

Providing Counseling for Transgendered Inmates: A Survey of Correctional Services

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Along with the rise of the multicultural movement, growing interest in transgender treatment has spread through the mental health and criminal justice community. Over the past 20 years, research has focused on the etiological aspect of transgenderism. Yet, almost no attention has been directed toward practice and policy standards for this population in correctional facilities. While thousands of individuals experience distress or dysphoria concerning their gender identity each year, little progress has been made in achieving standards of care, effective treatment models and programs for training correctional administrators and providers. Individuals with transgender needs (assessment, housing, and treatment) have been largely ignored despite that they remain a key minority population at risk to experience suicide, depression, and hate crimes (Lev, 2004). Many of these individuals are marginalized into areas with high rates of crime, poverty, and drug dealing and abuse. Consequently, transgenders have an increased risk of getting involved in the criminal justice system and committed to correctional facilities (Blight, 2000).

Although there is no reliable estimate of the percentage of prison inmates currently requiring transgender or transsexual treatment, there is a significant correlation with criminal behavior (Peterson, Stephens, Dickey, & Lewis, 1996; Walinder, Lundstrom, & Thuwe, 1978), specifically among those experiencing gender dysphoria (Peterson et al.). Other researchers suggest this correlation is a "consequence" due to social intolerance in conjunction with comorbid pathological symptoms (Shaylor, 2009, Peterson et al, 1978). As such, an estimated 40 percent of transsexual individuals have been involved with prostitution (Hoenig, Kenna, & Youd, 1970; Blight, 2000).

Criminal justice administrators and mental health providers are faced with the challenges that arise when dealing with individuals with transgender concerns. Although the literature addressing assessment, housing and treatment needs of transgendered inmates is limited, administrators and providers must be systematic in their responses. There is a realistic expectation on the criminal justice system to ensure effective services for transgendered inmates while in correctional facilities. This creates a burden on the corrections system as these administrators and providers are hampered by non-systematic approaches and practices for managing and treating this population (Richard, 2000).

Despite literature which correlates criminal behavior and gender identity disorders (transsexual, transgender) with disproportionately high prevalence rates of transsexuals within the cor-

rectional system, few studies have been conducted to suggest appropriate models of treatment for transgendered inmates. Numerous studies report transgendered inmates suffer considerably more problems than general population inmates. These include rape (Banbury, 2004), blackmail (Banbury, 2004; Knowles, 1999), contraction of HIV or other sexually transmitted diseases (Stephens, Cozza, & Braithwaite, 1999), relapse or increase of psychological symptoms (Banbury; Knowles; Peterson et al., 1996), lack of social support, limited or inadequate mental health treatment, denial of hormonal therapy (HRT) (Peterson et al, 1996), and death due to hate crime (Knowles, 1999). Yet the population remains virtually ignored by current researchers.

Corrections play a significant role in coordinating treatment services for transsexual and transgender inmates. When inmates with transgender issues are committed to correctional facilities, these institutions should be required to provide effective, adequate, and compassionate care. Sufficient care requires the application of empirically supported interventions; however there are few empirical studies which demonstrate best practices for the clinical management of transgendered persons confined in correctional facilities.

This study surveyed the current assessment, housing and mental health treatment provisions provided to transsexual inmates within state correctional facilities. The literature reviewed epidemiology, prevalence, assessment, and current standards of care. Implications for correctional administrators and mental health providers as well as recommendations for future research are provided.

■ Epidemiology and Prevalence

Epidemiology

Although several studies seek to estimate the prevalence of transgenderism, there have been no national or world-wide efforts to determine the actual rates of transgenders. Although international estimates differ, several studies indicate approximately 1:40,000 male to female (MtF) and 1:100,000 female to male (FtM) transgenders in the general population (Blight, 2000). Information provided by the DSM-IV-TR (2004) confirms these studies however; this estimate excludes transsexuals in early stages of development who have not fully actualized their gender identity and those who feel they can live as the opposite sex without undergoing surgery. This indicates that the actual numbers of transgenders and transsexuals may be understood. According

to Shaylor, (2009) there was an estimated 50,000 post-operative MtF transsexuals within the United States.

Research indicates there is a higher prevalence of anatomically male transsexuals than female around 3:1 (Meyer, et al, 2001). It is hypothesized that because FtM transsexuals do not receive the same social stigma as MtF, they less often seek treatment and are not accurately accounted for in estimates. Harry Benjamin reports in the Standards of Care for Gender Identity Disorders, Sixth Version, that FtM transsexuals tend to "be relatively invisible to culture, particularly to mental health professionals and scientists" (Meyer et al., 2001, p. 3). Evidence contrary to this ratio is reported in countries outside the United States. International studies from Europe and Australia indicate that the ratio may be approximately equal (Beemer, 2006).

Common Co-morbid Pathology

Even the earliest literature pertaining to transgenderism (Benjamin, 1964; Shively & DeCecco, 1977; Stroller, 1978; Pauly, 1968) addresses the impact of co-occurring mental health and substance abuse issues. Bockting and Coleman (1972) stress that it is imperative to distinguish co-occurring symptoms from gender-specific symptoms and that the efficacy of therapy depends on treatment of respective pathology. Co-occurring disorders commonly associated with transgender concerns include anxiety, depressive, substance-related, personality (American Psychiatric Association, 2000), and eating disorders (Sumner, 2010). There are also high prevalence rates of autogynephilia, HIV infection, and suicide attempt among the transsexual population (American Psychiatric Association, 2000). The potential severity of such comorbid pathology further illustrates the importance of provider competency, comprehensive assessment, and efficacious treatment.

■ Interrelated Terms

Transgender

According to Meyer et al. (2001), the term transgender was introduced between the publications of the *DSM-III* and *DSM-IV*. It is an umbrella term that refers to individuals who "have gender identities, expressions, or behaviors not traditionally associated with their birth sex" (Gender Education & Advocacy, 2001). Transsexuals only account for a small percentage of the transgender population as the term also encompasses transgenderists (individuals who live part or full-time as the opposite sex but do not desire sexual reassignment surgeries), and intersex (patients born with atypical chromosomes, genitalia, or reproductive systems), and transvestites (Kenagy, Moses, & Ornstein, 2006). Many transgender individuals are MtF or FtM, however, some

identify their gender as both male and female or neither male nor female.

Gender Identity Disorder

In 1994, the Subcommittee on Gender Identity Issues replaced the *DSM-III-R* diagnosis of Transsexualism with the broader diagnosis of Gender Identity Disorder in the *DSM-IV* (Meyer et al., 2001). According to the committee, the term Gender Identity Disorder (GID) was designed to suggest and allow for a “spectrum of gender dysphoria rather than discrete levels of symptoms” and should replace and encompass the *DSM-III-R* diagnoses of Gender Identity Disorder of Childhood, Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type, and Transsexualism (Bradley, et al., 1991; Vitale, 2006). Current diagnoses available to consider when assessing an individual with gender identity or dysphoric issues in the *DSM-IV-TR* include Gender Identity Disorder in Children (302.6), Adolescents or Adults (302.85), and Not Otherwise Specified (302.6; *DSM-IV-TR*, p. 582; Meyer et al., 2001). While a large percentage of empirical literature available pertains to the entire spectrum of GID presentation, the focus of the research in the paper will be on specifically on the pathology, adjustment, assessment, and treatment of MtF transsexuals.

Transvestite

Since the 1900s, the term transvestite has been specified to refer to a person who dresses or represents themselves as a member of the opposite sex, but identifies as their biological sex. The *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* (American Psychiatric Association, 2000) offers the diagnosis of Transvestic Fetishism, which is described as a paraphilia that “involves cross-dressing by a male in a women’s attire” (p. 574). Transvestites, by definition, are heterosexual men, whose recurrent sexual fantasies or urges to cross-dress cause them clinically significant distress or impairment in functioning (*DSM-IV*).

Transsexual

The term transsexual was used to refer to an individual who wanted to live as a member of the opposite sex. In 1980, Transsexualism was listed as a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders – Third Edition* (American Psychiatric Association, 1980) “gender dysphoric individuals who demonstrated at least two years of continuous interest in transforming the sex of their bodies and their social gender status” (Meyer et al., 2001). The term transsexual is currently understood as a person who identifies opposite of their anatomic sex, feels betrayed by their body, and often seeks to make their anatomic sex align with their gender identity through various surgical procedures and therapies. Vitale (2006) offers the definition “a state of existence in which one’s sense of gender identity differs markedly from that assigned

at birth” (p. 2). Transsexualism is opposite to transvestism on the transgender spectrum proposed by Benjamin (Bullough, 2000; Benjamin, 1964) and differs greatly in motivation: a transvestite is a man who is sexually aroused by dressing in women’s clothing and a transsexual is a biological man who feels and believes he is a woman trapped in a man’s body. The terms (MtF) and (FtM) are used to denote respectively an individual’s anatomic sex to gender identity.

■ Assessment and Interventions

When diagnosing individuals referred for transgender concerns, assessments are primarily completed through both observation and interview which is focused on both current clinical presentation and developmental history. Collateral sources may also be consulted or interviewed to verify criteria, including caretakers, family members, social workers, and medical/mental health professionals. Although assessment is generally considered to be an ongoing process, the initial interview should also be used to screen for history of abuse, suicidality, and comorbid pathology common to transgenderism, including anxiety, depression, social phobia, eating disorders, and substance abuse.

While sexual orientation and gender identity are considered separate issues in assessment, Harry Benjamin (1977) developed a Gender Disorientation Scale of six types based on Kinsey’s Sexual Orientation Scale. His model provides an insightful outline of typologies and presentation for practitioners to consider. According to Benjamin, the Type One patient (Pseudo Transvestite) identifies and lives as a male, but may find sexual arousal in occasionally cross-dressing. The Type Two patient (Fetishistic Transvestism) also lives and identifies as a man, but dresses more often as a woman and might wear female garments underneath male clothing. The Type Three patient (True Transvestism) identifies as male, but with less conviction. He dresses consistently as a woman and may live accepted as female. He may seek hormonal or psychological therapy and may assume a double personality. The Type Four patient (Nonsurgical Transsexual) is often undecided about his gender identity. He dresses as a woman as often as possible, but this does not effectively decrease his gender discomfort. He may be interested in gender reassignment surgery (GRS), but does not request or admit it. The Type Five patient (Moderate Intensity True Transsexual) identifies as female, feels as if he is a female trapped in a male body, and often lives and works as a woman. He requests both GRS and hormonal therapy, but frequently rejects psychotherapy unless a condition to surgery. The Type Six patient (High Intensity True Transsexual) has urgently requested and obtained gender re-assignment surgery and identifies fully as female. He is usually receptive to psychotherapy and risks suicide or self-mutilation if he does not receive surgery (Benjamin, 1977).

In addition to the Gender Disorientation Scale, Benjamin developed the Gender Identity Screening Tool, focused on the differentiation of transvestism and transsexualism. It provides information

on four axes and is, to date, the only widely-used assessment tool available to practitioners. It should be noted that the Gender Identity Screening Tool is used only for MtF transsexuals who are attracted to males and may be biased towards those who have had the resources to undergo electrolysis, hormone replacement therapy (HRT), or GRS (Benjamin, 1977).

Although gender identity specific assessment tools have not proven necessary to accurately determine the presence of *DSM-IV-TR* or *ICD-10* criteria, many mainstream tools may be used in research or to aid in more accurately identifying symptomatology if needed. Some of these include: the Rorschach (Exner System), the Minnesota Multiphasic Personality Inventory, and the Coolidge Personality and Neuropsychological Inventory, which contains a six-item gender identity disorder scale based on *DSM-IV-TR* criteria (Coolidge, Thede, & Young, 2002).

It is also suggested that the Gender Disorientation and Gender Identity Screening Tool be administered to help define recommendations for treatment if indicated. Inmates exhibiting or reported comorbid pathology should complete personality traditional to correctional settings such as the Rorschach or MMPI. Providers should be sensitive of issues more common to transgendered individuals such as: anxiety, identity disturbance, autogynephilia, poor or distorted body image, family discord, trauma history, and suicidality (Blight, 2000). Comorbid pathology should be treated separately with the most efficacious interventions available while keeping the overall mental health issue of gender dysphoria in mind. When conducting assessments, providers should maintain awareness of Axis II pathology, specifically antisocial personality disorder, and be careful not to provide a parasitic inmate with information needed to feign additional symptoms.

■ Treatment of Transgendered Individuals within the Community

Current Standards of Care

Treatment of transgendered individuals requires a comprehensive bio-psycho-social approach often employing a team of multidisciplinary caregivers, including a general physician, endocrinologist, plastic surgeon, psychiatrist, psychologist, electrologist, and social worker. The most widely referenced protocol of treatment for individuals with transgender issues was developed by the Harry Benjamin International Gender Dysphoria Association (HBIGDA). Harry Benjamin (1885-1986) was a German sexologist and gerontologist who began treating transsexual clients with HRT before gender identity disorder was recognized by mental health professionals when gender dysphoric individuals were mainly diagnosed with schizophrenia (Benjamin, 1977). HBIGDA released the first version of the standards of care (SOC) in 1979 and continued integration of practice, research, and public policy into revisions published in 1980, 1981, 1990, and 1998. The most current version (sixth, 2001) of the SOC includes sections ad-

dressings: Introductory Concepts, Epidemiological Considerations, Diagnostic Nomenclature, The Mental Health Professional, Assessment and Treatment of Children and Adolescents, Psychotherapy with Adults, Requirements for Hormone Therapy for Adults, Effects for Hormone Therapy in Adults, The Real-Life Experience (RLE), Surgery, Breast Surgery, Genital Surgery, and Post-Transition Follow-up. These sections can be grouped into five major clinical areas that should be addressed throughout the course of treatment: diagnostic assessment, psychotherapy, real-life experience, hormonal therapy, and surgical therapy (Lev, 2004). The SOC lists an “overarching treatment goal” of “psychotherapeutic, endocrine, and surgical therapy” for individuals with transgender needs in order to promote “lasting personal comfort with the gendered self” and to “maximize overall psychological well-being and self-fulfillment” (Meyer et al., 2001, p. 2). The authors specify that, while the SOC provides guidelines for the spectrum of treatment modalities, not all individuals will require physical therapy or surgery and treatment planning should be determined on an individual basis.

Mental Health

Individuals strongly identifying with the opposite sex, experiencing gender dysphoria, or living as a transsexual may benefit from an array of mental health services ranging from assessment to psychoeducation to intense psychotherapy. Although the SOC specifies “psychotherapy is not an absolute requirement for the provision of triadic therapy” (RLE, HRT, and GRS) or effective treatment of individuals with transgender issues, mental health intervention is needed to complete the first three clinical areas outlined (diagnostic assessment, psychotherapy, and RLE) along with letters of recommendation from mental health professionals are required for HRT and GRS (Meyer et al., 2001, p. 13). Mental health services vary depending on the individual’s severity of dysphoria, development of identity, age of onset, and progression in treatment. Given the frequent occurrence of pathology comorbid to transgender concerns, such as anxiety, depression, substance abuse, personality disorders (*DSM-IV-TR*), and eating disorders (Shaylor, 2009), treatment may be continued on a long-term basis even after GRS has been completed and the individual is living fully as their identified gender.

Referral for Treatment

Referral for mental health care of individuals with transgender concerns is often made during childhood by family members who worry that their feminized behavior and interests will have a negative impact on their lifespan development or the family’s reputation. Often parents are unaware of the distinction between sexual orientation and gender identity believe their son is gay and needs to be “fixed,” whereas others seek

supportive therapy or treatment for comorbid pathology associated with gender discomfort. Late-onset clients are usually self-referred, although some are referred by spouses or life partners who are disturbed by their cross-dressing behaviors or lack of interest in the traditional husband role.

Transgender-Specific Models of Therapy

With the understanding that gender identity issues do not function independent of comorbid symptomatology, many providers rely on traditional techniques of treating anxiety or depression (such as psychodynamic or cognitive behavioral therapy) and attempt to extend these interventions to address or their client’s struggle with gender identity. The SOC indicates effective psychotherapy should provide education, clarify options of transgendered living, improve relationships, explore identity, provide information about medical and legal resources, support and educate family and loved ones, and facilitate transition, in addition to decreasing problematic symptomatology (Meyer et al., 2001; Rachlin, 2002). These requirements, in conjunction with the need of proficient, detailed knowledge of psychological, medical and psychosocial components of the transgender experience (Brown, 2001), raise the question of whether traditional theoretical orientations allow for comprehensive treatment. Since the early 1990s, four promising transgender specific models of therapeutic treatment have been proposed, including; Harry Benjamin’s model proposed in the SOC (2001), Bockting and Coleman’s comprehensive five-task model (1992), Devor’s 14 Stages of Transsexual Identity Formation (2004), and Lev’s Stages of Transgender Emergence (2004). These models of treatment are based on years of clinical experience, treating transgender clients. Because they are only recently available to the mental health community, providers have integrated them into practice but no formal empirical research has been published supporting their efficacy.

Pharmacological Interventions

Of the literature reviewed, no studies directly examined the affects of pharmacological interventions on gender dysphoria or transgender issues. The consensus among transgender researchers and health care providers is to refer to mainstream literature for the most effective intervention strategies and integrate them into therapy utilizing standard protocol and considerations. Thus, if a client was exhibiting depressive symptoms, the provider may suggest integrating an antidepressant into treatment, or if the client was experiencing clinically significant anxiety, a benzodiazepine may be considered. However, it is imperative for providers treating transgendered individuals to consider contraindications involved with these therapies. For example, hormonal fluctuations or medications associated with HRT and GRS may negatively impact the

effectiveness of traditional psychotropic medication (Israel & Tarver, 1997). As transgender specific treatment models become more widely applied and researched, literature concerning the affects of pharmacotherapy should also be addressed.

■ Current Treatment of Incarcerated Transsexuals

Issues and Risks Specific to Inmates with Transgender Needs

Recent research identified a significant link between transsexualism and criminality, suggesting transsexual inmates are up to 10 times more likely to have committed multiple offenses in the general population (Peterson, Stephens, Dickey, & Lewis, 1996). Many studies correlate gender identity disorders with criminal behavior (Peterson, Stephens, Dickey, & Lewis, 1996; Walinder, Lundstrom, & Thuwe, 1978), specifically among those experiencing gender dysphoria (Peterson, Stephens, Dickey, & Lewis, 1996). Disregarding etiological reasons for the development of antisocial tendencies among the transgender population, there is an apparent proportional need for housing and treatment of those who are committed to correctional facilities. Those creating models for treatment and housing must first assess risk-factors specific to the population that should be addressed.

Although all inmates are at a risk of sexual assault, rape, and contracting HIV through sexual contact, the prevalence of sexual assault, sexual promiscuity, and associated risk-taking behaviors are considerable higher among transgendered inmates. A recent study by Stephens, Cozza, and Braithwaite (1999) examined a population of 153 inmates, 31 of which identified as transgendered. Transgendered inmates were found to be 5.8 times more likely to report having multiple sex partners in prison, two times more likely to have been tattooed while in prison, four times more likely to have received treatment for STDs while in prison, and two times as likely to have used injection drugs while in prison. Additionally, a separate study suggests an estimate of 40 percent of transgendered individuals have been involved with prostitution (Hoening, Kenna, & Youd, 1970).

In addition to rape (Banbury, 2004), blackmail (Banbury, 2004; Knowles, 1999), contraction of HIV or other sexually transmitted diseases (Stephens, Cozza, & Braithwaite, 1999), transgendered inmates are also at a particularly high risk of relapse or increase of psychological symptoms (Banbury, 2004; Knowles, 1999; Peterson, Stephens, Dickey, & Lewis, 1996). Lack of social support, limited or inadequate mental health treatment, denial of hormonal therapy (Israel, 2002; Peterson, Stephens, Dickey, & Lewis, 1996), psychosis, self mutilation (Israel, 2002), and death due to hate crime (Knowles, 1999) add to the list of problems to be considered by correctional management. Whether a transgendered inmate is perceived as attractive, weak, victimized, or is using her gender as a survival mechanism, prison officials must account for

these occurrences and provide adequate housing, treatment, and supervision.

Current Provisions within Correctional Facilities

The term “freeze-framing” is largely the current paradigm of treatment for transgendered inmates. It is argued that inmates should maintain status quo of their physical presentation upon incarceration for several reasons, including: prisons are artificial environments that do not accurately reflect the outside community, it is difficult to assess symptomatology of transgenderism due to need for protection and possible malingering, and the difficulty of conducting an accurate real life test in an all-male, controlled setting (Peterson, Stephens, Dickey, & Lewis, 1996). While many argue Dickey’s freeze-frame policy provides the most protection and order while allowing those who have already begun HRT to maintain treatment, it condemns transgendered inmates with life sentences who were not previously diagnosed with gender identity disorders to a life without adequate treatment.

In addressing current treatment issues and provisions allowed to transgendered inmates Gianna Israel (2002) writes:

Most prisons do not provide hormones, and some go to great lengths to avoid providing any treatment to transsexual inmates. Most transgendered inmates are not receiving appropriate medical and psychological care. Many repeatedly seek medical treatment, often for years, while enduring administrative harassment and difficult court battles in the pursuit of basic medical and civil rights. Prisons that do provide frequently have policies which allow for the treatment of those who were treated prior to incarceration, but fail to address the medical needs of those who develop gender identity disorder during incarceration or who have no documented proof of their pre-incarceration transsexualism. [Prison officials] sometimes maintain that the prison does not afford the opportunity for the real life experience...conveniently ignoring the fact that many MtF transsexual inmates consistently maintain their female identity year after year in an all male facility (p. 2).

Based on the self-report of inmates and relating case law review, Israel projects a grim, but accurate, portrait of treatment of transgendered inmates in most correctional facilities.

In the provision of safe housing and effective mental health treatment for transgenders, many aspects must be considered, including; single cell housing, maintenance of hormonal therapy, possible placement in female facilities, provision of clothing and undergarments, differing hygienic needs, protection or seclusion from sexually aggressive inmates, and gender identity disorder-specific psychological and pharmacological treatment. Because treatment in correctional facilities is guided by litigation, officials are reluctant to publish studies or release information concerning policies or guidelines of the treatment of transgendered inmates.

Of the research reviewed, only one study directly addressed policies within correctional settings. In

1996, Peterson, Stephens, Dickey, and Lewis published *Transsexuals within the Prison System: an International Survey of Correctional Services Policies*, a study focused on the European community, as well as Australia, Canada, and the United States. Of the 103 15-item questionnaires sent out, 64 usable questionnaires were returned, resulting in a response rate of 63%. The study concluded that only 20 percent of the 64 corrections departments surveyed used a formal model of policy for the treatment and housing of transsexual inmates.

When questioned how a diagnosis or classification of transgender is obtained, 21 of the 64 respondents reported they used self-report as criteria, 29 reported assessment within the correctional facility, 24 reported they referred to previous diagnosis within the community, and 13 reported they used external gender consultants for assessment and diagnosis. Twenty nine respondents indicated they would continue previous HRT, 26 reported they would decide appropriateness of provision on a case by case basis, and 9 reported they would not continue HRT treatments. Fifty three jurisdictions reported GRS would never be considered and 11 indicated it might be an option in specific circumstances.

With regard to mental health services and housing, 52 of the 64 respondents indicated they would provide standard counseling available to the entire prison population and only 12 reported they offered specialized mental health services for transgendered inmates. As for placement based on the inmate’s security, 52 respondents endorsed they would provide housing on a case by case basis, 25 of these considering placement in the general population. Only 22 indicated protective custody as an option in deciding appropriate housing needs.

The study reflects consistent difficulty in the assessment of transgendered inmates, suggesting numbers presented to not reflect an accurate percentage of inmates with transgender concerns. Respondents (60%) who indicated they had no formal policy based this decision on the premises that transgendered inmates would receive more adequate care if determined on an individual basis. Those who indicated they would deny transgendered inmates HRT largely expressed doing so would make the inmate more feminine and a greater risk of physical or sexual assault. Across the board, placement was based on the inmate’s genital sex at the time of assessment; however, several jurisdictions indicated they would transfer inmates who underwent GRS to a female facility. The authors stress the confirmation of their hypothesis that almost all correctional facilities reported they provide no specialized counseling or supportive therapy.

■ Method

Procedures

Surveys were mailed to 50 mental health directors of each state’s correctional department. The mailing list was compiled by obtaining phone numbers from each state’s website and then calling the mental health department to obtain a current mailing address. In many cases, the acting director was available by telephone. Fifty questionnaires were mailed, including pre-ad-

ressed and stamped envelopes. Two months later, a follow up letter was sent, containing a second copy of the questionnaire. Of the 21 responses received, 18 were fully completed questionnaires. The other 3 responses indicated that the states were not able to respond due to ongoing litigation concerning transgender issues. No further information was provided. Surveys were sent exclusively to state-level mental health services departments rather than individual prisons or jails. One state forwarded copies of the questionnaire to each facility in an effort to compile the most accurate information.

Participants

Participants in this study included 18 out of 50 state mental health directors of correctional systems. The majority of the mental health directors were psychologists, however, in some states the psychology department is a division of general health services and the surveys were completed by physicians. The survey included open and closed ended questions and was administered to the mental health directors as they reported on assessment, housing, treatment and training practices and then expressed their opinions on best practices. Additionally, they were invited to share further information they felt should have been addressed by the questionnaire and if they could be contacted. No items required information that could be used as identifiers to link participants to the survey, maintaining an anonymous study in an effort to receive higher response. Informed consent ensuring anonymity and confidentiality, as well as instructions on how to complete and return the survey was included in the survey material.

■ Research Design

Measures

A 16-item survey was developed to obtain information about current methods of treatment and policies used by correctional facilities. The survey was comprised of 12 binary response (yes or no) questions with follow-ups for further explanation depending on the question, in addition to three free form questions. All text responses were coded and categorized. The binary and categorized responses were then analyzed descriptively to find trends by examining every binary data point and free form question for quantitative association between addressing special needs against lower risk factors.

Issues addressed by the survey were determined to be need-based through discussions with mental health providers within a southeastern Department of Corrections and review of current literature addressing norms and legal precedent. Items included general, housing, assessment, and treatment issues specific to transgendered inmates, using both open and closed questions. The survey also included an item that encouraged respondents to share information which they felt should have been more adequately addressed by the survey, to which eight clinical directors responded.

Results

A total of 50 questionnaires were sent out and 18 usable were received with a response rate of 42%. Of the 18 states that provided usable responses, 45% reported they had no inmates who meet full criteria for gender identity disorders in any facilities. Of the 10 states that indicated incarcerating transsexual inmates, 6 states reported less than 5 inmates with transgender issues; 1 state reported awareness of seven inmates with transgender concerns, and 3 states reported awareness of between 14 and 20 inmates with transgender concerns. 45% of respondents indicated they were aware of several additional inmates who met partial criteria of gender identity disorder or had not yet been formally diagnosed. Out of these 8 states, 5 indicated they could not estimate a number, 1 estimated over 15, another estimated over 50, and the last estimated over 200. This accounts for an estimate 81 inmates who meet full criteria of gender identity disorder within 10 states and another estimated 265 inmates who meet partial criteria or have not yet been diagnosed within 3 states. Despite the fact that 10 states reported housing transsexual inmates, only 6 states endorsed having general guidelines specific to the assessment, treatment, and management of transgendered inmates.

Results concerning housing of transgendered inmates indicated the extent of options was limited to single cells. 9 respondents (50%) reported that their state offered no housing provisions for inmates diagnosed with gender identity disorder, 7 respondents (39%) reported their state offered single cells determined by safety needs on a case to case basis, and 2 respondents (11%) reported their states provided housing on segregation units. Additionally, 1 state that provided single cells also provided the opportunity for transgendered inmates to shower separately from the general population. 12 states (67%) indicated they have no inmates diagnosed with gender identity disorders housed in mental health units (MHUs), 4 states (22%) indicated they housed between two and three transgendered inmates in MHUs, and 2 states (11%) indicated they housed transgendered inmates in MHUs temporarily as needed for acute symptoms or comorbid disorders. Every state that responded to the survey indicated they had no transgender specific or special housing units for transgendered inmates, one indicating that many transgendered inmates are housed on a special management unit.

Concerning assessment and diagnostic procedures, 2 states indicated they had salaried employees whom they considered "transgender specialists" and 2 states (11%) indicated they worked with psychologists in private practice who have experience in transgender issues on a consulting basis. Of the 14 states (78%) that indicated they have no staff or consultant mental health professionals proficient with assessment and treatment of transgender concerns, one respondent reported his state consults with a university based endocrinologist for clients who receive HRT. 4 states (22%) indicated they had conducted between 2 and 10 evaluations to assess a diagnosis of transgender concerns, however, every

state that responded denied having a standard battery or assessment tool used in evaluation. 14 states indicated they do not administer or refer transgender specific evaluations.

Regarding treatment, 17 states indicated they have no transgender specific programs or treatment methods. One state indicated there is transgender specific therapy available at every DOC facility in the state, but did not elaborate on what type of treatment or program was offered. 13 states denied providing provisions (such as female undergarments or hygiene products) to transgendered inmates, one of which indicated such provisions were currently under consideration. 4 states indicated providing female undergarments or support bras and the last state indicated any provision would be provided if deemed "medically necessary" by a licensed psychologist or psychiatrist. 12 states reported providing HRT, 2 more states than indicated having inmates with transgender issues. Of these 12 states, 2 provide HRT to one inmate, 4 provide HRT to between 2 and 5 inmates, one provides HRT to more than 5 inmates, one provides HRT to more than 25 inmates, and 4 did not provide a specific number.

Overall, the most prominent obstacles reported by respondents were issues of housing, staff education, and treatment. 11 states (61%) indicated difficulty assessing the need for and providing single cells. Often, in these cases, transgendered inmates reportedly end up placed in a higher security level than required or in a segregation unit with little social contact or privileges. Deciding whether to house a MtF transgendered inmate with breasts in a female or male facility and sexual activity were also raised as housing security issues. 8 states (44%) reported obstacles concerning the education of mental health staff, nurses, and correctional officers about transgender specific concerns and related needs or pathology. Many of these states cited a "lack of understanding" as a significant issue, indicating controversy over the existence of the disorder and frequent reports of verbal abuse by staff members. 7 states (39%) raised concerns about the efficacy of treatment provided to transgendered inmates, explaining that mental health staff is not familiar with transgender specific models of care or effective interventions. 5 states reported that they did not complete the questionnaire due to ongoing litigation, listed lawsuits and legal restraints as significant obstacles to providing adequate transgender treatment.

Respondents were asked to list any intervention that had been effective in their facilities, which would be beneficial for other states to implement. Responses included: completing one-on-one consultations with medical staff and administration members to explain the criteria and treatment options for individuals with transgender concerns; providing transgendered inmates with individual therapy to address comorbid personality disorders; building a consultation team composed of behavioral health psychologists, directors of nursing, medical doctors, health services directors, and other site specific staff to consult regarding interventions and plans; acknowledging inmates who have transgender concerns closely monitoring them for persecution and retaliation; and continuing

to provide HRT to inmates diagnosed and treated for these concerns prior to incarceration. Four respondents (22%) recommended states should enhance transgender specific training available to staff members, including correctional officers and work supervisors.

5 of the 8 respondents stressed the issue of needing evidenced-based guidelines for the treatment of transgendered inmates that could be feasibly applied in a correctional setting, two of which suggested states should share their current policies of assessment, treatment, and management.

Discussion

The purpose of this study was to survey the current assessment, housing and mental health treatment needs of transsexual inmates within state correctional facilities. The literature reviewed epidemiology, prevalence, multiple uses of terms, assessment, and current standards of care. The results of the survey indicated not only a lack of psychological and physiological treatment, but also a consistent acknowledgement of discomfort with the lack of understanding about transgender specific issues. Fortunately, prison officials appear to be increasingly open to providing services to transgender and transsexual inmates who require special consideration. Responses also indicated a need for standardized quality of care, education for staff interacting with transgendered inmates, and general physiological and mental health guidelines pertaining to specific psychological and medical therapies.

Assessment and Mental Health Services

Mental health professionals working with transgendered individuals in correctional facilities should complete the 10 tasks outlined by the SOC. Basic standardized national level protocol would provide resources currently unavailable in some state institutions. Such protocols would allow states to share and develop groundbreaking methods in an age of limited resources. Tasks one and two (accurate diagnosis of the individual's gender disorder and comorbid pathology) should be addressed in a basic assessment process as discussed in the previous section. Task three (counseling the individual about treatment options and their implication) may be entirely limited by the providing institution. However, if an inmate is found eligible or in need of psychotherapy (task four), the mental health professional providing treatment should discuss with the inmate what interventions and provisions are available within the facility. If deemed reasonably necessary for safety or health, it may be appropriate to transfer the inmate to an institution better equipped to handle the treatment of gender identity disorders.

Frequent lawsuits from transsexual and transgender inmates about reasonable standards of care make it reasonable for states to observe task five (ascertaining eligibility and readiness for hormone or surgical therapy) when providing treatment to

transsexual inmates. Again, the SOC eligibility criteria require a documented real life experience or extensive psychotherapy prior to hormone administration. Readiness criteria also require consolidation of gender identity during RLE or therapy, stable mental health with control of sociopathy, substance abuse, psychosis, and suicidality, and demonstrated evidence that the inmate will take hormones in a responsible manner.

■ Housing and Provisions

The research determined that the largest transgender issue faced by corrections facilities is housing. Research indicates that transgender/transsexual inmates face a greater risk inmate-on-inmate physical and psychological harm when housed in the general population. However, because not all facilities offer single cell housing, transgender/transsexual inmates are often forced into mental health units, segregation, or special assignment units. This leads to a lower quality of life and a greater chance for comorbid symptoms because of the lack of services, social interaction, fewer privileges, and peer interaction.

While the development of transgendered units seemingly solves several problems of safety and treatment, it also causes many others. First, transgender inmates may prefer to live in the general population, however, their motivations for doing so must be assessed (drugs, prostitution, etc). But, creating special units may attract malingerers and psychopaths who seek special privileges thereby creating a need for exceptional screening to be accepted to a transgender unit. Also, states should develop more than one unit located in facilities of varied security levels across the state for transfer issues (enemies, institutional infractions, need to be closer to family, incident of being attacked or attacking others, level change, etc.). Until topics of housing have been further researched, states should provide the most protective and least restrictive arrangement available keeping in mind realistic budgetary and legal constraints.

Several respondents also expressed frustration with lack of training and awareness for prison officials, correctional officers, mental health, and support staff about transgender issues. Seemingly all literature stressed the importance of psychoeducation and training. A curriculum of awareness, budget planning, intervention, and identity specific issues should be researched further and presented to all prison staff during diversity trainings. Until transgender specific training for correctional settings is developed, mental health directors should assure that staff is familiar with the etiology, epidemiology, treatment, and management. Because screening and assessment of individuals with transgender concerns understandably limited, these issues should be addressed at all levels of the corrections community; city, county, state, and federal.

■ Implications for Further Areas of Research

Because research on the transgender population is in such an infantile stage, any well-conducted, ethical research would be an appropriate addition to the current bed of literature. However, analysis revealed several gaps which may be detrimental to the development or provision of “best care” practices to incarcerated transgendered individuals.

Clearly, a training model and curriculum for correctional staff concerning transgender issues is an immediate need. Information provided should include the criteria of GID and how gender identity differs from sexual orientation, current etiological research, and assessment/treatment methods. Training should also address treatments available to transgendered individuals within the community, as well as, those which are offered within state facilities. Although correctional officers and support staff may not require as in depth clinical training as mental health professionals, they should understand RLE and be overtly sensitive to situations which could potentially put any inmate at risk of harm. Most correctional facilities train all employees to be cognizant of transference and countertransference issues when interacting with criminals and psychopaths. The transgender train-

ing curriculum should equally address these issues with transsexual inmates. Staff should be encouraged to explore any transference or countertransference issues with supervisors or mental health staff with no fear of reprisal.

Social implications of accepting transgender/transsexual inmates reach far beyond prison walls. Arguments can be made that prisons and detention centers are not places for social or political experimentation. However, the reality is that larger populations of inmates are presenting with issues beyond the normally seen. In this case, transgender and transsexual communities, who have long been outcast, are now integrating into prison populations which forces prison management to address the psychosocial and medical needs of these individuals. Once taboo and relegated as an afterthought, this expanding community forces corrections staff, at all levels, to re-examine the safety and security for this group as it would for any other. But, because research is in short supply, more articulate examination must be completed.

Because this study had limitations, including a small sample population, and few respondents, similar surveys should be conducted to include individual prisons and jails rather than state level mental health executives. Future surveys should be designed to allow a greater response rate and more specific report of information. There is an emergent need for researchers to estimate a realistic prevalence of gender identity disorders within correctional systems. Also, more research is needed to address the prevalence, assessment, and treatment of comorbid pathology.

Studies should include the application of the SOC within correctional facilities and favorable revision should be tested and suggested where needed. Similarly, further research is needed on the feasibility and effects of embarking on the RLE while incarcerated. Case studies should be documented and any effective related interventions should be shared nationally. Additionally, the immediate and long-term psychosocial and psychological effects of GRS should be researched within correctional facilities and the community.

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