Psychological Perspectives on the Lives of Transgender Individuals: A Review of the Literature

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Abstract

Transgender people as a whole suffer from social invisibility, as the general public is often misinformed about them. Because of the misinformation and ignorance surrounding public opinion of transgender people, it is difficult to conduct psychological studies involving this population. The purpose for this review is to shed some light on how the lives of transgender peoples actually are. The main areas that will be addressed in this review include tracking how transgenderism has been viewed from a clinical psychology perspective in the current and past editions of the Diagnostic and Statistical Manual, how transgender people face transphobia and are victims of hate crimes, how they are affected by familial social support or lack thereof, and internalized feelings of distress experienced by transgender individuals.

Purpose for Review

Transgender people as a whole suffer from social invisibility, as the general public is often misinformed about them (Cook, 2004). Often, reports about them are from the view points of drag queens, celebrities (whose daily struggles may not match up with that of the average transgender person), or actors playing the role of a transgender person; all of these give a less than accurate portrayal of the lives of transgender individuals. Because of the misinformation and ignorance surrounding public opinion of transgender people, it is difficult to conduct psychological studies involving this population, which was one of the difficulties in conducting this review. The purpose for this review is to shed some light on how the lives of transgender peoples actually are, without the judgment or negative biases often found in media reports about transgender people. The main areas that will be addressed in this review include tracking how transgenderism has been viewed from a clinical psychology perspective in the current and past editions of the Diagnostic and Statistical Manual, how transgender people face transphobia and are victims of hate crimes, how they are affected by familial social support or lack thereof, and internalized feelings of distress experienced by transgender individuals.

Definition of Terms

In this paper, the term "transgender" will be used throughout to describe individuals who were born biologically as one sex and gender but grow to identify more with another gender or sex. This is more of an umbrella term as it can include individuals who are pre- or post-op for sex reassignment surgery. Transgender people may or may not take hormones as well to aid in becoming another sex. Identifying as transgender, consequently, is known as their transidentity. "Transgender man" refers to a female identifying as male and vice versa with "transgender

woman." Finally, the term "cisgender" is also used, meaning one's gender that aligns with their biological sex characteristics (Cook, 2004).

Clinical Classification of Transgenderism

Dr. Harry Benjamin was the first person to use the word "transsexual" in the early 1950s. A transsexual was distinguished from a cross-dresser (at the time considered deviant in the DSM) in that the person truly wanted to be the opposite gender and received no erotic pleasure from dressing in the opposite gender's clothes (Cook, 2004). Transsexualism first became sensationalized with the case of Christine Jorgenson, a World War II veteran who came back from the war wanting to become a woman. At first, in 1950, Jorgenson travelled to Denmark to try and find treatments to cure her homosexuality. She was treated b Dr. Christian Hamburger who agreed to conduct experimental hormone therapy, psychiatric evaluation, and surgery to remove Christine's male genitalia. She returned to the United States in 1952 as a woman and became instantly famous. The public reacted to her story with transphobic outrage. People of this time cried out that there was a "crisis in masculinity" going on and that such behavior was unnatural (Meyerowitz, 2006). At this time, the DSM and later the DSM-II classified transvestism as a sexually deviant disorder, reflecting public opinion (though at this time transvestism and transgenderism were not synonymous, but the American public was still ignorant to the clinical distinction at this time) (American Psychiatric Association, 1952; American Psychiatric Association, 1968). Indeed, Jorgenson's doctor was accused of failing to treat Jorgenson because he helped her to transform further into a woman (Cohen-Kettenis & Pfäfflin, 2010). Categorizing transgender people with transvestites did not acknowledge the psychological complexity of transgenderism as it only addressed one facet of being transgender: wearing clothes of the opposite gender. This was an easier diagnosis to make because of outward

appearances rather than an identity people tended to hide from public eye to avoid being ostracized. Plus, the amount of people who cross-dress far exceeds the number of people who are transgender (Sullivan, 1990). However, this case sparked discussion on how people express their own sense of being a man or a woman, first referred to as one's psychological sex, then later to their gender in 1955 (Meyerowitz, 2006). At this time, research in the United States was extremely limited on transsexualism as was common knowledge about the separation of gender and physiological sex. Legal battles ensued over the course of the 1960s to legally change one's sex on legal documents. Some were met with conservative opposition, and were told that one's chromosomes determine sex—that no amount of surgery or cross-dressing would persuade them that the transgender individual was a different sex than that which they were born with. Over time, judges would allow the changes made pending sex reassignment-surgery, but acceptance as a legitimate identity would take decades. Being transgender was neglected altogether from the DSM until its third edition, and then remained a disorder in the DSM until its fifth edition (American Psychiatric Association, 2013; American Psychiatric Association, 1980).

The DSM-III introduced a dramatic change to how transgenderism was diagnosed and classified. Gender Identity Disorder was first included in the DSM-III as a psychosexual disorder that occurred when the biological sex of an individual did not align with their gender. Criteria set in the DSM-III were used to help evaluate individuals seeking sex reassignment surgery. Other guidelines for evaluation were set by the World Professional Association for Transgender Health (WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association). This group set standards for treatment for gender dysphoric people and helped determine eligibility for hormone treatment and surgery (Cohen-Kettenis & Pfäfflin, 2010). Per the DSM-III, the decision to use these treatments depended heavily on the individual's diagnosis of being

transsexual by the definition in that edition. Doctors were fearful that their patients would experience post surgery regret and so standards were thorough but were often faced criticism for trying too hard to find a "true" transsexual (Cohen-Kettenis & Pfäfflin, 2010; American Psychiatric Association, 1980). In the DSM-IV-TR, the standards under Gender Identity Disorder were relaxed somewhat in order to provide appropriate care without need for vigorous diagnosing (Cohen-Kettenis & Pfäfflin, 2010; American Psychiatric Association, 2000). More commonly, transgender individuals would only desire partial treatment (hormones) or "top" surgery in order to feel more like the gender they identify as; only about a third of transgender individuals underwent sex reassignment surgery (Hage & Karim, 2000). This lends some evidence that gender is more of a spectrum in theory, as these individuals only desired to become partially like another gender physically (Cohen-Kettenis & Pfäfflin, 2010). These changes are reflected in the fifth edition of the DSM (American Psychiatric Association, 2013).

Recently, the formal diagnosis and treatment of transgenderism and gender dysphoria has been significantly changed in the DSM-5. Rather than classifying such symptoms as "Gender Identity Disorder," it is now diagnosed as "Gender Incongruence." (American Psychiatric Association, 2013; De Cuypere, Knudson, & Bockting, 2010; American Psychiatric Association, 2000). This is important because the diagnosis has been moved from the patient's identity to the dysphoria of identifying with a gender that they are unhappy with or does not match their sex characteristics. It also recognizes non-binary genders to encapsulate more patients and dysphorias than just transgender individuals (i.e. intersex). This is an improvement, but it still falls short of the World Professional Association for Transgender Health's recommendation to change the title to "Gender Dysphoria" in order to be more inclusive of distress felt in different aspects of one's gender identity. Revolutionarily, it recognizes that children may be transgender

by classifying them as having gender incongruence if they insist that they are another gender or show a strong desire to be another gender. This helps to narrow the diagnosis to children who need treatment for gender dysphoria rather than needlessly treat children who express behaviors of another gender, which children are often wont to do. They also removed the sexual orientation qualifier from the DSM-IV-TR, acknowledging that gender identity and sexual orientation have little bearing on the other and would therefore serve no assistance in treatment. It also allows for a clause stating that the incongruence has been successfully treated, instead of labeling the patient for life simply by being transgender (American Psychiatric Association 2013; American Psychiatric Association, 2000).

However, even with all the progress made, there are still areas for improvement in the DSM-5. Certain criteria in the new manual still diagnose one who desires to be another gender simply for wishing to be treated as another gender or believing like they have typical feelings and/or reactions of another gender (American Psychiatric Association, 2013). Neither of these criteria indicate that the individual is in distress for having these inclinations, and so De Cuypere et al. (2010) argue that there should be more revision done to this section. It would be more accurate to include that these characteristics caused a person's impairment leading to distress rather than just discomfort in adjusting to their new or changing identity.

Interpersonal Violence and Transphobia

Interpersonal Violence

Violence and traumatic events are, sadly, not uncommon in the transgender community, usually as a result of stigmatization, ignorance, discrimination, and prejudice. While there is limited research on the exact figures for exposure to traumatic events, there is some data that

exists for the amount of different types of violence transgender individuals experience (National Coalition of Anti-Violence Programs and Horizons, 1995). One study by Shipherd, Maguen, Skidmore, and Abramovitz (2011) found that 98% of their sample of 97 transgender individuals had experienced a potentially traumatic event, with 91% of that sample endorsing that they had experienced two or more potentially traumatic events. Experiencing multiple traumatic events in one's lifetime is associated with worse outcomes than only experiencing one traumatic event (Green et al., 2000). In the Shipherd et al. (2011) study, 17.5% of participants reported clinically elevated levels of PTSD symptoms and 64% reported clinically classified levels of depressive symptoms in the sample exposed to trauma. Both of these groups were higher than the national averages. Research estimates that over half of the transgender population has experienced violence at some point in their lifetime, with 14-53.8% of them experiencing sexual assault, depending on their socioeconomic status (Richmond, Burnes, & Carroll, 2012). The majority of transgender adults (55%) have reported that they have had an unwanted sexual event happen before the age of 18. Additionally, compared to cisgender people, transgender people are more likely to engage in substance abuse and sexual risk taking (Mustanski, Garofalo, & Emerson, 2010). Figures like these illustrate the importance of studying the issues surrounding the transgender community in order to better prevent them.

Passing and Trauma

The degree to which a person "passes" (i.e. physically looks like the gender that they are trying to portray) as another gender may also affect the level of distress and/or harm they experience. That is to say, how much the individual fits into the gender roles, stereotypes, and physical appearance that they are want to portray can affect how others perceive, interact, and react with them. It is difficult for transgender women to pass as women, and so they have higher

risk for hate crimes to be committed against them (Richmond et al., 2012). One potential explanation for trauma occurring is that the amount of time a transgender person spends dressing as their desired gender may influence their risk for traumatic events. Transgender people, according to Lombardi, Wilchins, Priesing, and Malouf (2001), are more at risk to experience interpersonal violence than drag queens and cross-dressers because transgender people spend more time dressed as a different gender. Indeed, the Shipherd et al. (2011) study found that those who spent more time dressed as their desired gender reported more depressive and PTSD symptoms than those who spent less time dressed as another gender. However, it is oftentimes crucial for transgender people to dress as their preferred gender to avoid gender dysphoria, highlighting why it is necessary to do more research to educate the public to prevent interpersonal violence.

Transphobia

Transphobia (discrimination based on one's identity as transgender) is a serious problem experienced by transgender individuals, affecting as much as 63% of the community. In a report by Grant et al. (2011) sampling over 6,500 transgender people, the overwhelming majority reported experiencing discrimination in one facet of life or another. For example, 47% experienced an adverse job outcome (e.g. being fired, not being hired, or being denied a promotion) because of their transidentity and 90% of adult respondents reported harassment or discrimination in the work place. These numbers are alarming, as transphobia has been linked to increased mental health issues and suicide (Hellman, Sudderth, & Avery, 2012; Kidd, Veltman, Gately, Chan, & Cohen, 2011). The transgender community also faces twice the unemployment rate as the general population and they are more likely to be underemployed (Grant, 2011; Nuttbrock et al., 2010). These issues can lead to increased unemployment, social isolation, risk

for mental health issues, financial problems, and suicide ideation (Kidd et al., 2011; Hellman & Klein, 2004; Nuttbrock et al., 2010). Transphobia in the workplace can negatively affect self-esteem and may prompt psychiatric distress (Chope & Strom, 2008), but employment problems can exacerbate lack of access to medical and mental health services (Willging, Salvador, & Kano, 2006).

Even without the problem of less employment, access to medical care is a significant issue in the transgender community. In fact, 19% of respondents report being refused medical care because of their transgender status, both major barriers to accessing treatment for these serious mental health issues (Grant, 2011). Half of respondents had to teach their medical provider about care for transgender people while visiting them (Grant et al. 2011) and research has found that medical doctors lack knowledge, sensitivity, and the training needed to treat transgender individuals (Kidd et al., 2011), not to mention transgender individuals' reports of alienation, prejudice, discrimination, and even danger from medical providers (Lucksted, 2004). Transgender people are underrepresented in mental health treatments as well (Hellman, Klein, Huygen, Chew, & Uttaro, 2010), making treatments less effective and potentially failing to meet their needs at all. This is an extremely important issue to address given the frequency transgender individuals experience mental health issues. Dealing with transphobia is difficult but may be managed by concealment of the individual's transidentity to increase chances of passing. However, this may increase hypervigilance and psychiatric distress when preoccupied with passing, and is therefore a less desirable option (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman 2013). Other methods of coping include self-affirmative coping (i.e. asserting one's sense of self and strengths), cognitive-reframing (i.e. thinking positively), social-relational coping (i.e. seeking social report), and resource-accessing coping (i.e. seeking legal counsel)

(Mizock & Mueser, 2014).

Social Support

Social support is extremely important in order to cope with distress and prevent health issues (Grant et al., 2011; Singh, Hays, & Watson, 2011) because it helps the individual build resiliency towards the stressor and can diminish the effects of trauma. Social support can come from any social circle (friends, family, one's workplace, organizations, religious affiliations, etc.) (Mathews, Stansfield, & Power, 1999). Unfortunately, there is also evidence that using social support when informing family and friends about one's transidentity increases interpersonal stress. Revealing one's new identity can change or extinguish relationship intimacy with family members and friends, and in the context of employment, often leads to job loss (Galupo, Krum, et al., 2014; Richmond et al., 2012). According to the survey by Grant et al. (2011), 57% of respondents were significantly rejected by their family after coming out as transgender. If the friendship or relationship persists, there may only be limited mutual understanding between friends or family; however, if the relationship is maintained with a cisgender friend or family member, it can help the transgender individual feel more "normal" in their new identity and that they will be accepted into the larger society (Galupo, Bauerband et al., 2014; Galupo, Henise, & Davis, 2014). Once they find acceptance from family and friends, transgender people are more easily able to integrate their new gender identity into their lives. Without such support, it is much more difficult to lead happy and productive lives (Cook, 2004). Indeed, a report by Valentiner, Holahan, and Moos (1994) stated that the less access to social support an individual had, the more likely they were to using avoidant coping strategies, which can lead to anxiety and depressive symptoms. For example, being rejected or consistently and offensively questioned about one's transidentity by friends can lead to avoidance of the topic by the individual, leading

to feelings of guilt and anger about their transidentity (Galupo, Henise et al., 2014). The shame transgender that individuals feel may hinder their ability to form and maintain relationships, as there may be less of an authentic connection (Hartling et al., 2004).

One interesting find from Budge, Adelson, and Howard (2013) was that transgender men were more likely to endorse using familial support to cope with distress during transition. They speculated that this was because these individuals were raised females and thus were socialized to be more dependent on and communicative with family members. In this way transgender men may have more access to social support and thus have the potential to experience less anxiety and depression while transitioning.

It is advantageous for transgender people to have relationships both in the larger Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) community and outside of it (i.e. having heterosexual, cisgender friends) during and after transitioning. Although lesbian, gay, and bisexual are sexual orientations, transgender is more of a gender orientation (though the two spheres are not mutually exclusive). Transgenderism falls into this community because this identity is a sexual minority, as are the other orientations and identities encompassed by the LGBTQ community. Relationships in the LGBTQ community help individuals to learn more about transgender issues and to gain different perspectives on the struggles of sexual minorities while friends outside this community can help individuals feel more "normal," have relationships less focused on one's gender and sexual identity, and to help the individual present as their desired gender (Galupo, Bauerband et al., 2014).

In their qualitative study, Galupo, Henise et al. (2014) interviewed transgender people about their experiences with microagressions from friends about their transidentity. Common responses were that they did not feel that their transgender friends deemed them "trans" enough

in their microagressions, that their friends from the LGBTQ community should know better when saying hurtful things, and that their friends outside the LGBTQ community rejected them or that their feelings did not matter to their cisgender friends. Many expressed that they felt that their transgender friends judged them for not expressing their gender identity in the "proper" way, which, according to the participants, was more upsetting coming from people that had similar experiences to themselves than from a cisgender person. Having friends that are transgender is important because they often are the first people that transitioning transgender people turn to for advice and counsel, as it is easier for them to offer support from sharing similar experiences. Encountering microagressions was especially distressing and disruptive when the friendship had more of a mentoring context, increasing the individual's uncertainity, doubt, and discomfort with their new identity (Galupo, Bauerband et al., 2014; Galupo Henise et al., 2014).

Social support from family, friends, and people of the LGBTQ community is exceptionally important in a transgender person's successful transition to their new identity. Disclosing one's transidentity can potentially increase negative outcomes (like job or relationship loss), but can also increase coping and prevent psychiatric stress. Additional research in this area is necessary to help families develop supportive skills for their transgender family member.

Self

Psychiatric Risk and Coping

It is common among transgender people to feel that they were born and are living in the wrong body, causing body and gender dysphoria, anxiety, depression, guilt, and even suicide (Cook, 2004). Instances of depression among transgender individuals have been found to be

about 54% for the transgender population (Nuttbrock et al., 2010; Reisner, Perkovich, & Mimiaga 2010). Much of the guilt transgender people experience comes from people in their lives using shame to try to convince them to conform to the traditional gender roles. This is first reinforced in childhood. According to Richmond et al. (2012), childhood bullying from the parents of transgender individuals is not uncommon with 77% reporting verbal abuse, 55% reporting social embarrassment, and 58% reporting guilt, all experienced before the individual was 15 years of age. Shame may also cause transgender people to hide parts of themselves from peers out of fear of this type of treatment. In turn, this can lead to avoiding social situations, withdrawing from potential relationships, and loneliness (Mereish & Poteat, 2015). This is especially important for transgender people because social support is very important in coping with outside stressors and building resiliency against them (Singh et al., 2011). Without social support, transgender individuals are at high risk for psychiatric distress. Suicide is a major concern for the transgender community. In the Grant et al. (2011) report, 41% of respondents endorsed that they had attempted suicide, with as many as 64% endorsing this if they had been victims of sexual assault. Suicide ideation (54%) as well as lifetime suicide plans (35%) are prominent as well in the transgender community (Nuttbrock et al., 2010). In addition to having increased risk for mental health issues, transgender people experience HIV at four times the rate of the general public, making medical care extremely pertinent to the transgender experience.

Often denial and suppression of one's transgender identity is common in the beginning of transitioning, resulting in emotional avoidance of the distress accompanying this stage (Budge et al., 2012). Avoidant coping is likely to be used in this stage in order to buffer the affects of this stress, but in the long run it can cause more depressive and anxious symptoms (Budge, et al., 2013). A study by Budge et al. (2013) sought to examine how the progressive stages of transition

to another gender affected an individual's symptoms of anxiety and depression. They found that avoidant coping was a mediator between transition stage and levels of anxiety and depression. Transition stage and avoidant coping were negatively related and avoidant coping and levels of anxiety and depression symptoms were positively related. Over time and stages of transition, individuals use less avoidant coping to deal with the stress of their new identity, and so they are less likely to exhibit symptoms of anxiety and depression. Socially disengaging is understandable, however, as it can be used as a coping strategy to buffer the effects of transphobia (Mizock & Mueser, 2014).

Transgender Women and Passing

There is some evidence that transgender women have more difficulty transitioning than transgender men do. According to Gagné and Tewksbury (1998), transgender women reported experiencing greater loss after beginning transitioning than transgender men did. They also are more likely to face discrimination, job loss, and relationship concerns as well as experience more distress than transgender men (Budge, Tebbe, & Howard, 2010). Many of these can be linked by their ability to pass as a woman, which is more difficult than women trying to pass as men; however the further the individual is in their transition, they more hope they express for the future that they will be able to pass successfully (Budge et al., 2012).

Transgender women are also likely to abuse illicit substances, with about 25% reporting using hard drugs (marijuana excluded) (Garofalo, Deleon, Osmer, Doll, & Harper, 2006). Because of this substance abuse, transgender women are at especially high risk for negative health outcomes like contracting HIV (Nemoto, Operario, Keatley, Han, & Soma, 2004), mental health distress, and suicide (Clements-Nolle, Marx, & Katz, 2006). Such high instances of substance abuse in this population can be attributed by a number of potential causes such as

internalized transphobia (e.g. hypervigilence), structural stressors (e.g. employment discrimination), and interpersonal stressors (e.g. fear of rejection in relationships) (Reisner, Gamarel, Nemoto, & Operario, 2014).

Individual mental health concerns are first caused by general body dysphoria and can be affected by social support, coping strategies, and resiliency when transitioning. Transgender women are more challenged during transition than transgender men, and so they are at higher risk for job loss, discrimination, and substance abuse. Additional research would be helpful to help find ways to bolster transgender women's resiliency before, during, and after transitioning.

Conclusion

The main purpose for the review was to examine and shine some light on the realities of transgender individuals. American psychology only began to research transgenderism in the 1950s, and so it is necessary to continue doing so in order to address the specialized needs of transgender individuals both in the medical and psychiatric fields. It is also important that the general public become more educated about transgender individuals so that they are better understood as people. Hopefully, this can help to reduce the stigma, discrimination, and interpersonal violence that affects a great many of transgender individuals' lives. Indeed, such information and research could further assist families, friends, and communities of transgender individuals be more supportive while the person transitions to reduce their risk for psychiatric distress, job loss, and bullying. All these factors can only help protect the individual cope with the changes that affect every facet of their lives and perhaps their chances of partaking in risky behaviors as a result. More research and public education about transgender individuals will help decrease public ignorance about them and to decrease their societal invisibility as a whole.

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