Transgender in Family Therapy

**The Neglected “T” in GLBT**

While growing attention has been given to issues of gay, lesbian, and bisexual (GLB) individuals and their families, issues specific to the transgender population have been largely neglected in the family therapy field. Using the acronym “GLBT,” authors often lump transgender issues together with GLB issues, not specifically addressing or differentiating the “T,” or transgender (e.g., Connolly, 2005; Hardy & Laszlof, 2002). This is problematic because of the distinct differences between sexual orientation (which encompasses GLB) and gender identity (which includes transgender). Sexual orientation refers to the gender(s) for which a person has internal attractions, feelings of falling in love, sexual feelings, thoughts, and fantasies (Isreal, 2005; Sanders & Kroll, 2000; Savin-Williams, 2001). Gender identity is an internal sense, a self-concept of one’s own gender, typically female/feminine or male/masculine (Lev, 2004; Stone Fish & Harvey, 2005).

Some issues faced by transgender people share common threads with GLB issues, such as societal oppression and disapproval, however transgender people also face many issues that are unique. For example, transgender people often desire to receive medical treatments to alter their presentation of gender, such as hormones and surgery. As is recommended by the Harry Benjamin International Gender Dysphoria Association’s Standards of Care (Meyer et al., 2001), many physicians require recommendations from mental health professionals. Because transgender people are often dependent on mental health professionals to “approve” their physical gender transition, it is particularly important for mental health professionals to understand the experiences and needs of transgender people.

Of specific relevance to the work of family therapists is that families often struggle to understand, accept, and integrate the identities of their transgender members. Some authors have proposed stage models that families experience when a family member comes out as transgender (e.g., Ellis & Erikson, 2002; Emerson & Rosenfeld, 1996; Lev, 2004). Collectively, these models acknowledge that families typically have a variety of emotional responses from the time of discovery or disclosure of the transgender identity (e.g., shock, confusion, denial, anger) and progress to an increased level of understanding and optimally acceptance of the transgender family member.

While GLB individuals and their families face similar challenges around acceptance of sexual identity, transgender identities in families also present unique challenges. Coming out as transgender questions families’ basic understanding of their family member and often involves physical and social role changes. Whereas GLB people may choose when to expose or include their partners, transgender people must constantly present themselves and their gender, pushing others to learn new ways to relate (Brown & Rounsley, 1996). Families that achieve full acceptance and integration must learn to see the gender of their family member in a new way, which can include a new name, different pronouns, and disclosing the transgender identity to people outside the family. With adequate education, understanding, and sensitivity, family therapists could potentially be an invaluable resource for families facing this struggle. However, most therapists have little formal training or knowledge about transgender issues (Lev, 2004; Raj, 2002), leaving them poorly equipped to successfully assist such clients.

**Assessment of Gender Identity and the Dilemma of Diagnosis**

Transgender is an umbrella term, encompassing all nontraditional gender expressions, including, but not limited to, transsexual, cross-dresser, gender-bender, gender outlaw, gender queer, and drag king/queen (Carroll et al., 2002; Cole, Denny, Eyler, & Samons, 2000; Coolhart, Provancher, Hager, & Wang, in press). Before beginning work with transgender clients, it is important to understand that there are many diverse ways of being transgender. For example, not every transgender person is interested in changing their gender presentation (e.g., from male to female). Instead, some transgender people wish to expand or discard traditional and dichotomous conceptualizations of gender. Thus self-labels within the transgender community are ever-evolving (Carroll et al., 2002). Upon meeting a new transgender client, therapists should assess how clients understand their own gender. Identity is self-presentation, how one wants to be seen, named, and treated, and should not be decided by others (Zandvliet, 2000). Therefore, therapists’ questions should be guided by curiosity, leaving space for a wide range of client definitions. For example, a therapist might say, “I’ve noticed you don’t present your gender in a traditional way. Can you help me understand what that means to you?”

While the term transgender encompasses varied gender identities, transsexuals were assigned one gender at birth and have an internal sense that they are really another gender. Transsexuals often wish to make a gender transition in order to present themselves physically and socially as their preferred gender. Transsexuals must commonly utilize the mental health system because they are required to obtain recommendations for medical procedures. Transsexuals and their families commonly seek the assistance of family therapists because transsexuals challenge the most basic assumption that gender is purely biological, pushing everyone in their lives to re-conceptualize gender. In these cases, therapy may be sought when families are struggling to integrate the transgender member and identity.
Transgender identity development involves many stages, beginning with awareness of one’s own gender variance, progressing to integration, which may include transition from one gender to another (Lev, 2004). Because transsexual people and their families may seek therapy at any time during this process, some clients have not yet fully transitioned to their preferred gender. For example, they may still be using the name assigned to them at birth even though it does not match the preferred gender. Therefore, it is necessary for therapists to respectfully ask questions in order to understand how clients view their gender identities.

In developing sensitivity for the experiences of transgender clients, which is the first step towards providing effective services, it is important to consider the current mental health system’s pathology-oriented view about gender variance. The DSM-IV (American Psychiatric Association, 1994) continues to include Gender Identity Disorder (GID) to categorize transsexual people. The issue of diagnosing gender identity is complex, controversial, and most often enters the realm of therapy when clients are seeking recommendations for hormonal and surgical treatments. Often a diagnosis of GID is necessary before such medical treatments begin (Lev, 2004). This can be a dilemma for therapists and clients alike who believe gender variance is a normal variation of humanity, not a problem or pathology. Therapists pressured to diagnose may experience a double bind where one must choose to either diagnose, colluding with the pathological system, or not diagnose, restricting a client from medical procedures. This dynamic further complicates therapist-client relationships because therapists inevitably have the role of “gatekeeper,” controlling access to medical treatments (Lev, 2004; Raj, 2002). Often, clients are frustrated with having to jump through hoops in order to get the care they need (Brown & Rounsley, 1996; Lev, 2004). It is important for therapists to be sensitive to this dynamic and validate clients’ emotional responses to this challenging process (Coolhart et al., in press).

Additionally, the continued inclusion of GID in the DSM-IV (American Psychiatric Association, 1994) serves to further marginalize transgender people. Classifying gender variance as a psychiatric disorder inherently implies psychopathology, meaning there is something wrong with the thoughts and feelings of transgender people, which should be treated and changed. Not surprisingly, receiving the diagnosis of GID results in some clients feeling stigmatized (Brown & Rounsley, 1996; Cole et al., 2000). Conceptualizing gender variance as a mental disorder also contributes to the larger cultural context, which has historically mistreated transgender people and continues to be a hostile environment (Cole et al., 2000). Much of the oppression faced by transgender people is rooted in the perception of gender-variance as a severe and bizarre psychopathology (Lev, 2004). This perception has relegated transgender people “to the back wards of mental hospitals and red light districts, and has made them fodder for the talk show circuit” (Lev, 2004, p. 1).

Despite these compelling reasons to exclude GID from the upcoming DSM-IV-R, some argue there are benefits to its continued inclusion. The most commonly cited reason is that it provides a possibility for diagnosis, and therefore for insurance reimbursement for medical treat-
ments (Cole et al., 2000). However, this reasoning is weak because most insurance companies do not cover procedures for gender tran-
sition (Lev, 2004). It has also been argued that having the diagnosis of GID may provide clients with validation of not being alone and normalization as having a medi-
cal condition (Brown & Rounsley, 1996). However, the DSM’s exclu-
sive focus on mental conditions implies a psychiatric disorder, which is qualitatively different than a medical condition.

Although insurance companies rarely reimburse for gender transition treatments, a medical diagnosis is necessary in order to receive medical treatments. Within the current medical system, it is always necessary to assign a diagnosis. Lev (2004) suggested GID be removed from the DSM and health care professionals use the diagnosis of “transsexualism” from the Internal Classification of Diseases, Tenth Revision (ICD-10; World Health Organization, 1992). This solution offers retaining the benefits of a diagnosis, which legitimizes medical treatment, but does not imply mental illness or psychopathology. Additionally, it is possible that this re-concep-
tualization of gender variance as purely a medical condition could lead to increased insurance reim-
bursement, as medical conditions often are covered more fully than psychological conditions.

As a result of the shift away from pathology in the transgen-
der community (Carroll et al., 2002; Denny, 2004), therapists are more commonly taking non-path-
ological approaches to assisting clients. Therapists should exam-
ine their own beliefs and develop a trans-positive or trans-affirma-
tive disposition, which involves advocating, educating, and being sensitive to the pathologizing his-
tory of the medical and psychiat-
ric establishments (Carroll, 2002; Malpas, 2006). Even therapists with a pathology-free concep-
tualization of gender variance must understand the oppressive conditions within which trans-
gender clients and their fami-
ilies are living. Therapists should become educated on the politi-
cal, historical, and psychological contexts of transgenderism (Carroll et al., 2002). This under-
standing of cultural context can allow therapists to validate the
understandable and appropriate frustration, anger, sadness, anx-
xiety, and fear many transgender clients experience, and especially transsexuals on their journey to gender transition.

### TERMINOLOGY OF TERMS

- **Assigned gender:** the gender announced at birth, almost always clearly female or male
- **Cross-dresser:** replacing the pathologized term “transvestite,” referring typically to heterosexual men who dress as women for a variety of reasons such as fun, self-expression, and sexual pleasure; most do not live full time in their cross-gendered role
- **Drag King/Queen:** typically lesbians who dress as masculine men (kings) and gay men who dress as feminine women (queens) for fun and show; most do not live full time in their cross-gendered role
- **Harry Benjamin Standards of Care (SOC):** consensus statement about appropriate and flexible treatment directions for the psychiatric, psychological, medical, and surgical management of gender identity disorders; developed by what has been historically known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA), which recently changed its title to World Professional Association for Transgender Health, Inc. (WPATH)
- **Preferred gender:** for some people, assigned gender does not match an internal sense of gender and the term “preferred gender” reflects the gender the person feels internally
- **Sex Reassignment Surgery (SRS):** surgery desired or obtained by many transsexuals to alter the physical appearance of their chest (top surgery) and/or genitals (bottom surgery). Top surgery is more often sought by female-to-male transsexuals, removing breasts, which often are a barrier to passing, and involves a mastectomy and chest reconstruction. For male-to-female transsexuals, hormones alone can often enhance breast tissue. Bottom surgery is more often sought by male-
to-female transsexuals due to the procedures being more advanced and affordable than female-
to-male bottom surgery.
- **Transgender:** an umbrella term, encompassing all diverse gender expressions that do not fit neatly into the categories of female or male; including but not limited to transsexual, gender-bender, gender outlaw, gender queer, drag king, drag queen, androgyne, and two-spirit
- **Transsexual (TS):** a person whose preferred gender is different from the gender assigned at birth and who wishes to take steps to present themselves externally as the gender they feel internally; encompasses gender transition in both the female-to-male (FTM) direction and the male-to-female (MTF) direction
- **Gender Identity:** an internal sense of one’s own gender which may or may not match one’s gender assigned at birth; differs from sexual identity because it defines one’s own gender, not the gender(s) of the people one is attracted to
- **Gender Outlaw, Gender Queer, Gender-Bender:** three examples of the evolving language within the transgender community to describe gender expression that transcends the rigid categories of female and male
- **Gender Transition:** taking steps to present as one’s preferred gender when it is different than assigned gender, such as adopting gendered clothing and mannerisms, getting a name change, hair removal, hormonal therapy, and/or surgical alterations of the body; also commonly referred to as gender reassignment or sex change
- **Passing:** for transsexuals, when other people commonly perceive them as their preferred gender which they are wishing to present
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**Therapy Directions and Recommendations for Medical Procedures**

Transgender clients and their families seek therapy for multiple reasons, which are not always gender-related concerns. Thus, it is important not to assume that gender is at the center of the presenting problem. However, it is helpful to be sensitive to transgender issues in order to identify when/if gender-related issues may be intersecting with other therapeutic issues. Conversely, many transgender clients do seek therapy for gender-related concerns and the direction of therapy differs depending on the clients’ needs (Lev, 2004). What follows is a brief discussion of three common gender identity-related concerns, identified in the literature, which are presented in therapy (Brown & Rounsley, 1996; Coolhart et al., in press; Lev, 2004; Zandvliet, 2000).

1. The first group of clients seeks therapy for issues related to gender questioning and exploration. These clients typically recognize feelings of gender dysphoria, but may not know what to do about their feelings. The second group seeks therapy with the primary goal of obtaining a recommendation for medical treatment. These clients have a clear vision of gender transition and therapy is structured to assist them with this specific goal. The third group seeks therapy for relational issues. In these cases, the family or partner of the transgender person is typically involved in therapy to create deeper understanding and integration of the transgender identity within the relational context. When clients seek therapy while questioning their gender identity, therapists should adopt a client-centered stance, understanding that different clients see the issues differently (Carroll et al., 2002). Some clients may be seeking therapy after years of distress from gender dysphoric feelings (Lev, 2004). Because there are many possible expressions of transgender, when clients do not have a clear picture of how they wish to express gender, therapists should assist in exploring possibilities. The goal is to help them find an expression of gender that feels most genuine to them (Coolhart et al., in press). During this exploration process, therapists might assist clients in developing social and self-help connections with other gender variant people (Lev, 2004).

2. The second gender identity-related reason clients enter therapy is to obtain recommendations for medical treatments. These clients often articulate a passionate, educated, centered, and long-lasting desire for gender transition (Coolhart et al., in press). Brown and Rounsley (1996) referred to these clients as “knowing patients.” In these cases, therapy takes the form of a thorough assessment of the client’s experiences of and wishes for their gender. These clients are often not in need of a therapist, rather, they are in need of a “transition assistant” (Lev, 2004). The Harry Benjamin International Gender Dysphoria Association provides Standards of Care (Meyer et al., 2001) that offer insight and instruction about concerns, questions, and appropriate actions when serving the transsexual population. While the Standards of Care serve as a general guideline, they provide little specific information to assist therapists in determining client readiness for gender transition. Other authors have briefly discussed therapeutic domains important in assessing transsexual clients’ readiness for gender transition (e.g., Brown & Rounsley, 1996; Carroll, 2000; Chong, 1990; Cole et al., 2000). However, the most thorough assessment tool was developed by Coolhart et al. (in press) and can be easily applied by any helping professional. The tool provides specific questions to be discussed with clients and is organized into the following sections: family/childhood context, current gender expression, sexual/relationship development, current intimate relationship(s), physical and mental health, support, and future plans/expectations. The assessment tool guides therapists in gathering the information necessary in order to make a sound recommendation for medical treatments. Additionally, therapists must often compose a letter of recommendation summarizing this assessment. Lev (2004) provided a helpful guideline for writing these letters of recommendation.

Simply put, assessing clients’ readiness for gender transition involves gauging two types of stability: that of the desire to transition, and that of emotional, social, and mental well-being. First, obtaining medical procedures for gender transition is a life-altering decision and results in both reversible changes, such as the hormonal effects on muscle tone and mood, and irreversible changes, such as surgical procedures and hormonal effects of voice lowering, hair growth, and development of breast tissue. Thus, it is important to determine that clients’ desires for transition have been relatively consistent over time and that they have a realistic understanding of the options and effects of different procedures.

Second, it is important to determine that clients have the emotional stability and social support needed to cope with the challenges of transition. Due to society’s rigid gender binary, transgender clients are subject to the stress of not fitting the norm. Not surprisingly, it is common for transgender people to exhibit mental health symptomology (Lev, 2004). Therapists must consider accompanying mental health symptoms and help stabilize clients so they can make centered decisions about transition. Assisting clients in gender transition often reduces gender-related stress, possibly helping to also reduce mental health symptoms. Due to the challenging and life-changing effects of transition,
Transgender clients are in need of social support. This support may come from inside and/or outside the family system. Therapists should inquire about the coming out process and explore the risks and dynamics of further disclosures (Cole et al., 2000). When adequate support is not found within the family, therapists may assist clients in finding alternative support systems, such as continued therapy, connections with other transgender people, friendships, and the Internet.

Working with clients in the process of transitioning may require therapists to intervene on multiple systemic levels. As clients take steps in gender transition, the decision naturally becomes apparent to more people in their lives, whether or not they disclose the information. Coupled with society's low level of understanding transgenderism, gender transition is a process often characterized by stress and misunderstanding. For example, clients often face opposition in the workplace, such as conflicts over whether the transgender employee should use the women's or men's bathroom. Therefore, therapists' roles may include advocating, educating, and consulting with employers, coworkers, family members, neighbors, and friends (Brown & Rounsley, 1996). This work of advocating and educating with partners and family members may shift the direction of therapy into the third group of gender-related concerns, assistance in dealing with relational issues.

3. Therapy for relational issues typically involves helping parents, siblings, children, and partners to process and integrate the disclosure of the transgender identity. While some parents do not react intensely to their transgender child's disclosure, other parents have described it as, “a profound and protracted personal crisis characterized by shock, confusion, devastation, fear, and grief” (Pearlman, 2006, p. 102). Partners of transgender people may have similar responses if they were unaware of the transgender identity; however, many partners are supportive and couples may seek therapy to deal with the implications of transition (e.g., a new definition of the relationship). Therapists working with transgender clients and their families should both acknowledge and normalize the seriousness of the family disruption (Lev, 2004).

In cases where family members are angry, intolerant, and rejecting of the transgender identity, it may be important to see family members without the presence of the transgender person, at least initially. Therapists can serve as a sounding board for negative affect, help educate family members on transgender issues, and explore new understandings of the transgender individual. Therapy may assist family members to: seek information, exposure, and support; understand the transgender person's suffering and alienation related to gender identity; understand the politics of gender; help navigate how to disclose the information to others; and realize that the transgender person is essentially the same person on the inside as they always were (Pearlman, 2006). Once family members have had time to process some of their own experiences around the disclosure, therapy, including the transgender person, may help families repair and redefine relationships, foster healthy communication of emotions, and nurture closeness.

**ETHICAL ISSUE: WORKING WITH TRANSGENDER YOUTH**

The issue of medical and mental health care for transgender youth is controversial and can be anxiety-producing for helping professionals and parents alike (Lev, 2004). Children with gender-variant behaviors have historically interfaced with mental health professionals due to concern expressed by adults (e.g., parents, teachers). Treatment strategies traditionally, and sometimes currently, pathologize transgender identity development, for example, teaching children that biological sex is unchangeable (Green, 1995) and attempting to reverse cross-gender behaviors (Rekers & Kikigus, 1998). Perhaps because of the increased societal visibility of transgender identities, transgender youth are increasingly seeking services for help with the transition process. This is also not surprising since the literature indicates transgender people often become aware that their gender identity does not match their assigned gender in childhood (Wilson, 1998).

Transgender youth are in particular need of trans-sensitive therapists due to their increased vulnerability to harassment, misunderstanding, and violence, both inside and outside the family. Additionally, youth may be more developmentally susceptible to the opinions of others, less capable of being self-sufficient, and dependent on and accountable to parents for receiving medical care. According to Grossman and D’Augelli’s (2006) study, transgender youth often experience a lack of safe environments, lack of access to health services, few resources for mental health concerns, and rejection and inconsistency from caregivers, peers, teachers, and communities. Thus therapists should be aware of this particularly hostile environment in which transgender youth are developing.

The Harry Benjamin Standards of Care (Meyer et al., 2001) recommend children not receive hormonal or surgical procedures for gender transition, however hormonal therapy for adolescents is permissible. Thus, some therapeutic work with transgender youth may involve recommendations for medical procedures, but more often will involve other therapeutic issues. Therapists can work with children to explore, process, and normalize gender-dysphoric feelings and expose them to positive examples of transgender identities. With families, therapy can explore and expand families’ levels of understanding and acceptance of the transgender child. Additionally, boundaries for expressing preferred gender inside and outside the home may be discussed. Therapists often need to advocate for children in school, helping teachers to understand the transgender identity. If the family decides that the child will present the preferred gender in school, therapists may also need to talk with teachers about supporting this choice. It is not uncommon for interventions with transgender youth to encompass multiple systemic levels.
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Resources for Practitioners


BORNSTEIN, K. (1998). My gender workbook: How to become a real man, a real woman, the real you, or something else entirely. New York: Routledge. This book can be used with clients and provides activities to help explore gender identity and beliefs about gender, which can be especially helpful for clients who are in a questioning or exploring stage of gender identity formation.


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REFERENCES


Here is a sample of the Consumer Update brochure on Gender Identity. This brochure is designed to educate consumers and to market your services, with space on the back to imprint your name and contact information.

**MARKETING TIPS**

To market your services to individuals and families who may be faced with this issue, distribute copies of the Consumer Update brochure to:

- Physicians and nurse practitioners in family practice
- Local hospitals and urgent care facilities
- Churches, synagogues and temples
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**References**


