Trans* 101 for Mental Health Professionals

Elizabeth Kent

Professor Fausto-Sterling & Professor Taylor

GRST 13

Final Project

Introduction

The following workshop is an overview of trans* identities and issues the trans* community faces with specific emphasis on intersectional experiences and the relationship of trans* individuals to the mental health system. It is intended for current or aspiring mental health professionals. Historically, the trans* community has been very closely intertwined with the mental health system. Mental health professionals have acted as gatekeepers in regard to accessing hormones, surgery, and legal sex change. This system is slowly changing as mental health professionals, endocrinologists, and surgeons allow more agency for trans* individuals in determining if, how, and when they want to transition. However, knowledge of the trans* community remains paramount for mental health professionals because they frequently provide access to transition, therapy for those struggling with their gender identity, and support for trans* individuals who experience other mental health issues as a result of discrimination. This workshop will both assist mental health professionals in interacting with and treating trans* patients. Furthermore, it will benefit trans* individuals, who often encounter inexperienced and/or transphobic mental health professionals. The overall goal of this workshop is to provide mental health professionals with a comprehensive overview of trans* identities, experiences, and issues facing the community from the perspective of someone who is both a community member and a scholar of trans* theory and history.

While this workshop is currently hypothetical, I hope to one day be in a position where I could facilitate such a workshop. I would also want to discuss this workshop with mental health professionals who are either trans* or trans* allies in order to improve based on their input. Furthermore, a useful addition to the workshop would be a panel consisting of trans* and trans* allied mental health professionals, as well as trans* individuals who have had negative or positive experiences in the mental health system. This panel would allow me to incorporate real-life experiences from both mental health professionals and trans* patients, providing workshop participants with more tangible examples of and advice on working with trans* patients.

Workshop Schedule

Section	Schedule	Time
	Lunch and Meet & Greet	**12:00 PM**
1	**Intro to Trans* Issues & Identities**	**1:00 PM**
	***Activity*: Introductions**	
	***Activity*: Gender as a Social Construct**	
	***Activity*: Terms & Definitions**	
	***Role-play*: Initial Encounter**	**2:30 PM**
	Break: 15 minutes	**3:00 PM**
2	**Experiences & Intersectionality**	**3:15 PM**
	***Role-play*: Dealing with Discrimination**	**3:45 PM**
3	**Trans* & The Mental Health System**	**4:15 PM**
	***Activity*: Cisgender Privilege Checklist**	
	***Role-play*: Being a Good Ally**	**5:00 PM**
	***Activity*: Workshop Evaluation**	**5:30 PM**
	Dinner and Informal Discussion	**6:00 PM**

Presentation

- **Slide 1:** Trans* 101 for Mental Health Professionals
- **Slide 2:** Schedule
    - Share the above schedule
    - Section divisions
    - Role-plays at the end of each section
    - 15 minute break after Section 1
    - Extra time between Evaluation and Dinner in case we go over time
- **Slide 3:** Section 1 – Intro to Trans* Issues & Identities
    - Section 1 Goals:
        - Understanding the differences between sex, gender, gender presentation, and sexuality.
        - Understanding the multiplicity of trans* identities, important terms, and the transition process.
- **Slide 4:** Safe Space
    - Safe space to ask any and all questions
    - I will correct you if you say something problematic
    - However, this is a space for learning, not judgment
- **Slide 5:** Positionality
    - Tension in queer community about who can discuss trans* issues
    - Should cisgender people be writing theory about trans* people?
    - For example, Judith Butler theorizes about trans* identities but she is cis
    - Transgender woman/theorist Julia Serano argues that cisgender people have been taking control of the discourse on trans* issues, this is problematic[1]
    - When a privileged group discusses a marginalized group (especially academically) there is always the risk of appropriation, misrepresentation, or harm to the community
    - On the other hand, the trans* community often disagrees about trans* issues/identities
    - There are many trans* people who think being transgender is a mental disorder; they are trapped in the wrong body; can only be treated with complete legal, social, medical "sex change;" do not respect non-binary identities
    - I do not have an answer for whether or not cis people should have a voice in discussing trans* issues, but I think it's important for me to state my positionality and identity
    - I identify as genderqueer but not as trans* (more explanation later)
    - I identify as a part of the trans* community
    - I cannot represent everyone but I always try to be conscious of how any one individual in the community might identify and try to incorporate that in my definitions and discussions
- **Slide 6: Activity** – Introductions
    - Have participants go around and state name, preferred gender pronouns, and reason for attending the workshop.

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[1] Julia Serano, *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity* (Emeryville: Seal Press, 2007) 356.

- **Slide 7:** Sex vs. Gender
    - In our society, people conflate sex and gender often
    - Sex and gender are separate
    - Common idea of sex as biological gender as mental
    - Both socially accepted as binaries
- **Slide 8:** Sex, Gender, & Presentation
    - Sex
        - Definition: At birth, individuals are assigned a legal sex, either male or female. Sex can be chromosomal, genital, hormonal or reproductive. Though chromosomal sex cannot be altered, reproductive sex can be altered by removal of reproductive organs, hormonal sex can be altered by hormone replacement therapy (HRT), and genital sex can be altered surgically. Legal sex can be changed in most states when an individual transitions medically, and requirements vary by state.
        - Sex can exist on a continuum (male → intersex → female)
        - Brief intro to intersex – some people are born with characteristics of both sexes
        - Some people think sex should refer to biology – chromosomes, genitals, secondary sex characteristics
        - Complicated because you can modify your sex (everything but chromosomes), so can you have a "sex identity"?
        - Also complicated because there are intersex people – categories of sex are imperfect, biological model of sex implies that intersex conditions are abnormalities that must be corrected, but often they are not harmful to the individual and do not need to be corrected other than to fit societal norms
        - Conclusion: sex is no more a binary than gender is
    - Gender/Gender Identity
        - Definition: Gender is a socially constructed set of cultural expectations that are ascribed to an individual in accordance with the sex one was assigned at birth. The gender binary posits that two genders, man or woman, correspond to two sexes, male or female; however, a minority of individuals experience their gender as different from the one that corresponds to their birth assigned sex.
        - Definition: Gender identity refers to an individual's self-identification and experience of gender. While we are all designated a gender that corresponds to our assigned sex at birth, individuals may grow to develop a gender identity that does not match their designated gender.
        - Gender can exist on a continuum (man → genderqueer → woman)
        - Criticism to continuum model because it still positions man/woman as polar opposites
        - The point of not having a continuum is that identity is fluid, can shift, and cannot be perfectly plotted on a line
        - You can identify your sex and gender differently
        - Sometimes sex matches your birth assignment but gender does not
    - Gender Presentation

        - Definition: Gender presentation is how you present yourself to society; often thought of as how you express your gender identity, but this might not be true if you are in the closet.
        - Can exist on a continuum (masculine → androgynous → feminine)
        - Again, the continuum is problematic
        - Identity and presentation do not have to match up in the way that society expects (ex. femme trans*men/butch trans*women)
- **Slide 9:** Sexuality
    - Sexual orientation and gender identity are separate parts of one's identity
    - Can exist on a continuum (homosexual → bisexual → heterosexual)
    - Continuum is problematic because there are so many different identity terms, such as pansexual, asexual, queer
    - Some conflate sexual orientation and gender identity and assume that trans* people cannot transition and be gay (ex. an FAAB person who identifies as a man and is sexually attracted to men, or an MAAB person who identifies as a woman and is sexually attracted to women)
    - Gender identity has nothing to do with sexual orientation, which is why there are gay trans*men and lesbian trans*women (and bisexual, pansexual, asexual, queer, etc.)
- **Slide 10: Activity** – Gender as a Social Construct
    - Have participants create a list of what it means to be a "man" or a "woman" in society. Discuss how these characteristics are socially constructed.
    - Have participants consider how they experience being a man, woman, or non-binary gender in society. Sharing is voluntary.
- **Slide 11:** Umbrella Terms
    - Trans* and gender non-conforming/gender variant
    - Image will have gender non-conforming as clouds and trans* as umbrella
    - Other terms will be rain, some will fall under trans*, some under both
    - Next section will follow from the terms in this image
- **Slide 12:** Terms & Definitions
    - **Handout**: "Trans* 101 Terms & Definitions"
    - This list comes from my M.A. paper (except for "Two-Spirit," which comes from the glossary of the National Transgender Discrimination Survey)
    - It is informed by scholarly works as well as the trans* community
    - **Activity**: Have participants go around and read terms out loud. Save questions until the end.
    - Gender non-conforming/gender variant: Individuals who are gender non-conforming or gender variant do not conform to the gender that corresponds to their birth-assigned sex. While "trans*" (defined below) has been used as the "umbrella term" for such identities, gender non-conforming is a more accurate umbrella term because some gender non-conforming individuals may not identify as trans*.
    - Trans*: The use of the asterisk (*) at the end of "trans" is a recent phenomenon that has emerged from within the community. It is beginning to replace "transgender" as the umbrella term to refer to the trans* community because it indicates the multiplicity of trans* identities.

- Transgender: Transgender is an identity term for individuals who do not identify with the gender that corresponds to their birth-assigned sex. Transgender also refers to the transgender community and the corresponding social movement for transgender rights. Though it was originally created to unite individuals who did not conform to the gender binary, the dominant narrative of transgender now indicates a cross-gender identification and medical transition, privileging what sexologists defined as "transsexuality" (defined below).
- Binary/non-binary: Transgender identities can either conform to the gender binary or reject it. One who identifies as either a man or a woman is binary-identified, while one who identifies as neither or both of those categories is non-binary identified.
- Transsexual: Transsexual refers to an individual who wants to or has medically changed his or her sex from the sex he or she was assigned at birth. This term was popularized by Dr. Harry Benjamin, an endocrinologist famous for his work with transsexual patients in the United States in the mid-twentieth century. This term has fallen out of popular use with the rise of the term transgender; however, older trans* individuals may identify strongly as transsexual, as well as those who identify their trans* status as a medial condition.
- Cissexual: Cissexual is the opposite of transsexual; it refers to anyone who identifies with the sex they were assigned at birth.
- Cisgender: Cisgender is the opposite of transgender; it refers to anyone who identifies with the gender that corresponds to the sex they were assigned at birth. This term is more widely used than cissexual, most likely because one can be a part of the trans* community and still be cissexual. It is often shortened to "cis" and used in discussions of cisgender privilege, which is the social power and acceptance given to those who are perceived to adhere to the gender that corresponds to the sex they were assigned at birth.
- Intersex: Although society views sex as a binary, there are many intersex conditions that cause an individual to be born with characteristics of both sexes. Intersex conditions can involve chromosomal abnormalities, the occurrence of both male and female secondary sex characteristics, and/or ambiguous genitalia. Sexologist Anne Fausto-Sterling argues that the idea of two binary sexes inappropriately marginalizes intersex conditions as "abnormal;" instead, she posits that society should recognize at least five sexes. Babies born with physically obvious intersex conditions are assigned a sex by a doctor, who surgically modifies ambiguous genitalia and uses hormone treatments to force the body into a binary sex. These children often grow up unaware of their intersex condition and may come to identify as transgender if their gender identity does not match the gender/sex to which they were assigned. There has been much resistance against these non-consensual procedures by intersex activists such as the Intersex Society of North America.
- MTF/FTM: Male-to-female and female-to-male, respectively. These acronyms came into use to indicate the direction of an individual's transition, either from a male sex to a female sex or from a female sex to a male sex. These terms have also been identified as problematic because they are binarist, and they imply that

one cannot identify with a sex other than the one they were assigned at birth until they transition.

- Trans*man/trans*woman: A trans*man is a man who is transgender (assigned female at birth), and a trans*woman is a woman who is transgender (assigned male at birth). These terms are now more popular than FTM or MTF because they are not problematic in the ways described above. Again, the asterisk connotes the multiplicity of trans* identities. It also indicates that there can either be a space between "trans" and "man" or "woman," or that the terms can be "transman" and "transwoman." Some individuals prefer the term without the space because they do not identify as a woman or a man, but specifically as a transwoman or transman. Other individuals prefer the space because they identify as a man or a woman who happens to be trans.
- FAAB/MAAB: Female assigned at birth and male assigned at birth, respectively. These terms have replaced others such as female/male bodied, which imply that certain bodies are inherently male or female despite gender identity. Variations on these acronyms exist among the community, such as DFAB/DMAB (designated female/male at birth) and CAFAB/CAMAB (coercively assigned female/male at birth).
- Transvestite: Transvestite refers to an individual who cross-dresses, or wears clothes that are associated with the gender opposite the one that he or she was assigned at birth but does not identify with that gender. Sexologist Magnus Hirschfeld coined this term to connote sexual pleasure derived from cross-dressing; however, in queer communities it was often used interchangeably with "cross-dresser" or "drag queen" (defined below). It is generally no longer used because of its negative connotations.
- Cross-dresser: A cross-dresser is an individual who often dresses in clothes that are associated with the gender opposite to the one that he or she was assigned at birth but does not identify with that gender. This is a neutral replacement for transvestite.
- Drag Queen/King: A man who dresses up as a woman or a woman who dresses up as a man, respectively, for entertainment purposes. Drag queens and kings are different from cross-dressers in that cross-dressers wear opposite-gender clothes in their daily lives, not for entertainment.
- Genderqueer: Genderqueer is an identity term for individuals who do not identify with a binary gender. Genderqueer individuals can identify as both male and female or neither male nor female, and they may or may not choose to physically alter their sex. Genderqueer is one of the most widely used non-binary identity terms, and it is often used as an umbrella term for non-binary identities.
- Bigender: Bigender is a non-binary gender identity term that refers to individuals who identify as two genders. This can mean that one identifies as two genders at once, or one gender at a time.
- Agender/neutrois/genderless: Agender, neutrois, and genderless are non-binary identity terms. Though these terms are not necessarily interchangeable, they are similar in that they can indicate either having a neutral gender or no gender. For example, similarly to how "asexual" indicates an individual who lacks sexual

attraction, agender indicates an individual who lacks a gender identity. These individuals may or may not choose to physically alter their sex.
    - Two-spirit: "A term that references historical multiple-gender traditions in some of the native cultures of North America. Some American Indian/Alaska Native people who are lesbian, gay bisexual, transgender, intersex, or gender non-conforming identify as Two-Spirit."[2]
    - Third gender: Third gender is a non-binary gender identity term that can refer to someone who identifies as neither male nor female, but as a third option. These individuals may or may not choose to physically alter their sex.
    - Butch: Butch is a term that originated in 1950s working-class lesbian communities to indicate a masculine woman. Butch lies in opposition to "femme," a term that originated in the same communities and to indicate a feminine woman. Though butch in its current use is more often considered a gender non-conforming identity, many femmes today also identify as gender non-conforming.
    - A.G. (Aggressive): A.G. is a term that can also refer to a masculine woman, specifically women of color.
    - Androgynous: Androgynous refers to a gender presentation that does not conform to traditional standards of femininity or masculinity. Androgynous is not an identity term, but many individuals who have a non-binary identity will also have an androgynous presentation.
    - Gender-neutral pronouns: Individuals who do not identify with a binary gender will often use gender-neutral pronouns rather than the gendered pronouns he/him/his or she/her. There are a multitude of gender-neutral pronouns within the trans* community. Widely used pronouns include singular they (they/them/their) and ze/hir (pronounced *zee* and *heer*).
    - Gender dysphoria: The discomfort a trans* or gender non-conforming individual feels in regard to their birth assigned sex and/or gender. Gender dysphoria can involve a discomfort with specific body parts, secondary sex characteristics, gender-appropriate clothing, etc. To treat or resolve gender dysphoria, an individual might undergo psychotherapy, change their gender presentation or role, take hormones, or surgically alter their body.
- **Slide 13:** Transition Process[3]
    - This is the typical transition process for binary-identified trans*men and trans*women who are over the age of 18
    - Any individual may choose to undergo or not undergo certain aspects of this
    - Those who are under the age of 18 cannot begin any medical transition without parental consent

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[2] Jaime M. Grant, et al., "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey," *National Center for Transgender Equality* & *National Gay and Lesbian Task Force*, February 03, 2011, http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf (accessed October 09, 2012).

[3] Entire "Transition Process" section informed by World Professional Association for Transgender Health, "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7," *International Journal of Transgenderism* 16 (2011): 165-232, DOI: 10.1080/15532739.2011.700873.

- Children who express possible trans* or gender non-conforming identities may transition socially and be placed on hormone blockers to delay puberty until they are able to articulate their gender identity and determine how they want to proceed, medically speaking (again, this is with parental consent and usually under the guidance of a qualified mental health professional). They may also be labeled as "gender non-conforming" rather than definitively diagnosed with Gender Identity Disorder or labeled as transgender in order to give them time to grow and articulate their gender identity.
- The World Professional Association for Transgender Health (WPATH) has their "Standards of Care" on their website; these are the most widely accepted standards of care for transgender patients (referred to hereafter as WPATH-SOC): http://www.wpath.org/documents/IJT%20SOC,%20V7.pdf
- Step 1: Therapy
    - Generally, any individual who intends to undergo some aspect of transition begins by seeking a mental health professional qualified to work with trans* patients
    - They will seek a diagnosis of Gender Identity Disorder
    - The mental health professional will help them determine their gender identity and begin the steps toward social transition and coming out
- Step 2: Social Transition
    - Changes in gender presentation, largely involving clothing
    - Individuals may begin using a new name and different gender pronouns
    - Individuals will likely begin coming out to family, close friends, etc.
    - Trans*women will likely begin wearing more feminine clothing; however, some trans*women can identify as masculine women and may still wear masculine clothing
    - Trans*women may alter their physical appearance with bras or bra inserts that provide the illusion of breasts, tight underwear to "tuck" the penis and hide a bulge, wigs, makeup, or changes in personal care (such as shaving their body hair)
    - Trans*men will likely begin wearing more masculine clothing; however, some trans*men can identify as feminine men and may still wear feminine clothing
    - Trans*men may alter their physical appearance by binding their breasts using sports bras, binders, or ace bandages (ace bandages are dangerous and not advised). They may also use a packer (essentially a flaccid dildo) to create a bulge; some packers come with an attachment and tube for use when urinating in a men's bathroom, some packers may also be used for "pack and play" and have a rod in the center that can be used to position the packer down when packing and up when having sex
- Step 3: Hormones
    - Once they have been diagnosed with Gender Identity Disorder and have lived as their identified gender for a certain period of time (to be determined by the mental health professional), the mental health professional will provide the patient with a referral (in accordance with the

WPATH-SOC). This referral can then be taken to an endocrinologist who works with trans* patients, and the patient will begin a hormone regimen.
        - Some mental health professionals allow their patients to choose for themselves when they want to begin hormones, which is preferable because it gives the trans* person more agency
        - Some endocrinologists will also accept patients without a referral from a mental health professional, but they are small in number
        - Trans*men will begin taking testosterone; trans*women will begin taking estrogen and progesterone
        - Effects of testosterone: increased facial/body hair, deepening of the voice, body fat redistribution, hardened features, male-pattern baldness, enlarged clitoris, increased libido, increased muscle mass, cessation of menstruation, acne, change in body odor, roughening of skin, potential emotional changes
        - Effects of estrogen/progesterone: breast growth, softened features and skin, body fat redistribution, sterility, less and lighter body hair, reduced penis size, decreased libido, difficulty achieving erection, change in body odor, decreased sweat production, decreased muscle development, potential emotional changes
        - Patients will need to be monitored by an endocrinologist to continue hormone prescriptions, adjust dosages, and monitor blood work
        - Many trans*women will also undergo laser hair removal to remove facial hair and/or lessen body hair as well as voice lessens to speak at a higher pitch (hormones for MAAB individuals cannot reverse a deep voice or remove facial/body hair or one's Adam's apple)
    - Step 4: Name Change
        - A trans* person may change their name at any stage in transition; however, typically the individual would want to change their name as their physical appearance begins to change
        - Name change laws vary by state and type of document
        - It can be very costly, especially to change all documents (ex. license, birth certificate, social security)
        - Some states require a court date, a newspaper announcement, etc.
        - As the mental health professional, it will be helpful for you to learn the laws in your state as well as federally so that you can prepare your patient for potential roadblocks
    - Step 5: Surgery
        - Mental health professionals must also provide referrals for surgery; the WPATH-SOC requires one referral for breast/chest surgery and two referrals for any genital surgery
        - Some surgeons will accept patients without a referral, but again they are few in number
        - Trans*men
            - "Top surgery" usually comes first, meaning the removal of breast tissue (mastectomy) and often alterations to the nipples to reflect a more masculine chest

- Tran*men are also likely to get a hysterectomy and oophorectomy (removal of uterus, ovaries, and Fallopian tubes)
- Trans*men may seek bottom surgery; however, most states only require top surgery for a trans*man to change his legal gender marker
- Bottom surgery can include a metoidioplasty, which involves freeing the clitoris from surrounding tissue. This can also include lengthening the urethra to expel urine through the clitoris/penis, adding scrotal implants and using the labia minora as scrotum, and closing the vaginal opening. Trans*men may also seek a phalloplasty, which involves constructing a penis from a skin graft, usually taken from one's arm or leg. This will also include urethral lengthening and possibly scrotal implants. In order to achieve erection, most phalloplasty techniques include a prosthesis that can be inserted during sexual activity and removed after. Phalloplasty is significantly more expensive and riskier than metoidioplasty.

  - Trans*women
    - Top surgery would involve breast augmentation; however, trans*women may not need top surgery depending on their reaction to hormones.
    - Most states require trans*women to undergo bottom surgery to change their legal gender marker
    - Bottom surgery involves the construction of a vagina by inverting the penis. Typically skin from the head of the penis is used to create a clitoris, while the scrotum is used for labia. Dilation is required after surgery, which involves inserting rods into the newly constructed vagina for a certain amount of time per day to ensure that it does not close.
    - Trans*women often undergo a variety of other surgical procedures, such as a tracheal shave to reduce the size of the Adam's apple, facial feminization surgeries, or voice surgery to alter one's pitch (this is very risky as it can permanently impair one's speech).
- Step 6: Legal Transition
  - Once they have completed the required medical transition, individuals may choose to change their legal gender marker
  - These requirements vary by state and type of document, and the process can become very costly
  - As the mental health professional, it will again be helpful for you to know the state and federal requirements for different documents

- **Slide 14:** End of Section 1. Pause for questions.
- **Slide 15: Role-play** – Initial Encounter
  - **Instructions for role-play**: Workshop participants will volunteer to play the mental health professional, patient, and other characters that the scenario calls for (ex. parents or other patients). Each role-play scenario will last for a few minutes, followed by discussion and critique.

    - Scenario 1: A new patient, Jess, arrives at your office. Jess is FAAB and seeking help with gender dysphoria she has been experiencing, especially in regard to her breasts. Jess is uncertain about her gender identity because she presents as masculine and is attracted to men.
    - Scenario 2: A new patient, Elliot/Ellie, arrives at your office. Elliot/Ellie is MAAB and has begun to cross-dress in women's clothes, go by "Ellie," and use female pronouns part-time. Elliot/Ellie is uncertain about their gender identity because they still enjoy using their penis during sex with women.
    - Scenario 3: Two parents have come to your office with their 10-year-old child, Avery. Avery is MAAB and has been interested in stereotypical "girl" activities since a young age, including playing house and wearing princess costumes. The parents are concerned because they recently saw a special on *Oprah* about transgender children.
- **Slide 16:** Section 2 – Experiences & Intersectionality
    - Section 2 Goals:
        - Learning about the types of discrimination that the trans* community faces.
        - Viewing the trans* community through an intersectional lens.
        - Understanding the different experiences between binary vs. non-binary trans* people and trans*women vs. trans*men.
- **Slide 17:** Discrimination[4]
    - Statistics from National Transgender Discrimination Survey
    - These are just some of the overall statistics, the rest of the report goes into much greater detail
    - Four times more likely to have a household income of less than $10,000/year compared to general population
    - 41% attempted suicide (1.6% general population)
    - Unemployment at twice the rate of the general population
    - Grades K-12 – 78% harassed, 35% physically assaulted, 12% experienced sexual violence, 15% left school because of harassment, all of this leads to worse health outcomes
    - 90% experienced harassment, mistreatment, or discrimination at work or lived stealth to avoid the above
    - 47% fired, not hired, or denied promotion
    - 71% lived stealth to avoid discrimination, 57% delayed transition
    - 16% working in underground economy (sex work/selling drugs)
    - 19% refused home/apartment, 11% evicted
    - 19% have been homeless, 2% currently homeless (twice the rate of general population)
    - 53% verbally harassed or disrespected in public
    - Only 21% have been able to update all legal documents, 33% have not updated any documents (gender marker, also name because it is expensive)
    - 40% of those who presented an ID that did not match their identity/expression were harassed, 3% attacked, 15% asked to leave

[4] All statistics from Grant, et al., "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey."

- 22% harassed by police
- 16% physically assaulted and 15% sexually assaulted in jail/prison
- 19% refused medical care, 50% uninformed doctors
- Four times the national average of HIV infection
- 57% rejected by family
- 63% have experience significant discrimination, meaning something that has a major impact on their quality of life and ability to sustain themselves financially or emotionally

- **Slide 18:** Non-Binary vs. Binary
  - Binary privilege: while all trans* people face discrimination, binary people have their gender identities legitimated by society and often receive conditional cisgender privilege if they "pass"
  - Explain what conditional cisgender privilege is – if you are read as the gender that you identify as, generally you are also read as cisgender. This is conditional because you might have documents that do not match your gender identity (this can create problems with jobs, housing, police, healthcare, etc.), or you might engage in a sexual situation with someone and have not had surgery, which would also out you as trans*.
  - Discrimination against non-binary people is also complicated because often they are read/discriminated against as gay/lesbian rather than trans*; this also relates to the fact that "visibly queer" (i.e. gender non-conforming) LGB people are harassed both because they are LGB and gender non-conforming. Gender non-conformity and queer sexuality are very much related when it comes to discrimination, and that is a main reason why we often refer to the LGBT community rather than the LGB community and the trans* community as separate.
  - Special supplement to the NTDS on non-binary people ("A Gender Not Listed Here")[5]
  - They originally were not going to survey non-binary people because they were under the impression that genderqueer people were doing better than transgender people, but they were ultimately proven wrong by the survey results[6]
  - Discrimination at higher rates than the overall survey: harassment and sexual assault in education, police harassment, physical/sexual assault in general[7]
  - Also more likely to be involved in illegal economies and to have attempted suicide[8]
  - Workplace bias at same rate as overall survey, only slightly less likely to lose a job or be refused medical care[9]

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[5] Jack Harrison, Jaime Grant, and Jody L. Herman, "A Gender Not Listed Here: Genderqueers, Gender Rebels, and OtherWise in the National Transgender Discrimination Survey," *LGBTQ Policy Journal* 2 (March 2011) http://content.epnet.com/ContentServer.asp?T=P& P=AN& K=79554821&EbscoContent=dGJyMNLr40Seprc4zdnyOLCmr0qep7ZSsqe4SLSWxWXS&ContentCustomer=dGJyMPGutlGzqbdLuePfgeyx%2BEu3q64A& D=qth (accessed October 09, 2012).
[6] Harrison et al., "A Gender Not Listed Here," 23.
[7] Harrison et al., "A Gender Not Listed Here," 21-23.
[8] Harrison et al., "A Gender Not Listed Here," 21-23.
[9] Harrison et al., "A Gender Not Listed Here," 21-23.

- **Slide 19:** Intersectionality
  - Race multiplies discrimination – POC have it worse compared to white trans* people across the board, especially black trans* people[10]
  - Race has a very high correlation to lower socioeconomic class, especially for trans* people[11]
  - Unemployment rate goes up to four times that of the national rate for POC[12]
  - Losing a job due to being trans* correlates with high rates of homelessness, incarceration, and working in illegal economies (drugs & sex work)[13]
  - Transgender Day of Remembrance – national day to remember trans* people who have been murdered, 13 transgender Americans murdered in 2012, all of them were trans*women of color[14]
- **Slide 20:** Transmisogyny vs. Male Privilege
  - Trans*men gain male privilege if they are read as male in society
  - Sociologist Kristen Schilt did a study of trans*men in the workplace, found that 2/3 reported receiving benefits associated with maleness in the workplace[15]
  - However, trans*men of color were more likely to experience negative changes in their workplace treatment (white trans*men by and large gain male privilege, not the same for trans*men of color)[16]
  - Trans*men more likely to "pass" and gain conditional cisgender privilege, meaning they are read as both male and cis and receive privilege for both
  - Schilt found that 56% of trans*men reported passing after transition, compared with 17% of trans*women[17]
  - Part of this is about hormones – testosterone is stronger; therefore, trans*men will easily gain male characteristics such as facial hair and a deep voice. Estrogen/progesterone (for trans*women) can soften features and stimulate breast growth, but it cannot create a higher-pitched voice, eliminate facial hair, change height, or remove one's Adam's apple
  - Research by psychologists Kessler & McKenna shows that we focus on male cues rather than female cues when determining gender, meaning that if we see one masculine cue we will automatically assume a male gender (depending on the cue), but to determine a female gender we cannot see any masculine cues (even if we see multiple feminine cues, they are not enough if there are irrefutably masculine cues)[18]

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[10] Grant, et al., "Injustice at Every Turn," 2.
[11] Grant, et al., "Injustice at Every Turn," 3.
[12] Grant, et al., "Injustice at Every Turn," 3.
[13] Grant, et al., "Injustice at Every Turn," 3.
[14] Diane Anderson-Minshall, "13 Transgender Americans Murdered in 2012," *The Advocate*, November 20, 2012, http://www.advocate.com/politics/transgender/2012/11/20/13-transgender-americans-murdered-2012 (accessed November 26, 2012).
[15] Kristen Schilt, *Just One of the Guys? Transgender Men and the Persistence of Gender Inequality* (Chicago: The University of Chicago Press 2010) 70.
[16] Schilt, *Just One of the Guys?*, 85.
[17] Schilt, *Just One of the Guys?*, 141.
[18] Suzanne J. Kessler and Wendy McKenna, "Toward a Theory of Gender," in *The Transgender Studies Reader*, ed. Susan Stryker and Stephen Whittle (New York: Routledge, 2006) 173.

- Kessler and McKenna also show that the penis is the only "cultural genital," meaning that we either attribute it or do not attribute it (we attribute the penis to anyone with male characteristics or do not attribute it to someone without male characteristics)[19]
- We can see the effects of this in that generally, top surgery is considered the "end" of transition for trans*men, while bottom surgery is considered the "end" for trans*women. Trans*women also more frequently have to get bottom surgery to change their gender marker.[20]
- Serano on transmisogyny: this is specific form of discrimination that trans*women face both for being female and transgender. Our society assumes that masculinity is superior; femininity is devalued and derided. That is why it is acceptable in a way for a "woman" to want to "become" a man, but it is not acceptable for a "man" to want to "become" a woman.[21]

- **Slide 21:** End of Section 2. Pause for Questions.
- **Slide 22: Role-play** – Dealing with Discrimination
  - Scenario 1: Avery, the gender non-conforming child from Scenario 3 in the previous role-play, has been attending school as a girl and is facing bullying from other students. Her parents are very concerned and are considering either home schooling, private school, or forcing Avery to go back to living as a boy.
  - Scenario 2: One of your trans* patients, Ashley (MAAB trans*woman, 25 years old, has just started hormones), is a sex worker. Last night, a client assaulted her. She does not want to go to the police both because her work is illegal and because the client was a white, upper-class, cisgender man, and she is a working-class Latina trans*woman.
  - Scenario 3: One of your trans* patients, Parker (FAAB, genderqueer, 16 years old) has been kicked out of their parents' house after coming out to them. They are suicidal and will not be able to afford therapy without their parents' support.
- **Slide 23:** Section 3 – Trans* & The Mental Health System
  - Section 3 Goals:
    - Learning about the history of trans* people in the mental health system.
    - Understanding specific problems in regard to access, GID criteria, and non-binary individuals.
    - Understanding the importance of taking oppression and life circumstances into account.
    - Learning about cisgender privilege and understanding how to be a good ally to trans* patients.
- **Slide 24:** History in the Mental Health System
  - Harry Benjamin pioneered medical care for trans* people – created the Standards of Care that are still widely used and updated (Harry Benjamin International Gender Dysphoria Association, now World Professional Association for Transgender Health)[22]

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[19] Kessler and McKenna, "Toward a Theory of Gender," 173.
[20] Grant, et al., "Injustice at Every Turn," 138-155.
[21] Serano, *Whipping Girl*, 15.
[22] Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Cambridge: Harvard University Press, 2002) 255, and World Professional Association for Transgender Health,

- Very focused on binary switch from one sex/gender to the other, also very heteronormative
- Excerpts from *The Transsexual Phenomenon*
  - "The normal male (normal by his genetic inheritance) has his masculine build and voice, an ample supply of androgen, satisfactory potency, a sperm count that assures fertility, feels himself to be a man, is sexually attracted to women, and would be horrified to wear female clothes or 'change his sex.' He is often husband and father, works in a job or profession in accord with his sex and gender that is never questioned legally or socially."[23]
  - "The genetically normal female presents the opposite picture. She feels, looks, acts, and functions as a woman, wants to be nothing else, usually marries and has children. She dresses and makes up to be attractive to men and her sex and gender are never doubted either by society or by the law."[24]
  - "The transsexual feels himself to be a woman ('trapped in a man's body') and is attracted to men. This makes him a homosexual provided his sex is diagnosed from the state of his body. But he, diagnosing himself in accordance with his female psychological sex, considers his sexual desire for a man to be heterosexual, that is, normal."[25]
  - "Transsexual women fall deeply in love with normal or homosexual girls, often those of a soft, feminine type. Besides wanting to be lovers, they want to be husbands and fathers."[26]
- Sandy Stone argues this meant that trans* people had to figure out what to say in order to access treatment: "The highest purpose of the transsexual is to erase him/herself, to fade into the 'normal' population as soon as possible. Part of this process is known as *constructing a plausible history* – learning to lie effectively about one's past."[27]
- Mental health system in relation to trans* issues has changed a lot
  - Heterosexuality post-transition is no longer a requirement
  - WPATH is consistently updating their Standards of Care, and these now are much more open to flexibility and the diversity of gender expression[28]
  - There are also a lot more doctors who deal with trans* patients in general (this includes mental health professionals as well as endocrinologists and surgeons)

"History of Association," *The World Professional Association for Transgender Health, Inc.*, 2013, accessed May 7, 2013, http://www.wpath.org/about_wpath.cfm.

[23] Harry Benjamin, *The Transsexual Phenomenon* (New York: The Julian Press, Inc., 1966), 9.

[24] Benjamin, *The Transsexual Phenomenon*, 9.

[25] Benjamin, *The Transsexual Phenomenon*, 14.

[26] Benjamin, *The Transsexual Phenomenon*, 85.

[27] Sandy Stone, "The *Empire* Strikes Back: A Posttranssexual Manifesto," in *The Transgender Studies Reader*, ed. Susan Stryker and Stephen Whittle (New York: Routledge, 2006) 230.

[28] World Professional Association for Transgender Health, "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7."

        - Trans* people now have a lot more agency; for example, the WPATH-SOC had received criticism for requiring psychotherapy and "real-life experience" (living as your identified gender) for a certain length of time (usually at least 1 year) prior to seeking hormones and surgery. They have since removed that criteria.[29]
        - Trans* people also have more agency because there are now more doctors who will provide trans* patients with hormones/surgery without a referral from a mental health professional/diagnosis of GID
- **Slide 25:** Access to the Mental Health System
    - Trans*people are more intimately connected to mental health system than other marginalized groups
    - You essentially cannot be trans* without the mental health system
    - The number of doctors who will provide hormones and surgery without a diagnosis/following the standards of care is slowly increasing, but for the most part individuals need a letter from a psychologist/psychiatrist that they have been diagnosed with GID before they can access hormones/surgery (must follow the guidelines and fit the DSM criterion)
- **Slide 26:** Gender Identity Disorder
    - Gender Identity Disorder – criteria are very focused on social norms of binary gender
        - "In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities. They may have a preference for dressing in girls' or women's clothes…There is a strong attraction for the stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female character. Stereotypical female-type dolls, such as Barbie, are often their favorite toys, and girls are their preferred playmates…They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks.'"[30]
        - "Girls with Gender Identity disorder display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire…They prefer boys' clothes and short hair…Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress-up or role-play activity."[31]

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[29] World Professional Association for Transgender Health, "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7."
[30] American Psychological Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (Washington, DC: American Psychiatric Association, 2000), 576.
[31] American Psychological Association, *DSM-IV-TR*, 576-577.

- Changing to gender dysphoria[32]
    - This removes the pathology from one's individual identity
    - Instead the problem is the feeling, much like depression
    - Could still be harmful to non-binaries –To be treated for "gender dysphoria" (i.e. access hormones/surgery), will one have to fit the same criteria as GID? Will the criteria imply that one must completely disavow their birth assigned sex? That one must hate and never use their genitals for sex?
- **Slide 27:** Non-Binary Individuals and the Mental Health System
    - Dean Spade is a transgender theorist who criticizes the medical system in relation to trans* people in "Mutilating Gender"
        - "The medical regime permits only the production of gender-normative altered bodies, and seeks to screen out alterations that are resistant to a dichotomized, naturalized view of gender."
        - "Containing gender distress within 'transsexualism' functions to naturalize and make 'healthy' dichotomized, birth-assigned gender performance. It casts the critical eye on the gender performance of those transgressing gender boundaries, and produces a norm that need not be criticized."
    - Non-binary people basically do not have access to the medical aspect of being trans* (unless they find one of the few clinics that is more open to non-binary people and against the standards of care)
    - Some non-binary people want hormones and/or surgery
    - Some non-binary people also want to change their legal documents (gender marker), but in most cases you cannot do that until you medically transition. Some binary-identified trans* people also want to change their legal documents without medically transitioning, either because they cannot transition due to health concerns or because they do not feel that they need to alter their bodies to identify as the gender they identify as.
    - Kay Siebler is a scholar who studies trans* media representations; she argues that we are doing harm to non-binary youth by even further marginalizing their identities; they see the dominant trans* narrative of medical transition and binary identification and assume they must fit that narrative even if they identify as non-binary[33]
- **Slide 28:** Tensions in the Trans* Community
    - Transgender theorist Jay Prosser argues that the ability to have a legible identity is paramount to the survival of transgender people[34]

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[32] Camille Beredjick, "DSM-V To Rename Gender Identity Disorder 'Gender Dysphoria," *Advocate.com*, July 23, 2012, accessed April 1, 2013, http://www.advocate.com/politics/transgender/2012/07/23/dsm-replaces-gender-identity-disorder-gender-dysphoria.

[33] Kay Siebler, "Transqueer Representations and How We Educate," *Journal of LGBT Youth* 7:4 (2010) 323, doi: 10.1080/19361653.2010.512521, and Kay Siebler, "Transgender Transitions: Sex/Gender Binaries in the Digital Age," *Journal of Gay & Lesbian Mental Health* 16:1 (2012) 76, doi: 10.1080/19359705.2012.632751.

[34] Jay Prosser, *Second Skins: The Body Narratives of Transsexuality* (New York: Columbia University Press, 1998) 32.

    - GID allows for legible identities and the possibility of insurance covering trans* related medical care
    - However, is it ultimately harmful to our community to perpetuate the dominant trans* narrative of medical transition from one binary sex/gender to the other?
- **Slide 29:** Circumstances & Oppression
    - Psychiatry does not take into account life circumstances or systems of oppression
    - "We are told that the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (American Psychological Association 2000) goes beyond symptoms and helps mental health professionals deal with patients' reality – that all this can be done in a few, short minutes. This is not true because in psychiatry, as in mainstream psychology, little or nothing has been done to raise mental health professionals' consciousness of racism, sexism, or other forms of oppression and the way they affect diagnosis."[35]
    - Trans* people face a lot of discrimination, which leads to psychological stress and mental health problems (beyond just GID)
    - High rates of suicide, depression, anxiety
    - Trans* people do not just need gatekeepers to hormones and surgery, they also need mental health professionals who can help them work through their gender identity in a world that does not legitimate their identities, especially if they are non-binary
    - And they also need mental health professionals who can take into account the discrimination they face and treat other mental disorders alongside, such as depression/suicidal thoughts/anxiety
- **Slide 30:** Cisgender Privilege
    - Cisgender privilege checklist: http://takesupspace.wordpress.com/cis-privilege-checklist/[36]
    - Learning about your privilege in such a way is helpful, it provides you with examples you can relate to and opens your eyes to situations you never have to think twice about but trans* people do
    - **Activity**: Discuss the cisgender privilege checklist in small groups of 3-5. Have you ever experienced any of these situations, even if you are cisgender? Do you disagree with any of the items on the list? Would you add anything to the list?
    - After small group discussion, bring discussion back to the big group. Talk about specific ways these situations impact trans* people versus cis people who may have experienced similar situations. Discuss how one can be aware of one's cisgender privilege when interacting with patients.
- **Slide 31:** Being a Good Ally
    - Respect trans* patients' identities: use preferred names and pronouns, ask if you are uncertain, and never assume what pronouns a person uses based on outward appearance.

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[35] Nayyar Javed, "Clinical Cases and the Intersection of Sexism and Racism," in *Bias in Psychiatric Diagnosis*, ed. Paula J. Caplan and Lisa Cosgrove (Lanham, MD: Jason Aronson, 2004), 78.

[36] Cedar (username: takesupspace), "Cis Privilege Checklist," *Taking Up Too Much Space* (blog), July 10, 2008, http://takesupspace.wordpress.com/cis-privilege-checklist/.

    - Question your assumptions: do not assume anything about your patient based on outward appearance, such as gender identity, sexuality, or what kind of transition they will or will not choose to undergo.
    - Understand and learn to check your own cisgender privilege; acknowledge that trans* people might have experiences that you cannot understand as a cisgender person. Listen to their experiences and learn from them.
    - Educate yourself – the Internet is an especially helpful resource. There are blogs and YouTube channels by trans* individuals, as well as books and films. Just remember to view these critically – no singular experience speaks for the entire community.
    - Speak out against transphobia and educate others so that trans* people do not have to constantly resolve ignorance about their own identities.
    - Know that any and every person's gender identity can be unique; take non-binary identities seriously and learn to critically examine sources that imply that binary gender is a reality.
    - Look at all circumstances of a patient's life and identity; take discrimination seriously as a psychological stressor and treat other mental health issues accordingly.
- **Slide 32:** End of Section 3. Pause for Questions.
- **Slide 33: Role-play** – Being a Good Ally
    - Scenario 1: You have just finished a session with Ashley, the trans*woman from the previous role-play. As you walk into your waiting room, your next patient makes a transphobic remark to Ashley. How do you handle the situation?
    - Scenario 2: One of your trans* patients, Judith (MAAB, butch trans*woman, on hormones, seeking bottom surgery), was just kicked out of a female bathroom in your office building. What are some steps you can take to make the building more trans* inclusive?
    - Scenario 3: Parker, the genderqueer FAAB adolescent from the previous role-play, has reconciled with their parents. However, Parker's parents refused to use their chosen name and pronouns. Parker and their parents have arrived at your office for a family therapy session.
- **Slide 34:** Resources
    - **Handout**: "List of Trans* Resources"
    - Websites
        - http://tranarchism.com/
        - http://itspronouncedmetrosexual.com/
        - http://srlp.org/
        - http://safe2pee.org/new/
        - http://www.thetaskforce.org/reports_and_research/ntds
        - http://genderfork.com/
        - http://www.t-vox.org/index.php?title=Trans_101
    - Books
        - *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*, Julia Serano
        - *Transgender History*, Susan Stryker

        - *How Sex Changed: A History of Transsexuality in the United States*, Joanne Meyerowitz
        - *The Transgender Studies Reader*, Ed. Susan Stryker & Stephen Whittle
        - *GenderQueer: Voices From Beyond the Sexual Binary*, Ed. Joan Nestle, Clare Howell, & Riki Wilchins
        - *Transgender Warriors: Making History from Joan of Arc to Dennis Rodman*, Leslie Feinberg
        - *Transgender Rights*, Ed. Paisley Currah, Richard M. Juang, & Shannon Price Minter
        - *Sexing the Body: Gender Politics and the Construction of Sexuality*, Anne Fausto-Sterling
        - *The Testosterone Files: My Hormonal and Social Transition from Female to Male*, Max Wolf Valerio
        - *Becoming a Visible Man*, Jamison Green
        - *Just One of the Guys? Transgender Men and the Persistence of Gender Inequality*, Kristen Schilt
        - *Gender Outlaw: On Men, Women, and the Rest of Us*, Kate Bornstein
        - *Transgender Explained For Those Who Are Not*, Joanne Herman
        - *Transgender Voices: Beyond Women and Men*, Lori B. Girshick
    - Also explain:
        - YouTube channels – many run by trans* people to document individual transitions
        - Blogs – on Tumblr you can track tags such as "transgender," "genderqueer," "trans," etc. to see what multiple people are writing about different subjects and identities
        - Simple Google searches can also yield great results
        - Remember to read critically! Always search for who the author is, what their positionality is, etc.
- **Slide 35:** Workshop Evaluation
    - **Handout**: "Trans* 101 for Mental Health Professionals Workshop Evaluation"
    - Anonymous evaluation will have the following open-ended questions:
        - 1. What did you like about the workshop?
        - 2. How do you think the workshop could be improved overall?
        - 3. Do you feel as if you have a greater understanding of your role in working with trans* patients? If not, why?
        - 4. Were there any concepts that you felt needed further discussion?
        - 5. Were the role-plays and activities useful? If not, what improvements would you suggest?
        - 6. Was the workshop facilitator approachable and effective at communicating information? What improvements would you suggest for the facilitator?
        - 7. Do you have any other comments, questions, or concerns?
    - If participants still have questions, they can ask during the dinner or email me at kent.eliz@gmail.com