**ETHICAL ISSUES IN PSYCHOLOGICAL TREATMENT OF TRANSSEXUAL PATIENTS**

**ABSTRACT**

The trans community, under the spectrum LGBTQ is one of the minorities that faces challenges on various psycho-social, economic and political fronts. One of the greatest challenges that these people face is not only being discriminated socially but also receiving discriminated treatments. The present article is a review of the various clinical and ethical dilemmas in the psychological treatment of transsexual patients. Multiple ethical issues from an Indian standpoint are discussed and certain recommendations are laid down. There is a lack of sensitivity, appropriate understanding and sufficient treatment modalities for treatment of trans community of patients. The present paper provides an overview of the various ethical issues encountered when treating transsexual patients in clinical practice.

**Key words:** transsexuals, treatment, mental health, ethics.

**INTRODUCTION**

A person’s gender identity is their own sense of whether they are male or female, or neither. Some transgender people identify themselves with their changed gender: from male to female or female to male. However, others see themselves as members of a third sex. Officially now, the transgender is the third gender, in recognition and identity (1). ‘Transsexual’ persons are a part of the minority LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer) community. The term ‘transsexual’ was coined by David O. Cauldwell (1949) (2), however it was popularised well only by 1966 with the efforts and work of Harry Benjamin (3). It was also around this time when the term transgender was coined and popularized; the term transvestite was replaced with the term transgender in 1980s (4). Eyler and Wright (5) gave a nine-point gender continuum that depicted a range of possible gender identities. These identities ranged from “female-based” identities to “male-based” identities, with “bigendered” identities (6).

The terms transgender and transsexual are often used interchangeably. However, it is important to note that there is a small difference between the term transgender and transsexual. Both individuals identify their gender as not conforming to their biological sex however, there is a minute difference. Transgender persons are those who simply live with a dissonance in their gender identity and biological sex; and transsexuals undergo a sex reassignment surgery in order to align their biological sex with their gender identity. Within the community, apart from transsexual and transgender persons, there is a third category called as the trans and gender non-conforming identities. ‘Trans’ is an umbrella term used for persons whose gender identity does not conform to their biological sex (7).

The Indian population has more than 5 lakh individuals that belong to the trans community, one of the largest communities globally (8). Despite the Indian government’s recognition of the transgender as the ‘third gender’ (NALSA judgement, April 2014) (8), the trans community continues to face discrimination and is denied their fundamental rights such as access to education, workplace and healthcare. Though there have been smaller strides in the wake to improve the status of the trans community, we still go a long way in reaching the frame of absolute justice. What is worth attention is the status of mental health within this community. The stigma and discrimination against the minority status of trans community unfortunately subjects them to multiple issues with their well-being: rejection at home, struggle for societal identity and acceptance, access to health care and well-being and to ingress fundamental human rights (7).

There are some cardinal ethical considerations that hold true for every patient on equal grounds without any discrimination on any grounds of socio-cultural-demographic variables. The implementation of these ethical principles holds a promise for better and just care for the trans persons as well, and they include the following (1, 10):

1. **Autonomy** – Transsexual patients have the right to have their self-identification respected by staff, and their preferred name and gender identity should be recorded as they wish it to be. Transsexual patients have the right to make healthcare decisions collaboratively with their providers under the principle of informed consent.
2. **Beneficence** – Mental health providers with expertise in trans-affirmative mental health care that is respectful, aware, and supportive of the life experiences of transgender people are scarce. Trans patients may view mental health assessments as an important gateway to accessing surgeons, endocrinologists, and legal changes. This perception could create a vulnerable power differential, making patients incredibly cautious during initial appointments.
3. **Nonmaleficence** – Healthcare providers may need to reflect on their approach to gender identity and patient experience and should critically assess gaps in their knowledge and acceptance of gender nonconforming patients
4. **Justice** –The principle of justice affirms that transgender patients are equally entitled to afair distribution of healthcare resources; however, transgender patients are less likely to have health insurance and access to mental health services.

Transgender people seek mental health care for various reasons apart from issues resulting from one's gender identity which could cause them distress or confusion. Some of the several mental health issues faced by the trans community involve depression, post-traumatic stress disorder (PTSD), anxiety (social anxiety, specific phobias), bipolar disorder, schizophrenia, suicidal ideation, sexual abuse relationship dissatisfaction like in any other heterosexual or homosexual relationship issues, emotional health concerns and lack of sensitive, affirmative therapy among the trans community (11). Some of the psychosocial downhills for the trans community involve, lack of acceptance by family, gender identity confusion, homelessness, domestic violence and sexual harassment, bullying and being treated as an outcast. There are several other vulnerabilities identified in relation to health issues that further predispose the risk of worse mental health: a lack of safe environments, poor access to health services, challenges to the continuity of care-giving by their family and friends, and poor mental health resources. Feelings of shame and unworthiness have been found to be common among trans communities (12). While some may be seeking specific assistance for gender-related themes, others are seeking assistance with depression, anxiety, or other clinical concerns unrelated to their gender identity (13).

There are several challenges specific to the mental health of the trans persons that the community faces, especially so in the Indian scenario (1):

1. The status of being trans was considered to be a mental illness which led to pathologizing of the person's unique psychosocial experiences, therefore, limiting therapeutic responses and treatment options (14). The diagnosis of “transsexualism” first appeared in the International Statistical Classification of Diseases and Related Health Problems 9 in 1975 and, in 1980, in the Diagnostic and Statistical Manual of Mental Disorders III. However, recent research advancements (beginning since 2013) have confirmed that being transgender is not a mental illness. But in India, little medical research has been conducted on the issues of trans persons and the notion that being transgender is a mental illness continues to pervade.
2. Gender identity disorder was earlier understood to be a mental health condition for having the status of being trans that is, living with a dissonance between the gender identity and biological sex. However, gender identity disorder is now replaced and recognised as gender dysphoria which solely addresses the distress that may arise as a result of the gender confusion or due to the various psychosocial consequences of identifying as a trans (15-16).
3. Health and social care needs along with experiences, vary across the lifespan. Identities for the young people often take shape by findings ways to integrate their identity into their cultural background, personal characteristics and family circumstances. Corliss and others (17) show through their research that the experiences of young transgender people; therefore, young people continue to remain invisible and their concerns often neglected.
4. To begin with, there is lack of psychoeducation among family members in order to understand the status of being trans (transgender / transsexual) which evades from the heteronormative norms of the society. This further means that there is lack of sensitivity to the issues that trans individuals face and feel as individuals which further leads to an unwarranted divide among them and their family members. Overall, in the larger picture, this translates into lack of acceptance from the society, by large (18).
5. On the other hand, families with children or family members belonging to the trans community have distinct and unique needs that fail to get met due to the lack of specialised care and trained professionals to address the same. For family member to settle with calling one of their children or family members with another pronoun (a boy who identifies with being female, may disclose at the age of 16 years that he would like to be addressed as ‘she’), simply acknowledging that their child or member is willing to undergo sex transformation or simple day to day issues can sometimes get difficult in the initial phase (19).
6. Importance of informed consent, confidentiality and anonymity is equally important for everyone irrespective of their age, gender or any other socio-demographical feature. However, the larger clinical practice sees that though these norms are maintained for the heterosexual population, there is a compromise in following these ethical principles of practice when it comes to homosexuals or trans individuals as a consequence of the inherent bias that may be held against them (20).
7. Another major ethical compromise that holds against trans patients is that there is greater stigma attached to approaching for help in and within a homophobic society. Chances are less to find to a homosexual doctor or therapist as oppose to a greater chance of finding heterosexual professionals (though they may and most often, they do lack specialised care skills and knowledge to treat trans patients) (21).
8. Not all trans adolescents have gender dysphoria or wish to undergo sex reassignment surgery, however, it is a commonly misunderstood paradigm where the dissonance between an individual’s gender and sex is always looked at reconstructing and fixing them to align. On the contrary, another problem can arise if an adolescent may wish to undergo the sex reassignment surgery where there may be two issues- one, either there is a confusion whether the teenager is sure enough for the surgery and second is the disagreement about the surgery between the adolescent and his or her parents (22).
9. There is no expert clinical consensus nor clinical guidelines regarding the treatment of prepubescent children or even adults who meet the diagnostic criteria for gender dysphoria (23). It is believed that gender dysphoria usually translates from adolescence to adulthood, however, the World Professional Association for Transgender Health (WPATH) has discussed that such is not the case. In their latest Standards of Care, merely 6 to 23 percent of boys and 12 to 27 percent of girls treated in gender clinics have shown persistence of their gender dysphoria into adulthood (24). Sometimes, it may also be after the age of 40 years that persons may come out as trans.
10. Sex change therapies are a practice till date despite the known fact that it is incorrect and impossible to medicate someone in order to make them conform to their biological sex. This raises a humongous ethical dilemma in the practice of those professionals who promise to change the ‘preference of sexuality’ as a consequence of the sex change surgery (25).
11. There are several instances when children, adolescents and young adults have been taken to psychotherapists or counsellors by their parents with the notion that counselling can ‘correct’ their sexuality. However, these are myths and anybody who conforms to these practices in affirmation would be suspected on ethical (health care) practices. As opposed to this view, sex reassignment therapies are meant for those who wish to get themselves biologically corrected in order to conform to their psychological sex or the gender they wish to conform to (which is usually biologically the opposite) (26).
12. The assessment before the sex reassignment surgeries and accessing hormone treatment remain at the merciful approval of the practitioners, some of them who continue to give a diagnosis of Gender Identity Disorder (the revision of Gender Identity Disorder in DSM IV TR has evolved to that of Gender Dysphoria in DSM 5 which implies the treatment of distress, depression or anxiety due to the non-conformity to the gender and does not involve any techniques or therapies to dissuade the personal choice / preference of an individual to identifying with a gender). The process of pre-counselling before the sex reassignment surgery may miss the underlying emotional factors and many a times, involves dissuasion rom the sex reassignment surgery in order to conform to the biological sex of the individual. Ethically, before the surgery, the individual is made to undergo various social norms and make lifestyle choices so as to prepare them for the post-surgery life (27).
13. Post-surgery and post hormone treatment care and counselling is missing, which is a crucial aspect in order to build and settle the transformations in the patient (28).
14. One of other nuances that often go amiss is the difference between sexual orientation and gender identity. Though the two are inter-linked they are different concept in existence and understanding. Professionals must be clear and precise about making of note of the same. When talking about sex reassignment surgery, it is important to know the gender identity of the individua and not the sexual orientation (29).
15. Unrequired electroconvulsive therapy (ECT), tying the patients to beds and institutionalisation are resorted to for convincing patients about the ‘consequences of sex change’ and instead stand the chance of an ethical dilemma. Unfortunately, several practitioners resort to giving ECT in order to prevent the sex reassignment surgery for the individual thinking it is part of the treatment, however, one must be aware that this means is hoax (30).
16. As a result of the apparent stressors, an increasing number of transgender people are seeking therapy. However, therapists often lack the skills to work effectively with transgender clients and are often insensitive, ignorant and unaware regarding the several transgender issues. Many mental health professionals and medical practitioners lack an understanding of the LGBTQ spectrum health issues. Thus, an expertise to treat their concerns with an understanding of the ethical standpoints is missing (31).
17. The distinct needs of families with a transgender family member have often been neglected and children are increasingly in need of support. It has been clearly identified that access to family and couples therapy remains limited if it exists in the first place (32). It transpires that most professionals in mental health services have received no training on transgender issues and there are visible shortcomings in terms of mental health education and curriculum developments (33-34). This denies the trans community the treatment they deserve. However, in the present times, the training for the same has taken a start but is a long way to go.
18. It has been noticed that practitioners harbour personal biases and prejudices in taking up trans patients for therapy or treatment. Psychiatrists and psychotherapists have a biased choice for taking up patients for treatment and thus may invariable deny the required and optimal mental health services needed by the trans individuals (35).
19. Counselling and psychotherapies also need a branch of specialisation in order to understand and appropriately address the concerns and mental health issues of trans communities that are amplified due to multiple concerns. After having recognised the ‘third’ gender, the education and training centres fail to be inclusive in terms of providing the care for trans community (35).
20. One of the greater challenges is also to assess that the psychological testing tools that are used also do justice to the heteronormativity of the society and does not give us normative data beyond the gender binary. There is a need for the development of tools and questionnaires that also map the trends in trans populations in order to present a diversity of norms (36).
21. Schools and colleges lack a curriculum to understand the sensitivity of the health problems and other concerns of the trans community thus the inclusivity of trans members is a continued struggle in the educational and socio-political sphere. This further leads to the lack of awareness and understanding required to incorporate the needs and concerns of their community (37).
22. Gender dysphoria clinics are a far-fetched dream in India and other places. It is the need of the hour to incorporate and make available the deserving treatment to the trans individuals.

Some very fundamental inclusive steps that can be taken up at an individual and societal level in order to ensure a just status of the trans community, as:

1. Gender Identity Disorder should be a discarded phenomenon. Gender dysphoria must be understood in the rightful definition of the underlying depression or distress due to gender confusion or social ostracization and not a pathological identity / personality (38).
2. Psychoeducation to one and all about the existing trans identities and their challenges should be addressed in order to ensure that the community acts in a sensitive manner towards them (38).
3. Health care settings must offer a safer environment for trans persons to bring up mental health concerns and should make access to mental health services easy for them. Every person taken as intake for primary health care concern should include a mental health history and an assessment for active mental health concerns. Screening should include for primary mental health problems, environmental and social stressors, and gender-related needs (39).
4. When there is a trans patient that a mental health professional is unable to handle, one must appropriately refer to transgender-affirming mental health services where mental health professionals specialise in the field of LGBTQ+ mental health and thus will be more equipped to treat them (40).
5. There should be specialisation courses run for treating individuals from the trans and LGBTQ+ community in order to better address their concerns and handle their specific mental health concerns with due sensitivity and responsibility (40).
6. School curriculums can also include to discuss the growing minority population and their challenges.

**CONCLUSIONS**

One of the greatest challenges that the trans community faces is not only being discriminated socially but also receiving discriminated treatments at a greater fundamental level-physical and mental health care. However, the increasing psycho-socio-political conscience around the LGBTQ+ community has been rising on a global platform that has raised sensitivity and awareness towards the needs and challenges of the community. The activist work and growing responsibility in the health care sector is a promise to a brighter health care future for all. For a population with special needs and challenges, mental health professionals must be well versed with the ethical dilemmas involved when treating such special groups.

**REFERENCES**

1. Lodha P, De Sousa A. Ethical issues in the treatment of Transsexual patients. *Global Bioethics Enquiry.* 2018;6(1):13-18.
2. Caldwell D, Golosow N, Weitzman EL. Psychosexual and ego repression in the male transsexual. *J. Nerv. Ment. Dis.* 1949;149:328-36.
3. Benjamin H. The transsexual phenomenon: A scientific report on transsexualism and sex conversion in the human male and female. New York: Julian; 1966.
4. Brierley H. *Transvestism: A handbook with case studies for psychologists, psychiatrists and counsellors.* Elsevier; 2013.
5. Eyler AE, Wright K. Gender identification and sexual orientation among genetic females with gender-blended self-perception in childhood and adolescence. *Int. J. Transgenderism.* 1997;1(1):37-51.
6. Davy Z. *Recognizing transsexuals: Personal, political and medicolegal embodiment.* Routledge; 2016.
7. Cohen L, de Ruiter C, Ringelberg H, Cohen‐Kettenis PT. Psychological functioning of adolescent transsexuals: Personality and psychopathology. *J. Clin. Psychol.* 1997;53(2):187-96.
8. Nanda S. *Neither man nor woman: The hijras of India.* Cengage Learning; 1999.
9. Dutta A. Contradictory Tendencies: The Supreme Court's NALSA Judgment on Transgender Recognition and Rights. *J. Indian Law. Socy.* 2014;5:225.
10. Balakrishnan VS. Growing recognition of transgender health: stigma, discrimination and lack of legal recognition remain major barriers for transgender people to access the health services they need. *Bull. WHO.* 2016;94(11):790-2.
11. Cohen-Kettenis PT, Gooren LV. Transsexualism: a review of etiology, diagnosis and treatment. *J. Psychosom, Res.* 1999;46(4):315-33.
12. Michel A, Ansseau M, Legros JJ, Pitchot W, Mormont C. The transsexual: what about the future ?. *Eur Psychiatry.* 2002;17(6):353-62.
13. Ettner R, Monstrey S, Coleman E. *Principles of transgender medicine and surgery.* Routledge; 2016.
14. Lea AS. Clinical dimensions of a ‘biological concept’: transsexualism and the interplay between etiological theory and clinical therapy. *Endeavour.* 2016;40(3):152-62.
15. Moleiro C, Pinto N. Sexual orientation and gender identity: review of concepts, controversies and their relation to psychopathology classification systems. *Front. Psychol.* 2015;6:1511.
16. Pfeffer CA. *Queering families: The postmodern partnerships of cisgender women and transgender men.* Oxford University Press; 2017.
17. Weiner BA, Zinner L. Attitudes toward straight, gay male, and transsexual parenting. *J. Homosexuality.* 2015;62(3):327-39.
18. von Vogelsang AC, Milton C, Ericsson I, Strömberg L. ‘Wouldn't it be easier if you continued to be a guy?’–a qualitative interview study of transsexual persons’ experiences of encounters with healthcare professionals. *J. Clin. Nurs.* 2016;25(23-24):3577-88.
19. Austin A, Goodman R. The impact of social connectedness and internalized transphobic stigma on self-esteem among transgender and gender non-conforming adults. *J. Homosexuality.* 2017;64(6):825-41.
20. Fitzgerald-Husek A, Van Wert MJ, Ewing WF, Grosso AL, Holland CE, Katterl R, Rosman L, Agarwal A, Baral SD. Measuring stigma affecting sex workers (SW) and men who have sex with men (MSM): A systematic review. *PloS One.* 2017;12(11):e0188393.
21. Wagner PE, Kunkel A, Asbury MB, Soto F. Health (trans) gressions: Identity and stigma management in trans\* healthcare support seeking. *Women. Lang.* 2016;39(1):49-74.
22. Drescher J, Cohen-Kettenis PT, Reed GM. Gender incongruence of childhood in the ICD-11: controversies, proposal, and rationale. *The Lancet Psychiatry.* 2016;3(3):297-304.
23. De Vries AL, Klink D, Cohen-Kettenis PT. What the primary care pediatrician needs to know about gender incongruence and gender dysphoria in children and adolescents. *Pediatr. Clin.* 2016;63(6):1121-35.
24. Deutsch MB. *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people.* University of California, San Francisco; 2016.
25. McQueen P. Authenticity, intersubjectivity and the ethics of changing sex. *J. Gender Stud.* 2016;25(5):557-70.
26. Ali N, Fleisher W, Erickson J. Psychiatrists’ and psychiatry residents’ attitudes toward transgender people. *Acad. Psychiatry.* 2016;40(2):268-73.
27. Wakefield JC. Diagnostic issues and controversies in DSM-5: return of the false positives problem. *Ann. Rev Clin. Psychol.* 2016;12:105-32.
28. Carroll L, Gilroy PJ, Ryan J. Counseling transgendered, transsexual, and gender‐ variant clients. *J. Couns. Dev.* 2002;80(2):131-9.
29. Lodha P. Better Mental Health Services for Trans-Persons in India-There is a Need for Understanding, Training and Infrastructure.

Available from http://newsnviews.online/news-n-views/better-mental-health-services-for-trans-persons-in-india-the-need-for-understanding-training-and-infrastructure/

1. Coffey MJ, Stevens JR. Safe and Successful ECT in a Female-to-Male Transgender Individual With Major Depression. *J. ECT.* 2016;32(3):e11-2.
2. Bockting WO. Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies.* 2008;17(4):211-24.
3. Hann M, Ivester R, Denton GD. Bioethics in Practice: Ethical Issues in the Care of Transgender Patients. *The Ochsner Journal.* 2017;17(2):144–5.
4. Benson KE. Seeking support: Transgender client experiences with mental health services. *J. Fem. Fam. Ther.* 2013;25(1):17-40.
5. Keogh B, Daly L, Sharek D, De Vries J, McCann E, Higgins A. Sexual health promotion programme: Participants’ perspectives on capacity building. *Health. Educ. J.* 2016;75(1):47-60.
6. Erickson-Schroth L. *Trans bodies, trans selves: A resource for the transgender community.* Oxford University Press;2014.
7. Joslin-Roher E, Wheeler DP. Partners in transition: The transition experience of lesbian, bisexual, and queer identified partners of transgender men. *J. Gay. Lesbian. Soc. Serv.* 2009;21(1):30-48.
8. Alegria CA. Relationship challenges and relationship maintenance activities following disclosure of transsexualism. *J. Psychiatr. Ment. Health. Nurs.* 2010;17(10):909-16.
9. Richards C, Bouman WP, Seal L, Barker MJ, Nieder TO, T’Sjoen G. Non-binary or genderqueer genders. *Int. Rev. Psychiatry.* 2016;28(1):95-102.
10. Spicer SS. Healthcare needs of the transgender homeless population. *J. Gay. Lesbian. Ment. Health.* 2010;14(4):320-39.
11. Shipherd JC, Green KE, Abramovitz S. Transgender clients: Identifying and minimizing barriers to mental health treatment. *J. Gay. Lesbian. Ment. Health.* 2010;14(2):94-108.

Acknowledgements – Nil

Conflict of Interest – Nil

Funding – Nil