


Spring 2015

Talking Mirrors: Experiences of Older Transgender Adults and Culturally Competent Mental Healthcare Professionals with Talk Therapy in the Netherlands

Kate Cieplicki
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Talking Mirrors:
Experiences of Older Transgender Adults and Culturally Competent Mental Healthcare Professionals with Talk Therapy in the Netherlands
Cieplicki, Kate

Academic Director: Kopijn, Yvette
Advisor: Verkerke, Vreer

Hamilton College
Psychology and Women's Studies

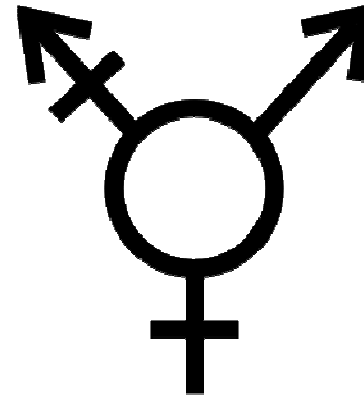
Europe, Netherlands, Amsterdam
Submitted in partial fulfillment of the requirements for
The Netherlands: International perspectives on sexuality & gender,
SIT Study Abroad, Spring 2015

Any person who has not sought mental healthcare
for fear of being judged, laughed at or turned away.

Transgender individuals who have lost their lives to suicide and their families.

Transgender activists who are doing so much work for their communities
that they don't have the time to write a 50-page research paper.

The transgender older adults of Philadelphia. Thank you for continuously
helping me to become a better ally and a better friend.



Special thanks to

The four individuals who had the courage and compassion to illuminate their unique
and complex experiences with me. I am humbled by your willingness to share.

Vreer, for your patience, kindness and commitment
to my work throughout this entire process.

The entire SIT staff for giving me the opportunity to do this research.

My friends in the program who supported
my work throughout this semester... we did it!

Christien and Nadia for your support, advice and hilarious dinner-time conversations.

Mom for being on the receiving end of many early morning text messages.

David for being a perfect teammate. Your unwavering support for my
work and belief in me (and us) doesn't go unappreciated. I love you.

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Historically, both the general population and mental healthcare providers specifically have misunderstood the transgender identity as pathological and unnatural. Despite persistent ignorance in the mental healthcare field about the background and needs of transgender adults, a psychoanalytic evaluation is required by the gender clinic for a transgender individual to begin the gender transition process in the Netherlands. This requirement creates a degree of tension and mistrust between the transgender individual and the mental healthcare field. Such discomfort is unfortunate because statistically transgender adults face more mental health problems than their cisgender peers, likely because of the stress that comes from their gender identities being constantly misunderstood and negated by society. To make mental healthcare more accessible and useful to transgender individuals, there is a push in the transgender population to recognize and support culturally competent mental healthcare providers who operate outside of the gender clinics and effectively serve the mental health needs of transgender individuals. Though the methodologies of these professionals vary, they generally reflect a shift away from pathologizing the transgender identity and a focus on helping the transgender individual to craft a new identity that matches who they feel themselves to be. This paper illuminates the experiences of transgender older adults, both good and bad, in a variety of mental healthcare settings as well as the counseling strategies of a culturally competent mental healthcare provider. The goal of this research is to provide suggestions for improving mental healthcare for all transgender people.

Key words: gender studies, mental health

“Who looks outside, dreams; who looks inside, awakes.” - Carl Jung

In the short time that I have been organizing around transgender issues, the topic of healthcare has come up again and again because a transgender identity can prevent access to necessary healthcare. If, for example, a healthcare provider refuses to acknowledge the gender identity of a transgender patient, the individual may not seek the care they need at all. The invalidation of gender identity is a risk a transgender person faces every time a they pick up the phone to call their insurance company or open up to a general practitioner about their gender identity.

Such invalidation is especially prevalent in the mental healthcare field which is full of professionals who would rather address issues they understand (e.g., anxiety, depression) than less familiar issues that may be contributing to these problems (e.g., gender identity). This shortcoming of mental healthcare professionals was the initial inspiration for this paper. The invalidation of gender identity by a mental health care professional is especially unfortunate because transgender adults statistically face more mental health problems than their cisgender peers. The transgender identity itself is *not* pathological and in need of psychological attention, but rather both the invalidation of the transgender identity that occurs throughout a transgender individual’s life and the stress that stems from transitioning can bring about negative affect. One way to offset this negative affect is to address it with effective, culturally competent talk therapy. Though an evaluation by a psychologist (along with a second opinion) is required in order to begin hormone therapy, it is not required for a transgender older adult to engage in talk therapy before, during, or after transitioning. Due to the disappointment that sometimes comes from transitioning later in life specifically, transgender older adults could perhaps stand to benefit the most from effective talk therapy.

serve the transgender older adults of the Netherlands? To do so, I evaluated effective and ineffective counseling strategies that occur outside of psychological evaluations at the gender clinic. This paper begins with an overview of the history of transgender individuals and mental healthcare and then centers in on the position of transgender adults in the Netherlands and their experience of mental healthcare within that context. It then outlines specific therapy methods that are currently being used to work with transgender adults outside of the gender clinic. Next, it introduces four interviewees' experiences with mental healthcare as receivers and service providers. These narratives are then analyzed for commonalities and differences. Trends in the narratives are used to provide suggestions for changes to mental healthcare for transgender older adults specifically. Limitations and suggestions for future research are discussed.

"To me, gender is the poetry each of us makes out of the language we are taught."

- Leslie Feinberg

A. Overview of the literature review

In this project I interviewed transgender older (44+) adults and a culturally competent mental healthcare provider to compile suggestions for bettering the experiences of transgender older adults in a talk therapy setting. For the literature justifying this research area and methodology I begin with an explanation of the language (i.e., transgender, mental health care) used in this paper. I then give a brief overview of interactions between the transgender identity and the mental health care community up to the present on an international scale along with statistics and speculation on why a disproportionately high number of transgender individuals seek out talk therapy¹. Then, I focus in on the Dutch context specifically to illuminate how the the transgender identity fits into Dutch value of tolerance, how the current transgender presence is addressed in the Netherlands, and how visibility and quality of life may influence the mental health of Dutch transgender individuals specifically. Next, I broaden my scale to discuss current talk therapy methods that are known to be effective in working with transgender older adults. I later compare and contrast these methodologies with both the experiences of transgender older adults in talk therapy and with the methodology of a culturally competent mental health care professional.

B. Explanation of language

Just as it is essential for the therapist to check in regularly with their transgender client about preferred pronouns and vocabulary (Budge 2013), it is essential for the researcher to justify the terms commonly used in her research. I use the word “transgender” in this paper as an umbrella term used to refer to any person whose gender assigned at birth does not match their gen-

¹This analysis is done in the American (not Dutch) context specifically, but no more data and a less participant

per were asked to self-identify their gender by giving their preferred pronouns. Extensive effort was made throughout this study to respect and use the interviewees' preferred pronouns while not pressuring them to conform to the gender binary at all. The purpose of this paper is to address gender identity, not sexual attraction. Being transgender says nothing about the gender to which an individual is attracted.

Not only were intentional language choices made to address the gender identity of interviewees, deliberate choices were also made in the way mental health is discussed in this paper. I chose to use the phrases "mental health" and "mental healthcare" because I believe that they are broad phrases that encompass most if not all of the reasons why people see a psychologist and how they experience talk therapy with a psychologist. I also wanted to stay away from the stigmatized phrasing of "mental illness," which may have put interviewees on the defensive. The language I have chosen constructs mental health as something that everyone has and sometimes works on. As one of the interviewees, Felix, said "Mental healthcare covers a lot of problems... I think it's a good thing because most people who need mental healthcare have a dysfunction for a term of time (i.e., it implies that mental health is something that can change over time)." Said another interviewee, Bear, "When I'm talking to my friends about my state I refer to my own mental health. To me that doesn't have to be a clinical term." The choice of these phrases was checked with each interviewee and each interviewee addressed whether or not the phrase "mental healthcare" best encompassed their experience in talk therapy. None of them voiced any concerns with the phrase "mental healthcare."

Trans as a denial of homosexuality

The transgender identity has been a largely misunderstood source of interest and analysis in the healthcare field and mental healthcare field specifically for centuries. Carl Westphal was the first known medical professional to record treatment of a transgender client in 1869 (van der Ven 2007). During this time, all LGBTI individuals were conceptualized as instances of “gender inversion” (i.e., attempts to reverse a gender assigned at birth). The transgender identity was seen as the most extreme manifestation of gender inversion.

In 1910 Freud, who believed gender was based in the genitalia, took this way of thinking one step farther and called transgenderism a “denial of homosexual feelings” (van der Ven 2007). In other words Freud thought of the transgender identity was based in attraction rather than genitalia (a mistake that some mental healthcare providers still sometimes make today). Freud viewed the treatment of transgender adults as unethical because he claimed that such treatment was giving into pathology. Such an assessment likely contributed to mental healthcare providers theorizing on and pathologizing transgenderism as a symptom *of* some sort of negative life event or character flaw, not as the source of a client’s distress. Thankfully, Freud’s theory was later disproven by Dr. Michael Dillon (an female to male transgender individual) who called himself homosexual. Some of Freud’s misunderstanding of the transgender identity, however, still ripple through mental health care professional circles today.

Towards modern transgender treatment

Following the fall of Freud’s transgender theory, Henry Benjamin created the first road map for transgender adults seeking mental healthcare between 1930-1960. In his methodology, Benjamin differentiated between clients based on motivation for expressing a gender different from their gender assigned at birth (i.e., he distinguished between transvestite and transgender).

gender identity. Though a seemingly well-intentioned suggestion meant to ensure that the transgender adult wanted and would not regret irreversible gender adjustment surgery this practice, which is still in use today, does not allow much space for gender-queer individuals (i.e. individuals who do not identify as man or woman) to craft their own preferred gender identity outside of the binary.

The mental healthcare community continued to speculate on and engage with the transgender identity after the 1960s, often in problematic ways. For example Leslie Lothstein, a psychotherapist, reportedly said that “most FTMs have borderline” (Henkin 2008). Of course this is a broad and somewhat inaccurate evaluation of transgender mental health care because the borderline symptoms (i.e., coldness, fickleness) would likely arise in any individual whose gender identity was continually denied. By the 1990s, perhaps to offset these offensive ways of conceptualizing transgender individuals, many transgender counselors throughout the world were transgender themselves (van der Ven 2007).

With 1997 and the increased visibility of Leslie Feinberg, a transgender activist, came the encouragement of transgender individuals to advocate for better healthcare. The lack of mental health support for transgender individuals pre and post transition represents a failure of healthcare for transgender people. The intention of this paper is to continue Feinberg’s vision of more compassionate and thorough healthcare for transgender individuals.

International research on transgender mental healthcare today

Mental healthcare needs are more prevalent in the transgender population than in the larger, cisgender population. Seventy-five percent of transgender individuals in the United States use therapy today compared with 3.8% of the general population (Budge 2013). Given certain

parable to those in Amsterdam.

There are several reasons why transgender individuals more often seek out mental health-care, most of which are due to prolonged negative affect from “gender dysphoria²”. The transgender identity remains stigmatized and being a member of a stigmatized group comes with a burden of psychological distress (Bockting et al. 2013). This distress manifests differently in trans men in comparison with trans women and gender-queer individuals (on which little has been written).

In one 2013 study based in the United States, 66% of transgender men experienced trans-related discrimination. Transgender men more easily pass because of testosterone, however passing does not eliminate psychological distress, but rather leads to hyper-vigilance, hiding, and less connection to others with a transgender past. Sixty-one percent of transgender women reported experiencing trans-related discrimination. Due to easier access to a community, they reported lower felt stigma (i.e., less need to hide) but conversely higher enacted stigma (i.e., aggression from others) due to the same increase in visibility (Bockting et al. 2013). Frequent experiences of discrimination take a toll on individual mental health. Though regular interaction with peers can decrease felt stigma, it also increases the visibility of the transgender individual and can lead to other forms of discrimination. In other words, for the transgender adult both seeking support and remaining isolated takes a psychological toll.

Transgender men, transgender women, and gender-queer individuals report disproportionately high rates of depression, anxiety, somatization, and overall distress. The Meyer’s minority stress model partially explains this negative affect. In short, it is distressing to be a minority and marginalized individuals must be vigilant in situations where their identity may be made

² This is the most established term of the medical community that is used to describe transgender individuals. It is

its stereotypes are made hyper-salient to the transgender adult. Since everyone must use the bathroom, the stress enacted by this situation cannot be avoided. Exposure to such a situation day after day causes deep psychological distress. Broader issues like the lack of mirroring identities (i.e., lack of interaction with other transgender people) may also cause negative affect.

Despite this negative affect, Bockting et al. (2013) found older transgender adults to be more resilient than their younger counterparts, perhaps because they have had more time to develop coping skills. My interviewees somewhat confirmed this finding, though time in counseling was a greater predictor of adjustment than age in my research. Sadly, 41% of transgender adults living in the U.S. have attempted suicide³ (Budge 2013). Though this number may be lower in the Netherlands due to an overall higher quality of life, it still reflects a troubling results of poor mental health in the transgender population in general. Transgender methods of coping with negative affect through talk therapy or other methodologies are therefore essential to illuminate and share.

D. Transgender Mental Health Care in the Dutch Context

Trouble with transgender “tolerance”

Though the Netherlands is often conceptualized as a very liberal country (and Amsterdam as one of the most tolerant cities in the world) there are limits and nuances to Dutch tolerance that are illuminated by the country’s treatment of transgender older adults. The first sex reassignment surgery took place for a trans man in the Netherlands at Rijnland hospital in 1954 (Bischoff 2011). In 1985, transgender adults were permitted to list the correct gender on their documents but only if they had completed transitional surgery. This condition forced transgender older adults living in the Netherlands to both identify within the gender binary and receive full

surgical alteration was further emphasized in 1997 when transgender adults were not allowed in the Gay Games (in the Netherlands) unless they had fully transitioned. The years from 1997-2004 marked budget cuts for transgender care. The Netherlands has therefore been fairly tolerant of the transgender identity but only if they identify within the binary and opt into all gender reassignment treatments.

The Dutch emphasis on transgender genitalia and transition often leaves the mental health needs of individuals with gender dysphoria by the wayside in favor of swift surgeries. There remains little support for transgender older adults who do not conform to the gender binary or who do not opt for total transition (Bischoff 2011). In the Netherlands, transgender identities are accepted only if they dress normally for their gender identity (which is either male or female) and bargain collectively (as a transgender “community”). The Dutch are tolerant of differences as long as transgender older adults make every effort to adhere to the norm and not become politicized.

Current transgender presence in the Netherlands

There is a sizable presence of transgender people living in the Netherlands. According to a study conducted in 2014, 4.6% natal men and 3.2% natal women have an ambivalent gender identity while 1.1% natal men .8% natal women feels as though they have an incongruent gender identity (Kuyper 2014). The presence of transgender older adults may therefore be underestimated in the Netherlands. Even certain factors of this most recent survey may have yielded a lower number of transgender responses. For example, the survey was described as being about sexual relationships and transgender adults have statistically less sexual partners than cisgender people for a variety of reasons. They may have therefore be more skeptical of taking a quiz on sexuality. More simple measures need to be applied to a greater population to ensure the most

transgender individuals in the Netherlands is sizable and consistently underestimated. Their prevalence combined with the high levels of mental healthcare received by transgender adults all over the world show that mental health needs of this population need to be addressed.

In the Netherlands, two distinct groups of professionals evaluate the mental health of transgender older adults: the gender teams evaluate whether or not an individual is eligible for transition. Though they psychoanalyze individuals, they do not provide counseling. They are the gatekeepers for the transgender identity (Henkin 2008), establishing a complicated relationship between transgender individuals and the mental healthcare community. Counseling organizations such as Transvisie Zorg, on the other hand, have a staff of mental healthcare professionals that meet the mental health needs of transgender older adults before, during, and after transitioning (or anytime if the individual decides not to fully transition). Peer support groups also exist in the Netherlands that are run by transgender adults who are not certified mental health care professionals. Other organizations such as Berdache and FACET cater to the mental health needs of parents of transgender individuals and spouses of transgender individuals respectively.

Despite sometimes questionable tolerance, the Netherlands hosts a couple of events intended to celebrate the transgender identity. The Transgender Day of Remembrance occurs on November 20 each day to remember transgender individuals who have lost their lives because of their gender identity (in conjunction with the international holiday). The Trans genderFilm Festival “Transcreen”, an event unique to Amsterdam, occurs every other year to show and celebrate film made by and for transgender individuals and to increase creative reflection on and engagement with the community.

E. Contemporary Talk Therapy Methods for Transgender Adults

therapy, four common trends emerge: the importance of self-reflectivity on the part of the therapist, the effectiveness of individualizing treatment, the effectiveness of group therapy, and the part cultural competence training plays in both assuring therapist self-reflexivity and individualizing treatment.

Self-reflexivity

The first step for effective psychotherapy with transgender older adults is thought by some scholars to be reflection on the self's own gender identity (Henkin 2008). One therapist speaks of their own potential to be transgender at great length and works to not take cisgender identity for granted. A queer identity is not essential for treating a transgender individual (though commonalities between LGB and trans adults are sometimes assumed when doctors recommend their trans clients to a therapist) but a queer understanding of the world and the ability to accept ambiguity and variation from the norm definitely is. Culturally competent counselors should to some extent reflect this queer way of thinking through how they discuss and conceptualize things like personal lifestyle choices, gender identity, sexual attraction, and even race.

Literature on the treatment of transgender individuals emphasizes the importance of individualizing treatment. There are several methods through which the therapist may allow the individual needs of the client to guide therapy.

The PLISSIT model is more therapy method used for treating transgender clients (Henkin 2008). It outlines the role of the therapist from gatekeeping the transition process all the way to helping the transgender client to work through day-to-day issues both related to and unrelated to gender identity. This method first establishes an understanding between client and therapist that the client's gender identity is accepted (**p**ermission to be). From that point, the therapist provides **l**imited **i**nformation to the client about what they need to know about their transition along with **s**pecific **s**uggestions. Following the transition, this framework posits that only then can **i**ntensive **e**motive **t**herapy begin. (PLISSIT, Henkin 2008).

Other therapy models discuss the therapists' role with the transgender adult outside of transitioning. This frame of counseling operates under the explicit assumption that the transgender identity is not inherently pathological (Fraser 2009) and encourages the use of Jungian theory to understand the transgender identity, rather than pathologize it. Such a method is also reminiscent of the Rogerian method of unconditional positive regard. Jungian theory frames the transgender identity as challenging societal expectations of gender, with this challenging comes negative affect that adds on to day-to-day stress (e.g., anxiety).

Jungian theory may be applied to the life trajectory of a transgender person (Fraser 2009). The role of the therapist changes as the client's understanding of their gender identity changes. Throughout this process depth work seeks to uncover the manifestations and resulting affect of the transgender identity throughout the client's life. It does not seek to uncover the source of transgender feelings. Coming out is the most common time in a transgender adult's life to seek

tial. It is the responsibility of the therapist to help the transgender person decide who their current authentic self is and how much of that self the client wants to show the world. Of course, therapy may address more ways to work on the self or more ways to cope with the outside world's response to the self (i.e., the cost of coming out to the client's reputation and relationships), but both angles must be driven by the needs of the client, not the therapists' presupposed ideas on the needs of transgender individuals. Some methodology for meeting the client's needs during this turbulent time include but are not limited to thoroughly accepting the client's identity and helping them relate to their gender fully and authentically by reminding them of various comments and feelings they have had about gender throughout therapy.

Jungian theory presents the relationship between therapist and transgender client in a fascinating light: in this discourse the therapist is one of if not the first person to see the client's "trans identity" (Fraser 2009). The role of the therapist is critical in helping to develop this identity during this "accelerate adolescence" (Fraser 2009). The difficult part of this relationship for the client is to support the gender identity of the client without encouraging the client to conform to the gender binary or even keep their gender identity constant over time. The individual is best celebrated in therapy when gender fluidity is celebrated.

Post-transition the role of the therapist in the life of the transgender older adult evolves yet again, according to Jungian theory (Fraser 2009). A full or partial transition recognizes for most transgender adults the realization of a fantasy that has been held since childhood. The reality is, however (especially for transgender older adults), that the physical transition does not necessarily result in the body the transgender adult had dreamed of. Such a discrepancy can result in negative affect, resentment, and jealousy, which must be addressed by the therapist. This time in

leads to an erasure of the trans past.

A first hand account of therapy by a psychotherapist working with a transgender older adults presents similar trends in treatment (Budge 2013). This therapist's methodology is framed similarly to Jungian therapy and seeks to help the transgender adult both improve the self and cope with discrimination as well as get help with transitioning. The client in this case study sought counseling at the most common time to do so: right before transitioning. In this case, the therapist found that a lack of social support was contributing to depression and anxiety for her client. To address this issue, the therapist in this study first evaluates the old gender role that the client occupied. Next, the therapist validates and pushes for the affect related to transitioning (which stems predominantly from transphobia). Then, the therapist creates a space for the client to facilitate a new social skill set. Finally, the therapist encourages the client to establish new social networks (e.g., family, friends) post-transition.

Several common themes emerge from these three separate discourses on effective models for engaging in talk therapy with transgender individuals. Most importantly, the therapist must demonstrate an unconditional focus on the needs individual independent of any judgements on the transgender identity. The effective therapist is along for the journey of the transgender adult's life before, during, and after transitioning (or wherever the individual stops their transition process). The therapist's office is a place where the transgender individual can practice their identity and develop tools for connecting with loved ones and navigating biases against the transgender older adults. Post-transition, the therapist may help the transgender adult confront the reality of their transformation in contrast with the fantasy body they desire (i.e., being young in their body, having functioning genitalia). Throughout therapy, the therapist must be cautious not to force the

accept the transgender client's identity with a positive but critical outlook.

Group therapy

Beyond the focus on the individual, group therapy is also an effective way of treating transgender older adults (Heck 2013). Such groups typically occur in a time constraint (e.g., twelve weeks with meetings once a week), and are closed (i.e., no one enters the group after the first meeting). These groups may be led by transgender peers or by one or more mental health-care professionals well-versed in transgender-related issues. The schedule for the group can vary depending on the type of transgender individuals the group caters to (i.e., pre-, during, post-, or non-transition). One schedule given by Heck et al. (2013) set aside time in the early sessions to set goals and make a plan for group cohesion. The middle sessions placed emphasis on helping group members to achieve goals and successfully interact with peers and loved ones outside of the group. The final sessions focussed on affirming group progress and planning for the future (Heck 2013). The mental healthcare provider that I interviewed outlined similar group trajectories.

Group therapy is effective for transgender older adults because it presents them with more “mirrors” which allow them to reflect on their own experience of gender dysphoria throughout their life and see it anew (Fraser 2009). The company of peers can also diffuse feelings of felt stigma (Bockting et al. 2013). There are benefits to group therapy either independent of or in conjunction with individual talk therapy for transgender older adults.

Not only is literature emerging on effective methods that talk therapists use treat transgender adults individually and in groups, there is also a push to get all (mental) healthcare professionals up to a certain level of “cultural competency” such that they may effectively and sensitively work with transgender individuals. Cross et al (1989) were first to use the phrase “culturally competent.” “Cultural competence” today most generally refers to an awareness of intersectionality⁴ on the part of the therapist (Henkin 2008). A push for cultural competency in the mental healthcare field is currently challenging because there is no formalized need or incentive for administrators to incorporate cultural competency into their practice. These concerns were discussed in the interview with a culturally competent mental healthcare provider.

Hanssmann, Morrison and Russian (2008) outlined a workshop in the United States aiming to teach practitioners how to better cater to the transgender experience illuminating its strengths as well as shortcomings. The training (which is presented as a fairly typical cultural competence training) is presented in three parts. The first part presents the terminology of and background on the transgender community including an interview with one or more transgender-identifying persons. The second part of the training discusses the distinction between sexual attraction and gender identity. The final part of the workshop illuminates clinical information on the unique needs of transgender individuals in healthcare. Following the training, the researchers conducted evaluations of the healthcare professionals and found several misunderstandings stemming from the training.

Though healthcare providers were fairly eager to learn about the transgender community, their post-session interviews illuminated several short-comings in the cultural competency train-

⁴ Though an understanding of how the transgender identity alone results in marginalization is essential for talk therapists, an intersectional approach is most effective. For example, the talk therapist should understand that it is not only the transgender identity alone that results in marginalization but also the intersection of gender and race.

and memorize, however, such a sterile approach to the transgender identity constructed in the minds of trainees the transgender identity as something exclusionary (Hanssmann 2008). An intersectional approach to understanding the transgender identity was also largely silenced (i.e., race was not discussed in the workshop), as was an understanding of the need for transgender adults to share their own definitions and express their own uncertainties (especially in the realm of talk therapy). The workshop also left the healthcare professions not well-equipped to address gender non-conforming individuals (an issue in counseling rhetoric as well). The use of a transgender older adult, another popular aspect of the training, was also slightly misunderstood by trainees. Though well-received, such an approach risked tokenizing and exploiting the transgender individual, as well as giving healthcare providers only a narrow view of what a transgender individual looks like and experiences.

Hanssmann, Morrison and Russian (2008) concluded their evaluation of cultural competency training with a few suggestions for improvement. They noted that trainings should provide several tools for healthcare providers encountering transgender older adults, rather than one methodology for treating all transgender identities. They emphasized, as do the therapists in the previous section (Budge 2013; Fraser 2009; Henkin 2008), the importance of not seeking to understand the transgender identity but rather creating a space where the gender identity of a person may be shared.

My paper examining culturally competency expands on the work of Hanssmann, Morrison and Russian (2008) in that it encourages transgender older adults to define cultural competency for themselves and speak on both culturally competent and culturally incompetent professionals. It also includes a current mental healthcare professional deemed as culturally competent

care field specifically.

The present study

Though some work has been done to illuminate certain effective methods for conducting talk therapy with transgender older adults through both focusing on the individual and conducting group therapy sessions as well as pushing for cultural competency in healthcare professions and academia, little research has examined the effectiveness of talk therapy through the perspectives of transgender adults. The purpose of the current study is to help transgender adults to share their experiences in talk therapy, both positive and negative, in order to compile suggestions for meaningful revisions both to talk therapy methods and cultural competency workshops. The interview with a culturally competent mental health care provider is not intended to be presented as ideal care but rather to confirm or challenge current published discourse on effective talk therapy methods for transgender individuals.

The focus on older (45+) adults specifically is to test for findings in the literature that suggest that in general transgender older adults have developed coping mechanisms through therapy and are relatively well-adjusted and, if still in therapy, coping with issues that are not extremely related to their gender identity. Transgender older adults are also sometimes left out of large-scale surveys on the transgender identity either because they have mobility issues that prevent them from being actively involved in queer communities in cities, or because they are not as involved with online communities that are being surveyed. I also believe, quite simply, that transgender older adults have seen the most history and experienced the widest range of mental healthcare over space and time. Their insights, therefore, can provide the broadest perspective on how mental healthcare has changed and what talk therapy methods are effective and which methods fall short.

A. Rationale for Conducting Oral Interviews

Though statisticians have recorded how many transgender adults engage in psychotherapy, and some psychotherapists have recorded their treatment sessions with transgender older adults, there is a little research that shows transgender adults speaking autonomously about their own experiences with talk therapy. Unlike with survey measures, the oral interview allows the transgender interviewee to elaborate on their answers with personal experiences and reflection. Unlike with case studies, the oral history interview eliminates mental healthcare professionals speculating on the transgender adult's experience with their counseling and instead invites the transgender individual to speak from their own experiences. I believe that such a way of conducting research can better illuminate where talk therapy falls short for transgender adults as well as meaningful steps that mental healthcare providers can take become more culturally competent.

The oral interview is also important in working with mental healthcare providers for similar reasons. Rather than the professional merely saying that they follow a certain broad school of psychological thought (e.g., Jungian theory), they must elaborate on why such theory best suits the needs of transgender older adults as well as how their own practice of theory has evolved over time. Through this reflection comes more meaningful and personalized answers that, when put together, can provide the framework for improving transgender mental healthcare.

B. Interviewee Recruitment

Participants were recruited through networking within the transgender community with the help of my adviser, Vreer and an employee of Transvisie Zorg, Bastiaan. On initial contact with each interviewee I explained the purpose of my research and my policy of maintaining the anonymity for each of my participants if requested. I also explained that each interview would be

conduct the interview.

C. Positionality

I have remained mindful of my own privileged positionality throughout this research. As a cisgender straight white middle-class woman, there is an unequal power dynamic between me and my interviewees which may make them uncomfortable to authentically share their story or, worse, make them feel taken advantage of and unsafe. To avoid the negative impact of an unequal power dynamic as much as possible I had my project advisor, Vreer, who is a transgender activist in Amsterdam, thoroughly review my interview guide to ensure that the questions included there are not insensitive or damaging. In the case that one of my questions, despite my best intentions, made an interviewee upset, I always reminded them that the interview could stop at anytime. I was mindful that, as the interviewer, I had the ultimate power to stop the interview and reserved this power as an important strategy for ensuring that I did not cause my interviewees any unnecessary distress.

I wanted to work with the transgender community because I believe that the poor treatment of transgender older adults in the mental healthcare field reflects a troubling human rights violation. Despite this intention, I was wary throughout my interviews of developing a savior complex or of infantilizing the transgender older adults. I also knew that I ran the risk of unintentionally being more cautious with my words with transgender adults than with cisgender adults. To offset this bias I reminded myself that the interviewees had deemed themselves capable of engaging in an emotionally-trying interview and that I had to trust in their own autonomy as well as resources I had on reserve (i.e., a referral to Transvisie Zorg) in case something went wrong. I also reminded myself that although the interviewees' gender identity had likely lead to more suffering and marginalization than what cisgender people have faced, that was just one aspect of

minded myself to treat, cater-to and speak with whole identities, not just the transgender aspect of the interviewees' identities.

My own biases also ran the risk of impacting my interactions with the mental healthcare providers. Since I want to become a social worker I sometimes hold mental health care professionals in too high of an esteem and forget to be critical of their methodology. I therefore remembered to not take what the culturally competent mental health care provider told me as the “best” way to treat transgender persons struggling with mental health. Through this paper I have attempted to find patterns in the discourses of both the mental healthcare provider and transgender older adults to construct thoughtful and useful suggestions for improvement.

D. Ethics

Since I worked with individuals who have received mental health care, extra steps were taken to ensure my interviewees' well-being. My methodology was reviewed and approved by the SIT local review board. In addition to IRB review, I took many small steps to ensure the well-being of my interviewees. Upon first contact and at the interview, I reminded them that the interview could stop at anytime either temporarily or permanently if they became uncomfortable. I also gave them the option to maintain anonymity in my paper (though some interviewees did not feel the need to remain anonymous). All transgender older adults who had received mental healthcare and demonstrated distress post-interview were provided with the contact information of Transvisie Zorg, a center that services the mental health care needs of transgender adults living in Amsterdam. I, as the researcher, did my best to remain vigilant to the emotional needs of my interviewees throughout the interview. If they did begin to look distressed I offered them a break. Many steps have been taken to ensure the emotional well-being of the interviewees of this study.

“It is essential for a therapist to talk about both mental health and gender. How you see your gender impacts how you see yourself and I don’t think it’s good to separate that.” - Felix
“She helped me figure out what I want to do the rest of my life and how I want to live and, well, that was very positive.” - Maria

A. Felix

Felix is a 47-year-old transgender man and political activist who lives in the Hague. He met with his first counselor when he was 14 and had his last talk therapy session six years ago. Despite one negative experience with a creative therapist who refused to acknowledge Felix’s gender identity, Felix was fairly optimistic when discussing his experiences with mental health-care saying “I think most social workers are very acceptable” and that today he thinks most people are “very professional with the way we treat people.” Despite a long history of talk therapy and counseling, Felix was very optimistic about the current state of his mental health saying “I have overcome my mental problems... I am now happy with who I am and what I’m doing. When you don’t feel happy or are not satisfied with what you’re doing and you have a history of mental illness it puts you in a bad mood but mental illness doesn’t bother me anymore.”

When discussing the stigma he felt as a transgender man Felix said he felt he suffered more as a gay man than as a transgender man. He also mentioned that he thought his ability to “pass” as a cisgender man may lead to better experiences with counselors, saying that friends he had who had transitioned from male to female later in life (and, according to Felix, were therefore more visibly transgender) had more negative experiences with talk therapy.

Ultimately, Felix believed that any therapist could effectively treat a transgender client, even if that counselor did not have much background in gender and sexuality. He said of one positive experience with a counselor “He was very acceptable, understandable, and serious... it

or a female.” Despite the importance Felix placed on a therapist first and foremost treating the client as a person, he also believed that gender should be an important part of personhood discussed, especially for a transgender client, saying “We [talked] about my mental problems but we also [talked] about my gender” and “It is essential for a therapist to talk about both mental health and gender. How you see your gender impacts how you see yourself and I don’t think it’s good to separate that.” Felix also noted that the therapists who have helped him the most just let him talk and work through his own problems.

B. Maria*⁵

Maria is a 64-year-old transgender women. She currently volunteers at schools around the Netherlands talking to children with transgender feelings and their families. She has participated in both individual and group therapy to discuss her gender identity specifically. Maria had transgender feelings from the age of 12 but only began to discuss these concerns in her thirties. Her first experience with a counselor was negative. Of that experience she says “It [the therapy] didn’t bring me much further.” She also said that the therapist tried to reduce her transgender feelings. Following this negative experience “It took me awhile [3-4 years] to go back again.” Between seeing the first counselor and the second Maria developed other coping skills.

Maria met the counselor she would later forge a great connection with at a conference. Throughout the interview Maria spoke often and fondly of this counselor saying things like “The only thing she said was I’m trying to let you see what you want out of your life.” To help Maria get the most out of life, this therapist referred often to Maria’s own written personal history to try to figure out the type of person Maria wanted to be. The therapist also confronted Maria with the realities of being a middle-aged trans women and of transitioning later in life.

time she said, “I didn’t learn much except for accepting yourself even more. You can be proud of what you achieve and you can be proud of yourself and that was what we did. We talked a lot about our private lives...”

While the group therapy sessions encouraged Maria to check out the gender clinic whose evaluation confirmed that she was a transgender woman, she has yet to begin the transition process. At the the time of this interview Maria was still “Mark” to some of her friends and family.

C. Bear

Bear is a 44-year-old two-spirit⁶ queer individual currently living in Amsterdam. In Amsterdam, they are a sexuality educator and home healthcare worker (for another month at time of publication). They also volunteer for different alternative organizations in Amsterdam such as the Holy Fuck Film Festival and at Vrankrijk, a community center and bar located in an old squat.

Bear has dealt with depression throughout their life. They first engaged in talk therapy when they were 11-12 during the divorce of their mom and her second husband. They were in talk therapy again between the ages of 16 and 17 and then again in their 20s and throughout the rest of their life so far. Their most positive experiences in talk therapy took place with individuals who did not judge them, were compassionate and empathetic and really “saw them for who they were.”

Bear did not see their gender identity as an important part of their talk therapy saying of gender identity: “It wasn’t why I was there. It was never brought up, never talked about” and “it wasn’t something important to come up for you in those settings...I mean I was four when I first had signs of gender deviance and I learned really early that that was really not cool.”

⁶ “Two-spirit” is a contemporary collection of words used by some indigenous North Americans used to refer to individuals

chemical imbalance in the brain, not from their gender identity. Though Bear had in the past had some positive experiences with talk therapy, they spoke extensively about a current preference for working through problems by talking with friends or using smart drugs⁷.

“Always there was this mix of what I learned, what I experienced at work, what I experienced in life...” - Thomas

A. Thomas

Thomas currently works as coordinator at Transvisie Zorg. Transvisie Zorg is an organization based in Amsterdam, The Netherlands, that serves transgender individuals and their family and friends ages 4-80. Thomas was trained as a developmental psychologist. His choice to study developmental psychology came largely from his own difficulties with his identity growing up. He described this choice saying “I wanted to help people but I didn’t choose clinical psychology because I didn’t believe in diagnosis and testing.... I chose developmental psychology actually because I thought I’m so confused myself about who I am maybe it’s a good idea to start with learning what is development at all.”

Early in his life, Thomas worked with children who had run away from home, but that work did not help resolve his own unhappiness. When speaking more deeply of what troubled him during that time, he said “It was always about my gender and not finding any place where I could experience my sexual identity because I always fell for boys but I would avoid sex because then I found out they saw me as a girl.”

Following a long stretch of difficulty, Thomas transitioned into his (male) gender identity. But his attempts to get involved with the gay community following this transition did not live up to his expectations. He tried to throw himself into work, “I worked and I worked and that gave me security and self-esteem” which helped for a time. Eventually, however, he sought refuge in a group at Transvisie Zorg for gay transgender men. He said “I thought I didn’t do all of this work to stay alone for the rest of my life and that was when I went to one of the self-help groups at the

offered the position of Transvisie Zorg center coordinator.

Thomas viewed mental healthcare as a way for transgender individuals to cope with the stress that comes from possessing an identity consistently invalidated by the outside world, saying “You’re not treated [because of your gender identity] you’re treated because of the consequences of being different and coming to terms with it.” He also advocated strongly for mental health consultation (not just analysis within the gender clinics) pre-transition, saying “If it was up to us [Transvisie Zorg], we would put much more emphasis on preparation.”

Thomas also spoke of the therapist’s role to help transgender older adults specifically come to terms with the reality of their transitions. “Of this he said this doesn’t open the door to you being a young girl... you do get to be a middle-aged women.” He spoke of the therapist’s role in both validating the transgender individual’s identity while also taking steps to ensure that they are taken seriously by the outside world.

Thomas also spoke extensively about the usefulness of both self-help groups and counselor-led group therapy sessions for “searchers” (people beginning to question their gender identity), individuals immediately pre-transition, and transgender adults post-transition. In describing the thoughts of an individual participating in the searchers group specifically, Thomas said, “After being in this group and seeing that there are such people as me I can finally have a picture of myself and so we are instrumental.” He added that differences in identity don’t matter much in these groups “it is just this recognition [of being transgender].”

A. Negative Experiences with Mental Healthcare

Maria, Felix and Bear all recalled ineffective sessions with talk therapists. Maria described the first counselor she saw as trying to invalidate her transgender feelings. “The psychologist didn’t know anything about transgender problems at all. Maybe she had read something about it but it wasn’t her cup of tea” she continued “she didn’t ask the good questions.” Maria was however, retrospectively optimistic about this negative experience, saying “that’s not what I want, I need other help” but also “that was the first step and it was important.” Despite the optimism Maria described to me this negative experience deterred her from seeking out talk therapy again for quite some time “It took me awhile [3-4 years] to go back again.” In the meantime Maria developed other coping strategies such as running marathons.

Though Felix’s perspective on mental healthcare was fairly positive, he too recalled a negative experience with a creative therapist. He said “I have one memory of a [creative therapist] I hated. I was a female at the time but I introduced myself as a man.” In recalling this individual Felix became slightly agitated. He elaborated that he said to the therapist “I’m not Jacqueline, I’m Jack. She laughed at me.” When recalling this negative experience Felix was also quick to remember the compassion other people in the center saying “Except for that one person everyone had no problem with it.”

Bear also spoke of ineffective therapy saying “In my early 20s I went to a therapist session and she was very nice but it just didn’t feel like it was going anywhere.” When prodded about the difference between this therapist and more effective therapists they said “Being seen. Being seen.” Later in the interview, when asked what would make for a negative counseling experience, Bear said that it would involve a counselor “Telling me what to do. Telling me what I

and said that the topic had never come up in their sessions.

The negative experiences of Felix and Maria support the importance of establishing an understanding that the client's gender identity is accepted early on in counseling process which is illuminated the PLISSIT model (Henkin 2008). In Maria's experience, the counselor's inability to demonstrate competence with transgender issues deterred her from seeking help again for years. Though she was able to develop other effective coping mechanisms, in the case of less well-adjusted individuals this setback could have been much more damaging. Felix recalled a more explicitly invalidating experience. Without the support of other workers this situation could have been much more damaging to Felix. Even the memory of it clearly caused negative feelings. Bear's negative experience didn't have to do with the invalidation of their gender identity specifically but did have to do with not feeling seen for who they are, which also speaks to the negative impact a therapist can have if they invalidate a client's experience.

B. Positive Experiences with Mental Healthcare

Maria talked extensively about a positive experience with a counselor whom she spent over two years with saying "I would advise everyone, first go out to a counselor not related to [the gender clinic] and let them first let you know what you really want and also if you are capable of doing it." Maria's counselor relied extensively on a personal history Maria had written of her life and would confront Maria often with her own feelings and opinions that she had written down. Of this Maria said "[my written life story] was her guideline to make an opinion about me... she confronted me again and again with things that I wrote down."

Maria's therapist's method of seeking for truth and consistency in her opinions and thoughts extended to conversations in the office. Maria recalled one conversation with her counselor in which they discussed why she wore a bra. Initially Maria responded "well not because I

has to be there.” Maria elaborated on this statement saying to me “but that was not true and she [the therapist] picked at it [saying] of course you like to wear a nice, beautiful white bra, you don’t buy a cheap one.” At this time in the interview, Maria smiled. “Nowadays it seems irrelevant to me but then it was a great step to make. I dared to say to her yes I do I like wearing a bra and it belongs to me and it is nice and I feel proud and that was important too but at the moment she did this I always realized afterwards because I thought about it and I said ‘yes of course.’” Clearly such a positive counseling experience came from Maria’s therapist’s commitment to helping Maria voice the truth of herself.

Felix also spoke of positive experiences with therapists. To him, his gender identity wasn’t quite as important to therapy as being treated like a person. Of one successful therapist he said “He was very acceptable, understandable, and serious... it doesn’t matter for him if I am a female or a male. He treated me like a person and not like a male or a female.” This psychologist did not have a previous background in gender and sexuality. More generally, Felix said that “most of the healthcare workers I had were more listeners.” Felix had less of a need to talk through his identity and more of a need to be listened to. Both Maria and Felix, however, wanted a space where their gender identity was accepted but, at the same time, not the most important part of their personhood.

The positive experiences of Maria in therapy closely mirror the teachings of Jungian therapy in which the therapist’s role is to help the individual to develop their authentic self (Fraser 2009). Felix’s own experience ties more closely into Rogerian teachings of unconditional positive regard in which the therapist’s role is less to provide advice or feedback and more to create a space where any thoughts can be expressed and accepted.

about the importance of the therapist accepting their sexuality saying when asked what an ideal counselor would be for them

BEAR: “Definitely somebody who was kink friendly”

KATE: “Can you explain that to me a little bit?”

BEAR: “Uh someone who’s not just aware of but accepting of BDSM and fetish, polyamory, I think it’s a little bit farther than LGBT. And not just kink aware but kink friendly. ‘Cause half of the reason we’re here is, you know, judgements from other people.”

Bear also mentioned the positive characteristics of past talk therapy experiences saying “I think in both cases [of good therapy] these were extremely compassionate and empathic people. I think in both cases they were also open. They must have shared some vulnerabilities or something.”

Bear spoke more specifically about the importance to them of being appreciated as an individual in therapy saying

“In both cases where there was some kind of connection it was about people being able to see me. I don’t think that anybody goes to any kind of mental health professional - like broken open guts all over you know? Everybody goes in somewhat guarded because you’re going to give your vulnerabilities to a stranger. And for me if I am going to give these vulnerabilities to somebody, to anybody, I need to know that they’re actually seeing me not just hearing the words but seeing all of me. And that’s hard to explain.”

Again, though gender identity was not an important aspect of Bear’s counseling, an unconditional acceptance of them as an individual was clearly very important.

C. Trans Past of the Counselor

In reviewing my conversations with Maria, Felix and Bear I began to wonder if the identity of the therapist mattered. Did sharing a transgender identity help facilitate a better counseling experience for the transgender client? Thomas spoke extensively about if and when the identity of a therapist mattered saying “It’s very important that people who come here know that they

matter saying “we have two therapists head the group and always one of them is transgender... we do that on purpose and also because that is the way that teams are made up.” He also discussed a time when the transgender identity was less favorable in a counseling setting, saying “we also always put children with a transparent with a non-trans therapist... because children are so loyal and we want them to be totally frank about what they experience.” The perspective illuminated by Henkin (2008) that the therapist’s own gender identity is always an important part of talk therapy was not confirmed by Thomas.

D. Counseling Strategies

Outside of general positive experiences in counseling, specific characteristics of effective counseling strategies came up again and again in the interviews such as group therapy, mirroring, checking client expectations with reality and building support networks.

Group therapy was one effective counseling method that came up in the interviews. Thomas spoke of group therapy as an important resource for transgender adults before, during, and post-transition. Thomas spoke extensively of a pre-transition group, the searchers, in which gender identity can be explored and experimented with. He explained one activity in this group saying

“we give people a paper and on it is a totally genderless person and give red, green and orange pencils and say this is you and use whichever body part you feel comfortable with make it green, a body part you hate or don’t know what to do with make it red and the rest make it orange. It’s the most simple thing but it gives so much insight.... so many things are forbidden and shameful and the moment you ask them to just show it then of course in little groups they tell others what they’ve done and the others say what they see and later, sometimes much later and I see them... he’s still referring back to that moment that he really could look at himself from the outside”

Of course such an activity could also take place in a one-on-one session, but the sharing of the

simply “When you’re here you are asked and invited to tell your truth.”

Thomas also spoke of how it was difficult to fill the post-transition group even though he thought those individuals still needed mental healthcare saying “we find it very important that people don’t stop with their mental health process once they’re operated” and “many people come years later with the questions: ‘I feel isolated, new friends are different from what I expected’ but it’s “very hard to fill this group [as opposed to searchers and people immediately before transition].”

Maria attended group therapy after finishing sessions with her effective counselor and before visiting the gender clinic. Of this time she said “for me the group therapy was very good for comparing yourself with the situation of other people.” Group therapy was also a place where she learned from the experiences of other transgender individuals. Of this Maria said “...that was a [diverse] group... but you could learn from each other. It was a lot of talking about your life and explaining to your fellow transgender how you cope with all your things.” Felix had also experienced group therapy but not for transgender individuals specifically. Of this experience he said “you see it (a reaction) from a different person and it is shocking.” Bear offered another, less positive perspective on group therapy, saying “It’s hard enough to show my guts to one person. I don’t want to put my guts out to a group” and elaborated saying “I just don’t feel like showing my guts to strangers and this goes back to, you know, if you had stronger bonds with friends there would be less need for that.” Perhaps, then, Bear sees the benefit of interacting with others and working on problems with them but mistrusts the clinical group therapy setting as the best place to find this support.

Throughout all of these narratives the importance of mirroring for the transgender older adult comes up again and again. As Thomas said in these groups there are “more mirrors” or

transgender individual has grown up without mirrors or without other people affirming their gender identity and showing them how to fit into the world. Group therapy can be one place where they encounter these mirrors (other transgender individuals) that can facilitate both reflection and growth (Fraser 2009).

Mirroring was also described as taking place in a one-on-one counseling setting throughout the interviews particularly in the case of what I came to refer to as “reality checking.” Maria described one instance in which reality checking took place with her therapist:

“There was a time, I told her when I thought girls, women, when you are a girl when you are a woman, you cannot be unhappy. You only can smile the whole day! It’s crazy to think of but I was thinking that. And I was thinking that when I was 12-13 years old. [My therapist] always said ‘well you think women can only have a nice life, but that’s not true. It is not so nice to be a woman all the time and there are a lot of women that have a hard life and it is not enough to be a woman.’ And then she advised me to try to be and live as a woman for two weeks, three weeks, and to experience day and night how it is to live as much as possible as a woman... sometimes it was uncomfortable but on the whole I liked it so much.”

Maria later went on to say “She brought me down to earth imagining how it is to be a woman.”

Maria also said that her therapist helped her stay realistic about what it would mean to transition later in life saying “[my therapist said] ‘you’ve had this successful life and you need time to mourn over that, you are putting that away and when you are going to live as a woman well there will be a lot of people who always identify you as a man.’ Well because of my length, my hands, my voice because I didn’t do it the way the kids do nowadays [with puberty blockers].”

Thomas also discussed the importance of reality checking in talk therapy, particularly for older adults saying “[Some people think that] “every problem in their life will be solved by having this operation... and if they go into the process with this attitude it will be total failure.” In regards to the reality of transitioning later in life Thomas said “this doesn’t open the door to you

important. They're about learning to live your life, the reality of your life, the reality and possibilities but still the reality." Thomas described a specific instance of reality checking in regards to how a newly trans woman was presenting herself:

"It was heartbreaking: this woman of almost 60 with her first wig and her first night out as a woman and she came to me and 'hello I'm Brittany' and for a longtime I thought 'should I tell her' and finally I said 'hey honey women of 60 are not called 'Brittany' I don't know if you realize that, it's not possible to be 60 in Holland and be called Brittany.' ... when you start dressing as Brittany and you are 60 people don't take you very seriously and from then on it is a recipe for loneliness, that's what it is. There are many options and in the end it is not that bad to be a middle-aged woman"

From the way Thomas spoke this story seemed to be the norm, not the exception, of treating transgender adults. He said "our therapists are absolutely very confrontational, but they can explain why that is." Confrontation was often the best way to ensure a client's gender identity would be respected and taken seriously.

A final effective counseling method that came up throughout the interviews was encouraging the transgender individual to build up support networks amongst family and friends. Maria described the role of her therapist throughout this process saying

MARIA: "well in the first place you have to tell your wife. I had to tell my children, my brother, the inner circle huh? And I had to tell two or three good friends. What I was trying to learn about myself. So I did that. Then there was another circle, a little bit more. People you frequently meet. People at work. People you are close to. So I did that too. Now I don't know how many people know now because the circles get wider and wider and you cannot control them any longer."

KATE: "Was your counselor at that time guiding you through that expansion?"

MARIA: "Yes. And she invited one of my best friends also to know him and to tell him how she was thinking about all those kind of things."

KATE: "So she was guiding them?"

about how they were thinking about me in my early days and when I was young. They knew me almost all my life.”

Maria also said that her therapist encouraged her to recruit the help of her female friends to explore womanhood saying: “That [exploring femininity] was one of the parts we did too. ‘What do you want as a woman? How do you want to present yourself?’ And she was the one who said ‘well you have to talk with friends and she meant women, to help you find your style. To help to find out what you want and what is important for you.’ And well that took me a while because there’s always a bit of shame with that but in the end it was good. She helped me very much. We [me and my friend] went out shopping and it was more and more easy.”

Thomas also spoke of the importance of building support networks in the context of the searchers group, saying “We also say who in your environment knows that you are a searcher? Now very often it is no one and then we say why is that not something you tell people [and they say] well I want to be sure. Ok do you want people to know who you really are? Is that what you would like? We encourage them to talk to family and many times they are totally flabbergasted that instead of the reaction that they feared people say ‘ I feel so special that you told me.’ Thomas elaborated on the importance of forging these connections saying “not having that [being trans] as a secret anymore comes with more in-depth relationships.”

Fraser (2009) outlined the important role of the therapist in guiding the transgender individual in coming out to friends and family but spoke less of the important role the therapist can play in building support networks, as Maria’s therapist did for her and as Thomas recommended. Forging such connections can not only help with the coming out process but also help ensure the stability of the client even after talk therapy has ended. Bear and Felix also spoke of the important role that friendship and community had played in them establishing coping mechanisms and, ultimately, living better lives.

Thomas spoke about Transvisie Zorg in comparison to the gender clinics. At the gender clinic, clients do not receive counseling but rather a consultation to see whether or not they should transition. Thomas rejected this philosophy saying “If it was up to us we would put much more emphasis and presence on preparation [before people transition].” He also said [the gender clinics] are independent and we are not too happy about that.” According to Thomas, some transgender individuals are skeptical about seeking help at a place like Transvisie Zorg for fear of being pathologized.

Thomas also expressed concern about the way less culturally competent mental health-care providers are approaching transgender clients saying

THOMAS: “...I see so many things going wrong in general practices that people have not that much experience.”

KATE: “What do you see?”

THOMAS: “Still so very often people start from our perspective from the wrong end. A client will say they are depressed, anxious and not sure of their gender when really they came in to talk about their gender in the first place. The regular therapist doesn’t pick up on this. People ask about the things (i.e., anxiety) that they know how they work. I know in most cases the last sentence [about gender] is the thing the person really came to tell but they don’t feel safe to put too much emphasis on it because you never know”

Thomas went on to say “... they [other therapists] feel uncomfortable addressing the gender dysphoria, they feel they have no experience, well that’s fair enough...” But of course giving room to discuss gender dysphoria can help make progress with the anxiety and depression. Thomas did say that as Transvisie Zorg has gained more recognition, more counselors are reaching out to them when they encounter a client with transgender feelings. He added, kindly that “You can’t expect someone to be competent on every scale.” Thomas himself also refers clients to specific therapists (i.e. those who specialize in story telling-related therapies).

signment surgery through the medical establishment despite a desire for surgical procedures. Of this they said “The whole reason that I’m going outside of the medical establishment is that I don’t want to be pathologized” and later “I would like to do surgeries and it really pisses me off that the only way to do that is to be pathologized first.” Though Bear mentioned that there are options for people who want to do the surgery without psychological consultation they added that this option is not feasible for all people, especially if their health insurance is based in the Netherlands. In Bear’s experiences it is clear that the conflation of psychoanalysis with gender transition has led to a mistrust of mental healthcare professionals in general.

F. Perspectives on Aging

Though the reality of transitioning later in life was discussed a bit in relation to reality checking, the interviewees had other comments on the implications of transitioning later in life as well. Maria described her therapist speaking of her age as saying ““Growing old means having less time to be the one you want to be’ so she said ‘I only can advise you go farther with your being a woman.’” Thomas also spoke of transitioning later in life saying “Sometimes [especially with older people] there is so much bottled up that the bottle bursts and very often it’s a situation in which they have gotten stuck in work and relations and they feel they have nothing to lose so they want this operation as fast as possible: no please don’t.” Though some older adults may feel they have little to lose, the opposite problem also presents itself in older adults: they have built a life for themselves and in transitioning risk all of the stability they have built. Thomas spoke to this saying “many of the people over 40 have stepped into a relation[ship], become a member of a family, have reached a certain level in their job and for them it feels like a very big risk to lose all of that and also it feels like they don’t want to go on being dishonest so that is a very pitiful

cerns arise in talk therapy when a transgender individual is deciding to transition later in life.

The importance of language

An understanding of language is the easiest way to compassionately engage with a marginalized group. It shows both a knowledge of what people value as well as a respect for their wishes and how they choose to identify. All counselors with transgender clients must use the preferred pronouns and names of their clients. The failure to do so can cause the client great distress (in Felix's case) or even discourage them from seeking out therapy in the future (in Maria's case). Cultural competency workshops like that of Hanssmann, Morrison and Russian (2008) are a perfect place to teach the importance of language to all mental healthcare providers.

Focus on the individual

Each of the interviewees brought up, to some extent, that the effective therapist focussed on helping them to forge their own identity as a person and as a transgender person specifically (except for in Bear's case). It is important for counselors to not attempt to trace the source of transgender feelings (which may not be there) but rather to address the consequences of having these feelings in a world that is not accepting of them. Then, the counselor should focus on helping the individual to, in the wake of these negative feelings and in acknowledgement of the transgender feelings, forge their best identity and life possible. Jungian theory presents an effective model for validating the individual that came up again and again as an effective approach in the interviews, especially in Maria's case.

Confrontation

Even as the counselors must be an encouraging presence for the client, at the same time they must act as a guide to ensure that the client's gender identity is respected. Thomas pointed out that sometimes transgender clients are not used to being taken seriously and that these dejected feelings can carry over into how they approach their transition. Thomas said it is important

tions of their transition to ensure the best experience possible. Maria's positive experience with her therapist echoed these sentiments. The tactic of confrontation is especially important when working with transgender older adults who may find that the way they imagine transitioning and the reality of transitioning are two very different things.

Network building

Network building is an important tactic that therapists treating transgender clients should utilize. Transgender clients may choose to hide their gender identity until they are "sure" for fear of rejection and judgement. This hiding can lead to feelings of isolation and shame. While the counselor is a valuable ally on the transgender individual's journey to mental health, they should not be the only ally. Encouraging network building will increase the client's quality of life and ensure long-term success after talk therapy is over.

Skepticism of the psychologist's role in the gender clinic

Bear's narrative in particular illuminates the problem with having psychologists as the gatekeepers of gender reassignment surgery. Though statistically many transgender adults could benefit from engaging in talk therapy outside of the gender clinic, when the talk therapist's role is so conflated with psychoanalyzing (and therefore judging) the transgender identity, the transgender individual may become skeptical of seeking any sort of counseling. Though Bear has found support in friendships, such resources may not be available to all transgender people and, in this case, a mistrust of talk therapists due to their involvement in the gender clinic can have very damaging results. The psychoanalysts at gender clinics should therefore further work to distinguish what they do from the work of talk therapists.

This project was completed in less than a month in fulfillment of a study abroad course requirement. In the short window of time provided, interviewees were chosen predominantly by convenience without much regard for versatility in opinion or experience. Race and class differences were largely erased as categories of analysis in my research. Similarly, having the ability to access mental healthcare was a prerequisite of participating in the study. Researchers with more time should seek for a more diverse pool of interviewees. They could also benefit from exploring barriers that transgender individuals face to accessing mental healthcare beyond the fear of not having their gender identity be validated such as financial or cultural factors. In other countries where mental healthcare is less subsidized by the government, such analyses are essential for activating greater access to mental healthcare for all.

This research also lacks the perspectives of non-culturally competent mental healthcare providers. Their perspectives on how treatment went with transgender clients could more specifically illuminate where failures in mental healthcare take place (i.e., Is it therapist apathy? A lack of training?). Researchers could also further the work of Hansmann, Morrison and Russian (2008) in illuminating what kind of cultural competency training works best for mental healthcare providers specifically to increase attention to language, the individual, confrontation, network building, and skepticism of the psychologist's role in the gender clinic.

These narratives ultimately illuminate the immense responsibility that the talk therapist has when approached by a transgender client. If the therapist is insensitive and unwilling to engage with the transgender identity, they will have a negative impact and possibly discourage the transgender older adult from seeking mental healthcare in the future. If, on the other hand, the therapist is understanding, compassionate and eager to help the transgender individual figure out who they want to be and how they want to live, they can greatly improve the quality of life of the

ineffective negative force. High rates of anxiety and depression in the transgender population indicate that many transgender individuals can stand to benefit from effective talk therapy. Attention must be paid, therefore, to changes that can greatly improve the experience of talk therapy for all transgender older adults.

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Introduction:

The purpose of this interview is to hear your experiences with mental health care. I will begin with broad questions on your thoughts on mental health care and mental illness. Then I will ask questions about how your personal perceptions of mental health have changed throughout your life. Finally, I will ask you to share personal experiences with mental health care throughout your life.

The purpose of my research is to compile suggestions that will help improve mental health care for all people and, specifically, the transgender community. If, at anytime, a question I ask makes you feel uncomfortable or unsafe, please say so. If you are uncomfortable we can take a break or stop the interview entirely. I will be recording this interview to refer back to what you say when writing my paper. Do you have any questions?

Questions:

I want to begin this interview by asking you to describe what comes to mind when you think of mental health care? Is this term too formal to you? Not formal enough? What do you like to call talk therapy?

Mental health care is typically seen as a way to treat “mental illness.” Think back to the first time you remember being conscious of what mental illness was. What did you define as mentally ill at that time? What sort of feelings, thoughts, and memories are connected to the phrase “mentally ill” for you?

Did you know anyone receiving mental health care when you were growing up?

Did your family ever discuss mental health or mental health care when you were growing up? What do you remember about what was said?

Please talk about discussions you’ve had with friends about mental health care, if any. Was there ever a time in your life when conversations about mental health were common? Why do you think that was? What were your friends’ perceptions on mental health care? How do your friends feel about you seeking therapy? Please be specific.

Please talk about discussions you’ve had with intimate partners about mental health care, if any. Why did these conversations come up? How did you feel about them when you were having them? How do you feel about them now? What were your partners’ perspectives on mental health care? How do your intimate partners perceive you receiving therapy? Please be specific.

What have been your personal experiences with mental health care? Have they been consistent or varied by place and service provider?

For this next question, I want you to imagine the type of person you would want to counsel you. What would they look like? How would they speak? Have you ever had this kind of counselor?

Now, please imagine the worst counseling experience you could have. What would make you

Given your reflections on perspectives on mental health care, do you have any further thoughts about how a mental health care provider could best suit your needs as a human being? As a transgender adult (not to imply that being transgender in and of itself warrants a need for counseling)?

Concluding remarks:

Thank you for taking time to speak with me today. Please sign this form agreeing that what we have discussed today may be used in my paper. Here is a copy of the form with my email address in case you have any follow-up questions or thoughts. I will be in contact with you soon to give you a final copy of my ISP. Thank you again.

Introduction: The purpose of this interview is to hear about your experiences as a culturally competent mental health care provider to transgender adults specifically. I will begin with broad questions on your thoughts on mental health care and mental illness. Then I will ask questions about how your personal perceptions of mental health have changed throughout your life. I will ask you what cultural competency means to you and what initially drew you to cultural competency as a mental health care professional. If you are uncomfortable at anytime during the interview, please say so. We can take a break or stop the interview entirely at anytime. I will be recording this interview to refer back to what you say when writing my paper. Do you have any questions?

Questions:

I want to begin this interview by asking you to describe what comes to mind when you think of mental health care? Is this term too formal to you? Not formal enough? What do you like to call what you do?

Mental health care is typically seen as a way to treat “mental illness.” Think back to the first time you remember being conscious of what mental illness was. What did you define as mentally ill at that time? What sort of feelings, thoughts, and memories are connected to the phrase “mentally ill” for you?

Did you know anyone receiving mental health care when you were growing up?

Did your family ever discuss mental health or mental health care when you were growing up? What do you remember about what was said?

Please talk about discussions you’ve had with friends about mental health care, if any. Was there ever a time in your life when conversations about mental health were common? Why do you think that was? What were your friends’ perceptions on mental health care? How do your friends feel about what you do? Please be specific.

Please talk about discussions you’ve had with intimate partners about mental health care, if any. Why did these conversations come up? How did you feel about them when you were having them? How do you feel about them now? What were your partners’ perspectives on mental health care? How do your intimate partners feel about what you do? Please be specific.

Have your thoughts on mental health care changed throughout your life? In what way? Can you point to any key experiences that have changed the way you conceptualize mental health care?

As you know, I have sought out an interview with you because you are a culturally competent mental health care provider who works specifically with transgender persons. How do you conceptualize cultural competency? Why is it important?

How can cultural competency be better taught to mental health care professionals?

What drew you to work with transgender adults specifically? Please talk about some challenges

What role does the psychotherapist play in the transition process? How do you feel about this role?

Which organizations exist in the Netherlands to support trans older adults and their family?

Concluding remarks:

Thank you for taking time to speak with me today. Please sign this form agreeing that what we have discussed today may be used in my paper. Here is a copy of the form with my email address in case you have any follow-up questions or thoughts. I will be in contact with you soon to give you a final copy of my ISP. Thank you again.