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Eliminating Counselors' Transphobia: Moving Counseling Forward with Transgender People

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Abstract

The year 2019 marked the 50-year commemoration of Stonewall and its community that sparked an uprising about sexual and gender identity (Bullough, 2002; Glasses-Baker, 2019). Half a century later, allied health professionals continue to debate the origins of gender identity, the perception of altering one's biologically determined sex, and whether society should accept the transgender community as a fact of neurobiological nature. The purpose of this article is to describe the more recent history of a disorder that has consigned the transgender population to society's margins. The authors include an overview of the World Health Organization's (WHO) leadership role in the depathologization of gender dysphoria which will shape the reassessment of and service provision to transgender people in the field of counseling and mental health.

Keywords: Identity development, gender issues

On May 25, 2019, the World Health Organization (WHO), a body of the United Nations (UN) that publishes the International and Statistical Classification of Diseases (ICD), passed a new diagnostic code for the ICD. The diagnosis, *gender dysphoria*—still in use by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (American Psychiatric Association [DSM-5], 2013), has been eliminated in the ICD (United Nations Web TV, 2019) and replaced with a diagnosis called gender incongruence, which the WHO found to be a more appropriate. More notably, the previous diagnosis has since been removed from the mental health chapter of the ICD and moved to the sexual health chapter. In an effort to reduce the stigma associated with being transgender, the change was completed with the participation of the transgender community, not just the professional medical community of the WHO (United Nations Web TV, 2019).

Dr. Leonid Poretsky, Director of Endocrinology of Lenox Hill Hospital in New York, described the change as offering a new frontier for the field of medicine and psychiatry as endocrinologists have been studying this for many decades since hormone replacement therapy has been a form of therapy that many patients have requested. In time, it became clear that hormone therapy was not the only intervention transgender people needed to achieve satisfaction in life. As a result, some hospitals have developed wraparound services to meet the broader needs of transgender clients (United Nations Web TV, 2019).

Next, to destigmatize the care of transgender individuals, the UN panel concluded that gender identity is part of a person's individuality, and is as equally relevant as one's ethnicity, height, or eye color to one's overall identity. Poretsky clarified that transgender identifications are not of mental illness, nor a physical illness. According to Lev (2004), to receive medical treatment, transgender and transsexual people must prove themselves "disordered;" while simultaneously, having prove themselves mentally healthy. Paradoxically, approval for treatment should not depend on being mentally ill, but on being mentally sound enough to make empowered and healthy decisions regarding one's body and life.

Historical Context

Transgender people's experience has historically been one of social exclusion. For example, in early 20th century Berlin, Germany, physician and sex-educator Dr. Magnus Hirschfeld and his colleagues advocated for Berlin's transgender community by providing gender affirmative care, along with hormone replacement therapy and surgeries (Beachy, 2014; Marhoefer, 2015). This changed when the Nazis took power and Hirschfeld was targeted for being Jewish and homosexual. His clinic was vandalized, staff were assaulted, and Hirschfeld's research and books were burned. Thereafter, the Berlin police permanently closed down Hirschfeld's clinic. Forced into exile, Hirschfeld died a short time later of a heart attack in France.

In the 1950's, Dr. John Money, a well-known medical psychologist from Johns Hopkins University, argued that gender was learned and could be changed through parental child rearing. Money did not believe gender was contingent on chromosomes, genitals, or even sex hormones (Money & Patricia, 1975). In 1967, a Canadian couple brought their identical twin infant boys (Bruce and Brian) to the hospital for routine circumcisions resulting in irreparable damage of one twin's penis due to a surgical mistake. After discussing their options with Money, the couple decided to have their son, Bruce, undergo surgical castration (removal of the testicles), transforming his genitals into those of female (Erhardt, 2007). Bruce became Brenda and was placed on hormone treatment beginning in adolescence to maintain her feminine appearance (Money & Patricia, 1975). For many years, this case was "proof" that children were psychosexually "neutral" at birth and that gender could be assigned (Diamond & Sigmundson, 1997).

Years later, a 1997 study published by a reproductive biologist at the University of Hawaii, exposed Money's case and discussed how Brenda struggled against her forced feminization from the beginning (Diamond, 2004). Despite hormone treatments, Brenda never felt that she was a girl and struggled with bullying and depression. Her parents then disclosed the truth, and at 15 years old, she stopped her hormonal treatments and changed her name to David. Although David eventually married and adopted children, he committed suicide at the age of 38 (Colapinto, 2000). Once Money's unethical behavior and fraudulent scholarship was exposed, endocrinologists began studying the link between transgender identity and neurophysiology (Zhou, Hofman, Gooren, & Swaab, 1995).

Ethical Considerations for Working with Transgender People

Counselors are often inadequately prepared to work with transgender clients. As a result, transgender clients often face adversity from well-intentioned counselors who, through lack of competence or knowledge, inadvertently harm them (McCullough, Dispenza, Parker, Viehl, Chang, & Murphy 2017). According to Hill and Willoughby (2005) if counselors exhibit transphobia, which is defined as an irrational fear or disgust toward transgender individuals, and/or the belief that individuals who do not conform to traditional gender roles are abnormal or deviant, it is possible that a counselor's behaviors can mimic discriminatory practices transgender people experience in their daily lives. According to Drabble and Trocki (2005), the unmet service needs of transgender people is thought to be disproportionately high, although it is difficult to determine given that many large scale surveys and treatment studies do not inquire about sexual orientation and many transgender people may not be comfortable reporting.

The question of one's values, especially when they differ within the therapeutic relationship, pervades the counseling process. Counselors must acknowledge and understand their own value systems, and how those systems may influence the therapeutic experience.

There are multiple indications that self-awareness is highly valued by the counseling profession (Corey, Corey, Corey, & Callanan, 2015; Hansen, 2009). Counselors may not agree with the values of their clients but it is essential that they respect the rights of their clients to hold a different set of values (Corey, Corey & Corey, Callanan, 2015). The impact of a counselor's value system regarding (but not limited to) transgender individuals, gender non-conformity, and/or sexual minorities on the client's therapeutic experience can raise ethical issues. According to the American Counseling Association (2014), the "primary responsibility of counselors is to respect the dignity and promote the welfare of clients (p. 4)."

This has increased the need for greater awareness and exploration of values of counselors, their biases, prejudices, and encapsulated worldviews (Aponte, & Kissil, 2016; Shamoon, Lappan, & Blow, 2017; Simon, 2006). Worldviews help determine which information will be attended to or ignored, how much importance to attach to stimuli, and how to structure information. Counselors must attempt to minimize personal bias, maximize the congruence between their values and their behavior, and strive to respect their clients' worldviews (Ivey, Ivey & Zalaquett, 2017). Beneficent treatment of clients (American Counseling Association, 2014) is of utmost concern, and ensures that the client is not harmed.

It is important to note that counseling is not a form of indoctrination, nor is it the counselor's function to teach clients "proper" behavior. It is unfortunate that some well-intentioned counselors believe their job is to help people conform to social standards considered acceptable by the heteronormative profession. According to the guidelines for ethical behavior of the American Counseling Association (2014), counselors act to avoid harming their clients. Moreover, they minimize or remedy unavoidable or unanticipated harm (A.4.a). Therefore, counselors strive to become aware of how their personal values influence their professional work. The challenge for counselors is to recognize when their values clash with a client's values. The American Counseling Association's guidelines read as follows, "counselors are aware of their own values, attitudes, beliefs and behavior and how these apply in a diverse society, and avoid imposing their values on clients" (A.5.b.). Merely disagreeing with a client or not particularly liking what a client is proposing to do is not ethical grounds for a referral (Lee, 2008). Whether or not the individual discloses their sexual orientation and/or gender identity, it is the counselor's duty to understand sex-related terminology (Russell & Viggiani, 2018). In the next section, we will discuss how to respectfully and compassionately provide counseling services to transgender people.

Transgender Emergence:

Implications for Counseling Practice

According to Carl Rogers (1980), the individual has their own personal resources to promote healing and learning more about the self, once there is an environment conducive to promote such an experience. Supportive evidence suggests improvements have been discovered in arrange of psychosocial measures once gender affirming interventions are exercised (Witty, 2006). For example, one type of gender affirmation model is Sevelius' model of gender affirmation (2013). It describes the ways in which denial of access to gender affirmation is associated with high-risk behaviors and increased rates of HIV infection. It is important to note that all transgender people may not seek all of the interventions provided, if at all, yet it is imperative that counselors be aware of the various models of development in offer to provide the most effective, relevant services possible.

The authors' present gender affirming counseling strategies that will help the practitioner to offer competent services and establish the therapeutic alliance with transgender clients**.** Extrapolating from the work developed by Appleby and Anastas (1998), this process argues that it is the counselor who has the duty to be aware and open to different worldviews and identities when it pertains to clients with whom the counselor is unfamiliar.

Transgender emergence (Lev, 2004) involves a complex interaction of developmental and interpersonal transactions. It is important to understand that the process of developing a gender identity is a normal, individual, and unique process everyone experiences, yet for many gender variant people, the process is possibly complicated by intra- and interpersonal dissonance with their core sense of self because of haunting societal gender/hetero normative expectations. The emergence process describes an adaptive stage model for transgender men and women who are coming to terms with their own gender variance and moving from an experience of denial and self-hatred to one of self-respect and gender congruence. These stages are not necessarily linear and can be impacted by other identity development. These stages are not meant to "label" people or define their transgender maturation process, these stages describe what counselors may witness when clients seek help for what may be gender dysphoria.

In this first stage of Awareness, gender variant people are often in great distress. As such, the therapeutic task is to normalize the life experiences of the emerging transgender client. In the second stage, gender variant people seek to gain education and support about transgender identity. Here, the therapeutic task is to facilitate linkages to trans-sensitive and/or trans-specific services and encourage outreach to trans support and/or social groups. The third stage involves the disclosure of identity to significant others -- spouses, partners, family members and friends; the therapeutic task involves supporting the transgender person's integration in the family system. The fourth stage involves the exploration of various (transgender) identities. The counseling task is to support the articulation and comfort with one's identity. The fifth stage involves exploring options for transition regarding identity, presentation, and body modification. At this point, the therapeutic task is the resolution of their decisions, and advocacy towards their actualization. In the final stage, the gender variant person is able to integrate and synthesize their transgender identity. As such, the therapeutic task is support in adaptation to transition related issues.

Affirming Strategies

For many lesbian, gay, bisexual, transgender, queer –questioning, intersex, asexual, two-spirit (LGBTQIA2-S) individuals, many have experienced a disproportionate amount of traumatic experiences in relation to the heterosexual community, and for some transgender people of the LGBTQIA2-S communities even more so. When providing counseling services, the goal is to decrease the chances of re-traumatization when serving the transgender community. One way is by employing trauma-informed strategies. There are six key principles central to a trauma-informed approach include (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014):

1. *Safety* – The organization, its staff and the clients serve feel physically and psychologically safe. The understanding of safety according to the client must be top priority. Because hate crimes, bullying, sexual prejudice, violence, and even death pervades LGBTQIA2-S, especially some transgender individual's culture and experience, both historically as well as currently, safety and confidentiality are of the utmost importance. Having brochures focused on transgender individual experiences, and transgender community symbol stickers on one's badge are some examples of notifying individuals who identify as LGBTQIA2-S that one's space is safe.
2. *Trustworthiness and Transparency* – When an organization operates with transparency and the goal is for that organization and its members to build and maintain trust with clients and their families. This can be demonstrated through policy procedure, mission statements, and inclusive paperwork.
3. *Peer Support* – Helps to establish safety and trust, and establish hope and build collaboration all while acknowledging the clients experiential reality to promote recovery and healing.
4. *Collaboration and Mutuality* – This principle focuses on leveling power differences between clients and staff—the sharing of power or an egalitarian approach. Counselors acknowledge societal discriminatory practices and sexual prejudices—and do not replicate similar practices in one's own thoughts and behaviors. Counselors must explore their worldview and value system regarding sexuality.
5. *Empowerment, Voice and Choice* – Recognize the clients' and communities strengths. Understand the historical injustices within the clients' lives and LGBTIQ2-S and transgender communities as a whole. This principle promotes clients' self-advocacy as service professionals provide safe, collaborative support.
6. *Cultural, Historical, and Gender Issues* – This principle "actively moves past stereotypes and biases"—for example, offering gender responsive services; understands the importance of clients' cultural values and incorporates them into service; policies are in place that are racially, ethnically, and culturally responsive; and historical trauma and it impact is recognized and addressed. Counselors must avoid pathologizing sexuality and consensual sexual practices.

Gay Affirmative Practice (GAP) means to provide services to individuals who identify as LGBTQIA2-S with safe, appropriate, efficient service in a way that allows the individual to openly express their sexual orientation and various gender identities and expressions (Dentato, 2017). There are three major themes of the GAP model highlighted in the following framework:

Attitudes –

1. Same gender sexual desires and behaviors are viewed as a normal variation in human sexuality.
2. The adoption of a GLBT [sic] identity is a positive outcome of any process in which an individual is developing a sexual identity.

Knowledge

3. Service providers should not automatically assume that a client is heterosexual.
4. Important to understand the coming out process and its variations.
   Skills
5. Practitioners deal with their own heterosexual bias and homophobia.
6. When assessing a client, practitioners should not automatically assume that the individual is heterosexual. Additionally, counselors must understand that the individual who identifies within the LGBTQIA2-S communities, the transgender community in particular, is the expert of their experience(s) and should also seen as the expert regarding the therapy's direction. Be mindful that the client's approach may include family and community members. And lastly, counselors must understand that the various identifications regarding gender, just as sexuality, have no bounds.

Summary

Just as elastic is flexible and tensile; gender—and its variations, possess similar metaphorical properties. The authors provided evidence for a neurological basis of gender dysphoria due to the areas of involvement in the self-body perception processes. As we continue to learn and understand the complexities of what it means to be human, it is imperative that one accounts for and appreciates the various nuances, abstractions, fluidity, and, at times, ambiguities that make gender identity and its variations unique. As mental health service providers, such appreciation for sexuality is necessary to understand how the client has (or has not) been impacted by society's heterosexist, gender-binary, hetero-normative systems. To develop an understanding of, and respect for, one's experiential reality and its impact on their mental health the transgender communities, is paramount when exploring aspects of mental health.

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