of necessity have to borrow clothes, often from their mother or sister if they start when young. If this is the case they generally buy their own female attire when they gain sufficient money to do so, which may be kept hidden in a *stash* and worn in suitably private locations. This stash may occasionally be *purged* through throwing out all the female clothes accompanied by a feeling of disgust, only to be bought again when the wish to transition reasserts itself.

There may also be a period of hypermasculine protest for those assigned male at birth and, less commonly, hyperfeminine protest for those assigned female. This is a period of time when a person attempts to throw themselves into their birth-assigned gender, for example by joining the army and getting married if assigned male, as an attempted 'cure' for the cross-gender feelings. Unfortunately, it seldom works and may delay transition causing further difficulties in moving job and renegotiating family roles, etc. This buying and purging and/or hypermasculine/hyperfeminine protest can continue for many years, even into old age, until some event, not uncommonly the death of a parent, leaves the trans person feeling able to commit to a fuller transition. After this time some trans people may endeavour to erase their history in order to become a 'proper' trans person (see comments on hierarchies below). Professionals can profitably work with clients to examine the positive outcomes of their past lives – children, careers, etc. – while accepting that the client may have had an internal sense of gender identity which was incongruent with their gender role throughout that time.

Especially in adolescence, trans women's cross-dressing is often accompanied by masturbation, although this usually abates during adulthood and is not necessarily evidence of a fetishistic attraction to female clothes as a great many things acquire an erotic charge during adolescence (for that which continues into adulthood, see Chapter 11). This can then evolve into a determination to have physiological changes and to live full time in a female role with associated implications for social, work and family structures – see below. It is, of course, important that those people who remain aroused when cross-dressing, and who do not wish to transition gender role permanently, do not have physiological interventions which they will inevitably regret when the erotic charge diminishes, possibly simply through familiarity (see Chapter 11).

Some trans women, especially those who are younger or a little more fluid or genderqueer in their presentation (see Chapter 5), do not go through this lengthy period of dual role, but rather present in a more feminine manner from childhood or adolescence. This may be partly to do

with their having a biological aetiology for their being trans – but may also be due to the greater latitude, especially in some Western urban areas in recent times, afforded to people who are assigned male at birth to present in a more feminine manner.

PHYSIOLOGICAL INTERVENTIONS

Being trans is simply another way of being and as such requires no ‘cure’. Nonetheless some people have sought one in the past and some have had one thrust upon them. All have been unsuccessful. Trans people, even those who have suffered through a significant period of living in their birth-assigned gender role, generally remain gender dysphoric until their body is adjusted to fit with their experience of themselves. Endeavours to change people’s minds through psychotherapy, behaviour therapy and even shock therapy have failed.

Consequently, the treatment of choice is now careful screening of trans people; supportive assessment and supportive psychotherapy where needed; and such physiological interventions as they may request and is thought appropriate by the expert professionals they are working with. Mandatory psychotherapy is damaging (Seikowski, 2007) most likely because it questions and troubles a comfortable, if nascent, identity.

TRANS MALE HORMONES

For a trans man, hormonal manipulation usually involves androgens alone, often via intra-muscular injection or topical gel. Independent suppression of oestrogens is not usually necessary as this is accomplished by androgens alone. Changes will induce beard growth, increasing musculature, stopping menses, increased body hair (and if genetically predisposed loss of head hair), deepening the voice, enlarging of the clitoris, and altering mood – including, all things being equal, somewhat increased aggression and sex drive. Masculinising hormones do not remove the breasts and so many trans men bind their breasts with a special elastic undershirt called a *binder* or through the use of bandages, and many opt to have them removed via a bilateral mastectomy and associated male chest recontouring.

TRANS FEMALE HORMONES

For trans women hormonal manipulation usually involves oestrogens and possibly an androgen suppressant. These will soften the skin, stop erections, possibly lead to a little less body hair – although electrolysis is usually

necessary to remove body, and especially facial hair. Trans women on hormones will grow breasts, usually to about a cup size less than their mothers. If they are older, or have self-medicated with hormones bought from the internet, there is an increased likelihood of them requiring an augmentation mammoplasty surgery to increase breast size. Those trans women who have not taken hormones, or who have only recently started to do so, often use padding in their bras to approximate breasts. These can include ingenious homemade devices such as tights filled with peas, or specially made silicone forms that approximate the size, feel and weight of a natural breast. Once the male voice has broken feminising hormones have no effect upon it and so speech therapy and possibly pitch surgery may be needed to effect a feminine voice; although it should be noted that voices differ between male and female not only in terms of pitch, but also choice of words, tempo, intonation and a number of other factors which a skilled speech and language therapist should be able to assist with. All things being equal, trans women also experience a change in mood becoming somewhat more 'emotional' and crying more easily. While feminising hormones can decrease sex drive, trans women are often comfortable with their bodies for the first time in their lives after the commencement of hormones and so sex drive can actually increase, with the modest pharmacological decrease more than offset by the psychological boost.

INFERTILITY

Both trans men and trans women will become infertile after taking cross-sex hormones and so should be counselled regarding this, with gamete storage offered prior to their commencement. It may be possible for people to stop hormones for some months in order to store gametes once started on hormones, but this is by no means assured. This is particularly an issue for younger trans people who at 18 may see having children as very incidental to their wish to transition, in a way they then regret at 30. A useful intervention can be to ask them to consider how much they have changed since they were very much younger and ask them if they might not change over that time period again. Some trans people feel that their gametes are in some way gendered, or that if they cannot have children in a way consistent with their gender (i.e. a trans woman carry a child to term) then they do not wish to have children at all. Trans clients should be reassured that many cisgender people cannot have children in such a way and so use other means (for example, cisgender women use surrogate mothers also). The DNA each parent contributes is, after all, simply a strand of nucleic acid and so reproductive education may be useful.

TRANS PARENTS

Some trans people think that, because they are trans they will be harmful to their children and so they should not have them; or if they already have them they should leave them. This is incorrect, despite some erroneous theorising by people who see few, if any, trans clients. The empirical literature is quite clear that having a trans parent in no way harms a child, or indeed appears to affect their sexuality. Harm to children seems to be caused by acrimonious break-ups (as it is for other reasons) and so separations should be handled with as much grace as possible (Freedman, Tasker & Di Ceglie, 2002).

Some trans parents retain a sense of self-blame with an extraordinary degree of vigour. The reason for this seems to be the feeling that they have hurt their children (although as mentioned children are not always hurt in these cases) and so, were they to give up their sense of blame, they would therefore be callous towards their children. Living a life while torturing themselves allows them to feel that, in some way, they are still a good parent; being happy themselves would mean that they are a bad parent and that is untenable. It can be useful to explore whether there was any choice involved, who has responsibility for their emotions, whether the 'children' are now independent adults (it's always useful to ask the age of any children), etc.

TRANS FEMALE SURGERIES

Trans women may also opt to have surgeries to alter their bodies such that they are in line with their gender identities. These are usually carried out after hormones have fully suppressed androgen production and oestrogens have had a chance to take effect, as this gives a better feel for where the person will be after surgeries and is a good indicator of whether a person will be happy to remain in their new gender role for the rest of their life. A key point with surgeries is that they are irreversible – once surgery has been done even the best reconstructive surgeries are inadequate. This is especially the case with genital surgeries sometimes called sex reassignment surgery (SRS) or gender reassignment surgery (GRS) or gender confirmation surgery; but perhaps most appropriately genital reconstruction surgery (GRS) (as that is what actually happens). Trans people should be counselled about the realities of their new bodies and may require assistance from professionals as they may not have had socialisation to them. For example, some trans women believe that breasts consist of fat – in fact they consist primarily of mammary glands – they are identical to female breasts and can be induced to lactate. Basic sex education can also be useful as trans people are just as much at risk of STIs as their cisgender

counterparts, but may feel that this is not so, or that they are not able to ask for protection, or even to refuse sex they do not want, on the basis that they are trans.

Trans women will only have an augmentation mammoplasty about 30% of the time if properly hormonally managed by a specialist endocrinologist. When they do have an augmentation mammoplasty it usually involves the insertion of a prosthetic breast either next to the developed breast or partially under the muscle also. Often trans women require a larger implant than their cisgender peers due to the proportionally larger size of the phenotypic male chest.

Trans women may also have a vagina formed from tissue that used to be their penis (with hair removal beforehand), with labia formed from scrotal tissue. The testicles are removed and the part of the tip of the penis, the glans, is used to create a clitoris, in the usual place, for erogenous sensation. The urethra is shortened and re-sited to allow the trans woman to urinate – for which she will likely sit down (as most cisgender women do). The neo-vagina will require regular dilation for the rest of the patient's life with an acrylic stent which she must place in her vagina periodically to stop it closing up. The cowpers glands are not removed and so there may be some lubrication when the trans woman is very sexually excited, but it is usual for her to need some form of other lubricant to be vaginally penetrated. Her prostate will also be left intact and should be medically treated accordingly. There is also another method of creating a neo-vagina using part of the colon (a colovaginoplasty) which is sometimes used if the patient has a very small penis, has been circumcised, or had puberty suppressed. However this is seldom used as it carries with it significantly higher risks. Some trans women who do not wish for vaginally penetrative sex, or who would be unable, or are unwilling, to care for a neo-vagina opt instead for a cosmesis in which the penis is removed, the clitoris is created and the labia formed, but no vagina is created.

TRANS MALE SURGERIES

Trans men may have a bilateral mastectomy and associated chest recontouring to effect a male chest. This can vary in outcome as larger breasts can mean less successful results and more scarring (scars may, of course, be tattooed over). In addition, if the breasts have been bound for long periods of time a poorer result may occur. Trans men may also have their clitoris released so it sits further forward and is more prominent – a procedure called a metoidioplasty. This is simpler and carries less risk than the creation of a neo-phallus by a phalloplasty. The phalloplasty uses tissue from the arm, abdomen or back to form a penis using microsurgical techniques

which aim to include protective, but not erogenous, sensation and blood supply. Erogenous sensation is retained as the clitoris remains intact and is sited underneath. This is usually a multi-stage procedure which all too often has complications such as urinary incontinence and the man's penis being abraded by his underpants due to lack of protective sensation. Nonetheless, some trans men are pleased to have phalloplasties which allow them to stand to urinate and/or to penetrate their partners through use of a hidden prostheses and a pump in place of one of his testicles – the other being an appropriately shaped implant. The scrotum is often shaped from labial tissue and the vagina, womb and ovaries are often removed. It should be noted that some trans men may have their womb and ovaries removed independent from the creation of a penis of any kind in order to stop any chance of menses and to remove the risk of various problems which may be associated with other treatments.

For all surgeries having appropriate support, such as people to do the shopping etc. after surgeries, as well as emotional support, is invaluable.

NON-SURGICAL OPTIONS

Literature and clinical experience suggest that the standardised mortality ratio of hormonal treatment for both trans men and trans women is one (with gender-specific risk reversed) – provided it is safely administered and that the correct associated tests and monitoring are carried out. However, some trans people opt not to have hormones due to understandable health concerns or because they are concerned about physiological changes. Some trans people do take hormones when they have full information, but others, quite reasonably, opt not to as they are more or less happy with their bodies as they are, but nonetheless wish to live as another gender. Similarly, some trans people opt not to have surgeries, and this is not at all uncommon with trans men opting not to have genital surgeries as they are concerned with the risks and potentially poor aesthetic outcome. Instead some trans people may reconstrue the gendered meanings of their body parts. For example, a trans woman may determine that she has a very large clitoris where others may read it as a penis; or a trans man may determine that he has a *manhole* where others would read a vagina. Of course, these are reasonable positions given how society marks bodies in different ways which may not always accord with perceived reality – for example long hair is not always feminine (consider the WWF wrestler), and muscles are not always masculine (consider the female sports person). Within the UK, legal recognition of one's gender *for all purposes* including marriage, gender-specific jobs, prison, etc. requires no physiological change of any sort (HMSO, 2004), although this is by no means the case globally.

It should be noted that while hormones and surgeries are often important things for trans people, they are not a panacea. Some trans people can have rather magical thinking about surgery especially and can become somewhat depressed after the magic has worn off when they find themselves in the same or similar job, home relationship, etc. with the same set of joys and difficulties – with just a few swapped for others that are different in kind but not in degree. Similarly, trans people can often think that any change in their psychology or physiology is down to their hormonal regimen and, while it is important that practitioners are aware of this as a possibility, hormones should not automatically be considered as being the first port of call when a difficulty arises. It does trans people a disservice if they are referred for a hormonal check-up when they are depressed if they have recently suffered a relationship breakdown, for example. Time, friends, self-care and perhaps psychotherapy would be far more immediately pertinent.

REFERRAL

Very few issues for trans people will require the services of a specialist in trans care. Trans people are just the same as others in terms of jobs, children, parents, bereavements, illnesses, etc. Of course there are occasionally matters wherein the services of a specialist are required – an endocrinological illness for example – however these will be rare. Notwithstanding this if the matter is trans related and a professional does feel they are inadequately equipped to deal with the matter it is professionally negligent not to refer on to a professional who has the necessary expertise. This is the case whether it is a matter of medicine, psychology or psychotherapy, social work or any other matter.

Within the United Kingdom people who wish to have physiological interventions may have these at no cost (other than through taxation) via the National Health Service. This includes hormones and genital surgeries, although other interventions such as facial feminisation surgeries and chest surgeries are often dependent upon the area the patient lives in for funding. People will usually be seen by their general practitioner or primary care physician who may then send them to be screened by a psychologist or psychiatrist for a mental health issue presenting as gender dysphoria. If a person does not have a mental health issue, or if their mental health issue (including schizophrenia, bipolar, etc.) is being managed and is not the cause of their gender dysphoria, they will be referred to a gender specialist multidisciplinary team of psychologists, psychiatrists, surgeons, speech therapists, endocrinologists, etc. with whom they will work towards an agreed outcome (it is worth noting that the members of this team may themselves be LGBTQ etc.) If the person wishes to have physiological interventions these

will usually come after a formal change of gender role, which will involve telling friends, family, work, etc. and making a change of name and identification documents (ID). At this point hormones may be initiated and then, when established, followed by any necessary chest surgeries; with genital surgeries following, usually after a period of two years from the change of gender role.

NAMES

Some clients may wish for assistance with changing their name – this is an important stage and should not be unduly influenced by clinicians. Having said that, some clients opt to choose a gender neutral name such as Sam in the hope that it will ease transition. Unfortunately, in some cases, this allows friends and family of the trans person not to make a cognitive shift (as they would with a change from Susan to Jeffrey say) leaving them thinking of the trans person in their old gender role. This can become particularly wearing for the trans person as their transition progresses, sometimes resulting in a further change to a gender unambiguous name.

It can also be useful to gently question clients who use the third person to refer to their gendered self. People who live in a dual role, being male at some times and female at others, may usefully employ this tactic to make syntactic sense, but for those who state that they have only one gendered identity referring to their other gender as “she” or using a name for “her” (or “he” and “him” for trans men) may demonstrate a degree of ambivalence, or at least non integration (as yet) of the identities (see Chapter 5 for the separate issue of those who explicitly identify as bigender).

Similarly some clients do not explicitly tell others, hoping that they will “just know”. However, if they do know there is no reason not to discuss it, and if they don’t and the client wishes to be thought of in their preferred gender, they will need to be clear. A period of adjustment may be necessary during which time more ambiguous clothing may be used, accessible toilets and such; but this should not be indefinitely as becoming established in the preferred gender role, and living just as a cisgender man or woman would is an important part of transition. Living in an ambiguous role, if not chosen, can be a major psychological stressor.

TRANS YOUTH

Trans youth are people who are under perhaps the age of 25; although the term usually refers to those who have not completed puberty yet. Most of this chapter refers to adult trans people, however trans youth is increasingly an issue, so is included briefly here. Most gender ‘non-conforming’

children (i.e. those who do not conform to conventional norms for their gender) will not transition gender when they grow up. The more they continue to be gender non-confirming as they grow up, the more likely it is that they will transition when they are adults. This is not to say that stopping the expression of gender non-conformity or offering psychological 'treatments' will stop the person being trans – rather they will be a miserable trans person, possibly with psychological problems. The best outcome seems to be assisting young trans people with their gender identities and expression as well as educating their social and educational networks such as schools, youth clubs, etc. Rather confusingly this is not to say that immediate transition is always the best thing either, as some young trans people who have transitioned have felt that they would like to transition back to their birth-assigned gender but have felt that they have not been able to due to all the interventions and change. Cautious, supportive interventions seem to be best.

For those young people who are extremely gender dysphoric, or cross-gendered in their identity and presentation, and who have been so for a long time, puberty-suppressing drugs called gonadotropin releasing hormone agonists (GnRHa) are sometimes administered when they reach Tanner stage 2 in puberty (just after the start). In this way the child can see a little of what puberty is like and, if they don't like it, it is stopped leaving them effectively pre-pubertal for sufficient time for them to fully consider if they would like to transition. If they would like to transition, cross-sex hormones are given and they develop accordingly; if they would not like to transition the puberty-suppressing drugs are stopped and they develop without the aid of drugs into their birth-assigned gender as an adult. Needless to say all this is done extremely carefully under the oversight of a large multidisciplinary team.

WIDER SOCIETY

Fear of abuse and violence is a very real concern held by many trans people. This may manifest in many ways, from physical attacks and abuse in public, to discrimination at work or at social events in which trans people may be subject to treatment which would be unthinkable for non-trans people (pulling at hairpieces, asking about genitalia, being told to use incorrect facilities, etc.). In addition, professionals and academics have sometimes co-opted trans voices, or been indiscreet with information about trans people in ways which have been damaging to trans people themselves. While it is important for professionals not to overplay these threats, as fear can be extremely disabling, it is important to recognise their potential and to treat fears accordingly – perhaps with

gentle experimentation to see if they are being realised. Professionals may also leverage professional power to assist trans people who are subject to such abuse – perhaps with letters to employers, etc. if asked by trans people themselves. Professionals may also usefully engage with political activism in order to assist trans people in these regards, whether or not they themselves identify as trans.

CONFIDENTIALITY

Within wider society trans is often seen as an object of fascination and as such should have especial confidentiality associated with it. Within the UK, the law (The Gender Recognition Act 2004) states that if a professional finds out that someone (client or colleague) is trans in their professional capacity, and then tells someone else – perhaps a secretary or a supervisor in the course of their work – then they have committed a criminal offence and will receive a criminal record, and a category five fine. They will most likely also be sued by the client or colleague afterwards. There are no ‘reasonableness’ criteria within this law as it is an absolute offence – saying that ‘of course my secretary must type my letters’, for example, is no defence. However, if the client or colleague consents to their details being given, under necessary circumstances the law allows this. There are also exceptions for the detection of crime, terrorism, and if the client or colleague is unconscious and needs medical assistance and you are a medic. Whether UK law applies to you or not, this gaining of consent to communicate details is rather easily done and should already be standard practice for most professionals – it just needs making explicit.

TOILETS

With regard to toilets and single-sex facilities, there are sometimes concerns about trans people using the appropriate toilets. It is, however, not acceptable for able-bodied trans people to have to use accessible toilets for any significant length of time as they may be needed in a hurry by people with physical needs. Instead trans people should use facilities appropriate to their presenting gender. Most trans people will be especially discreet in such facilities as they do not wish to draw attention to themselves. If a trans person were to cause a disturbance, the situation should be handled in just the same manner as if a cisgender person had done so as their trans status is not relevant. Within the UK and various other countries many trans people are protected by law in their use of single-sex facilities appropriate to their gender. It can be useful in these cases to consider the matter transposed into another arena. If some people were complaining that a

person of a certain class or religion had come into a toilet, gone into a stall, urinated and then washed their hands and left, they would be given short shrift.

SOCIAL GROUPS

It is worth noting that trans people can be made unwelcome in certain social groups. The mainstream of some religions (with notable exceptions) expressly forbids transition and are at best 'tolerant' in a way in which it is made clear that those in a position of power (i.e. non-trans people) are exercising that power over the trans members. This can also be the case in some lesbian, gay and, less commonly, bisexual spaces. Some radical feminist groups especially, may have a 'women-born-women' policy for membership which is problematic, exclusionary and rather counter-intuitive as it appears to be the only time that it is argued by this group that biology *is* destiny (cf. Serano, 2007). There are also class and cultural differences in the degree of acceptance of trans people, with some cultural groups having a history of recognition of some kind of gender transition.

Another group of people who have vilified trans people in the past, but who have shifted in positive directions of late, are medical professionals. It should not be forgotten that it was doctors who initially put their livelihood and profession on the line to fight for trans services, and continue to do so (often behind closed doors) with their multidisciplinary colleagues. It is also important to remember that medical professionals, like all other groups, are diverse and will have different levels of awareness and education around trans. Despite changes in this area, 'transsexualism' and 'gender identity disorder' are still classified as mental disorders in the main psychiatric taxonomies – the *International Classification of Diseases*, 10th edition (*ICD-10*) and *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (*DSM-IV-TR*) respectively. This allowed NHS funding in the UK and insurance funding elsewhere. However, many trans people and others argue that, given that being trans is not necessarily debilitating, it makes no sense to retain the diagnoses, especially after any surgeries, change of role, etc. are done with (cf. Karasic & Drescher, 2005). For this reason the most recent *DSM-V* contains the diagnosis of *gender dysphoria* to reflect the fact that being trans per se is not a disorder.

GROUP NORMS

HIERARCHY

Within some circles there is an implicit (or indeed explicit) and problematic hierarchy of perceived legitimacy with cisgender people at the top followed

by intersex people; then trans people who have had hormones and surgeries; then people who have ‘only’ had hormones or no genital surgeries; then people who have not had surgeries or hormones (‘dual role’ people); and then those with a sexual element to their gender presentation. Of course these also intersect with other demographics such as age, class, race, etc. Some trans women refer to cisgender women as ‘real girls’ or ‘bio girls’ – terms which serve to erase the reality and validity of trans women’s gender and may be a reflection of low self-esteem on the part of the trans women who use these terms, or internalised transphobia in which the trans woman herself does not like trans people. Similarly, but slightly less commonly, trans men may make reference to ‘real men’ or ‘bio men’. Trans men may also suffer from internalised transphobia, sometimes – but not always – associated with not having a penis and so feeling unable to be a ‘real man’.

It is imperative for clinicians to examine their own assumptions and to avoid thinking that someone is ‘really’ of their birth-assigned gender. If a person has transitioned and appears to be suffering in this way it can be useful to consider the ways in which cisgender people fall short of these targets and yet are still considered to be wholly male or female – for example, many older cisgender women have had hysterectomies and yet are still considered to be fully female, despite not having reproductive capacity; a cisgender man who has his penis removed, perhaps as a result of an accident, would still be a man. Trans, then, may be considered to be just another way of being a woman or a man. For this reason using the terms such as pronouns, name, etc. related to the gender of presentation (except in certain specialised and legal circumstances) is imperative. If in doubt use the *ask etiquette* – and simply ask what form of address is preferred.

PAUSE FOR CONSIDERATION

Take a moment to consider what constitutes a woman or a man in your own mind. Try to think of examples where this is troubled – for example, if men are constituted by being physically strong, what about elderly men?

Some trans people, especially trans women, may move from a position of ‘fetishistic’ sexualised cross-dressing (see Chapter 11) to a ‘dual role’ position before deciding to transition fully into the female role. This group may find it especially difficult to accept that they have lived in different roles, due to the different values these are given in the hierarchy. Similarly, trans men may have occupied a place as a queer or butch lesbian and found friends and a sense of community within that, sometimes linked with radical feminist

politics, particularly in the case of those growing up in the 1960s and 1970s. It can be especially difficult for such trans men to transition into a male role as they sometimes have to leave friendship groups and communities, and may feel they have betrayed them (or be told they have) as they move to a role which is more personally congruent.

It follows therefore that one of the most useful interventions professionals can make is to impress upon struggling trans people that they are just as male or female as a cisgender man or woman – and that it is okay to be trans. This bears repeating, as many people think that trans people will inevitably fail at life. However, this is not the case. Within the UK there are trans doctors, lawyers, professors and indeed members of just about every profession. Trans people often also have children, partners, etc. and all the accoutrements of what is commonly regarded as a satisfying life. This is not to say that being trans is not sometimes hard, but that it can be quite okay, and exceptional.

‘PASSING’ AND ABUSE

One particular issue for many trans people endeavouring to live comfortably is that of ‘passing’ as the gender of their identity. This can be a matter of safety as people who look less uncommon often suffer less abuse. However, some trans people fear that if found out they will invariably suffer abuse when in fact this is not so. A useful question is to ask when the last time was that abuse occurred and ask for a date and details. It may be that the perception is more damaging than the reality. Indeed the act of being ‘stealth’ – that is passing such that others are unaware that one is trans – can lead to people developing psychological difficulties as they are constantly concerned about being found out. This is called hyper-vigilance and may manifest as people looking at others in the street, thinking people are laughing at them or talking about them. Unfortunately, the very behaviours people use to address this – looking at people to see if they are looking, etc. can cause the effects they are concerned about. Therapeutic methods of addressing anxiety and panic attacks can be effective to address this.

Those people who choose not to ‘pass’ all the time, or who are unable to, tend to come to terms with their trans status and develop methods of handling any abuse (often through either ignoring or calmly giving information about trans to the abuser) – and consequently may be more content. Those who do suffer psychological difficulties as a result of being abused in this way are subject to *minority stress* in the same way people from other minority groups can suffer from depression and anxiety, etc. It should not be assumed that because of this being trans is psychopathological.

SUMMARY AND CONCLUSIONS

In summary, the following are good practice points when working with trans clients:

- Remember that trans is simply another way of being, albeit one which often involves a major life change.
- Examine one's own gender (whether trans or not) and avoid inadvertently influencing people who are deciding how they wish to be for themselves.
- Reflexively engage with assumptions and encourage staff to do the same.
- Recognise that fundamentally transition is not about becoming a woman or a man, but rather about becoming oneself and making one's peace with that decision.
- Make referral when necessary and involve a multidisciplinary team for any major physiological change.
- Treat people with dignity and respect and use the appropriate pronouns, names, etc.
- Respect confidentiality.
- Normalise trans, and most often simply ignore it when it is not pertinent to the matter under discussion.

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