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The state of affirmative mental health care for Transgender and Gender Non-Confirming people: an analysis of current research, debates, and standards of care

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Summary. Following the growth in visibility of Transgender and Gender Non-Confirming-identified people (TGNC) in popular culture and media, along with the increase in number of health clinics focusing on working with this population, and the development of a special interest in health professionals in TGNC-related issues, flourishing scientific literature and updated guidelines to help Mental Health Professionals (MHPs) work affirmatively with transgender individuals is pertinent. Despite the increased attention toward TGNC individuals, this population is still faced with political, economic, legal, and medical obstacles affecting their mental health and access to health care. Moreover, MHPs still report having limited training and experience in TGNC-affirmative care. This article aims at providing professionals with the most updated information and research findings to help them develop a more trans-affirmative practice. After defining key terms and providing a definition of TGNC-affirmative health care, this article will focus on summarizing the main documents that inform MHPs working with this population. This article offers research-based guidelines and discusses the major theoretical frameworks professionals are encouraged to incorporate in their work when developing TGNC-affirmative care. Additionally, this article will present the current debate around the diagnoses of Gender Dysphoria (DSM-V) and Gender Incongruence (ICD-11). The controversy between the Medical Model based on the Diagnosis of Gender Dysphoria and the emerging Informed Consent Model will be reviewed.

Key words. Gender-affirmative health care, gender competence, gender dysphoria, gender incongruence, gender non-conforming, informed consent model, medical model, transgender.

Lo stato di assistenza mentale affermativa per persone Transgender e Gender Non-Confirming: un'analisi della ricerca attuale, dei dibattiti e degli standard di cura.

Riassunto. A seguito della crescita in visibilità delle persone Transgender e Gender Non-Confirming (TGNC) nella cultura popolare e nei media, dell'aumento del numero di cliniche specializzate nel lavorare con questa popolazione e dello sviluppo di un interesse speciale da parte dei professionisti della salute in questioni correlate alla popolazione TGNC, è emersa una fiorente letteratura scientifica su tale argomento e sono state prodotte linee guida aggiornate per aiutare i professionisti della salute a lavorare in modo affermativo con le persone TGNC. Nonostante la maggiore attenzione nei confronti degli individui TGNC, queste persone si vedono ancora costrette ad affrontare problematiche a livello politico, economico, legale e medico che influiscono sulla loro salute mentale e sull'accesso alle cure. Inoltre, molti professionisti della salute riferiscono ancora di avere una formazione e un'esperienza limitate nel fornire un'assistenza affermativa per le persone TGNC. Questo articolo si da come obiettivo quello di fornire ai professionisti della salute le informazioni più aggiornate e i risultati di ricerche recenti al fine di aiutarli a sviluppare una pratica più affermativa per le persone TGNC. Dopo aver definito alcuni termini chiave e fornito una definizione di assistenza sanitaria affermativa per la popolazione TGNC, questo articolo si concentrerà sul riassumere i principali documenti che informano i professionisti della salute che lavorano con questa popolazione, offrendo linee guida basate sulla ricerca e sul discutere i principali quadri teorici che i professionisti della salute sono incoraggiati ad incorporare nel loro lavoro. Inoltre, questo articolo presenterà l'attuale dibattito sulle diagnosi di disforia di genere (DSM-5) e incongruenza di genere (ICD-11) e la controversia tra il modello medico basato sulla diagnosi di disforia di genere e l'emergente modello di consenso informato. Infine, l'articolo proporrà linee guida volte a migliorare le conoscenze e le abilità dei professionisti nel trattare le questioni relative alla popolazione TGNC.

Parole chiave. Assistenza sanitaria affermativa sulle questioni legate al genere, competenza di genere, disforia di genere, gender non-conforming, incongruenza di genere, modello basato sul consenso informato, modello medico, transgender.

Introduction

In recent years, there has been a growth in the visibility of Transgender and Gender Non-Confirming-identified people (TGNC) in popular culture and academia. There has been a significant increase in publications in the field of transgender healthcare and more professionals are developing a special in-

terest in transgender health. As a result, in the past 50 years, the scientific literature around transgender individuals has flourished leading to the development of progressively more trans-affirmative practice across the multiple health disciplines involved in the care of TGNC people. Consequently, there has been a transition in this growing field from a *disease-based* to an *identity-based model* of transgender health. In summary, the disease-based model assumes that the normative gender identity development has been compromised in TGNC individuals causing distress that can be alleviated by establishing congruence between sex, gender identity and gender role and, if necessary, hormonal and surgical sex reassignment. On the contrary, the identity-based model assumes that gender variance is simply an example of human diversity and that the distress transgender individuals might experience results from social stigma attached to gender variance[1]. Although the very term transgender is becoming more mundane, trans individuals' political, economic, legal, and medical challenges continue. Moreover, many psychologists and other MHPs still report having limited training and experience in TGNC affirmative care and they often report to generalize their competence to work with other diverse groups, such as LGB individuals, with TGNC population. For example, in 2009, the American Psychological Association (APA) Task Force on Gender Identity and Gender Variance found that fewer than 30% of psychologists surveyed viewed themselves as familiar with concerns of TGNC individuals[2]. The lack of familiarity with trans-affirmative care and the recognition of need for competent practitioners require guidelines and standards of care for MHPs. The most recent APA statement regarding working with TGNC individuals states that: «Affirmative psychological practice considers the role of stigma and oppression throughout various aspects of psychological practice and approaches sexual minority identities as a normative aspect of human sexuality, rather than pathologizing sexual minority persons»[3 (p.56)]. Starting from acknowledging MHPs' need to become familiar with TGNC population as a fundamental aspect of their clinical work, this article aims to provide professionals with updated information, guidelines, and research findings in order to lead them to work in a more affirmative, validating, effective, and respectful way with the TGNC population.

Key terms and definitions in TGNC-Affirmative Care

Terminology and definitions around the transgender experience are time dependent as this vocabulary continues to evolve within the TGNC community. The variability in terminology is related to different factors such as culture, context and the unique subjective experience around sex and gender that individuals present. As a result, there is substantial diversity of terminology in how people self-identify their sex or gender and there does not appear to be one term that encompasses every unique and distinct sex or gender experience[4]. For example, one study[5] found that over 500 respondents used different terms to describe their sex or gender. Due to the diversity of terms, the terms used in this article will be outlined.

In the 1960s, the term Gender Identity was coined to describe one's persistent inner sense of belonging to either the male or female gender category. Over time, the conception of gender identity expanded to embrace those people who do not identify either as female or male, leading to more expansive definitions. For example, Lev's definition of gender identity is a: «person's self-concept of their gender (regardless of their biological sex)»[6 (p.397)]. The American Psychological Association describe Gender Identity as «the person's basic sense of being male, female, or of indeterminate sex»[2 (p. 28)].

Transgender is «an adjective that is an *umbrella* term used to describe the full range of people whose gender identity or gender role do not conform to what is typically associated with their sex assigned at birth»[3 (p.57)]. It is important to note that: «although the term transgender is commonly accepted, not all transgender and gender nonconforming people self-identify as transgender»[3 (p. 57)]. Consequently, research with transgender populations cannot solely focus on individuals who are transgender women (i.e., individuals who were male assigned at birth and who identify as women) and transgender men (i.e., individuals who were female assigned at birth and who identify as men)[6]. It is widely recognized that the transgender umbrella encompasses a multitude of identities that goes far beyond a binary view of gender identities. For example, Harrison, Grant, and Herman[7] found that 13% of trans respondents in their US sample preferred a different identity than male/ man, female/ woman. Of the 860 written responses, the majority of respondents wrote in part time as one gender or part time another gender, *genderqueer*, or some variation thereof, such as *pangender*, *third gender*, or *hybrid*.

Gender Non-Binary is an umbrella term to describe people for whom the labels "man˝ and "woman˝ are not accurate or are insufficient in characterizing their gender identities. Some Gender Non-Binary people define themselves in relation to the concepts of male/man and female/woman, whereas others do not. Within the broader realm of non-binary gender identities, there are many other specific gender identities, labels and descriptors[8]. Underneath the umbrella term Gender Non-Binary, some people iden-

tify themselves as *Gender Non-Conforming* (GNC). The term Gender Non-Conforming describes people who feel their gender identity does not fully align with their sex assigned at birth. It is also frequently used to describe young children who exhibit an appearance or behaviors that seem to break, bend, or deviate from gender roles expected from boys or girls. Some, but not all, of these young people may eventually grow up to be TGNC[9].

Sex is typically assigned at birth (or before) based on the appearance of external genitalia. Sex is typically categorized as male, female, or intersex. *Intersex* describes a person that has atypical male and female characteristics or a combination of female/male sexual anatomy. There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia. While for most people gender identity is congruent with sex assigned at birth (*cisgender*), for transgender and gender non-binary individuals gender identity differs in varying degrees from their sex assigned at birth. Sexual Orientation refers to the sex of those to whom one is sexually and romantically attracted. Categories of sexual orientation have typically included attraction to members of one's own sex (gay men or lesbians), attraction to members of the other sex (heterosexuals), and attraction to members of both sexes (bisexuals). Although these categories continue to be commonly and broadly used, research has suggested that sexual orientation does not always appear in such definable categories and instead occurs on a *continuum* and can be *fluid* for some people[3].

Gender-affirming care refers to procedures that help align one's body with their gender identity. Many procedures follow under this type of care including hormone therapy, gender-affirming surgeries, gender-affirming mental health care, and puberty blockers. Even though these methods may help some TGNC people with gender dysphoria, it should be noted that not all TGNC people desire or pursue these health interventions. Additionally, some TGNC-identified individuals may not experience gender dysphoria, but they may still desire to access gender-affirming interventions and may still identify as non-binary after receiving such interventions. The complexities around sex and gender affirmation remain the main reason behind the skepticism some TGNC individuals may encounter when meeting health providers. Some TGNC individuals are reluctant to express their desire to medically alter their bodies, particularly when not espousing a more binary gender identity. In these situations, it is possible that a provider will refuse to proceed with gender affirming interventions because the individual is not fitting the medical model of TGNC care based on gender assumptions and biases ("not being trans enough to be approved for services")[9].

Finally, it is important to distinguish the two types of services that TGNC individuals may seek from MHPs. Some clients need to undergo an evaluation process aimed at obtaining physical modifications, such as hormone treatment and surgical procedures. According to current standards of care, the evaluation process is often necessary since MHPs are often asked to write a letter to a specialist (endocrinologist or surgeon) recommending the client for the indicated procedure. In this respect, the MHP is asked to provide *transition-related services*. MHPs involved in this evaluation process need to possess a high level of competence in specific areas such as an advanced level of understanding of gender identity and gender expression, and the transition options available to them. Beyond transition-related services, trans clients may also present for a full range of *psychological service*s (e.g., treatment of mood, anxiety, or substance use disorders) that requires knowledge that exceeds a merely "Trans 101" level of education[10].

What is TGNC-Affirmative Mental Health Care?

TGNC-affirmative Mental Health Care is founded in the core belief that «individuals know themselves». As a derivate of this belief, TGNC-affirmative Mental Health Care seeks to move beyond the traditional *gatekeeping approach* that has been historically used by MHPs when working with TGNC persons. Moving beyond the gatekeeping approach emphasizes the importance of establishing a working alliance with a TGNC person. The goal of the working alliance is to empower the person and affirm they are in charge of their own mental health. Since TGNC-affirmative care is a non-pathologizing approache, goals and aspirations are client-driven. Importantly, the need for the TGNC individuals to both educate their providers due to the MHPs' lack of competence in this specific area as well as the need to fit into a narrow and biased definition of being TGNC are reduced. Nonetheless, these concerns are often reported by the TGNC population and may result in a person choosing to not access regular health care[5]. TGNC affirmative care aims to develop an environment where TGNC people do not have to worry about the way they will be treated by MHPs[9].

Following Singh and Dickey's[9] definition, *TGNC-affirmative counseling and psychological practice* is intended to be: «Counseling that is culturally relevant and responsive to TGNC clients and their multiple social identities, addresses the influence of social inequities on the lives of TGNC clients, enhances TGNC client resilience and coping, advocates to reduce systemic barriers to TGNC mental and physical health, and leverages TGNC client strengths. In short, TGNC-affirmative counseling and psychological practice emphasizes the client's autonomy»[9 (p.4)]. Practicing

with this population also includes establishing a constant collaboration with other professionals (endocrinologists, primary care providers, surgeons, school personnel, and employers)[3]. Deutch[11] suggests that client engagement and retention are improved when health care providers collaborate. The collaboration allows the TGNC individual to feel that their providers are attentive, competent, and respectful. As a result, TGNC clients feel that their needs are heard, and they are a part of the interdisciplinary care team by playing a role in deciding their courses of treatment.

Important documents

Practicing with TGNC clients has evolved significantly over the past 50 years and over time a number of documents have been developed to help assist MHPs in providing competent care. One of the major documents guiding TGNC-affirmative health care is the "Standard of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People" (SoC). This document was first published by the World Professional Association for Transgender Health (WPATH) in 1979 and is now in the seventh edition[10]. These standards provide suggestions, via the Standards of Care, for medical and mental health providers. The history behind the development of this document highlights how science and advocacy combined contributed to the current change of opinions and views around the transgender community. For example, in earlier versions of the SoC, an assumption was made that people who identified as TGNC unanimously wanted to make a medical transition. In later versions of the SoC, it was acknowledged that although a medical transition is desired for many TGNC persons, it does not apply to all the TGNC community. In a similar way, earlier versions of the SoC contained tenants to further medicalize trans-identified individuals by requiring them to undergo a therapeutic assessment to obtain a formal DSM diagnosis of Gender Dysphoria. These therapeutic assessments required, for example, one referral from a mental health professional for hormone therapy and top surgery, and two letters from a mental health professional for bottom surgery. These services were required to occur prior to administering any hormonal or surgical interventions making the path to gender affirming care arduous for TGNC people. The forthcoming Standards of Care version 8 (SoC 8) of WPATH, expected to be released in August 2022, is likely to move towards an informed consent-based model of providing transgender healthcare which means that the needs of a diagnosis of Gender Dysphoria (GD), psychiatric assessment, and letters of recommendations may possibly be removed.

The American Psychological Association (APA) just released in 2021 the *"APA Guidelines for Psychological Practice with Sexual Minority Persons"*[3]. *Sexual minority persons* are a diverse population inclusive of lesbian, gay, bi+ (e.g., bisexual, pansexual, queer, fluid), and asexual sexual orientations. The *Guidelines for Psychological Practice with Sexual Minority Persons* assist psychologists in their work with sexual minority persons and take into account the advances in psychological science and affirmative psychological practice with sexual minority persons. This document contains 16 guidelines for psychological practice with sexual minorities and groups that are organized into five topical sections: (a) foundational knowledge and awareness; (b) impact of stigma, discrimination, and sexual minority stress; (c) relationships and family; (d) education and vocational issues; and (e) professional education, training, and research.

APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People[12]: in 2015, the APA Task Force developed guidelines to assist psychologists in the provision of culturally competent, developmentally appropriate, and trans-affirmative psychological practice with TGNC people. These guidelines are aimed at helping psychologists maximize the effectiveness of services offered and avoid harm when working with TGNC people and their families by practicing in a trans-affirmative way. As stated in the guidelines, *trans-affirmative practice* is the provision of care that is respectful, aware, and supportive of the identities and life experiences of TGNC people. This document contains 16 guidelines for TGNC psychological practice that are organized into five clusters: (a) foundational knowledge and awareness; (b) stigma, discrimination, and barriers to care; (c) life span development; (d) assessment, therapy, and intervention; and (e) research, education, and training.

APA Ethics Code[13] (2017): there is evidence that LGBTQIA+ persons resort to psychotherapy at higher rates than the non-LGBTQIA+ population[14]; hence, they may be at a higher risk for harmful or ineffective therapies, not only as a vulnerable group, but also as frequent consumers. In the APA Code of Ethics, it is possible to find elements that are essential in working with TGNC persons in order to practice in a competent way and avoid harm. A broad range of competence aimed at avoiding causing intentional or unintentional harm to this population can be achieved through continuing education, supervision, and consultation[15].

Gender Dysphoria (DSM-5) & Gender Incongruence (ICD-11)

A person's identification as TGNC can be healthy and self-affirming and is not inherently pathological. However, people may experience distress associated with discordance between their gender identity and

their body or sex assigned at birth, as well as societal stigma and discrimination. TGNC individuals may experience difficulties that the DSM-5[16] define as GD and the ICD-11[17] define as Gender Incongruence (GI).

The diagnosis of *Gender Dysphoria* is the current DSM-5 diagnosis used to initiate treatment for transgender individuals who are seeking medical care related to gender transition. To meet criteria for the diagnosis, a person must have a marked incongruence between their experienced/expressed gender and their assigned gender for at least 6 months of duration. This incongruence is evidenced by a strong desire to get rid of current secondary sex characteristics, a strong desire for sex characteristics of another gender, and a strong desire to be treated as an alternative gender different from one's assigned gender. The condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning[16].

In recent years, there has been an enormous debate around GD. Proponents of maintaining GD as a mental health diagnosis contend that a diagnosis is necessary to guide treatment decisions, determine standard of care eligibility for gender transition services, and assist in establishing research protocols for transgender individuals[6]. Additionally, advocates for the diagnosis requirement contend that insurance reimbursement is reliant on the diagnosis to justify interventions[18]. The other side of the gender dysphoria debate suggest that the diagnostic model undervalues the role of social stigma and discrimination of non-normative gender presentations[6]. This side of the debate believes that the psychological distress experienced by transgender individuals is more influenced by societies response to non-normative gender presentations rather than underlying internal psychological distress (as is suggested in the diagnosis of gender dysphoria)[18]. A contention against the DSM diagnostic model is that those persons who do not report a distress component to their identities or experiences may be determined as inappropriate to receive medical services for not meeting the gender dysphoria diagnostic criteria. For these reasons, transgender individuals may embrace the "distress narrative" in order to minimize barriers to services and treatment[19]. The DSM diagnostic model suggests a core component of a transgender individual's experience is internal personal distress over gender identity and severe body dysphoria. However, evidence suggests that transgender identity is not inherently a cause of distress but can be a *value* among transgender individuals who want to live a satisfying and meaningful life[19,20]. For example, Riggle et al.[20] found that more than 70% of their TGNC sample reported feeling extremely or very positive about being transgender. Therefore, it is not a surprise that some transgender individuals, even after medical interventions such as hormones and surgeries, may embrace and celebrate their transgender identity as a demonstration of ongoing identity development. Other transgender individuals may express that the goal of transitioning is not necessarily to become a "different" gender but is an intentional process of building a *self* that can be authentically queer and acknowledged in the transgender and queer communities.

The diagnosis of *transsexualism* was introduced in the International Classification of Diseases and Related Health Problems in 1978[21] (ICD-9). The diagnosis has also been in great debate over the last few decades. Transexualism was included in the section named "Sexual deviations and disorders" with other paraphilias. In 1992, with the introduction of the ICD-10[22], gender identity disorders became an independent group of disorders of sexual inclination and sexual dysfunctions. In 2018, the World Health Organization (WHO) established itself as a pioneer in the process of depathologizing transsexuality by eliminating the gender identity disorder from the international manuals of mental disorders and no longer considering transsexuality a mental disorder. As a result, the ICD-11 (that came into effect 1 January 2022) removes the term "transsexualism" and replaces it with the term GI[23]. GI is defined as a marked and persistent incongruence between the gender felt or experienced and the gender assigned to birth. This definition is no longer part of the chapter on mental disorders but is part of a new chapter called "conditions related to sexual health". The ICD-11 replaces the state of *distress* associated with that incongruence by the terms *dislike or discomfort* with less psychopathological connotations. Additionally, only two diagnostic criteria must be met without necessarily the individual wanting to get rid of their primary or secondary sexual characteristics of the felt gender. Feeling dislike with the primary or secondary sexual characteristics, along with the desire to be treated and accepted as a person of the felt gender, would be sufficient to make the diagnosis of GI and would not imply the desire to undergo medical-surgical interventions to achieve a gender confirmation. In spite of the advances these diagnostic changes have made for the transgender community, the name itself "conditions related to sexual health" may create confusion between the two realities sex/gender since the ICD-11 refers exclusively to sex and not to gender. This ambiguity may be problematic because this ICD-11 chapter, in addition to including GI, also contemplates sexual dysfunctions, which until now have also been considered mental disorders. More so, the ICD-11 has not completely depathologized transsexuality as was done with homosexuality. GI continues to be part of a chapter of the manual and therefore a diagnosis within sexual health. The WHO justifies the

maintenance of this diagnosis by suggesting that recipients of medical assistance interventions (harmonization and surgery) require the diagnosis[23].

Theoretical Frameworks for TGNC Affirmative Care

When developing TGNC-affirmative care for TGNC individuals, MHPs should ensure that their assessments, interventions, and advocacy are grounded in TGNC-affirming theories. According to different research on this topic, when developing TGNC-affirmative care, MHPs may find useful to incorporate theoretical perspectives from: 1) the *Minority Stress Model*[24,25], 2) *Trauma Counseling Principles*[26], 3) *Strength-Based and Resilience Approaches*[12], and 4) *Multiculturalism and Social Justice Advocacy Approaches*[27].

1. *Minority Stress Model*: Meyer[24] described three processes by which LGBT people are subjected to minority stress. First are the environmental and other external events that take place in a person's life as a result of that person's minority status (LGBT). These events create overt stress in the person's life and can be defined as objective, since they are observable and verifiable. They are also the distal sources of stress to the individual (i.e., discrimination and threats to the person's safety or security). The second set of processes are the individual's anticipation and expectation that external stressful events will occur. The consequence of this expectation is represented by the vigilance that the person must develop to cope with it. As a result of this vigilance, TGNC people may expect rejection or more serious consequences such as accusations or attacks because of their sexual minority status. Consequently, the TGNC individual attempts to hide their identity in order to protect themselves from psychological or physical harm. These attempts to hide one's identity create additional distress. This process is more proximal because it involves an intricate interaction between the individuals and their environment. Third are the processes in which negative attitudes and prejudices from society are internalized, resulting in the most proximal of the three processes. This is the concept of *internalized homophobia* as result of the person's direction of negative social attitudes toward the self[28]; for trans people, the epitome of this is *internalized transphobia* (i.e., discomfort with one's own TGNC identity due to the internalization of society's normative gender expectations)[29]. Meyer delineated the various pathways by which these processes contribute to an increased level of psychopathology, including substance abuse and dependence, mood disorders and suicidal ideation and attempts[25].
2. *Trauma Counseling Principles:* TGNC people experience high rates of traumatic life experiences including prejudice when accessing education, employment, health care and housing. Moreover, TGNC people are too often victim of *micro and macroaggressions* that may lead to negative health outcomes such as depression, anxiety, suicide attempts, and substance abuse. Comparing to the general population, TGNC individuals are more likely to experience reoccurring traumatic experiences[30], which increases their vulnerability to develop posttraumatic stress disorder (PTSD). The PTSD diagnosis does not acknowledge microaggressions as an insidious traumatic stressor (for example, recurring exposure to transphobia and other forms of oppression). In the health care system, examples of such microaggressions[31] might be automatically assuming that a client is heterosexual, trying to explain the etiology of the client's gender identity, or focusing on the sexual orientation of a client despite the fact that this is not an issue at hand. Over time, the cumulative effects of insidious traumas can increase the likelihood of developing PTSD and/or complex PTSD[32]. *Complex PTSD* (CPTSD) is a way to conceptualize trauma reactions following prolonged and repetitive trauma stressors. The diagnosis of CPTSD better captures the damaging psychological effects of chronic and long-term exposure to trauma. In addition to PTSD symptoms, CPTSD underscores the change in self-concept and worldview (changes in identity and relationships) that can occur following prolonged exposure to trauma. Finally, a distinctive component of CPTSD is that injury is regularly caused by a trusting person (e.g., family members) resulting in betrayal trauma. This better describes TGNC experiences because their first experiences of trauma usually occur in their family of origin.
3. *Strengths-Based Approaches to overcome Stigma and enhance Resilience*: the literature contains very few studies on the coping and resilience effects of identification with minority group members for trans populations. As Meyer[25] pointed out, the effects of minority stress can also be positive. Specifically, stress positives can be found by minority member coalescing around a minority identity. In these instances, minority members avail themselves of «important resources such as group solidarity and cohesiveness that protect minority members from the adverse mental health effects of minority stress»[25 (p.677)]. One way that minority members accomplish cohesiveness is by creating a within-group identity against which they may then compare themselves. In this process, minority members begin to «evaluate themselves in comparison with others who are like

them rather than with members of the dominant culture»[25] (p.677). Moreover, as a group, minority members can create a positive view of themselves that effectively counteracts stigma. In a more recent qualitative study, Singh and McKleroy[33] interviewed 11 ethnic minority trans persons who had all experienced traumatic events. This was a phenomenological investigation of the resilience strategies employed to cope with trauma. Six themes emerged that were common to all participants: «(a) pride in one's gender and ethnic/racial identity, (b) recognizing and negotiating gender and racial/ethnic oppression, (c) navigating relationships with family, (d) accessing health care and financial resources, (e) connecting with an activist transgender community of color, and (f) cultivating spirituality and hope for the future»[33] (p.5). Similarly, Bockting et al.[34] assessed the association between minority stress, mental health, and potential ameliorating factors in a large, community-based, geographically diverse sample of the US transgender population. Their hypotheses were that: 1) the minority stressors of felt stigma, enacted stigma, and concealment of transgender identity (investment in passing as a member of the opposite gender and living highly closeted) would be negatively associated with mental health and 2) that this association would be moderated by factors of resilience such as family, peer support, and identity pride. In comparison with norms for non-transgender men and women, their transgender sample had disproportionately high rates of depression, anxiety, somatization, and overall psychological distress. The reported distress was associated with enacted and felt stigma and not with gender dysphoria. They found that enacted and felt social stigma was positively associated with psychological distress and that family support, peer support, and identity pride all were negatively associated with psychological distress. This finding confirms that these assets are protective factors and an important source of resilience in the face of discrimination.

4. *Multiculturalism:* since clients' cultural backgrounds have important influences on their mental health and overall well-being, multicultural counseling must be an integral part of TGNC-affirmative practice. Multiculturalism includes being aware of the varying roles or identities the TGNC person may experience. Thus, developing multicultural competencies mean that MHPs need to develop awareness, knowledge, and skills to be able to work with this population. One important aspect when working with TGNC individuals is for MHPs to develop awareness about how their own culture, attitudes, gender identity, gender training, and gender journey influence their beliefs and attitudes towards TGNC people and, as a consequence, how they practice with this population. Furthermore, the role of *social justice and advocacy* should be integrated as new competency dimensions when working with this population[3,9].

Barriers to treatment and overcoming treatment barriers

Even with growing awareness of the benefits related to gender-affirming care, many TGNC individuals encounter significant challenges and barriers in pursuing health services. In order for TGNC people to access medical and surgical services, they must undergo a complex mental health diagnostic process that relies on criteria set by the American Psychiatric Association (APA) and the World Professional Association of Transgender Health (WPATH). Additionally, TGNC persons usually report trauma histories and negative expectancies about reactions to their trans identity status in health service encounters. Various studies have demonstrated that trans individuals are subject to negative life events directly related to their gender variance and that these events have potentially dire mental health effects[35].

Furthermore, TGNC individuals find themselves in front of multiple obstacles while navigating the health care systems that regulate gender-affirming care. For example, Puckett et al.[36] found that 256 TGNC individuals who had undergone different forms of gender-affirming care experienced barriers such as financial, insurance, and employment. Additionally, they also found other barriers to be: lack of service availability, fears/worries of rejection, verbal harassment, lack of medical provider awareness, age and need of parental consent for minors, other medical issues interfering with service enrollment, concerns about quality, and a lack of information about how to acquire care.

Stemming from these concerns, the *Informed Consent model* (IC) for gender-affirming treatment is a developing approach aimed at finding ways to overcome these barriers and facilitate TGNC access to gender-affirming care. The informed consent model holds that gender variance is non-pathological and affirming care is medically necessary[37]. This model seeks to better acknowledge and support individuals' personal autonomy in choosing care options without the requirement of external evaluations or therapy by MHPs. This model requires that MHPs effectively communicate anticipated benefits and potential risks of treatment, as well as reasonable alternatives to that treatment. In this way, this approach reflects a reconceptualization of the role of the MHP as a gender specialist, an advocate, and educator for transgender people and their families utilizing a non-pathologiz-

ing assessment process[38]. Integral to the informed consent model is the principle of respect for a person's right of self-determination, and the belief that clinicians will work to facilitate patients' decisions about the course of their own lives and care. According to the Informed Consent model, an individual who identifies as TGNC should not have to prove distress about identity or substantiate diagnostic criteria in order to gain access to desired health services. However, they must "possess the cognitive ability to make an informed decision about health care," including voicing an understanding of the risks, benefits, and information needed to make an informed decision about moving forward with medical services related to transition.

The IC model has been investigated in recent years and the results of this growing body of research are promising. Dewey[35] investigated decision-making among medical and therapeutic professionals who work with trans-identified persons to understand factors that might impede or facilitate the adoption of a collaborative decision-making model in their clinical work. Collaborative models of shared decision-making and informed consent reflect a shared professional and patient decision-making process, shared ownership of information, treatment options and responsibility for outcomes, as well as re-evaluation of conditions until they agree on the resolution. The results of this investigation found barriers in doctors and therapists' desire for collaboration with trans-identified individuals. Barriers include lack of formal education, little to no institutional support and inconsistent understanding and application of the DSM and SoC.

Shuster[39] examined how medical providers negotiate informed consent processes in their clinical encounters with trans patients. The author demonstrated that many providers of "trans medicine" give voice to following informed consent but fail to actually practice it in their work with trans patients. Shuster found that providers attempting to follow the informed consent model usually revert to a paternalistic model of care, which amplifies their medical authority while veiling power differentials in their practice.

Further, Tomson[40] compared the gatekeeping model and the informed consent model of providing gender-affirming care. The comparison is in terms of the four fundamental "pillars" of medical ethics, namely respect for autonomy, non-maleficence, beneficence and distributive justice. If access to care is gatekept by service providers, their gatekeeping can be considered a violation of the principle of respect for autonomy. Furthermore, it can be argued that since access to medical transition improves outcomes (e.g., minimizing suicide risk) for transgender persons, limiting access to these interventions can be seen as harmful and a violation of the principle of non-maleficence. Gatekeeping is cited as a barrier to accessing care, which can be deleterious to some transgender individuals, and possibly violate the principle of beneficence. Finally, within the gatekeeping model of access to care, it is the healthcare provider who ultimately assesses whether a patient will gain access to healthcare. Where in an informed consent approach, equity and fairness are promoted allowing patients to decide on their own healthcare. By refusing to prejudice a patient's right to access care based on such factors as race, social class, finances or genetics, the integrity of the principle of justice is respected and maintained.

Deutsch[41] published the results of a convenience sample survey of several clinical sites using the IC approach in the United States. The aims of this research were to (a) survey practice characteristics of clinics utilizing the IC care model, (b) assess potential legal risks to clinics utilizing the IC care model, and (c) assess for any known cases of regret by patients with respect to cross-sex hormone therapy (csHT). The results of the survey were the following: only seventeen known cases of regret were reported across all sites; no cases of malpractice claims or judgments relating to regret about the use of csHT were reported; and very little requests of contacts with a mental health provider prior to initiation of csHT were made.

Additionally, Reisner et al.[42] reported on Fenway Health, a Boston community health center that developed a multidisciplinary model of transgender healthcare, research, education, and dissemination of best practices. In 2007, Fenway Health implemented a modified informed consent model for cross-sex hormone therapy which pioneered the dissemination of an accessible, holistic, gender affirming, and multidisciplinary model of transgender care. Their informed consent model removed restrictions such as specifying prolonged mental health evaluations and "real life tests" (i.e., living full-time in one's self-identified gender) to obtain hormone therapy. At Fenway Health, transgender patients were asked to complete a hormone readiness assessment before accessing gender affirmation services, but mental health counseling was not automatically required.

Lastly, Spanos et al.[43] performed a retrospective audit of all new patients with a transgender or gender diverse identity presenting to a primary care clinic in Melbourne, Australia. This primary care clinic practices an Informed Consent model of care to initiate Gender-Affirming Hormone Therapy (GAHT). The Informed Consent model of GAHT removes the requirement for formal psychiatric approval before accessing GAHT to a shared decision-making process between the patient and their treating health provider. Typically, the primary treating provider will initiate GAHT as long as the patient is able to fully understand the potential benefits, known risks and unknown risks of GAHT, and has capacity to provide

consent. Secondary referral to mental health professionals to provide counseling may have occurred but was not mandated. Spanos et al. found there was a longer time between initial consultation and initiation of GAHT in people referred for a mental health assessment compared with those assessed solely by their General Practitioner (GP). Overall, patients were highly satisfied with their care at the clinic, with those undergoing assessments solely by their GP significantly being more likely to report that they were "extremely satisfied" with the process compared with those who underwent formal mental health assessment before initiation of GAHT.

Training protocols

LGBTQIA+ and TGNC people seek psychotherapy at higher rates compared with their heterosexual and cisgender counterparts, but often report dissatisfaction with health services due to limitations of practitioner knowledge and skills in LGBTQIA+ and TGNC-related issues. Despite this, remarkably little research has investigated the effects of therapist training in LGBTQIA+ and TGNC-affirmative psychotherapy. One exception is the study that Pepping et al.[44] conducted in order to examine the effectiveness of a training protocol for LGBTQIA+ affirmative psychotherapy with mental health professionals. The training protocol was developed based on theoretical and empirical work on LGBTQIA+ and TGNC-affirmative psychotherapy. Across all outcomes, therapists reported increased knowledge and skills related to working with LGBTQIA+ clients following the training. Therapists also displayed reductions in homo-negativity and trans-negativity, demonstrated improvements in their capacity to form a supportive therapeutic relationship and an increased capacity to conduct appropriate assessment.

Furthermore, the need for guidelines that can support other programs and MHPs are necessary for the continued improvement in health practice with TGNC persons. The guidelines that are being offered in this article are expanding Singh & Dickey's[9] and Lev's[45] list of recommendations for MHPs working with transgender individuals. The following guideline areas are proposed for providers in ensuring TGNC affirmative practice.

Avoid transnormative narratives: suggests the need to avoid dominant narratives about what it means to be transgender. As stated by Riggs et al.: «The transformative narrative emphasizes a particular and narrow set of tropes to which all transgender people are expected to adhere»[46 (p.913)]. *Keep an open mind*: encourages active listening, understanding, and willingness to learn about each TGNC persons' unique identity and needs. *Engage in self-examination*: Brown noted that «heterosexual bias in counseling and psychotherapy may manifest itself in sexual orientation blindness»[47 (p.350)]. Sexual orientation blindness is the struggle for a supposed neutrality and dismissal of the specificities of the minority condition of non-heterosexual clients. *Do not assume a destination*: suggests that not all non-binary individuals set "passing" as their ultimate goal. *Prioritize client self-determination over MHP frustration, confusion, opinion*: informs that nonbinary clients are not responsible to educate their MHPs, or to assist in the understanding of the MHPs' frustration or confusion about clients' gender identities and expression. *Be aware that social presentation or transition may be nuanced and complex*: suggests that nonbinary individuals demonstrate varying levels of disclosure depending on multiple factors such as safety, contexts, type of relationship and environment. *Understand barriers and be willing to advocate for clients*: informs that advocating on behalf of the TGNC person is an integral aspect of MHPs' competence. *Make sure to hit all the most relevant points while conducting initial assessments and throughout the whole treatment process*: requests MHPs to consider the impact of minority stress on TGNC's psychologies as well as culture, race, ethnicity, age, disability status, residence location, personal history, trauma, immigration status, and access to services. *MHPs' who work with trans clients may need to spend some time in the assessment process clarifying their position with regard to psychopathology and its relationship to transition*: it is imperative for psychologists to be aware that TGNC individuals often are informed that certain types or levels of psychopathology can interfere with obtaining a letter of recommendation for medical transition thus they may not disclose an accurate history for fear of being denied access to affirming services. *MHPs' can be helpful by increasing awareness of the available opportunities for their clients' engagement with the trans community and supporting their clients' accessing resilience factors through such involvement*: informs that minority group members can access "group-level coping" through engaging with and identifying with other members of their minority group. Community engagement allows for feelings of belongingness, feelings of connectedness, and accessibility to other affirming individuals.

Conclusions

The limitations of this article will be outlined to provide future areas of inquiry for TGNC-affirmative care. A limitation that emerged is within the assessment of TGNC persons. The current state of literature does not appear to identify specific assessment tools to address Minority Stress Model factors in trans individuals. How-

ever, Bockting et al.[1-29-34] have provided a framework for the exploration of Minority Stress within the TGNC population. Another limitation that emerged is the assumption of homogeneity in experience for TGNC persons. Currently within research and advocacy, the TGNC population have been combined into one entity. The assumption of uniformity is a disservice to the TGNC population. The TGNC community experiences are not uniform and are shaped by: race, ethnicity, primary language, socioeconomic status, geographical location, age, disability status, and other factors. Therefore, the heterogeneity of the TGNC lived experience is encouraged to be explored. The current research does not appear to provide answers to questions such as: is an affirmative approach the same for all the subpopulations within the umbrella term, including youth? How do culture and ethnicity impact the TGNC therapeutic experience? What about persons of color from a variety of socioeconomic statuses and generations? Another limitation that emerged from the literature regards different theoretical approaches having a different impact on the practice of gender-affirming care. In consideration of TGNC-affirmative care training, there are many courses and workshops aimed at helping MHPs practice in an affirming way with this population, but these trainings are varied. There is little research addressing the effectiveness of these training protocols. Moreover, who trains these practitioners? Are there specific trainings or supervision techniques that help clinicians to be more effective with specific subgroups? Another area of limitation that emerged is the consideration of treatment of TGNC persons in hospital settings and other health care systems. The questions that emerged for hospitals and other health care systems are: how can hospitals and institutions be supportive of affirmative practices and overcome the ethical considerations and legal aspects of practicing gender-affirmative care? How can this way of practicing fit into different health care systems in different countries?

In spite of these limitations, it is vital to emphasize the role of specific training and supervision in the development of clinical competence in the work with sexual minorities. Several authors (e.g., Pachankis and Goldfried)[47] have argued for the importance of continuous education and training of practitioners in individual and cultural diversity competences, across professional development. Continuous education and training are aligned with American Psychological Association ethical guidelines (APA 2000, 2012), and is even more relevant as we acknowledge the significant and recent changes in the research and practice with TGNC individuals. Furthermore, it is founded on the very notion that LGBTQIA+ and TGNC competence assumes clinicians need to be aware of their own personal values, attitudes and beliefs regarding human sexuality and gender diversity in order to provide appropriate care. These ethical concerns, however, have not been translated into training programs in medicine and psychology in a systematic manner in most countries. It is important to remember that: «Everyone has a right to their own gender expression; Everyone has the right to access medical, therapeutic, and technological services to gain the information and knowledge necessary to make informed and educated decisions about their own bodies and lives»[6 (p.185)]. Lastly, as Dewey[35] noted in one of their papers: «Trans variant individuals' most troubling experiences of discrimination were in navigating the medical and psychiatric systems… Medical knowledge is often thought to be objective, static, and based on "scientific" findings. However, in the area of transgender health care, we find psychiatric and medical knowledge is hotly debated and continually revised. So many changes have occurred in the last 30 years that we can see the social construction of transgender medical knowledge unfold before our eyes. Stereotypes about gendered and sexed embodiments, as well as the benevolence we attribute to doctoring, often obscure the historical processes through which they are produced. To ensure human rights and cease the dehumanization of trans people, we need to critically analyze how medical knowledge and the ways providers make decisions further regulate trans bodies even while simultaneously providing trans people with much desired legitimacy»[35 (p.2)].

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References

1. Bockting WO. Transforming the paradigm of transgender health: a field in transition. Sexual and Relationship Therapy 2019; 24: 103-7.
2. American Psychological Association. Task force on gender identity and gender variance. Report of the task force on gender identity and gender variance. Washington, DC: American Psychological Association, 2009.
3. American Psychological Association. APA Task force on psychological Practice with sexual minority persons. Guidelines for psychological practice with sexual minority persons. 2021.
4. Motmans J, Nieder TO, Bouman WP. Transforming the paradigm of nonbinary transgender health: a field in transition. Int J Transgend 2019; 20: 119-25.
5. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. Injustice at every turn. A report of the National Transgender Discrimination Survey. Washington: National center for transgender equality and National gay and lesbian task force, 2011
6. Lev AI. Transgender emergence: therapeutic guidelines for working with gender-variant people and their families. London: Routledge, 2013.
7. Harrison J, Grant J, Herman JL. A gender not listed here: genderqueers, gender rebels, and otherwise in the National Transgender Discrimination Survey. LGBTQ Public Policy Journal at the Harvard Kennedy School 2012; 2: 13.
8. Wilchins RA. Queer Bodies. In: Nestle J, Howell C, Wilchins H (eds). Genderqueer: voices from beyond the sexual binary. Los Angeles, CA: Alyson, 2002.
9. Singh A, Dickey LM. Affirmative counseling with trans-

gender and gender nonconforming clients. In: DeBord KA, Fischer AR, Bieschke KJ, Perez RM (eds). Handbook of sexual orientation and gender diversity in counseling and psychotherapy. Washington, DC: American Psychological Association, 2017.
10. Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. International Journal of Transgenderism 2012; 13: 165-232.
11. Deutsch MB. Use of the informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of selected clinics. International Journal of Transgenderism 2012; 13: 140-6.
12. American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. American Psychologist 2015; 70: 832-64.
13. American Psychological Association. Ethical principles of psychologists and code of conduct. American Psychologist 2002; 57: 1060-73.
14. King M, Semlyen J, Killaspy H, Nazareth I, Osborn D. A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual & transgender people. Lutterworth, UK: British Association for Counselling and Psychotherapy, 2007.
15. Singh AA. Transgender youth of color and resilience: negotiating oppression and finding support. Sex Roles 2013; 68: 690-702.
16. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Washington, DC: American Psychiatric Association, 2013.
17. WHO. International classification of diseases for mortality and morbidity statistics (11th Revision). 2019.
18. Schulz SL. The informed consent model of transgender care: an alternative to the diagnosis of gender dysphoria. J Humanist Psychol 2018; 58: 72-92.
19. Waszkiewicz E. Getting by Gatekeepers: transmen's dialectical negotiations within psychomedical institutions. Thesis, Georgia State University, 2006.
20. Riggle E, Rostosky S, McCants L, Pascale-Hague D. The positive aspects of a transgender self-identification. Psychol Sex 2011; 2: 147-58.
21. World Health Organization. International classification of diseases: [9th] ninth revision, basic tabulation list with alphabetic index. 1978.
22. World Health Organization. The ICD-10 classification of mental and behavioral disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization, 1992.
23. Rodríguez MF, Granda MM, González V. Gender incongruence is no longer a mental disorder. Journal of Mental Health & Clinical Psychology 2018; 2: 6-8.
24. Meyer IH. Minority stress and mental health in gay men. J Health Soc Behav 1995; 36: 38-56.
25. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull 2003; 129: 674.
26. Briere JN, Scott C. Principles of trauma therapy: a guide to symptoms, evaluation, and treatment (DSM-5 update). Thousand Oaks, California: Sage Publications, 2014.
27. Sue DW, Arredondo P, McDavis RJ. Multicultural counseling competencies and standards: a call to the profession. Journal of Counseling & Development 1992; 70: 477-86.
28. Meyer IH, Dean L. Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In: Herek GM (ed). Stigma and sexual orientation: understanding prejudice against lesbians, gay men, and bisexuals. Thousand Oaks, California: Sage Publications, 1998.
29. Bockting W. Internalized transphobia. In: The International Encyclopedia of Human Sexuality. Hoboken, NJ: Wiley-Blackwell, 2015.
30. Mizock L, Lewis TK. Trauma in transgender populations: Risk, resilience, and clinical care. Journal of Emotional Abuse 2008; 8: 335-54.
31. Sue DW. Microaggressions in everyday life: race, gender, and sexual orientation. Hoboken, NJ: John Wiley & Sons, 2010.
32. Herman JL. Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. J Trauma Stress 1992; 5: 377-91.
33. Singh AA, McKleroy VS. "Just getting out of bed is a revolutionary act" The resilience of transgender people of color who have survived traumatic life events. Traumatology 2011; 17: 34-44.
34. Bockting WO, Miner MH, Swinburne Romine RE, Hamilton A, Coleman E. Stigma, mental health, and resilience in an online sample of the US transgender population. Am J Public Health 2013; 103: 943-51.
35. Dewey JM. Challenges of implementing collaborative models of decision making with trans-identified patients. Health Expectations 2015; 18: 1508-18.
36. Puckett JA, Cleary P, Rossman K, Mustanski B, Newcomb ME. Barriers to gender-affirming care for transgender and gender nonconforming individuals. Sex Res Social Policy 2018; 15: 48-59.
37. Lipshie-Williams M. The peculiar case of the standards of care: ethical ramifications of deviating from informed consent in transgender-specific healthcare. Journal of Gay & Lesbian Mental Health 2020; 24: 392-405.
38. Cavanaugh T, Hopwood R, Lambert C. Informed consent in the medical care of transgender and gender-nonconforming patients. AMA J Ethics 2016; 18: 1147-55.
39. Shuster SM. Performing informed consent in transgender medicine. Soc Sci Med 2019; 226: 190-7.
40. Tomson A. Gender-affirming care in the context of medical ethics-gatekeeping v. informed consent. S Afr J Bioeth Law 2018; 11: 24-8.
41. Deutsch MB. Use of informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of select clinics. Int J Transgend 2011; 13: 140-6.
42. Reisner SL, Bradford J, Hopwood R, et al. Comprehensive transgender healthcare: the gender affirming clinical and public health model of Fenway Health. J Urban Health 2015; 92: 584-92.
43. Spanos C, Grace JA, Leemaqz SY, et al. The informed consent model of care for accessing gender-affirming hormone therapy is associated with high patient satisfaction. J Sex Med 2021; 18: 201-8.
44. Pepping CA, Lyons A, Morris EM. Affirmative LGBT psychotherapy: outcomes of a therapist training protocol. Psychotherapy 2018; 55: 52.
45. Lev AI. Transgender emergence: therapeutic guidelines for working with gender-variant people and their families. London: Routledge, 2013.
46. Riggs DW, Pearce R, Pfeffer CA, Hines S, White F, Ruspini E. Transnormativity in the psy disciplines: constructing pathology in the Diagnostic and Statistical Manual of Mental Disorders and Standards of Care. American Psychologist 2019; 74: 912.
47. Brown LS. The neglect of lesbian, gay, bisexual, and transgender clients. In: Norcross JC, Beutler LE, Levant R (eds). Evidence-based practices in mental health: debate and dialogue on the fundamental questions. Washington, DC: American Psychological Association, 2006.
48. Pachankis JE, Goldfried MR. Clinical issues in working with lesbian, gay, and bisexual clients. Psychotherapy: Theory, Research, Practice, Training 2004; 41: 227.

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