Mental Health

Introduction

This chapter is intended to provide guidance to health professionals (HPs) and mental health professionals (MHPss) who offer mental health care to transgender and gender diverse (TGD) people with mental health problems (symptoms or disorders) and substance use disorders. It is not meant to be a substitute for chapters on assessment or evaluation of patients for hormonal or surgical interventions. Many TGD people will not require therapy or other forms of mental health care as part of their transition, while others may benefit from the support of mental health providers and systems (Dhejne et al., 2015).

Some studies have shown a higher prevalence of depression (Witcomb et al, 2018), anxiety (Bouman et al., 2017), and suicidality (Arcelus, et al. 2016; Davey, et al. 2016) among TGD people (Thorne et al, 2020; Jones et al., 2020) than in the general population, particularly in those wishing gender-affirming medical treatment but who are not in treatment (Dhejne, 2011, Herman, et al. 2017). However, transgender identity is not a mental illness, and these elevated rates have been linked to complex trauma, societal stigma, violence, and discrimination (Nuttbrock et al., 2014; Peterson et al., 2021; Bränström and Pachankis, 2021). In addition, psychiatric symptoms lessen with appropriate gender-affirming medical and surgical care (Aldridge et al, 2020; Grannis et al., 2021) and with interventions that lessen discrimination and minority stress (Heylens et al., 2014; McDowell et al., 2020)

Mental health treatment needs to be provided by staff and implemented through the use of systems that respect patient autonomy and recognize gender diversity. MHPs working with transgender people should use active listening as a method to encourage exploration in individuals who are uncertain about their gender identity. Rather than impose their own narratives or preconceptions, MHPs should assist their clients in determining their own paths. While many transgender people desire medical or surgical interventions or seek mental health care, others do not (Margulies et al., 2021). Therefore, findings from research involving clinical populations should not be extrapolated to the entire transgender population.

Addressing mental illness and substance use disorders is important but should not be a barrier to transition-related care. Rather, these interventions to address mental health and substance use disorders can facilitate successful outcomes from transition-related care, which can improve quality of life (Nobili et al., 2018).

Summary of Recommendations

Statement 1: We recommend mental health professionals address mental health symptoms that interfere with a person's capacity to consent to gender-affirming treatment before gender-affirming treatment is initiated.

Statement 2: We recommend mental health professionals offer care and support to transgender and gender diverse people to address mental health symptoms that interfere with a person's capacity to participate in essential perioperative care before gender affirmation surgery.

Statement 3: We recommend when significant mental health symptoms or substance abuse exists, mental health professionals assess the potential negative impact that mental health symptoms may have on outcomes based on the nature of the specific gender-affirming surgical procedure.

Statement 4: We recommend health professionals assess the need for psychosocial and practical support of transgender and gender diverse people in the perioperative period surrounding gender affirmation surgery.

Statement 5: We recommend health professionals counsel and assist transgender and gender diverse people in becoming abstinent from tobacco/nicotine prior to gender affirmation surgery.

Statement 6: We recommend health professionals maintain existing hormone treatment if a transgender and gender diverse individual requires admission to a psychiatric or medical inpatient unit.

Statement 7: We recommend health professionals ensure if transgender and gender diverse people need in-patient or residential mental health, substance abuse or medical care, all staff use the correct name and pronouns (as provided by the patient), as well as provide access to bathroom and sleeping arrangements that are aligned with the person's gender identity.

Statement 8: We recommend mental health professionals encourage, support, and empower transgender and gender diverse people to develop and maintain social support systems, including peers, friends, and families.

Statement 9: We recommend health professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment, while acknowledging that psychotherapy may be helpful for some transgender and gender diverse people.

Statement 10: We recommend reparative and conversion therapy aimed at trying to change a person’s gender identity and lived gender expression to become more congruent with sex assigned at birth should not be offered.

All these statements have been recommended based on the large amount of background literature and a favorable risk-benefit ratio.

Statement 1:
We recommend mental health professionals address mental health symptoms that interfere with a person’s capacity to consent to gender-affirming treatment before gender-affirming treatment is initiated.

Because patients generally are assumed to be capable of providing consent for care, whether the presence of cognitive impairment, psychosis, or other mental illness impairs the ability to give informed consent is subject to individual examination (Applebaum, 2007). Informed consent

is central to the provision of healthcare. The healthcare provider must educate the patient about the risks, benefits, and alternatives to any care that is offered so that the patient can make an informed, voluntary choice (Berg et al. 2001). Both the primary care provider or endocrinologist prescribing hormones and the surgeon performing surgery must obtain informed consent. Similarly, MHPs obtain informed consent for mental health treatment and may consult on a patient's capacity to give informed consent when this is in question. Psychiatric illness and substance use disorders, in particular cognitive impairment and psychosis, may impair an individual's ability to understand the risks and benefits of the treatment (Hostiuc et al., 2018). Conversely, a patient may also have significant mental illness, yet still be able to understand the risks and benefits of a particular treatment (Carpenter et al., 2000). Multidisciplinary communication is important in challenging cases, and expert consultation should be utilized as needed (Karasic and Fraser, 2018). For many patients, difficulty understanding the risks and benefits of a particular treatment can be overcome with time and careful explanation. For some patients, treatment of the underlying condition that is interfering with the capacity to give informed consent— for example treating an underlying psychosis—will allow the patient to gain the capacity to consent to the desired treatment. However, mental health symptoms, such as anxiety or depressive symptoms that do not affect the capacity to give consent should not be a barrier for gender-affirming medical treatment, particularly as this treatment has been found to reduce mental health symptomatology (Aldridge et al., 2020).

Statement 2:
We recommend mental health professionals offer care and support to transgender and gender diverse people to address mental health symptoms that interfere with a person's capacity to participate in essential perioperative care before gender affirmation surgery.

The inability to adequately participate in perioperative care due to mental illness or substance use should not be viewed as an obstacle to needed transition care but should be seen an indication that mental health care and social support should be provided (Karasic, 2020). Mental illness and substance use disorders may impair the ability of the patient to participate in perioperative care (Barnhill, 2014). Visits to healthcare providers, wound care, and other aftercare procedures (such as dilation after vaginoplasty) are necessary for a good outcome. A patient with a substance use disorder might have difficulty keeping necessary appointments to the primary care provider and the surgeon. A patient with psychosis or severe depression might neglect their wound or not be attentive to infection or signs of dehiscence (Lee 2016). Active mental illness is associated with a greater need for further acute medical and surgical care after the initial surgery (Wimalawansa et al., 2014).

In these cases, treatment of the mental illness or substance use disorder may assist in achieving successful outcomes. Arranging more support for the patient from family and friends or a home healthcare worker may help the patient participate sufficiently in perioperative care for surgery to proceed. The benefits of mental health treatments that may delay surgery should be weighed against the risks of delaying surgery and should include an assessment of the impact on the patients' mental health delays may cause in addressing gender dysphoria (Byne et al., 2018).

Statement 3:
We recommend when significant mental health symptoms or substance abuse exists, mental health professionals assess the potential negative impact that mental health

symptoms may have on outcomes based on the nature of the specific gender-affirming surgical procedure.

Gender-affirming surgical procedures vary in terms of their impact on the patient. Some procedures require a greater ability to follow preoperative planning as well as engage in peri- and postoperative care to achieve the best outcomes (Tollinche, et al., 2018). Mental health symptoms can influence a patient's ability to participate in the planning and perioperative care necessary for any surgical procedure (Paredes, et al., 2020). The mental health assessment can provide an opportunity to develop strategies to address the potential negative impact mental health symptoms may have on outcomes, and to plan support for the patient's ability to participate in the planning and care.

Gender-affirming surgical procedures have been shown to relieve symptoms of gender dysphoria and improve mental health. (Van de Grift et al., 2017; Owen-Smith et al., 2018). These benefits are weighed with the risks of each procedure when patient and provider are deciding whether to proceed with treatment.

MHPs can assist TGD people in reviewing preplanning and perioperative care instructions for each surgical procedure (Karasic, 2020). Provider and patient can collaboratively determine the necessary support or resources needed to assist with keeping appointments for perioperative care, obtaining necessary supplies, addressing financial issues, and handling other preoperative coordination and planning. In addition, issues surrounding cosmetic and functional expectations, including the impact of these various factors on gender dysphoria, can be explored.

Statement 4:
We recommend health professionals assess the need for psychosocial and practical support of transgender and gender diverse people in the perioperative period surrounding gender affirmation surgery.

Regardless of specialty, all HPs have a responsibility to support patients in accessing medically necessary care. When mental health care providers are working with TGD people as they prepare for gender-affirming surgical procedures, they should assess the levels of psychosocial and practical support required (Deutsch, 2016a). Assessment is the first step in recognizing where additional support may be needed and enhancing the ability to work collaboratively with the individual to successfully navigate the pre-, peri-, and postsurgical periods (Tollinche, 2018).

In the perioperative period, it is important to help patients optimize functioning, secure stable housing when possible, build social and family supports by assessing their unique situation, plan ways of responding to medical complications, navigate the potential impact on work/income, and overcome additional hurdles some patients may encounter, such as coping with electrolysis and tobacco cessation (Berli et al., 2017). In a complex medical system, not all patients will be able to independently navigate the procedures required to obtain care, and HPs and peer navigators can support patients through this process (Deutch, 2016a).

Statement 5:
We recommend health professionals counsel and assist transgender and gender diverse people in becoming abstinent from tobacco/nicotine prior to gender affirmation surgery.

Trans populations have higher rates of tobacco and nicotine use (Kidd et al., 2018). However, many are unaware of the well-documented smoking-associated health risks (Bryant et al., 2014). Tobacco consumption increases the risk of developing health problems (e.g., thrombosis) in individuals receiving gender-affirming hormone treatment, particularly estrogens (Chipkin & Kim, 2017).

Tobacco use has been associated with worse outcomes in plastic surgery, including overall complications, tissue necrosis, and the need for surgical revision (Coon et al., 2013). Smoking also increases the risk for postoperative infection (Kaoutzanis et al.,2019). Tobacco use has been shown to affect the healing process following any surgery, including gender-related surgeries (e.g., chest reconstructive surgery, genital surgery) (Pluvy et al., 2015). Tobacco users have a higher risk of cutaneous necrosis, delayed wound healing, and scarring disorders due to hypoxia and tissue ischemia (Pluvy et al., 2015). In view of this, surgeons recommend stopping the use of tobacco/nicotine prior to gender affirmation surgery and abstaining from smoking up to several weeks postoperatively until the wound has completely healed (Matei & Danino, 2015).

Despite the risks, cessation may be difficult. Tobacco smoking and nicotine use is addictive and is also used as a coping mechanism (Matei et al., 2015). HPs who see patients longitudinally before surgery, including mental health and primary care providers, should address the use of tobacco/nicotine with individuals in their care, and either assist TGD people in accessing smoking cessation programs or provide treatment directly (e.g., varenicline).

Statement 6:

We recommend that clinicians maintain existing hormone treatment if a trans and gender diverse individual requires admission to a psychiatric or medical inpatient unit.

TGD people entering inpatient psychiatric, substance use treatment, or medical units should be maintained on their current hormone regimens. Stopping hormone treatment prior to surgery also does not appear to be necessary (Boskey et al., 2018). There is an absence of evidence supporting routine cessation of hormones prior to medical or psychiatric admissions. Rarely, a newly admitted patient may be diagnosed with a medical complication necessitating suspension of hormone treatment, for example an acute venous thromboembolism (Deutsch, 2016b).

Hormone treatment has been shown to improve quality of life and to decrease depression and anxiety (Aldridge et al., 2020; Nguyen et al, 2018; Nobili et al, 2018; Owen-Smith et al 2018, Rowniak et al, 2019). Access to gender confirming medical treatment is associated with a substantial reduction in risk of suicide attempt (Bauer et al 2015). Halting a patient's regularly prescribed hormones denies the patient of these salutary effects, and therefore may be counter to the goals of hospitalization.

Some providers may be unaware of the low risk of harm and the high potential benefit of continuing transition-related treatment in the inpatient setting. A study of US and Canadian medical schools revealed that students received an average of 5 hours of LGBT-related course content over their entire four years of education (Obedin-Maliver et al., 2011). According to a survey of Emergency Medicine physicians, who are often responsible for making quick decisions about medications as patients are being admitted, while 88% reported caring for transgender patients, t only 17.5% had received any formal training about this population (Chisolm-Straker et al., 2018). As education about transgender topics increases, more providers

will become aware of the importance of maintaining transgender patients on their hormone regimens during hospitalization.

Statement 7:
We recommend that clinicians ensure that if trans and gender diverse people need inpatient or residential mental health, substance abuse, or medical care, all staff use the correct name and pronouns (as provided by the patient), as well as provide access to bathroom and sleeping arrangements that are aligned with the person's gender identity.

Many TGD patients encounter discrimination in a wide range of health settings, including hospitals, mental health treatment settings, and drug treatment programs (Grant et al., 2011) When health systems fail to accommodate TGD individuals, they reinforce the longstanding societal exclusion that many have experienced (Karasic, 2016). Experiences of discrimination in health settings lead to avoidance of needed healthcare due to anticipated discrimination. (Kcomt, et al., 2020).

The experience of discrimination experienced by TGD individuals is predictive of suicidal ideation (Rood et al., 2015; Williams et al., 2021). Gender minority stress associated with rejection and non-affirmation has been associated with suicidality (Testa et al., 2017). Denial of access to gender appropriate bathrooms has been associated with increased suicidality (Seelman, 2016). However, the use of chosen names for TGD people has been associated with lower depression and suicidality (Russell et al., 2018). Structural as well as internalized transphobia must be addressed to reduce the incidence of suicide attempts in TGD people (Brumer et al., 2015). To successfully provide care, health settings must minimize the harm done to patients because of transphobia by respecting and accommodating TGD identities.

Statement 8:
We recommend mental health professionals encourage, support, and empower transgender and gender diverse people to develop and maintain social support systems, including peers, friends, and families.

While minority stress and the direct effects of discriminatory societal discrimination can be harmful to the mental health of TGD people, strong social support can help lessen this harm (Trujillo et al, 2017). TGD children often internalize rejection from family and peers as well as the transphobia that surrounds them (Amodeio et al., 2015)**.** Furthermore, exposure to transphobic abuse may be impactful across a person's lifespan and may be particularly acute during the adolescent years (Nuttbrock et al., 2010).

The development of affirming social support is protective of mental health. Social support can act as a buffer against the adverse mental health consequences of violence, stigma, and discrimination (Bockting et al., 2013) and can contribute to psychological resilience (Bariola et al., 2015; Başar and Öz, 2016) in TGD people. Diverse sources of social support, especially LGBT peers and family, were found to be associated with better mental health outcomes, well-being, and quality of life (Bariola et al., 2015; Başar et al, 2016; Kuper et al., 2018; Puckett et al., 2019). Social support has been proposed to facilitate the development of coping mechanisms and lead to positive emotional experiences throughout the transition process (Budge et al., 2013).

HPs can support patients in developing social support systems that allow them to be recognized and accepted as their authentic identity and help them cope with symptoms of gender dysphoria. Interpersonal problems and lack of social support have been associated with a greater incidence of mental health difficulties in TGD people (Bouman et al., 2016; Davey et al., 2015) and have been shown to be an outcome predictor of gender-affirming medical treatment (Aldridge et al., 2020). Therefore, MHPs should encourage, support, and empower TGD people to develop and maintain social support systems. These experiences can foster the development of interpersonal skills and help with coping with societal discrimination, potentially reducing suicidality and improving mental health. (Pflum et al., 2015).

Statement 9:

We recommend health professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming (medical?) treatment, while acknowledging that psychotherapy may be helpful for some transgender and gender diverse people.

Psychotherapy has a long history being used in clinical work with TGD people (Fraser, 2009b). The aims, requirements, methods and principles of psychotherapy have been an evolving component of the Standards of Care from the initial versions (Fraser, 2009b). At present, psychotherapeutic assistance and counseling with adult TGD people may be sought to address common psychological concerns related to coping with gender dysphoria and may also help some individuals with the coming-out process (Hunt, 2014). Psychological interventions, including psychotherapy, offer effective tools and provide context for the individual, such as exploring gender identity and its expression, enhancing self-acceptance and hope, and improving resilience in hostile and disabling environments (Matsuno and Israel, 2018). Psychotherapy is an established alternative therapeutic approach for addressing mental health symptoms that may be revealed during the initial assessment or later during the follow-up for gender-affirming medical interventions. Recent research shows that, although mental health symptoms are reduced following gender-affirming medical treatment, levels of anxiety remain high (Aldridge et al, 2020) suggesting psychological therapy can play a role in helping individuals suffering from anxiety symptoms following gender-affirming treatment.

In recent years, the uses and potential benefits of specific psychotherapeutic modalities have been reported (Embaye, 2006; Fraser, 2009a; Budge, 2013; Heck et al., 2015; Austin et al., 2017; Budge et al., 2021). Specific models of psychotherapy have been proposed for adult trans and non-binary individuals (Matsuno & Israel, 2018). However, more empiric data is needed on the comparative benefits of different psychotherapeutic models. (Catelan et al., 2017). Psychotherapy can be experienced as a fearful experience, as well as a beneficial one, by transgender persons (Applegarth & Nuttall 2016) and presents challenges to the therapist and to alliance formation when it is associated with gatekeeping for medical interventions (Budge, 2015).

Experience suggests that many trans and non-binary individuals decide to undergo gender-affirming medical treatment with little or no use of psychotherapy (Spanos et al., 2021). Although various modalities of psychotherapy may be beneficial for different reasons before, during and after gender-affirming medical treatments, and varying rates of desire for psychotherapy have been reported during different stages of transition (Mayer et al., 2019), a requirement for psychotherapy for initiating gender-affirming medical procedures has not been demonstrated beneficial, and may be a harmful barrier to care for those who don't need this type of treatment or who lack access to it.

Statement 10:
We recommend reparative and conversion therapy aimed at trying to change a person's gender identity and lived gender expression to become more congruent with the sex assigned at birth should not be offered.

The use of reparative or conversion therapy or gender identity change efforts is opposed by many major medical and mental health organizations across the world, including the World Psychiatric Association, Pan American Health Organization, American Psychiatric and American Psychological Associations, Royal College of Psychiatrists, and British Psychological Society. Six countries (Albania, Brazil, Ecuador, Germany, Malta, and Taiwan) (Savage, 2020). Many states in the US states have instituted bans on practicing conversion therapy with minors.

Advocates of conversion therapy have suggested it could potentially allow a person to fit better into their social world. They also point out that some clients specifically ask for help changing their gender identities or expressions and that therapists should be allowed to help clients achieve their goals. However, conversion therapy has not been shown to be effective (APA, 2009; Przeworski et al., 2020). In addition, there are numerous potential harms. In retrospective studies, a history of having undergone conversion therapy is linked to increased levels of depression, substance abuse, suicidal thoughts, and suicide attempts, as well as lower educational attainment, and less weekly income (Ryan et al., 2020; Salway et al., 2020, Turban et al., 2020). In 2021, the American Psychological Association resolutions states that "scientific evidence and clinical experience indicate that GICEs [gender identity change efforts] put individuals at significant risk of harm" (APA, 2021).

While there are barriers to ending gender identity change efforts, education about the lack of benefit and the potential harm of these practices may lead to fewer providers offering conversion therapy and fewer individuals and families choosing this option.

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