Affirmative Therapy for Trans/Gender Expansive Clients

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Learning Objectives

01 Distinguish between 5 concepts of of Sex Assigned at Birth, Gender Identity, Gender Expression, Sexual Orientation and Attraction

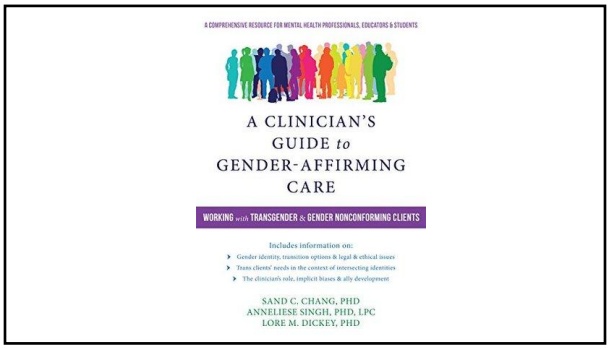
02 Identify 3 unique challenges experienced by trans/gender expansive folx

03 Identify 4 misconceptions/myths in trans care, concept of transition and/or "coming out"

04 Identify 3 ways of providing gender affirming care in mental health services for trans/gender expansive folx

Reminders

-Taking good care of needs
-Speaking from your experience
-Reflect on internal biases and discomfort arising during discussions
-Be open to feedback regarding implicit bias
-Awareness that this is a brief training which will miss opportunities for deep exploration of topic



Why is Language Important

- Consider CBT: connection between thoughts, feelings and behaviors
- Consider role of negative attributions by parents towards children & child maltreatment
- Discourse impacting perspectives, feelings, behaviors and policies
- Vital: creating an affirming environment increases access, increases wellbeing (**why pronouns are so vital!**)

Language Ever Evolving

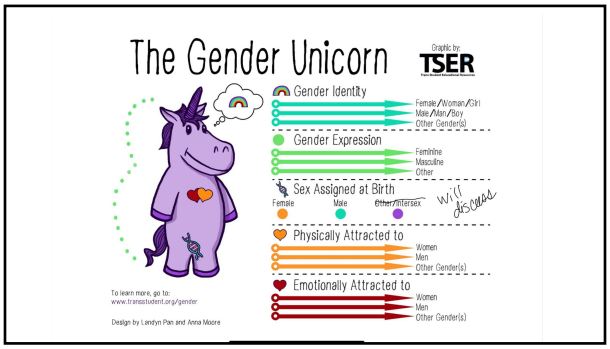
Examples:

Sex change operation (offensive, outdated)
Sex Reassignment Surgery (outdated, invalidating)
Gender Confirmation Surgery (outdated)
Gender Affirmation Surgery/Services

Trans* (always controversial, considered outdated and invalidating)

Preferred Pronouns (outdated, invalidating, offensive)
Queer (hx of slur, reclaimed)

LGBTQ2S vs LGPTQ2S vs many other

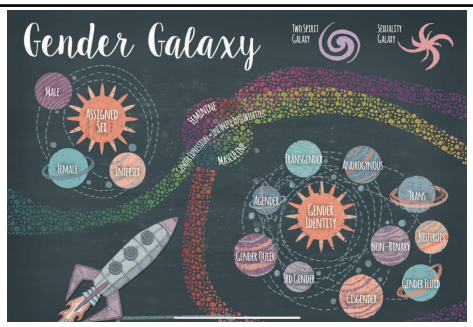


Breakout Group Discussion

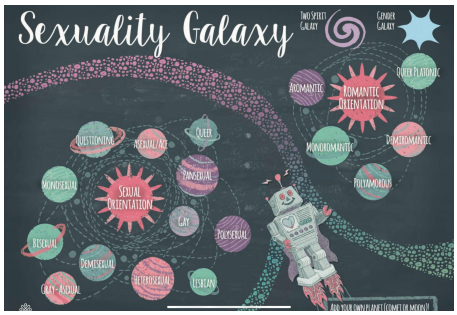
-What are the earliest memories I can recall of "gender" expectations?

-Who influenced my concepts of gender?

-How have I benefited from conforming to gender expectations?



Action Canada for Sexual Health and Rights



Action Canada for Sexual Health and Rights

Criticisms of Educational Tools

Examples:

-Spectrum/continuum

-emphasis on specific genders

-"othering"

-Issue with how Intersex is presented

Changes in Diagnosis

Transvestite (1918)
Psychopathia transsexulialis
Transsexual (1940s)
DSM III: Transexualism
DSM IV: Gender Identity Disorder

DSM 5: Gender Dysphoria
DSM 5-TR (changed language used in section)

Changes in Diagnosis: continued

WHO tweeted June 18th, 2018:
"In the new International Classification of Diseases #ICD11, transgender is no longer considered a mental disorder, but is classified under sexual health conditions. This should reduce stigma and improve care."
Classifying under sexual health conditions allows for continued necessary treatment and coverage of care under insurance.
(Klein, 2018)

Changes in Diagnosis: continued

ICD 11:
Gender incongruence
-Removed from mental health disorders section
-Now in the Conditions of Sexual health chapter

[Note on internal/external and avoiding this assumption]

Considerations/criticisms

"Co-Morbidity"
-Anxiety and Depressive Disorders
-Trauma related symptoms
-Neurodivergent diagnoses/presentations*
-Eating disorders*
"Differential Diagnosis"
-Nonconformity to gender roles (gender expansive/gender creative children/folks)
-Body Dysmorphic Disorder
-Transvestic Disorder
-Schizophrenia and other psychotic disorders

Considerations/criticism: continued

Research/Media:

While good research has increased:

-limitations, bias past/present, misinterpretation, misrepresentation

Example: Re-examination of Persisters and Desisters

-lost in attrition counted as "desisters"

Example: Detransition & Regret, Retransition

-hyperfocus, sensationalism, lack of context given (when rates are actually very low)

Example: Puberty Blockers article (UPATH and WPATH recently responded)

Transition

Social

Legal

Medical

Mental/Emotional

And More!
(spiritual, sexual, etc)

Transition: continued

-Can look different for each person (steps involved, time table, etc.)

-Can be a continuous process

-For children this involves social transition steps

-Harms from Misconceptions, myths and misinformation on transition and "coming out"

Medical Transition/Gender Affirming Medical Care

-Cohen-Kettenis & van Goozen (1997) observed that trans people who transition in adolescence using puberty blockers may have a more complete resolution of their gender-dysphoric symptoms than those who transition in adulthood.

-Gómez-Gil et al. (2014) also found an association between use of hormone therapy and greater quality of life among trans people, and Ainsworth & Spiegel (2010) observed that both facial feminization surgery and genital reassignment surgery are linked to a better mental health-related quality of life in trans women.

-A number of studies have found that sexual functioning, health, and satisfaction among trans people are improved following transition.

-A meta-analysis by Murad et al. (2010) found a marked increase in sexual functioning after transitioning in both trans women and trans men.

-January 2022 study results: Transgender people who began hormone treatment as teenagers were less likely to have suicidal thoughts or engage in substance abuse than those who began treatment as adults

Evolution of Trans Care

-Pathologizing/stigma

-Gatekeeping

-"Fly by night" providers

-Assessment, Informed Consent models

Who is involved in the decision making process?
What should be involved in accessing care?

(Requirements for stability?
Planning for better outcomes ≠ barriers to care?)

Standards of Care

WPATH
World Professional Association for Transgender Health
-Recommendations, not the only model
-insurance and providers won't necessarily follow

Standards of Care Version 8 (Sept. 2022)
A few examples of changes from version 7 to note:
-no distinct age cut offs
-decrease in letters needed (1 letter from health professional)

Gender Affirming Hormone Treatment (GAHT)

Gender affirming surgeries: "Top" "Bottom"

-Avoiding assumptions
Example: binary trans folx, non-binary trans folx
-getting connected to knowledgeable providers
-information, resources and support (when appropriate)
-Barriers and challenges

"Feminizing surgeries"
Breast/chest surgery: augmentation mammoplasty (implants/lipofilling); Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty; Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and more

"Masculinizing" surgeries:
Breast/chest surgery: subcutaneous mastectomy, creation of a male chest; Genital surgery: hysterectomy/ovariectomy(oophorectomy), reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and more.

Note how this is placed in a binary which isn't the whole picture

Examples of seeking support

- Exploration of gender identity
- Exploration of steps in transition (and fears such as reactions from others, loss/grief, trauma)
- Medical trauma interfering with transition steps
- Exploring medication transition & self advocacy around what they what for a procedure

Challenges/Systemic Inequities

Intersectional:

In all categories in studies, trans/gender expansive BIPOC folx experience higher rates of risk, discrimination and inequity in resources/care with trans femme and trans women of color usually with the highest rates

Not only higher rates, but those with intersecting marginalization experience interacting with the world and themselves in specific ways (i.e., not merely additive)

Housing:
-1 in 5 have experienced homelessness in their lives
- Of those nearly 1 in 3 have been refused shelter
-More than 1 in 10 have been evicted due to gender identity
-70% of respondents who had experienced homelessness, had also attempted suicide.

Economic:
- 29 % of transgender people live in poverty (more than double the 14 % of the general U.S. pop)

- Unemployment rate is 15 % (-three times the national average at the time of the survey)

Health/Healthcare:

-2% reported being physically attacked in a doctor's office.

-28% reported being verbally harassed in a medical setting.

19% reported being refused care altogether, due gender identity or expression, (higher for BIPOC folx)*

-60% of respondents whose doctor or healthcare provider refused to treat them, attempted suicide.

-Reported over 4 times the national average of HIV+

-Estimates are that 1 in 4 black transgender people in the United States is living with HIV/AIDS.

- 57% respondents whose families chose to not spend time with, or not speak with them, had attempted suicide.

-For youth whose families and support systems are affirming, rates of depression and suicidality decrease to around gen. pop

Documents:

-40% of respondents who presented gender incongruent identification reported harassment &

-3% reported being assaulted or attacked

Public accomodations: traveling: bus, planes, etc. , hotels/motels, retail/shops, clinics, police, courts

-Ranging from 4%-37% reported denial of service or harassment (ranging from verbal harassment to physical violence/attacks)

"Denial of health care by doctors is the most pressing problem for me. Finding doctors that will treat, will prescribe, and will even look at you like a human being rather than a thing has been problematic. Have been denied care by doctors and major hospitals so much that I now use only urgent care physician assistants, and I never reveal my gender history."

— NTDS study participant

Video

Creating an Affirming Environment

Forms/Language

Check Assumptions

Visuals

Referrals

Facilities

Adjust your interventions

Training and Consultation

Discussion

How do I communicate about gender in my professional work?

What are ways I can change my practice which may be more affirming to trans/gender expansive folx? [note: this will also improve things for cisgender folx]

Q and A

Thank you