Beginning Practice with Preoperative Male-to-Female Transgender Clients

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ABSTRACT. Preoperative male-to-female transgender clients often present with specific and unique psychological and social issues distinct from gay male and lesbian clients. Therapists must be ready to assess and help diagnose these in preparation for work with gender queer clients. Therapists must also be prepared to face and resolve the various countertransference dynamics inherent in therapeutic relationships with transgendered individuals. This Practice Note focuses on the author's beginning clinical and social case management experience working with two preoperative male-to-female transgender individuals.

KEYWORDS. Transgender, gender queer, gender identity disorder, psychotherapy, countertransference, psychosocial factors

I am a psychotherapist in New York City with a practice largely comprised of gay men. When I began working with gender queer clients, I

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felt I lacked specific knowledge on this population's psychological and social issues. This paper reflects my professional curiosity as an openly gay therapist to explore and share clinical issues that arose in the early phase of treatment with two preoperative male-to-female transgender clients. I welcome any comments, suggestions, and feedback to help broaden and enrich my own work, from other practitioners, who are providing mental health and social services to this population.

Preoperative male-to-female transgender individuals seek psychotherapy for a variety of reasons. Some may have feelings of depression, others present with gender identity disorder or come to therapy for problems around relationships, substance abuse, or other mental health issues (Bullough, 2000; Schaefer, Wheeler, & Futterwiet, 1995). It is essential that therapists understand that not all preoperative male-to-female transgender individuals are coming to therapy to move forward with sex reassignment surgery (SRS), although in the cases discussed in this paper, during the early phase of treatment with two male-to-female transgender individuals, both spoke frequently about SRS and hormone considerations.

I participate as an openly gay psychotherapist with several mental health managed care panels. One day about a year ago, I received a phone call from a male identified client, who was given my name by one of these panels. Todd (not his real name) stated that he was looking for a psychotherapist to "help me with my gender dysphoria." Like most first phone calls with prospective clients, I asked him to tell me a bit more about what was happening with him. It quickly became clear to me that this client was "testing" me to see if I knew about "gender identity dysphoria." He wanted to know if I had ever met or worked with a "gender queer person" and he sounded appalled that I had not heard of "Harry Benjamin's Standards of Care (SOC)." I informed the client that I had worked extensively with gay men and in the gay community, and I told him that I would welcome the chance to listen and learn about his experience. Todd told me that he knew of several "well known expert therapists working with transgendered individuals," but that none participated with his health insurance panel and financially he could not afford to go out-of-network. Thus, Todd agreed to schedule a consultation stating, "I'll give it a try."

After I hung up the phone with Todd, my feeling that I was unprepared to work with gender identity issues (perhaps countertransference) was so sparked that I immediately signed onto the Internet and started exploring transgender organizations, various journals, and The Harry Benjamin International Gender Dysphoria Association's Standards of

Care for Gender Identity Disorders. These standards of care, originally developed in 1979, and revised many times, are now in their sixth version. The purpose of the SOC is to "articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders" (www.hbigda.org/socv6.html, pg.1). I found the SOC to be a rich resource for learning. It is very thorough and informative, particularly concerning the role of the mental health professional in helping gender queer clients with the eligibility and readiness requirements for SRS and hormone therapy.

After Todd's initial session, it became clear that he was not coming to therapy expressly to focus on hormone or sex reassignment surgery. He did mention that "I may consider hormone therapy in the future," but he clearly concentrated on his struggles with financial and occupational issues, relationship problems with his male lover, and ongoing mental health issues. Todd exhibited classic symptoms of clinical depression and treatment initially focused on providing case management and a medication consultation with a psychiatrist. Once Todd's depressive symptoms were controlled by psychotropic medication, he was able to more fully explore a variety of psychological issues. Over time, through my active listening and therapeutic interaction, a working relationship developed and Todd was able to verbalize the intense "ambivalence" he felt about most things in his life, including his gender. During one session, Todd requested that I call him by the female name that his friends and others close to him used, "Jenny" (not his real female name). Jenny also preferred to be addressed as "she" not "he."

In assessing Jenny's ongoing mental health needs, I utilized the *DSM-IV Diagnostic and Statistical Manual of Psychiatric Disorders* to make a differential diagnosis. Although Jenny met the criteria for Major Depression, she also met the criteria for Gender Identity Disorder (GID), with designation "sexually attracted to men." Jenny felt uncomfortable in her assigned biological sex and was "annoyed" by her penis. She stated "my boyfriend is okay with me being gender queer but he told me that he could not handle it if I went through with the SRS, he likes my penis too much." Jenny reported she would wear feminine female clothes, but mostly in her home. She expressed ongoing fears of being verbally and physically harassed when outside of the home, which appeared justified as she had reported an assault in the past on more than one occasion. Jenny also shared her difficulties in "coming out" and "fitting in":

> First I figured I was gay and it took me a long time to "come out" to everyone, including my family. But then I realized I really wasn't gay. I just couldn't identify as a gay man. So after I figured out that I was gender queer, I had to "come out" all over again, only this time as a transgender person. Finally I found a support group for people like me. I am actually beginning to feel like there are other people who understand me for who I am. I have never felt that most people in the gay community could really understand me.

During Jenny's treatment, I noticed that after each session, I would feel inadequate as a therapist. No matter how adept I was at listening and relating my empathy, no matter how much I attempted to learn about gender identity disorder, sex reassignment surgery, hormones, and the challenges confronting transgendered individuals and communities, I felt that I was on the outside looking in. I shared this feeling at my weekly clinical supervision, and through this process I began to realize that my countertransference was being invoked by Jenny. Her ambivalence and gender guilt (Schaefer et al., 1995) kept her on the outside looking in, misunderstood, yearning to be a part of something, yet paralyzed from taking that leap. According to Schaefer et al. (1995, p. 2031), gender guilt can be described as a transgendered individual's feeling "that something must be inherently wrong with them–something for which they alone feel responsible–they develop a sense of secretiveness and shame; eventually this self-blame solidifies the guilt in irrevocable ways." Through discovering, understanding, and resolving her gender guilt, Jenny began to understand how the ambivalence she experienced in her life, was related to this guilt, and thus she was able to move forward in the treatment. For example, Jenny had feelings such as, "I don't deserve to be happy," and "I'll never fit in anywhere." Once she understood that these feelings stemmed from her sense of guilt, she was able to contemplate options and possibilities in her life in concrete helpful ways, such as finding meaningful employment.

Sandy (not her real name) was referred to me by a colleague. She called and stated that she was looking for a therapist to evaluate her for her scheduled SRS. I arranged to meet with Sandy, and at our first session, I was struck at how determined and focused she was with following through with her SRS. In fact, Sandy had been taking hormone therapy for more than a decade. She already had undergone the surgical procedures to implant breasts, and she was scheduled for her genital surgery within the next year. Sandy had been in therapy with another psychotherapist for a couple of years, but, according to the SOC, she is

required to have two letters from mental health professionals documenting her eligibility and readiness for genital surgery. The SOC defines the eligibility requirement as "a person must live full time in the preferred gender for twelve months prior to genital surgery." The readiness criteria is defined as the person's "further consolidation of the evolving gender identity or improving mental health in the new or confirmed gender role" (www.hbigda.org/socv6.html, p.7).

After my first session with Sandy, it became clear to me that her transgender issues were very different from Jenny's. Jenny struggled with clinical depression and with ambivalence about her gender identification, never having taken hormones, and only infrequently wearing women's clothing outside of her home. Sandy, on the other hand, entered therapy primarily to obtain the professional confirmation needed for her SRS. She already fully dressed as a woman in private and public and was in many ways well on her way to completing her SRS.

As Sandy's psychotherapy sessions focused on her eligibility and readiness for genital surgery, we addressed pertinent psychological and social issues related to her SRS. For example, before Sandy can move forward with her SRS, another SOC eligibility and readiness requirement is that she is expected to legally change her name and sex, as confirmation that she is continuing to consolidate her female gender into her overall identity. She is required to demonstrate that she understands the emotional and social consequences of her SRS on her family and social relationships, and on her work and career.

Sandy has been engaged in her "real life experience" for over 18 months, and has not had any periods of returning to her original gender, thus evidencing little ambivalence. She has been successful in legally changing her name and sex. Although she is currently married to a woman, they have plans to separate and they are working out the emotional and practical details. Sandy is keenly aware of the emotional issues involved in this separation and freely expresses her feelings of loss: "I love my wife very much." In addition to her individual therapy, Sandy also belongs to a gender identity support group in New York City where she receives help with emotional and practical problems.

Although Sandy identifies as a female, she is also sexually attracted to females. She talks openly about her nervousness of "dating other women after I have my SRS." Even though in the past she dated women, at that time she was a biological male, her assigned gender at birth. She states "it will take time for me to learn how to date women *as a woman*." Sandy also has financial problems and difficulties with occupational

functioning. She was formerly employed in a traditionally male oriented profession and is struggling with a decision on a suitable career.

My initial clinical and social case management experiences with two gender queer clients has shown me clearly that the psychological and social challenges relevant to transgender individuals are unique and different from gay and lesbian issues. As social workers who are educated about the treatment issues of gay and lesbian clients, and who work with people from the lesbian, gay, bisexual, and transgender community, we must also be prepared to address the unique and challenging psychosocial factors experienced by gender queer individuals. Issues of gender identity, mental health problems, occupational concerns, family and love relationships, along with hormone and sex reassignment surgery, are central factors. If one's experience is like mine, there may be a time when a phone call comes out of the blue from a gender queer client seeking psychotherapy services. Are we ready?

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