The Parallel Process of Trans Mental Health Providers – The Strengths and Complexities of Working as a Trans Person in Mental Healthcare

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I have been part of the trans community for nearly two decades, and a social worker weaving in and out of working with trans people in professional capacities for a decade. The intersection of those identities presented a myriad of opportunities to reflect on my role and the complicated context of trans identities and social services, especially trans healthcare. Along the way, I stumbled on the concept of the parallel process, which I have found useful in this context. In this chapter, I apply the concept of parallel process in an extended reflection on my personal and professional experience as a trans person working in the mental health system.

Parallel process is defined as "a treatment impasse that occurs when similar emotional difficulties emerge simultaneously in supervisory and treatment relationships" (Kahn 1979:520). This concept has fascinated me since the beginning of my social work career. As a graduate student, I was an assistant for research focused on the parallel processes that can occur when social workers are working within communities with whom they share a common identity-based experiences. I interviewed gay social work students working in LGBTQ centers, black social work students working in predominantly black neighborhoods of Boston, and in similar situations. The experiences reported to me were complex and nuanced. In my own career as a person who holds multiple identities outside of the hegemony, I have found myself frequently grappling with experiences of parallel process. I've witnessed their multidimensional impact on therapeutic relationships with clients and with supervisors alike. Most illuminating was exploring my own trans and non-binary identities while working with trans and non-binary clients or service recipients. Drawing on my own experiences, as well as existing research, I will

draw some conclusions about the emotional difficulties that emerge in this context, as well as the joyous successes that can significantly remove barriers and improve care.

I am an unlicensed social worker working in community mental health and housing access in the West Coast of North America. I am a white immigrant, a person with a disability, and I am trans non-binary and queer. My career has taken place in community mental health settings that are not deliberately trans-affirming. In this acknowledgment, I seek to locate my positionality, a concept which "directly incorporates ideas of power and privileges and seeks to describe researcher identity in terms of insider-outsider perspective, based on the researchers' relationship to the specific research setting and community" (Muhammad et al. 2015:4). While this chapter is not significantly research-based, those identities and others inform and shape my analysis. Additionally, language and culture are constantly evolving to better include and reflect dynamic concepts. I use the overall term 'trans' to include trans, gender non-conforming and non-binary identities. This helps to simplify my discussion but is by no means intended to limit further explorations of these categories.

The last two decades brought an increasing need for trans-specific services as well as increased visibility of mental health providers who are trans (Lurie 2014). However, in part due to discrimination and systemic barriers to education, wealth, and professional development (James et al. 2016) trans providers in the US are rare. Each is often the sole or one of the few providers with trans competency within a local system of care. As Shuster (2016: 329) puts it, "despite insightful research on the experience of trans people in workplace organizations and everyday life [...] there are still few studies on trans medicine, particularly from the providers' perspective." Meanwhile, trans therapists such as Hansbury (2011:212) report: "because I am publicly 'out', trans patients routinely come to me specifically seeking a trans therapist. In their own words and actions, they tell me they are looking for an experience of twinship and mirroring." The literature on the subject of trans mental health providers working with trans clients is limited in its scope. For this essay, I rely heavily on few existing articles as well as unpublished thesis papers. I also draw on my experience as a trans mental health provider in community mental health settings in the US.

While the concept of parallel process specifically seeks to illuminate difficulties, I argue that it should be considered for its benefits as well. Everett et

al. (2013) discuss the ethics of multiple relationships within queer, two-spirit[1], and/or trans communities in a similar vein, arguing that while these relationships are perceived as negative and potentially harmful in traditional ethical analysis, they may also have potential benefits. Here, I will explore some ways in which the trans-transference (Lurie 2014) and the trans-trans dyad (Hansbury 2011; Lurie 2014) impact the providers and the therapeutic relationships.

In an attempt to embrace the complexity of relationality, I seek to look beyond the binary labelling of experiences as "negative" or "positive". Borrowing from Buddhist concepts as well as behavioral neuroscience (Dolcos and Cabeza 2002), I choose to explore this topic using the lens of "pleasant" and "unpleasant". These concepts move away from a black and white thinking (something is either good or bad, right or wrong). It may offer a connection between the logical experience (interpreting our experience through morals, values, and past) with the somatic one (how does it feel in our body? How does it feel in our senses?).

> It is 2014 and I start looking for a therapist for the first time since my teenage years. I am a medically-transitioned non-binary person and a mental health provider myself, already have navigated the hoops of medical care for many years, and as a result, I minimize my interactions with the medical system as much as possible. My body and my identities put me at risk of not receiving the care that I need. Often, therapists would focus on trans identities as focal to treatment due to their own biases. Other times, doctors in various disciplines may fail to treat trans people in emergency situations and primary care alike, treating trans bodies as foreign, sometimes as inhuman. It is a common saying in the community to joke about the "trans broken arm syndrome", phenomena in which doctors blame everything (including a broken arm) on the patient's trans identity, neglecting their care. I just separated from my spouse, alone in a country that is thousands of miles away from home, and like many of my peers, I want to do some self-work. I start inquiring. I type in 'transgender' and 'therapist' and 'sliding scale', I seek recommendations in forums and websites: 'looking for a trans-competent therapist'. Living in a big urban city on the West Coast of the United States, I am privileged to have access to many therapists, who claim a competency, but I am still unsure what it means for them, and so what it would mean for me. Some therapists who share my identities are also my peers, so not accessible

1 See Glossary at the beginning of this book.

> to me as a client. I leave many tabs open in my browser, unsure how to proceed, and eventually take a deep breath and choose the one with an image in which the therapist looks kind.
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> In our introductory meeting, I tell her about my deep fear of being sensationalized, I tell her who I am, a laundry list of identities, just a beginning, and ask about who she is. I need to know. She is queer, she confirms, and partnered with a trans person, too. I feel my shoulders relaxing, my breath is easier. Ok, I tell myself, perhaps we have something to work with here.

While my therapist is not a trans person herself, her self-disclosure and visibility removed a significant barrier in my access to competent services. Visibility and self-disclosure are specifically highlighted in research as a pleasant part of the parallel process of trans mental health providers and a factor in the ability to provide affirming and competent services (Lurie 2014; Karnoski 2017). Lurie (2014) discusses the idea of modeling vulnerability ("bringing more of me into the room," 2014:48) as a therapeutic intervention, in which clients are able to witness and hold space for their therapist, and subsequently practice vulnerability and compassion as skills for their own lives. It has been my own experience that disclosure of trans status to trans clients often leads to increased trust, openness and relationship building. Moreover, trans providers have noted challenges in getting their own needs met because of their role and the potential for crossover or conflict. Some examples are accessing support groups, therapy, trans-affirming care, trans-competent supervision, or attending community events and engagement (Everett et al. 2013; Lurie 2014). This challenge has the potential to be unpleasant and lead to providers having a smaller life than before they entered the trans-trans dyad. This dynamic puts them at risk of isolation, lessened social support, and burn out. Shamai (2003:545) notes, "because helping professionals are themselves exposed to the political violence and uncertainty, their personal experience of it may affect their professional performance and result in feeling overwhelmed and burned out". As trans mental health providers largely live in the same political climate which impacts their clients, it is crucial to explore and seek to understand the nuanced way in which it may show up in the therapeutic relationship and the parallel process.

Hansbury (2011:210) therefore asks, "with few examples against which to compare myself, I am often left to wonder: Does the transgender analyst work differently from the cisgender analyst? Are the issues experienced by trans patients different from those those cis patients struggle with?" While

answers may differ, it is worth noting that culturally competent care must include those who are impacted by these issues. These people should not only be receiving services but also leading the implementation of care. Because of the unique cultural and sociopolitical aspect of trans healthcare worldwide, in which trans communities are simultaneously politicized as identities and medicalized as a measure of control, trans people are often dependent on providers. Mental health providers play a significant role as they are often required to 'assess' trans people before they are granted access to many forms of medical and social transition. Thus, trans mental health providers are often engaged in political activism. They lead transformations of workplaces and workplace ethics, and often occupy the position of role model due to their trans identity. While many find "purpose, meaning, and connection through [...] activist histories" (Lurie 2014: 61), this political context adds additional layers to their therapeutic relationships.

> I graduate with my Masters of Social Work and start working as a social worker, providing therapy, case management and mental health support in the community. I get swept into the field of homelessness and mental health and decide not to work in LGBTQ-specific organizations. 'We are everywhere', I say. And we are. As I am largely out at my workplaces, trans people are typically referred to me wherever I work. I am cis-passing and have the privilege (or burden) of choosing self-disclosure, as I find fit and so I begin to navigate self-disclosure and its relation to the construction of my professional identity. I particularly love witnessing the shift in my clients when I disclose. Often it is apparent by the relaxation of their shoulders that they find more ease with the knowledge of my identity. I cannot claim neutrality. I feel a special kind of joy when I get my trans clients housed, when they make it to an appointment, when I can advocate with and for them, when they access trans-affirming services. I feel a certain kind of sorrow when they drop off treatment, when I cannot find them in the shelter or their tent – when barriers are too enormous to scale. I also start organizing in the local trans community, making relationships even more complex. As my activist network grows, I at times refer people to services through social media engagement. Knowing that I have the capacity to support community members in accessing services even in a hostile environment means a lot to me, but I am worried about what my co-workers and supervisors may say about my professional integrity.

Trans mental health workers walk a fine line within little-charted territory. We often become experts on providing trans-competent care (Everett et al. 2013; Lurie 2014), relying on our professional capacity, our activism, our own identities, and our own communities. At the same time, we engage with self-surveillance (Everett et al. 2013), are impacted by microaggressions in our workplaces (Nadal et al. 2014), and by de-professionalization or fear of it (Everett et al. 2013). Many of us can feel trapped at times and not recognized for expertise that is unrelated to trans issues (Lurie 2014). Beyond microaggression, providers often experience harm, discrimination, and trauma in their own work environment, which puts an additional burden on them as staff, risking unpleasant experiences of burn out and cycles of trauma when working with trans clients who navigate similar experiences. The pressure to be 'professional' is rooted in the dominant culture, in this case cis- and heteronormative culture[2]. It is essential to seek ways to challenge that and to address the parallel process in which providers and clients are harmed in parallel to their establishing of a therapeutic relationship.

Although trans clients often seek mirroring (Hansbury 2011), it is false to assume sameness in the trans-trans dyad. If we assume sameness of the therapist and clients solely because of their trans identities, we ignore the fact that power dynamics are inherent to the therapeutic relationship. Additionally, intersectionality (Crenshaw 1991) plays a significant part in this differentiation of roles. Despite sharing the trans identity, there are many ways in which those identities can play out differently in people's lives. When I am a white transmasculine therapist who has had access to education and financial stability and I work with a black trans woman, who is homeless, our experiences are not mirroring each other. Moreover, providers may experience a parallel process which can include envy or jealousy of their clients (Lurie 2014:48), assimilation bias (having preconceived thoughts about a trans person should do or be), and simply not being a good match due to personality or professional mismatch.

> As a social work intern, I intern in a community health clinic for marginalized youth and young adults in Boston, MA. I get a small caseload of clients, some of them are trans. Most of the staff in the mental health team is queer.

2 Queer and/or trans healthcare providers often need to look, dress, speak, and conduct themselves in accordance to unspoken (and at times spoken) rules, often needing to 'tone down' queerness/transness in order to gain respect, validity, professional development, promotions, etc. in their workplace.

> There is a therapist who is trans. He tells me he stopped going to community events to maintain professional boundaries. I grapple with this question of where my personal identity ends and where the professional one begins. I am not sure. As part of my job, I provide 'Gender Assessment', a too-elaborated process that clients are required to undergo in order to access medical transition. I start writing letters that my clients need in order to access hormones, or surgeries. I tell them I am trans too, I try out self-disclosure and consider the ways my disclosure can be beneficial for my work with them, but I am not sure about what is best. I am angry that I need to write these letters, grateful that I can do it collaboratively and with as few barriers as I can.

Trans healthcare is steeped in the medical model and many trans people are dependent on medical and mental healthcare to get their healthcare needs met. A recent study (Gonzalez and Henning-Smith 2017:743; 726) found that "transgender and GNC [gender nonconforming] adults were more likely to be uninsured, to have no usual source of care, and to forgo needed medical care due to cost," and that "transgender and GNC adults may experience barriers to care for a variety of reasons, including discrimination and lack of awareness by providers in healthcare settings". This highlights a particularly interesting aspect of the parallel process that occurs when a trans mental health provider acts as a gatekeeper of a client's access to medical care. In Lurie's research (2014) and my own experience, this situation elicits a range of responses from the healthcare provider. Some sit in discomfort, some attempt to work collaboratively with the client to navigate the administrative hurdle they are facing, and some choose not to assume this role at all. Many contemporary trans mental health providers choose to use their position of power to relieve gatekeeping where possible and make the process easier for their clients. They may only meet the minimum requirements of the guidelines or find loopholes, they may write those letters with their clients and empower clients to use their own words, and some may risk scrutiny of co-workers and supervisors for doing so. Everett et al. (2013) in particular point at the scrutiny that results from supervisors who lack trans-specific knowledge, and trans providers' fear of job insecurity and the ensuing self-surveillance. In a recent study of trans and non-binary medical students, Dimant et al. (2019:215) found that "in many cases, individuals hid their identity due to fear of discrimination, substantiated by witnessing high levels of anti-TNB [trans nonbinary] stigma and discrimination. Both medical school and residency curric-

ula have not sufficiently included TNB health topics nor changed transphobic attitudes. Even attending physicians reported environments that continued to perpetuate stigma and discrimination." Although this research focused on medical students and physicians, it is fair to deduce that the medical world is not preparing or prepared to support trans people and their needs. As a result, trans mental health providers, who are both clients of and gatekeepers of trans healthcare, are asked to carry an incredibly complicated load in support of their clients and their communities.

What would it look like to practice as a trans mental health provider in a world that did not medicalize trans people? In a world where the power to determine someone's readiness for treatment was not put in the hand of the provider? How would that change the trans-trans dyad and trans-transference?

> At the same internship, I worked with a young trans person who also explored their multiple identities. We worked in therapy on various coping strategies and their transition-related goals. When they were ready to pursue surgery, I felt confident in my ability to write them a letter and support them. However, my supervisor was concerned about the intersection of their mental health diagnosis and was not fully supportive of moving forward with the letter. The case had to be moved 'up the channel' and reviewed by other clinicians. I had to employ more advocacy and support my client as we were both navigating barriers to their care. Eventually, the case was approved and my client was able to access their care.

This particular experience remained poignant for me over the years of my professional development and is reflected in the existing research. On the one hand, trans providers are viewed as having more experience and expertise than their cisgender coworkers and often supervisors (Lurie 2014), but on the other hand, they are also questioned and undermined for this expertise (Karnoski 2017).

> I apply to a supervisory position, my current position. The team I would supervise is part of my interviews and I tell them right away, I am trans, I am queer, this is who I am. I tell them my pronouns, too. I get the job. We learn together. We share this learning process with our clients. We grow. I work for a large agency in a progressive West Coast American city and I am shocked to see how much work is needed for the organization to become trans-competent – for both staff and clients. I enthusiastically throw myself into the work

> and start a working committee, where we all volunteer our time and expertise to improve the organization. We write a handout, we fix, we correct, we advocate, we are angry, we are shut down, we get misgendered (every day), our recommendations are at times dismissed, the system is slow to change, and the re-traumatization is alive and burning. On the workgroup some of us are therapists, some of us are peers, some of us are administrators, some of us are trans, some of us are allies. Our monthly meetings become a place of solace, support and solidarity, a community.

Exploring the concept of parallel process in the trans-trans dyad brings up more questions than answers. A lot is left to be researched, explored and conceptualized. Baril (2015:68) boldly states "trans suffering cannot be reduced to internalized cisgenderist oppression", and I postulate that this is true for trans joy as well. The experience and skills trans mental health providers bring to the field cannot be understated. The burden of the parallel process, as well as the immense joy, are equally significant in the impact they have on the well-being of providers. The importance of culturally competent services has been established as important to mental healthcare (National Association of Social Workers 2015), yet some of the challenges remain to be explored. As this exploration continues, it is critical to consider the significance of mirroring and counter-mirroring, where the provider's identity is reflected in their clients and vice versa. This unique situation creating a space with the potential of solace, support, solidarity, and healing for both client and provider.

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