REPORT REVIEW

Report Review

Trans Affirmative Mental Health Care Guidelines, Results of a Mixed- Method Inquiry in Three Cities of India, by Ketaki Ranade (and Team) : A Report Review

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The last decade has seen a rise in queer affirmative mental health care discourse, literature and practice in India. Globally too, the last decade gains prominence, as it saw the rejection of 'gender nonconformity as a disorder'. The American Psychiatrist Association rejected gender identity disorder in 2013 and reformulated it as gender dysphoria in DSM V, while the World Health Organization (WHO) rejected gender identity disorder in 2019 and referred to it as gender incongruence in ICD 11. This led to readdressing the stigma which was earlier related to pathologizing of transgender identity, presenting an affirming stance towards transgender and gender diverse (TGD) persons and consequently the related mental health care work (Perlson et al., 2021). One such positive step in this direction is this report which is freely accessible to mental health professionals (MHPs) in India, who are motivated to engage in trans affirmative mental health practices, with clear implications for their training and development.

The report in the initial segment resonates optimism about the changing politico-legal environment in the country through the passing of the Transgender Persons (Protection of Rights) Act, 2019, which was also reflected in a series of high court judgements in favour of transgender persons. With special reference to section 15 on healthcare facilities, the report highlights how gender-affirmative therapies will be brought under a comprehensive insurance scheme cover. A big positive. However, a close inspection of section 15 (g) of the act, shows that it does not specifically mention the term 'psychotherapy' or 'mental health

services' and focuses more on physical or medical therapies. With some scope left for interpretation of "other health issues of transgender persons" in 'point (g)', which depends on the whims of implementers and provides some hope for trans affirmative mental health care advocates. The report also briefly highlights the number of manuals/guides and associations related to mental health care of transgenders that have appeared in the last 5 years in India, which denotes some form of transformation in the trans affirmative mental health scenario in the country. Needless to say, a lot still remains to be done. Hence, these guidelines for trans affirmative mental health care, especially one that has been grounded in and has evolved from an empirical inquiry.

In order to ensure that practical guidelines drawn from research data and its related interpretations are valid and conclusive, researchers need to put in efforts to detail out the methodology, improve planning, and design the study to improve rigour (Silverman et al., 1990). Here too, the researchers are required to meticulously plan and execute the study which in turn has increased the dependability and potential efficacy of the guidelines which emerge from the research findings. Firstly, the study used a concurrent triangulation design in mixed method research to ensure interpretations are based on the confluence of both qualitative and quantitative data, which can enhance the fulfillment of study objectives (Greene & McClintock, 1985). Secondly, the study has clearly defined inclusion criteria on persons who can be considered mental health practitioners; those who have had an experience of working with at least three TGD clients. This shows the boundaries established in the study are congruent with the specific purpose the study is designed for. Thirdly, the tool developed for the study has been validated by persons who belong to the TGD community and also by TGD mental health experts. It brings together the inner and outer views in evaluating the content of the tool and incorporating meaningful changes from both perspectives.

Lastly, the representativeness of the sample has been ensured across different factors. Such as type of MHP, the type of mental health settings that the practitioners have worked in, the age of the practitioner, and the years of experience they had, among other factors. This would ensure a diverse pool of inputs useful to develop effective guidelines. Sample representativeness not only project the diversity of

inputs obtained but also the generalizability of the said findings, specifically to the social-cultural contexts in which these finding would be deemed relevant. A challenge very innate to research and which almost all researchers face is 'how representative is representative?'. This research among 165 MHP's most of whom were cisgender, had 9 MHPs who identified as TGDs. Furthermore, this research took a multi-site, multi-city approach, by identifying relevant MHP's from the 3 major cities of Mumbai, Banglore and Delhi, which is promising. However, the report cautions us that it is essential to take cognizance that these are all tier I cities. Here the exposure to modern and liberal value systems, influences of globalization and cosmopolitan exposure are more predominant, which can have some implications on the lived experiences of transgender people. This in turn influences level of self-acceptance and openness to seek mental health services in TGD persons. A pertinent question here is, would the findings change in tier II or tier III cities? let alone rural areas in India. Given a different sociocultural ethos and level of stigmatization that would exist in these societies. A look at the intersectionality of social class and gender expansiveness is important, to ask, which TGDs are more likely to seek mental health services? To demonstrate the point of intersectionality we need to look at a quantitative indicator in this study. Only around 30% of MPHs in this study who worked with TGD clients came from Public Hospital or NGO set ups. The remaining were from private hospitals, home-based practice, clinic-based practice or online practice, where accessibility and affordability become an important factor in determining the decision to seek mental health services. In research, pragmatically there are always limits to representativeness, but recognizing the limits would be imperative to the inferences drawn based on the findings. The derivatives of which are the 12 guidelines for mental health practice with TGD clients discussed in the report.

The findings of this study point out that major mental health concerns among TGD clients are related to gender dysphoria, lack of family acceptance and self-acceptance, sexual, intimate relationship issues and marriage pressure, comorbid illnesses such as substance abuse and personality disorders. On several accounts, clients also revealed issues related to needing referral for gender affirmative surgical intervention, suicidal ideation and self-harm and experiences of bullying and violence. Findings are a clear representation of internal conflicts and societal pressures TGD clients go through in their lived

experiences and the inability to cope with the same, causing distress. Workplace related issues contributed to nearly 5% of presenting problems of TGD clients. The problem, however with descriptive statistics is that it can be misleading at times if not interpreted in the right context. Do we mean that only few TGD clients had work place related issues like discrimination, lack of acceptance, work adjustment etc.? It is necessary to look at the employment status of the client. We would need to know the proportion of TGD clients who were working to the number of working TGD clients who reported the presence of workplace related issues. Only then it would be clear if workplace related issues were a major or minor contributor to mental health concerns. A workplace would also mirror the society in which it exists unless it has a well-implemented diversity policy in place. This would determine the nature of experiences a TGD person would have in the workplace.

The main segment of this report focuses on the twelve 'good practice guidelines' for trans-affirmative mental health care which is largely derived from MHPs reflections on their practice and the experience of working with TGD clients. The twelve guidelines are obtained through descriptive analysis of quantitative data and thematic analysis of qualitative data. In this review, we try to examine how these guidelines address certain domain specific attributes which MHPs need to address and equip themselves with. The first two guidelines represent the 'knowledge' domain of MHPs. Firstly, acknowledging the need for MHPs to understand specific stressors and mental illness conditions that are related to the experience of identifying as a TGD. This may include stressors related to growing up as a TGD child, specific cognitions related to their experience of distress, effects of denied opportunities, the inability to experience a free life, or the stressors related to the process of transitioning to a different gender than what was assigned at birth. Secondly, MHPs must improve their conceptualization of intimate relationship experiences and stressors, for example, in living as TGD couple or being forced into cis-heterosexual marriages. This entails stressors related to sexual intimacy, insecurities in relationships, absence of social support, effects of revealing transgender identity to the partner on cis-heterosexual marriages, or attachment issues in marriages which are manifested through TGD person's earlier painful parent-child experiences.

The third to fifth guideline relates to the domain of 'delivery of mental health services' for TGD clients. It requires MHPs to alter and customize their practice to suit the needs and concerns of TGD clients. MHPs can draw on techniques of paraphrasing, narrative techniques or solution focused approach techniques as per the specific needs of a TGD client. It requires working through the cultural context, queer relationship context, and social justice context when required. Furthermore, MHPs understand the use of appropriate language, terminologies and give examples that are relevant to the lives of TGD clients. It may also involve making relevant changes in consent forms, intake forms, etc. MHPs may utilize certain additional mental health services such as crisis intervention through law enforcement agencies, through parental and community support. MHPs may use of support groups when required, work in liaisons with LGBT organizations, engage in social media advocacy, and actively work towards identifying job resources for their TGD clients. Lastly, the focus is on increasing the accessibility of TGD clients to mental health services. This can be done by creating awareness about available trans affirmative services by using social media, MHPs being on an online list of trans affirmative counselors, hosting a website on queer mental health, and also aiding the financial concerns related to availing mental health services. The goal is to connect TGD persons in need of mental health care with available trans affirmative mental health services and to make availing these services financially feasible for them.

The sixth to tenth guideline relates to the domain of 'roles played by MHPs'. Firstly, the pivotal role of working with the TGD client's family of origin is emphasized. Families, specifically parents contribute to the major influences in the life of a TGD person. They may be the source of acceptance and support or the source of negativity, rejection, and stress. Mostly the latter is true in the case of TGD persons. Hence, working with families of origin requires addressing the family's negative attitude, providing psychoeducation, and answering questions to give more clarity about TGD identity. Families also require emotional support, to help them understand and deal with the sense of loss upon discovering their child's TGD identity. Secondly, data from the study shows that there is a high demand by families requesting MHPs to provide Conversion therapy to their TGD child. Surprisingly, almost one-third of the MHPs in the study were approached by TGD clients themselves to seek conversion therapy, which reflects internalized

stigma and a lack of self-acceptance. Despite the inefficacy and unethicality of such methods, many MHPs reported that they were aware of other MHPs who still provide conversion therapy. One cannot overlook such malpractices, which establishes the need for trans affirmative mental health care training, and situates the importance of such guidelines. MHPs need to dissuade such requests by families and address related issues, however insistent they may be. Parents could be explained the legality, unethicality, and nonfeasibility of such methods.

Thirdly, the process of gender transition is stressful. MHPs play a vital and affirmative role throughout the process. They aid in the assessment of gender dysphoria, and provide referral letters or letters of support to transition services. Nearly half the number of MHPs in the study were approached by TGD clients for assessment and referral letters to transition services. The assessments included the use of projective tests and personality tests, while some MHPs also used cognitive and neuropsychological tests and screening tools for psychopathology. It is also recommended in the report that a good case history and in-depth clinical interview could be very helpful. MHPs assist the TGD client in understanding their experience, providing them the right information from time to time, and helping them to see through the transition. Post-transition effects on mental health can also be addressed. The next most challenging role of MHPs is working with TGD minors. Helping preadolescents and adolescents understand their discomfort and restlessness with their body and the social representation of it. It requires addressing their questions, and whatever they need to know while engaging in the decision-making process. MHPs can support reversible changes such as social transition, while seeking peer and parental support in the process. This would also include preparing parents for the changes that are likely to come. Lastly, MHPs can play the role of allies and advocates at a client level or a community level. This could include helping TGD clients cope with trans-prejudice, making them aware of their legal rights, helping clients in active networking, engaging in social awareness campaigns, posting videos regarding the malpractice of conversion therapy, issuing public statements to advocate transgender rights and negating trans-prejudice.

Guidelines eleven and twelve represent the domain of 'competency development as a trans-affirmative MHP'. Every person from birth has gone through some level

of cisgender socialization which shapes their beliefs about themselves, about gender as a binary, and the inclination to display gender typical behaviours. These belief systems in turn influence the engagement of the MHP with their TGD client. Hence working on self-awareness is essential to understanding one's gendered journey, the biases we hold and the discrimination we may engage in, even in subtle forms like name calling, ignoring a TGD person, etc. Recognizing these processes within and engaging in queer sensitization is imperative to working with TGD clients. The innate fear in MHPs to discuss the issues of TGD persons stems from the idea that one is not skilled enough to understand and address these issues. Other issues that stem from the point of perceived ignorance about TGD issues are manifested as; feeling awkward in interacting with TGDs, being uncomfortable to ask questions related to their gender identity, and feeling ashamed about not being well versed with TGD concerns. Here reflexivity would include the MHPs ability to examine one's beliefs and emotions, understand how this influences their engagement with the TGD client, being mindful that our worlds are different and the flexibility that I may need to change some parts of my perspectives. This requires using a reflective lens while trying to understand the TGD client.

Moreover, the scenario of queer affirmative mental health training through formal education in India is grim. Nearly 65 % of MHPs who participated in the study reported they did not receive appropriate training on TGD issues in their formal mental health education. Majority of MHPs in the study reported that they felt the need for training to be able to provide proper mental health services to TGD clients. The report further acknowledges that most of the MHPs in the study, worked with TGD clients as a result of their motivation, despite not having any formal training. Therefore, training and supervision are both essential to develop the competence to work with TGD clients. MHPs in the study reported that they felt they were lacking and not well equipped to work with TGD clients. Training and supervised exposure to TGD clients can lead to building the capacity to better understand TGD clients and be more sensitive to their issues. Participation in trainings, workshops, seminars and conferences relating to TGD issues can also add to their competency to understand and work with TGD clients.

In conclusion, the researchers through a very rigorous exercise of applied exploratory research have compiled this comprehensive report which presents specific guidelines for affirmative mental health practice with TGD clients. In the applied sense the focus of the researchers was to develop guidelines that were informed by the quantitative and qualitative findings of the research, and based on actual experiences of MHPs work with TGD clients. Through this review, we try to examine if the guidelines are stand-alone factors or principles, or if they can be organized into domains of meaning. This signifies the efficacy of the study in providing a conceptual model for understanding trans affirmative mental health practice. Even though the report has a specific focus on developing good practice guidelines, a conceptual model would aid in understanding the relevance of these guidelines in becoming a trans affirmative MHP. The study and the report however fail to address the significance of intersectionality, the confluence of TGD identity with other social or cultural identities in mental health practice. The study recognizes that mental health care requires interdisciplinary expertise, all of whom require proper training for working effectively with TGD clients.

Works Cited

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