Trans Affirmative Mental Health Care Guidelines:
Results of a Mixed-Method Inquiry in Three Cities of India
Trans Affirmative Mental Health Care Guidelines: results of a mixed-method inquiry in three cities of India

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ENDORSEMENTS

The report on Trans Affirmative Mental Health Care is a much-needed step forward in a much-neglected domain. The research that led to this report is fine tuned to assess existing attitudes to transgender persons, including candid interviews with healthcare personnel of varying seniority. Guidelines have been suggested to improve the mental health care of trans folk, and these come not a day too early.

Dr Ajit V Bhide, Psychiatrist & Psychotherapist & Past President, Indian Psychiatric Society (IPS)

This is a well-researched first of its kind document that contributes evidence based guidelines for Trans affirmative mental health services and in doing so, fills a major gap in the medical education institution. The guidelines address the concerns not just of the transgender community but also their families, intimate relations, support groups and medical professionals, thereby advocating a holistic approach to mental health care that goes beyond diagnoses and treatment of disorders. This is a much-needed good practice reminder in the field of mental health today and always.

Dr Ranjita Biswas, Psychiatrist, Therapist, Member of Sappho for Equality, Kolkata & Co-author of the report, A Good Practice Guide to Gender-Affirmative Care (2017)

An excellent resource that bridges the gap between laws, guidelines and our experiences and challenges in the therapy room. The evocative narratives encourage us to reflect on structural inequalities and barriers, to question therapist neutrality and build ethical, affirming and contextually relevant mental health care services. A landmark report with the potential to transform training and practice processes across the country.

Poornima Bhola, Professor of Clinical Psychology, National Institute of Mental Health and Neuro Sciences (NIMHANS) & lead author of Reflective Practice and Professional Development in Psychotherapy (2022)
I congratulate Ketki Ranade/KP and their team for the very relevant and insightful Trans Affirmative Health Care Guidelines which has stemmed from a well conducted study. The report they have presented is a MUST READ for all mental health professionals. The 12 guidelines recommended in this report are very helpful. As a Psychiatric Social Work (PSW) Professional working with families and training mental health professionals in family therapy, the guideline on Working with Families of Origin of TGD clients has made me realise that the training in family therapy that we impart is not trans affirmative and there is an urgent need to rectify this.

Dr Sobhana H, Associate Professor, Department of Psychiatric Social Work, LGBRIMH, Tezpur and President, Association of Psychiatric Social Work Professionals (APSWP)

This report is timely and relevant, especially given the near absence of knowledge or capacity building in curriculum and training in the mental health disciplines about trans clients. Based on a research study on perceptions and practices of mental health practitioners, it provides a documentation of existing affirmative practices adopted by practitioners, and serves as a set of concrete and useful guidelines to adopt with trans clients. The key feature of the report is that it blends ably macro-level understanding of societal/systemic issues affecting transgender individuals, and micro-level psychosocial skills for alleviation of distress and promotion of their empowerment and agency. Hopefully, the report will stimulate those in the field to go beyond the ‘mandate’ of a mental health practitioner to work as allies and advocates in countering trans-prejudice and enabling trans-inclusive environments.

U. Vindhya, Former Professor of Psychology, Tata Institute of Social Sciences, Hyderabad campus & author of Feminist Psychologies in India in the Oxford Research Encyclopaedia of Psychology (2020)

The document validates the experiences of transgender and gender-diverse individuals, outlining guidelines for care providers to reduce disparities in mental health care delivery. Although limited to metropolitan cities, it sets the stage for developing a model for providing gender-affirmative care by mental health providers in India. Kudos to the entire research team for their excellent work.

Air Cmde (Dr) Sanjay Sharma (Retd), Managing Director, Association of Transgender Health India (ATHI) & Board Member, World Professional Association of Transgender Health (WPATH)
BACKGROUND

The last decade has seen increased visibility for the rights of transgender persons in public, legal and policy discourse in India. The Supreme Court judgement that provided recognition to transgender persons as equal citizens (Supreme Court of India, 2014) and the passing of the Transgender Persons (Protection of Rights) Act by the Indian Parliament (GOI, 2019) have been major milestones that have driven the formulation of national and state-level policy and welfare programmes for transgender persons in the country, especially in the areas of education, livelihood and shelter.1 In the context of health, the Transgender Persons (Protection of Rights) Act, 2019, Section 15 (healthcare facilities) promises a range of services and action by the government. These include making healthcare facilities – including gender-affirmative therapies – accessible to transgender persons; providing for a comprehensive insurance scheme that covers gender-affirmative therapies; developing a health manual related to ‘sex reassignment surgery’ in accordance with international protocols; and reviewing medical curricula and research for enhancing the competencies of healthcare providers to address trans-specific health issues. While the progress on implementation of the Act, especially in the area of healthcare, is arguably slow and uneven across states, the presence of the law has most definitively drawn attention to the hitherto neglected area of trans health and mental health.

Few High Court judgements in the country have addressed trans health; for instance, a Madras High Court judgement directed the National Medical Commission to address the issue of dignified inclusion of LGBTQ+ persons in medical curricula (S Sushma v/s Commissioner of Police, Chennai, 2021). The same judgement declared as illegal the use of conversion treatments aimed at curing sexual orientation and gender identity. In another judgement, the Kerala High Court directed the state to take stringent action against forced conversion treatments and to form an expert committee and guidelines to deal with the issue of conversion treatments (Queerala v/s State of Kerala, 2021).

Research on the health and mental health care needs of transgender and gender diverse (TGD)2 persons has also brought to the fore experiences of violations within mental health service contexts and other barriers to healthcare access. In the last decade, several studies have documented a higher incidence of mental illnesses such as depression, suicidality, substance use disorders (Hebbar et al., 2017; Virupaksha et al., 2016; Sartaj et al., 2021) among transgender persons. Research has also demonstrated a link between experiences of victimisation and stigma, and poor health outcomes in the form of alcohol use, depression and risk for HIV among transgender women (Chakrapani et al., 2017). A report based on a qualitative study in West Bengal documented practices of conversion/curative treatments carried out on young transgender persons. These treatments were provided by formal health and mental health care providers as well as quacks, and religious or spiritual leaders (APTN, 2021). A scoping review (Pandya et al., 2020) on barriers to accessing health services among transgender persons in India states that apart from the experience of discrimination at healthcare facilities, the lack of treatment protocols forms one such barrier. Other scoping reviews on LGBTQ+ health in India highlight the role of stigma, discrimination, violence, victimisation and non-availability of gender-affirmative medical care in government hospitals, as well as poor physical, psychological and sexual health among LGBTQ+ persons (Chakrapani et al. 2023; Saraff et al. 2022). Finally, as suggested by research on TGD mental health, TGD persons are more likely to use mental health services for three main reasons: one, they may have a higher incidence of mental health problems due to minority stress; two, those TGD persons who want to

1 There has also been an extensive critique of this law from within trans communities in India, leading to a legal challenge to some provisions of the Act by trans activists, before the Supreme Court of India.

2 Transgender and Gender Diverse Persons is a term used by the American Psychological Association in guidance documents on mental health practice with transgender clients (Hope et al. 2022).
access medical and surgical transition services need the assistance of MHPs to access these; and three, TGD persons may be brought to MHPs for conversion/curative treatments. It is against this backdrop that research on competence (knowledge, attitude, practice) among MHPs in India to deal with TGD issues becomes significant.

What do we know about Mental Health Practice with Transgender and Gender Diverse (TGD) clients in India?

There have been several initiatives by organisations and medical teaching institutions in India to articulate guidelines/frameworks for trans-affirmative healthcare. One of the earliest of these was in 2017 by Sappho for Equality, an organisation working on the rights of lesbian and bisexual women and trans persons in West Bengal, which brought out a guide, A Good Practice Guide to Gender-Affirmative Care. This was based on consultations with health and mental health care providers working with TGD clients in and around Kolkata (Sappho for Equality, 2017). Similarly, in 2021, the Association for Transgender Health in India (ATHI) developed the Indian Standards of Care for Persons with Gender Incongruence and People with Differences in Sexual Development/Orientation, along the lines of the ‘Standards of Care for the Health of Transgender and Gender Diverse People’ by the World Professional Association of Transgender Health (Coleman et al., 2012). There have been other initiatives, such as the ‘Idea Group Consensus Statement on Medical Management of Adult Gender Incongruent Individuals Seeking Gender Reaffirmation as Female’ by a group of endocrinologists (Majumder et al., 2020), and the ‘Adolescent Health Academy Statement on the Care of Transgender Children, Adolescents, and Youth’ (Pemde et al., 2023). The National Institute of Mental Health and Neurosciences (NIMHANS) published a ‘Manual on Mental Healthcare of Transgendered persons in India’ (Pai et al., 2021). The TransCare MedEd initiative, a collaboration of public health experts and institutions, brought out the ‘Competencies on Trans-Affirmative Medical Provision Booklet’ (TransCare MedEd, 2022).

It is encouraging to see this range of initiatives on trans healthcare occurring over a short span of five to six years. While it is beyond the scope of this document to review these multiple initiatives that has each sought to provide some guidance to clinicians working in the area of trans health and mental health care, we wish to highlight two aspects related to the mental health sections of these guidelines/statements. The first is that there seems to be, across these documents, a lack of dialogue and of incremental learning on trans mental health issues and care. As a result, some perceive the role of mental health professionals (MHPs) as limited to assessment and care in the context of gender transition; others take a broader developmental perspective on the roles of child and adolescent mental health professionals as well as of parents, schools, mental health organisations in working with TGD youth in light of emerging trans/gender diverse identities. Our second comment is in the context of the methodologies used to arrive at the consensus statements/guidelines. The framing of most of these documents is based on consultations with a few domain experts/practitioners or professional taskforces that have reviewed existing literature and, in a few instances, consultation with TGD communities. While reviewing existing Indian and international literature and drawing on the rich experience of experts in the field are valuable strategies, we suggest that empirical research documenting actual practice with TGD clients would be of much value, and is currently missing in the emerging discourse on trans-affirmative mental health care in India.

The current study is one of the initial attempts to document MHP knowledge, attitudes and practice with TGD clients as well as MHP training and supervision needs in the area of TGD mental health.
ABOUT THE RESEARCH STUDY

This is a multi-site research study employing a mixed-method approach and an exploratory, concurrent triangulation design. It is a mixed-method study because it employs both quantitative and qualitative methods. As literature in the Indian context on mental health practice with Transgender and Gender Diverse (TGD) clients from the practitioner’s perspective is sparse, this is a formative, exploratory research study on practitioners’ knowledge, competence, attitudes and practice with their TGD clients. Finally, it uses a concurrent triangulation design (Creswell et al., 2003), as we have collected quantitative and qualitative data simultaneously and analysed them together for the purposes of comparing, contrasting, corroborating and cross-validating findings. A total of 165 mental health practitioners (MHPs) currently practicing in the cities of Mumbai, Bangalore and Delhi were interviewed, using a quantitative interview schedule. 45 of these practitioners also responded to a qualitative in-depth interview. The three inclusion criteria for the study were: a) a postgraduate degree/ diploma in either Psychiatry, Psychology, Counselling, or Medical and Psychiatric Social Work and/ or an MPhil in Clinical Psychology or Psychiatric Social Work; b), a minimum practice duration of one year; and c), the MHP should have seen a minimum of three TGD clients in the course of their practice. Practitioners who had seen a relatively higher number of TGD clients, and/ or were actively working on TGD issues within their professional associations or in collaboration with NGOs, were approached for participating in the qualitative in-depth interview.

Ethics clearance for this study was obtained through the Institutional Review Board of the Tata Institute of Social Sciences, Mumbai.3 A content validation of the tools used in the study was done through experts in TGD mental health, in research methodology, and lived experience experts. A total of six mental health and research experts, along with five community members who self-identified as TGD and had experience of accessing mental health care responded to the relevance, adequacy, feasibility, clarity and organisation of the tools. Tool revision was done in accordance with this expert feedback. We recruited our study participants using purposive sampling: in addition to the inclusion criteria mentioned above, we tried to ensure diversity of sampling by approaching MHPs working in different settings, including public and private hospitals (teaching and non-teaching), clinics, NGO/ CBOs, home-based, online practice, and so on.

As can be seen in the infographics, of the 165 participants, 54 were from Mumbai, 44 from Delhi, and 67 from Bangalore. For the qualitative interviews, of these 165 participants, 15 participants were recruited in each of the study sites, making for a total of 45 qualitative interviews. The participants’ ages ranged from 24 to 76 years, with the mean age for the study sample being 39 years. The range for years of practice experience was a minimum of 1 year to a maximum of 45 years, with the mean practice experience for the sample being 12.9 years. There were a total of 105 cis women, 51 cis men, 8 participants who self-identified as transgender/ non-binary/ genderqueer and 1 participant who self-identified as agender. In terms of educational background, there were 49 psychiatrists, 61 with a postgraduate degree (MA) in Psychology, 27 with an MPhil in Clinical Psychology, 9 with an MPhil in Psychiatric Social Work, 6 with an MA in Social Work and 13 with a PG Diploma in Counselling.

Most participants (n=113) had seen up to 10 TGD clients over the past one year, while a few (n=36) had seen between 11 to 30 TGD clients, and fewer still (n=10) had seen more than 50 TGD clients in the same time period. In terms of the age range of the TGD clients, 15 participants reported having seen clients who were 12 years of age or younger for gender identity-/ dysphoria-related concerns, while 90 participants had seen clients between 13 to 18 years for gender identity- and dysphoria-related issues. 13 participants reported having seen TGD clients who were 60 years old or more.

3 IRB clearance was obtained on 2nd May 2022; Serial No. of IRB meeting: 2021-22, 35
PROFILE OF THE RESEARCH PARTICIPANTS
Total number of participants (N=165)

City

- Delhi 26.7% (n=44)
- Mumbai 32.7% (n=54)
- Bangalore 40.6% (n=67)

Educational Background [highest degree received]

- 29.7% (n=49) MD/ DPM Psychiatry
- 37.0% (n=61) MA/ MSc Psychology
- 16.4% (n=27) MPhil Clinical Psychology
- 5.5% (n=9) MPhil Psychiatric Social Work
- 3.6% (n=6) MA in Social Work (MSW)
- 7.9% (n=13) PG Diploma Counselling/ Counselling Courses

Gender Identity

- Cis Woman 63.6%
- Cis Man 30.9%
- Transgender/NB/ Genderqueer 4.8%
- Agender 0.6%
**Age Range**

- 20-30: 29.7%
- 31-40: 29.1%
- 41-50: 21.8%
- 51-60: 12.1%
- Above 60: 7.3%

Mean Age: 39.63 years

**Duration of Practice (in Years)**

- 1-3: 12.7%
- 3.1 - 5: 14.5%
- 5.1 - 10: 25.5%
- 10.1 - 20: 24.8%
- 20.1 - 30: 13.9%
- Above 30: 8.5%

Mean Duration of Practice: 12.9 years

**Practice Settings of Participants**

- Public Hospital: 23.6% (n=39)
- Private Hospital: 16.3% (n=27)
- Home-Based: 39.4% (n=65)
- Clinic-Based: 32.7% (n=54)
- Online: 24.8% (n=41)
- NGO: 6.06% (n=10)

* Total is greater than N=165 as there are multiple responses across categories
** Teaching & Non-Teaching
Number of TGD Clients seen in past 1 year

- **Up to 10 Clients**: 68.5% (n=113)
- **11-30 Clients**: 21.8% (n=36)
- **More Than 50 Clients**: 6.06% (n=10)

Number of Practitioners seeing TGD Minors & Seniors

- **12 years of age or younger**: 15
- **12 - 18 years**: 90
- **60 years of age or older**: 13

Common Presenting Problems Among TGD Clients

<table>
<thead>
<tr>
<th>Problem</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Dysphoria &amp; Discomfort with Gender</td>
<td>18.2</td>
</tr>
<tr>
<td>Difficulties With Family Acceptance &amp; Self-Acceptance</td>
<td>17.5</td>
</tr>
<tr>
<td>Sexuality, Intimate Relationship Issues, Marriage Pressure</td>
<td>14.3</td>
</tr>
<tr>
<td>Co-Morbid Mental Illnesses (including Substance-Use-Related Issues, Personality Disorders)</td>
<td>12.4</td>
</tr>
<tr>
<td>Needing Referral Letter for Medical/ Surgical Interventions &amp; Information about Gender Affirmation Surgery</td>
<td>10.1</td>
</tr>
<tr>
<td>Suicidal Ideation or Self-Harm</td>
<td>9</td>
</tr>
<tr>
<td>Bullying &amp; Violence</td>
<td>8.4</td>
</tr>
<tr>
<td>Workplace-Related Issues</td>
<td>4.6</td>
</tr>
<tr>
<td>Other</td>
<td>5.3</td>
</tr>
</tbody>
</table>
ABOUT THE TRANS-AFFIRMATIVE MENTAL HEALTH CARE GUIDELINES

This document presents twelve good practice guidelines for mental health practice with TGD persons in India. The guidelines have been developed based on the research study under discussion. Using descriptive statistics and thematic analysis, we have attempted to arrive at an understanding of practitioners’ knowledge of, attitudes towards and practice with their TGD clients, as well as their conceptualisations of the mental health problems faced by their TGD clients. The twelve guidelines presented below are thus grounded in empirical research data on MHP practice with TGD clients. Literature on guidelines, standards of practice, protocols of mental health interventions with TGD clients, globally and in the Indian context, has been used as background material to enhance the understanding of the data collected. We have particularly drawn on the ‘Guidelines for Psychological Practice with Transgender and Gender Nonconforming People’ by the American Psychological Association (2015) and ‘Community-Derived Practice Adaptations for Psychological Services with Transgender and Gender Diverse Adults’ (Hope et al., 2022).

Guideline 1. Trans-Affirmative Conceptualisation of Mental Distress/ Illness in TGD Clients

MHPs equip themselves with knowledge of trans-specific stressors and their impact on the self, identity, relationships and overall life of the TGD person, and use this understanding in assessment and conceptualisation of distress and mental illness in their TGD clients.

Many of the study participants opined that while the symptoms and syndromes with which TGD clients presented remained the same as with any other cisgender client/patient, the genesis and explanations for these symptoms/distress in TGD clients were more often than not related to the challenges faced by them due to their non-normative gender identities and expression. Some of the terms highlighted by participants while dwelling upon the explanations for TGD client distress included trauma/complex trauma, adverse childhood experiences, psychosocial/environmental factors. Some used terms such as structural problems and systemic and social justice lens to conceptualise TGD mental health concerns. Other terms used included exogenous or reactive (rather than endogenous). Our data suggests that participants conceptualised TGD distress from a macro/structural lens wherein cis-binary-gender structuring of social systems and of everyday life had an adverse impact on TGD persons’ mental health. Additionally, relational and interpersonal strain due to trans-related prejudice or ignorance in the immediate environment of the TGD person – within families, educational institutions and peer groups – added to their distress. Finally, the impact of structural and interpersonal adversity affected TGD persons at an intrapsychic level.

The minority stress model developed by Meyer (2007) and adapted by Hendricks and Testa (2012) for clinical work with transgender and gender non-conforming clients (TGNC) is a useful framework for a trans-affirmative conceptualisation of mental distress and illness. Hendricks and Testa (2012) explain three processes through which TGNC persons are subjected to minority stress. The first is a hostile and stressful social environment or external, objective and verifiable events that create stress for TGNC persons, for instance, being misgendered, forced to wear a school uniform based on the gender assigned at birth, being subjected to ridicule or jokes. The second is the anticipation and expectation of the
external stressors that cause the need for vigilance and having to hide one’s identity, and the final one is the internalisation by the TGNC person of negative social attitudes and prejudice. Clinicians seeking to provide trans-affirmative care would do well to incorporate the minority stress framework that views distress experienced by TGD persons in the context of trans-negativity at the societal and interpersonal level, and its impact on the self of the TGD person. In the Indian context, Ranade et al. (2022, pp. 142-145) use the minority stress lens to discuss the psychic impact of growing up as a minority in one’s own family that can foundationally affect the parent-child attachment and attunement, and may continue to affect the trans person even in adulthood.

The following quotes from the study participants discuss differential stressors at the intrapsychic and interpersonal level experienced by TGD persons, and the ways in which these affect them.

‘For trans kids, their every minute is torture if the parents know about it and refuse to ask and fail to accept. It starts with being bullied or beaten up but not understood, not being heard, forced to, you know, associate with a certain group of people – so if it’s a boy who asserts as a trans woman, then push more towards boys – “Ladkon ke saath jaakay khelo” (“Go play with the boys”). So, every minute is difficult for them… Surprisingly the bullying also happens at the hands of the teachers, the second layer of adults that you look up to… So, a lot of bullying happens from the adults around them, the ones that ordinarily people would consider as safe zones for children.’

42-year-old woman, Counsellor, Bangalore

‘I think it’s quite different in terms of the content, like content of the cognitions… like what the transgender client is worrying about, or feeling hopeful, hopeless about, or is feeling worthless about is a lot to do with that gender and adapting to it and to the people around them. So, if we’re talking about syndrome, and the symptoms, that syndrome is the same but from a cognition lens, it’s different.’

29-year-old woman, Clinical Psychologist, Bangalore

‘I think the kinds of stresses they face are very different, the anxieties that they have would be very different. It would be like, “Will I have a peer group which will accept me? Will they allow me to be the person I want to be?”… it was all a reaction to the whole situation that they were going through, which is natural. I think it was more reactive… though it was a mental health issue, but it was not pathological in that sense.’

68-year-old woman, Clinical Psychologist, Bangalore
‘For a regular client it may be like standard trauma but for a trans client, it may be childhood trauma plus being disappointed in one's body, so the reason would be different. There is also vigilance, right? They have to be vigilant about the way their body occupies space. So, you know, having to think about, like, in your binary spaces, how to dress and be able to pass, or suppose there is a function or something in which you have to dress with the gender assigned at birth, then navigating that, anticipating the distress, finding ways to minimise that time, that you spend in [that] clothing, I think all of that leads to extra stress. Umm, a lot of fatigue and mental work that you end up doing.’

29-year-old woman, Psychologist, Mumbai

‘I'm working with twins, so a set of two clients – and it is so different between the two. And it has always been seen as [a] temperament thing by the family. They both are 16. But when I speak to this young person who's exploring their gender and has come out as trans to the parents, they say, "I can't even think about asking for the kinds of opportunities that my brother does. So, I would really like, for example, to learn Bharatnatyam, but I ended up telling my dad that "Can I learn contemporary pop dance?" I see this very often ingrained in trans clients. This sort of sense of not being even able to think of a free life with entitlement. It's like, – "how will I ever seek something that in my own internal framework I don't believe can exist for me?"’

49-year-old woman, Psychiatrist, Delhi

Participants also discussed the role of macro factors such as housing or workplace issues as a source of trans-related stress among their TGD clients.

‘A client who, you know, finally started hormone, HRT (hormone replacement therapy) and all of that. We talked about it for such a long time and it was like this dream that they will start and they can finally transition. But then when they were about to start, this fear about, how safe would it be, you know because they live in a rented house, also at [their] workplace, what would transitioning publicly mean? So, this client was struggling with the fear of being thrown out of their rented house. Their plan was to start transitioning and give themselves three to four months in the current house, while they would still dress as the gender that they were assigned, to be able to pass and then once the effect of the transition started, then they will try and pass as the gender that they want to transition to. So this was a trans woman. So basically, she was planning that after three, four months she can dress more like a woman and then look for [a] house as a woman. So that kind of calculation, right? Like that kind of planning just to ensure your safety. I mean, it's just so terrible, you don't
get to experience like pure unadulterated joy at finally taking the step to transition because you have to deal with all these other things. Even if this was something that they were so excited about, something that they talked about [for] a long time now. It’s still a struggle – same thing with the office, as they are transitioning . . .’

31-year-old woman, Psychologist, Delhi

Guideline 2. Trans-Affirmative Conceptualisation of Intimate Relationship Concerns of TGD Clients

MHPs use a systemic lens informed by an understanding of trans-specific relationship stressors affecting the relational lives of TGD couples, such as lack of acceptance, poor social support, legal barriers, forced cis-heterosexual marriages.

Participants discussed relationship stressors involving TGD persons in light of trans-specific experiences. For instance, acceptance and understanding of trans identities by intimate partners, ways in which gender transitioning (social, medical, surgical, legal transitioning) affected their relationships, the impact of dysphoria on sexual relationships, dealing with the social pressure of forced cis-heterosexual marriage on TGD persons or their partners – especially so for cisgender partners of TGD persons. Participants also discussed the absence of social support for TGD individuals and the burden that this can put on their intimate relationships in the absence of validating and accepting families, friendship circles or colleagues. An absence of social recognition and validation of the relationships of TGD persons was recognised by many participants as a structural barrier to TGD mental health and relationship quality. Thus, participants sought to conceptualise the relationship concerns of TGD persons not from the normative frame of cisgender, heterosexual married couples but from a trans-specific lens of social, cultural, interpersonal, legal challenges that impact possibilities/ viability, quality and resilience in the intimate relationships of TGD persons.

Hudak and Giammattei (2014) alert us to the impact of heteronormative culture in the theory, research and practice of couple and family therapy, indicating the need for a paradigmatic shift in order to understand and respond to non-normative couple relationships. In the Indian context, there is a serious dearth of research on the relationship concerns and therapeutic needs of TGD persons and their partners. The following examples of couple work done by study participants assumes a greater significance in this context.

‘They had come as a couple. They were in a long-distance relationship. Also, they had a significant age gap between the two of them. And they were having a lot of difficulties in their relationship because one person was out and the other wasn’t. Also, there was a lot of dysphoria that they would experience when they would try and be sexually intimate because it was triggering to one of the individuals in the relationship.’

32-year-old woman, Clinical Psychologist, Delhi
‘I find a lot of insecurity in terms of relationships in the transgender population, especially among transmen, more than transwomen. Usually, they do not have a network also; transwomen like Hijras, they live in a network, they have community support. Transmen often live in isolation and not much of social support. They rely on one partner for all their emotional needs and all kinds of support and a lot of insecurities with respect to this relationship especially when there is disconnect from family, friends or even colleagues.’

34-year-old woman, Psychiatrist, Bangalore

‘The girlfriend initially thought it's a curiosity, not a diagnosis, and this is how he wants to be in a relationship. When they are having sex, he wants to wear feminine clothes and she thought it's his preference, but then when he disclosed to her that “I am a trans woman and I want to come out as a woman”, she took a back step and then the relationship was dissolved. Later on, when they came out as a trans woman and HRT was started, and then family came into the picture and family supported [the person]. They disclosed to the workplace also. Later this girlfriend again came back. And now since she's come back, there is this readjustment issue. What is the relationship now? What do we stand for? Because when they broke up, she thought of him as her boyfriend and now she's come back. So, this relationship – does it stand as a committed relationship or not? All these [are] issues we are dealing with now.’

38-year-old woman, Psychiatrist, Mumbai

‘Lot of issues in relationships, and not to say attachment issues, those are because of parenting and past experiences with partners, but for a trans client or a non-binary client, they’re more worried about whether or not this person is going to accept my trans identity?’

26-year-old non-binary person, Counsellor, Mumbai

‘There is a sense of accepting some of these complaints as part and parcel of the process, like relationship troubles... It’s very different because somebody who doesn’t belong to that community is not going to tell you they’re upset about their husband marrying another woman but they’re okay with it or they understand. But a transgender individual is able to say, “I understand that he has to marry someone who is born as woman.”’

29-year-old woman, Clinical Psychologist, Bangalore
Guideline 3. Customisation of existing Mental Health Services to Respond to TGD Concerns

MHPs move from a "neutral" stance of claiming that their services are non-judgemental and respond to "all" clients in the same way, to recognising the specificities of TGD experiences and altering their practice to respond affirmatively to these experiences.

A trans-affirmative approach involves making changes to one’s existing practice – such as through the use of trans-aware and inclusive language, recognising and countering the negative impact of trans-prejudice, supporting and validating the identities, strengths and experiences of trans individuals – are increasingly recognised as the gold standard in trans care (Austin et al., 2018). Adaptations made to standard mental health practice to respond to trans-specific concerns and contexts have yielded positive results (Lucassen et al., 2020; Straus et al., 2019; Austin et al., 2018).

MHPs participating in this study also recognised the influence of institutional barriers faced by TGD persons in accessing mental healthcare, for instance, the need to produce identity documents that often carry clients’ deadnames in order to register at the hospital/ clinic, or the difficulties of providing a photo identity proof, or the challenges involved in using gender-specific restrooms in hospital settings. Practitioners discussed multiple changes they made to their practice to better respond to their TGD clients. They discussed micro practices with their TGD clients that would be different from those used for their other clients. This included making an extra effort to make TGD clients feel safe and heard, in the context of knowing that the client may have had previous experiences of therapeutic spaces that were lacking in TGD-specific competence or understanding and empathy. Practitioners reported foregoing the standard practice of insisting on an informant accompanying an adult TGD client before recommending the latter for medical and surgical transitioning services. Some practitioners mentioned including non-family members in the care plans for crisis situations. They spoke about being self-reflexive about their evolving understanding and practice with TGD clients. Some talked of adapting their therapeutic model to better address TGD concerns, and others talked about ways in which their therapeutic model allowed for accommodating TGD-specific issues.

‘With my trans client I will be, like, in words reflect back what they said, because I want them to kind of register that I understood what they’re saying. So, I’m a little more verbal, than just being like, “Yeah, that sounds bad”.

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A deadname refers to the name given to the person in childhood, to which the person does not relate as it does not reflect their gender or their sense of self and identity.
So that changes, wherein you're doing a lot more paraphrasing and a lot more reflecting in the initial sessions because there is also a sense that you are also being tested.

32-year-old woman, Clinical Psychologist, Delhi

‘I think I have a very expressive face and when faced with a person who has gone through some experience because of their marginalised social identity, there's always this look. It almost feels like sympathy, this weird look... I want to look at them as a person, before anything else. You don't want to be too apologetic. You don't want to be too sympathetic; you don't want to be too anything. It also means that you don't have to glamorise that concern that much in the session or link it at every point. And I think in the beginning, I had these questions that would it be insensitive to not talk about it or talk too much about it... Eventually, I felt like, if your intention is sort of clear, I think the person in front of you will eventually understand that you don't mean any harm, and that sort of made me feel that okay, even if I'm not doing something correct, you know, I can always ask, like, I can always cross check and ask...’

25-year-old woman, Psychologist, Mumbai

‘I am a trauma therapist and I do transgenerational work. Of course, I have to adapt it to unconventional situations. That’s essentially what we did with this couple that involved a trans person. They both worked with their own genogram and what they understood of relationships. Genograms of not just their biological families, but also what they identified as like, you know, really significant queer relationships that they had witnessed, and were subconsciously emulating, because we’re all emulating something, whatever, you know, that may be in our mind.’

32-year-old woman, Clinical Psychologist, Delhi

‘I’m aligned to a particular way of working, which is called narrative practices. One of the things that we really hold on to is this idea that people have preferred ways of being, but also that the sense of self is supported by voices, that our sense of self is socially constructed. So, we’re always looking for those voices that might support, particularly when people are claiming a subjugated identity. So, I’m always alert in the conversations for who I can rope in. We may use therapeutic letter-writing or witnessing practices...’

44-year-old woman, Psychologist, Mumbai
‘The concerns need to be addressed in more of an atypical way and keeping in mind (the) cultural context of a community. Some of them have come to accept that they cannot remain a part of the natal family in the same way, but are still able to maintain some connections, maintain that distance, and yet being in touch, which is quite a confusing relationship and they struggle to rebuild a relationship. And, to be frank, many of them tell me that they have been able to do it.’

29-year-old woman, Clinical Psychologist, Bangalore, in the context of clients from the Hijra community

Participants discussed making changes to intake sheets, consent forms, the physical setting of the practice/clinic to make it inclusive, affirming and welcoming for TGD clients. Some of them spoke about the importance of using inclusive language and updating one’s knowledge of the terminologies, labels, pronouns that TGD clients use.

‘So I was not in a private set-up previously but while setting up my own practice after six years of working, I was making the whole intake sheet, consent form and everything. I was very sensitive about having all the genders mentioned and asking people for their preferred name on these forms.’

28-year-old woman, Psychologist, Bombay

‘Some kind of tailoring, modification is definitely necessary… So the way the therapist will talk to you, you know, using the same principles, but maybe different examples, maybe using, um, terminologies or just asking your pronouns… awareness about asking pronouns has really been there among most of us at the hospital.’

31-year-old man, Psychiatrist, Mumbai

‘They felt that they could come to the clinic and talk about what they wanted. And some of them would dress up differently when they came to the clinic because they felt it was a safe place. Or we had toilets, so they would sometimes come and just before the appointment would actually dress up and enter my room with that and feel good about it, and then after the appointment maybe dress down again and go.’

49-year-old woman, Psychiatrist, Delhi
A common dilemma that practitioners spoke about was that of conceptualising TGD concerns from a structural, eco-systems, social justice and psychosocial framework, while intervening not at the macro but micro, individual level – addressing feelings, affect, thought, behaviours and working towards reducing distress and enabling healing. A macro socio-political perspective is significant in understanding the context of suffering among all marginalised identities. Moreover, this perspective enables de-pathologisation by not locating social suffering within an individual, deficient psyche. However, at times a macro systemic analysis of the roles played by cisgenderism, heteronormativity and caste-patriarchy in the exclusion and marginality of TGD persons can create a sense of helplessness among clients as well as practitioners. Hence, working with a macro understanding while employing micro skills that enable clients to understand the source of their distress, that promote client empowerment and agency, that work with their strengths and enable healing, is vital. Some of our participants reflected on the ways in which they engage with this dilemma in their clinical work.

‘I don’t want to get caught up completely in a sympathy cycle. I don’t want to end up passing on a message that it’s not your fault at all, that the world is wrong, because that is painful too. To be honest, there has to be a certain ownership of emotional health, there has to be a certain, you know, sense of empowerment that the client also has to feel, but not at the cost of them doubting themselves. So, it’s that sweet spot of when do you introduce this conversation and say, hey, you know, here’s where there are things beyond our control, that is actively messing up with your life. And for now, let’s focus on what we can do with this reality.’

33-year-old woman, Psychologist, Bangalore

‘I find acceptance and commitment therapy (ACT) very useful to try to bring that internal locus of control in this way, that you’re the boss. You get to decide, you get to choose, you are the one deciding; people can direct things at you but there is a psychological filter between people and you. You get to screen those which are relevant to you and make sense to you. So, I kind of use a lot of ACT techniques with this population. So one of the very big concepts of ACT is that you need to live a life that deeply matters to you... From DBT (Dialectical Behaviour Therapy) I borrow a lot of self-validation approaches. I also borrow a lot from self-compassion research. I think the way you can validate yourself, things you can say to yourself to deal with it. I don’t stick to CBT (Cognitive Behaviour Therapy) at all these days or any form of behavioural intervention because I feel the issues that are present are more at a hurt and pain level and having to deal with this, especially in post-disclosure issues. I think making sense of their lives is something CBT cannot help with. The idea of CBT that you have a faulty cognition, one cannot go with that when they are already feeling labelled.’

33-year-old woman, Clinical Psychologist, Delhi
‘They sometimes feel that the world is very black. So there I have to help to make a subtle shift between definitely validating their experience but also giving them an alternate perspective to see where this is coming from, and help them take a solution-focused approach.’

34-year-old woman, Clinical Psychologist, Bangalore

‘I talk a lot more about ecosystems when I’m working with trans clients. So, I guess, in [the] sense of social justice, but that seems really broad a term to use . . . there is a lot of, like, need to contextualise their experience to what’s happening outside because a lot of times, all of it gets internalised.’

32-year-old woman, Clinical Psychologist, Delhi

Guideline 4. Mental Health Services Specific to TGD Clients

Apart from customising their existing services, MHPs provide additional services such as support groups and crisis intervention for their TGD clients, and liaise with local LGBT organisations

The previous guideline referred to adaptations in existing mental health services to respond to TGD client concerns. This guideline refers to psychosocial services that may need to be added to the usual repertoire of mental health services in order to respond affirmatively to TGD clients. These include crisis intervention services, particularly in the context of violence and discrimination, liaising with organisations working on LGBTQ issues that provide shelter, legal aid, police intervention, and so on. 93 of the study participants stated that they provided some form of crisis intervention support to their TGD clients. Running a support group for TGD clients and their families was another example of trans-specific psychosocial interventions that participants discussed. A few participants saw their role as extending beyond psychological interventions for their TGD clients to aspects such as connecting clients to community resources – such as job portals, support groups, blogs and other online resources, NGOs, TGD-affirmative healthcare and transition services, TGD-affirmative fiction and non-fiction literature. 58 of the study participants spoke of referring a client to a local NGO or CBO working on TGD persons’ rights. Connecting clients to support groups and NGOs was as much about vconnecting them to resources as it was about reducing isolation and enabling clients to find anchors and role models within their communities. Overall, this guideline refers to MHPs’ attunement to the unique life challenges of their TGD clients, and their efforts to creatively and innovatively respond to these.

‘I remember one client who was harassed by the police in their city and she was from Tamil Nadu... I tried, you know, some practical help kind of things like [taking] the help of the Commissioner, sending an email and speaking to the Commissioner myself for this client.’

44-year-old woman, Psychiatrist, Bangalore
‘So, one of the sought-after requirements for trans binary or trans and gender non-conforming clients is a peer group support. There, I sort of intervene and currently I run my own sort of community group on Telegram.’

42-year-old woman, Counsellor, Bangalore

‘I sort of connect people, you know, to resources... sometimes I also share or look for job opportunities for them. I send peoples’ CVs to those who might have a vacancy or something.’

31-year-old woman, Psychologist, Delhi

‘I have on my list about seven, eight people who’ve always said that, you know, we’ve had this journey and if you get a young person who you think would like to speak to somebody who’s been already a little bit ahead in that journey... So, they’ve said blanket consent from our side, you can just, you know, we trust you well, so I often connect them to each other. And there’s also a few parents who have been really instrumental, who said that [they would] be willing to speak to parents and all of that. So, there’s a good set of community, I use it with my discretion. But I think that’s also [an] important part of the work that not too many people talk about.’

49-year-old woman, Psychiatrist, Delhi

‘If the person expresses loneliness, says, “I don’t find my type of people, whom to go to, who to talk to, I don’t know where to ask these questions regarding transitioning and all that” — no matter how understanding, let’s say, there’s a women’s group on WhatsApp, which is good at heart and fantastic and everything. Even then, I cannot just put the client, a trans woman, on that group. It’s not the same as in a trans group where they will know when someone says that the hormones are playing havoc with me... The biggest need I have felt across almost all my trans cases is the[ir] need to socialise and associate with people of their own kind, like not just for [socialising], but for other things as well. You want to ask questions like “What are the TG-friendly bars around?” So it doesn’t have to be roney dhoney vale sawaal (questions related to distress), not always, yaar, it can be for enjoyment also, like “Which dating app do you use?”

42-year-old woman, Counsellor, Bangalore
I am in touch with NGOs, which work on trans issues, so I provide the contact of those NGOs to them. So it depends, some people, they ask me to help them connect with NGOs. So those people I will connect.

50-year-old woman, Psychiatric Social Worker, Bangalore

Guideline 5. Increasing Accessibility of Mental Health Services to TGD Clients

MHPs recognise challenges faced by TGD clients in accessing trans-affirmative mental health services and hence make an effort to visibilise their work through various media and find strategies to make their services affordable to TGD clients.

MHPs interviewed for this study were aware of the challenges involved in accessing trans-affirmative mental health services, especially in the context of harmful practices such as conversion treatments being prevalent even in the country’s metros, and in the absence of public awareness about the issues faced by TGD persons. While a majority of the participants (n=131; 79.4%) stated that they were seeing an increase in the number of TGD clients in their practice, they were aware of their clients’ challenges in accessing trans-affirmative care and believed that making their own services more accessible, and reaching out to the TGD communities, was important. Participants identified their sources of referral for TGD clients as word-of-mouth, i.e., being known as an MHP who works on TGD issues (27.2%); ex-patients/ clients (18.9%); psychiatrists/ other doctors (23.9%); social media (17.4%); and NGOs working on transgender rights (11.9%).

Participants discussed social media as an effective tool for putting out information about their services as well as their views on trans issues. Having their name and contact details placed on e-lists developed by LGBTQ+ organisations as well as crowd-/ client-sourced lists of MHPs in different parts of the country was another strategy to make their services visible and thereby accessible to TGD clients. Some practitioners also spoke of creating short YouTube videos for raising awareness on LGBTQ+ issues.

Instagram and LinkedIn are two amazing platforms where I’m posting regularly. Seeing my work, they connect and DM and then we take it forward.

42-year-old woman, Counsellor, Bangalore

‘I’m also listed on some of those e-lists of, you know, gender-affirmative counsellors. So that’s where my clients get my reference, and also on my social media – I’ve written it very clearly that I’m queer-affirmative, and I work with queer clients. So yeah, that’s where people usually get to know about me.’

28-year-old woman, Psychologist, Mumbai
A major barrier to accessing mental health services is the financial barrier. Young TGD clients who are still students, financially dependent on their parents, and often not “out”⁵ to their families, find it difficult to gather the resources to pay for MHP services. Also, for TGD clients from lower socio-economic strata, being able to afford health, mental health and, in this context, transition services is a major challenge. Many of our study participants, especially those in private practice, talked about having a sliding scale, providing concessions, and even raising funds for some of their TGD clients. One of the organisations had a “pay as you can” policy, wherein the TGD client paid whatever they could afford in a particular week for their therapy session.

‘Financially, also, you know, it’s a sliding scale for them. It may not be for other people but yes, there is a sliding scale for them. And I have also arranged finances, you know, not in terms of anything else, but at least for medication and stuff. I have tried whatever [works].’

5 Not being “out” here refers to the TGD person not having disclosed their gender identity to their family members.
Guideline 6. Working with Families of Origin of TGD Clients

MHPs work with families of TGD persons by providing trans-affirmative information as well as emotional support and seeking to increase attunement between the TGD client and their family.

Several participants reflected upon working with the families of TGD persons. One of the ways in which families responded to their TGD children was by seeking MHP appointments to cure what they read as gender deviance or disorder, hoping for their child to become better adjusted to their assigned sex at birth (this is addressed in the next guideline – on MHP responses to conversion treatment requests). However, families also responded to their child’s gender expression and identity with confusion, tentativeness, questions, worry, self-blame, guilt, and so on. Study participants discussed the role of MHPs in educating family members on TGD issues, addressing their questions and providing information as well as engaging with the affective and moral dimensions of parental reactions to their child’s transgender identity. These often took form of questions like ‘Isn’t this unnatural?’ or ‘Is it my fault that my child is trans?’ MHPs therefore have an important role to play not just in providing scientific information about TGD identities from mental health literature, including the depathologisation of trans identities, but also in unpacking the normative and moral questions about the naturalness and normalness of gender and the role of families and parents in shaping the child’s gender. Shifting the conversation from normal/abnormal or natural/unnatural to socially constructed norms around gender, and helping families examine their own understanding of gender norms, constitutes an important step towards helping them build empathy for their TGD child. Coolhart and Shipman (2017) suggest that normalising and affirming transgender identities as natural variations of humanity and working towards increasing attunement between family members and their TGD child’s gender expression are significant steps in enhancing familial acceptance.

The practitioners interviewed for this study used different routes to educate families and build empathy and understanding on trans issues. These included using a medical model of TGD identity or gender dysphoria as illness that can be treated through gender-affirmative therapies and thus avoiding any blaming of the TGD client or of their parents and families. Although an illness model contradicts the depathologisation position on TGD identities and is contrary to the present usage of gender incongruence in ICD-11, this was viewed by some practitioners as a first step in facilitating acceptance within families. It is important to note that family therapy approaches that seek to “manage” or accommodate non-normative sexualities or gender variance by enabling families to “cope” have been critiqued for their continuing pathologisation of LGBT identities. Hudak and Giammattei (2014, p.9) call for a transformation in family therapy that embraces diversity as the norm and ‘upholds the value and beauty of non-heterosexual and gender variant family members not in spite of their identity but because of it’. Ranade et al. (2022, p. 153) state in the context of working with queer clients’ families of origin ‘...being queer is not a tragedy, an accident, a catastrophe facing the family – it is about making space in the psyche and within the family for diversity and difference, which can be challenging, causing pain and, maybe, stretching the boundaries of the family system, but is also an opportunity for growth for all, as individual human beings and as a family.’

Another way in which participants responded to families was by helping them to work through the emotional loss of the child (son/daughter) they thought they had and to adjust to the new reality of their child’s life and future. Some participants used a more sociological approach to educate families on how gender norms are socially constructed and how, therefore, the gender given at birth need not be thought
of as an unchangeable and immutable truth that has to be guarded at all costs, with a person having to fit into one of the two genders or forcing themselves to get along with their assigned gender.

“They want to know whether it is an illness. Why is it that this has happened? is it a genetic condition? is it something that we did wrong? Some people would try to blame their peers, that friends were like that. So they want to understand why it happened... They have not usually talked about it as an illness. They think of it as a choice. Not that the person is ill but if he [does not want] to, he may not transition. So why does the person want to change?’

57-year-old man, Psychiatrist, Delhi

‘Families have a very negative attitude not only towards the person, but the people who are probably understanding them as well. They’re like, “Oh, you are telling this as a doctor, then how do you think he is or she is going to respond? You should be able to tell them that this does not exist, or something like this is not there.” So, their requests are entirely different. So, a lot of time is kind of spent on psychoeducation, making them understand.’

32-year-old woman, Psychiatrist, Bangalore

‘For a caregiver of the client or relative of the client, if they’re being brought to a doctor or a psychologist, they will think that this alternative sexuality or something, this identifying as a different gender is a mental condition. So, it is our responsibility to gently let them know that it’s not a disease entity. Probably some years back, 30 years back or 40 years back, it used to be, but as research and everything advanced, you know, they have realised that this is not a disease entity. It’s just a different form of normal. So that is probably our responsibility as mental health professionals to counsel and psychoeducate relatives about.’

31-year-old man, Psychiatrist, Mumbai

‘I’ve had several sessions with parents trying to understand their loss. They had certain expectations from the child and there is a loss. It’s like losing my child, I don’t know how or where she will be. So that kind of reaction. So, it is some support that is needed in these families. They have not sort of disowned them or, you know, ostracised them, but at the same time, complete acceptance has also not been there.’

68-year-old woman, Clinical Psychologist, Bangalore
‘We used to do this really interesting thing, where we would have family sessions, for anybody who’s just come out to their parents or wanting to come out to their parents, both trans clients as well as other queer identities, and we answered questions about – What is gender? What is natural and unnatural about it? What are the risks of any sort of conversion-treatment-like activities on the mental health of the person? How can you actually support? And it was a somewhat, we never wrote it down, but it kind of flowed as a module-like thing, almost. And then if they had questions, they would come back the next time. It was like a two-session thing that we were doing.’

32-year-old woman, Clinical Psychologist, Delhi

Guideline 7. Dealing with Conversion Therapy Requests

MHPs seek to educate families about the ill effects of conversion treatments on the TGD individual, and also about the position of MHPs in India and internationally on the inefficacy and unethicism of these practices.

- **68%** 112/165 MHPs were approached by families seeking conversion treatment for their TGD child
- **34.5%** 57/165 MHPs were approached by TGD persons themselves for conversion treatment
- **66%** 109/165 MHPs had heard of MHPs in their city practicing conversion treatments

112 of the 165 practitioners, i.e., nearly 68% study participants said they had been approached by families with a request for conversion treatment for their TGD child/ family member. 57 (34.5%) practitioners said that TGD clients had themselves requested conversion treatment. 109 (66%) practitioners stated that they had heard of MHPs in their cities who practiced conversion treatments to help clients live in their birth-assigned sex. Despite socio-legal changes in India over the past few years, including the Madras High Court declaring the use of conversion treatments illegal (Sushma v/s Commissioner of Police, 2021), the demand for conversion treatment persists. The practice of such treatments, purportedly to cure transgender gender identities, seems to persist as well, as indicated by the data quoted above, and as reported by a few other Indian studies (APTN, 2021; Chatterjee & Mukherjee, 2021). In this context, responding to familial requests for conversion treatments is a challenging task. Many practitioners lamented how, despite their best efforts to educate the family about TGD issues and the ill effects of conversion treatments, and providing support to the families to move towards acceptance, many of these families and TGD clients were lost to follow-up. Practitioners discussed various responses – outright and immediate refusal to provide conversion treatment services; engaging with the family,
building rapport and trying to educate them; using their expert authority to impress upon the family the ill effects of these treatments and their lack of efficacy. One of the practitioners actively encouraged a family to seek a second opinion from any other MHP on the efficacy and ethics of using these treatment options. Unfortunately, this practitioner could not be certain that other MHPs would necessarily have an affirmative view of TGD identities. Thus, despite strong activism from LGBT communities, MHP associations condemning conversion treatment practices, and a court order declaring these treatments to be illegal, MHPs have an uphill task ahead of them to help parents and families see their TGD child for who they are and support and cherish them in the face of a cis-binary-gender world. Despite top-down changes – such as legal change or MHP associations making public statements – the absence of wider social as well as professional education, and a lack of consensus on transgender identities being non-pathological, makes the task of responding to conversion treatment requests a difficult one. Nevertheless, the MHPs participating in this study sought to respond to such requests in different ways, none of which legitimised the use of, or the claims of cure made about, conversion treatments.

“A child psychologist discussed a case where, after a few sessions with the trans-identifying young person, she started working with the family to get them to engage with their child’s gender journey, but the father was unwilling and angry and wanted the psychologist to get the child to ‘stop zall this’. The child psychologist then suggested that they seek a second opinion in order to be surer. She said, ‘One part of my job with them was to help them consult with different people. They were in Bangalore, not in Delhi. So, I was giving them other people’s numbers and information, asking that they please speak to more people. Maybe see another psychiatrist – don’t need to see another psychologist [but] someone else, somewhere else. So I told them to go to NIMHANS and just do a random search and consult with someone else.’

33-year-old woman, Psychologist, Delhi

“The client came from a very interior part of rural Maharashtra. The mother as well as the brother did not really open up to the concept that a girl, a born girl could have a male gender. So, they wanted her to start acting like a girl, you know, grow out her hair. She had cut off her hair and she had started dressing as a boy like she wanted to. And they really wanted that to happen during the hospital stay. They were not really open. We tried a lot, but it’s the social conditioning over so many years that was difficult to penetrate. And we could not keep her beyond a point, because the moment the family realised that we were not doing much to change her, but we were actually psychoeducating them, they started requesting discharge… we really don’t know how much of our efforts got through to them.’

31-year-old man, Psychiatrist, Mumbai

“I’m very happy that right now, conversion therapy is kind of termed as illegal and people practicing it are to be punished by law. They should not
be promising such things to families, because they will then keep running around with the hope that there will be someone who can change this person’s mind from A to B and it will not help them understand that this is a real condition or this is definitely something that a person is going through, instead it gives them an understanding that this person might be acting, or this is not a real problem. I think people should not promote or encourage conversion therapy at all.’

32-year-old woman, Psychiatrist, Bangalore

Participants also discussed other forms of conversion/correction efforts apart from bringing the TGD person to MHPs for the purpose, and these included a range of micro-aggressions and gender policing practiced by parents, siblings, teachers, peers, and so on. They underlined that these forms of social correction/conversion treatment also had deleterious effects on the TGD person.

Guideline 8. Role of MHPs in Gender Transition Services

MHPs play a vital role not just in assessment of gender dysphoria/incongruence and providing letters of support/referral letters for gender transition services, but at every step of the gender transition/affirmation process.

78 of the 165 MHPs i.e., 47% of the participants reported being approached for assessment and referral letters for gender transitioning services. The assessment methods used by MHPs varied – in a few instances, it included reliance solely on a detailed clinical history and in-depth clinical interview of the client, and sometimes of an informant as well. However, a majority of the study participants used standardised psychological tests. They reported using projective tests (n=32), personality testing (n=24), cognitive and neuropsychological testing (n=12), screening tools for psychopathology (n=8), a sex role inventory (n=1) and a blood test (n=1) before recommending their TGD clients for transition-related services. Practitioners reported variously on the duration of assessment for providing a referral letter. Of the 78 who provided such letters, 36 reported needing under 3 sessions, 24 reported 4-6 sessions and 16 reported more than 6 sessions in order to provide referral letters for hormones or surgery. Two practitioners did not provide a number. There was no consensus among practitioners about the rationale for using psychological assessments. The absence of clear clinical protocols about mental health assessment to determine “fitness” for gender affirmation therapy or to screen for co-morbid mental health conditions meant that many MHPs sought to use standardised psychological tests in the belief that such test results would appear more unbiased and reliable if there were to be medico-legal scrutiny at any point. A clinical psychologist mentioned using psychological tests as part of an institutional requirement, more than as a clinical necessity. A psychiatrist commented that the elevations seen in psychopathology scales like the MMPI6 and MCMI7 could be looked at as trans-specific coping strategies in the context of prevailing stigma and discrimination. It is worth noting that no

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6 MMPI (Minnesota Multiphasic Personality Inventory) is a standardised psychometric test in adult psychopathology. MMPI-2, the widest used form of this test, published in 2008, has 567 true/false questions.
7 MCMI (Millon Clinical Multiaxial Inventory) is a self-report psychometric tool to assess personality traits and psychopathology. MCMI-IV, the most recent edition, was published in 2015 and has 195 true/false items.
78/165 approached for assessment and referral letters for gender transitioning services

Duration of Assessment for Providing a Referral Letter

<table>
<thead>
<tr>
<th>Duration</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>Under 3 sessions</td>
<td>36</td>
</tr>
<tr>
<td>4-6 sessions</td>
<td>24</td>
</tr>
<tr>
<td>More than 6 sessions</td>
<td>16</td>
</tr>
<tr>
<td>Did not provide number</td>
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</tbody>
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Assessment Methods used by MHPs

<table>
<thead>
<tr>
<th>Method</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>Projective Tests</td>
<td>32</td>
</tr>
<tr>
<td>Personality Testing</td>
<td>24</td>
</tr>
<tr>
<td>Cognitive and Neuropsychological Testing</td>
<td>12</td>
</tr>
<tr>
<td>Screening Tools for Psychopathology</td>
<td>8</td>
</tr>
<tr>
<td>Sex Role Inventory</td>
<td>1</td>
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<tr>
<td>Blood Test</td>
<td>1</td>
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available national or international guidelines for gender transition services recommend psychological testing as part of standard assessment.

Some participants in this study did question the utility of psychological tests being done in the absence of any clear rationale, and at a cost to the client in terms of both time and money. We have included this critical questioning of the uneveen practice of psychological testing before giving a letter of support/referral letter to TGD clients as a good practice, demonstrating as it does a client-centred and rational approach by some MHPs.

'I have stopped looking for anything in the MCMI profile because, you know. I read up not too long ago that even [with] the psycho-diagnostic tests like MCMI or MMPI, the results are very different pre-transition and post-transition and that was quite surprising, because these are not really state-dependent tests. They are supposed to be consistent over a period of time. A lot of parameters that come elevated and may [seem] pathological in the reports are actually ways of coping with the scenario of gender incongruence. The paranoia, for example – we usually see paranoid scales a little bit high. We see the depressive or dysthmic scales a little bit high. And these are very
obviously results of the way a person is coping with their environment.’

‘To be honest, many times I have felt like I am just doing the whole set of tests because I am supposed to do it, because the protocol of the place that I am working at says so and because it is a package. Like I said earlier, I genuinely don’t think that any projective or personality tests are required.’

‘A good case-history-taking with empathy is important. What was [their] identity like when there was some confusion, some conflict? When did they consolidate it? When did they become clear about it? Then how did they handle the society and family? Then the process of coming out right now, how long is it? Relationship issues now, the sexual orientation or sexual identity, their living arrangement, then I would ask about their work profile, how they will deal with this identity at workplace or at residence? Okay, and how comfortable are they? If they have not told anyone then what may be the reasons? What are the challenges? How they plan to handle these things, right? For surgery, what are the complications or consequences they’re aware of? And how they’re going to handle it. And are they mentally prepared for this permanent transformation? With surgical, do they understand it is irreversible? If it was hormonal, then are they aware about what will be the actual physical effects and side effects? What is their future plan after hormonal therapy? So these are some of the questions that I would ask in my clinical interview and ask them sensitively…’

All major guidelines recommend a continuum of care while working with the TGD population. Participating MHPs also discussed the importance of following up post-hormones and surgery to provide continued psychological support. They emphasised their pro-transition position while helping their clients set realistic goals. They recommended including assessment of financial, social and emotional status in the comprehensive clinical assessment. Assisting TGD individuals with severe psychiatric disorders like psychoses posed a challenge. Many practitioners commented that the psychiatric condition itself need not come in the way of seeking transition services; however, they wanted to ensure that the psychotic symptoms were not related to or causing gender identity issues. A small number of practitioners adopted a wait-and-watch approach while working with TGD clients with severe psychiatric illnesses.

‘Helping the person understand what exactly is going on – right from giving the right information to helping them see transition as a treatment. Actually, we should be pro-transition, because we are pro-treatment. Helping
them understand and build realistic expectations for medical transition, even for social transition. It’s not as smooth for everyone and it’s not as catastrophic also, as people think a lot of times... Addressing all the anxieties, misconceptions, helping them understand their family members’ emotional journey, and build [a] better support system. You know, a lot of times when parents are, for example, going through a phase of denial or anger, which is part of the journey towards acceptance, sometimes the patients may get angry about it, may dissociate from them. And that can lead to more difficulties. So, helping them build [a] good social support system, helping them with the right referrals. Even making decisions for surgery, for HRT, whatever it is, I think a psychiatrist should be part of that whole decision-making process to help the person understand what is to be expected. What will be the result of delaying a certain thing, what will be the result of, you know, going too rushed into something... also post-transition, providing them with all kinds of mental health support that’s needed. A lot of times being on hormones can lead to some mental health issues. So, to keep a check on that, recognise that early on and intervene.’

‘It’s complex how the hormone treatment will interfere with the psychotic illness and things like that but in principle I feel they should not be discriminated [against] just because they have mental illness, as long as the psychopathology is not about the gender itself.’

‘Not everything on the internet is true nor is everything available on the internet, [it’s] a scam. That’s when the role of an MHP comes in to sift the grain from the chaff. Counselling can become directive in such cases where it is more knowledge- and information-based. MHPs also need more knowledge, for instance, not in many other cases would the MHP need to have so much knowledge on legal rights or schemes for livelihood or whether in a particular state the government hospitals provide concessionary reassignment surgery.’

‘We have come to the consensus that a medical journey, be it for mental health concerns, is not a deal-breaker for going ahead with transition. The whole mental health disturbance might be precipitated by the dysphoria in itself. If there is readiness, in terms of emotional stability and the resources to be able to help themselves in terms of crisis, risk assessment, and generally those are the things that we do, look for red flags because we’d
One participant, a psychiatrist, discussed her experience with some of her university-educated and articulate clients, who questioned the authority of MHPs to certify anyone’s gender. Some of these clients brought copies of court judgements to her that were related to the right to self-determine one’s gender. In response, she invited these clients to write joint letter/s of support to be used for practical purposes such as seeking medical transition, change of name on documents, in educational institutions, and so on. She says,

‘So, I will do two letters, one, you and I will write and if you find a progressive surgeon, use this letter, if not, you still want to get the surgery done, you can then use the other (the conventional format of a certificate for gender dysphoria). So, we just make do with whatever there is. But in all of this, keeping the meaningfulness of that letter very clear. Some of it is needed for the logistical purposes of where we are at today. And I'm not taking away your dignity.’

Guideline 9. Working with TGD Minors

The Indian Standards of Care for Gender Incongruent Children and Adolescents (ATHI, 2021) suggest that health professionals working with minors should employ the mnemonic LEARN (L – look, listen, learn from the child about their gender identity; E – educate self, parents and society; A – advocate for the rights of the child at home and in the educational institution; R – resources for parents, children and society; N – being non-judgemental).

Research suggests that gender identity development can occur as early as between the ages of 1.5 and 3 years (Ehrensaft, 2016) and that variability in sex-typed behaviour exists from a young age, wherein masculine girls and feminine boys can be recognised, as much as feminine girls and masculine boys. Research also suggests that the degree of sex-typed behaviour observed in a person as a toddler predicts the degree of sex-typed behaviour they will show in adolescence (Golombok et al., 2012), indicating that degrees of sex-typed behaviour may be consistent over time. Researchers and clinicians differ in their position on the extent to which childhood gender non-conformity persists into adult transgender identities, and consequentially have divergent views on the management of childhood gender incongruence. Newhook (2018) suggests that the polarising desisters v/s persisters debate on childhood gender incongruence (about the extent to which childhood gender non-conformity persists into adulthood) has led to an excessive focus on futurity (the adult future of childhood gender non-conformity) and stability of trans identities over time, at the cost of being sidetracked, in the present moment, from the needs of young people with gender non-conformity.
Despite divergent views about the continuity of childhood gender non-conformity into adult TGD identities, there seems to be consensus on the harm caused by reparative treatments that seek to fit gender diverse children into their birth-assigned gender or natal sex, and on the importance of social and familial support to gender diverse children in navigating their gender journeys (Keo-Meier & Ehrensaft, 2018). Ehrensaft (2016) uses the concept of a gender web, a four-dimensional structure that is each child's personal creation, spinning together the three major threads of nature, nurture, and culture, interfacing with each other and with the fourth dimension of time, that allow the child to construct a gender self. The gender affirmation model developed by Keo-Meier and Ehrensaft (2018, p. 13) defines gender health as 'the opportunity for a child to live in the gender that feels most real and/or comfortable for the child and the ability for children to express gender without experiencing restriction, criticism, or ostracism. In the model, the role of the mental health professional is that of a facilitator in helping a child discover and live in their authentic gender with adequate social supports.'

In the present study, 105 of the 165 participants reported seeing TGD minors in the course of their practice. 15 participants reported having seen clients who were 12 years old or younger referred for issues around their gender identity and expression, while 90 reported seeing clients who were between 13 and 18 years old. A minority of the study participants engaged therapeutically with their TGD clients and their families. The most common response among participants was an advice of “wait and watch” until the TGD person was an adult. However, some of the participants described their therapeutic work with TGD minors. A child psychologist talked about her work with a trans masculine 9-year-old, who was referred to her for behavioural issues and impulsivity. She discusses ways in which she centres a trans-affirmative perspective while integrating a developmental lens using stabilisation along with bodily and emotional regulation to work on impulsivity.

"What was worrying the family and bothering the school was [an] early sexualisation of relationships and very early exploration of body with other people in the school. There were a lot of gender themes that we had to navigate... we realise this young person is doing things to get a response from others, because they want a response, which is going to eventually help them, say, and present as a man and boy, and like a male person, that they're desperately trying to show everybody around them. And it was coming from a space of gender presentation, but it looked very different,"
right? So, say, drink alcohol, like dad does in a party, for example, then he would, like, hide alcohol from his father’s cupboard and drink when no one’s watching. And they were, like, as young as nine, and that would be potentially risky . . . Yes, he is seeking attention, but he’s seeking attention also towards his gender presentation. Because for him, that’s what he understands of the social context of being a man that when you express your sexuality, or your choices or your intentions, that’s what’s making me a man… looking at my older brother, or looking at my father or my cousins, or TV or whatever they’re watching. That’s where they’re learning the social representation of it and he has to explore it to be able to find out what fits him…There was high impulsivity and lack of overall body regulation, we knew that some of it is coming from the restlessness in the body also. And once the overall regulation will get better, they would be able to assess whether they need to navigate every space by being this thunderbolt…”

33-year-old woman, Psychologist, Delhi

Another psychologist discussed working with a TGD minor to deal with the bullying, related to their gender expression, that they were facing in school.

‘He would come with his mother and mother had, to some extent, accepted, or she thought of it as a possibility. So the concerns that this boy had were that he was being bullied at school because he was a bit effeminate and that made it worse for him and he was not able to assert himself in school. And so, we did a lot of work on that and I helped him with it… Being internet-savvy, he had read up a lot on gender affirmation and he wanted to start off on hormone therapy early. He must have been in [the] 10th standard, I think. He wanted to start hormone therapy, while his mother was feeling that we should wait a little bit till he is an adult and then start the process. So, there was this negotiation going on, and I, I would kind of try to facilitate whatever was possible between them. He would ask me these questions, whether I’m making the right decision and, you know, then we would go through, asking him to do, all the pros and cons and the usual decision-making approach, so I helped him with that.’

68-year-old woman, Clinical Psychologist, Bangalore

A child psychiatrist who has worked with TGD minors talked about the role of changes in international guidelines such as the Standards of Care by the WPATH, particularly on the administration of puberty blockers to adolescents, and the evolving conversations among clinicians in India including recent online conferences on trans health that have helped mutual learning and education among MHPs as well as other medical professionals involved in trans health and mental health care. Some MHPs discussed offering treatment for mental illnesses to their TGD clients while educating families not to confuse mental illness and its symptoms with gender dysphoria or incongruence.

‘So initially, when we had a 13-year-old or a 12-year-old saying, “I’d like to go
for changes right now”, we didn’t have any guidelines. So, we used to say, “Wait till 18.” I think in the last about one-and-a-half to two years, I’ve started saying, “Okay, wait, something can be done even now.” And for the 7- or 8-year-olds, I’m already preparing the parents that things can be done. Because they are pre-pubertal. So I think that’s a result of the SOC 7 of WPATH, which changed certain things completely.

49-year-old woman, Psychiatrist, Delhi

‘With younger clients, reversible changes such as social transition can be supported and even puberty blockers are okay, especially with good parental and peer support.’

38-year-old man, Psychiatrist, Mumbai

‘So the 17-year-old had come predominantly because he had bipolar disorder and the parents were not keen on them getting any treatment at all, because they felt that the medications that were given in the past for the treatment were responsible for the gender or a transgender feeling that this person had developed this year, and that this was not there at all for the last 15 years. They developed a psychiatric condition, started on treatment, and following that this person has been reporting clearly that he has become a “he” from a “she”. And [the] parents were completely against psychiatric medications. And the kid was having significant difficulty in studying or, you know, completing the course; she was, he was in 12th then. He had great difficulty with getting it done. And the parents were not for medication. So, a lot went into how this is not responsible primarily for change in gender. That this is a completely different issue from what transgender is, and so on.’

32-year-old woman, Psychiatrist, Bangalore

Guideline 10. MHPs as Allies and Advocates

MHPs recognise that their role goes beyond helping their TGD clients cope with the effects of trans-prejudice, towards helping build awareness on TGD rights, creating trans-inclusive environments and combating trans-prejudice as allies and advocates for TGD persons.

MHPs recognise the myriad ways in which trans-related stigma, discrimination and violence affect the mental health, well-being and quality of life of their TGD clients. These experiences of TGD persons as gender minorities often start within natal families and continue in educational institutions, workplaces, public spaces, among peer groups, as well as within intimate relationships (APA, 2015). Trans-affirmative MHPs recognise their role in working with TGD clients not only to help them cope with the effects of
trans-prejudice and build resilience, but also to create trans-inclusive environments and combat trans-prejudice. The Supreme Court of India, in its judgement decriminalising homosexuality, emphasised the role of MHPs and counsellors in creating awareness on LGBT issues within families, educational and employment spaces, and thereby helping to foster self-acceptance by LGBT persons and to create a discrimination-free society for all (Kapoor & Pathare, 2019). Pertinently, a group of MHPs had in fact played an ally and advocate role for the LGBT community by filing a petition in the Supreme Court in support of decriminalisation of homosexuality (Ranade et al., 2022).

MHPs participating in this study, too, recognised the many challenges faced by their TGD clients and sought to go beyond the clinical/therapeutic space in supporting them. The study participants acknowledged their dual privilege as cis-gender persons and as experts, and used this privilege to speak up for the cause of transgender rights to the larger public as well as within their professional circles. MHPs discussed the need to go beyond clinical competence to work with TGD clients and equip themselves with information such as legal rights, governmental schemes and other resources for TGD persons.

‘In a lot of other cases, you don’t need to have so much of legal knowledge, but here you also need to make them aware of their legal rights... if you have knowledge of the law of the land of the particular state you’re operating in, if you know of any schemes that are available for transgender [persons] propagated by the government...’

42-year-old woman, Counsellor, Bangalore

‘When the Transgender Act came in, I read it. It’s a very small Act, to be very honest, it’s barely some 30 pages. And it’s just about eight sections. It’s a great read. I just read through all of it. I then converted the Act into a PPT. And then I presented it at multiple forums to help spread awareness about the legalities.’

42-year-old woman, Counsellor, Bangalore

‘I remember once, just a quick personal sharing here, consulting a gynaecologist for my own health and trying to have a conversation about how many clients does she see that are gender non-conforming? And seeing if she’s actually open to it or not? No, I’m not doing it with any specific intention in that moment. But I know it’s coming from a little bit of a space of advocacy and awareness-building conversation that why not, if I can, you know, at least identify two or three new such people. I just have more safe spaces to offer to my clients as well. (A) little bit of that active networking can definitely help and go a long way, while we’re still struggling to find a community of helpers who are affirmative.’

33-year-old woman, Psychologist, Bangalore
Another participant shared how she took the initiative of printing T-shirts with slogans such as ‘Trans men exist’ and ‘Trans lives matter’ in liaison with some of her co-workers for a group of health professionals in her running group. This was her way of spreading awareness within the community of medical professionals.

‘I just said, why don’t we make a T-shirt? just to raise awareness. Everyone is wearing something just to create some awareness, so instead of wearing the event T-shirt why don’t we wear this T-shirt –and we distributed it in the running group of the hospital, and many times when we run, we wear that and we run, some people do ask us... many people don’t know so they ask us, “What is this?” and “Why are you wearing this?” and all that, and we tell them, so it’s like [an] awareness campaign.’

44-year-old woman, Psychiatrist, Bangalore

A participant narrated how he, along with some colleagues, reported videos by an MHP advertising conversion therapy. In this case, being an ally/advocate was synonymous with standing up for what is right and being ethical in one’s practice so as not to promote maleficence.

‘I will not name [anyone] but I’ve seen psychiatrists, senior psychiatrists from Maharashtra, not psychiatrists, just one person actually, who would really advertise about conversion treatment in his clinic. And that had caused a great disturbance among some of the health professionals who were working for queer people. So we had reported his videos, and shortly after that the IPS (Indian Psychiatric Society) gave out this statement against conversion therapy, like within a week or something. That could be connected to our reporting or could be a coincidence, we don’t really know.’

31-year-old man, Psychiatrist, Mumbai

Guideline 11. Practitioner Self Awareness and Reflexivity

MHPs reflect on their own personal gender-sexuality journeys, associated beliefs and values as well as professional engagement with non-normative genders and sexualities and changes in these trajectories over time. Most significantly, MHPs recognise that their personal and professional beliefs impact their engagement with their clients.

Literature on reflective practice alerts us to the fact that ‘who we are influences what we see (and do not see) and how we see it’ (Bhola et al., 2022, p. 2). Knowing oneself, one’s values and beliefs and actively using self-awareness to work with clients and in one’s own journey of change and growth is thus a vital aspect of being an MHP (Bennett-Levy, 2019). We present here the complex layers of personal and professional experiences with TGD persons upon which participants of this study reflected. These reflections also
had a dimension of historical time. Historical time here refers to external time/calendar years, and changes occurring over time in the ways in which TGD lives have been represented within diagnostic and classification systems, curriculum and textbooks of psychiatry and psychology; as also to subjective time, i.e., the age, experience, values/beliefs of the MHP, and changes in these aspects over time.

With respect to personal experiences, most MHPs spoke of being socialised in normative ways and hence believing in the naturalised cis-binary-gender system, while encountering the gendered “other” mainly in the form of the Hijra figure engaged in begging at traffic signals or seen singing and dancing at weddings. Some recalled the emotion of fear associated with this figure, due to otherness/distance, stigmatising social beliefs about the Hijra community being child kidnappers, or the power of cultural beliefs around the curses of the Hijras. Some participants reflected on having had a trans masculine person at their all-girls school or a trans feminine classmate in their undergraduate medical college. One of the participants talked about having a trans student in the postgraduate psychiatry programme that they taught and supervised at; another talked about a trans person in the family and the exclusion and ostracism that this person faced from the family.

‘So the first client was my student. And one day, she told me that she has this feeling that actually she’s not a, uh, means, biologically, she’s a girl but she feels from her mind in her brain, she feels that she’s a boy. And she’s very, very uncomfortable with her body. And she would like to consider sex change operation... And finally, she underwent sex change operation, hormonal therapy and now she has become he, and he’s doing excellent work and he got married also now, and he’s staying with his wife and he’s living a very fruitful and very creative life. So that gave us the feedback that there are people and after [an] operation, you can really provide them a very good life and they’re very happy after the operation.’

60-year-old man, Psychiatrist, Mumbai

‘My first interaction goes back a very long time. This was in my childhood. My mother’s cousin is a trans woman. Today she’s out and proud, but back in the day I remember I was not allowed to talk to him. I am not misgendering him but back then he was my mother’s male cousin, who would grow his hair out and paint his nails and have effeminate mannerisms. Whenever we would go to their place, his mother would try and shut him off in a room saying, “Don’t come out when there are guests.” I was not allowed to interact with that person. I was asked to stay away. I was told that even if you see him on the road, just ignore, don’t talk to him. So those were my first memories of someone that I knew upfront, you know, without knowing that the person is trans... Only when I grew up. I understood – and I have been guilty of a lot of discrimination myself, because whenever I used to see him, I used to ignore him. I used to look the other way. When I began to realise what I had done, when I began to realise who she was, and why she was the way she was [back] in the day, it was to no fault of hers. It was no fault of hers that I was discriminating against her, and my entire family had pitted me against meeting or
interacting with her. For many years, I lived with a lot of guilt. A lot of my work towards queer sensitisation also stemmed from there...’

42-year-old woman, Counsellor, Bangalore

‘I think my contact with the transgender community was only seeing people from the Hijra community in trains, buses, traffic signals, and I earlier thought of them as scary people. But that was the only image that was there. I had absolutely no idea about gender, sexuality, about trans, who trans people are until my Master’s.’

28-year-old woman, Psychologist, Mumbai

As participants reflected on their personal journeys of shifting from their normative gender socialisation that involved ignorance about TGD issues or even trans-prejudice, they identified the role of engagement, social contact with TGD persons, and information on TGD issues as factors that enhanced their cognitive and, eventually, empathic awareness. 111 of the 165 study participants (67.2%) said that they had a TGD person in their social circle of colleagues, friends or family. 101 (61.2%) stated that they had attended an LGBT-themed film festival, social event, or pride march. Thus, as suggested by literature on stereotype and prejudice reduction (Dixon et al., 2016), exposure to counter-stereotypic information and intergroup contact have significant roles to play in the process of “de-biasing” and enhancing empathy.

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61.2% stated that they had attended an LGBT-themed film festival, social event, or pride march

On the professional front, participants reflected on their initial contact with TGD clients and the tentativeness, confusion and, at times, the sense of helplessness they felt in the absence of any guidelines, protocol or training on TGD mental healthcare. Participants also reflected, however, on self-motivated and self-initiated efforts to learn about TGD mental health, and acknowledged the importance of being mindful of the experiential distance between a cisgender therapist and a TGD client.

‘I think that the first time I interacted with a trans client, I did validate what the client was going through. But apart from that, I was not really able to
do a lot. I was just able to contain the client. I think I did not have the skill and ability to maybe delve deeper as to how this journey has been, what do they feel right now about themselves, about being trans, about living with a family, about living within a normative family, having children, and all of that. So, I was not able to delve deeper for the fear that even if I were to retrieve this information, I don't know what to do with it, because I don't think I'm skilled enough to be able to address that…'

28-year-old woman, Psychologist, Mumbai

'I distinctly remember my first one. This was 1999 or 2000. I was working at that point of time in one of the government hospitals in Delhi in the psychiatry department, and this was a young person who said that they were a man and the assigned gender at birth was female and they had basically reached the government hospital next door to try and get surgery done and the surgeon had referred them to the psychiatry department saying that unless you get some sort of consent from them, nothing can be done. So that's how they landed up with us, and I clearly told them that I had never seen this before. I went to my seniors and they said, “Well, this is rare but here is the paragraph in the book that tells you about it.” So, I read up that one paragraph and then over a period of the next few weeks this young person, trans man – now I know the vocabulary, [at] that time I didn't. So, I ended up speaking to them for about three and a half to four hours. Eventually, they got admitted along with their father on the male side, that was their only condition that I will not get admitted on the female side. And I spent quite a few hours with them over the next few days, every evening.'

49-year-old woman, Psychiatrist, Delhi

'The first interaction was pretty awkward… when I began working, there were times when I used to be a little, you know, taken aback by just the appearance, because I was just 24-25, you know. I was young back then when I started practicing and I used to feel uncomfortable asking some questions in the very beginning. So, in the very beginning I was awkward, I was confused, I didn't know and I was a little ashamed of the fact that I'm not very well-versed with gender identity and things.'

34-year-old woman, Psychologist, Mumbai

'The difference between then and now, I will say, is that it was very, very clinical. The first time I saw this patient, who was trans, it was all about the symptoms and all about relieving the symptoms. The other aspects of it, which also should be ideally part of the treatment, like using the right pronouns,'
using the chosen name, not the given name, you know, helping out with social adjustment, helping out with the legal adjustment, that was completely outside of our perspective then. So, I think that would be a major difference. of course, and another thing was, we stuck very starkly to the standard of care guidelines back then, six months of HRT or more, or having that real life experience first, even before starting the medical transition, insisting upon that, and you know, having six months of that, with all the social difficulties that the person had to go through. That was how we approached it first, but over the years I learned that you have to be way more helpful to the patient than just relieving the clinical symptoms.’

38-year-old man, Psychiatrist, Mumbai

‘So I’ve always wanted to go read up and understand the community better. Learning that there is a distance [from] which we are operating. And, you know, maybe we cannot co mpletely close that gap. So, learning to function in that gap, being mindful that, you know, our worlds might be different. And I have to change some parts of my perspective [when] I’m meeting someone from the community. So, the looking lens is more reflective.’

29-year-old woman, Clinical Psychologist, Bangalore

‘Firstly, what I learned in the process is that I wouldn't be able to help unless I deconstructed my own beliefs about my own gender and my own sexuality. So, what it means to be a woman, what it also means to express myself as a woman, what it means to identify as a woman, so I had to look back, reflect on all of that. And I felt that unless I genuinely felt this from within, I wouldn't be able to help people.’

28-year-old woman, Psychologist, Mumbai

Participants reflected on their own gender-sexuality and on other marginal locations, in the process of understanding the challenges faced by their TGD clients. Two of the participants who were Muslim women, one a queer woman and another a heterosexual, single woman who had broken several norms expected of cisgender, heterosexual Muslim women, spoke about their struggles and the resultant empathy for lives that are lived outside of social norms. Another queer psychiatrist spoke of being out and how that meant that she would lose clients when they found out about her sexuality, and also of gaining clients from the queer-trans community who would choose to come to her with the expectation that she would understand them better. Some of the queer-trans MHPs spoke about using self-disclosure as a therapeutic tool, especially with younger clients suffering from internalised queer- and trans-prejudice, and also in order to serve as role models.
‘So they were calling me “ma’am” and I was like, I am not “ma’am”, I identify as non-binary and they were like, “Oh! it’s so nice to meet an older NB person. I didn’t know people like this existed.”’

28-year-old non-binary person, Psychologist, Delhi

‘Personal identity? Bringing your personal in, into the therapy, I feel, for queer people there is also that absence of the positive norm, positive defining of their identity and experiences. As a teacher, I had definitely seen that when you are a teacher and you are “out”, it lends some dignity to the student. They drew some strength from that. That was helpful. This is how I negotiated in my therapeutic practice too. I don’t shy [away] from giving that example.’

42-year-old woman, Psychologist, Delhi

Guideline 12. Training, capacity building and supervision to develop competence for working with TGD Clients

MHPs recognise the need for specialised training on TGD mental health including but not limited to assessments of gender incongruence and providing letters of support for gender affirmation therapies. They are motivated to build their own capacities and to seek supervision for providing TGD-competent and affirmative mental health care.

The American Psychological Association (APA) Task Force on Gender Identity and Gender Variance (TFGIGV) survey of 2009 had found that less than 30% of psychologists and graduate student participants reported familiarity with issues that Transgender and Gender Non-Conforming (TGNC) people experience. The National Transgender Discrimination Survey (Grant et al., 2011) reported that 50% of TGNC respondents had to educate their health care providers about TGNC care, 28% postponed seeking medical care due to anti-trans bias, and 19% were refused care due to discrimination. Stryker et al. (2022) conducted a survey to study training experiences of clinicians for TGNC care with 281 counsellors, social workers, psychologists, psychiatrists – and found that only 20% of their participants had been exposed to relevant content on TGNC care during their graduate training, and that the most common sources of training opportunities were professional conferences (76.4%) and mentorship (41.2%).

In India, as recently as June 2021, a High Court order (S Sushma v/s Commissioner of Police, Chennai) led the National Medical Commission (NMC) to take note of the derogatory content regarding LGBT lives in undergraduate medical curricula and textbooks (Agarwal & Thiyam, 2022). The NMC later set up a committee to suggest changes to the psychiatry curriculum for a well-informed inclusion of LGBTQ issues. Such reviews of the curricula of other streams of mental health education, such as psychology, counselling and social work, have not taken place. It is not surprising, then, that in our present study 104 of the 165 participants (63%) stated that TGD issues were either not covered at all or only partly covered during their formal education as mental health professionals. This percentage is, however, likely to be much higher, as LGBTQ+ inclusion in the formal training of MHPs is still quite sparse in India. 129 (78.2%) participants said that they felt the need for training on TGD mental health, while
114 (69.1%) said that they had attended some workshop, seminar or training (online or offline) on LGBT+ mental health. Most of these trainings ranged in duration from a few hours to a few days; most were not specifically focused on TGD mental health but addressed TGD issues alongside those of cisgender gay, lesbian and bisexual clients. 98 of the MHPs (59.4%) said that they had heard of some guidelines or protocols on TGD mental health care, although only 89 were able to name any such guideline. A majority of these 89 (n=52) mentioned the WPATH guidelines, while a few had heard of protocols by NIMHANS, Indian Standards of Care (ATHI, 2021) and Queer Affirmative Counselling Practice (Ranade et al., 2022).

137 participants (83.03%) said that they had heard about the Transgender Persons (Protection of Rights) Act and 79 (47.9%) said that they knew what this Act said about the role of health care providers in TGD health. Thus, although the formal training of MHPs in India may not equip them with the necessary knowledge and competence to work with their TGD clients, increased public discourse about trans-specific legislations and rights along with motivation among MHPs to build their own capacities and seek supervision are, admittedly, important steps towards building competency for trans-affirmative mental healthcare.

Several of the MHPs reported reaching out to seniors and peers who had experience of working with TGD clients, for supervision and resources on TGD mental health. Some had had the opportunity to work outside the country in specialised gender clinics; others mentioned having attended trainings abroad on gender-sexuality where they learnt more about TGD mental health. Many spoke of the value of learning from the lived experiences of TGD communities. Mental health educators, too, have been taking the initiative to conduct additional training sessions on queer- and trans-affirmative counselling.
The role of MHP associations in developing practice guidelines and protocols on TGD health and in providing ongoing training programmes for continued medical education (CME) was highlighted by some participants.

‘When it comes to hands-on training, we don’t get that or, like, we are not as well-equipped to deal with trans clients. All the knowledge accumulated with respect to the practice, you know, actual practice was from M (a colleague who had been working with TGD clients at the hospital for almost a decade). M helped me out. He gave me resources, and this is after I became a clinical psychologist, you know, so this kind of training should have probably been there during my MPhil itself, which I felt was lacking, and I think that was a huge obstacle.’

29-year-old woman, Clinical Psychologist, Bangalore

‘I went through this training, a certificate course in Amsterdam. There I got to meet people who had sex reassignment surgery and how they felt about it, and they spoke openly about their lives. So there also I got it, you know, [a] better understanding of the whole thing. Initially, the understanding was very theoretical, very [little], I would say. But as I got exposure, I think it definitely improved, and I was more sensitive to all the issues that they could be going through.’

68-year-old woman, Clinical Psychologist, Bangalore

‘In my formal education there was no exposure, although my teachers were queer-affirmative. After I finished my training, two of my teachers took the initiative to teach us about queer-affirmative counselling practice during the COVID period. These were online sessions and they started from the very basics like who is L, G, B, T etc. That was my first exposure. They educated us about the queer community. We were so involved that the duration of the classes kept on extending, and one session became almost three sessions . . . My current supervisor in the organisation is from the initial batches of the Queer Affirmative Counselling Practice (QACP) course. She is very good and very supportive. I also have friends around me who have done both, the online sessions conducted by my teachers and later the QACP course. This enables us to consult each other when we are stuck.’

25-year-old woman, Psychologist, Mumbai
The societies that we have, like the Indian Psychiatric Society (IPS) or the national level societies of endocrinologists, or the plastic surgeons, they can formulate their guidelines. There has been useful material published by NIMHANS, which is one of the apex institutes for psychiatry. It has a detailed step-by-step, things that should be done. So, the same thing converted into a small and simple, say, flowchart, which could be circulated by the IPS among the psychiatrists, or something like that, would help.'

31-year-old man, Psychiatrist, Mumbai

'We definitely have a lot of CMEs regarding LGBT issues because the Indian Psychiatric Society has a subcommittee on LGBTQ issues that keeps on taking such training or CMEs and conference[s] regarding this.'

35-year-old man, Psychiatrist, Mumbai
CONCLUDING REMARKS AND WAYS FORWARD

Trans Affirmative Mental Health Care Guidelines has been an effort to document good practices employed by psychologists, psychiatrists, social workers and counsellors in their varied practice settings of hospitals, clinics, NGOs, online consulting spaces. The significance of this document is two-fold: it’s a first-of-its-kind attempt to document mental health practice with TGD clients in India; and second and most importantly, it highlights the self-motivation of MHPs who, in the absence of formal training on TGD mental healthcare, strive to provide the best care they can to their TGD clients. It is our hope that this document presenting the practice wisdom of our study participants will make the path easier for all MHPs who struggle to provide comprehensive care to their TGD clients.

It is important to note that the findings of this study are not generalisable to all MHPs and their knowledge or practice with TGD clients in India, primarily because we selected our study participants purposively to include those MHPs who were known in each of the study sites to be working with TGD clients.

In conclusion, we would like to highlight some areas of therapeutic practice with TGD clients and their families that are missing in this document and in research on TGD mental health in India, in the hope that these research gaps may be filled in the future.

a. There is a need for using a life course perspective to understand TGD mental health concerns – as each developmental period from childhood, adolescence, youth to being older adults would affect the kinds of concerns that TGD clients would present with, in counselling. Moreover, the normative developmental tasks associated with each developmental stage in life-span studies would be complicated for TGD persons due to trans-specific stressors.

b. The impact of transitioning on family relationships has not been articulated much in this document, as we have primarily focused here on the immediate responses of the family and on the need for their psychoeducation and dealing with their requests for conversion treatments.

c. This document does highlight a few relationship and couple concerns among TGD persons; however, the families of choice that TGD persons make, particularly in the absence of support from their families of origin, and which may be constituted in varying ways and may include persons not related by blood or marriage – these non-normative family structures have not been included in this document. Similarly, we have not engaged here with TGD person/s as parents, and their support needs in raising children.

d. Finally, although there is consensus on not using conversion treatments with TGD clients among MHP associations in India, there is an urgent need to develop some guidance document on ways of responding to these requests by TGD clients and their families that would help to build awareness, normalise variations in gender identities and expressions, deal with internalised trans-prejudice, and provide support to these individuals and families to move towards acceptance.
NOTE ON TERMINOLOGIES USED IN THE DOCUMENT

Literature on transgender health and mental health uses a number of terms to refer to persons whose self-defined gender identity or expression does not match the sex-gender assigned to them at birth. Some of the identity terms that have been used in literature to refer to transgender persons are also used in this document:

* Transgender Person – A person whose gender identity does not match with the gender and sex they were assigned at birth
* TGD – Transgender and Gender Diverse
* TGNC – Transgender and Gender Non-Conforming
* Trans person – A transgender person

A few other terms used in this document:

- Cisgender Person – A person whose gender identity conforms with the gender and sex that they were assigned at birth
- Gender incongruence – A marked and persistent incongruence between the gender felt or experienced by a person, and the gender associated by society with the sex they were assigned at birth
- Gender Dysphoria – The psychological distress that results from an incompatibility between a person’s self-perceived gender identity, and the gender associated with them by society based on the sex they were assigned at birth
- Gender Identity – How an individual defines their own gender, which depends on a person’s deeply felt internal experience of gender. It need not correspond with the sex assigned to the person at birth, and to the expectations that society has from this assigned sex or its associated gender. ‘Gender Identity’ is self-determined – that is, only the individual concerned can declare what their gender identity is. There is no medical or psychological test to determine a person’s gender identity
- Gender Transition Service – Includes services that help an individual affirm their gender identity, including social (clothes, hair, grooming, in ways that are perceived to be closer to the self-identified gender); medical (hormones, laser); surgical; and legal (changing name and gender on identity documents and certificates)
- Queer – An umbrella term used to refer to diverse sex characteristics, genders and sexualities that are not cisgender and/or heterosexual
- Passing – refers to a transgender person being correctly perceived to be of the gender they are, or identify with, and not being perceived as a transgender person or as a person with the gender identity assigned to them at birth.
- Ally – Someone who, while not identifying as queer themselves, is supportive of the rights of LGBTQIA+ persons and communities, and may also use their privilege/position in society to promote LGBTQIA+ rights.
Note on misgendering in quotes from participants

We have sought to retain verbatim the quotes from study participants, which has meant at times that if the participant misgendered a client or a patient or used statements like 'he became she', this has not been corrected by the authors. In a few instances, the practitioner self-corrected in the course of the interview, and that has been retained as well.
REFERENCES:


