Counseling and Mental Health Care for Transgender Adults and Loved Ones

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SUMMARY. Increasingly, transgender individuals and loved ones (partners, family, and friends) are seeking assistance from mental health professionals working in the community rather than in university or hospital-based gender identity clinics. Drawing on published literature specific to transgender mental health, interviews with expert clinicians, the authors' clinical experience, and three key guiding principles (a transgender-affirmative approach, client-centered care, and a commitment to harm reduction), we suggest protocols for the clinician providing mental health services in the community setting. Practice areas discussed include assessment and treatment of gender concerns, trans-specific mental health issues, and trans-specific elements in general counseling of transgender individuals and their loved ones. doi:10.1300/J485v09n03_01 *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2006 by The Haworth Press, Inc. All rights reserved.]*

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INTRODUCTION

Transgender individuals and loved ones (partners, family, and friends) may seek assistance from mental health professionals for trans-specific or more general health concerns. Transgender mental health practice may include: (a) Evaluation, care planning, and treatment of gender identity concerns; (b) evaluation, care planning, and treatment of mental

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health concerns; (c) psychotherapy for individuals, couples, families, and groups; (d) short-term consultation (typically 1-3 sessions)–including information, resources, and referral assistance for a transgender individual or loved one, or peer consultation for another clinician; (e) psychoeducational workshops and groups offering information and facilitated discussion on specific topics (e.g., sexual health, feminizing or masculinizing hormone therapy, gender role transition), as well as training for employers, schools, and other interested members of the public; (f) case and global advocacy (see article in this volume by White Holman and Goldberg, 2006b); (g) clinical support or supervision for facilitators of peer-led support group; and (h) training of other clinicians.

This article addresses *trans-specific* elements of mental health practice, including assessment, care planning, and treatment. It is intended to assist clinicians providing mental health services in the community setting–counselors, family physicians, nurses, psychologists, psychiatrists, psychiatric nurses, and social workers–who are already familiar with basic terms and concepts in transgender care and are seeking more advanced clinical guidance in work with transgender adults. Mental health practice with transgender adolescents is discussed elsewhere in this volume (de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; White Holman & Goldberg, 2006a).

Mental health is intrinsically connected to cultural, physical, sexual, psychosocial, and spiritual aspects of health. Complete mental health care for the transgender community must similarly be considered in the context of a holistic approach to transgender health that includes comprehensive primary care as well as psychosocial care (Keatley, Nemoto, Sevelius, & Ventura, 2004; Raj, 2002). Close coordination between mental health and other services is essential for optimal practice (Bockting & Fung, 2005; Feldman & Bockting, 2003).

This article should not be perceived as a rigid set of guidelines or standards for care. In any clinical practice it is paramount that protocols be tailored to the specific needs of each client, and mental health practice is particularly dynamic in this regard. Research in transgender health is still in its infancy, and there are widely diverging clinical and consumer opinions about "best" practice. In this article we offer suggestions based on published literature specific to transgender mental health, interviews with expert clinicians, the authors' clinical experience, and the guiding principles of the co-sponsoring organizations–a transgender-affirmative approach, client-centered care, and a commitment to harm reduction (Kopala, 2003). Ongoing interdisciplinary research and collegial meetings are important in further developing practice protocols. Clinicians are encouraged to adapt and modify our suggested protocols to address changing conditions and emerging issues in practice.

CLINICAL PICTURE

As a heterogeneous population, there is great diversity among transgender individuals and their needs relating to mental health services. In a 2002 survey of individuals in British Columbia requiring transgender health services (N = 179), 53% of respondents reported a current need for counseling relating to gender issues, with 32% requiring mental health assessment relating to pursuit of feminizing or masculinizing hormones or surgery and 39% stating a current need for mental health care for issues not relating to gender identity concerns (Goldberg, Matte, MacMillan, & Hudspith, 2003). Clients may present seeking assistance with mental health issues, concerns relating to gender identity or expression, or non-transgender-specific psychosocial issues. For some clients all three concerns may be relevant, and the focus of treatment may need to shift over time to address the most pressing concerns.

Regardless of the presenting concern, the clinician must be able to evaluate the impact of transgender-specific issues on mental health (e.g., transphobia, impact of gender issues on psychosocial and identity development, psychological effects of feminizing or masculinizing hormones) and the implications for treatment. For individuals seeking help relating to gender identity concerns, the clinician must be knowledgeable about gender and sexual identity development, transgender "coming out," crossdressing, gender dysphoria, gender

transition, and the common concerns and reactions of loved ones.

Figure 1 outlines the basic assessment, treatment, and evaluation process in mental health care for transgender individuals. The initial evaluation (A) involves determination of the client's reasons for seeking service and a general client history. If the client has current gender identity concerns, the next step may be a gender assessment (B) to provide more detailed information about the client's gender identity issues and to determine any co-existing conditions, or it may be to provide supportive counseling until the client feels ready to engage in such a process. If the client does not have gender concerns but is instead presenting with mental health concerns, a more detailed mental health assessment (C) is performed. Based on the assessments, a clinical impression is generated, including a multi-axial diagnosis and assessment formulation where appropriate. The next step, care planning (D), involves recommendations for treatment and discussion of treatment options. If the client wishes to pursue hormonal or surgical feminization or masculinization, a specialized assessment (E) must be done to evaluate eligibility and readiness (Meyer et al., 2001). Each of these tasks is discussed in detail below.

INITIAL EVALUATION

Initial evaluation typically consists of one to three 50-minute clinical interview sessions with a new client. The goals of the initial evaluation are to build therapeutic rapport, discuss client and assessor goals and expectations, record client history and objectives, evaluate current psychological concerns and capacity to consent to care, and form an initial clinical impression. Each task is discussed below.

After the rules of confidentiality and other information required at any mental health consultation have been discussed, the next question should be an open question as to what leads the client to seek assistance at this time. Once the client has been able to describe the presenting complaint, the interviewer should decide which assessment tasks are most appropriate for the initial visit and which should be postponed to subsequent sessions. For clients in acute crisis, stabilization is the immediate priority; assessment will, by necessity, be more brief and focused on content directly related to the current situation, rather than a detailed life history.

Trans-Specific Issues in Building Therapeutic Rapport

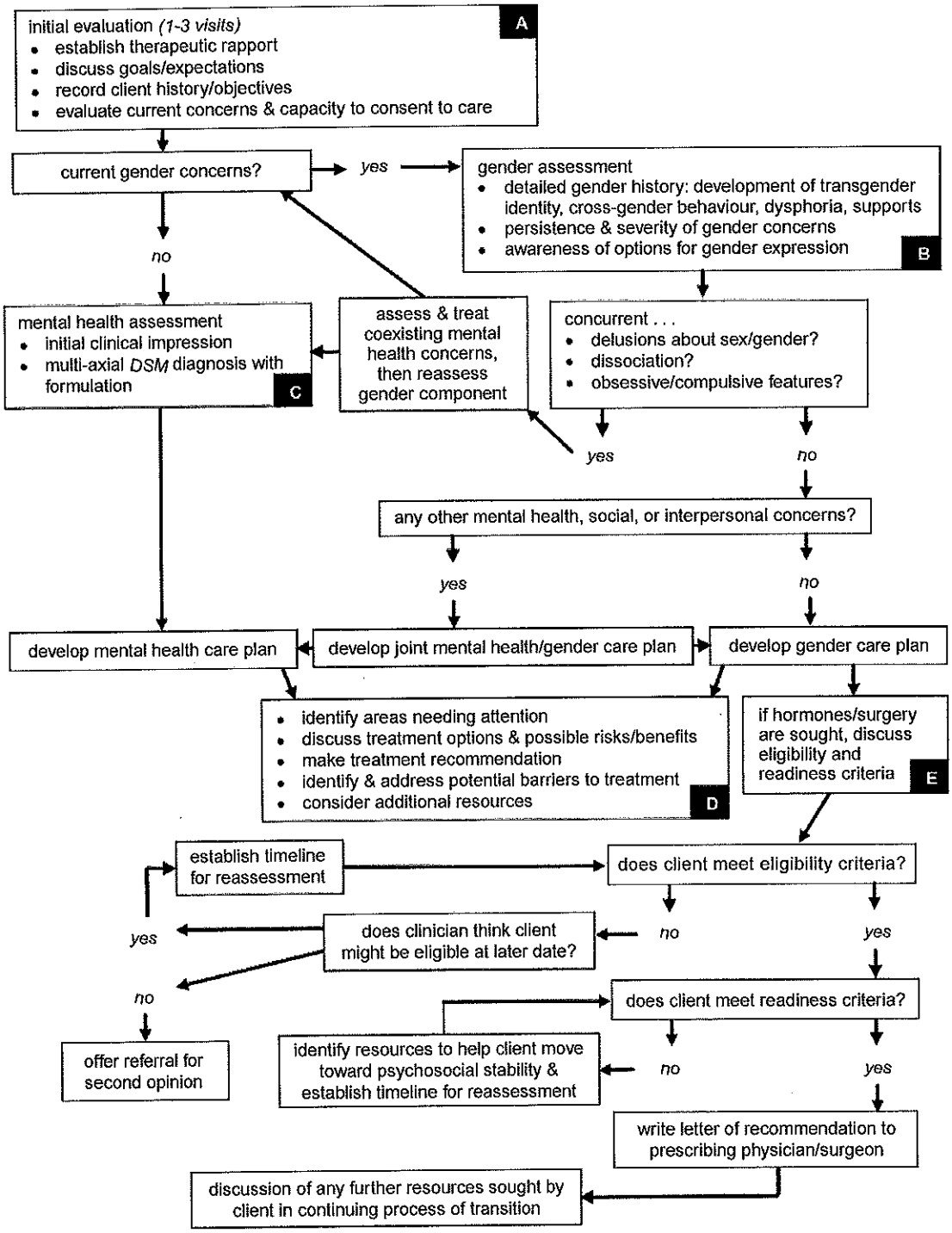
Many transgender individuals and loved ones have had negative experiences with health and social service professionals, and may be wary about entering unreservedly into a relationship with the clinician. This is particularly true when the interaction is mandated–for example, as part of obtaining access to hormone therapy or surgery–rather than voluntarily sought (Bockting, Robinson, Benner, & Scheltema, 2004; Brown & Rounsley, 1996). Issues relating to hormone and surgery assessment are discussed in detail in a later section of the article.

In addition to the regular techniques used to build therapeutic rapport, it can be helpful to actively demonstrate transgender-specific sensitivity by discussing privacy issues in setting appointment times (e.g., whether a message can be left at the client's home or workplace) and the client's preferred name and pronouns. Visible transgender brochures, books, and posters signal to clients that you are aware of transgender concerns and are supportive of the transgender community. Similarly, intake forms should be transgender-inclusive.

Discussing Client and Clinician Goals and Expectations

Every client has goals and expectations, and often fears, about working with a mental health professional. Transgender clients may have a particular idea about what to expect based on previous experience with health professionals or the experiences of transgender peers. Clinicians also come to this work with particular goals and expectations, as well as a framework for how the initial evaluation and subsequent care planning and treatment will proceed. It is recommended that the protocols and approach used by the clinician be explained in detail so the client knows what to expect.

FIGURE 1. Clinical Pathways and Task in Mental health Practice with Transgender Individuals



In particular, if the client is presenting with a desire to be assessed for hormones or surgery, it is important to ensure the client understands the process the clinician will use to conduct the evaluation, the specific eligibility and readiness criteria to be evaluated, and the way the clinician will handle possible outcomes of the evaluation process. Whether pursuing hormone therapy or surgery is the main issue or not, it is helpful to make it clear that you are not judging the client's gender presentation or passability. Instead, the assessment will focus on core gender identity, authentic self, and psychosocial adjustment.

Documenting Client History and Current Concerns

Documentation of client history–including relevant medical, gender, and psychosocial information–is addressed in the evaluation interview by asking the type of questions listed in Table 1. Initial evaluation and documentation should be paced to facilitate therapeutic rapport. For some clients, in-depth discussion of potentially sensitive topics at an early stage helps reassure the client that the therapist is knowledgeable, sensitive, and non-judgmental; for other clients it can be anxiety-provoking

TABLE 1. Potential Areas of Inquiry in Initial Evaluation

Topic	Questions
Medical history	Does anyone in your family have a history of chronic physical or mental health concerns? Do you have any chronic physical or mental health conditions, and if so, what are they? Have you ever been diagnosed with a physical or mental health condition, and if so, when and what was the diagnosis? Have you ever been hospitalized, and if so, when and what for? Are you currently taking any medication (including illicitly obtained hormones) or herbal supplements, and if so, what is the name, dose, and length of time you have been taking it? Have you ever had any injuries or surgeries?
Substance use	Do you smoke, and if so how much per day? Have you ever had any concerns relating to drugs or alcohol? Has anyone else ever expressed concern about, or objected to, your use of alcohol or drugs? Have there been any unpleasant incidents where alcohol or drugs were involved? Do you have any concerns about drugs or alcohol now?
Family	People define 'family' in many ways; who do you define as being in your family? How would you characterize your relationships with your family members when you were a child, and now? Do you have any concerns relating to your family?
Sexuality	How do you identify in terms of your sexual orientation? Are you sexually attracted to men, women, or both? Are you sexually attracted to transgender people? Are you currently involved with anyone romantically, and if so, how do you feel about your relationship? Have you had any concerns about relationships or sexuality in the past? Do you have any current concerns about relationships or sexuality today? Have you ever had any concerns about sexual abuse or sexual assault?
Social	What are your social supports? When you are under stress, who do you turn to for help? Are you currently working, in school, or volunteering? Do you have any concerns relating to work, school, or community involvement? Do you feel connected to any particular communities–e.g., transgender community, ethnic or cultural community, lesbian/gay/bisexual community, youth groups, seniors' groups, Deaf community? What are your hobbies or social interests?
Economic	What is your primary source of income? Do you have any current financial stress? Are you worried about future financial stress? Are you satisfied with your current housing? Do you have any concerns about housing? Do you have any concerns about work?
Gender concerns	Have you ever had any concerns relating to your gender? Do you currently have concerns or questions relating to your gender? How do you feel about being transgender? Are there any cultural or religious conflicts for you as a transgender person? Have you ever pursued any changes to your appearance or body to bring it closer to your sense of self? Have you ever sought to change your body through hormones or.surgery, or thought about pursuing this in the future? Do you have any concerns about your appearance or body now? Are there any kinds of supports you feel might be helpful as a transgender person?

to be asked questions about drug and alcohol use, sexual concerns, history of sex work, etc.

Standardized psychological testing and paper-and-pencil questionnaires are helpful tools to screen for a range of health and psychosocial adjustment issues and to assess the client's identity in greater depth. Using these instruments as an adjunct to the clinical interview can make the interview more efficient by reducing the areas and questions to be explored verbally, and allows cross-referencing of verbal and written responses (as clients vary in their comfort to reveal certain personal information verbally or in writing). In addition to instruments used to evaluate general mental and physical health, Table 2 presents an overview of commonly used tests and questionnaires relevant to transgender-specific concerns. The instruments chosen depend on the client's presenting complaint.

While it is important to gain an accurate sense of areas of concern, evaluation should also include discernment of client strengths. Determining personal strengths and positive supports is necessary not only to give a complete picture of the client's life and psychosocial adjustment, but also to bolster a client's sense of competency and agency. The care plan that will be developed based on the evaluation will build on these strengths to promote resilience.

In some cases, evaluation by another professional may be useful. For example, if the initial interview is conducted by someone other than a psychiatrist, a separate psychiatric evaluation may be indicated to assess psychiatric symptomatology and, if there are co-existing mental health issues, explore options for pharmacological or other treatment. Depending on answers to screening questions about drug and alcohol use, a formal chemical dependency evaluation may be recommended. The stigma associated with substance use may lead clients to be hesitant to frankly discuss details of drug and alcohol use during an initial evaluation. However, given the relatively high prevalence of drug and alcohol use among transgender individuals (Hughes & Eliason, 2002; Lombardi & van Servellen, 2000; Nemoto, Operario, Keatley, Nguyen, & Sugano, 2005; Pasillas, Anderson, & Fraser, 2000) and the difficulties faced by transgender individuals in accessing substance abuse treatment that is transgender-sensitive and competent, we believe it is important to enquire about drug and alcohol use as part of the intake process. Visible pamphlets about substance abuse treatment and harm reduction can be helpful in providing clients with reassurance that it is safe to discuss these concerns.

TABLE 2. Testing and Questionnaire Instruments

Assessment area	Possible instruments
Transgender identity	Gender Identity Questionnaire (Docter & Fleming, 2001)
Internalized transphobia	Transgender Identity Survey (Bockting, Miner, Robinson, Rosser, & Coleman, 2005)
Components of sexual identity	Assessment of Sexual Orientation (Coleman, 1987)
Psychosexual functioning	Derogatis Sexual Functioning Inventory (Derogatis & Melisaratos, 1979), Compulsive Sexual Behavior Inventory (Coleman, Miner, Ohlerking, & Raymond, 2001)

Evaluating Capacity to Make Care Decisions

Decision-making capacity is the ability to understand relevant information and to appreciate the reasonable foreseeable consequences of a decision (Appelbaum & Grisso, 1988). As in the non-transgender population, most transgender clients will not present any challenge in terms of ability to consent to care, and the evaluation is usually a spontaneous and straightforward judgment based on routine interactions between a clinician and client (Tunzi, 2001). Sometimes determination of the capacity to make medical decisions is more challenging because a client has limited cognitive capacity due to neurological illness, developmental disability, head injury, or intoxication. In these cases, formal capacity assessment such as the Aid to Capacity Evaluation (ACE) may be used by the mental health clinician or the patient's primary care provider (Etchells et al., 1999). ACE is a semi-structured decisional tool that prompts inquiry into the seven relevant areas outlined in Table 3.

TABLE 3. Aid to Capacity Evaluation[1]

Area of capacity to assess	Interview questions
Ability to understand the medical problem	What problem are you having now?
Ability to understand the proposed treatment	What is the treatment for your problem? What can we do to help you?
Ability to understand the alternatives to the proposed treatment (if any)	Are there any other treatments? What other options do you have?
Ability to understand the option of refusing treatment (including treatment withdrawal)	Can you refuse the treatment? Can we stop the treatment?
Ability to accept the reasonably foreseeable consequences of accepting treatment	What could happen to you if you have the treatment? How could the treatment help you? Could the treatment cause problems and side effects?
Ability to accept the reasonably foreseeable consequences of refusing proposed treatment	What could happen to you if you don't have the treatment? Could you get sicker or die without the treatment?
Ability to make a decision that is not substantially based on hallucinations, delusions, or cognitive signs of depression	Why have you decided to accept or refuse the treatment? Do you think we are trying to hurt or harm you? Do you deserve to be treated? Do you feel that you are being punished? Do you feel that you are a bad person?

[1]An ACE scoring form is available online at the University of Toronto Joint Centre for Bioethics website, http://www.utoronto.ca/jcb/disclaimers/ace_form.htm
Adapted from Etchells, E. (n.d.). Aid to Capacity Ealuation (ACE). Toronto, ONT: University of Toronto Joint Centre for Bioethics. Retrieved January 1, 2005, from http://www.utoronto.ca/jcb/disclaimers/ace.pdf

In complex cases, additional evaluation should be sought from a psychologist or other clinician who specializes in medical competency evaluation. It may also be appropriate to seek collateral information from loved ones or caregivers (see case studies of Jamie and Patricia in Appendix A).

Initial Clinical Impression

After the interview is complete and any testing is scored, the assessor should review the completed questionnaires, the interview notes and test results, supplemental evaluations (e.g., psychiatric assessment, chemical dependency evaluation, competency testing) and collateral evidence, and integrate the information gathered into an overall assessment of the client's presenting complaint, goals and expectations, background, and biopsychosocial adjustment. In complex cases the clinical impression may be tentative at this point, and will need to be confirmed during the course of treatment.

ASSESSMENT AND TREATMENT OF GENDER CONCERNS

The prevalence of gender concerns is unknown. There are no data about the number of persons who have concerns or questions about gender identity or crossdressing, only some limited data on those who have sought surgical sex reassignment. The prevalence of transsexuals pursuing sex reassignment surgery is estimated at 1 in 11,900 for male-to-female transsexuals and 1 in 30,400 for female-to-male transsexuals (Bakker, van Kesteren, Gooren, & Bezemer, 1993) and annual incidence rates are estimated to range from 0.15-1.58 per 100,000 (Kesteren, Gooren, & Megens, 1996; Olsson & Möller, 2003).

Gender identity concerns can affect individuals of all ages. Male-to-female (MTF) transsexuals may not seek psychological or medical intervention until middle age (Blanchard, 1994), while female-to-male (FTM) transsexuals typically present somewhat younger. However, gender issues can affect all age groups, including children and adolescents. Seniors may also present with previously unarticulated or untreated gender concerns.

Gender issues can arise in a variety of ways in mental health practice. Some clients disclose at the first session that they are seeking help for gender issues, and may specifically ask about the clinician's experience in working with the transgender community as part of the initial

meeting. Others are unsure how to articulate their concerns or are more cautious about divulging gender issues, presenting with generalized depression or anxiety, seeking help "coping with stress," or other general concerns. As gender-variance is often assumed to be evidence of homosexuality, individuals who are questioning their gender or are confused about gender identity issues may describe their feelings in terms of confusion about sexual orientation. In some cases gender issues emerge over time as part of the clinical picture for clients who initially seek help relating to substance use, self-harming behavior, disordered eating, or other issues.

The language used by transgender individuals is continually changing, as transgender people become more visible and are better able to articulate similarities and differences in identities and experiences. To facilitate communication, it is helpful for the clinician and client to reach a common understanding of terms and concepts key in discussion of gender concerns, including those relating to gender, sex, and sexual orientation.

Gender Assessment

Assessment of gender concerns involves a detailed history of transgender identity development and gender expression. In addition to the interview questions outlined in Table 4, paper-and-pencil instruments listed earlier in Table 2 (e.g., Gender Identity Questionnaire, Transgender Identity Survey) may be utilized. If the client presents with gender confusion or is in the early stages of exploring identity, it may be too soon in their identity development to allow an in-depth gender assessment. In these cases, further exploration of identity and experimentation with the various options to manage or express one's transgender identity in the context of psychotherapeutic treatment is advised before completion of a full gender assessment. For clients in later stages of incorporating transgender identity into daily life, a more detailed interview will be possible.

There is controversy within the transgender community and among mental health professionals about the *DSM-IV-TR* (American Psychiatric Association, 2000) diagnoses of *Gender Identity Disorder* (GID) and *Transvestic Fetishism* (TF) as part of evaluation and treatment planning (Bockting & Ehrbar, 2006). Some clinicians feel that a diagnosis of GID or TF is fundamentally important to guiding clinical consideration of options for treatment and helps promote client access to health care, including access to hormone therapy and sex reassignment surgery (Brown & Rounsley, 1996). Others believe that these diagnoses pathologize transgenderism, normalize dominant Western gender binary norms as culturally universal, and conflate distress relating to societal marginalization with distress relating to a condition that may require medical intervention (Davis, 1998; Hill, Rozanski, Carfaginni, & Willoughby, 2003; Israel & Tarver, 1997; Moser & Kleinplatz, 2003; Wilson & Lev, 2003). Although a diagnosis of GID is not explicitly required to gain access to hormones or surgery in the World Professional Association for Transgender Health (WPATH) *Standards of Care* (Meyer et al., 2001), the diagnosis is required by many individual clinicians as a prerequisite to hormonal or surgical treatment.

Regardless of approach and beliefs relating to GID and TF diagnosis, or a history of GID or TF diagnosis, we consider it essential to evaluate specific parameters in assessment of clients who present with gender identity concerns. These include the specific nature of the gender concerns, their persistence and severity, any associated mental health concerns (e.g., obsessive or compulsive features, delusions relating to sex and gender, dissociation, personality disorders), any associated concerns about sexual identity (e.g., sexual orientation), and any coexisting conditions such as anxiety and mood disorders (Bockting, Coleman, Huang, & Ding, 2006; Clements-Nolle, Marx, Guzman, & Katz, 2001) or Asperger's Disorder (Robinow & Knudson, 2005). Appendix B provides two sample letters summarizing the gender assessment findings of a MTF and FTM transgender client.

Nature of the Gender Concerns

Not all transgender individuals struggle with gender issues; among those who do, there are varying concerns. Some individuals seek help because they are confused about their identity; others are struggling with despair, shame, or

TABLE 4. Potential Areas of Inquiry in Gender Evaluation: Transgender Person

Topic	Questions
Gender identity	How would your describe your gender identity? How did you come to recognize that your experience of gender is different than most individuals? Were there any life events that you feel were significant in influencing your gender identity? Have there been changes to your gender identity over time? What do you remember feeling about your gender as a child, during puberty, and as an adolescent? How do you feel about your gender now? Do you have any questions or concerns about your gender? How does your gender identity impact how you feel about work, relationships, family, or other aspects of your life?
Gender expression	Are there any activities you did as a child or that you do now as an adult that you think of as being cross- or trans-gendered, and if so, how have these been viewed by your family and others in your life? Did you prefer to be around individuals of any particular gender as a child, and if so, is this different than your preferences now? Have you ever crossdressed; if so, what was that experience like for you, and if not, what do you imagine it would be like? If you could change your external appearance in any way you wanted to more closely match your sense of who you are, what would this look like in terms of your gender? Have you ever taken feminizing or masculinizing hormones or had sex reassignment surgery, and if so, what was that like for you?
Perceptions of others	How do you think others perceived your gender when you were a child, and how do you think others perceive your gender now? How do you want to be perceived in terms of your gender? How important is it to you that there be a fit between how you feel about your gender and how others perceive you?
Sexuality	How does gender play out in your sexual desires or fantasies? Does gender impact the kinds of sexual activities you do (on your own or with others) or wish you could do? What is a typical sexual fantasy for you? Do your sexual fantasies involve other men, women, or transgender people, or do you mainly fantasize about yourself? If you are in your fantasies, do you imagine yourself to be female, male, or transgender? What are your feelings about the parts of your body that are often associated with sexuality (e.g., genitals, chest/breasts)?
Support resources	Do the people in your life know that you are transgender; if so, what was it like to tell them, and if not, how do you feel about them not knowing? Have you had any contact with other transgender individuals, and if so, what was that like for you? What do you see your relationship being to the transgender community now, and what would you like it to be in the future? Have you used the Internet to access support and information about being transgender; if so, what have you learned, and in what ways was it helpful or not helpful for you?

guilt relating to crossdressing or transgender feelings; others are dysphoric about physical characteristics associated with their sex, the perceptions of others relating to gender, and/or the social roles associated with their sex and gender assigned at birth.

Persistence and Severity of Gender Concerns

For some individuals, gender concerns are mild and/or transient; for others they are persistent and severe enough to cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning"–considered the minimum clinical threshold necessary for diagnosis of Gender Identity Disorder or Transvestic Fetishism (American Psychiatric Association, 2000). Clients who are gender-variant but not preoccupied with gender concerns to the degree that it is negatively affecting their quality of life should not be diagnosed with GID or TF. Distress relating to others' transphobia is not GID; if it is so severe that the transphobia of others is negatively affecting quality of life, a diagnosis of Adjustment Disorder may be appropriate (Israel & Tarver, 1997).

Associated Obsessive or Compulsive Features

Compulsive crossdressing, obsessive pursuit of validation of transgender identity through sexual pursuits, or other obsessive or compul-

sive behaviors should be evaluated. If there is sexual compulsivity, a diagnosis of Sexual Disorder NOS or Transvestic Fetishism may be appropriate (American Psychiatric Association, 2000). If the client is not seeking hormones or surgery, compulsivity can be treated concurrent with addressing transgender issues. If the client is seeking hormones or surgery, the obsessive or compulsive features should first be addressed, with subsequent reassessment to determine whether gender identity concerns persist (Bockting, 1997).

Delusions About Sex or Gender

In rare cases, schizophrenia or other thought disorders manifest as gender- or sex-based delusions (Campo, Nijman, Evers, Merckelbach, & Decker, 2001; Manderson & Kumar, 2001). For example, the client may believe that their body has spontaneously transformed from one sex to another, or that internal organs of the other sex are present even after laboratory examination confirms there is no evidence of intersexuality. In some cases the delusion may be expressed as "really being of another gender." This can be distinguished from gender dysphoria, the latter usually being more persistent and longstanding, and present also when the client is not actively delusional.

Dissociation

For some individuals, growing up transgender is experienced as traumatic. Others have experienced additional trauma such as physical or sexual abuse. Coping strategies with such trauma may include dissociation of the self, and this may involve a split of identity into a separate male and female self (Bockting & Coleman, in press). By addressing this trauma in therapy, an integrated self can be achieved (Bockting & Coleman, in press; Brown & Rounsley, 1996).

A diagnosis of Dissociative Identity Disorder as defined in the *DSM-IV-TR* is not a contraindication to sex reassignment surgery (Brown, 2001) but should be very carefully evaluated as part of the overall care plan. A diagnosis of Dissociative Identity Disorder is not appropriate for individuals who have a bi-gender identity but no dissociation, even if they describe their gender as having different "personalities" or "selves." As stated by Israel and Tarver (1997), "The transition from one gender to another occurs across psychological and physical planes and is experienced as self-fulfilling and stress-relieving for the transgender individual, in contrast to the increased confusion and insecurity felt by the person with a dissociative condition" (pp. 29-30).

Personality Disorders

It can be challenging to evaluate gender identity concerns in clients with personality disorders such as borderline personality disorder. Sometimes it is difficult to determine whether symptoms of gender dysphoria are solely due to the personality disorder or were pre-existing, with the personality disorder evolving as a way of coping with the dysphoria. In other cases, gender dysphoria and a personality disorder may be unrelated and simply co-exist.

Internalized Homophobia

Clients who have difficulty accepting same-sex or same-gender sexual feelings or attractions may fantasize about or describe themselves as being of the other gender (Brown & Rounsley, 1996). Assessment of gender concerns should include a thorough sexual history, and appropriate counseling offered for any concerns about sexual orientation. Gender identity concerns should be reassessed after sexual orientation has been clarified and comfort with sexual orientation has been achieved.

Asperger's Disorder

Asperger's Disorder is classified in the *DSM-IV-TR* as a qualitative impairment in social functioning with restricted repetitive and stereotypical patterns of behavior, interests, and activities (American Psychiatric Association, 2000). There is no clinically significant delay in language and cognitive development. This disorder is typically diagnosed in childhood.

For reasons that are not understood, gender dysphoria is present in clients with Asperger's Disorder at a greater rate than those in the unaffected population (Robinow & Knudson, 2005). The gender dysphoria is usually present quite

early in life but may not become apparent until later. Because of the obsessive and compulsive nature of Asperger's Disorder, clients will usually be very persistent in obtaining sex reassignment surgery, but do not appear to be as concerned about social adjustment as their observance of social cues is impaired (see case of Patricia in Appendix A). Diagnosis of previously unrecognized Asperger's Disorder can facilitate any needed social, education, or pharmacotherapeutic interventions (Volkmar, Cook, Pomeroy, Realmuto, & Tanguay, 1999), as well as ensuring that treatment of co-existing gender concerns accommodates the communication patterns typical of Asperger's. It may also be relevant in determining competency in making care decisions.

Care Plan for Gender Identity Concerns

Treatment of gender concerns depends on numerous factors, including the client's stage of transgender identity development, the client's knowledge of and pre-existing pursuit of gender identity management options, and co-existing mental health or psychosocial concerns. Prior to treatment of gender issues, co-existing conditions that are more emergent or that present a barrier to treatment must be addressed, and if other concerns become more emergent during treatment of gender issues the focus of care should shift accordingly. Mental health or psychosocial concerns identified during the initial evaluation or during treatment of gender identity concerns should be evaluated and incorporated into the overall care plan. Axis IV psychosocial stressors are best addressed through coordination with social, housing, legal, and vocational services (White Holman & Goldberg, 2006b).

Care planning should include consideration of socioeconomic factors that influence clients' ability to access or engage in treatment. Seventy-two percent of participants in a survey in British Columbia (N = 179) reported difficulty accessing services relating to crossdressing or gender transition; the most common barriers reported were cost (40%), lack of services in the client's home region (31%), and waitlists for services (26%) (Goldberg et al., 2003). As private psychotherapy is often not covered by public health insurance, psychotherapy may not be economically accessible even when the client is highly motivated to engage in treatment. Global advocacy is needed to ensure that transgender individuals in need of professional assistance are able to access psychotherapeutic services.

Psychotherapy for Gender Identity Concerns

Some individuals explore gender identity issues through peer support, use of the internet, or self-directed reading, writing, and reflection. Others voluntarily seek professional psychotherapeutic assistance, or have psychotherapy recommended as a prerequisite to consideration for feminizing or masculinizing hormone therapy or sex reassignment surgery.

Mental health professionals may, depending on their theoretical orientation and training, apply a number of different therapeutic approaches to the treatment of gender identity concerns (Fraser, 2005). What is most important is that the treating clinician has developed specific competence in transgender care, which often includes a re-examination of theory on gender and sexual identity development within their own discipline and training under supervision of an established gender specialist (Israel & Tarver, 1997). A trusting, authentic relationship with the client is paramount to the success of any psychotherapeutic approach. Because working with transgender clients can involve challenging transference and countertransference issues (Koetting, 2004; Milrod, 2000), ongoing clinical supervision and peer consultation are essential.

Addressing Co-Existing Mental Health or Psychosocial Concerns

Unless treatment of gender identity concerns and concurrent mental health concerns are embedded in safeguarding or improving the client's social adjustment, it is unlikely that the goal of achieving better mental health and well-being will be achieved. Treatment of concurrent mental health concerns is necessary both to relieve the distress associated with these concerns and also to help the client engage in psychotherapy to address the gender identity issues. It takes courage and persistence on the client's part to confront gender identity concerns

that have often been surrounded with fear, shame, hopelessness, and despair. Addressing the overall mental health of the client will improve the client's ability to work toward resolution of gender confusion or distress and, if desired, to pursue gender transition.

Many clients are appreciative of an integrated approach, but others see the discussion of psychosocial or mental health concerns as a "distraction" from working on gender issues. To promote active client engagement in treatment, it can be helpful to explain to the client how addressing co-existing concerns will be of benefit not only in terms of improved mental health, but also in terms of achieving and sustaining resilience in living life as a transgender person in the face of social stigma. Moreover, the client's strengths and resilience displayed so far should be acknowledged and validated, and treatment should build on these strengths.

Exploring Gender History and Development of Transgender Identity

The emphasis of this aspect of therapy is on internal reflection and on the meaning the client assigns to past and present experiences (Bockting, 1997). The goal is not to theorize or speculate about causative factors relating to transgender identity, but rather to explore the client's understanding of their own identity development and the impact of life events.

Exploration of gender history, development of transgender identity, and related concerns begins with an in-depth review of the client's personal history. This review of personal history provides the opportunity to cognitively restructure significant events and experiences, facilitate grief and healing, and foster a stronger sense of self and identity. It can also aid in identifying and changing patterns of compulsivity, understanding the development of Axis I and II disorders, and illuminating and changing present maladaptive thoughts and behaviors. The telling of one's history to a willing listener is also validating and, by speaking of it, helps to clarify and consolidate the client's self-understanding. It may be helpful to discuss these experiences in a framework of developmental stages of transgender coming out or emergence (Bockting & Coleman, in press; Lev, 2004).

Journaling has been shown to lessen the impact of trauma and improve health (Esterling, L'Abate, Murray, & Pennebaker, 1999). Clients who are literate can write their life stories chronologically as homework between therapy sessions, and bring this journal to share in individual or group therapy. Those who struggle with writing can create genograms, photo montages or collages, or other visual depictions of life story.

During therapy, issues may arise relating to family-of-origin intimacy dysfunction, abuse, or neglect. Consultation or referral to specialized services may be useful if clients need assistance for childhood sexual abuse. In some cases, transgender clients may seek to involve family members in therapy to explore and resolve childhood issues, and use this as an opportunity to improve these relationships. Support from family and friends has been associated with resilience of transgender individuals facing gender-related stigma and discrimination (Bockting, Coleman, Huang et al., 2006).

Another area of focus may be internalized transphobia. Clients who have internalized societal stigma (Goffman, 1963) typically struggle with profound shame, guilt, and self-loathing. This may manifest in a hope that psychotherapy will stop transgender feelings or, more typically, in an over-emphasis on passing as a non-transgender woman or man and a discomfort associating with other transgender individuals onto whom feelings of guilt and self-hatred are projected. Exploring these issues may help the client move toward self-acceptance (Bockting & Coleman, in press). For some clients, psychotherapy to alleviate internalized transphobia is a long-term process.

After personal history has been reviewed and gender identity concerns have been clarified, it is appropriate to shift to actively exploring options for expression and management of gender identity. However, such exploration may trigger a need to revisit issues in the past, resulting in new insights and further resolution. To maintain a trusting therapeutic relationship, it is helpful to continue to clarify expectations of the degree and value of reflecting on the past, or "soul-searching," to facilitate the client in making a fully informed decision about the various options for expression and management of gender identity.

Exploration of Options for Gender Expression

The WPATH *Standards of Care* (Meyer et al., 2001) list a range of possible options for transgender identity exploration and expression, including (a) participation in peer support/self-help groups or in the transgender community, (b) counseling to explore gender identity and to deal with pressures relating to work or family (c) learning about transgenderism from the Internet, guidelines for care, or literature relating to legal rights, (d) disclosing transgender identity to family, friends, and other loved ones ("coming out"), (e) integration of gender awareness into daily living, (f) temporary and potentially reversible changes to appearance, such as changes in hairstyle or makeup; shaving, plucking, or waxing facial or body hair; applying facial hair; wearing prosthetic breasts or penile prosthesis; tucking or binding the chest or genitals; and crossdressing, (g) change in vocal expression, pitch/tone, inflection, and other aspects of speech, (h) episodic cross-living, (i) change in gender pronoun or name, in common usage or legal change, (j) semi-permanent changes to appearance such as masculinizing or feminizing hormones (some changes are reversible, while others are not), and (k) permanent changes to appearance, such as surgical reconstruction of the face, chest, or genitals, or electrolysis or laser removal of facial and body hair. This list is not meant to be exhaustive, but simply to illustrate that there are multiple options that may be pursued, and that there is no right or wrong way to manage one's identity. Frequently, a client's expression of transgender identity evolves over time, requiring re-evaluation of possible options. The role of the mental health professional is to assist the client to consider all of the options and make an informed decision regarding identity management. Whatever options the client considers, there should be thought as to how the client will realistically integrate changes into daily life.

Discussion of options should take into account previous treatment and identity exploration. For example, if the client is already living full-time in the desired gender role and is satisfied with this, exploring options such as integrating crossgender feelings into the gender role assigned at birth or "episodic crossliving" would not be appropriate; ensuring the client is cognizant that there is not one way to be transgender will suffice.

Gender role transition, hormone therapy, and each surgical procedure may be considered separately. A gender role transition could be undertaken with or without hormone therapy or surgery; similarly, hormone therapy does not need to be followed by surgery, and chest or breast surgery is not necessarily accompanied by hormone therapy or followed by genital surgery. Feminizing or masculinizing hormones have systemic effects and it is not possible to pick and choose specific changes, but endocrine agents that cause menstrual cessation (FTM) or mild feminization without breast development (MTF) may be appropriate for clients who identify as androgynous, bi- or nongendered and wish only to minimize sex and gender characteristics (Dahl et al., 2006).

Contact with peers who are expressing their gender identity in various ways can help clients appreciate the multiplicity of options for gender expression, understand what is involved in the various possible change processes that may be pursued, and anticipate potential challenges. Peer contact may include group therapy, self-help groups, participation in Internet discussions, social contact, or one-to-one peer support available through transgender community organizations. Peers can help with information about ways other than medical intervention to feminize or masculinize appearance, such as clothing, hairstyle, breast prostheses, chest binders, and genital prostheses.

Many transgender individuals initially immerse themselves in a specific transgender social network or group as part of their desire to find community. While strong transgender identification and community affiliation can be a helpful path to self-discovery, peer opinion can at times also be a negative force if there is pressure to conform to group norms or to pursue a particular identity or course of action. For example, some transgender individuals emphasize physical change and transition, whereas others reject the idea of transition to pass as a member of the other sex as "selling out" to fit mainstream norms. The mental health clinician can assist with referral to peer groups that explicitly support diversity of gender identity and

expression, and individual choice in decisions relating to identity management.

Implementation of Identity Management Decisions

Once the client has come to a decision for gender identity expression and management, therapy focuses on supporting the individual to implement this decision. Some clients may choose strategies that do not require disclosure of transgender identity to others, keeping transgender identity and expression private. For others, disclosing transgender identity to family and friends, co-workers, teachers, or students, community, and others in the transgender person's life is an important step.

Disclosure of transgender identity is often considered analogous to disclosure and coming out for lesbian women, gay men, and bisexual individuals. However, the two processes are not identical (Brown & Rounsley, 1996). While both processes involve disclosure of a personal secret that may evoke a negative response by others, the existence of homosexuality and bisexuality is generally recognized; in contrast, transgenderism is not widely recognized or understood, and challenges societal beliefs about sex, gender, and sexuality in a way that is disorienting to many non-transgender individuals. For those undergoing gender transition, coming out involves not only the disclosure of a secret, but also subsequent visible changes in social role and physical appearance; for loved ones the consequences are also different as physical changes cannot be concealed and gender-based definitions of relationships may change. (e.g., the loss of a "father" who changed gender roles).

Despite the differences, the tools for disclosure of transgender identity are the same as those used in other circumstances where a client wants to discuss a potentially emotionally charged issue (Israel & Tarver, 1997). Clients are encouraged to take calculated risks in disclosure (Bockting & Coleman, in press; Horton, 2001), starting with people who are most likely to be accepting. This builds a base of support for the client and possibly for other individuals in the transgender person's life who may have difficulty following disclosure. Although some loved ones are not surprised by disclosure of transgender identity and are strongly supportive, in most cases immediate acceptance is not a realistic expectation. Loved ones often go through stages of adjustment involving feelings of shock, disbelief, denial, fear, anger, and betrayal, followed by sadness and eventual acceptance (Ellis & Eriksen, 2002; Emerson & Rosenfeld, 1996). Peer support can be vital to help clients put reactions of loved ones in perspective. Family therapy or counseling for loved ones of a transgender person can be helpful as well.

The importance of social support cannot be underestimated. Research has shown that transgender individuals often have low levels of social support and that support from family and peers buffers the negative effects of social stigma and discrimination on transgender individuals' mental health (Bockting, Coleman, Huang et al., 2006; Nemoto, Operario, Sevelius et al., 2004). One study found that lack of familial support was predictive of regret following sex reassignment surgery (Landen, Walinder, Hambert, & Lundstrom, 1998).

Clients going through a gender role transition–with or without hormones or surgery–face many challenges. These include the adjustment of learning a new gender role and also the discrimination and harassment that is frequently experienced by someone who is visibly gender-variant, as many clients are–especially in the early stages of transition. During this time the counselor can be an important support, helping the client to cope with stress and to reflect on how the changes are affecting gender identity and overall comfort. The mental health professional can play an important role in assisting with planning and pacing such a transition.

For any of the feminizing or masculinizing medical interventions–including hormones, surgery, speech change, and permanent hair removal–the counselor can assist the client in obtaining information about the procedures; understanding the possible impact of these interventions on mental, physical, and sexual health; and, if surgery is needed, planning for pre-operative and post-operative care and support. As discussed in a later section, the clinician may also be asked to evaluate the client's eligibility and readiness to begin hormones or undergo surgery. If the clinician providing ther-

apy will be assessing hormone or surgery eligibility and readiness, it is important for the client and therapist to mutually agree on psychotherapeutic tasks, goals, or milestones relating to eligibility and readiness criteria to be reached before the recommendation can be made. Doing so helps prepare the client for this assessment and emphasizes that this is a shared process. The weight and implications of identity management decisions, and the associated fears, may lead the client to look to the therapist to affirm that making a gender role transition is the right course to take; it is important that the responsibility for the actual decision as to how to express or manage gender identity be consistently directed back to the client.

Ongoing Management of Gender Issues Throughout the Client's Life

Coming out does not end with realizing one's option of choice for identity management. Rather, transgender coming out is a lifelong process. Identities may continue to evolve, and psychosocial challenges will continue to arise. Disclosure issues continue throughout life with the establishment of new relationships with friends, co-workers, partners, and others. The client may seek ongoing counseling or return to counseling in the future to further improve or maintain mental health, address concerns about gender identity and aging, deal with grief and loss, and/or address relationship issues. Even after years of living in the preferred gender role, clients may seek support relating to social stigma, such as coping with discrimination and harassment or internalized transphobia.

Some transgender individuals have an unchanging gender identity, while others have a more fluid identity that evolves over time. For example, a client may initially identify as bi-gender and spend time in both gender roles, but after doing so for many years pursue a more full-time gender role transition. Conversely, a client who initially transitions and strongly identifies as one gender may later feel more comfortable with a blended or androgynous presentation. Some clients initially focus on passing as a non-transgender woman or man, but in time express a consciously transgendered identity; others who initially dismissed passability later come to value it more. Identity shifts may happen spontaneously over the course of one's life, or may be in response to new situations, experiences, and challenges relating to aging or relationships with others (e.g., retirement, children leaving home, divorce).

Developmental tasks that were previously disrupted or halted because of gender dysphoria are often taken up once comfort with one's gender identity has been achieved. For many, this includes dating and relationships. The working relationship that the client has established with the therapist can be an important resource to assist with such issues as questions about sexual orientation, disclosure of transgender identity within dating and sexual relationships, safer sex, and sexual functioning. Hormones can affect sexual desire and responsiveness. Increased comfort with one's role and body may result in a sexual renaissance, including possible high risk behavior (Bockting, Robinson, & Rosser, 1998).

For those who have surgery, adequate postsurgical care is crucial. In addition to physical care following surgery, clients may need counseling to deal with physical discomfort or pain, altered physical sensation or sexual function, complications that may be transient or persistent, and psychosocial adjustment. Hormones will also need to be changed following removal of the ovaries/testicles, and fluctuations in hormone levels may cause psychological changes requiring therapeutic intervention.

The vast majority of clients are satisfied and report further reduction in gender dysphoria following surgery (Green & Fleming, 1990; Pfäfflin & Junge, 1998). However, clients may also experience grief over lost time or mourning for the idealized fantasy of self prior to change (Hansbury, 2005). Clients who have been very focused on surgery to the exclusion of other life goals may need support to explore other directions in their lives once the long sought after surgery has been achieved.

Hormonal and Surgical Treatment of Gender Dysphoria

Some individuals with gender dysphoria seek hormonal and/or surgical feminization or masculinization to reduce a discrepancy between their sense of self and their primary or

secondary sex characteristics. The clinicians involved in the care of the individual presenting with gender dysphoria have a shared responsibility to determine the client's eligibility and readiness for hormone therapy or sex reassignment surgery. Ultimately, the prescribing clinician or the surgeon must decide whether to prescribe or perform the surgical procedure.

Most clinicians follow the WPATH *Standards of Care* (Meyer et al., 2001), which outline guidelines for clinical evaluation of eligibility and readiness in both adults and adolescents. The WPATH guidelines for transgender adults are summarized in Table 5; guidelines for adolescents are discussed elsewhere in this volume (de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006). *Eligibility* refers to the minimum criteria that anyone seeking these medical interventions must meet, and *readiness* refers to the client being mentally ready for the procedure. Readiness does not imply that the client can no longer have any mental health concerns to be ready for reassignment services; rather, sufficient stability needs to be in place to both make an informed decision and to be adequately prepared to deal with the physical, emotional, and social consequences of the decision.

Although psychotherapy is not an absolute requirement in the WPATH *Standards of Care*, the *Standards* do require mental health assessment by one qualified professional prior to hormone therapy or breast/chest surgery, and assessments by two mental health clinicians–including one with a doctorate degree–prior to hysterectomy or genital reconstructive surgery (Meyer et al., 2001). As with other types of psychological assessment, evaluation of hormone or surgery eligibility and readiness may take

TABLE 5. Summary of the World Professional Association for Transgender Health's *Standards of Care: Hormone and Surgery Eligibility and Readiness Criteria for Adults* (Meyer et al., 2001)

Hormones	
Eligibility	**Readiness**
1. Able to give informed consent 2. Informed of anticipated effects and risks 3. Completion of 3 months of "real life experience" OR have been in psychotherapy for duration specified by a mental health professional (usually minimum of 3 months)[1]	1. Consolidation of gender identity 2. Improved or continuing mental stability 3. Likely to take hormones in a responsible manner
Chest or Breast Surgery	
Eligibility	**Readiness**
1. Able to give informed consent 2. Informed of anticipated effects and risks 3. Completion of 3 months of "real life experience" OR have been in psychotherapy for duration specified by a mental health professional (usually minimum of 3 months) 4. FTM chest surgery may be done as first step, alone or with hormones; MTF breast augmentation may be done after 18 months on hormones (to allow time for hormonal breast development)	1. Consolidation of gender identity 2. Improved or continuing mental stability
Genital Surgery, Hysterectomy, and Oophorectomy	
Eligibility	**Readiness**
1. Able to give informed consent 2. Taking hormones for at least 12 months (if needing and medically able to take hormones) 3. At least 1 year "real life experience" 4. Completion of any psychotherapy required by the mental health professional 5. Informed of cost, hospitalization, complications, aftercare, and surgeon options	1. Consolidation of gender identity 2. Improved or continuing mental stability

[1]The WPATH *Standards* note that "in selected circumstances, it can be acceptable to provide hormones to patients who have not fulfilled criterion 3–for example, to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use" (Meyer et al., 2001, p. 13).

place in the context of a pre-existing therapeutic relationship, or the evaluation may be performed as a circumscribed process by a clinician who has not previously worked with the client.

A client-centered approach generally emphasizes care as a collaborative process involving the clinician, the client, and other clinicians or loved ones that the client wants to be included in decision-making. While evaluation of hormone or surgery eligibility and readiness technically does not involve a fully collaborative process as the client does not have latitude to negotiate the eligibility or readiness criteria, it is important to be flexible enough during the assessment to consider areas that may be open to negotiation and to discuss these with the client. For example, interpretation of what constitutes "real life experience" or "mental stability" may be negotiated and mutually agreed upon.

Qualifications of Hormone and Surgery Assessors

Most prescribing clinicians and surgeons require that the evaluation for hormone therapy or sex reassignment surgery be performed by an assessor who meets the competency requirements outlined in the WPATH *Standards of Care* (Meyer et al., 2001), including completion of specialized training and demonstrated competence in the assessment of sexual and gender identity disorders (e.g., certification by the American Association of Sex Therapists, Counselors and Therapists).

Prescribing clinicians with a practice structure that allows extended appointments and appropriate training in transgender medicine–including training in behavioral health and in the mental health aspects of gender dysphoria–may choose to take sole responsibility for initiating hormone therapy. In this situation, the prescribing clinician will conduct both physical screening (Dahl et al., 2006) and psychological screening to determine whether hormone therapy is appropriate. A mental health clinician may be asked to conduct an additional psychological assessment if a more detailed assessment or second opinion is desired.

Some insurance plans that provide coverage for sex reassignment surgery set requirements for evaluation beyond those in the WPATH *Standards of Care*. If the client is considering surgery, determination of assessor credentials required by the third party payer is recommended as early in the process as possible. It can be devastating for clients who have completed a gender role transition, with or without hormone therapy, to be told years into the process that they do not qualify for coverage of surgery.

The "Gatekeeper" Role and Its Impact on Therapeutic Rapport

Clinicians conducting the assessment to determine eligibility and readiness of hormone therapy or surgery are in a "gatekeeper" role that involves a power dynamic which can significantly affect therapeutic rapport (Bockting et al., 2004; Rachlin, 2002). The client often perceives the evaluation not as a desired tool to help them therapeutically determine a plan of action, but rather as a hoop that must be jumped through to reach desired goals, a frightening loss of autonomy over one's body and life, or a type of institutionalized oppression or discrimination, as a mental health evaluation is not required for non-transgender individuals requesting hormones, breast augmentation, or hysterectomy (Brown & Rounsley, 1996).

The approach to building rapport during hormone and surgery assessment depends on the nature of the clinical relationship. Some clients come for evaluation having already made a clear decision supported by self-directed research about treatment options, substantial internal reflection, and in some cases peer or professional counseling; having already disclosed their transgender identity to loved ones, coworkers, or others; and having relatively good supports and overall stability. In these cases a relatively short evaluation may be feasible, and the strategies to build rapport will be different than in circumstances where a more prolonged relationship is required to determine whether hormonal or surgical treatment is appropriate.

If tension arises related to the assessor's role of gatekeeper to the desired medical interventions, it may be helpful to openly discuss this. Strategies used to manage client anxiety and anger and promote a collaborative relationship in mandated treatment settings can be useful (de Jong & Berg, 2001). Normalizing emo-

tional reactions and behaviors clients commonly display–such as anger, anxiety, and fear; being belligerent, uncooperative, or manipulative; or telling the assessor what the client thinks they want to hear (Bolin, 1988)–helps frame this as a systems issue rather than a personal power struggle. Discussion about what the assessment process involves is imperative as the client's anxiety or anger is often heightened by inaccurate understanding of the process.

When the gatekeeper issue is posing a serious barrier to rapport in an ongoing psychotherapeutic relationship, it may be advisable to separate assessment from psychotherapy so two different clinicians are working with the same client (Anderson, 1997). The psychotherapist's role would then be to work with the client towards their stated goal of meeting hormone or surgery eligibility or readiness criteria, making it clear that there can be no guarantee of a particular outcome. The combined advocate-therapist role (Lev, 2004) can be particularly appropriate if a client needs to work on issues such as substance use, borderline personality disorder, or self harm, as there is often anxiety that a history of these concerns will be considered evidence that the client is not stable enough to proceed with hormones or surgery. Separating psychotherapeutic treatment of present issues from a future assessment can help reassure the client that assessment will focus on the adaptation they have achieved rather than on a history of instability or mental health concerns.

In our experience, clients who feel prepared for hormone or surgery evaluation are more willing to share information than clients who are highly anxious or fearful about the process. At minimum we recommend a letter explaining the assessment process (Appendices C and D) be sent well in advance of the appointment to the client and their primary care provider, both to ensure the parameters of assessment are understood and also to ensure that the client is aware of required supporting documentation.

Clinicians not involved in the assessment can assist by engaging in therapeutic discussion relating to any previous experience, such as anxiety related to having been denied support for hormone therapy or surgery in the past, and open discussion about the topics the client is most worried about. Some clinicians may feel hesitant to discuss terms of the hormone or surgery evaluation for fear they are "coaching" the client; however, asking the client how they might respond if they are asked questions about specific topics is different than coaching the client on how to answer questions about those topics.

Evaluating Eligibility

Informed consent. Informed consent requires the capacity to make decisions relating to medical care and an understanding of the specific treatment options that are proposed. Mental health clinicians are not expected to have detailed knowledge of the medical risks and benefits of specific hormones or surgical feminization or masculinization procedures–these will be discussed with the client by the prescribing physician or surgeon–but should be sufficiently knowledgeable to be able to assess whether the client has a generally accurate understanding of medical options, risks, and benefits. Clinician-reviewed consumer education materials developed by the Trans Care Project are available online (Ashbee & Goldberg, 2006a, 2006b; Simpson & Goldberg, 2006a, 2006b). Key issues are the irreversibility of some changes even if hormone therapy is discontinued and an appreciation that the long-term impact of hormone therapy on one's physical health is not fully known.

The mental health clinician should explore the client's awareness of possible psychosocial risks and benefits, including the possible impact of visible physical changes on existing relationships. In some cases hormone therapy or sex reassignment surgery improves the ability to pass as a non-transgender woman or man, reducing the risk of harassment and discrimination; in other cases the changes increase visibility as a transgender person, thus adding to the social risks. Awareness of these risks relates to informed consent; capacity to anticipate, withstand, and cope with the challenges posed is relevant in evaluating readiness.

"Real-life experience." The WPATH *Standards of Care* define the "real life experience" as the act of "fully adopting a new or evolving gender role or gender presentation in everyday life" (Meyer et al., 2001, p. 17), with the inten-

tion of achieving an experiential understanding of the familial, interpersonal, socioeconomic, and legal consequences of gender transition. The "real life experience" is a way for the transgender person who wishes to permanently change gender roles to move from an imagined experience to a lived experience. For some individuals this experience is liberating and exhilarating; for others there is disappointment that the real experience does not live up to a fantasized ideal.

A fundamental premise of the "real life experience" is that the person should experience life in the desired role before making irreversible physical changes. The WPATH *Standards of Care* do not require a "real life experience" prior to hormone therapy, breast surgery, or chest surgery, but do include a minimum of one year of "real life experience" as an eligibility criterion for genital reconstructive surgery or gonadal removal (Meyer et al., 2001). The WPATH *Standards* explicitly state that the "real life experience" is not a diagnostic test to evaluate the severity or nature of the gender identity concerns, but that the process tests "the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports" (Meyer et al., 2001, p. 18). For FTM transsexuals it is often difficult to live in the desired role without first undergoing chest surgery, hence a real life experience is not required for such surgery.

It is important to note that the "real life experience" is not defined by adherence to stereotypical ideas of masculinity or femininity. Just as there is a range of gender expression among non-transgender women–with many choosing not to wear makeup, dresses, or otherwise displaying attributes conventionally considered feminine–transgender women also have a range of gender expression. Similarly, not all transgender men are masculine in appearance or behavior. The real life experience is not defined by ability to pass as a non-transgender woman or man. Rather, it is defined by actualizing and continuously expressing one's unique gender identity.

Too often the "real life experience" is perceived by the client only in terms of an eligibility criterion that must be met to gain access to surgery, with the client feeling pressure to demonstrate uncritical adoption of a stereotypical feminine or masculine role. From a therapeutic perspective, the "real life experience" is a time of adjustment, exploration, and experimentation, learning how to relate to oneself and to others as the previously hidden self emerges. Psychotherapy is not an absolute requirement during this process, but it can be a valuable support during a time of profound internal and external change. Some assessors prefer to see the client periodically throughout the "real life experience" to try to get a sense of how the client is progressing and to offer support to those who are having difficulty. If the clinician or client feels that the assessor's role as gatekeeper prevents frank discussion of challenges, disappointments, and surprises during the "real life experience," involvement of a peer or external professional counselor may be useful in providing a space for the client to discuss problems or concerns without fear that access to surgery will be delayed or blocked.

In evaluating completion of the required "real life experience," the WPATH *Standards of Care* suggest a review of involvement in the community via work, volunteering, student activity, or a combination of all three; the acquisition of a name that conforms to a person's gender identity; and evidence that individuals other than the mental health professional know the patient in the desired gender role (Meyer et al., 2001). Flexibility in interpreting the "real life experience" is needed for clients who are housebound, living in a prison or residential long-term care facility, or who are otherwise unable to work, volunteer, or attend school. Additionally, we encourage a broad understanding of "work" that validates the life experience of those who are caregivers or parents, sex trade workers, and others who may not be able to provide documentation of employment. Ideally, the means of validating this aspect of transition will be at the discretion of the clinician who is performing the evaluation. Some insurance plans that cover the cost of surgery require specific documentation and may have "real life experience" criteria beyond the WPATH *Standards*.

Assessing Readiness

As discussed earlier, *readiness* relates to stability of gender identity and also the psycholog-

ical stability needed to cope with the physical, emotional, and social consequences of the decision to undergo hormone therapy and/or sex reassignment surgery. To assess readiness it is important to determine what the consequences of the treatment will likely be based on the individual circumstances of the client, including awareness and preparedness to cope with the potential challenges.

While some degree of ambivalence and uncertainty is to be expected with any life-changing process, the client should have a clear sense of the gendered self prior to initiating hormones or surgery. Physical change is not appropriate for clients who are just beginning to explore their identity or options for gender expression. While it is not necessary for transgender feelings or gender dysphoria to have existed since childhood, a longer period of assessment is required if the dysphoria is newly discovered, episodic, or possibly transient.

As per Figure 1, delusions about sex or gender, dissociative disorders, thought disorders, or obsessive or compulsive features should be evaluated and treated prior to proceeding with hormone therapy or surgery. Thought disorders, dissociative disorders, and obsessive-compulsive disorders can, rarely, cause a transient wish for sex reassignment which disappears or significantly lessens when the underlying mental health condition is treated. It is important to treat these disorders before proceeding with hormones or surgery to ensure that the desire for alteration of primary or secondary sex characteristics is not a temporary desire.

Other mental health concerns, psychosocial concerns, or substance use are not absolute contraindications to sex reassignment. Sometimes these issues are a direct result of the gender dysphoria or suppressed transgender feelings and alleviate or remit entirely as the gender identity concerns are addressed. However, the clinician should be confident that supports are adequate and that any co-existing conditions are under control to the degree that (a) the introduction of a new stressor will not seriously destabilize the client, and (b) the client has sufficiently clear thinking to be competent to consent to treatment (Brown & Rounsley, 1996). If there are any questions about competency or substance use, a formal evaluation may be required.

If the client returns for hormone or surgery assessment long after the initial evaluation, it may be necessary to repeat some of the standardized psychological testing administered during the initial evaluation to determine progress. Improvement in mental health and psychosocial adjustment should be documented and the care plan for addressing these concerns updated.

Evaluation of hormone or surgery readiness should include the gender assessment described earlier to explore issues relating to stability of gender identity and appropriateness of hormones or surgery. Table 6 lists additional areas of inquiry specific to evaluating readiness to start hormone therapy or undergo sex reassignment surgery.

Recommendation Regarding Treatment

If the assessor judges the client to be an appropriate candidate for hormone therapy or sex reassignment surgery, a letter of recommendation should be written to the prescribing clinician or surgeon confirming eligibility and readiness as per the WPATH *Standards of Care* (Meyer et al., 2001). Sample letters are included as Appendices E and F. As outlined in the WPATH *Standards*, these letters should include (a) the client's general identifying characteristics, (b) explanation of the duration of professional relationship, including type of evaluation and/or therapy, (c) initial diagnoses relating to gender identity issues or any other concerns, (d) the rationale for hormones or surgery (why it is appropriate treatment), (e) evaluation of the client's eligibility and readiness for hormones or surgery, (f) the degree to which the client and mental health professional have followed the WPATH *Standards of Care*, and the likelihood that this will continue, (g) explanation of the clinician's relationship to others involved in the client's care, and (h) a statement that the clinician welcomes a phone call to verify any of the information in the letter.

If the assessor feels the treatment is generally appropriate but the client does not meet eligibility or readiness criteria, the reasons for this should be explained to the client and a timeline established for reassessment. If the client is consistently cross-living and just needs more time to complete the required "real life experi-

TABLE 6. Potential Areas of Inquiry: Hormonal or Surgical Evaluation

Topic	Questions
General readiness	What leads you to come for hormonal or surgical assessment at this time in your life? What are your hopes and dreams relating to hormones or surgery? What do you expect hormones or surgery to change, and what do you think is not likely to change? How do you think hormones or surgery may affect your relationships with loved ones, and how do you think they will impact you at work, at school, or in the broader community? What will you do if the hormonal or surgical change process doesn't turn out as you had hoped? Have you taken any other steps to change your outward appearance, and if so, what was that like for you? Are there any issues in your life that you think might complicate a decision to take hormones or have surgery, or that might increase stress during this time? What kinds of supports do you feel might be helpful before or during hormonal therapy, or before and after surgery?
Hormones	Which changes are you most looking forward to from hormone therapy? Are there any changes from hormone therapy that you are not sure about? What medical care do you need to monitor for side effects, and who will provide this? If you experience side effects as a result of hormone therapy, what will you do? Are there any side effects of hormones that you are particularly concerned about? How do you feel about the permanence of some effects of hormone therapy, including the possibility of permanent sterility? The long-term effects of cross-sex hormones are not yet clear; how do you feel about taking this risk?
Sex reassignment surgery	What medical care might you need following surgery, and how will you obtain this care? Where will you rest and heal after surgery? Are there people who can help look after you as you recover following surgery? How do you feel about the permanence of surgery? How do you feel about the possibility of scarring? How do you feel about the risk of possible change in sensation, including the possibility of loss of sexual sensation or ability to achieve orgasm? Even when surgery is wanted there is sometimes a sense of loss, as with any big change; how do you feel about the changes to your body, and how have you dealt with other losses in your life? What additional issues or adjustments do you anticipate after surgery?

ence," the reassessment plan is straightforward; if the client is not consistently cross-living, psychotherapeutic interventions may be necessary to explore reasons for this and to assist the client to gain the support needed to be able to live full-time in the desired role. In some cases, referral to a transgender-sensitive financial planner or advocate may be helpful in identifying economic resources for the costs of transition. If there are psychosocial readiness concerns, resources should be identified to help the client move toward psychological and social stability, with specific and measurable goals established. Denial of access to desired treatment can be highly disappointing and it is important to emphasize that reassessment is believed to be appropriate, and to ensure that clients are aware of peer and professional supports in the interim.

In some cases, the assessor may feel that hormonal or surgical feminization or masculinization is not an appropriate treatment and that future reassessment of eligibility and readiness is not indicated. This may be the case if a client is seeking hormones or surgery for reasons other than gender dysphoria, where another type of assessment is more appropriate (e.g., a male without gender dysphoria seeking hormonal or surgical castration to reduce sexual urges). If the prescribing physician or surgeon has informed the client that their physical health is too fragile to ever proceed, or a client is judged to be incompetent to make medical decisions and the cause for diminished competency is not likely to change, the client should be supported to come to terms with this and to explore alternative forms of transgender expression rather than false hope being held out of eventual reassignment.

Counseling of Loved Ones

Significant others, family members, friends, or allies of transgender persons (SOFFAs) typically come to therapy to address their own concerns relating to a loved one's disclosure of being transgender or the impact of transgender issues on their relationships over time. Alternatively, SOFFAs may participate in family or

relationship therapy as part of a transgender person's therapeutic process.

As with the transgender population, SOFFAs are a heterogeneous group. Some SOFFAs are encouraging and supportive, and may take a strong stand in helping counter the shame and embarrassment that many transgender individuals feel. For others, transgender issues are a source of conflict. Evaluation of the SOFFA who presents for individual counseling includes discussion of the nature of their relationship to the transgender person, the impact of gender issues on this relationship and on the relationships with others, and awareness of available support resources (see Table 7).

Some SOFFAs may have always known or suspected that their loved one is transgender. More typically, SOFFAs are shocked and surprised. Responses upon disclosure range from acceptance to disgust, depending on the individual's frame of reference, their relationship with the transgender person, cultural beliefs about gender variance, and the timing and means of disclosure. When transgender issues have been a secret and are disclosed late in a relationship, there can be feelings of betrayal and questioning of intimacy, as with the disclosure of any large secret (Reynolds & Caron, 2000). Adjustment also varies depending on the degree of change requested in a specific aspect of the relationship. For example, disclosure relating to the hope that a partner will participate in erotic crossdressing is different than disclosure that will affect the entire relationship, such as a gender transition.

Ellis and Eriksen (2002) describe an emotional process for SOFFAs similar to stages of bereavement (Kübler-Ross, 1969). Stage 1 may include denial, shock (Lantz, 1999), post-traumatic reactions (Cole, Denny, Eyler, & Samons, 2000), and trying to bargain with the transgender person or a higher power for the gender issues to disappear (Covin, 1999). Stage 2 may include anger at the transgender person (Lantz, 1999), fear of others' reactions (Bullough & Weinberg, 1988; Reynolds & Caron, 2000), and fear about how the transgender person will be treated (Samson, 1999). Parents may blame themselves, assuming their child is transgender because of a failure in parenting (Lantz, 1999). At this stage sexual dysfunction may occur in the relationship between the transgender client and their partner (Cole et al., 2000). Counseling may be helpful at this stage to help restore intimacy and reduce isolation. During Stage 3, family and loved ones are able to start to grieve the losses on many levels, and may seek support from others who are in similar situations. Peer support or social contact with other SOFFAs can be helpful at this stage (Weinberg & Bullough, 1988). Stage 4 involves self-discovery and change. SOFFAs may not agree on the

TABLE 7. Potential Areas of Inquiry in Gender Evaluation: Loved One of a Transgender Person

Topic	Questions
Disclosure	When did you learn that your (partner, child, sibling, etc.) was transgender? How did you find out that your (partner, child, sibling, etc.) was transgender? What was your initial reaction to finding out about your loved one's feelings, and how do you feel about it now? Do individuals in your life know that your (partner, child, sibling, etc.) is transgender, and how do you feel about them knowing/not knowing?
Impact on relationships	It is common for loved ones to have fears and questions about gender issues, and question their relationship to the transgender person or their own identity (including sexual orientation); are any of these concerns for you? Have you ever seen your (partner, child, sibling, etc.) crossdressed, and if so, how was that for you? Has your (partner, child, sibling, etc.) ever taken hormones or had surgery to bring their body closer to their sense of self, or is this something they are considering; if so, how do you feel about this? How have transgender issues affected your relationships with others (e.g., other family members, friends)? Do you worry about how others might react when they learn that your loved one is transgender?
Support resources	Have you had any contact with other (partners, parents, siblings, children, etc.) of transgender people, and if so, what was that like for you? What do you see your relationship being to the transgender community now, and what would you like it to be in the future?

changes the transgender individual is making and counselors can be helpful in conflict resolution. At this stage, couples may decide whether to stay together. Stage 5 is a time for acceptance and welcoming the transgender person into daily life. At this point, the SOFFA often joins the journey of the transgender person, including the adjustments that must be made. Counselors may help by providing a place to process the anger and frustration that arises as a result of discrimination and harassment directly experienced or witnessed by the SOFFA. Finally, the goal of stage 6 is pride in their loved one's courage. This pride may take the form of advocating for transgender people and educating others about them (Lantz, 1999).

TRANSGENDER-SPECIFIC ASSESSMENT AND TREATMENT OF MENTAL HEALTH ISSUES

Although studies are limited, one team of researchers found that a large group of transgender individuals (N = 435) who sought services from a gender clinic did not appear to have increased rates of major psychiatric illness (operationally defined as disruption in mood or personality that affected life, work, and relationships in identifiable ways) compared to the general population (Cole, O'Boyle, Emory, & Meyer, III, 1997). However, the impact of psychosocial stressors, including harassment, discrimination, and violence experienced by many transgender individuals (Lombardi, Wilchins, Priesing, & Malouf, 2001), as well as the high incidence of poverty resulting from employment discrimination (Nemoto, Operario, Keatley, & Villegas, 2004), are cause for concern. In a study of 515 transgender individuals in San Francisco, 62% of MTF and 55% of FTM respondents met clinical criteria for depression, 22% of MTFs and 20% of FTMs reported a history of mental health hospitalization, and 32% of MTFs and 32% of FTMs reported prior suicide attempts (Clements-Nolle, Katz, & Marx, 1999). As a medically underserved population (Feldman & Bockting, 2003), transgender individuals with mental health concerns are at risk for late diagnosis and treatment. Those undergoing a gender transition may avoid disclosing symptoms of mental illness for fear that this will jeopardize access to hormone therapy or surgery, further delaying treatment.

The presence of apparent mental health symptoms in initial sessions does not necessarily indicate chronic mental health issues. Transgender people who are seeking help for gender identity concerns are often anxious or defensive about seeing a mental health professional. Moreover, establishment of a trusting relationship with a trans-positive, supportive clinician can result in release of longstanding suppressed emotions and feelings of powerlessness related to past experiences of neglect or mistreatment, with the potential for transference of anger. Lack of language to articulate gender identity concerns can lead the transgender individual to appear confused, disoriented, temporarily unable to communicate, profoundly frustrated, or labile. Nevertheless, evidence of mental health symptoms should not be ignored. Even when mental health symptoms are the sequelae of social stigma or oppression, relief of these symptoms may help give the client the stability and resilience needed to engage in psychotherapeutic healing. Careful evaluation is required. Regardless of the reason for the mental distress, the transgender client deserves appropriate mental health care to alleviate these symptoms and treat any existing mental disorders.

In our experience, in the overwhelming majority of cases mental health symptoms have psychosocial causes. Rarely, there may be a physiological component. As per the standard diagnostic process outlined in the *DSM-IV-TR*, there should be consideration of possible pharmacologic or medical factors as part of the standardized mental health interview for any client with acute mental health symptoms. There are rare case reports of psychosis in transsexual women related to sudden cessation of estrogen therapy (Faulk, 1990; Mallett, Marshall, & Blacker, 1989), and observations of depressive mood changes related to initiation of estrogen or progesterone therapy (Asscheman, Gooren, & Eklund, 1989; Feldman & Bockting, 2003; Flaherty et al., 2001; Israel & Tarver, 1997; Steinbeck, 1997). Psychiatric decompensation has been observed in some FTM clients with pre-existing Schizoaffective Disorder, Bipolar Disorder, and Schizophrenia upon initiation of testosterone therapy (Feldman, 2005). Additionally, as a medically underserved popula-

tion, transgender individuals can present with untreated physical conditions that may have psychological symptoms, including HIV and syphilis.

After a thorough evaluation and history, the clinician should offer a diagnostic opinion based on the multi-axial system of the *DSM-IV-TR* (American Psychiatric Association, 2000) and a diagnostic formulation. During initial evaluation any psychiatric diagnosis should be considered tentative, to be confirmed during the course of treatment. This is particularly true for personality disorders or other complex conditions that usually take more time to assess than the initial diagnostic evaluation allows.

Treatment options may include psychotherapeutic techniques such as cognitive-behavioral therapy, dialectical behavior therapy, and eye movement desensitization and reprocessing; pharmacotherapy; and social or advocacy interventions. If the client intends to start or stop hormones while undergoing pharmacologic treatment for mental health concerns, medication may need to be re-evaluated as part of this process. Potential interactions between hormones and psychoactive medications should be carefully evaluated by the prescribing physician, and regular visits scheduled to monitor the risk of psychological decompensation (Dahl et al., 2006).

In some cases, referral to other clinicians may be needed for pharmacologic treatment or to overcome socioeconomic barriers to treatment. When multiple clinicians are involved, close communication is required to ensure coordinated care. Ideally, all clinicians involved in care of a transgender client will have transgender-specific training. If no practitioners with transgender health expertise are available, the client should be informed of this. In some cases clients may feel they or an advocate can sufficiently educate the practitioner about transgender issues, while in other cases a clinician with transgender-specific training will be needed to effectively treat the client's concerns.

In determining a care plan, the presenting complaint of the client is the starting point. When there are multiple co-existing mental health concerns, a staged approach is recommended that begins with the issues that most negatively impact the client's quality of life and/or ability to engage in treatment. The client should be meaningfully involved in creating the treatment plan, and goals and expectations of treatment should be clear. While the client is ultimately responsible for deciding among the available treatment options, the clinician is expected to provide an informed clinical opinion and recommendations as part of care planning. Recommendations may include type of treatment, anticipated duration of treatment, timeline and criteria for re-evaluation, and involvement of peer or additional professional resources. Ideally, mental health care plans will be developed in coordination with the client's primary care provider and any other clinicians involved in the client's care. The timeline of the overall treatment plan should be explicitly discussed, jointly agreed upon, and reviewed on a regular basis. For some clients, it is better to discuss goals in terms of tasks rather than time, or at least the timeframe should be tentative. Progress in meeting the goals of the care plan should be reviewed regularly during the course of treatment; adjustments may have to be made.

Some transgender individuals have sophisticated knowledge about mental health treatment options, and have a clear direction they wish to pursue. Others have no knowledge and expect guidance from a professional. As part of care planning it is important to assess the individual's knowledge and the accuracy of their information, and to offer consumer education materials discussing treatment options if needed. In all cases, the clinician is responsible to ensure that clients understand what is involved in specific types of treatment.

Depression, Anxiety, and Suicidality

Depression and suicidality are not uncommon among transgender individuals. Among 181 transgender seminar participants at the University of Minnesota, 52% reported depression and 47% had considered or attempted suicide in the last three years (Bockting, Huang, Ding, Robinson, & Rosser, 2005). A comparison of psychosocially matched transgender and non-transgender individuals found that transgender individuals reported significantly more suicidal ideation and attempts (Mathy, 2002).

Depression and anxiety may be directly related to gender issues. For example, a long history of suppression of transgender feelings may

have resulted in isolation, loneliness, and feelings of hopelessness; the fear of disclosing this secret to partners, family, friends, and coworkers–risking rejection and employment discrimination–can provoke a great deal of anxiety. In other cases, however, depression and anxiety may be unrelated to gender issues and may simply be a result of a predisposition to these symptoms or a result of other life experiences such as childhood neglect, death of a loved one, or relationship violence. Whatever the etiology, the goal is to alleviate the symptoms, address situational issues that create or contribute to the depression or anxiety, and build resilience (Israel & Tarver, 1997). Such resilience is particularly important as life as a transgender person may be highly stressful due to the prevailing social stigma. If psychoactive medication is part of the treatment plan, continued use should be re-evaluated as psychotherapeutic or other treatment progresses.

Self-Harm

Self-harm refers to intentional head-banging, cutting, burning, self-poisoning, car crash, or other behavior likely to cause injury, and may or may not be accompanied by suicidality. Self-harm may be a ritualized, chronic behavior used to self-regulate hyperarousal, dissociative states, or otherwise uncontrollable stress (Sachsse, Von der Heyde, & Huether, 2002), or an attempt to channel emotional futility, despair, and hopelessness into visible physical form (Israel & Tarver, 1997).

The prevalence of self-harm among transgender individuals is not known. A therapist who specializes in transgender care at a health centre in Toronto described seeing numerous transgender clients seeking care for self-injurious behaviors (Gapka & Raj, 2003). Deliberate damage to the testicles or penis by gender dysphoric MTF transsexuals has been described in a number of published case reports (Martin & Gattaz, 1991; McGovern, 1995; Mellon, Barlow, Cook, & Clark, 1989; Murphy, Murphy, & Grainger, 2001), and may reflect despair, lack of awareness of options for medical intervention, lack of access to transgender-specific and competent care, or ineligibility for desired surgery. Impulsively attempted auto-castration, auto-penectomy, or auto-mastectomy may be followed by contrition, shame, and fear of ridicule or institutionalization for having committed a self-destructive act (Israel & Tarver, 1997).

No-harm agreements are commonly used in clinical practice where there are concerns about the risk for self-injurious behavior. A verbal or written no-harm agreement should not be considered a substitute for careful clinical assessment, and should not be relied upon as the sole tool for prevention of further attempts (American Psychiatric Association, 2003). In any instance of self-harm, medical treatment of injuries should take priority. Mental health treatment focuses on reducing further harm by detecting and treating underlying mental health problems (e.g., underlying Axis I or II disorder), reducing distress–including distress about having engaged in self-injurious behavior–and strengthening coping skills and resources (Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003). There is no evidence regarding optimal treatment for transgender individuals who are chronically self-harming, but in our clinical experience, dialectical behavior therapy has been helpful. This treatment modality has been shown to reduce self-harm in chronically suicidal non-transgender women diagnosed with Borderline Personality Disorder (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991).

Compulsivity

Compulsive crossdressing or obsessive/compulsive features of gender dysphoria–whether secondary to an anxiety or mood disorder or, as is more commonly the case, simply associated with suppression, shame, and anxiety about transgender feelings–can often be alleviated through psychotherapy. If necessary, pharmacotherapy (e.g., Selective Serotonin Re-uptake Inhibitors) may also be employed in conjunction with psychotherapy.

Psychotherapy focuses on identifying the pattern of obsessive/compulsive behaviors that developed over time and on changing this pattern through defining and adhering to boundaries that prevent self-destructive behaviors (see case vignette of Carlos in Appendix A). In addition, therapy aims to decrease isolation, alleviate shame and self-hatred, and confront internalized transphobia. Alternative, more con-

structive ways of expressing or validating one's transgender feelings are explored.

Thought Disorders

Schizophrenia, Schizo-affective Disorder, and other thought disorders should be treated as per standard protocols. For clients with co-existing gender dysphoria and delusional disorders, it is critical to manage the thought disorder through medications and support, monitor the client's identity over time, encourage experience in the preferred gender role, and require an extended period of stability prior to initiating medical interventions. Coordination with all the other health providers that work with the client–and, with the client's consent, inclusion of caregivers, family, and friends in therapy–can create a strong support system to facilitate an eventual gender transition if that is the direction chosen by the client. If well controlled, a thought disorder is not necessarily a contraindication for sex reassignment. Addressing gender dysphoria as part of a comprehensive care plan has the potential of rehabilitating a client with schizophrenia to a level that previously seemed out of reach (see case vignette of Jamie in Appendix A).

Personality Disorders

Personality disorders may be found among transgender clients (Bodlund, Kullgren, Sundbom, & Höjerback, 1993) and can be challenging to treat. Personality disorders may be unrelated to gender issues, or may seem to be linked to transgender concerns. Little is known about a possible relationship between the development of personality disorders and gender identity concerns; we offer the following speculative theoretical formulation derived from clinical observation.

Growing up transgender in a society that does not understand or accept gender-variance can be a challenge to the development of a coherent and confident sense of self. In children with transgender feelings who are also visibly gender-role-nonconforming, an early transgender "coming out" involves learning to cope with social stigma; possible rejection, harassment, ridicule, and abuse by age-peers and/or family; and an ensuing sense of shame and low self esteem–all of which could potentially contribute to the development of a personality disorder. In children with transgender feelings who are not visibly gender-variant, the response to social stigma and pressure to conform is more likely to lead to suppression of crossgender feelings and dissociation. This can lead to a "split" identity of a "false" self presented to the world that overcompensates or conforms to the expectations associated with the sex assigned at birth, and a hidden "true" self that is compartmentalized and may be expressed in imagination, fantasy, and emerging sexuality that may be of a paraphilic or compulsive nature. In this scenario, mirroring by the social environment of the "false" instead of the "true" self may play a role in the development of psychological difficulties in identity and attachment (Fraser, 2005).

Whatever the etiology, management of personality disorders needs to be part of the treatment plan. A variety of psychotherapeutic techniques such as rational emotive therapy, cognitive behavior therapy, or dialectical behavior therapy can be applied, possibly in combination with pharmacotherapy. Selective Serotonin Reuptake Inhibitors have been used to treat clients with compulsive behaviors, and atypical antipsychotics have been used with success for clients with impulse control problems. If gender identity concerns co-exist, treatment of the gender concerns, potentially including a gender role transition, often aids in lessening symptoms of personality disorders.

If well managed, personality disorders are not a contraindication for a gender role transition, hormones, or surgery. However, any issues of concern should be discussed with the client, with clear goals for treatment and stabilization.

TRANSGENDER-SPECIFIC ELEMENTS IN GENERAL COUNSELING

Transgender individuals experience the same general life problems as everyone else, and may seek counseling for assistance with general life stressors. Although gender identity concerns may not be a factor, social stigma, internalized transphobia, and untreated gender dysphoria can have a significant impact on a

transgender client's general psychosocial development, resilience, and functioning. Common transgender psychosocial concerns outlined below include body image problems, multiple losses resulting in cumulative grief, sexual concerns, social isolation and resultant social skill deficits, spiritual or religious concerns, substance use issues, and difficulty coping with historical or current violence or abuse. While employment dissatisfaction, discrimination, and loss of employment are also common, vocational counseling is a specialized area outside the scope of this article; issues relating to employment discrimination and transition planning in the workplace are discussed elsewhere in this volume (White Holman & Goldberg, 2006b).

For transgender individuals who seek general counseling, areas to explore in the initial evaluation may include any of the questions outlined in the previous sections. Questions depend in large part on the client's chief presenting concern. For example, if the presenting concern is grief relating to the recent death of a loved one, it is not appropriate to include detailed questions about gender history in the initial interview. If the client does not indicate whether transgender issues are relevant to the presenting concern, the clinician can ask about transgender issues with appropriate framing (e.g., "For some transgender people, being transgender affects their relationships–is this an issue for you?").

Body Image

The cultural norms of femininity and masculinity include strong cultural messages about what "real" men and "real" women should look like as well as norms relating to attractiveness. Some transgender individuals have difficulty accepting their bodies regardless of gender dysphoria, although gender dysphoria obviously complicates this picture. Weight gain associated with estrogen or testosterone can be distressing and can be a health risk in some cases.

Eating disorders can appear in both MTF and FTM transgender individuals (Fernández-Aranda et al., 2000; Hepp & Milos, 2002; Surgenor & Fear, 1998; Winston, Acharya, Chaudhuri, & Fellowes, 2004). Eating disorders may originate in attempts to conform with societal conventions relating to thinness, may relate to a feeling of estrangement from the body (Gapka & Raj, 2003), or may be unrelated to body image per se (but rather may develop as a type of compulsive behavior to provide relief from stress). The published case reports cited above suggest that MTF transgender individuals typically struggle with anorexia, bulimia, or other disordered eating more typically seen in girls and women, while FTM transsexuals more often struggle with a drive to be muscular as typically seen in men with body image problems. However, FTM transgender individuals may also seek to minimize hips and breasts by excess exercising or disordered eating, or prevent menstruation by staying underweight. FTM transgender individuals who are attracted to other men may be particularly vulnerable to struggles with body image in an attempt to conform to the overemphasis on norms of appearance, weight, and muscularity in some gay communities (Williamson & Hartley, 1998; Yelland & Tiggemann, 2003).

Surgical procedures intended to alter primary or secondary sex characteristics can reduce gender dysphoria and are not intrinsically problematic; indeed, they are an important part of medical treatment for some transgender individuals. However, other transgender individuals desperately pursue cosmetic procedures in an attempt to erase any perceived sign of their birth sex or of being transgender (see case study of Anne in Appendix A) or to alleviate body image concerns. The clinician should focus on the underlying internalized transphobia or other psychological issues (e.g., anxiety and fears, isolation and loneliness, low self esteem, body image distortions or Body Dysmorphic Disorder, possible personality disorder) rather than focus on the cosmetic procedures themselves.

Following sex reassignment surgery, there may be body image concerns related to visible scarring or surgical results that do not fit the client's hopes and expectations in terms of aesthetic outcome. The clinician should distinguish between surgical complications, normal adjustment, and excessive preoccupation with the physical results.

Grief and Loss

Grief and loss can appear at many levels. Transgender individuals may experience multiple losses when they disclose that they are transgender, including loss of work as well as rejection by family, friends, and ethnocultural or faith community. This may be especially painful for transgender individuals who have high value for familial and cultural continuity.

On a developmental level, there can be a feeling of loss associated with aspects of physical and social experiences associated with sex or gender that are not possible even with transition. For example, some MTF transsexuals grieve the inability to menstruate, become pregnant and give birth (De Sutter, Kira, Verschoor, & Hotimsky, 2002); some FTM transsexuals grieve their inability to impregnate a partner. Some transgender individuals seek to create gendered rites of passage typically associated with adolescence to mark emergence as women or men (Cameron, 1996), or approach aspects of gender transition as a rite of passage into womanhood or manhood (Bolin, 1988; Fleming & Feinbloom, 1984).

Hormonal and surgical sex reassignment procedures can reduce fertility and lead to permanent sterility. Regrets and grief relating to sterility were noted in one study of transsexual women who had already undergone hormonal treatment (De Sutter et al., 2002). Discussion of reproductive impacts and options such as sperm banking for MtF transsexuals is advised in the WPATH *Standards of Care* as part of the informed consent process prior to hormonal or surgical intervention (Meyer et al., 2001). In some cases reproductive counseling may be advised.

As discussed earlier, even when surgical feminization or masculinization is highly desired there can be grief following surgery. Doubt, dissatisfaction, or regret immediately after surgery may relate to physical issues such as post-operative pain, surgical complications, or changes to sexual function; disappointment with the results; or stress caused by disclosure to loved ones (Lawrence, 2003; Michel, Ansseau, Legros, Pitchot, & Mormont, 2002). These type of regrets are typically temporary and resolve spontaneously or with psychotherapeutic assistance (Pfäfflin, 1992), and do not necessarily signify regret about having made the transition. A review of 82 outcome studies published between 1961 and 1991 found that gender dysphoria in the new gender role accompanied by attempts at reversal of surgery or role change was less than 1% among FTM transsexuals and less than 1.0-1.5% among MTF transsexuals (Pfäfflin & Junge, 1992/1998). In most cases, regret resulted from improper differential diagnosis and treatment of co-existing mental health concerns, failure to complete the "real life experience," and unsatisfactory surgical results.

Sexual Concerns

As in the general population, there is a range of sexual identification, practices, and concerns among transgender individuals (Bockting, Robinson, Forberg, & Scheltema, 2005; Coleman, Bockting, & Gooren, 1993; Devor, 1993; Lawrence, 2005). Trans-specific sexual concerns may include managing gender dysphoria in a sexual relationship; concerns relating to erotic crossdressing; shifts in sexual orientation or sexual preferences as part of gender exploration or gender transition; and the impact of hormonal or surgical feminization or masculinization on sexual desire, sexual functioning, and safer sex negotiation.

Frank discussion of sexuality is comfortable for some transgender individuals, and not for others. Transgender individuals are often asked invasive and inappropriate questions by strangers or health professionals relating to genitals or sexual practices (O'Brien, 2003), and may be wary of the therapist's motivations if explicit questions are asked. Discomfort discussing sexuality in a therapeutic relationship may or may not extend to discomfort communicating about sex in an intimate relationship. In addition to feelings of embarrassment and shame commonly associated with sexuality, transgender individuals may have extra difficulty discussing sexual issues because of the dysphoria associated with their genitals and body, and with sexual roles associated with gender. Therefore, many transgender clients can benefit from exploring strategies for disclosure of identity, sexual negotiation, and setting boundaries regarding touch and sexual activity. Psychotherapeutic strategies proven effective

for victims of sexual abuse may be useful in addressing anxiety or dissociation that some transgender clients may experience during sex.

In a therapeutic relationship and in intimate relationships, communication about transgender sexuality is made more difficult by the paucity of sexual language that is respectful and inclusive of the sexual experiences of transgender individuals and their partners. O'Brien (2003) describes this as "assumptions about bodies, genders, and genitals that simply do not speak to the real bodies that some transgender people live with, or the specific ways a transgender person might understand and describe their body" (p. 2). For example, an MTF transsexual who is married to a woman, transitioned late in life, and who has had little contact with the lesbian community may or may not describe her relationship as a lesbian one. Transgender individuals may also conceptualize their genitals in ways that fit their sense of self, with FtM transgender individuals using language such as a phantom penis, dicklit, or phalloclit rather than clitoris to refer to their genitals (Bockting, 2003; Kotula, 2002; O'Brien, 2003). For some transgender clients, discomfort discussing sexual issues in the therapy environment is due to difficulty finding appropriate language to refer to body parts that do not match their gender identity. In these cases, it may be helpful to normalize the discomfort and to spend time exploring language that feels comfortable to the client (Bockting, Robinson, et al., 2005).

Assumptions should not be made about sexual activities. While some transgender individuals are strongly dysphoric about their genitals and do not like them to be touched or looked at, others are comfortable using their genitals. For example, some FTM transsexuals may engage in receptive vaginal intercourse with other men (Coleman et al., 1993). Like non-transgender people, both MTF and FTM transgender individuals may engage in a wide variety of sexual behaviors, including erotic touch; receptive or insertive oral, vaginal, and anal penetration; and role-playing. Some transgender individuals identify as asexual and/or choose to be celibate.

Despite the challenges in talking about sex and the great need for sensitivity in approach, it is important for therapists to inquire about sexual issues in working with transgender clients. Unaddressed sexual concerns can significantly impact quality of life. This is most obvious in case of sexual trauma or sexually transmitted infections, but more generally, sexual concerns can negatively impact self esteem and identity development. For example, an FTM transsexual who likes vaginal penetration may doubt his masculinity, as might a man who likes to have sex while crossdressed. Conversely, gender identity concerns can negatively impact sexual health. For example, attempts to affirm one's gender identity can drive drive high-risk sexual behaviors (Bockting, Robinson, & Rosser, 1998; Clements-Nolle et al., 1999; Nemoto, Operario, Keatley et al., 2004; Nuttbrock, Rosenblum, & Blumenstein, 2002).

No surveillance data are available to accurately enumerate the prevalence of HIV and other sexually transmitted infections (STI) among transgender people. However, needs assessment studies indicate that HIV/STI prevalence is high, particularly among transgender individuals who have sex with men (Bockting & Avery, 2005). For example, in a study of 392 MTF and 123 FTM transgender individuals in San Francisco, 35% of MTFs and 2% of FTMs tested positive for HIV, and 53% of MTFs and 31% of FTMs had been diagnosed with an STI (Clements-Nolle et al., 1999); among respondents in a New York survey, 36% of MTFs and 36% of FTMs indicated having had an STI (McGowan, 1999). Cofactors related to unsafe sex, such as low self-esteem, depression, suicidal ideation, substance use before sex, and physical or sexual abuse, are increased among the transgender population (Clements-Nolle et al., 2001; Keatley, Nemoto, Operario, & Soma, 2002; Kenagy, 2002; Mathy, 2002; Nemoto, Sugano, Operario, & Keatley, 2004). To promote safer sex, transgender individuals are in need of psychoeducational interventions to promote sexual health (Bockting et al., 2005; Nemoto, Sugano, Operario, & Keatley, 2004).

As discussed previously, changes relating to gender transition commonly impact sexuality, and psychotherapeutic assistance may be required to adjust to changes in sexual desire and function resulting from feminizing or masculinizing hormones or surgery. Additionally, gender transition can be accompanied by shifts in sexual orientation (Daskalos, 1998; Lawrence, 2005). For example, an MTF transgender per-

son who has been primarily attracted to women prior to transition may experience attraction and pursue relationships with men following transition. Adjustment to these changes often involves developmental tasks similar to those in adolescence (Bockting & Coleman, in press). In other cases, the client's attractions remain consistent throughout transition but the gender role transition may involve change in sexual orientation identity (e.g., an FTM transgender person who loses a previously held lesbian identity).

Crossdressing for sexual excitement is a relatively common phenomenon. In a random sample of 18- to 60-year-olds in the general population of Sweden (N=2,450), 2.8% of men and 0.4% of women reported at least one experience of crossdressing for erotic purposes (Langström & Zucker, 2005). Erotic crossdressing is not intrinsically problematic, and is a celebrated aspect of sexuality in some relationships (Vitale, 2004). However, as erotic crossdressing is a stigmatized act that is often considered sexually deviant, it is not uncommon for erotic crossdressers to need psychotherapeutic assistance to cope with shame, guilt, and conflict with partners (Dzelme & Jones, 2001). The stigma can lead to secretive and increasingly compulsive behavior which may need to be addressed.

Social Isolation

Visibly gender-variant individuals often have difficulty with public spaces, experiencing stares, harassment, and threats or actual violence. This can lead to increasing difficulty navigating public life, social seclusion, and anxiety. Anxiety disorders such as Social Anxiety Disorder, Agoraphobia, and Panic Disorder can be extreme and debilitating. If the individual presents with an anxiety disorder such as these, a combination of pharmacological treatment and cognitive-behavioral therapy is recommended.

Individuals who are not open about being transgender may find that concealment of identity and history causes decreased intimacy or feelings of disconnection and social alienation. This can be particularly difficult for transsexuals after transition, as much of life prior to transition cannot be discussed without disclosing transsexuality. Crossdressers may similarly experience isolation if there is rigid separation between social life, work life, and home life. For those who are fully open about being transgender or are comfortable talking about life prior to transition, there can still be a feeling of social disconnection based on differences in history and life experience compared to non-transgender peers.

Transgender people who feel socially disconnected may look to other transgender people for companionship, support, and a sense of belonging or community. While peer contact can be a significant positive element in many transgender individuals' lives (Grimaldi & Jacobs, 1996; Odo, 2002; Schrock, Holden, & Reid, 2004), as in any oppressed group there are complex social dynamics within transgender communities that may result in disappointments when expectations of safety, acceptance, and support are not met; when internalized transphobia results in hostility toward peers; or when a shared transgender identity is insufficient common ground for close and supportive relationships.

Some transgender individuals shun connection with the transgender community in an effort to normalize and mainstream their lives in conformity with prevailing social norms. While fear of others' reactions can be a driving force behind attempts to live life away from the transgender community, avoidance of transgender people suggests a degree of internalized transphobia that may negatively affect health and well being.

Spiritual and Religious Concerns

There is a diverse range of attitudes toward gender-variance, crossdressing, and transsexuality across spiritual traditions (Ramet, 1996; Sheridan, 2002). Transgender individuals from spiritual or religious traditions that prohibit cross-dressing and other transgender behavior often struggle with shame and guilt, feeling torn between self and community beliefs. Even those who are not actively involved in religious practice may have concerns about transgenderism rooted in the religion of upbringing or religious norms reflected in society. It can be helpful to assist the client to explore the impact that religious beliefs have on reactions of family

members and society at large toward their transgender identity and behavior. However, reactions and attitudes of individuals are not always consistent with the doctrine promulgated by their religious institutions. Within many communities of faith acceptance can be found.

As with gay, lesbian, and bisexual persons hoping for religious salvation from same-sex desire, transgender individuals who are deeply religious and pray for help to overcome transgender feelings may feel betrayed if no answers are forthcoming. In addition, experiences of rejection, discrimination, and violence by members of a religious community can also impair faith.

Supportive spiritual counseling can be helpful in resolving dilemmas of faith and in finding acceptance. Consultation with progressive spiritual leaders can be helpful in determining ways for transgender individuals to be accommodated and included in gender-specific ceremonies and rituals.

Substance Use

Studies across North American suggest that alcohol and drug use (including nicotine use) is common among transgender individuals (Bockting, Huang, et al., 2005; Clements-Nolle et al., 1999; Hughes & Eliason, 2002; Macfarlane, 2003; Mason, Connors, & Kammerer, 1995; McGowan, 1999; Reback, Simon, Bemis, & Gatson, 2001; Risser & Shelton, 2002; Xavier, 2000). As with the general population, reasons for substance use vary widely among transgender individuals. Some use alcohol or drugs in an attempt to cope with transgender feelings, mental health issues, painful emotions relating to socioeconomic concerns, memories of physical or sexual abuse or assault, work-related stress and fatigue, or physical pain. Others start using alcohol or drugs to facilitate social interactions or to meet peer expectations.

As in the non-transgender population, there is great diversity in patterns of substance use; not all individuals who use drugs experience a negative impact in overall function. A chemical dependency evaluation by a trained evaluator may be necessary to determine to what extent the substance use is problematic. In a survey of transgender individuals (N = 179) conducted in British Columbia, 12% reported a current need for substance abuse or addiction services; 16% reported a past need and 8% anticipated the need for services in the future (Goldberg et al., 2003).

As with other areas of care, in substance abuse treatment we encourage a client-centered approach that supports the individual's choice of treatment goals and treatment modalities. Possible goals range from reduction of risky patterns of use to total cessation of drug or alcohol consumption. Treatment options depend on the drugs being used; for some substances both psychotherapeutic and pharmacologic treatment options are available.

Clients with co-existing mental health issues may require a dual diagnosis program where substance use and mental illness are treated in an integrated fashion (Osher & Drake, 1996). Similarly, an integrated approach is needed in working with clients whose substance use is affected by their gender identity concerns. While substance use can negatively impact psychotherapy and potentially affect the client's capacity to make medical decisions, a client who is struggling with substance use should not be excluded from treatment for gender identity concerns, and substance abuse treatment should not require that clients have resolved their gender identity concerns first. Rather, the clinician should focus on helping the client to address substance use as an integral part of the care plan toward resolution of the gender identity concerns.

Although transgender individuals may be highly motivated to engage in substance abuse treatment, particularly if they feel that substance use is interfering with their ability to transition, it can be difficult to find transgender-sensitive and competent treatment providers. Many drug and alcohol programs are gender-specific (i.e., for men or for women), posing a problem for individuals who are in the middle of transition, who do not identify as either man or woman, or who are visibly transgender. Residential treatment facilities must consider transgender-specific accommodations in sleeping, bathing, and group activities (White Holman & Goldberg, 2006b).

As with all other areas of transgender care, it is not enough for substance abuse treatment programs to be accessible and welcoming. Successful treatment requires understanding of the

multiple issues that commonly drive transgender individuals' substance use and make recovery difficult. These issues may include coping with gender dysphoria, social stigma, experiences of abuse or violence, and mental health concerns. Specific strategies beyond those discussed in this article are needed to build capacity for transgender-competent substance abuse prevention and treatment services (Barbara & Doctor, 2004; Leslie, Perina, & Maqueda, 2001; Lombardi & van Servellen, 2000; Oggins & Eichenbaum, 2002).

Violence and Abuse

It is difficult to estimate the extent of violence against transgender people as the vast majority of violence is not reported. Tracking mechanisms typically do not differentiate between lesbian, gay, bisexual, and transgender individuals (Goldberg & White, 2004), and there are no mechanisms to track transgender-related violence against non-transgender loved ones. Transgender-specific studies suggest high prevalence of sexual abuse, sexual assault, relationship violence, and hate-motivated assault (Courvant & Cook-Daniels, 1998; Devor, 1994; Kenagy, 2005; Lombardi et al., 2001). Data relating to transgender-specific hate crimes indicate that 98% of incidents were perpetrated against MtF transgender individuals (Currah & Minter, 2000). Non-transgender SOFFAs are also vulnerable to hate-motivated violence, as evidenced by the murders of Philip DeVine, Lisa Lambert, Willie Houston, and Barry Winchell (Cook-Daniels, 2001; Goldberg, 2006).

Vulnerability related to being transgender may be exploited in an abusive relationship. For example, abuse may include hurtful statements that invalidate gender identity (e.g., "You'll never be a real woman") or threats to "out" the transgender person to family members or co-workers. Violence may also include attempts to harm gendered aspects of the body or destruction of clothing, make-up, wigs, or prosthetic devices used for gender expression (Goldberg, 2006). Fears of being exposed as a transgender person and the possibility of additional abuse or ridicule upon disclosure pose a barrier to reporting violence and to accessing support services.

Transgender issues can also affect SOFFAs who are experiencing abuse in a relationship (Cook-Daniels, 2003). For example, a SOFFA who is being abused by a transgender person may be reluctant to seek assistance for fear of further isolating their transgender loved one, having to disclose transgender issues to friends and family, or fear of being perceived as gay or lesbian for being in a relationship with a transgender individual.

Although resources exist to promote awareness of transgender issues in anti-violence services (Courvant & Cook-Daniels, 1998; Goldberg, 2006; Goldberg & White, 2004; Munson & Cook-Daniels, 2003; White, 2003; White & Goldberg, 2006, in press), no guidelines currently exist for transgender-specific abuse prevention or treatment of victims and perpetrators of violence and abuse. Further work is needed in this area.

While not all transgender individuals experience overt violence or abuse, for many the daily trials of living in a society that does not sufficiently understand, accept, or accommodate their transgender identity constitutes an ongoing source of distress. For some, this distress becomes traumatic. Others experience the physical or emotional distress associated with the conflict between their sex assigned at birth and their gender identity as profoundly traumatic. This may result in symptoms of Post Traumatic Stress Disorder (American Psychiatric Association, 2000). Regardless of the severity of distress, it may be helpful to consider a trauma framework in understanding and treating the related mental health concerns of transgender individuals.

CONCLUDING REMARKS

Transgender persons and their loved ones are an underserved community in need of empathic, comprehensive, and clinically competent care. Health and social service providers engaged in mental health care will likely be approached for assistance by transgender community members at some point in their practice. Mental health professionals can have a significant positive influence in helping transgender people and loved ones address their gender and mental health concerns, build resilience in cop-

ing with social stigma, and reach their full potential. We hope this article helps clinicians feel more prepared and confident in clinical practice with the transgender community.

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APPENDIX A. Case Vignettes

The following case vignettes are from the first two authors' clinical practices. Names and identifying details have been changed to protect client anonymity.

The first case is of "Jake," who presented seeking assistance to pursue hormones and surgery as part of sex reassignment. The second case is of "Carlos," who came for treatment to deal with obsessive/compulsive features of his crossdressing and gender dysphoria. Although Carlos has, to date, decided not to change gender roles or undergo sex reassignment, some clients with similar profiles do so after the obsessive/compulsive features have been sufficiently alleviated. The third case, of "Anne," illustrates the quest for affirmation of gender identity. A physical change usually does not suffice to alleviate the impact of gender dysphoria and social stigma on one's mental health; psychotherapy and peer support play a key role in confronting internalized transphobia. The fourth case of "Jamie" illustrates how such mental illness as Schizo-affective Disorder may complicate treatment of gender dysphoria, yet does not necessarily constitute a contraindication for medical intervention. Rather, treatment of both conditions reinforce one another and result in improved stability and psychosocial adjustment. Finally, the fifth case, of "Patricia," illustrates gender dysphoria in a client with Asperger's Disorder. This case illustrates the difficulty in assessing a client with limited ability for psychotherapeutic interaction with the therapist.

The case vignettes reflect the diversity in transgender identities found among the transgender population, but illustrate the more complex cases in which gender identity concerns co-exist with other mental health and psychosocial concerns. Hence, these cases are not equally representative of the overall population of transgender clients. For example, the first case (Jake) is far more typical of FTM clients seeking hormones or surgery than the fourth case (Jamie).

The length of therapy and treatment in these cases varied widely. The first case (Jake) involved a straightforward assessment completed in three sessions. In the other four cases, the types of changes described took a considerable amount of time to emerge.

Jake (Female-to-Male)

Jake presented at age 23 seeking assistance to pursue hormones and surgery as part of sex reassignment. Jake started living as a man when he moved from Regina to Vancouver 18 months earlier. By the time he sought assessment he was already dressing as a man and using the men's restroom at work and in public settings. Jake sought chest surgery as he found it difficult to pass as a man during the summer and found it uncomfortable to bind his chest tightly, especially during warm weather. He also was hoping to start hormone therapy as soon as possible and to undergo a hysterectomy.

At the time of his first appointment, Jake lived alone and had been working as a manager of a fast food restaurant for the past year. Six years ago, he emigrated from Uganda to Regina and lived with his family until he decided to move out on his own to Vancouver.

Jake grew up in a Bahá'í family. Throughout Jake's childhood he was considered to be a tomboy and fought to be able to wear boys' shoes and clothes. Jake described himself as a loner throughout his childhood, not associating much with either boys or girls. He explained always wanting to be a boy and dreaming about getting married to a woman when he grew older. Prior to age 14 he had done well at school and was consistently at the top of his class. When his breasts started growing and he started menstruating, he became very distressed and his academic performance dropped so he was in the bottom third of his class. He subsequently became depressed and described having suicidal thoughts as a regular part of daily life (but not making any attempts). He described being sad about how difficult his life had been as a young woman and feeling that a mistake regarding his gender had been made.

Jake's father died of kidney complications secondary to diabetes when Jake was 15 years old. His mother and brothers moved to Regina two years later. Shortly after the move, Jake discovered information about transsexualism and spoke with his mother about wanting to have surgery. His mother could not accept this, and at age 18 Jake moved out to live with other relatives. It was at this point that he began to request that people call him Jake and that they refer to him as a man. Most members of his family were able to accept this.

After a series of three appointments involving discussion of Jake's gender feelings and personal and family history, it was agreed that the testosterone, chest surgery, and hysterectomy sought by Jake were appropriate treatments. A letter recommending hormone therapy was written to Jake's family physician. Jake described his doctor as supportive, but lacking experience in transgender medicine. Accordingly, a list of endocrinologists with experience in treating transgender individuals was provided for Jake to discuss with his physician for possible referral. Requirements for surgery were discussed with Jake and information regarding surgery was provided to his family physician. Jake returned for a specific assessment for transgender surgery after another year of living in the male gender role, and proceeded with chest surgery shortly thereafter. A hysterectomy was not performed until another year later as Jake was concerned about having sufficient time off work for recovery after the surgery.

Carlos

Carlos (age 41) presented with gender dysphoria and a request for sex reassignment. The mental health history revealed that he had a history of Dysthymia. Psychological testing indicated current symptoms of anxiety and depression. Carlos described a long history of crossdressing. He used to become sexually aroused and masturbate to an article of women's clothing. However, over time, he gradually needed more and more feminine accessories such as wigs, make-up, high heels, and jewelry to satisfy his urges. He described sexual fantasies of himself changing sex. Recently, on several occasions, he stayed up all night when his wife was out of town, impersonating a woman, and calling phone lines advertised in the local newspaper to talk to and meet men for sex. He explained that sex with a man made him feel more feminine, completing the image of himself as a woman. He shared this information with intense shame. He finally mustered the courage to come to therapy to pursue sex reassignment to resolve his situation.

Carlos met criteria for diagnoses of Dysthymia and Transvestic Fetishism with Gender Dysphoria. Individual psychotherapy was recommended to explore his crossdressing and gender dysphoria further. Pharmacotherapy was recommended to alleviate symptoms of anxiety and depression, and to alleviate obsessive/compulsive features of his crossdressing and gender dysphoria. Carlos began taking fluoxetine, and along with the psychotherapy sessions, this eased his feelings of despair. He brought his wife to therapy and shared the concerns with her. She was shocked, yet appreciated her husband's efforts to get help. When she learned that this had been a problem of Carlos dating back to the time before their marriage, she felt betrayed and was angry at Carlos for not telling her sooner.

Carlos began writing his personal and sexual history. It became clear that his crossgender feelings dated back to childhood. He described his family of origin as rather cold. Expressing one's emotions was deemed a sign of weakness. Carlos described much pressure from his family, particularly his father, to be "a man." He kept his crossgender feelings secret, fantasized about waking up one day as a girl, and these fantasies became more sexual in puberty. He secretly put on clothes of his sister, which added to sexual arousal, followed by masturbation. Over the course of his life, his fantasies became more elaborate, and so did his crossdressing. He described fantasies of his body changing from male to female, with breasts and a vagina appearing. He also fantasized about being admired and romanced as a woman by men.

What was particularly problematic for Carlos was that these fantasies at times became so intense that he would stay up most of the night pursuing their fulfillment. The fantasies took on the characteristics of an obsession, interfering with the responsibilities toward his family and job. To address these obsessive/compulsive features, Carlos joined a therapy group for men with compulsive sexual behavior. In this group, he shared his story which helped to alleviate shame. He made a commitment to this group to no longer call phone lines or seek sex with men to affirm his femininity. Carlos discovered that continuing to crossdress made it hard for him to adhere to these boundaries, and crossdressing without these activities became less and less appealing. Eventually, Carlos decided to stop crossdressing altogether. His gender dysphoria persisted, albeit in a more manageable way. He began to read and attend educational events about transgenderism. He eventually became at peace with himself identifying as "a crossdresser who does not crossdress," integrating his transgender feelings into the male gender role. He recommitted himself to the sexual relationship with his wife, and broadened his sexual fantasies to include her as well as other women. Finally, he developed lasting friendships with members of his therapy group.

Anne (Male-to-Female)

Anne (age 24) was referred for treatment of Gender Identity Disorder after completing an inpatient substance abuse treatment program. Her history revealed that she grew up as a gender-role-nonconforming boy. This led to substantial conflict with parents and with peers in school. Her father put pressure on Anne to act more masculine, and forced her to join an all boys hockey team. Peers in school made fun of Anne, calling her a "fag" and a "queer." At age 15 she dropped out of school and, shortly thereafter, ran away from home. After spending time in a shelter for runaway youth, she returned home and from then on lived in the female gender role. At age 18, she left home permanently. She met other transgender women, who provided her with illicitly procured feminizing hormones and introduced her to sex work. She participated in "pump parties" where peers injected silicone into her body to further feminize her appearance. They affirmed how beautiful she was, and for the first time in her life, Anne felt attractive and wanted. The attention from heterosexual men was initially very exciting; however, soon the hazards of working in the sex industry became overwhelming and she began to use drugs to cope. At age 20, she attempted suicide and was subsequently hospitalized and referred to substance use treatment.

Anne requested medically assisted hormone therapy, along with breast augmentation. Anne clearly met criteria for Gender Identity Disorder. In addition, she met criteria for Major Depression and for Histrionic Personality Disorder. Despite passing extremely well as a woman, she felt very insecure about herself and was hypervigilant about being discovered as transgender. The care plan included individual psychotherapy, group psychotherapy, pharmacotherapy for depression, and hormone therapy. In individual therapy, the depth and sources of Anne's self-hatred were exposed. Group therapy was difficult for Anne. She was unable to be vulnerable or accept help from others. She felt like she did not fit in and discontinued group therapy prematurely. Anne was then encouraged to bring her family into therapy. Both parents had been very concerned about Anne's welfare, and were glad to see that she was getting help. Anne's transgenderism was, at this point, the least of their concerns; they wanted to see Anne stay abstinent from drugs and alcohol, and find happiness.

Anne struggled to let go of her involvement in the sex industry. On the one hand, she recognized the negative impact of sex work on her self esteem and on her ability to establish a primary relationship. On the other hand, sex work provided her with income without having to face her fear and insecurity of finding and functioning in mainstream employment as a transgender woman. After a number of missed therapy appointments, Anne explained that it had been hard for her to come to therapy because "coming here makes me feel so transgendered." She further explained that she consulted with another therapist who recommended vaginoplasty to alleviate this feeling. Moreover, Anne unfolded extensive plans for feminizing surgery of her face, and how she had been working hard to save money for

this surgery. Rather than supporting her in pursuing these procedures, the therapist empathized and gently confronted Anne's internalized transphobia. Anne was able to see that no matter how much surgery she would have, she would always be transgender. While she meets the WPATH *Standards of Care* for genital surgery, Anne has so far opted not to undergo this procedure. She did opt for breast augmentation. Anne enrolled in school and eventually found employment outside of the sex industry.

Jamie (Female-to-Male)

Jamie (age 26) presented with questions about his sexual orientation and identity. He was very tense and slow to answer interview questions. It took several sessions to develop adequate trust to obtain sufficient information to conclude that Jamie struggled with gender dysphoria. In one of the extended intake evaluation sessions, Jamie shut down to the extent that the therapist became concerned about his safety; upon probing, Jamie admitted he felt suicidal. During the hospitalization that followed, Jamie was diagnosed with Schizo-affective Disorder. Upon release from the hospital, he was referred to a psychiatrist who had experience working with transgender clients and was able to separate gender identity issues from symptoms of Jamie's Schizo-affective Disorder. Jamie struggled with both. Pharmacotherapy was able to stabilize him.

Jamie lived with his mother, and she was invited to join him in therapy. Jamie's mother explained that Jamie was a loner. He worked in a factory on the assembly line and frequently changed jobs because once colleagues warmed up to him, he would become uncomfortable and quit. His mother also revealed that she divorced Jamie's father because he sexually abused Jamie when he was a child. In individual therapy, this was followed up on and Jamie was able to describe what happened. He felt that since his father had left, he had to be the man in the household and take care of his mother. Working through these issues in therapy did not change Jamie's resolve to live in the male gender role and pursue chest surgery and hormones.

Once Jamie had become more comfortable talking with his therapist, he joined a group with other transgender clients. In this group, he learned a great deal about what it is like to be transgender, what was involved in a gender role transition, and how to deal with people's reactions. He began living full-time in the male gender role and bound his breasts. Although Jamie's mental health had improved, his interpersonal functioning remained impaired. Therefore, once he met the WPATH *Standards of Care*, a competency evaluation was conducted determining that Jamie was competent to make an informed decision about chest surgery.

Jamie did not want to wait the two years required for public health coverage for chest surgery and saved every penny to pay privately. Upon its completion, he was visibly relieved and became more and more comfortable with himself. Subsequently, he requested support for hormone therapy. Because several clients with similar mental health concerns had destabilized after starting testosterone therapy, the possibility of this happening was discussed with Jamie. On the basis of this information, he decided to forego hormone therapy as he did not want to take the risk that his mental health would deteriorate. Jamie subsequently left home and fulfilled his lifelong dream of moving to an area with a warmer climate. Since he left, he has kept his therapist informed of his whereabouts and appears to be content and doing well.

Patricia (Male-to-Female)

Patricia (age 19) was referred for assessment by her family physician. Patricia had researched the referral process via the Internet, where she spent most of her time. Since junior high school she had had few friends, socializing primarily on-line where she adopted a female identity. The diagnosis of Asperger's Disorder became obvious after the first two or three sessions; unfortunately, this had not been detected earlier by the school or the family physician.

Patricia's mental health history included two bouts of depression in her mid-teens which were treated with an antidepressant. She was also hospitalized on one occasion after a suicide attempt. There was no history of abuse but the mother left the father because of his alcohol dependence. Patricia denied using alcohol and drugs.

The most difficult task was to assess the degree of gender dysphoria or to diagnose Gender Identity Disorder as Patricia's ability to participate in the interview was limited. This was somewhat remedied by asking her to write about her process. With her permission, we also interviewed family members and a school guidance counselor for collateral information.

Patricia graduated from high school with an opportunity to study computing science at a university. She wanted to go to the university as a woman, and began her real-life experience in the summer prior to starting college on hormone therapy in the fall. She presented to therapy in clothing that was feminine but a few years younger than her peers would have been wearing. However, as time passed, her clothing became more age-appropriate. Although she did not pass well, this did not seem to

be of concern to Patricia in terms of her identity or general social acceptance. She was, however, concerned with the potential for violence perpetrated against her.

Throughout the course of treatment Patricia continued to live at home with her mother and doing casual work repairing computers. She did not socialize any more than she used to but felt more content with her life. She continued to spend much time on the computer, and attended college on a part-time basis. There was no recurrence of the depressive episodes or suicide attempts. Therapy sessions continued to be therapist-driven with little input from Patricia; however, she continued to dialogue with the therapist through computer assignments. She went on to complete two years of "real life experience" and subsequently had genital surgery.

APPENDIX B. Sample Gender Assessments

All clinician and client names in the sample assessments are fictional, as are the depicted client characteristics. They are included for illustrative purposes only.

Female-to-Male Sample Assessment

Dear Dr. Smith:
Re: Majida Khattari
DOB: August 10, 1952
Reason for Referral: Client is a 52-year-old natal female who identifies as a man and who hopes to have a bilateral mastectomy/chest reconstruction surgery as part of gender transition.

Thank you for asking me to see your 52-year-old patient in consultation. The following letter represents a summary of my assessment of Majida over three sessions (November 14, December 12, and January 31). Majida was referred to me for gender assessment and to assess eligibility and readiness for chest surgery.

History of Gender Identity

Out of deference to Majida's gender identity, I will use male pronouns throughout this assessment. Majida has been masculine since early childhood. His preferred playmates were boys and his preferred games involved physical activities with boys such as football and hockey. As a child, he wore unisex or boys' clothing. He was often perceived as a boy by strangers and by teachers.

As puberty commenced, Majida remembers his male friends becoming uncomfortable with his masculine appearance, and less interested in spending time with him. To fit in, Majida began growing his hair, wearing make-up and more feminine clothing, and attempting to socialize with teenage girls and date boys. Romantic attempts with males were unsatisfying as he was not interested in boys in a sexual context, although he continued to prefer the social company of men.

In 1975 Majida began working at a mattress factory and became friends with a co-worker who was a butch lesbian. Majida became involved in the local lesbian community, participating in dances and other social events, and dating women. He returned to dressing in a more masculine fashion, and came out to his family as lesbian. He remembers this as an exciting time of self-discovery and clarity relating to his identity.

In recent years, through supporting some of his butch friends through their process of exploring their gender identity and options for gender transition, Majida came to realize that his self-concept is more of himself as a man in a female body rather than a masculine female. In his current life Majida avoids situations such as swimming that would require him to reveal his female body. In his sexual relations he does not remove his top, and imagines himself as having a male body. He binds his breasts using a spandex back brace.

As a very masculine-appearing person, Majida feels little dissonance between his identity and his role. However, to facilitate his comfort he would like to pursue chest reconstruction. He is not interested in testosterone as he has a history of chronic liver disease, and feels the risks of side effects would outweigh the possible benefits. Additionally, he has already gone through menopause so no longer feels any discomfort relating to menstruation.

Majida has a strong supportive circle around him. He has told many of his friends of his transgendered feelings and has received positive feedback.

Medical History

1. cigarette smoking–25 years, currently one pack a day
2. obesity
3. Hepatitis C

Medications

1. has taken interferon for Hepatitis C–not currently taking any medication
2. no known drug allergies

Mental Health History

Majida sought counseling in 1992 to deal with issues relating to being molested by a neighbor at age 10. He reports being depressed and suicidal at that time, but having stable mental health in the years since.

Substance Use

Majida started drinking alcohol at parties in high school and continued to drink recreationally through the 1980s and early 1990s. In the mid-1980s he experimented with amphetamines to assist in working night shifts. His use gradually increased and he reports being addicted for several years. He went through an amphetamine addiction program in 1991 and has not been using recreational drugs since that time. In 1993 he was diagnosed with Hepatitis C and has not been drinking alcohol since that time. He typically smokes one pack of cigarettes and drinks several cups of coffee per day.

Personal History

Majida was born and raised in Nanaimo. He has two younger twin brothers age 42, and an older sister age 53. His parents and grandparents are deceased. As a child Majida spent much time with his family fishing, camping, and playing sports. As both his parents worked during Majida's childhood, his grandparents and aunt were primary caregivers. He remains close with his aunt.

Majida began his career doing heavy physical labor in factories in the 1980s. In the late 1980s he lost his job as the result of difficulties relating to amphetamine addiction, and made his living through selling drugs. In the early 1990s after going through an addiction program he started driving taxis. Fatigue related to Hepatitis C has become increasingly debilitating and Majida is no longer able to work. He is currently receiving disability benefits through the Ministry of Human Resources.

Majida has had sexual relationships in the past but is not dating at this time. He is sexually attracted to women.

Summary and Treatment Plan

Majida does not experience clinically significant distress relating to his gender role or gender identity, as his physical masculinity has enabled him to live in a way that is congruent with his strong masculine identity. However, Majida does report distress relating to his female body. Specifically, he feels he would be more comfortable with a more masculine appearing chest and that it would enable him to be more comfortable in sexual relations and other activities that may involve disrobing. Majida is a mature individual who has carefully considered the pros and cons of surgical intervention, and he has been cross-living for many years. In my opinion, Majida meets both the eligibility and readiness criteria of the World Professional Association for Transgender Health *Standards of Care*. I do not find any mental health considerations that would negatively impact his ability to make an informed decision regarding chest surgery.

Please do not hesitate to contact me with any questions you may have.

Male-to-Female Sample Assessment

Dear Dr. Smith:
Re: Sandeep Singh
DOB: January 15, 1970
Reason for Referral: Client is a 34-year-old natal male who identifies as a woman and is seeking assistance to resolve gender confusion.

Thank you for asking me to see your patient in consultation. I saw Sandeep on three occasions (January 12, February 2, and February 20, 2005) and the following letter represents a summary of these sessions.

Sandeep is a 34-year-old anatomical male who identifies as a woman (out of deference for her gender preference I will refer to her as "she" throughout this letter). Sandeep is a 34-year-old agricultural worker who has been married for 15 years and has two daughters age 8 and 11. Her wife Parmit works as a school teacher. Sandeep presents today wanting to explore options for resolution of her gender confusion.

History of Gender Identity

Sandeep was the youngest child in a family of four, with three older sisters. As a young child, she lived in a rural area of the Fraser Valley and played most of the time with her sisters. All of the children in the family were expected to participate in helping the mother work at a berry farm on the weekends, while the father worked in a local lumber mill.

At age 8, Sandeep began wearing female undergarments under her clothes to school. She was afraid of being caught with these articles on, and tried to either avoid physical education class or change in the cubicle. As she went through puberty, she was very distressed by the erections and nocturnal emissions she experienced, and started to tape down her penis.

At age 19, Sandeep married Parmit, and did not discuss any of the crossdressing activity or gender

identity concerns with her. Sandeep put all of her energies into her work and family in hope that her feelings about being a woman would disappear. Four years into the marriage, Sandeep and Parmit had a daughter and Sandeep wished that she would have been the one to bear the child. Both were happy in the parenting role, and they had another child three years later. Throughout this time Sandeep continued to crossdress in private, and continued to struggle with feeling a conflict between her public life as a man and her private identity as a woman.

Shortly after the birth of their second child, Sandeep's mother was diagnosed with breast cancer and died within a year of the diagnosis. The time with her mother prior to her death made Sandeep re-evaluate her life, and she disclosed both the crossdressing and her conflict over her identity to her wife. Parmit was very angry and upset but did not want to lose Sandeep as her partner and wanted the family to remain together. They sought counseling and Parmit decided that she would not be able to stay with Sandeep if she were to live her public life as a woman. Sandeep at this time also did not want to lose the family and so she continued to crossdress in private for the next six years. As time progressed, she realized that she did not want to continue living as she was, and so she is presenting today with hopes of discussing her marital situation as well as getting information about options for transition.

Medical History

1. Tonsillectomy at age 9

Medications

1. No medications
2. No known drug allergies

Substance Use

Sandeep reports not smoking, drinking alcohol or caffeinated drinks, or using recreational drugs.

Mental Health History

Sandeep suffered from depression after the death of her mother and was treated with sertraline for one year, after which time the depression had been alleviated sufficiently to stop this medication.

Personal History

Sandeep started school when she was 6 years old. She remembers disliking school as the few Sikhs in the class were frequently teased by the White boys. She left school at age 15 to work full-time.

Sandeep has been close to her three sisters throughout her life, and maintains a close connection to them and to their families. None of them are aware of Sandeep's gender identity concerns. Sandeep is not currently close with her father. She has always found it difficult to connect emotionally with him, and in recent years the father has become more reclusive following the death of his wife.

Sandeep has little connection with the transgender community as she lives in a rural area where there are no peer support groups. She has seen a documentary on transsexuals and would like to explore the possibility of hormones and surgery. She does not have any detailed information at this time relating to either option, nor is she certain what she wants to pursue.

Summary and Treatment Plan

Sandeep is a 34-year-old anatomical male who identifies as a woman. She presents with a history of strong and persistent cross-gender identification, persistent discomfort in the male gender role, and clinically significant distress relating to her gender concerns. She has limited support from the people around her, who are either unaware of her gender identity or are opposed to her transition. She presents today to obtain information about hormones and transitioning but is reluctant to move forward at this time, particularly until an agreement is made with her wife relating to their marriage. She agrees that it is premature at this time to consider hormone therapy and will enter a course of relationship counseling that will hopefully include her wife Parmit.

Please do not hesitate to contact me with any questions you may have.

APPENDIX C. Sample Letter to Client Prior to Assessment for Hormone Therapy

Dear client:

This letter is intended to explain what to expect from the hormone eligibility and readiness assessment process and help you prepare for the first appointment.

Purpose of the Assessment

The clinician providing the assessment will:

1. Determine whether you meet the eligibility and readiness criteria for hormone therapy outlined in the current version of the World Professional Association for Transgender Health (WPATH)'s *Standards of Care*.

2. Make a recommendation to the prescribing physician about whether or not they feel hormone therapy is appropriate in your treatment.

Eligibility Criteria

1. Able to provide fully informed consent to medical treatment.
2. Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks.
3. Either a documented "real life experience" of at least three months prior to the administration of hormones, OR a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation. This may be waived in some special situations.

Readiness Criteria

1. Further consolidation of gender identity during the real-life experience or psychotherapy.
2. Progress in mastering other identified problems, leading to improving or continuing stable mental health.
3. Likelihood of taking hormones in a responsible manner.

Assessment Sessions

Appointments are 50 minutes long. Assessment may take one or more appointments to complete. Discussion topics may include:

- general personal history: who you are, home life, what you do during the day, education, work, friends, family, hobbies, interests
- history of gender identity concerns, from start to present day
- medical and mental health history, including medications taken in past/present
- substance use history
- gender transition process thus far, and future plans
- any questions or concerns you have

Documentation to Bring to First Session

You will need to bring your health insurance card and picture identification (e.g., passport, driver's license). The picture identification is necessary to confirm that you are the person being assessed. It is not required that you have had a legal name change, but if you have, please bring documentation of this name change.

If you want assistance with documentation or support relating to the assessment process, peer support and advocacy groups are listed below.

APPENDIX D. Sample Letter to Client Seeking Sex Reassignment Surgery

Dear client:

This letter is intended to explain what to expect from the surgery eligibility and readiness assessment process and help you prepare for the first appointment.

Purpose of the Assessment

The clinician providing the assessment will:

1. Determine whether you meet the eligibility and readiness criteria for sex reassignment surgery outlined in the current version of The World Professional Association for Transgender Health (WPATH)'s *Standards of Care*.
2. Make a recommendation to the surgeon about whether or not they feel surgery is appropriate in your treatment.

Eligibility Criteria

For all types of sex reassignment surgery:

1. Able to provide fully informed consent to medical treatment.
2. Demonstrable knowledge of what sex reassignment surgery medically can and cannot do; potential benefits, risks, and complications; approximate cost; expected time in hospital; aftercare requirements; and surgeon options.

For female-to-male (FTM) chest surgery, assessment by one mental health professional who meets the competency requirements outlined in the WPATH *Standards of Care* is sufficient. In addition to the general criteria, FTM transgender persons seeking chest surgery must:

3. Have completed either a documented real-life experience of at least 3 months prior to chest surgery, OR a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation.

For male-to-female (MTF) breast surgery, assessment by one mental health professional who meets the competency requirements outlined in the

WPATH *Standards of Care* is sufficient. In addition to the general criteria, MTF transgender persons seeking breast augmentation must:

3. Have completed either a documented "real-life experience" of at least 3 months prior to breast surgery, OR a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation.
4. Have taken feminizing hormones for at least 18 months before surgery to allow for maximal hormonal breast growth, unless there are medical contraindications to hormone therapy.

For genital surgery (FTM or MTF) or removal of the ovaries and uterus (FTM), assessment by two mental health professionals who meet the competency requirements outlined in the WPATH *Standards of Care* is required. In addition to the general criteria, individuals seeking "lower surgery" must have:

3. Completed at least 1 year "real life experience" (RLE).
4. Taken hormones continuously for at least 12 months, unless there are medical contraindications to hormone therapy.
5. Completed any psychotherapy required by the mental health assessor.

Readiness Criteria

1. Further consolidation of gender identity during the real-life experience or psychotherapy.
2. Progress in mastering other identified problems, leading to improving or continuing stable mental health.

Number of Sessions

Appointments usually are 50 minutes long. Assessment may take one or more appointments to complete. Discussion topics may include:

- general personal history: who you are, who you live with, what you do during the day, education, work, friends, hobbies, interests
- history of gender identity concerns, from start to present day
- medical and mental health history, including medications taken in past/present
- substance use history
- gender transition process thus far, and future plans
- any questions or concerns you have

Documentation to Bring to First Session

You will need to bring your health insurance card and picture identification (e.g., passport, driver's license). The picture identification is necessary to confirm that you are the person being assessed. It is not required that you have had a legal name change, but if you have, bring your documentation of this name change.

If you have completed "real life experience" (i.e., living as the gender you identify as), it is helpful to bring documents to confirm the length of time that you have done this. For example:

- Pay stubs or a letter from your supervisor indicating the length of time you have been employed
- A letter from your academic advisor or teacher indicating the length of time you have been in school, and/or a school transcript
- A letter from your supervisor in a volunteer position indicating the length of time you have been involved in volunteering
- If you are unable to work, attend school, or volunteer, bring a letter from your doctor explaining your circumstances and confirming that to the best of their knowledge you are living full-time in the gender you identify as

It is not necessary to disclose your gender history to your employer, teacher, or supervisor: you can tell them you need a general reference letter without saying what it is for. The letter can be a short statement that includes your name, the gender pronoun you are called, and the length of time you have been working, volunteering, in school. For example:

- "I have known John Doe for two years. He began work for me on (date) and has worked full-time since then."
- "Jane Doe has volunteered ten hours a week for (name of organization) for over two years. She began as a volunteer here on (date)."
- "Jan Doe has been taking a full academic courseload since (date)."

If you wish, you can include letters from friends, relatives, neighbors, or others who you interact with socially as additional evidence of completion of the real life experience.

Letters must be *signed originals*, and transcripts or pay stubs must be original copies. We encourage you to make a photocopy of all documents for your records prior to the appointment, as the originals will be kept in your file.

If you want assistance with documentation or support relating to the assessment process, peer support and advocacy groups are listed below.

APPENDIX E. Sample Letter to Prescribing Clinician, Recommending Hormone Therapy

All clinician and client names are fictional, as are the depicted client characteristics. They are included for illustrative purposes only.

Dear Dr. Smith:
Re: Saul Cohen (a.k.a. Sarah Cohen)
DOB: April 23, 1980
Reason for Referral: Client is a 23-year-old natal female who identifies as a man and seeks medically monitored testosterone therapy as part of gender transition.

I am writing to support my client's request for testosterone therapy. Saul (whose legal name is Sarah) is a 23-year-old anatomical female who identifies as a man. He has been my client since January 12, 2003 when he sought my services to assess for suitability for hormone prescription as part of gender transition. I am a registered clinical counselor in private practice, working with other professionals who have an interest in transgender health but not as part of a formal gender team.

I have seen Mr. Cohen in two 50-minute counseling sessions. In those sessions we have discussed Saul's gender identity, as well as his overall psychosocial history and current status. I note that Saul does not see his identity as a type of mental illness and thus does not want to be labeled as having Gender Identity Disorder, despite having a strong cross-gender identity.

In the last year Saul has come to strongly identify as a gay man. For the past 2 months has been taking testosterone he purchased from the Internet, to alleviate discomfort he feels when he is perceived as a woman and also to change his voice and appearance to be more congruent with his sense of self. Thus far Saul reports a deepened voice, enlarged and sensitized clitoris, heightened libido, and acne as a result of the testosterone he has taken. Saul is pleased by these changes and is eager for other changes, particularly cessation of menses and growth of facial hair. He cannot currently afford to legally change his name from Sarah to Saul, but does prefer that Saul be used.

Saul is aware of the risks of taking testosterone without medical assistance, and wishes to have regular medical monitoring from this point onward. According to Saul, he started taking testosterone without medical assistance because there was a lengthy wait to see a family physician with expertise in transgender medicine.

Saul is well-informed about the female-to-male (FTM) community, having read several articles on hormonal and surgical options (including the World Professional Association for Transgender Health's *Standards of Care*) and also participating in a FTM Internet mailing list. I believe that Saul understands his options for peer and professional support should he need assistance to adjust to any of the changes that occur as a result of taking testosterone.

In closing, while Saul has not yet been cross-living or attending psychotherapy for the full 3 months recommended in the World Professional Association for Transgender Health's *Standards of Care*, I am confident that he does meet the other eligibility and readiness criteria defined in the *Standards of Care*, and I believe it would be beneficial for him to move from medically unsupervised use to medically supported use of testosterone. I feel confident that Saul understands the permanence of continuing to take testosterone, and that he will take hormones in a responsible manner.

If you have any questions or concerns, please do not hesitate to contact me.

APPENDIX F. Sample Letter to Surgeon, Recommending Sex Reassignment Surgery

All clinician and client names are fictional, as are the depicted client characteristics. They are included for illustrative purposes only.

Dear Dr. Smith:
Re: Shirley Alexander
DOB: September 9, 1959
Reason for Referral: Client is a 45-year-old natal male who identifies as a woman and who hopes to have vaginoplasty as part of gender transition.

This letter will introduce Ms. Shirley Alexander, a 45-year-old anatomical male who identifies as a woman, whom I would like to refer for vaginoplasty as part of sex reassignment. Ms. Alexander has been my client since January 2, 2003 when she was referred to me by her family physician. I am a psychiatrist in private practice, working with other professionals who have an interest in transgender health but not as part of a formal gender team.

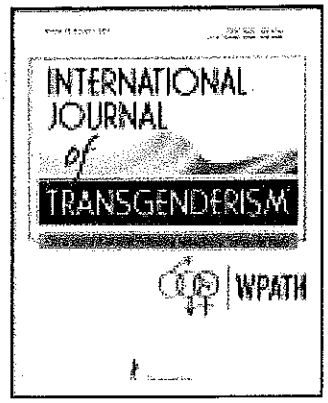
After an initial assessment of three sessions, I diagnosed Ms. Alexander with Gender Identity Disorder. Since then I have been seeing her every three weeks and she has been engaged in therapy focusing on family of origin issues.

Ms. Alexander began facial electrolysis in May 2002, and with the support of her family physician (Dr. John Bigelow) was started on feminizing hormone therapy by endocrinologist Dr. Doris Reinbolt on April 1, 2003. She began her "real life experience" May 15, 2003, and her legal name change was granted June 15, 2003. Psychologist Dr. Robert Jones completed a second assessment on April 3, 2005 and concurred with my initial diagnosis. Contact information for all professionals involved in Ms. Alexander's care relating to Gender Identity Disorder is included at the end of this letter; if you have not already received reports from them, you should be receiving them soon.

Past medical history includes Type II diabetes (controlled by diet and exercise), exercise-induced asthma, ankle fracture at age 11, and an appendectomy at age 10. Ms. Alexander is physically fit and is a non-smoker. Current medications include transdermal estradiol patch (0.2 mg/24 hours, applied twice per week), spironolactone 300 mg po daily, and ventolin inhaler PRN. She has no known drug allergies.

In closing, Ms. Alexander meets the criteria for Gender Identity Disorder. She has been living as a woman full-time for over two years and has adjusted well to this role. I have discussed the risks and benefits of vaginoplasty with Shirley and feel confident that she understands the seriousness and permanence of the surgery. I also feel confident that she will undertake the appropriate self-care that is necessary after vaginoplasty.

If you have any questions or concerns, please do not hesitate to contact me.



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Counseling and Mental Health Care for Transgender Adults and Loved Ones

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