Counselling the patient with gid

AbstractAppreciating and counseling the patient with Gender Identity Disorder is not always an easy task.? Each counselor must comprehend the in depth ideas to these individuals who need assistance with their mental health needs and their individual diagnostic needs.? Considering the etiologies, the differential diagnoses, and the treatment strategies available not only to the client but for the therapist as well to help the client in their needs is an understanding that every therapist should learn and know.

IntroductionWith the emergence of numerous psychological concerns in therapy over the years, one may suggest that counseling the transgender individual, or a client diagnosed with Gender Identity Disorder, is even more of a challenge than perhaps any other concern in this field of study.? In order to understand the transgender person and their mental health requests, the therapist should not only concern themselves with the various matters that could arise in the counseling sessions, but they should conduct an in-depth assessment of who the transgendered individual is as a human being and what other possible concerns they might have relating to their identity. ? With the evolution of medical science, it is no wonder that the field of psychology is seeing a rise of individuals needing the assistance of professionals in determining if complete gender reassignment surgery is appropriate for them or if a less radical procedure (e. g.

only hormone treatment, psychotherapy treatment alone) would be in order if one is called for at all. With the amount of time given to complete this undertaking, some therapists may perhaps find it complexing to recognize the nature of Gender Identity Disorder, or Transgenderism in main stream thought, in a short period of time.? With an assortment of issues that can

present themselves throughout the path of an individual??™s transition, the inexperienced therapist may find it easier to refer the client to a more qualified therapist in the field and then decide to gain the information needed in assisting such individuals.? Gordon Allport once said that ??? the goal of psychology is to reduce discord among our philosophies of man and to establish a scale of probable truth??? (1955), and in one of his previous texts he relayed that ??? general psychology??¦selects a single attribute or function that can be conveniently isolated for study??? (Allport, 1937).? It is no surprise therefore, that there is a need to counsel each of these individuals with a more open mind, complete understanding, to beware of our biases, and to be cautious and ? aware of our own manifesting countertransference issues that could surface for even the most culturally sensitive and experienced therapist.? It is because of the refinement of my personal biases, and the newly understood education that I have acquired from good friends who have been diagnosed with Gender Identity Disorder (GID) over the last two years, that I have had a better understanding of GID and have become an advocate on their behalf for the last 18 months with hopes to have it removed from the DSM-5.? It is because of these truly wonderful, remarkable, and brave individuals that GID was chosen to be written about in this research. Hypotheses Regarding Etiology? ? ? ? ? ? ? ? ? ? With as many as 3.

04 million individuals in the United States living with GID, rather diagnosed or not, it appears that this area needs to be highly addressed in regards of diagnosing people without setting a stigma on them.? Unfortunately, because of our societal norms, a stigma has been set on any mental disorder

that we diagnose a patient with, and in an area such as Tulare County, where as many as 4, 200 people, again are or are not diagnosed with GID, stigmas need to be addressed in order for these individuals to receive treatment as to not harm themselves, such as in the instance of Martina, who earlier this year took her life in Visalia because of the lack of assistance she was unable to find.? And with suicide rates for individuals with GID being more than 50 per cent in some studies (University of New Hampshire, 2008), with these statistical numbers, it is a good thing to understand the etiology of GID in order to be able to treat it appropriately.? The Diagnostic and Statistical Manual of Mental Disorders did not have a diagnosis for transgenderism or transsexuality prior to their release of their DSM-III.

? It was only in this third edition that the American Psychiatric Association used the term transsexualism for the first time, making it a mental disorder in the mental health and medical field (1980).? This terminology again was changed in the DSM-IV (1994) to GID, or gender identity disorder, in which there were three classifications, Gender Identity Disorder in Children or Gender Identity Disorder Not Otherwise Specified (NOS), 302. 6 and Gender Identity Disorder in Adolescents or Adults, 302. 85.? ? ? Because of this definition, many people believe that transgender people are mentally ill, however some authors believe that having a transgender identity is not in and of itself being ??? mentally disordered??? (Israel & Tarver, 1996; Melby, 2009).? ??? Regardless of the stage of life in which individuals with gender identity disorder find themselves, the key root of their cross-identification behavior is the conflict over their biological sex role and their perceived

sexual identity??? (Kirk & Belovics, 2008).? ? ? ? ? ? ? ? ? ? ? ? In Pauly??™s article ??? Terminology and Classification of Gender Identity Disorders,??? the author states that clinicians have been describing patients with some form of gender discomfort for more than 150 years (1992).

? Since 1830, German clinicians have written about gender dysphoria in various European literature.? Since 1980, the American Psychiatric Association (APA) has been explaining GID in one form or another in the DSM and since then, numerous individuals as well as many organizations have been pressuring to have the removal of GID from the DSM completely. There are several current theories about the causes of GID and these appear to include chromosomal abnormality, hormonal imbalance, and impaired early parent-child bonding and child-rearing practices (Causes of Gender Identity Disorders, 2010), although none of these could actually be confirmed in literature.? In ??? The Theory of Gender Identity Disorders???, Meyer reviewed existing hypotheses stating that there are three of them regarding ??? transsexualism??? which is the previous term to Gender Identity Disorder in the DSM-III.? These three hypotheses include the biological/ imprint hypothesis, the nonconflictual hypothesis, and the conflict/defense hypothesis (1982). In his first hypothesis, Meyer views the biological/ imprint hypothesis of transsexualism as the ??? unfolding of a predisposition or the manifestation of a biological vulnerability.???? He also states that Money and Gaskin believed that transsexualism to be a clinical syndrome, possibly triggered by ??? critical period affects.???? Both of these ideas would be supported by the thought that one??™s ideas are established early in life as male and female (Parlee, 1998; Harre, 1991).

? Various people consider that gender identity, or the individual ideas of being a man, woman, both, or neither, is fixed in biology, although what the genetic ??? cause??? of gender identity may be, has by no means been established (Stryker, 2008).? This is found to occur during Erik Erikson??™s initiative versus guilt stage of development (Berger, 1980/2006) and Jean Piaget??™s preoperational stage.? It is during this age frame of three to seven years of age, in which individuals dealing with gender identity typically come to the belief that they were born in the wrong body.? The criteria listed for GID are descriptive of various individuals who experience conflict between their gender as assigned at birth and their gender identity, which is typically developed in early childhood and comprehended to be decisively established by age four, which agrees with both Piaget??™s? and Erikson??™s stages as mentioned above.? Nevertheless for some transgender individual, gender identity may remain rather fluid for many years (WPATH Board of Directors, 2008).? ? With the previous notion that there is a chromosomal abnormality, we now take a look at the biological etiology of GID.? Zhou, Hoffman, Gooren, and Swaab looked at the bed nucleus of the stria terminals (BSTc) to see if this area of the brain would possibly be due the reason for sex differences and its correlation on transsexuality (1997).

? In their study, which was the first of its kind, the authors show a female brain structure in genetically male transsexuals which supports their hypothesis that gender identity develops as a result of an interaction between sex hormones and the developing brain.? In their main findings however, they found no relationship between the BSTc size and sexual orientation, yet they believe that this decrease is size of BSTc in male-to-

female transsexuals is related to the gender identity alteration instead.? This research should be replicated again using pre-operative and post-operative, pre-hormonal therapy and post-hormonal therapy transsexuals as well as non-transsexual individuals to see if the findings agree. Biologically, the transsexual debate continues on with such research as ??? The Heritability of Gender Identity Disorder in a child and Adolescent Twin Sample??? (Coolidge, Thede and Young, 2002) and Blanchard and Bogaert?? ™s ??? Homosexuality in Men and Number of Older Brothers???.? Many other thoughts have been explained on this hypothesis, yet at this time none of them were able to be located for this research. Although the second hypothesis by Meyer, nonconflictual identity, did not seem to hold up any relativity in this research, the third hypothesis of conflict/ defense appeared to have validity.? This hypothesis which has been supported by numerous other authors, has a probability that transsexualism is the result of an unconscious conflict from the earliest years of life (1982).

? Socarides (1969) regarded transsexuality as an attempt to ward off paranoid psychosis that might develop if one engaged in homosexuality. (This is why as therapists, we need to look at the differential diagnoses to make sure that we are not misdiagnosing a patient.)? Many others as well agreed that transsexuals choose their identity as to avoid another possible issue that may actually be a concern at hand.? Some of these concerns will be further addressed under the differential diagnoses in the next section.? It is for this reason that the Harry Benjamin International Gender Dysphoria Association (HBIGDA) introduced the Standards of Care (SOC), which has been revised numerous times in order to meet today??™s standards for

Gender Identity Disorders.? It is in the SOC that the World Professional Association for Transgender Health, Inc.

(WPATH) explains the areas of focus on GID??™s and states that the universal objective of psychotherapeutic, endocrine, or surgical treatments are designed for individuals with GID to receive a lifelong reassurance with their gendered self in order to get the most out of their overall psychological welfare and self-fulfillment (2001).? In addition to these etiologies, other possible causes of GID are constantly being researched in this in depth field of study. Differential Diagnosis? ? ? ? ? ? ? ? ? ? In understanding these differential diagnoses, one needs to be aware of the current criteria of the DSM-IV-TR??™s GID diagnosis.? This includes: * A. A strong persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following: 1. Repeatedly stated desire to be, or insistence that he or she is, the other sex. 2. In boys, preference for cross-dressing or simulating female attire; In girls, insistence on wearing only stereotypical masculine clothing. 3. Strong and persistent preferences for cross-sex roles in make believe play or persistent fantasies of being the other sex. 4.

Intense desire to participate in the stereotypical games and pastimes of the other sex. 5. Strong preference for playmates of the other sex.

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she

has the typical feelings and reactions of the other sex. * B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In children, the disturbance is manifested by any of the following: In boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities.

In girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e. g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex. * C.

The disturbance is not concurrent with physical intersex condition. * D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Code based on current age: * 302.

6 Gender Identity Disorder in Children * 302. 85 Gender Identity Disorder in Adolescents or AdultsSince its inception in 1952, the DSM has had a number of revisions with various disorders removed as well as added to the plethora of disorders throughout the years.? With the introduction of transsexualism in the DSM-III in 1980, a new idea and criteria was born to diagnose an

individual based on characteristics inherent to the opposite gender.? With criteria under the GID in the DSM-IV-TR including a repeatedly stated desire to be the opposite sex and discomfort of one??™s own sex, it is not surprising why as professionals we need to be aware of these differentials. The first differential is the simple nonconformity to stereotypical sex-role behaviors.

? With more parents allowing their children to express themselves more openly, and more adolescents and adults finding themselves more open minded in regards to stereotyping, it is no surprise that this was the first differential listed.? Just because a boy plays with a doll or a girl gets dirty does not mean that these children need to be diagnosed with GID. Another differential is the possible confusion between GID and transsexual fetishism.? Typically when a heterosexual or bisexual man dresses the part of a woman, this part is for sexual excitement.? Typically these individuals have no previous childhood cross-gender behaviors that would indicate the need to diagnose them with GID.? However, if gender dysphoria is present as explained in the DSM, with a lack of the full GID criteria, the specifier With Gender Dysphoria can be included.

Another Careful consideration when diagnosing would to be careful not to confuse GID with GID NOS (Not Otherwise Specified).? GID NOS is usually given in situations where the individual is showing signs of intersex conditions along with gender dysphoria. ? There are also transient, stressor related cross-dressing behavior, such as males performing as females for entertainment such as drag queens, or a persistent preoccupation with castration (with the removal of the testicles) (also known as orchidectomy)

or penectomy (the surgical removal of the penis) with no desire to acquire the sexual characteristics of the female.? This last definition, although does not define as such for the woman, (i. e. oopherectomy, the operation of removing one or both ovaries, or vaginectomy, the surgical removal of all or part of the vagina), it is the authors understanding that the terms defining GID NOS criterion number three are implied for females as well. The final differential diagnosis is one of greater concern to watch for.

? The DSM-IV-TR gives the following criteria for schizophrenia, in which one would need to carefully examine a possible GID patient against these criteria as well in order to rule out any possible erroneous diagnoses.? These criteria include, but are not limited to, delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms (i. e. flattened affect).? Should these specific symptoms appear, then a diagnosis of schizophrenia would be more apt than a GID diagnosis.? When comparing these two diagnoses criterion in the DSM, we are able to notice that there is a vast difference that needs to be identified with careful detail as to not misdiagnose the patient. Treatment Strategies? ? ? ? ? ? ? ? ? ? When considering treatment options for the GID patient, one must consider the many options and the length of time that some of the treatments take when working with a client.

? Like any other field of study, transgender counseling may be more beneficial when done with a Gender Specialist or Senior Gender Specialist, however if the client is unable to find a specialist, it is best to work with a therapist that is willing to look out for their best interests.? To understand a gender specialist and senior gender specialist over a traditional

psychotherapist, in their book Transgender Care, Gianna E. Israel and Donald E. Tarver II, M. D.

(1997) explain the work of both of these specialized fields.??? The Gender Specialist may be a professional, paraprofessional, or peer-support care provider.? The Gender Specialist is an active practitioner in psychotherapy counseling, or education directly oriented toward gender-identity issues.? ??? The Senior Gender Specialist is a care provider who has actively practiced as a Gender Specialist for five years.

? Senior Gender Specialists are deemed appropriate to provide assessment and evaluation letters, as recommended for Genital Reassignment Surgery.??? During the mental health treatment process, there are many possibilities for helping the client in their mental health needs, including, but not limited to: individual counseling by counselors who have an adequate knowledge base for understanding transgender, transsexual and GID issues in counseling (Carroll and Gilroy, 2002; Carroll, Gilroy, and Ryan, 2002; Ellis and Erikson, 2002 Schaefer and Wheeler, 2004), self-help and social support groups, group psychotherapy, having a transgender friendly office and staff (Kirk and Belovics, 2008), properly assess and diagnose GID patients (Koetting, 2004), hormone treatment (Asscheman and Gooren, 1992; Cohen-Kettenis and Gooren, 1992), endocrinology, surgery, and psychiatry (Seil, 2004).? Also it is important to help the client??™s immediate family members and spouse individually, or conjointly if they so desire, in order for them to be able to understand the gender reassignment process and so that they can discuss any issues that they may have about their loved one as well.? Besides family therapy (Bockting, Knudson, and Goldberg, 2006), it

may also be important to the spouse/ partner to be involved in relationship therapy along side the transgender client, in order for them to be able to focus their effort on issues in their relationship regarding the transition process. ? Additionally, Devor??™s Fourteen Stage Model of Transsexual Identity Formation could help likewise in treating individuals with GID and may assist them in their transition of their identity (2004).

ConclusionTransgenderism is not always a painless path to follow (Hotchkiss, 1995), and transgender individuals, as well as their loved ones have often been an underserved community that are in need of empathic, comprehensive, and clinically competent care providers who are not there to judge or try to mislead them in any direction.? With the knowledge that has been presented in this paper and through the research undertaken, any motivated mental health care professional or counselor will be able to come to the same knowledge and level of empathy and compassion that is needed to counsel these clients.? With a typical time frame of two and one half years from the beginning of the counseling process to the completion of post-operative psychotherapy, it is also important not to set specific time frames and to allow for other issues that may need to be addressed prior to any further treatments.? It is also imperative to understand that post-operative counseling is just as important as pre-operative counseling.? With little to no literature found on post-operative counseling, it is important that further studies be undertaken to understand this part of the transition process.?