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Trans-affirmative cognitive behavioural therapy

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Abstract

Transgender people experience negative prejudice, discrimination, and violence significantly more often than cisgender people. The minority stress model explains the impact of these experiences on the increased prevalence of mood disorders, anxiety, and suicidal behaviour, among transgender people compared to the general population. Cognitive behavioural therapy (CBT) is a widely used and highly effective method of working with people presenting symptoms of the above disorders. Trans-affirmative cognitive behavioural therapy (TA-CBT) has been adapted to the needs of transgender people — it takes into account the additional specificity of their development and experiences. TA-CBT is a model of short-term therapy that can be carried out in individual or group format. Clinical studies confirm the effectiveness of TA-CBT in reducing the severity of depressive symptoms. In addition, people who have completed TA-CBT think better about themselves than those in the control group, cope more actively with challenges, plan activities more effectively, and seek support. A major problem for transgender people is the low availability of tailored mental health services, and the dissemination of the TA-CBT model can improve this situation.

Keywords: transgender, cognitive behavioural therapy, affirmative therapy

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Transphobia and its depathologisation in psychology and medicine

Gender identity is a fundamental dimension of human sexuality. It is defined as an inner sense of gender, related to 'how I feel' and/or 'naming my own gender'. When there is a discrepancy between the gender felt and the gender socially assigned (usually based on the sex organs at birth), we speak of transgender identity. The aetiology of transgender identity appears to be multifactorial, with neurodevelopmental, genetic, and environmental factors influencing its formation. [1]. The DSM-5 classification introduced a new diagnostic entity, gender dysphoria, which replaced the previous gender identity disorder. Gender dysphoria was defined as a discrepancy between the sex experienced and the sex assigned at birth [2]. The above change is particularly important in understanding chronic suffering, the source of which is not transgender identity per se, but a sense of discrepancy between the gender experienced and its expression and the gender assigned at birth [3]. The ICD-11 also depathologises transgenderism by moving it from the classification of mental disorders to so-called sexual health conditions. The diagnosis of transsexualism is being replaced by a new diagnostic entity: gender incongruence which is defined as a persistent marked discrepancy between the experienced sex and the assigned sex, often associated with a desire to undergo hormonal, surgical interventions to conform one's body to the desired and possible extent to the experienced sex [4].

Transgender and co-occurring disorders — the minority stress model

The diagnoses that occur more frequently in the transgender group than in the general population are mainly anxiety disorders and depressive disorders [1]. The results of Polish studies indicate the prevalence of at least mild depressive symptoms in most LGBTA people, while the proportion of people with significantly increased depressive symptoms is more than 5 times higher than in the general population [5]. Studies conducted in the USA provide data on the prevalence of non-self-harming behaviour (42%) [6], suicidal thoughts (54%) [7], or suicide attempts (28–45%) by transgender

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people [7, 8]. Referring to Polish analyses from 2016, as many as 44.2% of LGBTQA respondents had suicidal thoughts [5]. Eating disorders are also observed more frequently than in the general population, which may be related to the desire to reduce muscle tissue in transgender women or the desire to reduce body fat and induce menstrual atrophy in transgender men [9]. A meta-analysis by Marshal and colleagues [10] found that among transgender adolescents in the US, rates of depression range from 28% to 60%, suicidal thoughts are reported more frequently than in non-LGBTQA+ adolescents, and suicide attempts are 3 times more common. A higher prevalence of social anxiety is also noticeable [11]. According to a Polish study, up to 70% of LGBTQA adolescents have contemplated suicide [5]. Importantly, studies show a significant reduction in psychopathology in transgender people following affirmative medical interventions carried out as part of gender reassignment [12]. The best empirically validated model for understanding the development of psychological distress in LGBTQ people is the minority stress model [13]. It explains the concept of minority stress by referring to its social origin, chronicity, and uniqueness (linking minority stress only to specific social groups). The most important assumption of the model is to understand the social situation in which people from minority groups live as exposing them to manifestations of hostility. Polish analyses show that as many as 78.6% of the surveyed population of transgender people have experienced various forms of violence. The most frequently mentioned were physical violence, sexual violence, threats, and verbal violence [5]. The author of the minority stress model distinguishes 2 groups of processes that influence the occurrence of minority stress in exposed individuals: proximal and distal. The former involves the thinking, emotions, and behaviour of the individual. It involves hiding one's orientation or gender identity from society, and the expectation of rejection and internalised homophobia, biphobia, or transphobia. Distal (external) processes refer to manifestations of aggression, discrimination, and overt hostility towards individuals belonging to minority groups. According to the model's assumptions, they are the basis for the resonance of proximal processes located in the individual's psyche [13].

Trans-affirmative cognitive behavioural therapy (TA-CBT)

Psychotherapeutic work with transgender people involves additional competences – in addition to specialist knowledge, it is important to have an affirmative attitude towards gender diversity, to be aware of one's own beliefs about gender roles, sex, and the privileges of cissexuality, i.e. the state of congruence between the socially assigned sex and the perceived gender identity [9, 14]. The aim of psychotherapeutic work with a transgender person is most often to support issues related to social or medical transition (the process of reconciliation between the ascribed/biological sex and the perceived sex) and to work on co-occurring disorders with transgenderism [15]. Unfortunately, access to competent professionals and evidence-based affirmative interventions for transgender people to improve mental health coping is limited [16]. LGBT+ people in Poland face difficult access to medical care or unqualified staff. Following stereotypes or prejudices and a lack of sexual health knowledge remain a major problem. A Polish study found that as many as 83% of doctors and 51% of psychologists encountered by transgender people did not have adequate knowledge in the area of gender identity [17]. Approximately 43% of respondents faced discrimination in the use of medical services, the most common behaviour being to question their gender identity [17]. One in 5 transgender people were persuaded in psychological visits to accept the gender assigned at birth [17]. Transgender people also point to the incompetence of the person diagnosing them or making general diagnoses such as gender identity disorder [15].

The effectiveness of cognitive-behavioural therapy (CBT) has been confirmed in the treatment of disorders frequently affecting the transgender group, including anxiety, mood, substance abuse, PTSD, self-harm, and suicidal behaviour [8]. In contrast, trans-affirmative cognitive behavioural therapy (TA-CBT) additionally takes into account the specificity of the developmental experiences and functioning of transgender people, e.g. the impact of minority stress on the formation of negative beliefs and maladaptive coping strategies (Fig. 1).

The specific experiences of transgender people and their possible impact on experiencing chronic stress, symptoms of mood disorders, anxiety, powerlessness, engaging in suicidal behaviour should be taken into account when collecting the interview, creating a conceptualisation (a way of understanding the patient's problem), and planning therapy. As part of the interview, detailed information on the following should be collected:

— early memories of recognising and experiencing one's own transsexuality, the reactions of others to its manifestations, and the meaning given to them by the individual;
— messages coming from the environment (family, peers, school, media, places of worship) about gender and gender roles;

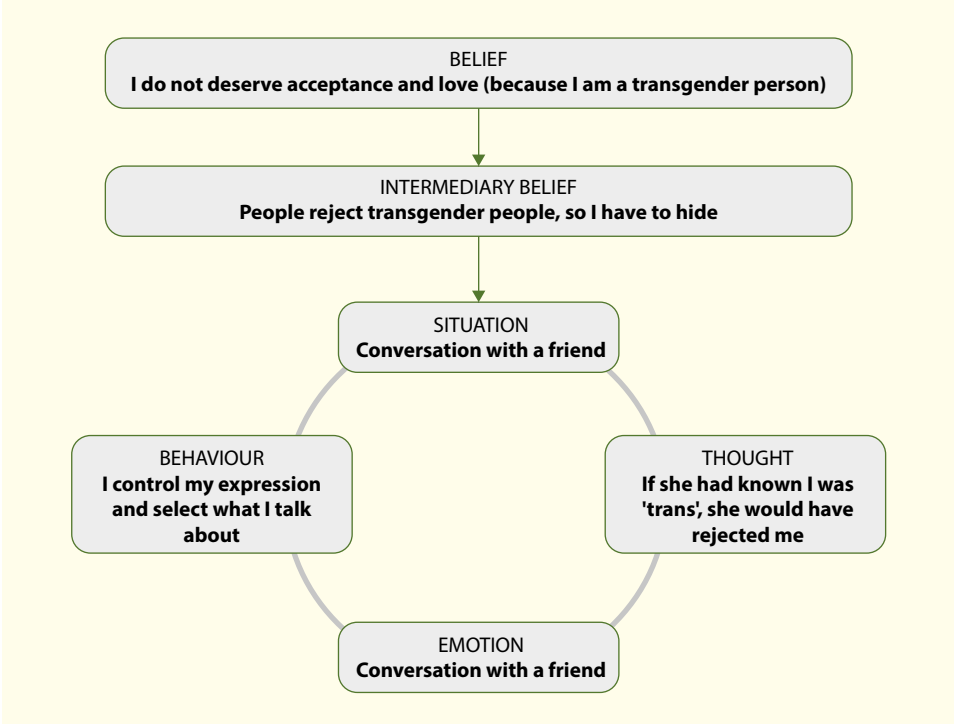

Figure 1. Example of conceptualising a patient's problem. Source: own elaboration

— specific stressors related to transgender — anxieties about coming-out, transition (the process of realigning one's perceived sex with one's assigned sex) socially and medically;
— elements of the transition that cause the most stress;
— unexpected stressors of post-transition life;
— specific stressors of non-binarity;
— experiences of discrimination and violence [8].

The main aims of cognitive work are to change maladaptive ways of thinking, to question, discuss, and reformulate automatic thoughts, mediating and core beliefs with special attention to content that may be derived from experienced minority stress, discrimination, or violence. In the area of behavioural work, activation is an important element (especially with mood and anxiety disorders). The difficulties in working with the often-traumatic experiences of transgender patients may be due to their lack of ability to self-regulate their emotional states. The therapy plan should therefore include learning self-regulation strategies, e.g. breathing training, progressive muscle relaxation training, or mindfulness. An important element is also building resilience. At the same time, when planning interventions, e.g. behavioural experiments or social exposure, the therapist needs to be careful, knowledgeable about the patient's environment, and sensitive because there is a higher risk of the patient being exposed to experiences of rejection or violence than in the cisgender population [18].

Austin and Craig [19] proposed a plan for trans-affirmative cognitive-behavioural therapy (see Table 1), which includes 8 meetings. Each session includes the following:
— introduction, building of the therapeutic and group relationship, reference to previous meetings and discussion of the patients' own work assigned at the previous meeting;
— setting and briefing of the objectives of the current meeting;
— psycho-education related to the topic of the current meeting;
— practising new skills;
— summarising and setting own work for the following week between sessions (homework).

Clinical studies have shown significant efficacy of therapy based on the above protocol [20, 21]. Individuals in the clinical group compared to those in the control group had lower levels of severity of depressive symptoms, perceived stressful events as challenges to a greater extent and better assessed their resources for coping, coped more actively with challenges, sought social and instrumental support more effectively, and planned activities. The effectiveness of the above protocol has been confirmed in group and online therapy work with adolescents and young adults [20, 21]. This method allows a wider range of patients to access treatment due to its short-term, group, and online options. Its characteristics translate into a lower

Table 1. Therapy plan in the TA-CBT model

No.	Objectives	Tasks
Session 1	Psychoeducation on the CBT model and minority stress	Discuss the theoretical assumptions and practical applications of CBT. Discuss the phenomenon of stress and the specifics of minority stress. Discuss the causes of stress in life.
Session 2	Understanding the impact of anti-LGBTQ+ attitudes on behaviour and stress	Discuss the phenomena of homophobia, transphobia, heterosexism at individual, institutional and cultural levels and their impact on thoughts, feelings, and behaviour. Learn strategies to deal with discrimination.
Session 3	Understanding the influence of thoughts on emotions	Distinguish thoughts from emotions. Discuss the impact of thinking on feeling and behaviour. Identification of non-adaptive ways of thinking. Learn to recognise negative and self-critical thoughts. Learn to work with thoughts.
Session 4	Using thoughts to change emotions	Discussion technique with thoughts. Seek more adaptive and positive ways of thinking. Work with beliefs linked to internalised transphobia through the discussion method with thoughts, e.g. automatic thought — "if a friend knew I was trans, she would reject me". Sample discussion questions with a thought: "What evidence do I have to believe that?" "Do I have any experience that contradicts this thought?" "Does this thought help me?" "Even if this thought is true, what could be the worst consequences?"
Session 5	Understanding how behaviour affects emotions	Discuss the impact of behaviour on emotions and well-being. Identify supportive activities (e.g. physical, social, pursuing interests, doing things one enjoys) and exploring their impact on emotions.
Session 6	Work with breaking the pattern of maladaptive thinking and negative emotions	Distinguish between realistic and unrealistic goals. Set short-, medium-, and long-term goals. Strengthen a sense of agency and hope.
Session 7	Understanding the impact of minority stress on social attitudes and behaviour, relationship building	Discuss the negative consequences of minority stress on building social relationships, e.g. feeling uncomfortable in social situations. Learn to be assertive.
Session 8	Developing support networks	Discuss the impact of having supportive, secure relationships on the way you think, feel, and behave. Create a plan to build your own support network.

Source: own elaboration based on Austin and Craig [20]

cost of participation and less burden associated with potential long-distance travel to psychotherapy. The authors indicate that further research should compare the effectiveness of TA-CBT with classical unadapted CBT protocols [21].

Conclusions

Due to the high prevalence of anxiety disorders, mood disorders, self-aggressive and suicidal behaviour among transgender adolescents and adults, it is important for this patient group to have access to effective mental health tools. Cognitive behavioural therapy is a method the effectiveness of which in working with people experiencing the aforementioned disorders has been empirically verified and well documented. CBT helps not only to reduce the severity of the symptoms of the disorders, but also to change dysfunctional beliefs and develop a more realistic (usually more positive) view of self and others. The knowledge of the techniques used and the skills learned help to address problems that arise even after therapy, which strengthens the patients' sense of influence over their own lives. Trans-affirmative cognitive behavioural therapy (TA-CBT) has been further adapted to the specificities of working with transgender people, and its effectiveness has been positively verified. It offers hope for improving transgender patients' access to tailored mental health services.

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Conflict of interest

The author declares no conflict of interest.

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