Counselling and Mental Health Care of Transgender Adults and Loved Ones

Walter Bockting, PhD[*]
Gail Knudson, MD, MPE, FRCPC[†]
Joshua Mira Goldberg[‡]

January 2006

a collaboration between Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program, with funding from the Canadian Rainbow Health Coalition's Rainbow Health – Improving Access to Care *initiative*

---

[*] Coordinator, Transgender Health Services, University of Minnesota, Minnesota, USA
[†] Department of Sexual Medicine, University of British Columbia/Vancouver Hospital, Vancouver, BC, Canada
[‡] Education Consultant, Transgender Health Program, Vancouver, BC, Canada

Table of Contents

Scope 1

Clinical Picture 2

Initial Evaluation 4
- Trans-specific issues in building therapeutic rapport 4
- Discussing client and clinician goals and expectations 4
- Documenting client history and current concerns 5
- Evaluating capacity to make care decisions 6
- Initial clinical impression 7

Assessment and Treatment of Gender Concerns 8
- Gender assessment 8
- Care plan for gender concerns 11
- Psychotherapy for gender concerns 12
  - Addressing co-existing mental health or psychosocial concerns 12
  - Exploring gender history and development of transgender identity 13
  - Exploration of options for gender expression 13
  - Implementation of identity management decisions 15
  - Ongoing management of gender issues over the client's lifespan 16
- Hormonal/surgical treatment of gender dysphoria 17
  - Qualifications of hormone/surgery assessors 18
  - The "gatekeeper" role and the impact on therapeutic rapport 19
  - Evaluating eligibility 20
  - Assessing readiness 21
  - Recommendation regarding treatment 23
- Counselling of loved ones 24

Trans-specific Assessment and Treatment of Mental Health Issues 25
- Depression, anxiety, and suicidality 27
- Self-harm 27
- Compulsivity 28
- Thought disorders 28
- Personality disorders 29

Trans-specific Elements in General Counselling 29
- Body image 30
- Grief and loss 30
- Sexual concerns 31
- Social isolation 33
- Spiritual/religious concerns 33
- Substance use 34
- Violence/abuse 35

Case Studies 35

Concluding Remarks 40

Summary of Recommendations 41

References 49

Appendices 57

Counselling and Mental Health Care of Transgender Adults and Loved Ones

Scope

Transgender* individuals and loved ones may seek assistance from mental health professionals for trans-specific or more general concerns. Transgender mental health practice may include:

- evaluation, care planning, and treatment of gender concerns
- evaluation, care planning, and treatment of mental health concerns
- psychotherapy: individuals, couples, families, and groups
- short-term consultation (typically 1-3 sessions): information, resources, and referral assistance for transgender individual or loved one, or peer consultation for another clinician
- psychoeducational workshops and groups: information and facilitated discussion on specific topics (e.g., sexual health, hormones, transition); training for employers, schools, etc.
- case and global advocacy (see *Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians*, White Holman & Goldberg, 2006)
- clinical support/supervision for facilitator(s) of peer-led support group
- training of other clinicians

This document 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 (counsellors, family physicians, nurses, psychologists, psychiatrists, psychiatric nurses, 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 separately in *Caring for Transgender Adolescents in BC: Suggested Guidelines* (de Vries, Cohen-Kettenis, Delemarre-van de Waal, White Holman, & Goldberg, 2006).

This work is part of the Trans Care Project, an initiative aiming to improve clinical resources for trans-serving professionals in British Columbia (BC). Prior to 2002, a hospital-based gender clinic provided the majority of services relating to evaluation of gender concerns and treatment for those undergoing medically-assisted gender transition. With the gender clinic's closure in 2002 and the subsequent move to a decentralized, community-based network of clinicians (Kopala, 2003), mental health professionals with varying degrees of transgender training and experience are now responsible for all aspects of care sought by transgender individuals and loved ones. In keeping with the Trans Care Project focus, some of the information in this document is specific to the health system in British Columbia; other recommendations are broader in nature and may be of interest to practitioners in other regions.

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.

---

* In this document, *transgender* includes any person who (a) has a gender identity that is different from their natal sex, and/or (b) who expresses their gender in ways that cross or transcend societal expectations of the range of possibilities for men and women. This umbrella term includes crossdressers, drag kings/queens, transsexuals, androgynous individuals, Two-Spirit individuals, and individuals who are bi-gendered or multi-gendered.

Mental health clinicians may find it useful to read other documents in this series (e.g., Bowman & Goldberg, 2006; Dahl et al., 2006) to gain a fuller understanding of care options and issues in other disciplines. Clinicians engaged in transgender care in BC are encouraged to become part of the Transgender Health Program's virtual network of care to facilitate interdisciplinary collaboration and communication (see Appendix A).

This document 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/patient, 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 document 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 (e.g., non-pathologizing/trans-affirming approach, client-centred care, commitment to harm reduction). 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.

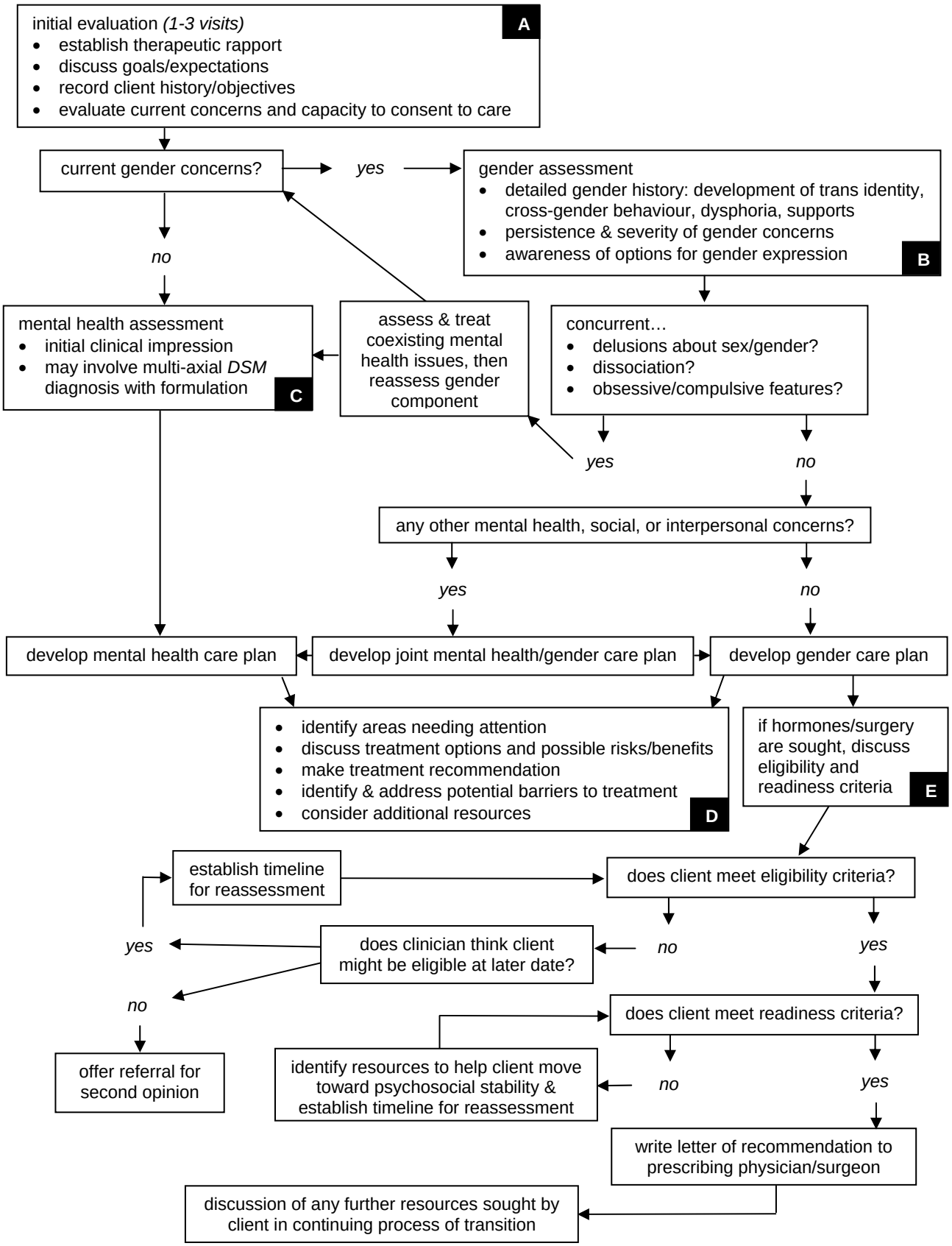
Clinical Picture

As a heterogeneous population, there is great diversity among transgender individuals and their needs relating to mental health services. In a recent BC-wide survey of individuals requiring transgender health services (n=179), 53% of respondents reported a current need for counselling relating to gender issues, with 32% requiring mental health assessment relating to pursuit of feminizing/masculinizing hormones or surgery and 39% stating a current need for mental health care for issues not relating to gender concerns (Goldberg, Matte, MacMillan, & Hudspith, 2003). Clients may present seeking assistance with mental health issues, gender concerns, or non-trans-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 trans-specific issues (e.g., transphobia, impact of gender issues on psychosocial and identity development, psychological effects of feminizing/masculinizing hormones) on mental health and the implications for treatment. For individuals seeking help relating to gender 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 on the following page 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 concerns, the next step may be a gender assessment (B) to provide more detailed information about the client's gender issues and to determine any co-existing conditions, or it may be to provide supportive counselling 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 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/ masculinization, a specialized assessment (E) must be done to evaluate eligibility and readiness. Each of these tasks is discussed in detail in the subsequent sections of the document.

Figure 1: Clinical Pathways and Tasks in Mental Health Practice with Transgender Individuals



Initial Evaluation

Initial evaluation typically consists of 1-3 one-hour 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 on the following pages.

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 (e.g., as part of hormone/surgery assessment) rather than voluntarily sought (Brown & Rounsley, 1996). Issues relating to hormone/surgery assessment are discussed in detail on pages 17-24.

In addition to the regular techniques used to build therapeutic rapport, it can be helpful to actively demonstrate trans-specific sensitivity by discussing privacy issues in setting appointment times (e.g., whether a message can be left at the client's home/work) and the client's preferred name/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. The Transgender Health Program can be consulted for information and training relating to these general sensitivity/awareness issues.

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.

In particular, if the client is presenting with a desire to be assessed for hormones/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 assessment 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 below. 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 sensitive, respectful, and non-judgmental; for other clients it can be anxiety-provoking to be asked questions about drug and alcohol use, sexual concerns, history of sex work, etc.

Table 1: Potential Areas of Inquiry in Initial Evaluation

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? If so, when and what was the diagnosis? • Have you ever been hospitalized? If so, when and what for? • Are you currently taking any medication (including illicitly obtained hormones), vitamins, 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?
Alcohol & drug	• 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	• Do you identify in a particular way in terms of your sexual orientation? Are you attracted to men, women, and/or transgender people? • Are you currently involved with anyone romantically? If so, how do you feel about your relationship? • Have you had any concerns about relationships or sexuality in the past? Any current concerns? • 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/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, 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 stresses? • Are you worried about future financial stresses? • Are you satisfied with your current housing? 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? Do you have any concerns relating to this now? • Have you ever sought to change your body through hormones/surgery? Is this something you have thought about pursuing in the future? • Are there any kinds of supports you feel might be helpful as a transgender person?

Standardized psychological testing and paper-and-pencil questionnaires are helpful tools to screen for a range of health and 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 below presents an overview of commonly used tests and questionnaires relevant to trans-specific concerns. The instruments chosen depend on the client's presenting complaint.

Table 2: Testing and questionnaire instruments

Assessment area	Possible instruments	Citation
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	Bockting, 1997; Bockting, 1999; Coleman, 1987
Psychosexual functioning	Derogatis Sexual Functioning Inventory	Derogatis & Melisaratos, 1979
	Compulsive Sexual Behaviour Inventory	Coleman, Miner, Ohlerking, & Raymond, 2001

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 bolster a client's sense of competency and agency, but also to give a complete picture of the client's life and psychosocial adjustment.

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 trans-competent addiction services, we believe it is important to enquire about drug and alcohol use as part of the intake process. Visible pamphlets about trans-competent addiction services and harm reduction approaches to substance use can be helpful in providing clients with reassurance that it is safe to discuss substance use concerns. For clients who report high anxiety, it may be appropriate to ask about caffeine intake as part of substance use evaluation.

Evaluating capacity to make care decisions

Under the *Health Care (Consent) and Care Facility (Admission) Act*, health care professionals in BC must normally obtain informed consent before treating an adult patient. This may be waived if the patient is experiencing a medical or psychiatric emergency and is too ill to give informed consent (as per the *Mental Health Act*). As the types of care covered in these guidelines are non-emergent, clinicians should confirm the client's capacity to make care decisions as part of the initial evaluation.

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, intoxication, etc.). 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 below.

Table 3: Aid to Capacity Evaluation

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/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/refuse the treatment? • Do you think we are trying to hurt/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?

Note: 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

In complex cases, additional evaluation should be sought from a psychologist or other advanced 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 on pages 39-40).

Initial clinical impression

After the interview is complete and any testing is scored, the assessor should review the completed questionnaires and the interview notes, 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. Transsexuals pursuing sex reassignment surgery are estimated at 1 in 11,900 natal males (transsexual women) and 1 in 30,400 natal females (transsexual men) (Bakker, van Kesteren, Gooren, & Bezemer, 1993).

Gender concerns can affect individuals of all ages. MTF transsexuals may not seek psychological or medical intervention until middle age (Blanchard, 1994), while 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 about gender issues, and may specifically ask about the clinician's experience 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/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 behaviour, disordered eating, or other issues.

The language used by transgender individuals is continually changing, as transgender people become 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 (e.g., gender, sex, sexual orientation).

Gender assessment

Assessment of gender concerns involves a detailed history of transgender identity development and gender expression. In addition to interview questions (outlined in Table 4 on the following page), 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; most of the work in exploring the various options to manage or express one's transgender identity will occur in psychotherapeutic treatment (as discussed on pages 12-17). For clients in later stages of incorporating transgender identity into daily life, a more detailed interview will be possible.

Table 4: Potential Areas of Inquiry in Gender Evaluation – Transgender Person

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? What was puberty/adolescence like? • How do you feel about your gender now? Do you have any questions/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-gendered? 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? Is this different than your preferences now? • Have you ever cross-dressed? If so, what was that experience like for you? 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/masculinizing hormones or had feminizing/masculinizing surgery? What was that like for you?
Perceptions of others	• How do you think others perceived your gender when you were a child? 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 it 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 trans 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? If not, how do you feel about them not knowing? • Have you had any contact with other transgender individuals? What was that like for you? • What do you see your relationship being to the transgender community now? What would you like it to be in the future? • Have you used the internet to access support and information about being transgender? What have you learned? In what ways was it helpful or not helpful for you?

There is controversy within the transgender community and among mental health professionals about the *DSM-IV-TR* diagnoses of *Gender Identity Disorder* (GID, Appendix B1) and *Transvestic Fetishism* (TF, Appendix B2) as part of evaluation and treatment planning (Bockting & Ehrbar, in press). 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 hormones/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 requires medical intervention (Davis, 1998; Hill, Rozanski, Carfaginni, & Willoughby, 2003; Israel & Tarver, 1997; Moser & Kleinplatz, 2003; Wilson & Lev, 2003). Although GID diagnosis is not a prerequisite for hormones or surgery in the Harry Benjamin International Gender Dysphoria Association (HBIGDA) *Standards of Care* (Meyer et al., 2001), the diagnosis is required by some individual clinicians as a prerequisite to hormonal/surgical treatment, and by the BC Medical Services Plan (MSP) as a prerequisite to surgery funding.

For transgender individuals who are planning to apply for MSP coverage for sex reassignment surgery (or are considering this as a possibility), it is important to obtain a GID diagnosis by a MSP-appointed assessor as early in transition as possible, to facilitate the later application process. Individuals who do not have a GID diagnosis will not be eligible for MSP surgery coverage. MSP eligibility criteria are discussed further in the section on surgery assessment (pages 17-24).

Regardless of approach and beliefs relating to GID/TF diagnosis (or past GID/TF diagnosis), we consider it essential to evaluate specific parameters in assessment of clients who present with gender concerns.

- *What is the 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 guilt relating to crossdressing or transgender feelings; others are dysphoric about physical characteristics associated with sex/gender, the perceptions of others relating to gender, and/or roles associated with gender.

- *How persistent and severe are the 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 Gender Identity Disorder or Transvestic Fetishism diagnosis). Clients who are gender-variant but not preoccupied with gender concerns to a degree that is negatively affecting 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 it is negatively affecting quality of life, Adjustment Disorder may be appropriate as a diagnosis (Israel & Tarver, 1997).

- *Are there obsessive/compulsive features?* Compulsive crossdressing, obsessive pursuit of validation of transgender identity through sexual pursuits, or other obsessive/compulsive behaviours should be evaluated. Where there is sexual compulsivity, diagnoses 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/compulsive features should first be addressed (discussed on page 28), with subsequent reassessment to determine whether gender concerns persist (Bockting, 1997).

- *Is there a history of homosexuality combined with internalized homophobia?* Clients who have difficulty accepting same-sex/same-gender desires 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 psychotherapeutic treatment offered for any concerns about sexual orientation. Gender concerns should be reassessed after treatment.

- *Are there 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) – e.g., that one's body has spontaneously

[*] The *DSM-IV-TR* definition of Transvestic Fetishism limits the diagnosis to heterosexual males. However, compulsive crossdressing for sexual purposes can theoretically be a concern for people of any gender or sexual orientation. Erotic crossdressing is not intrinsically a mental health concern, but if it becomes so consuming that it is affecting a person's ability to function, the compulsivity and obsessive qualities are of clinical significance.

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 by persistence (gender concerns are usually longstanding) and presence when the client is not actively delusional.

- *Is there evidence of dissociation?* For some individuals, growing up transgender is experienced as traumatic. Others have experienced additional trauma. 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. By addressing this trauma in therapy, an integrated self can be achieved (see also Brown & Rounsley, 1996). A diagnosis of Dissociative Identity Disorder (as defined in the *DSM-IV-TR*) is “not a contraindication to either eligibility or readiness for SRS” (Brown, 2001) but should be very carefully evaluated as part of the overall care plan. DID diagnosis is not appropriate for individuals who have a bi-gender or multi-gender identity (even if this is described as having different “personalities” or “selves”) in the absence of dissociation. As stated by Israel & 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).

- *Is there evidence of Asperger’s disorder?* 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 present itself until later. Because of the obsessive/compulsive nature of the 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 on page 39). 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 (page 6-7).

- *Is there evidence of a personality disorder?* It can be challenging to evaluate gender concerns in clients with personality disorders (e.g., 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 some cases, gender dysphoria and a personality disorder co-exist and may be unrelated.

Appendices C1 and C2 provide two sample letters summarizing the gender assessment findings of a male-to-female and female-to-male transgender client.

Care plan for gender 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 concerns) should be evaluated

and treatment incorporated into the overall care plan. Axis IV psychosocial stressors are best addressed through coordination with social, housing, legal, and vocational services.

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 BC-wide survey (n=179) reported difficulty accessing services relating to crossdressing or gender transition; the most common barriers reported were financial expense (40%), lack of services in the client's home region (31%), and waitlist for services (26%) (Goldberg et al., 2003). As private psychotherapy is not covered by the BC Medical Services Plan and public counselling agencies outside of Vancouver and Victoria typically do not have transgender experience (and/or have long waitlists and limited sessions), psychotherapy may not be 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 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 hormonal or surgical feminization/masculinization (see pages 17-24).

Mental health professionals may, depending on their theoretical orientation and training, apply a number of different therapeutic approaches to the treatment of gender 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. In addition, the establishment of 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), clinical supervision and peer consultation are essential.

Addressing co-existing mental health or psychosocial concerns

Unless treatment of gender 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 is necessary both to relieve the distress associated with these conditions and also to help the client engage in psychotherapy relating to gender issues (e.g., past or current reactions of others to the client's evolving gender expression; preparation for possible sequelae of being more openly transgender). It takes courage and persistence to confront gender concerns that have often been surrounded with fear, shame, and feelings of 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. (The client's resilience to have reached this point should be acknowledged and validated.)

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. 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 in illuminating and changing present maladaptive thoughts and behaviours. 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. To put these experiences in perspective, it may be helpful to compare these experiences with developmental stages of lesbian/gay/bisexual emergence (Coleman, 1982).

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/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. Many transgender individuals are estranged from family-of-origin members, but 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 their relationships.

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 (similar to conversion therapies coerced upon or sought by some lesbian, gay, and bisexual individuals), or refusal to associate with other transgender individuals (e.g., in a support or therapy group) as the feelings of guilt and hatred are projected onto others like them. Exploring these issues may help the client move toward self-acceptance and ease the identity formation process. Psychotherapeutic work on internalized transphobia can be a long-term process for some clients.

For some clients, therapy moves in a linear chronological fashion, and the movement from past to present signals readiness to explore options for gender identity management. Alternatively past issues may emerge or resurface throughout treatment, with new insights as gender work progresses. It is important to continue to clarify expectations in terms of the degree and value of "soul-searching" prior to embarking on exploring the various options for gender identity management and gender expression.

Exploration of options for gender expression

The HBIGDA *Standards of Care* (Meyer et al., 2001) list a range of possible options for transgender identity expression:

- participation in peer support/self-help groups or in the transgender community
- counselling to explore gender identity and to deal with pressures relating to work, family, etc.

- learning about transgenderism from the Internet, guidelines for care, lay and professional literature relating to legal rights, etc.
- participation in peer support/self-help groups or in the transgender community
- counselling to explore gender identity and to deal with pressures relating to work, family, etc.
- coming out: disclosing transgender identity to family, friends, and other loved ones
- integration of gender awareness into daily living
- temporary and potentially reversible changes to appearance: changes in hairstyle/makeup, temporary removal of facial/body hair (shaving, plucking, waxing) or applying facial hair, wearing prosthetic breasts or penile prosthesis, tucking/binding chest or genitals, crossdressing (undergarments only, gender-neutral clothes, or wearing outer clothes that conform to a person's sense of gender)
- change in vocal expression, pitch/tone, inflection, and other aspects of speech
- episodic cross-living
- change in gender pronoun or name, in common usage or legal change
- semi-permanent changes to appearance: masculinizing or feminizing hormones (some changes are reversible, while others are not)
- permanent changes to appearance: surgical reconstruction of face/chest/genitals, electrolysis/laser removal of facial/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 different options to express one's transgender identity (such as integrating crossgender feelings into the gender role assigned at birth or "episodic crossliving") would not be appropriate; ensuring the client is cognisant 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/breast surgery is not necessarily accompanied by hormone therapy or followed by genital surgery. Cross-sex 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 androgynization without breast development (MTF) may be appropriate for clients who identify as androgynous or non-gendered and wish only to minimize sex/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 or the Transgender Health Program. Peers can help with information about non-medical ways to feminize/masculinize appearance (e.g., clothing, hairstyle, breast prostheses, chest binders, and genital prostheses).

Some 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 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; others reject the idea of transition 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 decided on a course of action, therapy focuses on supporting the individual to implement their decisions relating to gender expression/identity management. Some clients may choose strategies that do not require disclosure of transgender identity to others, keeping transgender identity and expression a part of private rather than public life. For others, "coming out" (disclosing transgender identity) to family, friends, co-workers, teachers/students, cultural or social community peers, or others in the transgender person's life is an important step.

Disclosure of transgender identity is often considered analogous to the coming out process for lesbian women, bisexuals, and gay men. 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). 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 et al, 1997).

Clients are encouraged to take calculated risks in disclosure (Coleman, 1982; Horton, 2001), starting with people who are most likely to be accepting. This builds a base of support for the client and possibly for another individual in the transgender person's life who may have difficulty following disclosure. Although some loved ones are not surprised by a disclosure of intention to transition 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. Counselling assistance for loved ones is further discussed on pages 24-25.

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, Huang, Ding, Robinson, & Rosser, 2005; Nemoto, Operario, Sevelius, Keatley, Han, & Nguyen, 2004) One study found that lack of familial support was predictive of regret following sex reassignment surgery (Landen, Walinder, Hambert, & Lundstrom, 1998).

Clients who undergo gender role transition (with or without hormones/surgery) face many challenges relating to 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 when they begin transitioning). During this time the counsellor can be an important support, helping the client cope with stress and also reflect on how the changes are affecting gender identity and overall comfort. The mental health professional may play an important role in assisting with planning and pacing such a transition.

For any of the feminizing or masculinizing medical interventions (hormones, surgery, speech change, hair removal, etc.), the counsellor may 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 desired, planning for pre-operative and post-operative psychological care. As discussed on pages 17-24, the clinician may also be asked to evaluate the client's eligibility and readiness to begin hormones or undergo surgery. If the clinician providing therapy (rather than an independent clinician) will be assessing hormone or surgery eligibility/readiness, it is important for the client and therapist to mutually agree to psychotherapeutic tasks, goals, or milestones (relating to readiness criteria) to be reached before assessment. Doing so helps prepare the client for assessment and emphasizes assessment as a shared process. The weight of treatment decisions and any associated fears may lead the client to look to the therapist to affirm that gender transition is the right course to take; it is important that responsibility for decision-making be consistently directed back to the client.

Ongoing management of gender issues over the client's lifespan

Treatment 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 the lifespan with the establishment of new relationships (friends, co-workers, partners, etc.). Potential needs and issues may include facilitating further improvement or maintenance of good mental health, continued identity development and aging, addressing grief/loss issues, or sex and relationship therapy. Even after years of living in the preferred gender role, clients may seek support relating to experiences of transphobic discrimination or harassment.

Some transgender individuals have an unchanging gender identity, while others have a more fluid identity that changes 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 may 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 mixed 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 lifespan, or may be in response to new situations, questions, and challenges relating to the aging body or relationships with others.

Developmental tasks that were previously disrupted or put on hold 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 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 behaviour.

For those who have surgery, adequate post-surgical aftercare is crucial. A new sex reassignment surgery program under development in Vancouver (Bowman & Goldberg, 2006) aims to improve the consistency of pre-operative, peri-operative, and post-operative care for individuals in BC. Until this program is fully operational, clients can only access genital surgery outside BC; even after the program is running, clients living outside the Lower Mainland may need to travel to Vancouver or the Fraser Valley for facial feminization, chest/breast surgery, or hysterectomy/oophorectomy. In addition to physical care following surgery, clients may need counselling to deal with physical 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.

Many clients report a drastic change in their lives after genital surgery. Although changes are often positive, with dysphoria replaced by the euphoria of being able to live in a way that is more congruent with sense of self, there may be grief over lost time, a feeling of loss of direction, or a 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/surgical treatment of gender dysphoria

Some individuals with gender dysphoria seek hormonal and/or surgical feminization/masculinization to reduce discrepancy between sense of self and primary or secondary sex characteristics. The clinicians involved in care of the gender dysphoric individual have shared responsibility to determine client eligibility/readiness for feminizing/masculinizing hormonal therapy or surgery. Ultimately, the prescribing clinician must decide whether to prescribe or perform the surgical procedure.

Most clinicians follow the HBIGDA *Standards of Care* (Meyer et al., 2001), which outline guidelines for clinical evaluation of eligibility and readiness in both adults and adolescents. The HBIGDA guidelines for transgender adults are summarized in Table 5 below (guidelines for adolescents are discussed in *Caring for Transgender Adolescents in BC: Suggested Guidelines*). *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 in order to be ready to access 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.

Table 5: Summary of the Harry Benjamin International Gender Dysphoria Association (HBIGDA) *Standards of Care* (6th edition): Adult eligibility and readiness criteria

<table>
<tr><th></th><th>Eligibility criteria</th><th>Readiness criteria</th><th>Minimum timeline</th></tr>
<tr><td>Hormones</td><td rowspan="2">1) Legally able to give informed consent
2) Informed of anticipated effects and risks
3) Recommended completion of 3 months of “real life experience” OR have been in therapy for duration specified by a mental health professional (usually minimum of 3 months)

The HBIGDA 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”.</td><td rowspan="3">1) Consolidation of gender identity

2) Improved or continuing mental stability</td><td>Three months of “real life experience” OR psychotherapy recommended but not required</td></tr>
<tr><td>Chest/breast surgery</td><td>FTM chest surgery may be done as first step, alone or with hormones; MTF breast surgery may be done after 18 months on hormones (to allow time for hormonal breast development)</td></tr>
<tr><td>Genital surgery / hysterectomy</td><td>1) Legally able to give informed consent
2) On hormones for > 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 assessor
5) Understand cost, hospitalization, potential complications, aftercare, and surgeon options</td><td>At least one year of “real life experience”</td></tr>
</table>

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

A client-centred 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/surgery eligibility and readiness does not involve a fully collaborative process (i.e., the client does not typically have latitude to negotiate the eligibility/readiness criteria), it is important to be flexible enough in hormone/surgery assessment to consider areas that may be open to negotiation (e.g., interpretation of what constitutes “real life experience” or “mental stability”), and to discuss these with the client.

Qualifications of hormone/surgery assessors

The HBIGDA *Standards of Care* include recommended qualifications for clinicians performing assessment prior to hormone therapy or surgery (Meyer et al., 2001). The BC Medical Services Plan has more stringent requirements for clinicians assessing eligibility for surgical coverage.

Most clinicians require that hormonal/surgical evaluation be performed by an assessor who meets the competency requirements outlined in the HBIGDA *Standards of Care*, 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). The Transgender Health Program can provide information about local clinicians who have completed training provided by Vancouver Coastal Health and are contracted to provide free assessment for individuals seeking hormones/surgery. Transgender individuals who can pay for private assessment may elect to do so, and are responsible to determine that the assessor of their choice will be recognized as qualified by their prescribing physician or surgeon.

Family physicians or nurse practitioners[*] with appropriate training in transgender medicine (including training in behavioural health and in mental health aspects of gender dysphoria) and a practice structure that allows extended appointments may choose to have sole responsibility for initiating and monitoring hormone therapy. In these circumstances the prescribing clinician will conduct both psychological and physical 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.

The BC Medical Services Plan (MSP) will only consider recommendations for surgery coverage that are made by advanced mental health clinicians (2 psychiatrists, or 1 psychiatrist + 1 Ph.D. psychologist) who have been approved by MSP. If hormone assessment is performed by a family physician, nurse practitioner, mental health clinician with a Masters degree, or a clinician with a Ph.D. in educational psychology or social work, the client should be made aware that this assessment will *not* be considered by MSP towards coverage for surgery. If the client is considering surgery or has decided to pursue surgery, evaluation by a MSP-appointed assessor is recommended as early in the process as possible. It can be devastating to clients who have

[*] In BC, nurse practitioners can prescribe anti-androgens, estrogen, and progestins, but not testosterone (Registered Nurses Association of British Columbia/College of Registered Nurses of British Columbia, 2005).

completed hormonal and social role transition to be told years into the process that they do not qualify for surgical coverage.

The "gatekeeper" role and impact on therapeutic rapport

Clinicians conducting assessment prior to initiation of hormones or surgery are in a "gatekeeper" role that involves a power dynamic which can significantly affect therapeutic rapport (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 physical and psychological autonomy, or a type of institutionalized transphobic discrimination – as psychological evaluation is not required for non-transgender individuals requesting hormones, breast augmentation, or hysterectomy (Brown & Rounsley, 1996). In BC, surgery assessors are appointed by the BC Medical Services Plan, further reducing clients' sense of choice about the assessment process.

Approach to building therapeutic rapport in hormone/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 counselling); having already disclosed their transgender identity to loved ones, co-workers, 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 desired medical interventions, it may be helpful to openly discuss this. Strategies used to manage client anxiety/anger and promote a collaborative relationship in mandated treatment settings (de Jong & Berg, 2001) can be useful. Normalizing emotional reactions clients commonly have (e.g., anger, anxiety, fear) and also the common behaviours (e.g., trying to tell the assessor what the client thinks they want to hear, being belligerent/uncooperative, being manipulative) helps frame this as a systems issue rather than a personal power struggle. Discussion about what the assessment process involves (discussed in the next section) is imperative as client anxiety or anger is often heightened by inaccurate understanding of the process.

When the gatekeeper issue is posing a serious barrier to therapeutic rapport (for the clinician or the client) 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/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 clients need to work on issues such as addiction, mental health issues, or self-harm but there is anxiety that a history of these concerns will be considered evidence that the client is not stable enough to proceed with hormones/surgery. Separating out issues that require therapeutic attention in the present from a future assessment can reassure the client that hormone/surgery assessment will focus on their current capabilities rather than their past concerns.

In our experience, clients who feel prepared for hormone/surgery evaluation (with assistance by peers or clinicians as part of this process) 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 (see Appendices D and E) 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 and identification.

Clinicians not involved in the assessment can assist by engaging in therapeutic discussion relating to any previous experience (e.g., anxiety about having been denied approval for hormones/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/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

1. Informed consent

Informed consent requires the capacity to make decisions relating to medical care (pages 6-7) 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/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 (two other documents in this series, *Endocrine Therapy for Transgender Adults in British Columbia: Suggested Guidelines* and *Care of the Patient Undergoing Sex Reassignment Surgery*, may be useful in this regard). Key issues are the irreversibility of some changes (even if hormone treatment is stopped) and an appreciation that the long-term health impacts of cross-sex hormone use are not yet known.

The mental health clinician should explore client awareness of possible psychosocial risks and benefits, including issues relating to possible changes to relationships as changes become visible. In some cases hormones/surgery improve passability, reducing the risk of harassment and discrimination; in other cases the changes increase visibility as a transgender person, thus serving to increase social risks. Awareness of these risks relates to informed consent; capacity to anticipate, withstand, and cope with the challenges posed is an issue in evaluating readiness (discussed on pages 21-22).

2. "Real-life experience"

The HBIGDA *Standards of Care* define the "real life experience" (RLE) as "the act of fully adopting a new or evolving gender role or gender presentation in everyday life", with the intention of achieving an experiential understanding of the familial, interpersonal, socioeconomic, and legal consequences of gender transition (Meyer et al., 2001). RLE is a way for the transgender person who wishes to permanently change their gender role to move from an imagined experience to a lived experience. For some individuals this experience is liberating and exhilarating, and for others there is disappointment that the real experience does not live up to a fantasized ideal.

A fundamental premise of the RLE is that the person should experience life in the desired role before making irreversible physical changes. The HBIGDA *Standards of Care* do not require RLE prior to hormone therapy or breast/chest surgery, but do include one year RLE as an eligibility criterion for genital surgery/gonadal removal (Meyer et al., 2001). The HBIGDA *Standards* explicitly state that RLE is not a diagnostic test to evaluate whether gender concerns are present, 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". For female-to-males it is often not possible to live in the desired role without first undergoing chest surgery, so RLE 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 behaviour. 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 RLE 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 psychotherapeutic perspective, RLE is a time of adjustment, exploration, experimentation, and learning (often through trial and error) 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 RLE 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 in the RLE process, involvement of a peer or external professional counsellor may be useful in providing a space for the client to discuss problems or concerns without fear that surgery will be delayed or blocked.

In evaluating completion of the required RLE, the HBIGDA *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 (e.g., employer, loved ones) know the patient in the desired gender role (Meyer et al., 2001). Flexibility in interpreting RLE is needed for clients who are housebound, living in a prison or residential long-term care facility, or 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 family caregivers/parents, sex trade workers, and others who may not be able to provide documentation of proof of employment.

Ideally, the means of validating this aspect of transition will be at the discretion of the clinician who is performing the evaluation. For those applying for BC Medical Services Plan coverage to assist with the costs of surgery, specific documentation is required. Additionally, MSP has RLE criteria beyond those in the HBIGDA *Standards of Care*: two clinicians appointed by MSP must recommend surgery, and a two-year RLE must be completed (regardless of the type of surgery). The supporting evidence required by MSP to confirm completion of RLE is discussed in greater detail in *Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians* (White Holman & Goldberg, 2006).

Assessing readiness

As discussed earlier, *readiness* relates to a relative stability of gender identity and also the psychological stability needed to cope with the physical, emotional, and social consequences of the decision to take hormones or have surgery. To assess readiness it is important to determine what the consequences of the treatment will likely be (based on the specific circumstances of a client's life and the treatment the individual will be undergoing), and also the client's awareness and preparedness to deal 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/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 to be lifelong, or for dysphoria to have existed since childhood, caution (i.e., longer period of assessment) is needed if dysphoria is transient, episodic, or newly discovered.

As per the flowchart on page 3, delusions about sex/gender, dissociative disorders, thought disorders, or obsessive/compulsive features should be evaluated and treated prior to proceeding with sex reassignment. Thought disorders, dissociative disorders, and obsessive/compulsive disorders can, rarely, cause a transient wish for sex reassignment which disappears when the underlying mental health condition is treated. It is important to treat these disorders before proceeding with hormones or surgery to ensure that sex reassignment is not a temporary desire.

Other mental health concerns, psychosocial concerns, or substance use issues 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 conflicts 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 (i) the introduction of a new stressor will not seriously destabilize the client, and (ii) 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 these were not performed in the initial evaluation). If the client returns for hormone/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/surgery readiness should include the gender assessment described on pages 8-11 to explore issues relating to stability of gender identity and appropriateness of hormones/surgery. Table 6 below lists additional areas of inquiry specific to evaluating readiness to undertake hormones or surgery.

Table 6: Potential Areas of Inquiry – Hormonal/Surgical Evaluation

General readiness	• What leads you to come for assessment at this time in your life? • What are your hopes and dreams relating to hormones/surgery? What do you expect hormones/surgery to change? What do you think is not likely to change? • How do you think hormones/surgery may affect your relationships with loved ones? What do you think the impact will be at work/school or in terms of your involvement in the broader community? • What will you do if the change process doesn't turn out as you had hoped? • Have you taken any other steps to change your outward appearance? 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?
Hormones	• Which changes are you most looking forward to? Are there any changes you are not sure about? • What medical care do you need to monitor for side effects? Who will provide this? • If you experience side effects, what will you do? Are there any side effects you are particularly concerned about? • How do you feel about the permanence of some effects of hormones, including the possibility of permanent sterility? • The long-term effects of cross-sex hormones are not yet known. How do you feel about taking this risk?
Surgery	• What medical care might you need following surgery? How will you obtain this? • Where will you rest and heal after surgery? Are there people who can help look after you as you recover? • How do you feel about the permanence of surgery? • How do you feel about the possibility of scarring? • For genital surgery: How do you feel about the risk of possible loss of sexual sensation? • 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? How have you dealt with other losses in your life? • What additional issues or adjustments do you anticipate after surgery?

Recommendation regarding treatment

If the assessor judges the client to be an appropriate candidate for hormonal/surgical treatment, a letter should be written to the clinician(s) involved in care confirming eligibility and readiness as per the HBIGDA *Standards of Care*. Sample letters can be found in Appendices F and G.

As outlined in the HBIGDA *Standards of Care* (Meyer et al., 2001), letters recommending hormonal or surgical treatment should include:

- the client's general identifying characteristics
- explanation of the duration of professional relationship, including type of evaluation and/or therapy
- initial diagnoses relating to gender identity issues or any other concerns
- the rationale for hormones or surgery (why it is appropriate treatment)
- evaluation of the client's eligibility and readiness for hormones/surgery
- the degree to which the client and mental health professional have followed the HBIGDA *Standards of Care*, and the likelihood that this will continue
- explanation of the clinician's relationship to others involved in the client's care
- 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. Concerns about eligibility typically relate to failure to complete the full amount of "real life experience" required for surgery. If the client is consistently cross-living and just needs more time, the reassessment plan is straightforward; if the client is not consistently cross-living, psychotherapeutic interventions may be needed to explore reasons for this and to assist the client to gain supports needed to be able to live full-time in the desired role. In some cases, reference to a trans-positive financial planner or advocate may be needed to help explore economic resources for the costs of transition. If there are psychosocial readiness concerns, resources should be identified to help the client move toward psychological/social stability, with specific and measurable goals established. Denial of 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/masculinization is not an appropriate treatment and that future reassessment of eligibility/readiness is not indicated. This may be the case if a client is seeking hormones/surgery for reasons other than gender dysphoria, where another type of assessment is more appropriate (e.g., a non-dysphoric male seeking hormonal or surgical castration to reduce sexual urges). If the prescribing physician/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.

The preceding discussion of eligibility and readiness relates to the HBGIDA *Standards of Care* (Meyer et al., 2001). In some cases a client may meet the HBIGDA eligibility and readiness criteria, but may not meet the additional criteria set by the BC Medical Services Plan for individuals seeking coverage for sex reassignment surgery (two years "real life experience", defined by MSP as full-time work, schooling, and/or volunteering; and a diagnosis of Gender Identity Disorder). As with the evaluation of "real life experience" in consideration of HBIGDA eligibility criteria, in some cases it is simply necessary for a client to return for reassessment after they have completed two years. In other cases advocacy with MSP may be required to support the application of a client who is not

able to attend school, work, or volunteer full-time (White Holman & Goldberg, 2006). The course of action for clients who have gender dysphoria but do not meet criteria for Gender Identity Disorder is less clear. It is the responsibility of the assessor to explain to the applicant why the assessor believes the criteria for GID have not been fulfilled, and offer the client the opportunity to meet with another designated assessor if they wish another opinion. To prevent cases where the client is rejected for surgical coverage despite having completed hormonal and social role change, it is strongly advised that any client considering surgery be evaluated by an MSP-appointed assessor early in transition, so GID diagnosis can be established and clarity obtained about the requirements beyond the HBIGDA SOC to qualify for MSP surgical funding.

Counselling of loved ones

Significant others, family members, or friends (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 the relationship over time. In some cases, SOFFAs may participate in family/relationship therapy as part of a transgender person's therapeutic process.

As with the transgender population, significant others, family members, and friends (SOFFAs) are a heterogenous group. Some SOFFAs are encouraging and supportive, and may take a strong stand in helping counter the internalized shame and embarrassment that many transgender individuals feel. In other relationships transgender issues are a source of conflict.

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 excitement to disgust, depending on an individual's perspectives, 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 (e.g., disclosure relating to the hope that a partner will participate in erotic crossdressing), or to the entire relationship (e.g., gender transition). Further discussion of disclosure and specific relationships (children, partner, parents, etc.) can be accessed through the Transcend online resource guide (http://www.transgender.org/ transcend/guide/sec131.htm), with links from the bottom of the page to text on specific types of relationships.

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 spouse/partner (Cole et al., 2000). Counselling may be helpful at this stage to help restore intimacy and reduce isolation (Ellis & Eriksen, 2002). 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 (Ellis & Eriksen, 2002; Weinberg & Bullough, 1988). Stage 4 involves self-discovery and change. SOFFAs may not agree on the changes the transgender individual is making and counsellors 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. Counsellors may help by providing a place to process the anger and frustration

that arises as a result of transphobic discrimination directly experienced or witnessed by the SOFFA. Finally, the goal of stage 6 is pride in their loved one's courage (Ellis & Eriksen, 2002). This pride may take the form of advocating for transgender people and educating others about them (Lantz, 1999).

Evaluation of the SOFFA who presents for personal counselling includes discussion of the nature of their relationship to the transgender person, the impact of gender issues on the relationship with the transgender person and also with other loved ones, and awareness of support resources, as discussed in Table 7 below.

Table 7: Potential Areas of Inquiry in Gender Evaluation – Loved One of a Transgender Person

Disclosure	• When did you learn that your (partner, child, etc.) was transgender? • How did you find out that your (partner, child, etc.) was transgender? • What was your initial reaction to finding out about your loved one's feelings? How do you feel about it now? • Do individuals in your life know that your (partner, child, etc.) is transgender? 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, etc.) cross-dressed? If so, how was that for you? • Has your (partner, child, etc.) ever taken hormones or had surgery to bring their body closer to their sense of self, or is this something they are considering? 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, spouses, children, parents, etc.) of transgender people? What was that like for you? • What do you see your relationship being to the transgender community now? What would you like it to be in the future?

Trans-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/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 stresses, including transphobic harassment, discrimination, and violence experienced by many transgender individuals (Lombardi, Wilchins, Priesing, & Malouf, 2001), as well as high incidence of poverty resulting from employment discrimination (Nemoto, Operario, Keatley, & Villegas, 2004), are cause for concern. In a study of 515 transgender people in San Francisco, 62% of male-to-female (MTF) and 55% of female-to-male (FTM) respondents met clinical criteria for depression, 22% of MTFs and 20% of FTMs reported a history of mental health hospitalization, and 32% (both groups) 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 gender transition may avoid disclosing symptoms of mental illness for fear that approval will not be given for hormones 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 concerns are often intensely anxious or defensive about seeing a mental health clinician. An encounter with a trans-positive, supportive clinician can result in release of longstanding suppressed emotions relating to feelings of powerlessness and past experiences of neglect or mistreatment, with the potential for transference of anger. A lack of language to articulate gender concerns can lead the transgender individual to appear confused, disoriented, temporarily unable to communicate, or profoundly frustrated (sometimes manifesting as lability). However, mental health symptoms should not be ignored. Even when mental health symptoms are the sequelae of societal oppression, symptomatic relief 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 care to alleviate the distress.

In the overwhelming majority of cases, mental health symptoms have psychosocial causes (i.e., impact of societal stigma on psychosocial development, untreated unrelated mental health issues). 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.

- *Are the symptoms the result of a pharmacologic etiology* (i.e., medication or illicit drug use)? There are rare case reports of psychosis in transsexual women relating to sudden cessation of hormonal therapy (Faulk, 1990; Mallett, Marshall, & Blacker, 1989), and observations of depressive mood changes relating to initiation of estrogen or progesterone therapy (Asscheman, Gooren, & Eklund, 1989; Feldman & Bockting, 2003; Flaherty et al., 2001; Israel & Tarver, 1997; Steinbeck, 1997). One physician interviewed for this project commented that testosterone had resulted in psychiatric decompensation in some of her FTM patients with pre-existing schizoaffective disorder, bipolar disorder, and schizophrenia.

- *Are the symptoms the result of a medical etiology* (i.e., general medical condition)? Transgender individuals are a medically underserved population and can present with untreated physical conditions that may have psychological symptoms, including HIV and syphilis.

After a thorough evaluation and patient 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 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 (e.g., cognitive-behavioural therapy, dialectical behaviour therapy, 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 for psychological decompensation (Dahl et al., 2006).

In some cases, referral to other clinicians may be desired or required (e.g., to discuss pharmacologic treatment or to address socioeconomic barriers to engagement in treatment). When multiple clinicians are involved, close communication is required to ensure coordinated care. Ideally, all clinicians involved in mental health care will be trans-competent. If no trans-experienced practitioners are available, the client should be informed of this. In some cases clients may feel they

can sufficiently educate the practitioner about transgender issues, while others will be unable to work productively with a clinician who lacks transgender expertise.

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 decision-making, 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 care (addiction counsellor, social worker, endocrinologist, etc.). 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 (consumer booklets are available at no cost from the Transgender Health Program – see Appendix A). 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, et al., 2005). A comparison of psychosocially matched transgender and non-transgender individuals found that significantly ($p < 0.05$) more transgender participants reported suicidal ideation and attempts than non-transgender participants (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 (e.g., childhood neglect, death of a loved one, relationship violence). Whatever the etiology, the goal is to alleviate the symptoms, address situational issues that create or contribute to the depression/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 behaviour likely to cause injury, and may or may not be accompanied by suicidality. Self-harm may

be a ritualized, chronic behaviour 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). 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 behaviours (Gapka & Raj, 2003). Deliberate damage to the testicles/penis by dysphoric MTFs 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 medically assisted transition, lack of access to trans-competent care, or ineligibility for desired surgery. Impulsive attempted autocastration or autopenectomy may be followed by contrition, shame, and fear or 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 client risk for self-injurious behaviour. 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/II disorder), reducing distress (including distress about having engaged in self-injurious behaviour), and strengthening coping skills/resources (Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003). There is no evidence relating to optimal treatment for transgender individuals who are chronically self-harming. Dialectical behaviour therapy 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 are sometimes associated with anxiety about transgender feelings and may alleviate as the client resolves conflicted feelings or is able to live in a way that is more congruent with felt sense of self. In some cases obsessive/compulsive symptoms can be alleviated through pharmacotherapy (e.g., selective serotonin re-uptake inhibitors) and psychotherapy in which the client identifies a pattern of compulsive behaviours that developed over time and works to change this pattern through defining and adhering to boundaries that prevent self-destructive behaviours (see case vignette of Carlos on pages 37-38). Psychotherapeutic treatment may involve confronting shame, self-hatred, and internalized transphobia, and helping the client find alternative sources of validation.

Thought disorders

Schizophrenia, schizo-affective disorders, 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 disorder through medications and support, monitor the client's identity over time, encourage experience in the crossgender 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 transition if that is what the client needs or desires. 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 on page 39).

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 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 (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 behaviour therapy, or dialectical behaviour therapy) can be applied, possibly in combination with pharmacotherapy. Selective serotonin reuptake inhibitors have been used to treat clients with compulsive behaviours, and atypical antipsychotics have been used with success for clients with impulse control problems. If gender 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 gender transition, hormones, or surgery. However, any issues of concern should be discussed with the client, with clear goals for treatment and stabilization.

Trans-specific Elements in General Counselling

Transgender individuals experience the same general life problems as everyone else, and may seek counselling for assistance with general life stresses. Although gender concerns may not be a factor, societal transphobia, 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/abuse. Employment dissatisfaction/discrimination and loss of employment are also common, but vocational counselling is a specialized area outside the scope of this document (issues relating to employment discrimination and transition planning are discussed in White Holman & Goldberg, 2006).

For those who present seeking general counselling, areas to explore in the initial evaluation may include any of the questions outlined in 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, you 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 (as well as medically worrisome in some cases).

Eating disorders can appear in both MTFs and FTMs (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 behaviour to provide relief from stress). The published case reports cited above suggest that MTFs typically struggle with anorexia/bulimia or other disordered eating more typically seen in females, while FTMs more often struggle with a drive to be muscular as typically seen in males with body image problems. However, FTMs may also seek to minimize hip/bust ratio by excess exercising or disordered eating. FTMs attracted to other men may be particularly vulnerable to struggles with body image, as conformity with norms of appearance, weight, and muscularity are emphasized in many gay/bisexual men’s communities (Williamson & Hartley, 1998; Yelland & Tiggemann, 2003).

Surgical procedures intended to reduce female or male features can reduce gender dysphoria, and are not intrinsically problematic (indeed, they are an important part of medical treatment for some transgender individuals). However, some transgender persons become obsessed with cosmetic procedures relating to discomfort with their general body image, internalized transphobia, or feelings of not being conventionally feminine/masculine, rather than gender dysphoria per se (see case study of Anne on page 38). The clinician should focus on the underlying issues around wanting the change rather than focusing on the procedure itself.

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 cosmetic result. The clinician should distinguish between normal adjustment versus obsessive worrying about the results.

Grief and loss

Grief and loss can appear at many levels. It is still not uncommon for transgender individuals to experience multiple losses when they come out as transgender, including loss of work as well as rejection by family, friends, and ethnocultural/religious 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/gender that are not possible even with transition. For example, some MTFs grieve the inability to menstruate, become pregnant and give birth (De Sutter, Kira, Verschoor, & Hotimsky, 2002); some FTMs 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/men (Cameron, 1996), or approach aspects of gender transition as a rite of passage into womanhood/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 (e.g., sperm banking for MTFs) is advised in the HBIGDA *Standards of Care* as part of the informed consent process prior to hormonal or surgical intervention (Meyer et al., 2001). In some cases reproductive counselling may be advised.

As discussed on page 17, even when surgical feminization/masculinization is highly desired there can be grief following surgery. Doubt, dissatisfaction, or regret immediately after surgery may relate to physical issues (post-operative pain, surgical complications, changes to sexual function), disappointment with the results, or stresses 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 relating to cross-gender living. 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 surgical/role change was less than 1% among FTMs and less than 1-1.5% among MTF patients (Pfäfflin & Junge, 1992/1998). The authors concluded in most cases significant regret resulted from improper differential diagnosis and treatment of co-existing mental health concerns, failure to complete real-life experience, and deficient surgical protocols.

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, changes to sexual orientation or sexual preferences as part of gender exploration/gender transition, the impact of hormonal or surgical feminization/masculinization on sexual desire, sexual functioning, and safe 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 the same emotions often experienced by non-transgender individuals relating to sexuality (embarrassment, shame, etc.), transgender individuals may have difficulty discussing sexual issues for trans-specific reasons. For transgender individuals who are dysphoric, it can be uncomfortable to talk about sexual acts that involve parts of the body or roles associated with sex/gender. The gender dysphoric client may need assistance to explore strategies for disclosure and negotiation regarding sexual touching/activity. Psychotherapeutic strategies used with sexual abuse survivors may be useful in addressing anxiety or dissociative responses.

Communication about transgender sexuality (both in a therapeutic relationship and in intimate relationships) 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, a male-to-female transsexual who married young, transitioned late in life, and had little contact with the lesbian community before transition 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 people in the FTM spectrum describing a "phantom penis" or "dicklit" (Kotula, 2002; O'Brien, 2003) rather than a clitoris. 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 yet match 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 not (Coleman et al., 1993). Like non-transgender people, individuals in both the MTF and FTM spectrum may engage in the full spectrum of sexual behaviour, including erotic touch; receptive or insertive oral, vaginal, and anal penetration; and role-playing. Other transgender individuals identify as asexual, or choose celibacy.

Despite the challenges in communication about sexuality and the great need for sensitivity in approach, it is important for therapists to inquire about sexual issues in work with transgender clients, as unaddressed sexual concerns can significantly impact quality of life. This is most obvious with sexually transmitted infections and sexual trauma, but more generally sexuality can impact on identity, self-esteem, and self-concept for transgender individuals. For example, an FTM who likes to be vaginally penetrated may have doubts about his masculinity, as might a man who likes to have sex while crossdressed. Conversely, gender identity issues can impact sexuality. For example, studies indicate the struggle to affirm one's gender identity can drive high-risk sexual behaviors (Bockting, Robinson, & Rosser, 1998; Clements-Nolle, Katz, & Marx, 1999; Nemoto, Operario, Keatley, et al., 2004).

Data on the rates of STIs (other than HIV) among transgender populations are limited, but existing studies suggest that both MTFs and FTMs are in need of psychoeducational services relating to safer sex. In a 1999 San Francisco study, 53% of MTF participants and 31% of FTM participants reported a prior sexually transmitted infection (Clements-Nolle et al., 1999), with 36% reported for both groups in a New York survey (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, Marx, Guzman, & Katz, 2001; Keatley, Nemoto, Operario, & Soma, 2002; Kenagy, 2002; Mathy, 2002; 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/masculinizing hormones or surgery. Additionally, gender transition can be accompanied by shifts in sexual orientation (Daskalos, 1998; Lawrence, 2005). For example, an MTF who has been primarily attracted to women prior to transition may experience attraction and pursue relationships with men following transition. This can involve further loss and according adjustment.

Crossdressing for sexual satisfaction is a relatively common phenomenon. In a random sample of 2,450 18-60 year-olds in the general population of Sweden, 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, agoraphobia, and panic disorders can be extreme and debilitating. If the individual presents with an anxiety disorder such as these, a combination of pharmacological treatment and cognitive-behavioural therapy is recommended.

Individuals who are not open about being transgender may find that the concealment of some areas of life causes decreased intimacy or feelings of social disconnection. 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 feeling of 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 group there are complex social dynamics within transgender communities. Individuals with an idealized image of safety and support may be surprised and disappointed to find that they are not uncritically accepted and welcomed, that shared transgender identity is not sufficient common ground for intimate relationships, or that internalized transphobia affects bonding between transgender peers.

Some transgender individuals shun connection with the transgender community in an effort to normalize and mainstream their lives in conformity with 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.

Spiritual/religious concerns

There is a diverse range of attitudes toward gender-variance, crossdressing, and transsexuality across spiritual traditions (Ramet, 1996). Transgender individuals from spiritual/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 prevailing societal religious norms. It can be helpful to assist the client to explore the impact that the religious beliefs of family members and society at large have on personal beliefs and values.

As with gays/lesbians hoping for religious salvation from homosexual feelings, transgender individuals who are deeply religious and pray for help to overcome transgender feelings may feel betrayed if no answers are forthcoming. Experiences of transphobic violence, discrimination, or rejection by a religious community can also affect faith.

Supportive pastoral counselling can be helpful in resolving dilemmas of faith and acceptance. Consultation with progressive spiritual leaders also can be helpful in determining ways for transgender individuals to be accommodated and included in sex/gender-specific rituals (e.g., bathing, prayer, dances, burial traditions).

Substance use

Studies across North American suggest that drug (including nicotine) and alcohol 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, transgender individuals' history of substance use varies widely. Some use drugs or alcohol 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, or work-related stress and fatigue. Others start using alcohol or drugs to facilitate social interactions or to meet peer expectations. There may be dependence on narcotics, benzodiazepines, or other psychoactive drugs.

As in the non-transgender population, there is great diversity in patterns of use; not all individuals who use drugs and alcohol 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 BC-wide survey (n=179), 12% of respondents reported a current need for addiction services, with 16% reporting a past need and 8% anticipating a future need (Goldberg et al., 2003).

As with other areas of care, in addiction treatment we encourage a client-centred approach that supports the individual's choice of treatment goals and treatment modalities. The Transgender Health Program follows the principles of harm reduction, with possible goals ranging from reduction of chaotic, consumptive, or risky patterns of use to total cessation of drug or alcohol consumption. Treatment options depend on the drugs being used; for many substances there are both psychotherapeutic and pharmacologic treatment options. First Nations purification ceremonies and herbal therapies, acupuncture, or other traditional healing methods may also be desired.

Clients with co-existing mental health issues may require a dual diagnosis program where addiction and mental illness are treated in an integrated fashion (Osher & Drake, 1996). Similarly, an integrated approach is needed in working with clients who have co-existing gender concerns and substance use concerns. While addiction can negatively impact psychotherapy (and potentially affect the client's capacity to make medical decisions), a client who is struggling with addiction should not be excluded from treatment for gender identity concerns, and addiction counselling should not require that clients have resolved gender concerns prior to treatment. 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 addiction treatment (particularly if they feel that addiction is interfering with their ability to transition), it can be difficult to find trans-accessible treatment options. Many drug and alcohol programs are gender-specific (i.e., for men or for women), posing a problem for individuals who do not identify with a binary identity as well as those who are visibly transgender and do not feel they will fit in with other women or men in the program. Residential treatment facilities must consider trans-specific accommodations in sleeping, bathing, and group activities (White Holman & Goldberg, 2006).

As with all other areas of transgender care, it is not enough for addiction treatment programs to be accessible and welcoming. Successful addiction treatment requires understanding of the multifactoral issues that commonly drive transgender individuals' addiction (e.g., coping with stigma and psychosocial stresses, attempted suppression of transgender feelings, management of historical violence/trauma, self-medication for physical or mental illness) and make it difficult for transgender individuals to change or stop substance use. Specific strategies beyond those discussed in this document are needed to make addiction prevention and treatment services trans-competent

(Barbara & Doctor, 2004; Leslie, Perina, & Maqueda, 2001; Lombardi & van Servellen, 2000; Oggins & Eichenbaum, 2002).

Violence/abuse

It is difficult to estimate the extent of violence against the transgender community 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 trans-related violence against non-transgender loved ones. Trans-specific studies suggest high prevalence of sexual abuse/assault, relationship violence, and hate-motivated assault across the lifespan (Courvant & Cook-Daniels, 1998; Devor, 1994; Kenagy, 2005; Lombardi et al., 2001). Data relating to trans-specific hate crimes indicate that 98% of incidents were perpetrated against people in the MTF spectrum (Currah & Minter, 2000). Non-transgender significant others, family members, and friends (SOFFAs) are also vulnerable to transphobic hate-motivated violence, as evidenced by the murders of Philip DeVine, Lisa Lambert, Willie Houston, and Barry Winchell (Cook-Daniels, 2001; Goldberg, 2005). The extent of relationship violence against SOFFAs is unknown.

Trans-specific elements can be evident not only in hate-motivated attacks, but also in the structure of relationship violence for both transgender individuals and SOFFAs (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/lesbian for being in a relationship with a transgender individual. Conversely, SOFFA-perpetrated relationship violence may include attacks on aspects of the body associated with sex/gender, trans-specific verbal denigration (e.g., “You’ll never be a real woman”), threats to “out” the transgender person to co-workers or family members, or destruction of prosthetics, wigs, or clothing associated with cross-gender expression (Goldberg, 2005). Trans-specific concerns also create barriers to reporting and accessing of support services.

While resources exist to promote awareness of transgender issues in anti-violence services (Courvant & Cook-Daniels, 1998; Goldberg, 2005; Munson & Cook-Daniels, 2003; White, 2003), no clinical guidelines currently exist for trans-specific issues in trauma treatment. Further work is needed in this area.

While not all transgender individuals experience violence or physical/sexual abuse, for many transgender individuals the daily trials of living in a transphobic society constitutes ongoing trauma. Others experience having intense physical dysphoria as profoundly traumatic. Some of the individuals we have worked with have described life as a daily humiliation. We recommend that transgender research and clinical practice consider this expanded understanding of trauma, rather than responding only to hate crimes or other obvious acts of violence.

Case Studies

The following case vignettes are taken from the authors’ clinical practice and illustrate some of the issues described above. 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 paraphilic aspects of his crossdressing and gender dysphoria. Although Carlos has, to date, decided not to change gender roles or pursue 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 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 (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.

These case vignettes were chosen to illustrate the diversity of the transgender community, including treatment considerations in complex cases where the client has co-existing gender, mental health, and psychosocial concerns. They are not equally representative of the concerns among transgender clients – for example, the first case (Jake) is far more typical of FTMs seeking hormones/surgery than the fourth case (Jamie).

The length of therapy and treatment in these cases varied widely. The first case 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 (23) presented 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 ago. By the time he sought assessment he was already dressing as a man, and using the men's washroom at work and in public settings. Jake sought chest surgery as he found it difficult to pass as a man during the summer, and also found it uncomfortable to wear tight chest binding during warm weather. He was hoping to start hormone treatment as soon as possible, and to also have a mastectomy and hysterectomy.

At the time of his first appointment, Jake lived alone and had been working as a manager of a fast food outlet for the past year. He originally emigrated from Uganda to Regina with his family six years ago 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 uncomfortable wearing girls' clothes and being a loner throughout his childhood, not associating much either with boys or girls. He described always wanting to be a boy, and dreaming about getting married to a woman when he grew older. Prior to age fourteen 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 marks 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 had been made.

Jake's father died of kidney complications secondary to diabetes when Jake was 15, and 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 eighteen and a half 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 male. 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 testosterone and chest surgery/hysterectomy were appropriate treatments. A letter recommending hormone treatment was written to Jake's family physician. Jake described his doctor as supportive, but lacking transgender experience. Accordingly, a list of trans-experienced endocrinologists was provided for Jake to discuss with his physician in terms of possible referral. The BC Medical Services Plan requirements for surgery were discussed with Jake and an information sheet included in the package for his physician. Jake returned for surgery assessment after another year of cross-living, and proceeded with chest surgery shortly thereafter. Hysterectomy was delayed by another year as Jake was concerned about taking time off work for recovery after surgery.

Carlos

Carlos (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 Prozac (fluoxetine), and along with the psychotherapy sessions, this eased his feelings of desperation. He brought his wife to therapy and shared his 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. They took on the characteristics of an obsession, interfering with the responsibilities toward his family and job. To address these obsessive/compulsive features, he joined a therapy group for men with compulsive sexual behaviour. In this group, Carlos 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 crossdressing made it hard for him to adhere to these boundaries, and crossdressing without these activities became less and less appealing. Eventually, Carlos decided to

discontinue crossdressing altogether. His gender dysphoria, however, 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 his 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 (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 run-away 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 abuse 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 and 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 HBIGDA *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 (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 sufficient 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, however, 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 HBIGDA 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 (19) was referred for assessment by her family physician. She had researched the referral process via the Internet where she spent most of her life. Since Junior high school she had had few friends, socializing primarily on-line. She had a female identity on-line. 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.

Asperger's disorder is classified in the *DSM-IV-TR* as a qualitative impairment in social functioning with restricted repetitive and stereotypical patterns of behaviour, 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.

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 school guidance counsellor for collateral information as Patricia was continuing to live at home with her mother.

Patricia graduated from high school with an opportunity to study computing science in university. She wanted to start university as a woman, and began her real-life experience in the summer prior to university and started 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. She was more concerned with the potential for violence perpetrated against her.

She 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 as much time on the computer, and attended university 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 a real life experience and applied for genital surgery.

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 clinicians can have a significant positive influence in helping transgender people and loved ones build resilience to heal from and cope with societal stigma, promoting healthy psychosocial development, and facilitating timely treatment of mental health concerns. We hope this document helps clinicians in BC to feel more confident in clinical practice with the transgender community.

Summary of Recommendations

Treatment principles

1. Complete mental health care for the transgender community should be considered in the context of a holistic and non-pathologizing approach to transgender health that includes comprehensive primary care as well as economic and social issues.

2. The following services should be available within the public health system as part of mental health practice:

    - evaluation, care planning, and treatment of gender concerns
    - evaluation, care planning, and treatment of mental health concerns
    - psychotherapy: individuals, couples, families, and groups
    - short-term consultation: information, resources, and referral assistance for transgender individual or loved one, or peer consultation for another clinician
    - psychoeducational workshops and groups: information and facilitated discussion on specific topics; training for employers, schools, etc.
    - clinical case advocacy and global advocacy
    - clinical support/supervision for facilitator(s) of peer-led support group
    - training of other clinicians

3. Close coordination between mental health and other clinical services is essential for optimal practice. Ideally, treatment for gender concerns or mental health concerns will involve the mental health clinician, the client's primary care provider, and any other clinicians involved in care.

4. In determining a care plan, the presenting complaint of the client is the starting point. When there are multiple co-existing 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.

5. The client should be meaningfully involved in creating the treatment plan, and goals and expectations of treatment should be clear. The overall treatment plan should be explicitly discussed, jointly agreed upon, and reviewed on a regular basis. Progress in meeting the goals of the care plan should be reviewed regularly during the course of treatment, with modifications as needed.

6. While the client is ultimately responsible for decision-making, 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.

Clinical competence

7. For any work with transgender individuals or loved ones, the mental health clinician should be knowledgeable about transgender identity development, gender confusion, gender dysphoria, gender transition, compulsive crossdressing, and the common concerns of loved ones, and should be able to document a history of transgender development.

8. For any work with transgender individuals or loved ones, the mental health clinician must be able to evaluate the impact of trans-specific issues on mental health and the implications for treatment.

9. As is always the case when beginning to work with any special population, it is the responsibility and obligation of the clinician to become familiar with relevant literature (including the Harry Benjamin International Gender Dysphoria Association's *Standards of Care*), resources, culture, and special needs of that population.

10. Mental health clinicians evaluating eligibility and readiness for hormonal/surgical feminization or masculinization are not expected to have detailed knowledge of the medical risks and benefits of specific hormones or surgical procedures, but should be sufficiently knowledgeable to be able to assess whether the client has a generally accurate understanding of potential options, risks, and benefits.

Initial evaluation

11. The initial evaluation (1-2 one-hour clinical interview sessions with a new client) involves determination of the client's reasons for seeking service and a general client history. Specific areas to explore in the initial evaluation depend on the client's chief presenting concern.

12. To build therapeutic rapport, trans-specific sensitivity should be proactively demonstrated (e.g., by discussing the client's preferred name/pronouns). Intake forms should be trans-inclusive.

13. Protocols and approach should be explained early in evaluation so the client knows what to expect.

14. Initial documentation of client history may include information about relevant medical history, mental health history, gender history, family issues, drug and alcohol use, social supports, economic concerns, and sexual concerns. Intake should be sufficiently flexible to address the client's immediate needs, and paced in a way that facilitates therapeutic rapport.

15. Capacity to make care decisions should be confirmed as part of the initial evaluation. If there are questions about competency, formal evaluation is recommended.

16. The initial clinical impression consists of an overall assessment of the client's presenting complaint, goals and expectations, background, and biopsychosocial adjustment. While it is important to gain an accurate sense of areas of concern, evaluation should also include discernment of client strengths.

17. Following initial evaluation, if the client has current gender concerns a gender assessment should be completed. If the client does not have gender concerns but is instead presenting with suspected mental health issues, a more detailed mental health assessment should be performed.

Gender concerns

Assessment of gender concerns

18. Assessment of gender concerns involves a detailed history of transgender identity development and gender expression. Potential areas of inquiry include gender identity, gender expression, perceptions of others, sexuality, and supports.

19. The specific nature of the concerns and persistence and severity of the gender concerns should be clarified.

20. If there are obsessive-compulsive features, delusions about sex or gender, or evidence of dissociation, gender concerns should be re-assessed after appropriate psychotherapeutic and/or pharmacologic treatment. Any other co-existing mental health concerns should be evaluated and treatment incorporated into the care plan.

21. If there is a history of homosexuality combined with internalized homophobia, gender concerns should be re-assessed after appropriate psychotherapeutic treatment for concerns about sexual orientation.

22. If there is evidence of Asperger's disorder, the care plan should include accommodation of the communication patterns typical of Asperger's.

23. Crossdressing for erotic purposes does not intrinsically require treatment, but erotic crossdressers may need psychotherapeutic assistance to cope with shame, guilt, and conflict with partners. Stigma can lead to secretive and increasingly compulsive behavior which may need to be addressed. Erotic crossdressing can also co-exist with gender dysphoria or other transgender issues.

Care planning for treatment of gender concerns

24. If co-existing mental health, medical, or psychosocial concerns are more emergent than gender issues or present a barrier to treatment of gender concerns at any point in treatment, the focus of the care plan should shift accordingly.

25. Care planning should include consideration of socioeconomic factors that influence clients' ability to access or engage in treatment. Systemic advocacy is needed to ensure that psychotherapeutic services are economically accessible.

Psychotherapeutic treatment of gender concerns

26. Exploration of gender history, development of transgender identity, and related concerns begins with an in-depth review of the client's personal history. The goal is not to theorize or speculate about causative factors relating to a transgender identity, but rather to explore the client's understanding of their own identity development and the impact of life events.

27. The client and therapist should come to agreement about indicators that life history has been sufficiently explored prior to discussion of options for gender identity management and gender expression. This should include identification of issues which require further attention, and a joint decision regarding whether these should be addressed concurrently or consecutively with transgender issues.

28. The mental health clinician should assist the client to consider options for gender expression and make an informed decision regarding identity management. Although the clinician is responsible to provide professional assistance, the client is ultimately responsible for decisions relating to gender identity management and gender expression.

29. If peer contact is desired as part of the decision-making process or for ongoing support, the therapist may assist the client to explore options for group therapy, self-help groups, internet resources, social resources, or one-to-one peer support.

30. Discussion of gender identity management options should take into account previous treatment and identity exploration. Whatever options the client considers, thought should be given as to how the client will realistically integrate changes into daily life.

31. 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; hormone therapy does not need to be followed by surgery.

32. Once the client has decided on a course of action, therapy focuses on supporting the individual to implement their decisions relating to gender expression/identity management, while always leaving room for the client to reassess and alter a previously espoused course of action.

33. For those who choose to "come out" as transgender, calculated risks in disclosure should be encouraged, starting with individuals who are most likely to be accepting. Resources should be identified to assist loved ones who require peer or professional assistance following disclosure.

34. Psychotherapeutic assistance relating to hormonal or surgical change may include obtaining information about the procedures; exploring the possible impact on mental, physical, and sexual health; and, if surgery is desired, planning for pre- and post-operative care.
35. If the therapist (rather than an independent clinician) will be assessing hormone or surgery eligibility/readiness, the client and therapist should mutually agree to a specific timeframe or goals to be met prior to assessment, to ensure that the client has sufficient time to consider this decision and to prepare for the assessment process.

36. If tensions relating to hormone/surgery evaluation are significantly undermining therapeutic rapport in an ongoing psychotherapeutic relationship, assessment may be separated from psychotherapy so two different clinicians are working with the same client. The psychotherapist's role would be to work with the client towards their stated goal of meeting hormone/surgery eligibility or readiness criteria, making it clear that there can be no guarantee of a particular outcome.

37. Even after identity management decisions are made and implemented, psychotherapeutic assistance should be made available over the lifespan to address the challenges of living as a transgender person.

Hormonal/surgical treatment of gender dysphoria

38. Prior to initiation of feminizing/masculinizing hormonal therapy, chest/breast surgery, gonadal removal, or genital surgery, eligibility and readiness should be clinically evaluated as per the most recent version of the Harry Benjamin International Gender Dysphoria Association (HBIGDA)'s *Standards of Care*. Transgender individuals who are seeking public health coverage to assist with the costs of surgery will need to be evaluated for fulfillment of the BC Medical Services Plan (MSP)'s criteria, which exceed the HBIGDA *Standards of Care*.

39. As with other types of psychological assessment, evaluation of hormone/surgery eligibility and readiness may take 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 worked with the client prior to evaluation.

40. Assessors must be qualified as per the HBIGDA *Standards of Care* (or standards set by the BC Medical Services Plan if applicable), including completion of specialized training and demonstrated competence in the assessment of sexual and gender identity disorders. Training

by the Transgender Health Program, or an equivalent level of training, is strongly recommended.

41. Clients should be informed about the protocols used in hormone/surgery evaluation. At minimum, a letter explaining the assessment process should be sent well in advance of the appointment to the client and their primary medical care provider.

42. While evaluation of hormone/surgery eligibility and readiness does not involve a fully collaborative process (i.e., the client does not have latitude to negotiate the HBIGDA eligibility/readiness criteria), the clinician should discuss with the client areas that may be open to negotiation (e.g., interpretation of what constitutes “real life experience” or “mental stability”).

43. In assessing hormone/surgery eligibility, assessors should determine that the applicant is capable of making decisions relating to medical care and understands the potential options, risks, and benefits.

44. In evaluating completion of “real life experience”, flexibility is needed for clients who are housebound, living in a prison or residential long-term care facility, or otherwise unable to work, volunteer, or attend school. Consideration should also be given to individuals who are family caregivers/parents, sex trade workers, or otherwise unable to provide documentation of proof of employment.

45. In assessing hormone/surgery readiness, assessors should evaluate the stability of the applicants’ gender identity and also psychological stability to cope with the physical, emotional, and social consequences of hormonal/surgical change.

46. Physical change is not appropriate for clients who are in early stages of exploring their identity or options for gender expression. While it is not necessary for transgender feelings to be lifelong or for gender dysphoria to have existed since childhood, caution (i.e., longer period of assessment) is needed if dysphoria is transient, episodic, or newly discovered.

47. Dissociative disorders, thought disorders, or obsessive/compulsive features should be evaluated and treated prior to proceeding with sex reassignment. Thought disorders, dissociative disorders, and obsessive/compulsive disorders can, rarely, cause a transient wish for sex reassignment which disappears when the underlying mental health condition is treated.

48. While cosmetic procedures (e.g., facial feminization) can be appropriate, if cosmetic procedures seem to relate to discomfort with general body image, internalized transphobia, or feelings of insufficient femininity/masculinity rather than gender dysphoria per se, the clinician should focus on the underlying issues around wanting the change rather than focusing on the procedure itself.

49. Other mental health concerns, psychosocial concerns, or substance use issues are not absolute contraindications to sex reassignment, but the clinician should be confident that any co-existing conditions are under control to the degree that (i) the introduction of a new stressor will not destabilize the client, and (ii) the client is competent to consent to treatment.

50. If the assessor judges the client to be an appropriate candidate for hormonal or surgical treatment, a letter should be written to the prescribing physician/surgeon (and, for those seeking Medical Services Plan coverage for surgery, to the BC Medical Services Plan) confirming eligibility and readiness as per the HBIGDA *Standards of Care* (or the requirements of MSP).

51. If the assessor believes hormonal or surgical treatment to generally be appropriate but the client does not meet eligibility or readiness criteria, the reasons for this should be explained to the client, a timeline established for reassessment, and resources identified to help the client maintain or improve psychological/social stability.

52. If the assessor feels that hormonal or surgical treatment is not an appropriate treatment, the assessor should explain the reasons to the applicant, and offer the client the opportunity to meet with another designated assessor if they wish another opinion.

53. Following sex reassignment surgery, psychotherapy may be useful in adjusting to physical and psychological changes. 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 cosmetic result. The clinician should distinguish between normal adjustment versus obsessive worrying about the results.

Counselling of loved ones

54. Psychotherapy should be made available to significant others, family members, or friends who require assistance to come to terms with a loved one's disclosure of being transgender or to deal with the impact of transgender issues on the relationship over time.

55. Evaluation should include discussion of the nature of the client's relationship to the transgender person, the impact of gender issues on the relationship with the transgender person and also with other loved ones, and awareness of support resources.

Trans-specific assessment and treatment of mental health issues

56. In addition to a standardized mental health interview, evaluation of a transgender person who presents with mental health symptoms should include consideration of possible pharmacologic (e.g., hormonal) or medical etiology.

57. Diagnostic opinion and formulation should be based on the multi-axial system of the *DSM-IV-TR*. During initial evaluation any psychiatric diagnosis should be considered tentative, to be confirmed during the course of treatment.

58. If the client intends to start or stop hormones while undergoing pharmacologic treatment for mental illness, 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 for psychological decompensation.

59. In treatment of depression and anxiety, goals include alleviating symptoms, addressing contributing situational issues, and building resilience and social supports. Psychoactive medication may be appropriate; continued use of psychoactive medication should be re-evaluated as psychotherapeutic or other treatment progresses.

60. Treatment of compulsive crossdressing or obsessive/compulsive features of gender dysphoria may include pharmacotherapy and psychotherapy.

61. Schizophrenia, schizo-affective disorders, and other thought disorders should be treated as per standard protocols. For clients with co-existing gender dysphoria and delusional disorders, the delusional disorder should be managed through medications and support, with gender

concerns and “real life experience” monitored over time and an extended period of stability required prior to initiating hormonal or surgical change.

62. For clients with co-existing gender concerns and personality disorders, a variety of psychotherapeutic techniques can be applied, often in combination with pharmacotherapy.

Trans-specific elements in general counselling

63. When transgender individuals present seeking general counselling, areas to explore in the initial evaluation depend on the client’s chief presenting concern. Detailed questions about gender history are not appropriate in the initial interview if the presenting concern is not related to gender concerns.

64. If the client does not indicate whether transgender issues are relevant to the presenting concern, appropriate framing should be used for an inquiry (e.g., “For some transgender people, being transgender affects their relationships – is this an issue for you?”).

Sexual safety

65. Trans-specific psychoeducational services relating to sexual safety should be developed for both MTFs and FTMs. Sexual safety includes management of disclosure of transgender status to sexual partners, negotiation relating to safer sex, negotiation of dysphoria relating to the chest or genitals, issues relating to sexual violence/abuse, and the prevention of sexually transmitted infections.

66. Assumptions should not be made about sexual activities, sexual orientation, or the transgender status of sexual partners.

67. Cofactors related to unsafe sex, such as low self-esteem, depression, suicidal ideation, and physical or sexual abuse, should be addressed in efforts to prevent HIV and other sexually transmitted infections.

Spiritual/religious concerns

68. Pastoral counselling can be helpful in resolving dilemmas of faith and acceptance. Consultation with progressive spiritual leaders can be helpful in determining ways for transgender individuals to be accommodated and included in sex/gender-specific rituals.

Substance use

69. A client-centred approach to addiction treatment involves support of the individual’s choice of treatment goals and treatment modalities. Possible goals may range from reduction of chaotic, consumptive, or risky patterns of use to total cessation of drug or alcohol consumption.

70. For individuals with co-existing substance use and gender concerns, an integrated plan is needed to treat both issues. Individuals who are struggling with addiction should not be excluded from treatment for gender concerns, and addiction counselling should not require that clients have resolved gender concerns prior to treatment.

71. Residential addiction treatment facilities must consider trans-specific accommodations in sleeping, bathing, and group activities.

72. Trans-competence in substance use treatment includes understanding of the multifactoral issues that commonly drive transgender individuals' addiction and make it difficult for transgender individuals to change or stop substance use.

Future work

73. Ongoing interdisciplinary research and collegial meetings are important in further developing practice protocols.

74. Additional research is needed in all areas of transgender mental health.

75. Further work is needed to develop trans-specific clinical protocols in vocational counselling, addiction treatment, and trauma treatment.

References

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision ed.). Washington, DC: Author.

American Psychiatric Association (2003). *Practice guideline for the assessment and treatment of patients with suicidal behaviors*. Arlington, VA: Author.

Anderson, B. F. (1997). Ethical implications for psychotherapy with individuals seeking gender reassignment. In G. E. Israel & D. E. I. Tarver (Eds.), *Transgender care: Recommended guidelines, practical information and personal accounts* (pp. 185-189). Philadelphia, PA: Temple University Press.

Appelbaum, P., & Grisso, T. (1988). Assessing patients' capacities to consent to treatment. *New England Journal of Medicine, 319,* 1635-1638.

Asscheman, H., Gooren, L. J. G., & Eklund, P. L. (1989). Mortality and morbidity in transsexual patients with cross-gender hormone treatment. *Metabolism, 38,* 869-873.

Bakker, A., van Kesteren, P. J., Gooren, L. J. G., & Bezemer, P. D. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatrica Scandinavica, 87,* 237-238.

Barbara, A., & Doctor, F. (2004). *Asking the right questions 2: Talking with clients about sexual orientation and gender identity in mental health, counselling, and addiction settings* Toronto, ONT: Centre for Addiction and Mental Health.

Blanchard, R. (1994). A structural equation model for age at clinical presentation in nonhomosexual male gender dysphorics. *Archives of Sexual Behavior, 23,* 311-320.

Bockting, W. O. (1999). From construction to context: Gender through the eyes of the transgendered. *SIECUS Report, 28,* 3-7.

Bockting, W. O. (1997). The assessment and treatment of gender dypshoria. *Directions in Clinical & Counseling Psychology, 7,* 11-3 to 11-22.

Bockting, W. O., & Ehrbar, R. D. (2006 – in press). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology & Human Sexuality, 17,* 125-134.

Bockting, W. O., Huang, C.-Y., Ding, H., Robinson, B., & Rosser, B. R. S. (2005). Are transgender persons at higher risk for HIV than other sexual minorities? A comparison of HIV prevalence and risks. *International Journal of Transgenderism, 8,* 123-132.

Bockting, W. O., Miner, M., Robinson, B. E., Rosser, B. R. S., & Coleman, E. (2005). *Transgender Identity Survey*. Minneapolis, MN: University of Minnesota, Program in Human Sexuality.

Bockting, W. O., Robinson, B. E., Forberg, J., & Scheltema, K. (2005). Evaluation of a sexual health approach to reducing HIV/STD risk in the transgender community. *AIDS Care, 17,* 289-303.

Bockting, W. O., Robinson, B. B. E., & Rosser, B. R. S. (1998). Transgender HIV prevention: A qualitative needs assessment. *AIDS Care, 10,* 505-526.

Bodlund, O., Kullgren, G., Sundbom, E., & Höjerback, T. (1993). Personality traits and disorders among transsexuals. *Acta Psychiatrica Scandinavica, 88,* 322-327.

Bolin, A. (1988). *In search of Eve: Transsexual rites of passage*. New York: Bergin & Garvey Publishers, Inc.

Bowman, C., & Goldberg, J. M. (2006). *Care of the patient undergoing sex reassignment surgery (SRS)*. Vancouver, BC: Vancouver Coastal Health Authority.

Boyce, P., Carter, G., Penrose-Wall, J., Wilhelm, K., & Goldney, R. (2003). Summary: Australian and New Zealand clinical practice guideline for the management of adult deliberate self-harm. *Australasian Psychiatry, 11,* 150-155.

Brown, G. R. (2001). *Sex reassignment surgery in a patient with Gender Identity Disorder and Dissociative Identity Disorders: Report of a successful case*. Paper presented at 17th Biennial Symposium of the Harry Benjamin Gender Dysphoria Association, Galveston, TX.

Brown, M. L., & Rounsley, C. A. (1996). *True selves: Understanding transsexualism – For families, friends, coworkers, and helping professionals*. San Francisco, CA: Jossey-Bass.

Bullough, V. L. & Weinberg, T. S. (1988). Women married to transvestites: Problems and adjustments. *Journal of Psychology & Human Sexuality, 1,* 83-104.

Cameron, L. (1996). *Body alchemy: Transsexual portraits*. San Francisco: Cleis Press.

Campo, J. M., Nijman, H., Evers, C., Merckelbach, H. L., & Decker, I. (2001). Gender identity disorders as a symptom of psychosis, schizophrenia in particular. *Nederlands Tijdschrift Voor Geneeskunde, 145,* 1876-1880.

Clements-Nolle, K., Katz, M. H., & Marx, R. (1999). *Transgender Community Health Project: Descriptive results*. San Francisco: San Francisco Department of Public Health.

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health, 91,* 915-921.

Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer, W. J., III (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26,* 13-26.

Cole, S. S., Denny, D., Eyler, A. E., & Samons, S. L. (2000). Issues of transgender. In L. T. Szuchman & F. Muscarella (Eds.), *Psychological perspectives on human sexuality* (pp. 149-195). New York: John Wiley.

Coleman, E. (1982). Developmental stages of the coming-out process. *American Behavioral Scientist, 25,* 469-482.

Coleman, E. (1987). Assessment of sexual orientation. *Journal of Homosexuality, 14,* 9-24.

Coleman, E., Bockting, W. O., & Gooren, L. J. G. (1993). Homosexual and bisexual identity in sex-reassigned female-to-male transsexuals. *Archives of Sexual Behavior, 22,* 37-50.

Coleman, E., Miner, M., Ohlerking, F., & Raymond, N. (2001). Compulsive sexual behavior inventory: A preliminary study of reliability and validity. *Journal of Sex & Marital Therapy, 27,* 325-332.

Cook-Daniels, L. (2003). *Trans/SOFFA specific power and control tactics*. Glendale, WI: Transgender Aging Network.

Cook-Daniels, L. (2001). *SOFFA questions and answers*. Glendale, WI: For Ourselves Reworking Gender Expression.

Courvant, D., & Cook-Daniels, L. (1998). *Trans and intersex survivors of domestic violence: Defining terms, barriers, and responsibilities*. Portland, OR: Survivor Project.

Covin, A. (1999). Dee and Anni's story. In M. Boenke (Ed.), *Trans forming families: Real stories about transgendered loved ones* (pp. 92-93). Imperial Beach, CA: Walter Trook.

Currah, P., & Minter, S. (2000). *Transgender equality: A handbook for activists and policymakers.* New York, NY: National Gay and Lesbian Task Force and The National Center for Lesbian Rights.

Dahl, M., Feldman, J., Goldberg, J. M., Jaberi, A., Bockting, W.O., & Knudson, G. (2006). *Endocrine therapy for transgender adults in British Columbia: Suggested guidelines*. Vancouver, BC: Vancouver Coastal Health Authority.

Daskalos, C. T. (1998). Changes in the sexual orientation of six heterosexual male-to-female transsexuals. *Archives of Sexual Behavior, 27,* 605-614.

Davis, D. L. (1998). The sexual and gender identity disorders. *Transcultural Psychiatry, 35,* 401-412.

de Jong, P., & Berg, I. K. (2001). Co-constructing cooperation with mandated clients. *Social Work, 46,* 361-374.

De Sutter, P., Kira, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: A survey. *International Journal of Transgenderism, 6*. Retrieved January 1, 2005, from http://www.symposion.com/ijt/ijtvo06no03_02.htm

de Vries, A. L. C., Cohen-Kettenis, P. T., Delemarre-van de Waal, H., White Holman, C., & Goldberg, J. M. (2006). *Caring for transgender adolescents in British Columbia: Suggested guidelines*. Vancouver, BC: Vancouver Coastal Health Authority.

Derogatis, L. R., & Melisaratos, N. (1979). The DSFI: a multidimensional measure of sexual functioning. *Journal of Sex & Marital Therapy, 5,* 244-281.

Devor, H. (1993). Sexual orientation identities, attractions, and practices of female-to-male transsexuals. *Journal of Sex Research, 30,* 303-315.

Devor, H. (1994). Transsexualism, dissociation, and child abuse: An initial discussion based on nonclinical data. *Journal of Psychology & Human Sexuality, 6,* 49-72.

Docter, R. F., & Fleming, J. S. (2001). Measures of transgender behavior. *Archives of Sexual Behavior, 30,* 255-271.

Dzelme, K., & Jones, R. A. (2001). Male cross-dressers in therapy: A solution-focused perspective for marriage and family therapists. *American Journal of Family Therapy, 29,* 293-305.

Ellis, K. M., & Eriksen, K. (2002). Transsexual and transgenderist experiences and treatment options. *Family Journal: Counseling and Therapy for Couples and Families, 10,* 289-299.

Emerson, S. & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy, 7,* 1-12.

Esterling, B. A., L'Abate, L., Murray, E., & Pennebaker, J. W. (1999). Empirical foundations for writing in prevention and psychotherapy: Mental and physical health outcome. *Clinical Psychology Review*, *19*, 79-96.

Etchells, E., Darzins, P., Silberfeld, M., Singer, P. A., McKenny, J., Naglie, G., Katz, M., Guyatt, G. H., Molloy, D. W., & Strang, D. (1999). Assessment of patient capacity to consent to treatment. *Journal of General Internal Medicine, 14,* 27-34.

Faulk, M. (1990). Psychosis in a transsexual. *British Journal of Psychiatry, 156,* 285-286.

Feldman, J., & Bockting, W. O. (2003). Transgender health. *Minnesota Medicine, 86,* 25-32.

Fernández-Aranda, F., Peri, J. M., Navarro, V., Badía-Casanovas, A., Turón-Gil, V., & Vallejo-Ruiloba, J. (2000). Transsexualism and anorexia nervosa: A case report. *Eating Disorders: The Journal of Treatment & Prevention, 8,* 63-66.

Flaherty, C., Franicevich, J., Freeman, M., Klein, P., Kohler, L., Lusardi, C., Martinez, L., Monihan, M., Vormohr, J., & Zevin, B. (2001). *Protocols for hormonal reassignment of gender*. San Francisco: San Francisco

Department of Public Health. Retrieved January 1, 2005, from http://www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols.pdf

Fleming, M. Z., & Feinbloom, D. (1984). Similarities in becoming: Transsexuals and adolescents. *Adolescence, 19,* 729-748.

Fraser, L. (2005). Therapy with transgender people across the life-span. *American Psychological Association Division 44 Newsletter, 21,* 14-16.

Gapka, S. & Raj, R. (2003). *Trans Health Project: A position paper and resolution adopted by the Ontario Public Health Association* (Rep. No. 2003-06 (PP)). Toronto, ONT, Canada: Ontario Public Health Association.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Goldberg, J. M. (2005). *Making the transition: Providing services to trans survivors of violence and abuse.* Vancouver, BC: Justice Institute of BC and Trans Alliance Society.

Goldberg, J. M., Matte, N., MacMillan, M., & Hudspith, M. (2003). *Community survey: Transition/crossdressing services in BC – Final report.* Vancouver, BC: Vancouver Coastal Health and Transcend Transgender Support & Education Society.

Goldberg, J. M. & White, C. (2004). Expanding our understanding of gendered violence: Violence against trans people and loved ones. *Aware: The Newsletter of the BC Institute Against Family Violence*, *11*, 21-25.

Grimaldi, J. M., & Jacobs, J. (1996, July). *HIV/AIDS transgender support group: Improving care delivery and creating a community*. Paper presented at XI International Conference on AIDS, Vancouver, BC.

Hansbury, G. (2005). Mourning the loss of the idealized self: A transsexual passage. *Psychoanalytic Social Work, 12,* 19-35.

Hepp, U., & Milos, G. (2002). Gender identity disorder and eating disorders. *International Journal of Eating Disorders, 32,* 473-478.

Hill, D. B., Rozanski, C., Cargainni, J., & Willoughby, B. (2003, May). Gender Identity Disorder in children and adolescents: A critical review. In D. Karasic & J. Drescher (Co-Chairs), *Sexual and gender identity disorders: Questions for DSM-V*. Symposium conducted at the 156th Annual Meeting of the American Psychiatric Association, San Francisco, CA. Transcript retrieved January 1, 2005, from http://www.tsroadmap.com/info/div-44-roundtable.html

Horton, M. A. (2001). Checklist for transitioning in the workplace. Retrieved January 1, 2005, from http://www.tgender.net/taw/tggl/checklist.html

Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *Journal of Primary Prevention, 22,* 263-298.

Israel, G. E. & Tarver, D. E. I. (1997). *Transgender care: Recommended guidelines, practical information, and personal accounts*. Philadephia, PA: Temple University Press.

Keatley, J., Nemoto, T., Operario, D., & Soma, T. (2002, July). *The impact of transphobia on HIV risk behaviors among male to female transgenders in San Francisco*. Poster presented at XVI International AIDS Conference, Barcelona, Spain.

Keatley, J., Nemoto, T., Sevelius, J., & Ventura, A. (2004, November). *Expanding mental health services for transgender people*. Poster presented at the 132nd Annual Meeting of the American Public Health Association, Washington, DC. Retrieved January 1, 2005, from http://www.caps.ucsf.edu/pdfs/APHA_Keatley.pdf

Kenagy, G. P. (2002). HIV among transgendered people. *AIDS Care, 14,* 127-134.

Kenagy, G. P. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work, 30,* 19-26.

Koetting, M. E. (2004). Beginning practice with preoperative male-to-female transgender clients. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 16,* 99-104.

Kopala, L. (2003). *Recommendations for a transgender health program.* Vancouver, BC: Vancouver Coastal Health.

Kotula, D. (2002). *The phallus palace: Female-to-male transsexuals*. Los Angeles: Alyson Publications.

Kübler-Ross, E. (1969). *On death and dying*. New York: Simon & Schuster.

Landen, M., Walinder, J., Hambert, G., & Lundstrom, B. (1998). Factors predictive of regret in sex reassignment. *Acta Psychiatrica Scandinavica, 97,* 284-289.

Langström, N., & Zucker, K. J. (2005). Transvestic fetishism in the general population. *Journal of Sex & Marital Therapy, 31,* 87-95.

Lantz, B. (1999). Is the journey worth the pain? In M. Boenke (Ed.), *Trans forming families: Real stories about transgendered loved ones* (pp. 13-18). Imperial Beach, CA: Walter Trook.

Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32,* 299-315.

Lawrence, A. A. (2005). Sexuality before and after male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 34,* 147-166.

Leslie, D. R., Perina, B. A., & Maqueda, M. C. (2001). Clinical issues with transgender individuals. In U.S. Department of Health and Human Services Center for Substance Abuse Treatments (Ed.), *A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals* (pp. 91-98). Rockville, MD: U.S. Department of Health and Human Services.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: The Haworth Clinical Practice Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48,* 1060-1064.

Lombardi, E. L., & van Servellen, G. (2000). Building culturally sensitive substance use prevention and treatment programs for transgendered populations. *Journal of Substance Abuse Treatment, 19,* 291-296.

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality, 42,* 89-101.

Macfarlane, D. (2003). *LGBT communities and substance use – What health has to do with it: A report on consultations with LGBT communities.* Vancouver, BC: LGBT Health Association of B.C.

Mallett, P., Marshall, E. J., & Blacker, C. V. (1989). "Puerperal psychosis" following male-to-female sex reassignment? *British Journal of Psychiatry, 155,* 257-259.

Manderson, L., & Kumar, S. (2001). Gender identity disorder as a rare manifestation of schizophrenia. *Australian and New Zealand Journal of Psychiatry, 35,* 546-547.

Martin, T., & Gattaz, W. F. (1991). Psychiatric aspects of male genital self-mutilation. *Psychopathology, 24,* 170-178.

Mason, T. H., Connors, M. M., & Kammerer, C. A. (1995). *Transgenders and HIV risks: Needs assessment.* Boston, MA: Gender Identity Support Services for Transgenders, prepared for the Massachusetts Department of Public Health, HIV/AIDS Bureau.

Mathy, R. M. (2002). Transgender identity and suicidality in a nonclinical sample: Sexual orientation, psychiatric history, and compulsive behaviors. *Journal of Psychology & Human Sexuality, 14,* 47-65.

McGovern, S. J. (1995). Self-castration in a transsexual. *Journal of Accident and Emergency Medicine, 12,* 57-58.

McGowan, C. K. (1999). *Transgender needs assessment*. New York City, NY: Prevention Planning Unit, New York City Department of Health.

Mellon, C. D., Barlow, C., Cook, J., & Clark, L. D. (1989). Autocastration and autopenectomy in a patient with transsexualism and schizophrenia. *Journal of Sex Research, 26,* 125-130.

Meyer, W. J., III, Bockting, W. O., Cohen-Kettenis, P. T., Coleman, E., Di Ceglie, D., Devor, H., Gooren, L., Hage, J. J., Kirk, S., Kuiper, B., Laub, D., Lawrence, A., Menard, Y., Monstrey, S., Patton, J., Schaefer, L., Webb, A., & Wheeler, C. C. (2001). *The standards of care for Gender Identity Disorders* (6th ed.). Minneapolis, MN: Harry Benjamin International Gender Dysphoria Association.

Michel, A., Ansseau, M., Legros, J. J., Pitchot, W., & Mormont, C. (2002). The transsexual: what about the future? *European Psychiatry, 17,* 353-362.

Milrod, C. (2000). Issues of countertransference in therapy with transgender clients. Los Angeles, CA: Southern California Transgender Counseling. Retrieved January 1, 2005, from http://www.transgendercounseling.com/trans1.htm

Moser, C. K., & Kleinplatz, J. (2003, May). DSM-IV-TR and the paraphilias: An argument for removal. In D. Karasic & J. Drescher (Co-Chairs), *Sexual and gender identity disorders: Questions for DSM-V*. Symposium conducted at the 156th Annual Meeting of the American Psychiatric Association, San Francisco, CA. Transcript retrieved January 1, 2005, from http://www.tsroadmap.com/info/div-44-roundtable.html

Munson, M., & Cook-Daniels, L. (2003). *Transgender/SOFFA: Domestic violence/sexual assault resource sheet*. Milwaukee, WI: For Ourselves Reworking Gender Expression.

Murphy, D., Murphy, M., & Grainger, R. (2001). Self-castration. *Irish Journal of Medical Science, 170,* 195.

Nemoto, T., Operario, D., Keatley, J., Nguyen, H., & Sugano, E. (2005). Promoting health for transgender women: Transgender Resources and Neighborhood Space (TRANS) program in San Francisco. *American Journal of Public Health, 95*, 382-384.

Nemoto, T., Operario, D., Keatley, J., & Villegas, D. (2004). Social context of HIV risk behaviours among male-to-female transgenders of colour. *AIDS Care, 16,* 724-735.

Nemoto, T., Operario, D., Sevelius, J., Keatley, J., Han, L., & Nguyen, H. (2004, November). Transphobia among transgenders of color. Poster presented at the 132nd Annual Meeting of the American Public Health Association, Washington, DC. Retrieved January 1, 2005, from http://www.caps.ucsf.edu/pdfs/APHA_Nemoto.pdf

Nemoto, T., Sugano, E., Operario, D., & Keatley, J. (2004, July). *Psychosocial factors influencing HIV risk among male-to-female transgenders in San Francisco*. Poster presented at XV International AIDS Conference, Bangkok, Thailand.

O'Brien, M. (2003). *Keeping it real: Transgender inclusion in safe sex education – Notes for risk reduction educators and outreach workers*. Retrieved January 1, 2005, from http://www.deadletters.biz/real.html

Odo, C. F. O. (2002). *The combination of culturally-relevant prevention case management, community building activities and OraSure testing proves effective for Native Hawaiian transgenders*. Poster presented at XIV International AIDS Conference, Barcelona, Spain.

Oggins, J. & Eichenbaum, J. (2002). Engaging transgender substance users in substance use treatment. *International Journal of Transgenderism, 6*. Retrieved January 1, 2005, from http://www.symposion.com/ijt/ijtvo06no02_03.htm

Osher, F. C. & Drake, R. E. (1996). Reversing a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry, 66,* 4-11.

Pasillas, A., Anderson, B., & Fraser, L. (2000, May). Addressing psychosocial issues in the transgender client. Panel discussion, Transgender Care Conference, San Francisco, CA.

Pfäfflin, F. (1992). Regrets after sex reassignment surgery. In W. O. Bockting & E. Coleman (Eds.), *Gender dysphoria: Interdisciplinary approaches in clinical management* (pp. 69-85). Binghamton, NY: Haworth Press.

Pfäfflin, F. & Junge, A. (1998). *Sex reassignment – Thirty years of international follow-up studies; SRS: A comprehensive review, 1961-1991* (R. B. Jacobson & A. B. Meier, Trans.). Düsseldorf , Germany: Symposion Publishing. (Original work published 1992)

Rachlin, K. (2002). Transgender individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6.* Retrieved January 1, 2005, from http://www.symposion.com/ijt/ijtvo06no01_03.htm

Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgendered clients. *International Journal of Transgenderism, 6.* Retrieved January 1, 2005, from http://www.symposion.com/ijt/ijtvo06no02_04.htm

Ramet, S. P. (1996). *Gender reversals and gender cultures: Anthropological and historical perspectives*. London: Routledge.

Reback, C. J., Simon, P. A., Bemis, C. C., & Gatson, B. (2001). *The Los Angeles Transgender Health Study: Community report*. Los Angeles, CA: University of California at Los Angeles.

Registered Nurses Association of British Columbia/College of Registered Nurses of British Columbia (2005). *Scope of practice for nurse practitioners (family): Standards, limits and conditions* (Rep. No. 424). Vancouver, BC: Registered Nurses Association of British Columbia/College of Registered Nurses of British Columbia.

Reynolds, A. L., & Caron, S. L. (2000). How intimate relationships are impacted when heterosexual men crossdress. *Journal of Psychology & Human Sexuality, 12,* 63-77.

Risser, J., & Shelton, A. (2002). *Behavioral assessment of the transgender population, Houston, Texas*. Galveston, TX: University of Texas School of Public Health.

Robinow, O., & Knudson, G. (2005, April). *Asperger's Disorder and gender dysphoria*. Paper presented at 19th Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy.

Sachsse, U., Von der Heyde, S., & Huether, G. (2002). Stress regulation and self-mutilation. *American Journal of Psychiatry, 159,* 672.

Samson, A. (1999). Mom, Dad, we need to talk. In M. Boenke (Ed.), *Trans forming families: Real stories about transgendered loved ones* (pp. 56-60). Imperial Beach, CA: Walter Trook.

Schrock, D., Holden, D., & Reid, L. (2004). Creating emotional resonance: Interpersonal emotion work and motivational framing in a transgender community. *Social Problems, 51,* 61-81.

Steinbeck, A. (1997). Hormonal medication for transsexuals. *Venereology: Interdisciplinary, International Journal of Sexual Health, 10,* 175-177.

Surgenor, L. J., & Fear, J. L. (1998). Eating disorder in a transgendered patient: A case report. *International Journal of Eating Disorders, 24,* 449-452.

Tunzi, M. (2001). Can the patient decide? Evaluating patient capacity in practice. *American Family Physician, 64,* 299-306.

Vitale, A. (2004). Couples therapy when the male partner crossdresses. *T-Note, 11*. Retrieved January 1, 2005, from http://www.avitale.com/cdcouples.htm.

Volkmar, F., Cook, E. H. Jr., Pomeroy, J., Realmuto, G., & Tanguay, P. (1999). Practice parameters for the assessment and treatment of children, adolescents, and adults with autism and other pervasive developmental disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 38,* S32-S54.

Weinberg, T. S., & Bullough, V. L. (1988). Alienation, self-image, and the importance of support groups for the wives of transvestites. *Journal of Sex Research, 24,* 262.

White Holman, C., & Goldberg, J. M. (2006). *Social and medical advocacy with transgender people and loved ones: Recommendations for BC clinicians* Vancouver, BC: Vancouver Coastal Health Authority.

White, C. (2003). *Re/defining gender and sex: Educating for trans, transsexual, and intersex access and inclusion to sexual assault centres and transition houses.* Unpublished master's thesis, University of British Columbia, Vancouver, BC.

Williamson, I., & Hartley, P. (1998). British research into the increased vulnerability of young gay men to eating disturbance and body dissatisfaction. *European Eating Disorders Review, 6,* 160-170.

Wilson, K., & Lev, A. I. (2003, May). Disordering gender identity: Issues of diagnostic reform. In D. Karasic & J. Drescher (Co-Chairs), *Sexual and gender identity disorders: Questions for DSM-V*. Symposium conducted at the 156th Annual Meeting of the American Psychiatric Association, San Francisco, CA. Transcript retrieved January 1, 2005, from http://www.tsroadmap.com/info/div-44-roundtable.html

Winston, A. P., Acharya, S., Chaudhuri, S., & Fellowes, L. (2004). Anorexia nervosa and gender identity disorder in biologic males: a report of two cases. *International Journal of Eating Disorders, 36,* 109-113.

Xavier, J. (2000). *The Washington, DC Transgender Needs Assessment Survey: Final report for phase two – Tabulation of the survey questionnaires, presentation of findings and analysis of the survey results, and recommendations* Washington, DC: Administration for HIV and AIDS, District of Columbia Department of Health.

Yelland, C., & Tiggemann, M. (2003). Muscularity and the gay ideal: body dissatisfaction and disordered eating in homosexual men. *Eating Behaviors, 4,* 107-116

Appendices

Appendix A: Resources

Appendix B: DSM-IV-TR diagnostic criteria

- **B1: Gender Identity Disorder**
- **B2: Transvestic Fetishism**

Appendix C: Sample gender assessments

- **C1: Female-to-male (FTM)**
- **C2: Male-to-female (MTF)**

Appendix D: Sample letter to client prior to hormone assessment

Appendix E: Sample letter to client explaining assessment process for individuals seeking BC Medical Services Plan coverage for sex reassignment surgery

Appendix F: Sample letter to physician recommending hormone therapy

Appendix G: Sample letter to physician recommending sex reassignment surgery

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

Appendix A: Resources

Transgender Health Program

The Transgender Health Program is an anonymous and confidential free service for anyone in BC who has a transgender health question or concern.

Services for mental health clinicians include:

- training in treatment of gender concerns and hormone/surgery assessment
- assistance in care planning for transgender clients and loved ones
- information about best practice guidelines and standards of care
- assistance with development of trans-inclusion policies and procedures
- information about transgender health research findings and implications for practice
- joint program planning and research initiatives

Services for transgender people and loved ones include:

- help finding health/social services, and assistance to navigate health/social service systems
- information about best practice guidelines, standards of care, and client/patient rights
- peer-based exploration of gender identity, gender expression, and life stresses in a non-judgmental setting
- support and information for family members, partners, friends, and other loved ones
- free condoms and needle exchange
- outreach to transgender people working in the survival sex trade
- free training sessions for peer support volunteers
- information about transgender community organizations and peer support groups

The Transgender Health Program is an initiative of Vancouver Coastal Health.

For more information, contact:

Transgender Health Program
Three Bridges Community Health Centre
#301-1290 Hornby Street, Vancouver, BC V6Z 1W2
Phone/TTY/TDD: 604-734-1514 or 1-866-999-1514 (toll-free in BC)
Fax: 604-633-4241
Email: transhealth@vch.ca
Web: http://www.vch.ca/transhealth

Harry Benjamin International Gender Dysphoria Association

http://www.hbigda.org

The Harry Benjamin International Gender Dysphoria Association (HBIGDA) is a professional organization devoted to the understanding and treatment of gender dysphoria, with 350 members from around the world in fields such as psychiatry, endocrinology, surgery, psychology, sexology, counseling, sociology, and law. HBIGDA provides opportunities for scientific interchange among professionals through biennial conferences and publications, and develops and publishes Standards of Care.

Appendix B: *DSM-IV-TR* Diagnostic Criteria
(American Psychiatric Association, 2000)

B1: Gender Identity Disorder in Adolescents and Adults, 302.85

Section: Sexual and Gender Identity Disorders
Subsection: Gender Identity Disorders

Diagnostic Criteria:

a) A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

b) Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

c) The disturbance is not concurrent with a physical intersex condition.

d) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

B2: Transvestic Fetishism, 302.3

Section: Sexual and Gender Identity Disorders
Subsection: Paraphilias

Diagnostic Criteria:

a) Over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.

b) The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix C: Sample Gender Assessments

C1: Example #1 – Female-to-male

Re: Majida Khattari
DOB: August 10, 1952

Reason for Referral: Client is a 52-year-old male-identified natal female who hopes to have a bilateral mastectomy/chest reconstruction surgery as part of gender transition.

Dear Dr. Smith:

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 identified as 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 male 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 counselling in 1992 to deal with issues relating to being molested by a neighbour 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 labour 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 feels that 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 Harry Benjamin International Gender Dysphoria Association *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.

C2: Example #2 – Male-to-female

Re: Sandeep Singh
DOB: January 15, 1970

Reason for Referral: Client is a 34-year-old female-identified natal male who is seeking assistance to resolve gender confusion.

Dear Dr. Smith:

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 2 girls 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 dress 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 confusion with her. Sandeep put all of her energies into her work and family in hope that her feelings about being female 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 counselling and Parmit decided that she would not be able to have a life with Sandeep if she began 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 transformation.

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 coffee/other 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 Sertraline use.

Personal history

Sandeep started school when she was six 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 concerns. Sandeep is not currently close with her father. She has always found it difficult to connect emotionally with him, and in recent years he 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 female-identified anatomical male who 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 counselling that will hopefully include her wife Parmit.

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

Appendix D: Sample Letter to Client Prior to Hormone Assessment

Dear client:

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

Purpose of the Assessment

The clinician providing the assessment will:

- Determine whether you meet the eligibility and readiness criteria for hormone therapy outlined in the current version of the Harry Benjamin International Gender Dysphoria Association (HBIGDA)'s *Standards of Care*.
- 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 (as defined by BC law).
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) The patient has had further consolidation of gender identity during the real-life experience or psychotherapy.
2) The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health.
3) The patient is likely to take 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 BC CareCard and picture identification (e.g., passport, driver's license, BC ID). The picture ID 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 your Name Change certificate.

If you want support relating to the assessment process, you are welcome to call the Transgender Health Program at 1-866-999-1514 (toll-free in BC), or email transhealth@vch.ca.

Appendix E: Sample Letter to Client Seeking BC Medical Services Plan Coverage for Sex Reassignment Surgery

Dear client:

The Medical Services Plan (MSP) of British Columbia requires that all patients requesting approval for payment relating to sex reassignment surgery (SRS) be assessed by two mental health clinicians (a psychiatrist and a Ph.D. psychologist or 2nd psychiatrist) who MSP has deemed have "recognized and demonstrable expertise in the treatment of gender dysphoria".

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

Purpose of the Assessment

The mental health professionals doing the assessment will:

- Determine whether the patient meets MSP's eligibility criteria for SRS (see below).
- Make a recommendation to MSP about whether or not SRS is appropriate in the patient's treatment.

If the assessors agree that surgery is appropriate and that the patient meets MSP's eligibility criteria, they will contact MSP and ask for surgery coverage to be approved. MSP's “Gender Re-assignment Surgical Review Committee” will then review the assessors' recommendations and the supporting documentation submitted by the patient, and then decide whether to authorize surgery or not. MSP will inform you and your doctor of their decision via letter.

MSP Eligibility Criteria

For a patient to be granted MSP coverage for SRS, MSP requires:

a) "The patient must be sufficiently emotionally and psychologically stable such that although a delay in surgery may be disappointing, it would not be a crisis."

b) "The patient must have had at least two full years of full societal cross-gender immersion. A patient can fulfill this criterion through full-time employment in a public workplace, full-time attendance at an educational or other training institution, significant time spent in voluntary service in a public occupation or any combination of the foregoing."

[Note: In the past, individuals who can't work/study/volunteer full-time (because of disability, caregiver responsibilities, lack of opportunity, etc.) have still been considered by MSP to be eligible for surgery. If this is your situation, your doctor should write a letter explaining your circumstances and confirming that to the best of their knowledge you are living full-time as a man or a woman.]

Assessors

Drs. Gail Knudson and Oliver Robinow, psychiatrists formerly with Vancouver Hospital's Gender Dysphoria Program, will be jointly interviewing patients in their private offices. With the patient's consent, Drs. Knudson and Robinow may be joined by a third psychiatrist or a Ph.D.-level psychologist who is in training to become a GRS assessor. You can choose to be seen either in Vancouver or Victoria. *If you do not want to have a trainee present, please let the receptionist know this when you book your appointment.*

Number of Sessions

Appointments will consist of a 50-minute discussion between the patient and the assessors. 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 BC CareCard and picture identification (e.g., passport, driver's license, BCID). It is not required that you have had a legal name change, but if you have, bring your Name Change certificate. You will also need to bring at least one of the following documents to confirm that you have met the MSP criterion of "at least two full years of full societal cross-gender immersion":

- 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

Note: 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. It is important that they include your name, the gender pronoun you are called at work, and the length of time you have been working/volunteering/in school. This can be a short statement:

- "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]."

MSP will not accept letters from friends, relatives, neighbours, or others who you interact with socially.

Letters must be *signed originals*, and transcripts/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 forwarded to MSP by the assessors.

If you need help obtaining picture ID or collecting letters, or want other support relating to the assessment process, you are welcome to call the Transgender Health Program at 1-866-999-1514 (toll-free in BC), or email transhealth@vch.ca.

Appendix F: Sample Letter Recommending Hormones
(to prescribing GP, nurse, or endocrinologist)

Re: Saul Cohen (aka Sarah Cohen)
DOB: April 23, 1980

Reason for Referral: Client is a 23-year-old male-identified natal female who seeks medically monitored testosterone therapy as part of gender transition.

Dear Dr. Smith:

I am writing to support my client's request for testosterone therapy. Saul (whose legal name is Sarah) is a 23-year-old male-identified anatomical female. 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 counsellor 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 counselling 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 labelled 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 two months has been taking testosterone he purchased from the internet, to alleviate discomfort he feels when he is perceived as female 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 GP 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 Harry Benjamin Gender Dysphoria Association'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 three months recommended in the Harry Benjamin Gender Dysphoria Association'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 at (555) 555-5555.

Sincerely,

Yoshi Nakamura, M.A. - Registered Clinical Counsellor

Appendix G: Sample Letter Recommending Sex Reassignment Surgery (to surgeon)

Re: Shirley Alexander
DOB: September 9, 1959

Reason for Referral: Client is a 45-year-old female-identified natal male who hopes to have vaginoplasty as part of gender transition.

Dear Dr. Smith:

This letter will introduce Ms. Shirley Alexander, a 45-year-old female-identified anatomical male, 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 GP. 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 GP (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 GID 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. Doe is physically fit and is a non-smoker. Current medications include CES 0.625 mg po OD, Provera 30 mg po OD, Spironolactone 400 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 at (250) 555-5555.

Sincerely,

José Figueroa, MD, FRCPC
Psychiatrist

Family Physician: Dr. John Bigelow, 1234 Caring St., Victoria, BC V6R 2A1, Phone: 555-1234
Endocrinologist: Dr. Doris Reinbolt, 4321 Robins St., Victoria, BC V8R 1X2, Phone: 555-1123
Psychologist: Dr. Robert Jones, #153-2232 Douglas St., Victoria, BC V8R 5J3, Phone: 555-4432