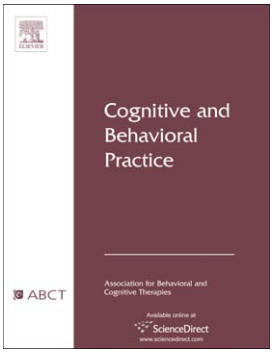

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Treating Transgender Individuals in Inpatient and Residential Mental Health Settings

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Abstract

This article describes the need for specific guidelines regarding how to manage inpatient and residential mental health programming with respect to transgender individuals. The article discusses what is known about transgender mental health and how it is related to sociopolitical factors, how inpatient and residential programs can address the impact of sociopolitical factors on transgender individuals and send a welcoming message to prospective consumers, how programs can attend to policies and procedures in ways that create the best milieu for an inpatient or residential unit that provides care for one or more transgender individuals, and how providers and interdisciplinary teams can meet the unique clinical needs of transgender individuals. These guidelines are designed to assist providers in creating a safe environment that affords quality inpatient and residential mental health care to transgender individuals.

Keywords: transgender; inpatient; residential; mental health

Transgender individuals have recently received more attention in the public eye: prominent Olympic athlete Caitlyn Jenner has identified as transgender, and the military recently lifted its ban on transgender individuals serving in the armed forces. This previously invisible community is now becoming more visible, and may be more willing to present for health care needs, including mental health care, in the future. However, little guidance exists in current literature regarding how best to integrate transgender individuals into inpatient and residential mental health units and programs. This is particularly important given that transgender individuals have an increased need for mental health care compared to the general population, largely due to the impact of discrimination and minority stress, including greater prevalence of specific conditions that might warrant an inpatient hospitalization or a residential treatment program (e.g., suicidality, substance use disorders; Johnson, Shipherd, & Walton, 2016).

The need for specific guidelines regarding how to manage inpatient and residential mental health programming with respect to transgender individuals is particularly important because these treatment settings differ in significant ways from outpatient settings, particularly with respect to the fact that individuals reside within the treatment program or facility. Patients and staff members are in more continuous, often daily, contact with one another and interact around a broader range of issues than merely the content of their treatment (e.g., adjusting to roommates and community living). Patients share space more intimately than in a waiting room and confront a broader range of interpersonal situations than in a group therapy session. These settings therefore offer a set of unique challenges and opportunities for transgender individuals and their providers.

In order to manage these more complex elements of treatment, inpatient and residential treatment programs create policies around program size and staffing, services offered, patient expectations, and treatment orientation, among others, and these factors can predict patient outcomes (Moos, King, Burnett, & Andrassy, 1997). Inpatient psychiatric and residential programs often differ even amongst themselves in terms of factors such as admissions policies, expectations regarding residents' behavior, the manner in which patient policies are communicated to patients, individual choice and privacy, and daily living assistance, all of which can relate to program-level outcomes (Timko, 1995). Scant research exists regarding the experiences or outcomes of transgender individuals in inpatient hospitals or residential programs. One qualitative study of transgender individuals' experiences in residential addiction treatment settings indicated that participants who felt stigmatized left treatment prematurely (Lyons et al., 2015). The authors noted that, in contrast, study participants who reported having felt included and respected in treatment settings reported positive treatment experiences. The authors observed that their findings illustrate the need for gender-based, antistigma policies and programs to be established within existing treatment programs.

In creating policies and structuring programs to be welcoming of transgender individuals, it is crucial to examine how systemic and sociopolitical factors, unit and program factors, the content of treatment, and provider teamwork may impact transgender individuals in inpatient and residential settings. We will discuss: (a) what is known about transgender mental health and how it is related to sociopolitical factors, (b) how inpatient and residential programs can address the impact of sociopolitical factors on transgender individuals and send a welcoming message to prospective patients, (c) how programs can attend to policies and procedures in ways that create the best milieu for an inpatient or residential unit that provides care for one or more transgender

individuals, and (d) how providers and interdisciplinary teams can meet the unique clinical needs of transgender individuals. While some of the recommendations may be applicable to any inpatient setting (e.g., a medically oriented setting), we highlight the unique needs of transgender individuals with regard to their mental health, and how the unique milieu of an inpatient or residential mental health setting can address those needs.

Transgender Mental Health and the Impact of Discrimination

It has been clearly documented that transgender individuals have higher rates than the general population of certain mental health conditions, including higher rates of depression (Fredriksen-Goldsen et al., 2014), PTSD (when compared to other traumatized populations; Shipherd, Maguen, Skidmore, & Abramovitz, 2011), nonsuicidal self-injury (dickey, Reisner, & Juntunen, 2015), and suicidality (Clements-Nolle, Marx, & Katz, 2006). The discrepancy is even more pronounced among subgroups resulting in more than one minority status, such as women and people of color (Jefferson, Neilands, & Sevelius, 2013), individuals with disabilities (James et al., 2016), and veterans (Blosnich et al., 2013).

The higher rates of these disorders appear to be largely related to experiences of discrimination and stigma. For example, Shipherd et al. (2011) noted that among the transgender research participants in their study who had potentially traumatic experience exposures, 42% reported that at least one event was transgender-bias related. Another study examined stigma as a risk factor for suicide attempts among transgender adults and found that lower levels of structural stigma (i. e., the local climate, including higher density of same-sex couples in the area, prevalence of gay-straight alliances at local high schools, and existence of anti–sexual

orientation discrimination policies) were associated with fewer lifetime suicide attempts (Perez-Brumer, Hatzenbuehler, Oldenburg, & Bockting, 2015). Similarly, in a national sample of transgender veterans, transgender-related stigma felt during military service was correlated with rates of past-year suicidal ideation as well as history of suicide plan or attempt (Lehavot, Simpson, & Shipherd, 2016).

The above findings are consistent with the minority stress model, initially posited by Meyer (1995) in relation to gay men, and later adapted by Hendricks and Testa (2012) to apply to transgender individuals. The minority stress model proposes that the higher incidence of mental disorders found among the transgender population is related to correspondingly high rates of discrimination, violence, and rejection related to their gender identity or expression. This may include direct traumatization as well as the structural stigma described above. Crenshaw's (1989) theory of intersectionality also posits that overlapping or intersecting social identities intersect to form a unique experience of oppression or discrimination, which, when combined with the minority stress theory, supports the above findings that subgroups of transgender individuals experience increased psychological distress, and furthermore, that the experiences of multiple marginalization are more than additive (Jefferson et al., 2016).

Recent support for the minority stress model can be found in a study demonstrating the effects of statewide nondiscrimination laws on mental health outcomes. Participants who lived in states without nondiscrimination laws reported higher levels of perceived community stigma, which was positively associated with reports of lifetime discrimination and victimization, related to anxiety symptoms, and related to the odds of reporting a lifetime suicide attempt (Gleason et al., 2016). In sum, all evidence suggests that transgender individuals experience high rates of

mental health concerns, and that their distress is related to personal experiences of stigma, violence, and trauma, as well as the cultural climate.

Creating a Welcoming Environment

Despite this strong need for mental health care compared to the overall population, transgender individuals have reported that previous negative experiences are a barrier to health care utilization (Shipherd, Green, & Abramovitz, 2010). Previous research has documented transgender individuals' experience of insensitivity as well as outright discrimination by health care providers (Bockting, Robinson, & Rosser, 1998). One third of transgender individuals who responded to the U.S. Transgender Survey had at least one negative experience with a health care provider, such as being harassed or refused treatment due to their transgender identity, in the year prior to completing the survey, and 23% of respondents reported that they did not seek health care in the year prior to completing the survey because they feared mistreatment based on their transgender identity (James et al., 2016). Another study reflected that transgender people were deterred by intake forms that are not representative of their gender identities, and by hostile treatment from previous providers (Mollon, 2009). As a result, many transgender individuals are reluctant to engage with mental health providers (American Psychological Association, 2015) and have reported delaying their health care; those who had to educate health care providers about transgender people were four times more likely to delay their care (Jaffee, Shires, & Stroumsa, 2016).

It stands to reasons that, given the level of intensity of inpatient and residential programs, transgender individuals may be at least as likely, if not more likely, to fear or avoid engaging in

such treatment. However, many steps may be taken to address transgender individuals' concerns about engaging in treatment and to encourage individuals to consider a facility or program, as well as to create a welcome environment once they arrive. With regard to increasing potential patients' willingness and confidence to consider the treatment, it is essential that each inpatient and residential program create a nondiscrimination and inclusiveness policy that includes transgender individuals (if not already in place), and publicize the policy. Avenues also exist to obtain recognition for offering LGBT-patient centered care; for example, hospitals and other health care facilities can utilize a benchmarking tool such as the Healthcare Equality Index (Human Rights Campaign, 2016) and can publicize being recognized as a leader in LGBT health care.

It also is important to evaluate any area in which a prospective patient may spend time (e.g., emergency room, waiting room, offices, and the residential/patient areas themselves), and demonstrate in these areas that transgender individuals are welcomed. Hospitals and programs can display posters or brochures that explicitly welcome transgender or LGBT individuals, and include depictions of diverse individuals. For example, at the VA facility where the authors practice, the facility hangs posters that state, "We serve all who served," with a depiction of rainbow-colored dog tags. Intake forms and processes also should be inclusive of transgender identity. On forms and in interviews, individuals should be asked their self-identified gender as well as birth sex. Self-identified gender should include nonbinary response choices, such as *gender fluid/nonbinary, gender questioning, none/agender, transgender (female to male), transgender (male to female), and other,* and everyone should be asked how they identify so as to avoid relying on your assumptions or singling people out. Providers also should use gender-neutral terms for relationships (e.g., *relationship partner,* instead of gender-specific titles such as

husband or *wife*), and ask about both sexual orientation identity (e.g., straight, gay, lesbian, bisexual, other/none), as well as ask descriptively about sexual behavior (e.g., "Do you have sex with men, women, neither, or both?"), as individuals' self-identified sexual orientation is separate from gender identity, and sexual behavior may or may not correlate with self-identified sexual orientation.

Transgender individuals can also be made to feel safe and welcomed by policies designed to protect them. It's important to review confidentiality policies with transgender individuals and to assure them that their identifying as transgender will be kept confidential unless they choose to self-disclose. This can occur during the intake/acceptance process and/or at the time of admission, depending on the nature of the program/unit and how admissions occur. For example, in one author's women's program, she explicitly states during the screening process that because the program is gender-specific, residents are treated as female in every aspect of the treatment, and that transgender status is not disclosed to anyone at any time. She adds a statement like, "Staff will know your identity and will be available to support you in any way you need, but the other program participants will not know what you don't tell them. You will be living with other women and have a roommate and it will be up to you to choose what, if anything, you disclose about yourself, and if so, when and how you disclose it."

It also is recommended to establish and communicate a policy regarding documentation, if feasible for your agency, that patients' names and pronouns used in documentation should be consistent with the individual's self-identified gender and preferred name, even if this is not consistent with their legal name or sex. Especially if individuals' medical records are shared among providers, departments, or other entities, as they are in the VA system and other large medical systems, transgender individuals may have concerns about discrimination from other

providers and may feel safer if they are asked permission before documenting their transgender identity in the medical record. Finally, a unit or program should establish and communicate a visitation policy that anyone who is considered family, whether or not that person is legally family, should be permitted to visit, unless there are other clinical contraindications. For example, one of our hospital policies states that we allow for "a same-sex partner, family member, friend, or other individual to be present with the patient for emotional support during the course of their stay. This may include multiple individuals unless otherwise limited by other hospital policies for health reasons (e.g., for health reasons in intensive care unit). Visitors will not be discriminated against based on perceptions of their sexual orientation or gender identity or relationship status to the veteran, as this can adversely impact the healthcare system and our patients."

We also recommend working at the program or facility level to evaluate and, if necessary, improve provider education and training. All staff members who will potentially be involved in providing treatment or support services to transgender individuals need to receive education regarding relevant aspects of their care. It is not appropriate for transgender consumers to need to educate their providers (for example, for providers to ask transgender consumers about definitions of terms [e.g., gender queer] or to tell them about hormone therapy). For inpatient and residential programs, it is important to include not only licensed clinicians but all staff who might have contact with transgender individuals (e.g., dorm supervisors or support staff). Often, staff members with the least clinical training have the most direct contact with residents, and their training therefore may be of particular importance. Offering training opportunities to all staff can assist them in feeling more prepared and confident, which creates a more positive environment for transgender individuals and the program or unit as a whole. If facilities do not

have anyone with the expertise to provide such training, we recommend looking to the broader community to gain it. This could include utilizing online trainings and resources, especially if local face-to-face resources are not readily available in your area.

Regardless of professional role or background, or even exposure to training, situations may still arise in which staff members feel uncomfortable or unprepared. Staff members therefore also should be coached to seek additional guidance and training when needed. Supervisors and directors can create a safe environment to do so by reacting to staff concerns supportively and nonjudgmentally and by encouraging active involvement in problem solving.

Managing the Milieu

A welcoming environment with a trained staff and clear policy guidelines are all necessary to set the stage for a positive treatment experience for transgender individuals, but further steps also must be taken to ensure that the milieu of an inpatient or residential program is a supportive one. Specifically, attending to environment of care, conveying additional policies and community expectations to all patients, assessing individuals for appropriate placement, and developing a positive attitude all contribute to the shaping of a welcoming milieu.

Environment of Care

In both inpatient and residential settings, binary gender designations play out in more structurally significant ways than in outpatient settings. Units are almost universally set up according to the designations of male and female in terms of room, bathroom, and roommate

selections. There may be separate wings, corridors, or community spaces where individuals are segregated according to binary gender. Entire programs or units may be designated as either all-male or all-female. While cisgender individuals may feel that the provision of separate spaces affords them a measure of physical, psychological, and emotional safety, transgender individuals may find that these structural designations can represent obstacles to accessing care that fits their needs. It is important to consider that these kinds of settings provide more opportunities to replicate real-life experiences of discrimination and stigma, or of welcoming and support, than the waiting room or offices of an outpatient setting.

In addition to the policies described earlier, unit or program policies for the treatment of transgender patients should be developed to guide decision-making regarding the environment of care. Transgender individuals should be assigned housing according to their self-identified gender, including room assignment, roommate assignments, and use of bathrooms and community spaces. Transgender individuals should be referred to by their preferred name, pronouns, and self-identified gender by all staff at all times in both conversation and documentation. If preferred name or pronouns are unknown, best practice is to simply ask the person. The individual's self-identified gender should be used in applying any program policy, including regarding supervision of urine toxicology screens. (For example, if the policy is that a staff member supervises a patient of the same gender, then the staff member supervising a transgender individual should be the same gender as that individual's self-identified gender, regardless of sex or anatomy. Alternatively, where possible, every patient—whether or not transgender—may be offered a choice regarding the gender of the provider who supervises.)

Communication of Nondiscrimination Policy

A concern often raised regarding the placement of transgender individuals is how the other residents will react to sharing a room, bathroom, or community space with a transgender individual. One step that has proven helpful in residential settings is to inform all potential residents, prior to admission, that the program has a nondiscrimination policy and provide them with a clear statement of what that may mean in terms of their experience while in treatment. The following is an example of a question that is part of the screening process for all applicants to a female-only PTSD/SUD residential treatment program within the VA: *Our program admits women veterans and assigns roommates without regard to race, ethnicity, religious beliefs, sexual orientation, or birth sex. Would you be able to tolerate such differences without becoming unduly distressed or critical of others?*

Presenting this information to every individual prior to their being admitted accomplishes a number of important goals: It conveys to prospective patients who identify as transgender that the program does not tolerate discrimination, it conveys clear expectations to cisgender individuals that allow them to make a choice prior to entering the program about whether they are willing to be welcoming themselves, it lets all patients know that the program will expect them to be tolerant of diversity if they do choose to come, and it provides a clear policy to refer back to in the event that another patient behaves in an unacceptable manner. If a given individual demonstrates intolerance in their attitude or behavior, the program can be clear that it is that individual who will need to adjust to the situation and, ideally, use it as an opportunity for their own growth. In cases where staff and patients may not have a choice regarding whether or where a patient is admitted (for example, if a patient is in crisis or at risk of harm to self or others and requires an inpatient hospitalization), a nondiscrimination policy can still be communicated and

enforced. For example, an individual behaving in an intolerant fashion can be directly confronted with the fact that their attitude or behavior is in conflict with unit policy, can be separated from the transgender individual, and can be monitored to ensure the behavior does not occur again.

Assessing Individuals for Placement Within a Treatment Program

Even when policies are in place, transgender individuals seeking admission to inpatient or residential programs are faced with a decision regarding where to place themselves within a treatment setting. Due to the binary nature of our culture, including most of our mental health facilities, individuals typically have to choose to identify as either male or female. For individuals whose gender identity is uncertain, nuanced, or fluid, being forced into a binary choice may be a source of significant stress in the context of already being in need of intense mental health care. Utilizing these decision points as opportunities to address the individualized needs of transgender individuals in clinically meaningful ways can set a positive tone for the rest of treatment. Whether or not the individual has any gender dysphoria, the process of residents being able to make their own choices can set a welcoming tone and provide the best chance of maximizing the person's comfort within the environment.

In assessing the best fit within the existing structure of a treatment setting, providers can begin by asking whether the individual identifies with a specific gender. Providers can also clarify that individuals may prefer to identify differently in different settings (e.g., a transgender individual may want to identify as the gender they are internally comfortable with during treatment, but may not be ready to transition outside of treatment), and collect information about the nuances of their preferences. This may be particularly relevant if and when family contact or

discharge planning occurs. Ideally, this information would be collected for all prospective patients, as noted earlier. If so, the clinician should then explore the individual's level of comfort and identification with their stated gender preference. If the individual expresses that they are comfortable with their self-identified gender, then the clinician can describe the treatment and facilities available for individuals of that identified gender. For example, a transgender individual who self-identifies as female would be given information about where the women are housed within a unit and what facilities and services are available for females.

Most acute inpatient admissions occur in the setting of a crisis that may not allow for an extended decision-making process. In these cases, helping the transgender individual establish a sense of physical, psychological, and emotional safety as they enter the treatment setting may be the only priority. In addition to providing a welcoming physical environment, interventions should be aimed at validating concerns and alleviating fears that might represent obstacles to engaging in treatment. Transgender individuals can and should still be housed according to their self-identified gender, and, if uncertain about identity or do not identify as either gender, may be provided with detailed information regarding the options available, including options for a private room or bathroom, if available, or any other available options. In at least one case on our hospital's acute inpatient unit, a patient was admitted several times and presented with a different self-identified gender identity during different admissions. During each admission, the patient was asked to follow the gender-based guidelines for that admission (e.g., using the women's day room during an admission when identifying as female, while avoiding it during an admission when not identifying as female).

In any setting, it also is helpful to explicitly acknowledge the systemic limitations of the binary housing system and to validate the inherent stress and difficulty in having to choose a

gender-based treatment or room selection. Addressing this with the individual could provide support to the individual and may promote therapeutic relationships with providers. It may be helpful to offer a statement such as, "In this program [or hospital, etc.], like many other systems, residence is set up according to gender. I'm sorry that you have to make a gender-based selection at all. For many people, it can add unnecessary stress to the treatment process. We hope that gender will be less relevant to placement in the future, but in the meantime we will work with you to make you as comfortable as possible in making your choice and residing according to your self-identified gender."

Residential treatment settings present more opportunities for exploring the appropriateness for admission, including what action to take if a resident expresses feeling uncertain about gender identity, or does not identify as either male or female. Admission to a residential program usually involves a more extended screening or admission process than is possible with inpatient admissions. The general purpose of the screening process is to ensure that the program is an appropriate match in terms of the level of care and the treatment focus. Additional aspects of the screening may include the reasons the individual is seeking a particular form of treatment at this time, their immediate and long-term goals for treatment, and their capacity to function successfully within the milieu (e.g., living with others, participating in groups, maintaining sobriety, managing behavior). Transgender individuals who are considering residential treatment, and the providers who are evaluating them, also have a chance to explore comfort with, and preferences for, co-ed versus male-only versus female-only programming.

A guiding principle in this decision-making process should always be the transgender individual's current beliefs about what they need in terms of their physical, psychological, and emotional safety. Transgender individuals may need to be reassured that this choice is one step in

the treatment process and that there will be ongoing support to help them reassess and navigate through further steps of treatment. Whatever decision individuals make, they can be reassured that it is not final. If it turns out that, for their own reasons (i.e., not due to the behavior of other residents), the individual feels uncomfortable with their choice once they have been admitted to a program, they can be offered support in making a decision about whether to remain in the program or seek an alternative. If the screening process uncovers that perhaps a given individual is not comfortable with the available setting, this in itself may be therapeutic and allow that individual to find a different placement that is more comfortable. For the most part, however, the screening process should be utilized to convey how a transgender individual would be made to feel safe and accommodated (as opposed to sending the message that the person has to conform to the program or that the person should look elsewhere if it doesn't feel like a perfect fit). This can include, but should not be limited to, conveying the policies noted above, including nondiscrimination, visitation, and confidentiality policies.

Managing Provider Expectations and Patient Conflicts

Provider concerns often parallel those of transgender individuals in that providers also wonder how transgender individuals will be integrated into inpatient and residential treatment settings (e.g., how well will they be accepted by other residents of the unit or program, and what to do if they are not). One of the authors' all-female residential PTSD/SUD program admits male-to-female transgender individuals who have not had any gender-confirming surgeries (because surgeries may or may not be part of someone's transition, and may or may not be important to someone in reflecting their self-identified gender). When initially presented with

this policy, many staff members expressed reservations about whether and how this would work. What would happen if we were to place an individual with male genitalia in the same room as a woman who had been assaulted by a male perpetrator? Although we notified transgender individuals that their identity would be kept private, and had asked the question in the interview about acceptance of those with a different gender identity, we weren't specific about such details. Confidentiality rules would not allow us to discuss the issue with a transgender individual's potential roommate. Staff members from that program as well as from the other author's inpatient units were concerned about potential problems, but after 10 years of applying a hospital-wide, transgender-affirmative treatment policy, fears regarding a negative outcome have been unfounded.

The authors' units/programs have avoided problems likely because of several factors, including that (a) individuals often do not even realize that a fellow resident is transgender (in the women's program, at least three transgender individuals completed the program that, to the providers' knowledge, the other residents never even knew were transgender), (b) providers can establish and maintain an environment of respect, (c) patients make positive connections that override other concerns, and (d) individuals respect one another as fellow patients with similar struggles despite their differences.

In our hospital, the avoidance of problems may also relate to the residents sharing a veteran identity in which they learned to protect one another. However, residents also develop a strong sense of connectedness based on shared struggles, for example, addiction and the aftermath of traumatic experiences. The power of these connections has tended to decrease differences based on identity, including transgender identity. Future research is warranted to explore, and perhaps learn how to build, that type of rapport between program residents.

The few complaints or concerns we have heard involved cisgender residents discussing their concerns with staff, not causing conflict with fellow residents. For example, nursing staff members on our acute inpatient unit have fielded concerns or reports about there being a man in the women's day room, on occasions when a male-to-female transgender individual may have outwardly appeared to others as male. Nursing has responded with a statement such as, "We know that individual is in that room. We can't discuss other patients with you, but we can tell you that we are aware of where patients spend their time and ensure that no one is in a place where they do not belong." On another occasion, a resident of the acute inpatient unit was moved to accommodate a transgender individual who was given a private bathroom. That resident complained during an individual psychotherapy session about being moved and referred to the other resident in a derogatory manner. The resident who complained was reminded that all patients' individual needs are accommodated as much as possible, and that the other resident's specific needs could not be discussed, but that we need to try to respect all patients and their needs. The resident who complained was reminded that in fact she herself had many needs that she felt were not being met, and was encouraged to put herself in the other patient's shoes, and her own needs were explored. In this way, the complaint was actually used therapeutically to explore that resident's feelings about her own unmet needs.

While these types of concerns have arisen over time, we recommend that inpatient and residential program providers expect their residents to make positive, rather than negative, connections while in the unit or program. If providers seem fearful or judgmental, they may be setting up a negative climate and the expectation of conflict; however, if they seem positive and accepting, that attitude likely will be reflected in the residents' interactions.

The Content of Treatment

Mental health concerns endorsed by a transgender individual may or may not be related to their gender identity (American Psychological Association, 2015). The mental health needs of transgender individuals typically reflect many of the same areas of presenting complaints (e.g., anxiety disorders, depression, substance use) as in the general population and may be secondary to, or unrelated to, transgender identity (Shipherd et al., 2010). Previous research has established that cognitive behavioral interventions are effective in inpatient settings (Peters & Kanas, 2014) as well as in residential settings (e.g., programs that focus on treating PTSD or substance use; e.g., Alvarez et al., 2011; Greenfield et al., 2004). In some cases, an individual's self-identification as a transgender individual may have little or no bearing on the treatment.

During a screening or admission process, or after admission to a unit or program, we recommend assessing a transgender individual's presenting needs or concerns as you would with any patient, while also making sure to assess for presenting problems that are known to be more likely to occur in transgender individuals, including history of physical or sexual assault or violence, substance use (often used as a way of coping), and suicidality (Bockting et al., 2013). Endorsement of those or any other presenting concerns may be used in formulating an appropriate treatment plan. It also is important to assess whether gender dysphoria is present. This may include asking or observing if individuals have a clear sense of their self-identified gender, and if they experience distress related to their gender identity or body or to how others react to them. It is important not to "out" a transgender individual by openly discussing or treating their gender dysphoria in groups or other public settings, but individuals who communicate distress regarding their identity often benefit from individual interventions (e.g., individual psychotherapy, if available).

While the program or unit's standard treatment is generally appropriate for transgender individuals, there are a few important factors to consider when providing treatment. One important difference between cognitive behavioral therapy for the general population versus for transgender individuals is the fact that transgender individuals' negative thoughts, beliefs, and expectations are, in many cases, realistic. Most mental health consumers, including transgender individuals, have a life history that includes negative experiences that contributed to the formation of negative cognitions. The key difference in working with transgender individuals is that some of those cognitions have a higher likelihood of continuing to be realistic. For example, as noted earlier, transgender individuals are genuinely likely to experience discrimination or even violence, and therefore may have thoughts such as, "The world is dangerous." In such cases, it is important to validate the individual's thoughts, beliefs, and expectations. At the same time, the individual does not have to remain stuck in hopeless, negative thoughts.

In our clinical experience, transgender individuals often benefit from an exploration of how they can maximize their personal control or sense of control. For example, one of the authors worked with a transgender individual who wanted to meet new people through a website for meeting new friends and engaging in shared activities but was concerned about both her safety and the reactions that others might have toward her appearance and her identifying as transgender. We reviewed that she could minimize potential danger by arranging a public meeting location and increase her sense of control by managing her own transportation and having an "escape route" in mind (e.g., one time she rented a car and reassured herself she could leave at any time; at other times, she relies on public transportation and makes sure she knows the schedule and the system well enough to navigate it adeptly when needed). In this way,

therapy can still challenge all-or-nothing beliefs (e.g., "I will be in danger"), even when risks are real.

Another way to approach realistic concerns is to challenge individuals' beliefs about the worst-case scenario. For example, as noted above, there is an actual likelihood that a transgender individual may be at risk of discrimination. As long as the individual's basic safety is not in question, the individual can work on skills to problem-solve how they might encounter discrimination in a given situation they may be considering (e.g., a date, a job interview), and also work on skills to avoid internalizing any negative feedback they receive. If personal safety genuinely is in doubt, then therapy skills can focus on problem-solving (e.g., how to avoid a potentially dangerous situation). This may overlap with other types of therapy that may already be part of an inpatient or residential program (e.g., relapse prevention skills or interpersonal dialectical behavioral therapy skills; e.g., Linehan, 1993).

Another key point is that the reality of experiencing discrimination may make challenging negative cognitions more difficult. For example, when working with an individual with low self-esteem, we might include feedback from others as evidence for or against their beliefs, and encourage them to surround themselves with supportive others. As a transgender person, there is often overwhelming negative feedback, and an inability to control how others react, especially if the transgender identity involves a nontraditional appearance that others may react negatively to. In these cases, providers can use the milieu as a tool.

A unique benefit of inpatient and residential treatment is that individuals live in community with one another. Provided the program has taken policy and programming steps for making it a safe place, the community and the process of living in it—both formally, e.g., in

therapy groups, as well as informally, e.g., during free time spent together socializing or engaging in activities of daily living—can serve as part of the treatment. One study focusing on effective ingredients of a residential program for PTSD in the VA noted that providers cited the therapeutic milieu as one of the most effective elements of residential care (Cook et al., 2014). All residents of such programs may have the chance for a corrective emotional experience, and it is especially true for transgender individuals. Transgender individuals have the chance to experience positive interpersonal interactions with others that can challenge negative beliefs about what to expect from others as well as regarding their self-esteem. If and when it's possible to discuss this privately with a transgender individual (e.g., during an individual therapy or case management meeting), it may be helpful to point this out explicitly. We have heard from our own transgender residents that they experienced a sense of belonging, and that they had a chance to explore and solidify their gender identity by socializing with other members of their self-identified gender, in some cases even learning new skills related to their self-identified gender, such as hairstyles or makeup tips. For example, one transgender individual who attended our women's program was afraid to go out in public dressed as a woman prior to her residential stay, and in previous treatment had been forced to wear a nametag with her former, male name. Being welcomed and housed in a women's-only program allowed her to explore and feel safe presenting as a woman. She disclosed her identity to other residents, who provided support and practical tips in clothing and makeup. She reported that she felt safe in her identity for the first time ever. Providers can explore with a transgender individual what positive interactions they've encountered during their treatment, with staff members and/or with other residents, and discuss that as evidence of the individual's worth, of the validity and possibility of self-identified gender, and of the possibility for further, future positive interactions. At the same time, it is also

important to recognize if a transgender individual does not have any negative cognitions related to their identity and is therefore not in need of these targeted interventions.

Importance of Interdisciplinary Care

Interdisciplinary care is often standard practice in residential and inpatient settings, and it's especially important in the care of transgender individuals, who may have more complex medical and/or case management needs (Ducheny, Hendricks, & Keo-Meier, 2017). Previous studies have demonstrated that interdisciplinary care increases the effectiveness of treatment for transgender individuals (e.g., Spack et al., 2012). When assessing a transgender individual's needs as a member of your program or hospital, it is helpful to assess several possible areas of need, including medical and case management concerns.

While many consumers may encounter medical needs while undergoing mental health treatment, transgender individuals may have specific needs related to their transition process; for example, they may be undergoing hormone therapy. As with other aspects of care, it also is important to pair them with medical treatment that reflects their self-identified gender. For example, at the authors' VA hospital, male-to-female transgender individuals are seen in the women's clinic for primary care, if that is their preference. The providers are aware that those individuals also may have unique needs related to their male sex at birth (e.g., prostate exams).

Financial needs related to medical and mental health care, including the cost of the inpatient or residential treatment, also may be of concern. Evidence suggests that transgender adults are more likely to have lower household incomes than their nontransgender counterparts (Factor & Rothblum, 2007). Nearly one-third of respondents (29%) who completed the U.S.

Transgender Survey were living in poverty, compared to 14% in the U.S. population, and about the same amount (30%) reported having experienced homelessness at some point in their lifetimes, with 12% reporting homelessness in the past year (James et al., 2016). Their unemployment rate was also three times higher than the overall rate for the U.S. population (15% compared to 5%; James et al.). Transgender individuals in Shipherd, Green, and Abromovitz's 2010 study cited cost of treatment as a barrier to care. We recommend that inpatient and residential programs engage social workers or other mental health providers who are well educated regarding the resources (including financial resources) available to transgender individuals, and that programs also publicize any availability of financial assistance, recommendations or resources for financial assistance, and availability of social work or related resources when considering how to pay for treatment. Gender dysphoria, depression, and PTSD may result in long-term loss of capacity to work, which may result in qualification for social security disability (Center of Excellence for Transgender Health, 2016). However, individuals may need assistance in identifying and applying for these types of benefits. If individuals are employed, then staff can potentially assist those individuals in arranging to gain the necessary time off to attend a residential or inpatient treatment.

Once financial concerns have been addressed and transgender individuals are engaged in treatment, they may present ongoing case management concerns. Transgender individuals may be seeking assistance with changing their name or gender marker on vital documents, such as a driver's license, social security card, passport, or birth certificate (Ducheny et al., 2017). Discharge planning also needs special attention with regard to transgender individuals. Providers can assist transgender individuals in locating housing (if needed) and/or other services that appropriately support transgender individuals and allow them to function according to their self-

identified gender. In many places, it is still legal to discriminate against transgender individuals in housing and employment, so it is important for providers to explore whether a particular discharge plan will be physically and emotionally safe for a transgender individual.

The interdisciplinary teams in our hospital have encountered several challenges and have learned some solutions. For example, inpatients looking to discharge to a shelter or other community living environment are often faced with the same binary housing issue as at the hospital, in which they have to be housed according to gender. Our social workers work with transgender individuals to determine whether and how they might want to disclose their transgender identity. Often, if both providers and the individual in question think the patient can "pass" in their self-identified gender, they make a joint choice to refer based on self-identified gender and not disclose transgender identity at all. Our social worker advises that residents are well aware of these issues and notes that any attempts to support them and to try to problem-solve their challenges are typically well-received.

Another example in our system concerns an inpatient resident who was trying to balance seeking residential treatment while undergoing hormone therapy. He had previously been terminated from a residential program because the program did not allow passes long enough for him to travel to a location where the hormone therapy was offered. Our providers worked with the individual and the desired treatment providers to pursue additional travel supports and program accommodations that would allow the individual to complete his residential treatment while also being able to attend ongoing appointments for hormone therapy.

While all of these presenting issues may be new to many providers, working as an interdisciplinary team can allow providers to pool their knowledge and resources, and to spread

the work involved in educating oneself and connecting transgender individuals with these resources.

Conclusion

Meeting the mental health needs of transgender individuals, especially in an inpatient or residential setting, can be varied and complex. Some transgender individuals may have little to no concerns related to their transgender identity and may simply want to participate appropriately in their mental health treatment. Other individuals may be experiencing distress related to their transgender identity, and/or present with complex interdisciplinary needs. The key to successful inpatient and residential care of transgender individuals lies in treating these and all residents fairly and respectfully, conducting a thorough assessment, placing individuals appropriately, coordinating resources to meet individuals' needs, and treating all transgender individuals according to their self-identified gender. See Table 1 for a summary of recommendations. The treatment of transgender individuals is new to many providers, and we encourage you to seek education and training and try your best to provide excellent care, while also being forgiving of yourself. If you make a mistake, provide a genuine apology, and attempt to move on. The goal in treating transgender individuals, in addition to treating their presenting mental health concerns, is to help them navigate their treatment in a way that identifies and ideally removes obstacles to their care, providing them with an equal chance at achieving recovery.

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Table 1. Recommendations for Treating Transgender Individuals in Inpatient and Residential Mental Health Settings.

Recommendations	Strategies
Creating a welcoming environment	
Create a nondiscrimination and inclusiveness policy that includes transgender individuals	Refer to existing policies established by other facilities
Publicize your nondiscrimination policy	Utilize electronic and paper resources
Obtain recognition for offering LGBT patient centered care	Utilize the Healthcare Equality Index
Demonstrate that transgender individuals are welcome	Display posters or brochures that explicitly depict/welcome LGBT individuals
Make intake forms and processes inclusive of transgender identity	Include nonbinary response choices on forms, use gender-neutral terms for relationships, ask descriptively about sexual history, avoid labels
Establish and communicate confidentiality, documentation, and visitation policies	Refer to existing policies established by other facilities
Evaluate and improve provider education and training	Include all staff; seek training from outside your facility if needed
Create a safe environment for providers/staff	Communicate explicitly that staff may ask for help or clarification without being judged
Managing the milieu	
Assign individuals to appropriate housing & care	Treat according to self-identified gender, (including rooms, roommates, bathrooms, community spaces, program policies)
Use appropriate terminology	Refer to individuals by their preferred name, pronouns, and self-identified gender at all times (if unknown, ask politely)
Acknowledge the limits of binary space designations	Validate stress, offer support, make the process clinically meaningful to the extent possible
Set clear and positive expectations	Encourage residents to establish and maintain an environment of respect
Utilize opportunities for corrective emotional experiences	Promote and reinforce positive interpersonal interactions within the milieu that challenge negative beliefs about self and others
Manage conflict therapeutically	Treat any/all interpersonal conflicts in the same manner, consider individual meetings with the parties involved, adhere to policies
Content of treatment	
Assess for issues known to be prevalent among transgender individuals	Assess history of assault, substance use, suicidality, gender dysphoria
Consider whether concerns about identity need to be addressed	Address privately if support is needed; do not overemphasize transgender identity if unrelated to the patient's presenting needs

Conduct CBT/therapy interventions appropriately	Negative beliefs and fears may be realistic: explore how to maximize control, manage worst case scenarios, problem-solve
Interdisciplinary care	
Assess need for specialized medical care	Medical treatment should reflect self-identified gender but also address biological needs; note specialized needs such as hormones
Assess and assist with financial needs	Assess need for assistance with paying for treatment, benefits/disability
Attend to case management concerns	Assess need for assistance with name changes on vital documents, ensure a discharge plan that will be safe an accepting of a transgender individual
Pool resources	Work as a team to allow providers to pool knowledge and spread the work in learning about resources
Self-care	
Manage expectations	Try your best, but be forgiving of yourself
Address mistakes	Provide a genuine apology, learn from the situation, and move on

Highlights

- Minority stress contributes to mental health conditions in transgender individuals.
- Guidelines to include transgender patients in inpatient and residential programs are presented.
- Providers can create a safe environment which affords quality care to transgender patients.