Transgender Literature Review & SOAP Note

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There are many misconceptions about being transgender. Much of this confusion comes from misgendering, misdiagnosing, and the broad array of people linked with transgender. The basic definition of transgender refers to individuals who identify with a gender different from their biological sex (Morris et al., 2020). Often, counselors use this definition for all gender diversity, but not all gender diverse individuals identify as trans (Knutson & Koch, 2018). For this short review, gender nonconformity and gender identity are treated as separate entities, as gender expression (behavior) and identity (internal belief) are not the same (Knutson & Koch, 2018), however interrelated they are. Sexual orientation, which is also incorrectly applied to many trans and gender non-conforming individuals (Morris et al., 2020), will not be discussed outside of its inclusion in the LGBTQ+ community.

Gender nonconformity, at its most basic, is how a person expresses their gender (Adelson et al., 2016). This expression could include natal males preferring to play with dolls or a natal female who likes rough-and-tumble play. Later in life, this expression could become changing one's appearance to match an opposing gender. Gender identity, on the other hand, is a person's internal sense of gender (Adelson et al., 2016). Gender dysphoria is the distress caused by incongruence between one's biological sex and gender identity (Adelson et al., 2016).

The diagnostic criteria for gender dysphoria are a marked disparity between experienced or expressed gender and assigned gender, for at least six months and cause significant distress to the client. The incongruence must manifest in a strong belief that ones gender is wrong, various cross-gender expressions (e.g., preferred activities, playmates, and rejection of activities typical for assigned gender), a strong dislike for one's sexual anatomy, and a strong desire for primary or secondary sex characteristics that match ones gender identity (American Psychiatric Association,

2013). Typically, Hormone Replacement Therapy (HRT) and Gender Affirmation Surgery require a diagnosis of gender dysphoria and, possibly, a referral letter from a mental health professional before authorizing the treatment (Transgender hormone therapy, 2020). Full transitions are the extreme in many transgender cases but are frequently due to the interpersonal and systemic pressures and stigmas to be physically congruent with one's expressed gender.

Transgender individuals are at a much higher risk of developing comorbid issues like depression, anxiety, substance use, and suicidality (Adelson et al., 2016), as well as disruptive and impulse-control disorders (APA, 2013). They are also a much higher risk of harassment, physical altercations, and sexual assault than their cis counterparts (Morris et al., 2020). There are a couple of theories that try to explain the cause of these disparities. The first is the minority stress model. The other is the self-stigma model.

The minority stress model postulates that minorities experience daily stressors like microaggressions, stigmas, prejudice, and discrimination, based solely on their alternative gender identities (Morris et al., 2020). These stressors, thought to cause the mental health disparities seen in the LGBTQ+ community, are believed to be unique, chronic, and socially based (Hatzenbuehler & Pachankis, 2016). These actions can be overt (e.g., bias-based hate crimes) or covert (e.g., unintentionally misgendering), but the result remains the same. The hostile environment creates an unbearable living situation for the stigmatized person (Morris et al., 2020) with may result in maladaptive coping mechanisms (Knutson & Koch, 2018).

The self-stigma model takes this one step farther and posits that, over time, daily prejudice in any form becomes internalized, and the stigmatized individual begins to conceal their expressed identity and to self-hate (Corrigan et al., 2013). Those who self-stigmatize are more likely to experience a significant loss of self-esteem and self-efficacy (Hatzenbuehler &

Pachankis, 2016). Further, Hatzenbuehler and Pachankis (2016) state that the internalization of a social stigma harms emotional health because of the stigma's perceived legitimacy threatens the person's identity. For example, internalized transphobia is correlated with increased lifetime suicide attempts in trans adults (Hatzenbuehler & Pachankis, 2016). Therefore, it seems likely that most of the comorbid issues concurrent with being transgender have nothing to do with the individual, but the environment in which that individual exists.

According to Morris et al. (2020), 77% of respondents to *The Report of the 2015 U.S. Transgender Survey* said they wanted to attend counseling or therapy, but just over half of these reported going. So, how does one treat an individual who presents as a transgender person with mental health issues? Though empirical studies of evidence-based treatments are lacking (Morris et al., 2020), in theory, Rogerian, or person-centered, therapy seems like it would be a good fit for someone working through gender identity issues while also trying to tackle the internalized social stigmas of their status.

Person-centered (PC) therapy tends to work well with those who are different from societal norms (Knutson & Koch, 2018), as the central tenet of PC therapy is congruence. To be congruent, one's perceived self and experienced self must be in alignment (Murdock, 2017). A person struggling with gender dysphoria is the definition of incongruent, as their distress comes from the disparity of their perceived gender and assigned gender. This incongruency causes anxiety, self-loathing, and psychological distortion (Murdock, 2017). A person who is congruent with their authentic self, allows that self to shine through, regardless of the feedback they receive from others (Knutson & Koch, 2018).

Another tenet of PC therapy is an environment of unconditional positive regard and acceptance (Murdock, 2017). This means that the counselor creates an unconditionally accepting,

affirming, non-biased, and empathetic environment within the session and the therapeutic relationship. For many transgender individuals, a session like this may be the first time they have been allowed to express as they wish and been accepted (Knutson & Koch, 2018). The hope then becomes that, as the client becomes comfortable with the acceptance, they seek it outside of the safety of the therapeutic alliance (Knutson & Koch, 2018).

A final tenant of person-centered therapy is that sessions are client-lead (Knutson & Koch, 2018). In other words, the counselor sits back and lets the client dictate what they want to discuss, with little interference. Basically, the counselor is an educated friend who is helping the client along their journey. Rather than working to overcome problems, the PC counselor helps to peel back the layers and get to the heart of the dysfunction (Murdock, 2017). When working with a transgender client, this dysfunction is believing that they are, in fact, dysfunctional just because they are different (Knutson & Koch, 2018).

To that end, a PC counselor must also be aware of their own biases and prejudices, so as to not unintentionally oppress the client (Knutson & Koch, 2018). Rogerian belief in continual self-awareness for the counselor (Murdock, 2017) forces them to look at their personal biases, so as to be genuine with the client. This cannot happen if an implicit bias exists. In many ways, this theory is ideal when avoiding ethical violations and microaggressions within the therapeutic relationship, as well.

Unfortunately, as previously noted, there is not a lot of empirically based literature on treating transgender clients. Most of the current research is involved in explaining the why of transgender expression, rather than worrying about treating the person experiencing it. There are, of course, competencies and ethical guidelines that must be met, but outside of that, evidence-based treatments are in their infancy. Future studies should consider using person-center therapy

as primary, affirming therapy for outcome research, as its central tenets revolve around unconditional client affirmation and overcoming external expectations. Systemic campaigns of tolerance, targeting social expectation and categorizing, would likely be beneficial as well. Eventually, people will accept that no everyone fits into a category, but until then, it is up to the counselors of the world to help transgender individuals understand that they are not dysfunctional. They are who they are supposed to be, beautiful souls who break the mold.

SOAP NOTE

Subjective

Rachel presents as a 9-year-old transfemale, in the early stages of transition. Rachel was born Ryan. At 2 ½ years old, Ryan began exhibiting gender nonconforming characteristics. At 3, Ryan attempted a penectomy with a pair of unopened nail clippers because he "it did not belong there". At 4, Ryan became depressed and began withdrawing from any situation that would force him to gender express as a boy. In kindergarten (age 5), his main playmates were girls and he preferred to wear his sister's hand-me-downs, rather than his masculine clothing. At 6, Ryan expressed his anger at God for not fixing His mistake of not making Ryan a girl. Ryan also began exhibiting anxiety and suicidal ideation, in addition to his depressed mood. His father was unaccepting of Ryan's gender expression and desired to mold him into a boy. This created tension between the parents, as the mother was accused of encouraging Ryan's gender nonconformity.

After finding a pediatric doctor who specialized in gender issues, Ryan was diagnosed with Gender Identity Disorder (GID). Ryan's parents finally agreed to allow him to begin his transition. He began to grow his hair longer, wear feminine clothes, and go by the name Reggi. At age 7, Reggi's parents were ready to begin using feminine pronouns. Reggi began to excel socially and at school and proved to be a resilient child. To reduce the amount of misgendering and bullying, Ryan's name was legally changed to Rachel in 2005. Rachel's parents have also left the ball in her court, so to speak, as far as future transitions.

Objective

Rachel is a happy, healthy 9-year-old girl. She is resilient, tests well academically, and has friends. She is engaged and, currently, comfortable with her identity.

Assessment

According the diagnostic criteria at the time, Rachel was diagnosed with GID by her pediatrician. The DSM criteria has since changed to Gender Dysphoria, to reduce the stigma and pathology of having an identity disorder (Heffernan, 2012). There is more than enough evidence to maintain the Gender Dysphoria diagnosis (APA, 2013). The family should be made aware of this diagnostic change and have the differences between the diagnoses explained. Rachel's mood should be monitored, and suicidal ideation ruled out, due to her previous struggles with it. However, it seems that feminine gender expression has reduced these symptoms.

Plan

Future sessions with Rachel should focus on furthering her congruence using person-centered therapy, building a relationship of unconditional positive regard to overcome external pressures to express as her biological sex and internal confusion as puberty hits. Schedule some psychoeducational family sessions, especially including her father, so that everyone can understand and support the challenges that she is currently facing and those she will face in the future. Work with Rachel's school to understand and help maintain their stance on gender expression bullying, so that she has multiple safe places as she needs them. As Rachel enters puberty, reassessment of the current plan must occur, if she decides her needs have changed.

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