TRANSGENDER 101:
WHAT MENTAL HEALTH PROFESSIONALS
SHOULD KNOW

Silvestro (Silvio) M. Weisner, Ph.D.
cisgender male, he/him/his
TODAY’S AGENDA

• Terminology & core concepts
• Myths & misconceptions
• Assessment & diagnosis
• Medical & surgical concerns
• Psychological & contextual factors
• Treatment issues
WHAT IS TRANSGENDER?
IMPORTANT TERMS & CORE CONCEPTS

SEX vs. GENDER
Physiological / genetic vs. socio-cultural & psychological / emotional

SEXUAL ORIENTATION vs. GENDER IDENTITY
“who I go to bed with” vs. “who I go to bed as”

GENDER IDENTITY vs. GENDER EXPRESSION vs. GENDER ATTRIBUTION
internal / psychological vs. external / behavioral vs. societal perception

TRANSGENDER vs. TRANSSEXUAL

TRANSGENDER vs. CISGENDER (retronym)
WHAT IS TRANSGENDER?
IMPORTANT TERMS & CORE CONCEPTS

TRANSGENDER

PHYSIOLOGY / GENETICS
Intersex

IDENTITY
Transgender man / woman
Fluid / variant / expansive / creative
Genderqueer / non-binary
Third gender / pangender / agender

BEHAVIOR / EXPRESSION
Cross-dressing
Masculine / feminine
Androgynous / non-conforming

SEXUAL AROUSAL
Transvestic Disorder
Sexual interest in cross-dressing

PERFORMANCE / ENTERTAINMENT
Drag queen / drag king
Male / female impersonator
# Defining Gender Identity: Dimensions

<table>
<thead>
<tr>
<th>Psychological / Emotional (Internal)</th>
<th>Behavioral / Expressive (External)</th>
<th>Identity / Labeling (Language)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts</td>
<td>Clothing &amp; grooming</td>
<td>Boy / man / masculine</td>
</tr>
<tr>
<td>Feelings</td>
<td>Mannerisms</td>
<td>Girl / woman / feminine</td>
</tr>
<tr>
<td>Fantasies / dreams</td>
<td>Speech patterns</td>
<td>Transitioning</td>
</tr>
<tr>
<td>Self-image</td>
<td>Toys, games, hobbies</td>
<td>Trans[gender]</td>
</tr>
<tr>
<td></td>
<td>Social &amp; interpersonal behavior / affiliations / expectations</td>
<td>Non-binary, fluid, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Genderqueer</td>
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<td></td>
<td></td>
<td>Questioning</td>
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<td>“I don’t know”</td>
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</tbody>
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**NOTE:** At any given point in one’s development, these three dimensions may not necessarily align with one another.
Genderbread Person v3.3

Gender is one of those things everyone thinks they understand, but most people don’t. Like inception. Gender isn’t binary. It’s not either/or. In many cases it’s both/and. A bit of this, a dash of that. This tasty little guide is meant to be an appetizer for gender understanding. It’s okay if you’re hungry for more. In fact, that’s the idea.

Gender Identity
- Woman-ness
- Man-ness

How you, in your head, define your gender, based on how much you align (or don’t align) with what you understand to be the options for gender.

Gender Expression
- Feminine
- Masculine

The ways you present gender; through your actions, dress, and demeanor, and how those presentations are interpreted based on gender norms.

Biological Sex
- Female-ness
- Male-ness

The physical sex characteristics you’re born with and develop, including genitals, body shape, voice pitch, body hair, hormones, chromosomes, etc.

Sexually Attracted to
- Nobody
- (Women/Females/Femininity)
- (Men/Males/Masculinity)

Romantically Attracted to
- Nobody
- (Women/Females/Femininity)
- (Men/Males/Masculinity)

In each grouping, circle all that apply to you and plot a point, depicting the aspects of gender toward which you experience attraction.

For a bigger bite, read more at http://bit.ly/genderbread
The Gender Unicorn

Gender Identity
- Female/Woman/Girl
- Male/Man/Boy
- Other Gender(s)

Gender Expression
- Feminine
- Masculine
- Other

Sex Assigned at Birth
- Female
- Male
- Other/Intersex

Physically Attracted to
- Women
- Men
- Other Gender(s)

Emotionally Attracted to
- Women
- Men
- Other Gender(s)

To learn more, go to: www.transstudent.org/gender

Design by Landyn Pan and Anna Moore
ADDITIONAL IMPORTANT TERMS AND CORE CONCEPTS

• Transitioning
• Pre-op[erative], post-op, no-op
• Hormone replacement therapy (HRT)
• Gender confirmation surgery (GCS) or gender affirmation surgery (GAS)

• MTF (Male to Female) = Trans[gender] woman
• FTM (Female to Male) = Trans[gender] man
  • NOTE: both of the above terms assume a gender-binary framework
• Sex assigned (or designated) at birth
  • e.g., AMAB (assigned male at birth); DFAB (designated female at birth)
OUTDATED / OFFENSIVE TERMS & PRACTICES

• Transsexual (use transgender or trans, not transgendered)
• A/the transgender (use “a/the transgender person / individual”)
• Transvestite [& cross-dresser] (use “a sexual interest in cross-dressing” or “cross-dressing behavior”)
• Tranny / she-male / chicks with dicks / bonus hole / dicklet (used among sex workers / in pornography industry)
• Passing (cf. how term is used regarding racial/ethnic expression / attribution)
• Sex-change operation / sex reassignment surgery
  ➢ Use gender confirmation or gender alignment surgery / treatment
• Hermaphrodite (use intersex as adjective, not intersexed)
• Opposite sex (use other gender / another gender / other than one’s assigned gender)

• Dead-naming & mis-gendering (common forms of familial, social, and institutional oppression)
• Quotation marks around pronouns / names
• Slashing (he/she / him-her / son/daughter / etc.)
• Outside of clinical contexts / “need to know) situations: Inquiring about surgical status, hormone treatments, birth name, transition process, “passing”
THE GREAT PRONOUN / NAME DEBATE

➢ There is no universal usage among transgender individuals
➢ When in doubt, ask about (and use) preferred pronouns / names

• he/him/his
• she/her/hers
• they/them/theirs
• ze / hir (pronounced /zee/ and /here/)

➢ Use client’s preferred pronouns / names / relational terms when describing / discussing an individual’s history both before and after transitioning
➢ In documentation, note when a client’s preferred name / pronouns differ from their current legal name / gender, but try to honor & use preference whenever possible
➢ Challenges regarding relational terms (e.g., mother/father, son/daughter)
➢ Being a cisgender ally: inform others of your own pronoun choices / preferences when introducing or identifying yourself
MYTHS & MISCONCEPTIONS ABOUT GENDER, GENDER IDENTITY, & TRANSGENDER INDIVIDUALS

• There are only two sexes / genders
• Gender is immutable → assigned at birth (cisgenderism)
• Everyone should be classified as male or female (binary)
• Transgender females are gay; transgender males are lesbian
• Transgender individuals (especially children & adolescents) are confused and/or going through a phase
• All transgender individuals desire hormone treatment or surgery to change their assigned sex
302.6 GENDER DYSPHORIA IN CHILDREN

- Marked incongruence between one’s experienced / expressed gender and one’s assigned gender, of at least six months’ duration, as manifested by at least six of the following (one of which must be the first):
  - Strong desire to be, or insistence that one is, a gender different from one’s assigned gender
  - Strong preference for cross-gender clothing / resistance to assigned-gender clothing
  - Strong preference for cross-gender roles in make-believe / fantasy play
  - Strong preference for the toys, games, activities stereotypically used by one’s experienced gender
  - Strong preference for playmates of another gender
  - Strong rejection of assigned-gender toys, games, activities, play styles
  - Strong dislike of one’s sexual anatomy
  - Strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender

- Associated with clinically significant distress or impairment of functioning

- Specify if:
  - With a disorder of sex development (e.g., congenital adrenogenital disorder, congenital adrenal hyperplasia, androgen insensitivity syndrome)
302.85 GENDER DYSPHORIA IN ADOLESCENTS AND ADULTS

• Marked incongruence between one’s experienced / expressed gender and assigned gender, of at least six months’ duration, as manifested by at least two of the following:
  • Marked incongruence between one’s experienced / expressed gender and one’s primary and/or secondary sex characteristics (developed or anticipated)
  • Strong desire to be rid of one’s primary and/or secondary sex characteristics (developed or anticipated)
  • Strong desire for the primary and/or secondary sex characteristics of the experienced gender
  • Strong desire to be different from one’s assigned gender
  • Strong desire to be treated as the experienced gender
  • Strong conviction that one has the typical feelings and reactions of the experienced gender

• Associated with clinically significant distress or impairment of functioning

• Specify if:
  • With a disorder of sex development
  • Post-transition (living as experienced gender and/or pursuit of gender-confirmation treatment / medical procedure)
GENDER DYSPHORIA: HISTORICAL PERSPECTIVES

• Formerly Gender Identity Disorder (GID)
• Many transgender activists assert that a DSM diagnosis pathologizes those individuals in society (especially children & adolescents) who do not conform to gender-role stereotypes, including (but not limited to) transgender men & women
• Some activists have advocated the removal of this diagnosis from the DSM, similar to the removal of ego-dystonic homosexuality in the 1980’s
• In compiling the DSM 5, efforts were made to take these concerns into consideration while maintaining the diagnosis (including changing the name to remove the word “disorder”)
• This diagnosis allows for insurance coverage of, and medical approval for, hormone treatments and gender confirmation surgeries
GENDER DYSPHORIA: PREVALENCE AND COURSE

• Meerwijk & Sevelius (2017) conducted a meta-analysis of 12 national surveys (2007 to 2015), and found that approximately one million Americans (1 in 250 adults, or .4%) identify as transgender (greater prevalence in younger populations)

• The Williams Institute @ UCLA College of Law (2016) conducted an analysis that found that 1.4 million Americans (.6%) identify as transgender

• DSM 5 (2013) prevalence & course data:
  • Natal adult males: .005 - .014%
  • Natal adult females: .002 - .003%
  • NOTE: Both are considered underestimates, given that not all transgender individuals seek treatment
  • Ratio of natal boys to girls: 2:1 to 4.5:1 (approaches parity in adolescence)
  • In some countries (e.g., Japan, Poland), ratios favor natal females
  • For children, persistence into adolescence ranges from 2.2-30% (for natal boys) to 12-50% (for natal girls)
  • For natal boys who do not persist, the majority are sexually attracted to males and often self-identify as gay (63-100%)
  • For natal girls who do not persist, sexual attraction to females and self-identification as lesbian is lower (32-50%)
TRANSITIONING PROCESS

1. LEGAL
2. SOCIAL
3. MEDICAL
TRANSITIONING LEGALLY: NAME CHANGE

• Legal process varies, depending upon state of residence; may involve hiring attorneys, petitioning courts, filing public notices

• OUTING ONESELF AS TRANSGENDER:
  • Background checks / security clearances / job applications involve needing to disclose name change (and, therefore, the transition process)
  • Identity fraud may be considered a felony if name change is not disclosed properly

• Name change touches everything: educational history / transcripts, government-issued ID (licenses, passports, etc.); credit / debt; property; taxes; personal accounts (utilities, loans, email, social media, etc.)
TRANSITIONING LEGALLY: GENDER MARKER CHANGE

- State-issued documents: functional and professional licenses, birth certificates
- Federal government documents: Social Security cards, passports
- Requirements vary by state: Requires doctor's letter, sometimes proof of medical treatment or that one has made (or is in the process of making) “permanent changes”; if not born and licensed in same state, additional documentation may be required
- Obtaining health insurance, organ-appropriate testing, access to hormone treatment often requires ongoing self-disclosure ( outing) and difficulty finding appropriate providers
TRANSITIONING SOCIALEY

• Often associated with gender expression / presentation
• Timing and approach (and risks) vary according to domain / environment (friends, family of origin, spouse / children, neighborhood, school / workplace)
• Cross-living (living full-time as one’s experienced gender) used to be (but now no longer is) a required hurdle (gate-keeping tool) to access medical / surgical transition process
• Like legal transitioning, social transitioning is a lifelong process, insofar as one’s social domains / environments change over time
• Especially challenging for gender-fluid / non-binary individuals, whose gender expression may change day to day
WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH (WPATH)

- Former the Harry Benjamin International Gender Dysphoria Association; name changed in 2006
- Non-binding Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH-SOC)
- Original SOC published in 1979; current version (7th) published in 2011
- Thirteen (13) sections:
  - Sections 1-4 – Introduction (nature, purpose, & need for SOC; epidemiology; diagnostic nomenclature; role of mental health professional)
  - Sections 5-8 – Guide to medical treatment (diagnostic criteria for children, adolescents, adults; documentation of recommendations [“the letter”]; requirements for use of hormones)
  - Section 9 – Expectations regarding “real-life experience” & transitioning
  - Sections 10-12 – Guide to surgical treatment (six eligibility criteria and two readiness criteria)
  - Section 13 – Post-transition follow-up
- Changes in most recent version of SOC:
  - Mental health practitioners are not gatekeepers
  - Criteria for hormone treatment and surgery is now broader and more flexible
EVOLUTION OF WPATH-SOC

• WPATH-SOC are updated and revised regularly, taking into consideration research and feedback from the transgender community
• A set period of psychotherapy is no longer required (although counseling is still recommended); mental health professionals are no longer expected to be gatekeepers
• Criteria for HRT and GCS are now broader and more flexible
• Very low percentage of post-surgical regret found
• Criticism of “real-life experience” requirement, noting difficulty, trauma, and danger in doing so pre-transition
• Criticism of very strict treatment requirements for minors – now allowances for HRT in limited circumstances, to delay the onset of puberty
• Current standards for children & adolescents include:
  • Pre-pubertal children: “watchful waiting”; support in gender exploration encouraged
  • Pubertal children & adolescents: puberty blockers recommended @ age 12, cross-gender hormones @ age 16+, surgery @ age 18+
Female to Male (FTM)

- Testosterone (injections, implants, patches, topical gels)
- Cross sex hormone therapy effects include:
  - Increase in body & facial hair
  - Male-pattern baldness
  - Deeper voice
  - Increased libido
  - Clitoral enlargement
  - Increased muscle mass
  - Increased skin oils & acne
  - Cessation of menses
  - Body fat redistribution
  - Increased difficulty w/anger & emotions (associated with supra-physiologic levels)

Male to Female (MTF)

- Androgen suppressants (pills)
- Estrogen / projesterone (pills, patches, injections)
- Cross sex hormone therapy effects include:
  - Breast tissue (moderate)
  - Body & facial hair decrease & skin softens
  - Decrease in libido
  - Decreased muscle mass
  - Body fat redistribution
  - Decrease of spontaneous erections and sexual functionality
  - Increased emotionality (in some)
HORMONE THERAPIES: CONSIDERATIONS

• Insurance companies are more likely to cover HRTs than GCS (endocrine-related versus surgeries considered “cosmetic” or “elective” procedures by some plans; anti-discrimination regulations limit this if WPATH guidelines are met)

• Fertility considerations (especially when working with young adults who may decide to harvest and freeze sperm/eggs)

• HRTs are life-long commitments; several HRT effects are irreversible

• Hormones to delay puberty temporarily → bone density issues?

• Hormones affect one’s libido, but NOT sexual orientation

• Testosterone can increase blood pressure, lipid & cholesterol levels; cause sleep apnea; and destabilize bipolar, schizoaffective, and other psychiatric disorders that include manic or psychotic symptoms [also associated with supra-physiologic levels]

• Estrogen can increase blood pressure, liver enzymes, and blood clots; cause gallstones and weight gain

• Anti-estrogens can lower blood pressure, disrupt electrolyte balance, and cause dehydration (it is a diuretic)
GENDER CONFIRMATION SURGERIES & OTHER RESOURCES / OPTIONS

Female to Male (FTM)
• Top surgery = Mastectomy & chest masculinization
• Liposuction (part of and separate from top & bottom surgeries)
• Bottom surgeries:
  • Hysterectomy / vaginectomy
  • Oophorectomy (removal of ovaries)
  • Metoidioplasty
  • Phalloplasty
  • Urethral extension
• Binding (breasts)
• Packing (penis)
• STP (Stand to Pee) devices
• Reshaping hairline
• Vocal therapy / voice training

Male to Female (MTF)
• Tracheal shave (Adam’s apple)
• Facial Feminization Surgery (FFS)
• Top surgery = Breast augmentation (not always needed; some MTF grow large breasts with HRT)
• Bottom surgeries:
  • Orchiectomy (removal of testicles)
  • Vaginoplasty
  • Buttock enhancement
• Breast forms
• Tucking (penis)
• Electrolysis / laser hair removal / plucking / shaving
• Makeup (temporary and permanent)
• Vocal therapy / voice training
GENDER CONFIRMATION SURGERIES: CONSIDERATIONS

• Some transgender individuals never have surgery:
  ➔ ONE IS NO LESS TRANSGENDER FOR NOT UNDERGOING SURGERY / TREATMENT

• Informed consent vs. gatekeeper models: Desperation leads to desperate choices (e.g., hotel surgeries by non-professionals; travel to other countries for less expensive / more accessible surgeries; purchasing hormones on the black market / from other countries)

• Political factors:
  • Obama-era D.C. & federal protections required insurance companies and Medicaid to stop discriminating regarding transgender health care; Trump administration is attempting to (and has begun to) undo many protections that have been enacted.

• Financial factors
  • Top surgeries can cost from $5000 to $10,000 each
  • Bottom surgeries can cost from $15,000 to $25,000 each
  • Some insurance companies cover GCS, but many do not

• Medical factors
  • Overweight individuals & those with pre-existing / co-morbid conditions may be excluded

• Occupational factors
  • Surgeries require recovery time ➔ some lack sufficient sick leave
  • Some workplaces will not be hospitable to transitioning
TRANSGENDER (& GENDER NONCONFORMING) CLIENTS: CLINICAL ISSUES & RISK FACTORS

- Lack of role models & safe forums to explore identity & discuss issues
- Chronic criticism & disapproval by family members & peers
- Verbal, emotional, & physical abuse at home
- Coerced into disproven and damaging “conversion” therapies
- Ostracism from & rejection by families of origin
- Peer rejection, teasing, & violence at school & in workplaces
- Academic performance problems
- Occupational, financial, & legal problems (downward drift; sex work)
- Homelessness & lack of access to health care
- Substance abuse & dependence
- Depression & suicide
“THE VILLAGE”  (JULY 2017)
STEPHEN WRABEL

https://www.youtube.com/watch?v=tilsrO-3gcQ
TRANSGENDER CLIENTS: 
PSYCHOLOGICAL & CONTEXTUAL FACTORS

**Female to Male (FTM)**
- Equal or greater numbers of pubertal clients are FTM
- Cross-gender behavior more acceptable pre-puberty (tomboys)
- Some identify first as lesbian
- Often “pass” more easily, even post-puberty & before HRT / GCS

**Male to Female (MTF)**
- More likely to be bullied, rejected, ostracized
- Less able to “pass” post-puberty
- Some identify first as gay
- Some post-transition MTFs who are attracted to women live as lesbians in the LGBT community
- Transgender women of color have the highest murder rate
“Every breath a black trans woman takes is an act of revolution.”

– Lourdes Ashley Hunter

“There is no such thing as a single-issue struggle because we do not live single-issue lives.”

– Audre Lorde

Gender identity, sexual orientation, race / ethnicity, age, class, disability, religious affiliation

• Intersectional theory addresses the interlocking systems of inequality that affect individuals with multiple oppressed identities

• Most directly impacts legal and medical transition access, which in turn impacts the social transition process

• Trans women of color who are poor and/or have disabilities are most affected
BASIC PRINCIPLES OF GENDER AFFIRMATIVE THERAPY

• Gender variation / diversity is **NORMAL, NOT PATHOLOGICAL**
• Gender can be **FLUID** and is **NON-BINARY**
• Gender identity / expression occur along a **CONTINUUM**
• Gender dysphoria and co-occurring emotional distress is largely the product of **MINORITY STRESS** and **LACK OF ACCESS** to care and treatment
• Most symptoms of mental illness go away when clinicians **VALIDATE AND SUPPORT** the gender diversity of their clients and **FACILITATE ACCESS** to appropriate medical and mental health treatment
• Mental health providers are **NOT GATEKEEPERS**
THE FAMILY ACCEPTANCE PROJECT:
WORKING WITH FAMILIES OF TRANSGENDER PEOPLE

• Even a small shift in acceptance is enough to reduce risk factors (including and especially depression & suicide)
• Parents & family members of transgender individuals often experience the stages of grief (denial, anger, bargaining, depression, acceptance)
• Cultural & religious factors often play a prominent role in how family members react to disclosure; acknowledge cultural / religious conflicts
• Parents & families also go through a coming-out process as they contemplate when and how to disclose to family members, coworkers, and peers their identity as a family member of a transgender person
• Spouses who choose to remain in relationship with a transitioning / transitioned partner may struggle to understand / label / explain if/how their own sexual orientation has changed
• Counselors should help family members process grief & anger; provide information and resources; and encourage family counseling, if appropriate
SUGGESTIONS FOR THOSE WHO WORK WITH TRANSGENDER CLIENTS

• Understand & address your own biases, prejudices, discomforts, misconceptions, & assumptions

• Recognize the courage it takes to disclose one’s gender identity (especially, when one is underage and/or questioning, or when one’s family dynamics, culture, or other circumstances may make such disclosures risky or dangerous)

• Acknowledge & inform clients that identity exploration at all levels is normative; helping clients figure out where they “fit in”

• Remember that, although clients’ gender identity may be transgender, other aspects of their social, sexual, & romantic life likely are equivalent to those of cisgender individuals

• Adults who transition may experience a “second adolescence” that may create tension with existing roles, relationships, & responsibilities
SUGGESTIONS FOR THOSE WHO WORK WITH TRANSGENDER CLIENTS

• Do not assume cisgender identity; make every effort to be gender-neutral when inquiring about every client’s identity & relationships, or when discussing a client’s future plans & goals

• Assure clients that decisions need not be made immediately regarding identity or labels, and that changes in labels & identities are always possible

• Acknowledge & inform clients & family members that the internal components of gender identity are not a choice, even if behaviors & labeling are a choice

• Provide frank information to families about risk factors for transgender youth & stress the importance of family acceptance for an individual’s health, safety, and well-being
SUGGESTIONS FOR THOSE WHO WORK WITH TRANSGENDER CLIENTS

• Empathize with clients who may be struggling with negative family and/or peer reactions to disclosure

• Encourage clients to objectively assess (reality-test) the risks involved when contemplating the timing & circumstances of transitioning & disclosure to others

• Assure students that harassment & violence against transgender people is not acceptable and should not be tolerated by family members, peers, or those in authority

• Take action to protect transgender individuals from mistreatment at home, at school, and in the workplace (consult with EEO offices)
SUGGESTIONS FOR THOSE WHO WORK WITH TRANSGENDER CLIENTS

• Address actively & openly the heterosexism, homophobia, & transphobia of those with whom you work; hostile environments are created when comments, slurs, and violence go unchallenged

• Provide accurate information & resources regarding transgender issues to clients, family members, and colleagues

• Encourage the establishment of gender-neutral bathrooms and policies regarding use of bathrooms, locker rooms, and other gender-segregated facilities and programs

• Actively use gender-inclusive / transgender-affirming language when speaking and writing about clients (see next slide)

• Encourage transgender clients and families to seek out resources where they can receive accurate information, support, & assistance in a confidential, non-judgmental setting
SUGGESTIONS REGARDING INTAKE FORMS & CASE SUMMARIES

• The category of GENDER should be separated from SEXUAL ORIENTATION and RELATIONSHIP STATUS

• GENDER (rather than SEX)
  • Male
  • Female
  • Cisgender
  • Transgender
  • Other _______________
    • Check all that apply (rather than forcing a binary (M/F) choice)
    • Consider adding Genderqueer, Non-binary, agender, exploring/questioning
    • Consider adding PRONOUN CHOICE (he/him, she/her, they/them, other: _______)

• Use gender-inclusive occupational terms (e.g., firefighter, mail carrier, police officer, chair(person), etc.; staffing (rather than manning) the booth; workforce (rather than manpower); work hours (rather than man-hours)

• Use gender-neutral relational terms: parent, child / offspring, sibling, spouse

• Use the client’s CURRENTLY PREFERRED pronouns / names / relational terms, even when reporting about pre-transition history (when in doubt, ASK; remember, this is the client’s official record)

• DO NOT “quote-ify” or “slash” the client’s pronouns / names / relational terms (“he”, mother/father, etc.)

• Remember that ALL PEOPLE (including yourselves!) HAVE A GENDER:
  • Add “cisgender” or “transgender” to ALL male / female (self-)descriptors
    • Jamie Smith is a 37 year-old, African-American, cisgender male employee …
THE LETTER:
WHAT TO INCLUDE

• Meets the criteria for Gender Dysphoria
  • Emotional distress and difficulty functioning
  • Gender incongruence

• Support for gender transitioning and HRT / GCS

• CONSISTENT (across contexts)
• PERSISTENT (over time)
• INSISTENT (firm self-identification)
READINESS PROCESS FOR GCS
(COOLHART, BAKER, FARMER, MALANEY, & SHIPMAN, 2015)

• Early awareness of gender and family context
• Parental / family attunement
• Current gender expression
• School context
• Sexual / relationship development
• Current intimate relationship(s)
• Social supports
• Future plans / expectations
TRANSGENDER RESOURCES

- FTM International
- National Center for Transgender Equality
- Transgender Network International
- Transgender Health & Education Network
- World Professional Association for Transgender Health (WPATH)

- Advocates for Youth
- Bisexual Resource Center
- Children of Lesbians And Gays Everywhere (COLAGE)
- DC Center for the LGBT Community
- DC Rape Crisis Center
- Gay, Lesbian, & Straight Education Network (GLSEN)
- Human Rights Campaign (HRC)
- National Gay & Lesbian Task Force (NGLTF)
- OutProud: The National Coalition for Gay, Lesbian, & Bisexual Youth

- Parents, Families, & Friends of Lesbians & Gays (PFLAG)
- The Family Acceptance Project @ SFSU: familyproject.sfsu.edu
- Sexual Minority Youth Assistance League (SMYAL; DC metro area)
- Whitman-Walker Clinic (DC metro area LGBTQ & HIV/AIDS services)

- LGBT religious organizations:
  - Dignity (Catholic)
  - Integrity (Episcopalian)
  - Affirmation (Methodist & Mormon)
  - Interweave (Unitarian Universalist)
  - Lutherans Concerned
  - World Congress of Gay & Lesbian Jewish Organizations
  - Muslim Alliance for Sexual and Gender Diversity