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The Ten Tasks of the Mental Health Provider: Recommendations for Revision of the World Professional Association for Transgender Health's *Standards of Care*

Arlene Istar Lev

ABSTRACT. This article outlines recommendations for the World Professional Association for Transgender Health's (WPATH) *Standards of Care* (*SOC*) regarding the roles, responsibilities, and tasks of the mental health provider in assessing eligibility and readiness for medical and surgical treatment of gender nonconforming, transgender, and transsexual clients. It reflects a reconceptualization of the role of the mental health provider as a gender specialist and an advocate and educator for transgender people and their families utilizing a nonpathologizing assessment process. This article reflects a need for clinical SOC that minimize the role of "gatekeeping," and increase the use of informed consent and harm-reduction procedures, while still providing guidelines for psychosocial evaluation. Recommendations are made for less pathologizing nomenclature, clearer definitions for the professional qualifications of those specializing in working with gender-variant people, and increased collaboration across disciplines. Suggestions are made for the *SOC* to recognize greater diversity in gender expression and identity, increased focus on the families and occupational environments of transgender people, and a broader view of gender issues throughout the lifecycle. Guidelines for psychosocial assessment and referral letters to physicians are outlined, including proposals to revisit the professional qualifications of letter writers and the need for two letters for surgical assessment. It is suggested that WPATH take leadership in the training and credentialing of gender specialists. These recommendations require a reorganization of the format of the *SOC* that will create a state-of-the-art standard of health care for transgender, transsexual, and gender nonconforming people and ensure the provision of high-quality clinical services for those individuals and their families.

KEYWORDS. Standards of care, transgender, transsexual, gender dysphoria, mental health

Standards of care (SOC) are the essential clinical foundations for providing consistent, evidence-based, and effective treatment across all disciplines and fields of medicine (Agency

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for Healthcare Research and Quality, 2007; Kinney, 2001). Trans-medicine is a rapidly evolving field and the development of the highest *standard* for medical and psychological treatment requires continuous modification and synthesis of emerging knowledge.

The World Professional Association for Transgender Health (WPATH) has been a leader in the development of Standards of Care for treating gender-variant people and reflects the expanding knowledge of gender identity development and gender dysphorias within the medical and clinical professions. WPATH attempts to provide an overarching standard of care that is international in focus, incorporating the needs of providers and consumers of services from vastly different countries, cultures, and backgrounds, with varying access to economic resources. Originating within the scientific and medical community, the current revisions will attempt to incorporate the feedback and critique of the nascent, burgeoning, and organized transgender civil rights movement that has challenged the medical model of treatment, specifically the role of gatekeeping as it has historically been provided by mental health providers. This is part of an emerging dialogue between trans-activists and professionals specializing in the needs of gender-variant clients (see Bockting, Knudson, & Goldberg, 2007; Lev, 2004; Rachlin, 1999) including the work of those who are both professionals and are themselves trans-identified (Denny, 1992; Ehrbar, Witty, Ehrbar, & Bockting, 2008, Hale, 2007; Israel & Tarver, 1997; Raj, 2002; Vanderburgh, 2007; Vitale, 1997). These authors represent a diversity of viewpoints on many different topics, and the last revision of the *SOC* included transgender professional representation for the first time (Meyer, et al., 2001).

WPATH stands at the crossroads where medical hegemony meets a sociopolitical process of identity and community development (Denny, 2004, Green, 2004, Lev, 2006; Whittle, 1998). The SOC have been a major focal point of transgender community activism, a target of incisive criticism, specifically regarding the rights of gender-variant people to actualize themselves without psychological scrutiny and consequent "approval" to receive necessary medical treatments (Burns, 2004; Hale, 2007; MacDonald, 1999; Wilchins, 1997). In many ways, the nucleus of this tension rests on the clinical relationship between the person seeking medical and clinical treatment and the mental health professional who serves as the initial contact and gatekeeper to the medical community. Therefore, the first task for any mental health professional, especially those who view themselves as advocates for the civil rights of transgender people, must be to acknowledge the challenges and implications inherent in being a professional gatekeeper.

MENTAL HEALTH PROFESSIONALS AS GATEKEEPERS

The section of the *SOC* that will be examined for revision in this article clarifies the responsibilities and expectations of mental health professionals (MHPs) (Section IV). This is a complex section precisely because the MHP's role in providing services for gender-variant people, as it has been formulated and outlined in the *SOC* has been much maligned, particularly by advocates for the civil rights of transgender people who view MPHs as gatekeepers who can selectively block services for those seeking medical treatment. For physicians, MHPs are the source of their referrals, essentially lower-status professionals who are often viewed as adjunctive to the medical services, which are often seen as the "real" treatments. The revision of this *SOC* must be more than a modification of words with adaptations for new evidence-based research and must reflect a *reconceptualization* of the role of the MHP in the provision of services for people seeking treatment for gender dysphoria.

Perhaps the first questions to address are: Why do people desiring gender-related medical and surgical treatments need to see a MHP first? Why can't they simply request treatment directly from a physician, much as one would go to dentist for a toothache? What purpose does a MHP serve in the provision of trans-health services? These are salient questions, and since MHP's are viewed by some as sentinels at the gate of medical treatments, situated between the physician and those requesting body-modification treatment, it is necessary for the SOC committee to respond to the accusation that psychosocial evaluation

and letters of approval are unnecessary, including the insistence from some that hormones be available "on demand" of the clients (Pollack, 1997; Stryker, 1993).

So what exactly are the sentinels guarding? Who gets to pass through the gate and who does not? These questions are reminiscent of a scene in the *Wizard of Oz,* when Dorothy and her friends first reach the Emerald City. After a long and perilous journey, they are met at the door by a gatekeeper, who, after they ring the doorbell, tells them to read a notice that is not there. When the notice is then abruptly placed on the door it says "Bell out of Order. Please Knock." For the client seeking therapeutic help, the gatekeeper's rules of entry often appear equally cryptic and confusing. Dorothy was able to enter because she wore ruby slippers; even if those seeking treatment are lucky enough to own their own ruby slippers, few are granted such immediate access. Instead, many clients are scrutinized at the doorstep through a process of clinical inquiry, complete with historical examination and hypothetical questions to determine their proper diagnosis (Speer, 2006). The MHPs primary responsibility is to make sure that the client does have a bona fide gender identity disorder (GID) as it is outlined in the DSM-IV-TR (APA, 2000) and does *not* have some other disorder that may resemble a gender identity issue. These are the first two tasks of the MHP listed in the current *SOC*.

The problem, however, is that the DSM criteria and the SOC, as they are presently written, rely on a limited, bipolar view of gender identity. A greater range of transgender expressions are recognized in the contemporary world of trans-health than are reflected in current DSM diagnostic criteria (Carroll, 1999; Fraser, 2009/this issue; Raj, 2002; Devor, 2004; Vanderburgh, 2007). In the absence of evidence-based criteria for the inclusion of GID in the DSM, gender identity diagnoses often appear tautological—He has GID because he wants to be a woman; he wants to be a woman because he has GID (Pilgrim, 2005). There currently is extensive professional disagreement and discussion about whether GID should remain in the DSM (see Bockting, 2009 ; Karasic & Drescher, 2006) and surely the outcome of that discussion impacts its inclusion and utility in the revised *SOC*.

Professionals who do not view gender-variance as a mental disorder recognize, of course, that gender nonconforming experience can be distressing (Lev, 2005; Winters, 2005) and that those suffering with gender dissonance should have access to quality mental health services. Referral for medical services should not rely solely on meeting the criteria for a pathological diagnosis, although utilizing the DSM *can* remain one of many tools available to the MHP in a broader biopsychosocial evaluation and assessment process.

Diagnosis is particularly complex regarding gender identity issues because they are mostly self-assessed, that is, clients seek out services based on the symptoms they are experiencing and labeling. Richard Docter (1988) has said transsexual surgery is, "the only major surgical procedure carried out in response to the unremitting demands of the patient" (p. 25). This makes it very difficult for clinicians to "accurately diagnose the individual's gender disorder"—as outlined in the first task of the MHP—and therefore the language of the *SOC* should acknowledge the lack of precision in making gender identity diagnoses and the need to rely on information presented by the client (Riley, personal communication, June 4, 2007).

Setting aside the issue of whether disturbances of gender identity are diagnosable mental illness does not allow us to set aside as easily the issue of other mental illnesses. Most gender-variant people do not have mental illnesses; however, transgender and transsexual people are not immune from having mental disorders (Lev, 2004). It would be irresponsible medically and clinically to not assess for comorbid mental health problems when recommending someone for medical treatments that will initiate extreme body modification. Some people requesting medical services for gender issues have undiagnosed or untreated mental illnesses and previous unresolved traumas, (Bockting, Knudson, & Goldberg, 2007; Hartmann, Becker, & Rueffer-Hesse, 1997). There is evidence that those people who regret having had sex reassignment procedures may suffer from more personality disorders and other emotional instabilities (Bodlund & Kullgren, 1996). There are also people who confuse issues of sexual orientation

and gender identity, as well as many people who are uneducated or misinformed about the goals, outcomes, or expectations of gender reassignment processes. Some clients, struggling with long-term gender identity concerns, may have concurrent substance-abuse problems or marital problems, whose life circumstances would be made far more complicated by beginning medical treatment without first addressing these other psychosocial issues (Lev, 2004). People with unresolved mental health issues and psychosocial instabilities are, in essence, not good candidates for medical and surgical treatment at the time they are seeking referral; they are neither eligible nor ready for medical treatments without first addressing these other concerns.

Medical and surgical treatments are permanently life altering, and in the absence of objective or laboratory testing, physicians are justifiably concerned that a person requesting services may not fully comprehend the treatments and later regret them. The first rule of medicine is to "do no harm," and, clearly, altering, hormonally or surgically, the body of a person who may be suffering from a mental disorder, may not be capable of understanding the consequences of his or her actions and may ultimately come to regret the decision would constitute "harm." Decision-making regarding harm in the area of trans-medicine is particularly value-laden, since the need for body modification for transsexuals has been poorly understood and culturally maligned. Indeed, resistance to and pathologization of gender-confirmation procedures has often been initiated by the medical and therapeutic communities (Meyer & Reter, 1979). If clinicians assume that gender dysphoria is a mental illness, or that it is caused by a mental illness, they may infer that harm would result from medical or surgical treatments. MHPs are placed in a very powerful position—gatekeeping access to treatment—ostensibly to protect clients, although the MHPs may be potentially causing more harm from withholding treatments then they would by providing a referral for reassignment

The focal point of the dilemma is whether transgender people have the right to actualize their bodies and are capable of the process of informed consent. According to Gross (2001) three criteria are necessary for informed consent: the client must understand the information presented, the consent must be given voluntarily, and the client must be competent to give consent. Gender-confirmation procedures are unique in that clients are generally *seeking* surgical treatments, so issues of consent are rarely the issue. The concerns in evaluating competence are more often regarding the client's ability to understand the information presented and whether they are competent to give consent. Hale (2007) identifies the ethical concerns of inhibiting clinical autonomy for those capable of informed consent (i.e., "legally competent adults"). It is easy to understand how it can feel patronizing to many educated and informed people, who are not suffering from mental illnesses or addiction and who have stable families and careers, to have to undergo a routine and often invasive psychosocial assessment. However, a clinical assessment can also serve to confirm the client's competence in giving their consent and their ability to understand the information presented. Additionally, the process of determining informed consent can assist in "promoting client autonomy and self-determination, minimizing the risk of exploitation and harm, fostering rational decision-making, and enhancing the therapeutic alliance" (Snyder & Barnett, 2006, p. 37). This process can be empowering and informative for the client, although certainly the fear of not being approved for the treatment one is desperately seeking can be emotionally challenging.

Given the historic control that medical and therapeutic establishment has had over transgender actualization (Denny, 1992), it has been assumed that most people *would not* be approved for transsexual medical treatments, due to the strict definitions for approval; hence the fury over the gatekeeper's power. However, as transgenderism becomes better understood culturally, and more providers view gender nonconformity through a nonpathologizing lens, it can be assumed that most people *would* be found to be mentally competent of informed decision-making. The assessment process would allow those with complex psychosocial issues to be more easily identified, and therefore to receive the treatments they need, including gender-related treatments, when they were eligible and ready. Disallowing access to medical treatments that permanently alter the body, for

those unable to give informed consent, may feel harsh or even cruel; it may appear paternalistic. Indeed, it raises valid ethical issues. However, it is also within the logical, respectable, and legal limits for physicians to refuse serious and life-altering medical treatment for a patient without a *physical* disorder or disease and who exhibits serious mental health problems or cognitive difficulties that might impact his or her ability to understand the treatment or consent to it. The inability to give consent may not be a permanent state; many people can become informed and develop competence over time—a process with which the MHP can assist the client.

So if physicians can ultimately decide whether or not to treat clients, why are they not the gatekeepers, which is what Hale (2007) recommends? Why the need for a MHP to assess the client before they even meet the medical expert? Simply put, most physicians generally do not have the skills or time to provide psychosocial assessment for gender identity concerns. Endocrinologists and surgeons have generally not had the training necessary to provide mental health assessment (including substance abuse and familial components) or therapeutic evaluations for gender dysphoria. To discern mental competence regarding gender identity issues can be a time-consuming process requiring substantial training in diverse issues of mental health assessment. Certainly, if physicians do have the training and time to complete their own assessments, there is no reason why they should not provide that service (Dahl, Felman, Goldberg, & Jaberi 2006).

The *SOC* have been criticized because people seeking treatment for gender identity issues are required to undergo evaluative processes that clients in other settings seeking similar services (i.e., hormones, plastic surgery) do not have to submit (Denny, Green, & Cole, 2007; Hale, 2007). However, gender issues are not the only area of medical treatments where physicians employ the use of skilled MHPs to assess clients undergoing emotionally difficult and voluntary medical treatments. (The use of the word *voluntary* here should not be construed to imply "cosmetic.") It is standard practice for physicians treating clients for infertility to require a psychosocial assessment before beginning treatment (Burns & Covington, 2000), including those who are donating eggs to assist others in having children (Lindheim, Frumovitz, &, Sauer, 1998). It is interesting to note, reproductive endocrinology is also a field involving hormone therapies and potential surgical procedures, as well as an emotionally challenging journey.

Psychosocial evaluations are also sought for bariatric, or weight-loss, surgeries (Pratt, Cummings, Vineberg, Graeme-Cook, & Kaplan, 2004), and preabortion counseling (Breitbart, 2000). This last area is especially salient for the discussion of gender dysphoria since criticism has been levied regarding "mandatory" counseling for women seeking abortions that is reminiscent of the criticism of the *SOC* requirement for mandatory psychological evaluations. Preabortion counseling has often meant counseling women *away from* having abortions, rather than developing supportive, nonjudgmental, advocacy-based practices that empower women to make choices and understand their medical options (Ely, 2007).

Along a similar vein, the psychological-assessment process as outlined in the *SOC* has often served to block treatment for transgender people. Utilizing "options-counseling," and "decision support" techniques borrowed from counseling women contemplating abortion (Baldé, Légaré, & Labrecque, 2006) or men considering vasectomy (Singer, 2004), the *SOC* can employ assessment processes that empower clients in decision-making. These techniques focus on nonjudgmental support, education, and nondirective advocacy, rather than leading the client towards a particular solution or guiding the clinician through diagnostic criteria. This is similar to the psychosocial-evaluation process that prospective adoptive parents complete (Crea, Barth, & Chintapalli, 2007).

Realistically not everyone is suited for sex reassignment procedures, which are considered irreversible. A thorough evaluation can assist those who are ambivalent, confused, or misinformed in avoiding medical procedures that they might later regret having undergone. Although research has shown that post-surgical regrets are rare (Lawrence, 2001; Pfäfflin & Junge, 1998), numerous researchers have

documented a small but consistent presence of regrets in some transsexuals (Blanchard, Steiner, Clemmensen, & Dickey, 1989; Landen, Walinder, Hambert, & Lundstrom, 1998). It is worth noting that the incidence of regrets might be low precisely because the system has been so rigid; a less rigid system might result in an increase in medical treatments that show a higher percentage of regrets. As transgender treatments become increasingly obtainable due to more accessible information, some post-operative people are expressing regrets (Olsson & Moller, 2006). Some people have taken their regrets to the judicial system; in particular they are questioning whether they received adequate assessment before being referred for medical treatments (Papadakis, 2003).

In one noteworthy situation a clinician, Dr. Russell Reid in the United Kingdom, was accused by fellow colleagues of not providing thorough evaluation before referring clients for medical treatment. The legal determination was based on Dr. Reid's lack of adherence to the guidelines set forth in the *SOC* (Batty, 2007). The SOC committee would be foolish to not take these litigious situations extremely seriously.

On one hand, trans-activists say the system is too rigid, keeping those out who should be in; on the other hand, the judicial system harshly judges those who do not take their gatekeeping duties seriously enough. Additionally, in a consumer-driven market, transsexual treatment is a commodity and gender dysphoric clients desiring treatment are vulnerable to physicians without adequate training who might bypass any assessment process.

So, the MHP is thrust into a complex situation, guarding the gate for the protection of a client who may resent being protected. Clients seeking medical services are compelled to pass through the gate as quickly as they can (or to bypass the gate altogether) and will go to extreme means to do so. It has been documented that clients are well aware of what to say in order to receive the treatments they require and that they often lie to the MHP, telling a predetermined story that they hope will provide the referral letter they desire (Denny & Roberts, 1997; Lewins, 1995; Stone, 1991; Walworth, 1997). This rote repetition becomes *the* transsexual narrative (Prosser, 1998) and interferes with the MHPs ability to assess for comorbid mental health issues, let alone determine whether or not the client has a "bona fide" gender identity issue. It also maintains the fallacy that gender-variance has limited expressions, reinforcing a rigid, diagnostic perspective. As Butler (2004) has pointed out, those seeking medical treatments often subscribe to pathological diagnoses for the sole purpose of receiving referral for treatment.

The current *SOC* states, "The establishment of a reliable trusting relationship with the patient is the first step toward successful work as a mental health professional. This is usually accomplished by competent nonjudgmental exploration of the gender issue with the patient during the initial diagnostic evaluation" (Meyer et al., 2001). As they currently exist, the *SOC* and the evaluative process interfere with the ability of MHPs to create a nonjudgmental therapeutic environment and an authentic helping relationship. As Speer (2006) says, "the interaction reflects, constitutes and reconstitutes . . . a certain kind of institution or social structure" (p. 806), literally recreating itself over and over again, since the established transsexual narrative remains the only story to be told, and each repetitive story-telling reinforces it as the only narrative. The very structure itself interferes with the ability to develop authentic therapeutic relationships and creates an "adversarial encounter" between client and therapist (Newman, 2000, p. 399). The discussion that follows below is an attempt to recognize this conundrum and honestly and respectfully addresses it.

Schaefer, Wheeler, and Futterweit (1995) say that "[t]he knowledgeable and empathic psychotherapist should become a partner in the therapeutic alliance" (p. 2032). In order for this to happen, the conceptualization of the gatekeeper role needs to be expanded. The term *gatekeeper* was first used by the brilliant social psychologist and systems thinker Kurt Lewin (1947) to describe the way mothers decide which foods end up on the family's dinner table. Note the issue is not simply what foods do *not* end up the table, but what is actually shopped for, cooked, presented to, and imbibed by the family. A gatekeeper, in addition to being someone who keeps out those who are not appropriate for treatment, must also

be someone who advocates for and supports processes and procedures that efficiently move people through the health system so they receive the treatments they need. Like triage ("sorting") in emergency medicine, many people seeking medical treatments for their gender dysphoria need to simply be evaluated and referred on to the next level of care.

People seeking services for gender-related issues fall into three broad categories: clients who are struggling with gender-dysphoric feelings; clients who are expressing gender variance and seeking letters of referral for medical treatment; and clients who present with family-related issues" (Lev, 2004). These three categories of people need and deserve different levels of treatment, and the SOC can provide distinct guidelines to ensure that people receive individualized assessment and treatment.

1. Clients seeking medical and surgical treatments for unremitting gender dysphoria who are ready, eligible, and mentally stable should receive prompt and attentive evaluation and referral with the goal of alleviating their dysphoria and providing them with medical services as quickly as is reasonably possible.
2. Clients struggling with gender dysphoria who are confused, ambivalent, mentally ill, addicted, or intellectually or cognitively impaired, should be very carefully evaluated before they are referred for medical treatments that they may be unable to consent to or fully understand and therefore may come to regret. These clients must be offered supportive ongoing therapeutic assistance, with clearly stated guidelines of how treatment will impact a referral for medical treatments.
3. Clients who have family responsibilities and loyalties that are unresolved and problematic and interfere with their capacity for decision-making must be offered appropriate referral and/or treatment for family therapy and legal advice about how their medical decisions can impact child custody, employment, and other life cycle–related issues. Medical treatments must be weighed carefully with the larger needs of the family and the clients' understanding of the potential consequences.

The educated and informed transgender or transsexual client who is not suffering from mental illness or addiction, and is relatively stable socially and vocationally, and who has the support of loved ones, should be able to undergo a psychosocial assessment and referral process within a few sessions, typically between two and six hour-long appointments. Anderson (1997) recommends that evaluations be conducted by a different clinician than the one who is providing ongoing psychotherapy, which might help alleviate some of the tension between client and therapist; this is a workable system as long as there remains communication between the clinicians.

Although clients can, of course, always still rely on deceitful "transsexual narratives" to replace their actual experiences, there is little that will necessarily surface in more sessions to ensure veracity on the part of the client. If the clinician is seen as supportive and without an agenda then the client is far more likely to be receptive to the clinical process. From a therapeutic perspective the tension itself can be fodder for in-depth exploration. The dialectic between wanting to move forward with transition and the fear associated with doing so exists in various ways within many clients seeking treatment. When clients trust their therapist, their internal dialogue can become externalized; the therapist can "hold" both perspectives, transition AND caution, thus allowing the client to move forward hesitantly and then retreat while they explore possible futures. Indeed, when clients see the gatekeeper as a welcoming door "man," a greeter if you will—someone who opens the door to welcome those seeking entrance —they are more likely to reveal themselves, and be open to advice, suggestions, and discerning feedback, as well as share their fears and resistances and engage in a thoughtful dialogic process, which is the essence of all good therapy.

Nonetheless, the criticism that trans-activists have voiced about the SOC being tedious, expensive, and creating strained relationships between clinician and client have much validity. Hale (2007) suggests that the mental health evaluation

interferes with gender-variant people's right to autonomous decision making, and that the evaluation essentially infantilizes them. The extant process *is* unnecessarily paternalistic. Clients who are eligible for treatments should undergo an efficient assessment process and referral for treatments in a timely manner. (Of course, there is little about any aspects of the current health systems in general that is either "efficient" or "timely," but certainly much in trans-health care can be streamlined.) Gatekeepers must develop an open door policy that is welcoming, offering support, advocacy, education, referral, and guidance.

However, many clients reaching out for services are *not* educated and informed consumers, ready to begin medical treatments. Some are suffering from severe gender dysphoria and are emotionally distraught and in tremendous psychological pain. They come into treatment seeking "diagnosis" and "help," and often the gender issues are only a piece of their presentation, albeit a key piece. These clients are in need of ongoing therapeutic care. The *SOC* currently focuses on the physician referral process and does not provide the MHP with substantial guidance in the treatment of complex clinical cases in which gender identity disturbances are paramount.

Some clients with gender issues also struggle with cognitive deficits, pervasive developmental disorders (PDD) and/or chronic and persistent mental illnesses (Lev, 2004; Hartmann, Becker, & Rueffer-Hesse, 1997; Parkes, 2006; Robinow & Knudson, 2005, as cited in Bockting, Knudson, & Goldberg, 2007) that manifest in limitations that may interfere with the clients' ability to make informed decisions about their medical treatment. This group of people need more than referrals or even good psychotherapy; they *do* need to be protected from making decisions that they may not be able to handle, that will negatively impact their quality of life. That is the reason many adults in these situations live with parents, in group homes, or in supervised housing. They may indeed have gender dysphoria, but they may not have the cognitive ability to fully understand the implications of the medical treatments. This population requires extensive evaluation and psychosocial support, and if medical treatments are recommended, they will likely require ongoing support and advocacy to manage the social impact of any gender confirmation procedures.

Additionally, some clients who struggle with persistent and chronic mental illness, trauma-related symptomatology, debilitating physical illness (e.g., AIDS, cancer), and/or addictions, may also struggle with homelessness, poverty, and other psychosocial problems and may not have the financial means to access medical treatments. Furthermore, many clients purposely reject or sidestep the standard treatment protocols for financial, cultural, or political reasons. Lacking health insurance or knowledgeable providers within geographical reach, many gender-variant people receive their hormones and medical treatments through alternative means (legally and illegally) on the streets or from the Internet (Grimaldi & Jacobs, 1998; Lombardi, 2001; Lombardi & van Servellan, 2000).

Despite not having been assessed using established protocols, gender-variant people in these circumstances will likely continue taking hormones. Providing a harm-reduction approach to medical treatment can reduce potential negative consequences and ensures medically monitored hormonal treatments. Harm reduction can diminish hazardous practices ("pumping" silicone and needle sharing) by providing access to medical treatments. Community-based programs can serve as frontline support for many clients in offering overall health services to people who experience multiple barriers to treatment. Additionally, opening the door for marginalized groups can provide a "bridge" to general medicine helping them access all kinds of care and social supports (Feldman & Goldberg, 2007; Goldberg, 2007). This is an opportunity for providers of care to serve as advocates for those most truly in need.

Surely, the majority of clients seeking medical treatments are not mentally ill or cognitively impaired; the majority of people seeking treatment are mentally stable and cognitively astute regarding their gender issues and treatment needs. Indeed, for some people their refusal to access standardized protocols derives from sophisticated philosophical, moral, and ethical critiques of the *SOC* highlighting their intellectual

TABLE 1. Recommendations Regarding Gatekeeping, Diagnoses, and Harm Reduction

No.	Recommendation
1.	The section on the MHP should be introduced with a discussion about the role of "gatekeeping" that reframes the role of the Gender Specialist as someone who is, not merely a sentinel guarding the gate, but also a skilled professional who can advocate, mediate, broker, and support persons seeking medical treatments by providing timely assessments and efficiently moving people through the health system so they receive the treatments they need.
2.	Remove the necessity to diagnose utilizing the DSM. It is possible to provide thorough and accurate psychosocial assessment for people seeking referral to physicians without utilizing the DSM or ICD. Referral for medical services should not rely on meeting the diagnostic criteria of GID but should rely on broader psychosocial evaluative procedures that can include utilizing diagnostic manuals as one of many tools and skills available to Gender Specialists.
3.	Different levels of care are needed for those who are seeking medical treatments and those who are seeking psychological services. The distinctions between psychosocial evaluation and ongoing psychotherapy needs to be made clearer, providing ways for clients who are seeking referral to physicians and who are assessed as capable of informed consent to move through that process with relative ease.
4.	The *SOC* currently focuses on the physician-referral process and does not provide the Gender Specialist/psychotherapist with substantial guidance in the treatment of complex clinical cases in which gender identity disturbances are paramount. The section on psychotherapy needs to be expanded to discuss issues related to assessment, treatment, and comorbid mental health issues.
5.	Harm-reduction approaches should be developed to assist marginalized populations in gaining access to trans-specific and general medical needs, regardless of whether they have been previously assessed using the *SOC*.
6.	Standard medical practice for prescribing physicians or for those performing surgery should include a signed informed consent and waiver of responsibility. This protects the physician/surgeon, and deflects the boomerang of litigation from the referring MHP. This should be outlined in the section pertaining to the provision of medical and surgical treatment.

and cognitive competence. The SOC must address the needs of diverse populations if they are to be effective.

All clients desiring medical treatments for gender-related issues should be required to sign legal documents, acknowledging their ability to understand the procedures requested and their irreversibility. It is simply good medical practice to have patients sign informed consent and waiver of responsibility paperwork (Albany Law Review, 2001; Karasic, 2000).

The revised *SOC* can expand the gatekeeper role, from one that restrains referral processes to one that can more efficiently provide referral and advocacy for those who are eligible and ready for medical services (see Table 1 for recommendations). It is essential that WPATH address the concerns of trans-activists for a more efficient, respectful, and less-expensive process, and this can be accomplished without compromising the need for a more thorough assessment and/or treatment for those who may need it.

LANGUAGE CONCERNS

This section outlines some suggestions for language changes in the *SOC*.

The term *patient* is a word commonly used in the medical field, whereas the term *client* (or sometimes *consumer*) is more commonly used by those providing psychosocial evaluation and psychotherapy. As identified above, the process of providing mental health evaluations is only partially based in standard medical model diagnoses and can also include other psychological assessment tools and corroborative information from family. Therefore it is suggested that the language of the *SOC* in the section on MHPs use the word "assessment" to replace the word diagnosis (except when referring to actual diagnostic processes), and the word "client" to replace the word patient. The word "patient" can certainly continue to be used in the sections on medical and surgical treatments. It is also suggested that the term "management of GID" be removed. If trans-medicine is to be based on a collaborative client-centered approach, clinicians should not have to "manage" their clients.

The *SOC* states that "professional involvement with patients with gender identity disorders involves any of the following: diagnostic assessment, psychotherapy, real-life experience, hormone therapy, and surgical therapy" (p. 8), which is clearly a five-part process. It is unclear

how this five-part process becomes reduced to a three part "triadic" process, but the net result is excluding two of the three tasks that MHPs are expected to perform: diagnostic assessment and psychotherapy.

Triadic therapy, which is defined in the *SOC* as "a real-life experience in the desired role, hormones of the desired gender, and surgery to change the genitalia and other sex characteristics" (p. 8) are all treatments that *follow* the psychosocial evaluation completed by the MHP. Eligibility and readiness under the current *SOC* differs for hormones, chest or breast surgery, and genital surgeries (see Bockting, Knudson, & Goldberg, 2007), and all are dependent on the real-life experience (RLE). Although the monitoring of the RLE is not listed in the Ten Tasks of the MHP, it is later stated that the MHP is expected to supervise this process (p. 13, p. 25).

The theory of triadic therapy that holds the RLE as one of its focal points assumes that complete transsexual transition is the foundation of transgender medicine, ignoring the spectrum of gender expressions currently available. There are numerous questions about the usefulness of the RLE—both Levine (in press) and Lawrence (2001) have identified potential problems with the RLE as a determination of eligibility, readiness, and/or future success in the gender of choice—especially since there appears to be no evidence to show its efficacy. Some people struggling with gender dysphoria seek the assistance of helping professionals yet do not engage in any part of the triadic therapy, and others choose medical treatments but do not desire to live full-time. The language "triadic therapy" ignores major aspects of the MHP role in gender therapy, creating and reinforcing a view that the MHP is adjunctive to the medical procedures, which are the "real" treatments. The role of the MHP in the RLE is unclear regarding the one aspect of the triadic therapy that they are expected to provide.

The language usage in the *SOC* is confusing in parts, which is perhaps simply the result of having a large committee write the document collectively. For example, "specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders" (p. 12) sounds like one needs to be trained and competent in assessing the DSM and ICD manuals themselves, a lofty goal for sure, but outside of the scope of the SOC. The SOC committee needs to clarify the language used throughout the document and ensure that there are quality *clinical* editors reviewing the document before publication (see Table 2 for recommendations).

The term "gender identity disorders" must be examined, especially in light of the new name for WPATH and the controversies referred to previously regarding the validity of GID as a useful diagnostic category. Except when referring directly to the DSM diagnostic criteria, the term "gender identity disorder" should be replaced with "gender dysphoria" when referring to the emotional or psychological pain caused by gender dissonance; the terms "gender issues" and "gender concerns" could also be used to describe clients' presenting problems. The contemporary language of "gender-variant," "gender nonconforming," "transgender," and "transgender health" should be used when referring to more general issues of gender expression. The term "transsexual" should be used when specifically addressing people seeking full and complete gender transitions. This would reflect the profession's movement away from pathologizing terminology.

Lastly, and foreshadowing the next section, the term "mental health professional" is a complex and cumbersome title, which is vague and not easily operationalized. The term does not identify the specific and specialized tasks that the *SOC* address. It might be beneficial to develop a specific designation for the unique role clinicians play in treating those with gender identity concerns. Israel and Tarver (1997) have suggested the use of the word "gender specialist," a word conveying the unique identity and skills for those of us who specialize in working with gender-variant clients. It is suggested the words "mental health professional," "clinical behavioral scientist," and "psychotherapist" be replaced with the term "gender specialist" and this term must be clearly defined in the revised *SOC*.

TABLE 2. Recommendations Regarding the Specificity of Language

No.	Recommendation
7.	The term "patient" should be replaced with the word "client" in the section(s) pertaining to the work of mental health professionals and psychotherapists. (Physicians can, of course, retain the word "patient" in the sections on medical and surgical treatments). The term "management of gender identity disorders" should be discontinued.
8.	The term "diagnose" should be replaced with the term "assess," allowing clinicians to utilize the DSM and ICD if they find diagnostic manuals useful, but also fostering a more inclusive psychosocial assessment process, utilizing other psychological evaluative tools and family corroboration.
9.	The current use of the term "triadic therapy" should be discontinued since so many clients do not actually utilize all (or any) of these three elements, rendering the term obsolete. Additionally, "triadic process," excludes two of the three tasks that MHPs are expected to perform: diagnostic assessment and psychotherapy. If the term triadic therapy is maintained, one aspect of the triad should include "clinical assessment and ongoing therapeutic support" (in addition to hormones and surgery).
10.	The term "real-life experience" (the third element that the MHP should be addressing) should be removed from the SOC as an outdated term that does not acknowledge the diversity of solutions people find to resolve their gender dysphoria, or the variable time-frames available for "full-time" living. Alternative ways of determining eligibility and readiness should be explored.
11.	The words, "specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders)," should be replaced with "competent in utilizing the DSM and ICD for diagnostic purposes." The current language infers that the DSM is being assessed, not the client.
12.	The term "gender identity disorders" should be avoided, except when referring directly to the DSM diagnostic criteria, and replaced by the words "gender dysphoria," "gender issues," or "gender concerns," when that is accurate. The contemporary language of "gender-variant," "gender nonconforming," "transgender," "transsexual," and "transgender health" should be adopted which would reflect the profession's movement away from pathologizing terminology.
13.	It is suggested that the words "mental health professional," "clinical behavioral scientist," and "psychotherapist" be replaced with the term "gender specialist" and that this term be clearly defined in the revised *SOC*. The section "Mental Health Professional" (Section IV) should be renamed "The Gender Specialist."

DEFINITION AND QUALIFICATIONS OF THE MENTAL HEALTH PROFESSIONAL: "THE GENDER SPECIALIST"

The term "mental health professional," which is used throughout the document, is not adequately defined, nor does it describe who precisely qualifies for this title. MHP is an ambiguous term, and it must be assumed it is purposely vague in order to not alienate those in the therapeutic allied professions and to avoid creating a hierarchy of qualified professionals. As an international community, it must also be recognized that mental health care is managed in diverse ways from one country to the next, university degrees are conferred utilizing different academic standards, and national and state-wide credentialing processes vary widely from one locale to another.

The current *SOC* outlines the qualifications for an adult specialist and a child specialist. It says, "Clinical training may occur within any formally credentialing discipline—for example, psychology, psychiatry, social work, counseling, or nursing." This statement establishes a general broad categorization. The *SOC* later clarifies that the professional must have

> [a] master's degree or its equivalent in a clinical behavioral science field. This or a more advanced degree should be granted by an institution accredited by a recognized national or regional accrediting board. The mental health professional should have documented credentials from a proper training facility and a licensing board. (p. 12)

The problem stems from the fact that different academic programs accredit different learning experiences, and different countries, states, and provinces have different time requirements for clinical supervision. Conceivably, two MHPs

graduating from two different universities in two different locations, both with master's degrees, may have widely different numbers of supervised hours, continuing educational credits, and actual clinical experience, not to mention completely different clinical training. For example, in the United Kingdom, referrals for sex reassignment procedures utilizing the National Health Services would generally be made by a psychiatrist or psychologist with significant specific medical training (Whittle, 2007); in the United States, the same referral can be made by a psychotherapist in private practice, with a master's degree in any number of fields (e.g., social work, counseling) and a clinical license but no specialized background in medicine.

A master's level psychologist who has studied behavioral research or experimental psychology has a somewhat different skill set than one who has studied community mental health or educational psychology, although they may have the same university degree and even the same clinical credentials. The training of a psychiatric nurse practitioner is vastly different from a licensed professional counselor (LPC) or a marriage and family therapist (MFT). PsyD- and PhD-level professionals both have advanced degrees and licensure, but different levels of education regarding clinical and research experiences; many MEds also practice psychotherapy, as do specialists in art and music therapy, with diverse academic degrees and vastly different clinical perspectives.

Additionally, the terms "psychotherapy" and "psychotherapist" are used throughout the *SOC*, and psychotherapy is one of the tasks that MHP are expected to perform. It is not clear in the *SOC* if all MHP *are* considered psychotherapists, or if those who provide psychotherapy have some specific expertise. As suggested in Recommendation No. 3 (see Table 1), there are benefits to distinguishing between psychosocial-assessment processes and psychological *treatment.* Psychotherapeutic treatment modalities can include diverse skill-sets, and clearly psychoanalytic psychotherapists will utilize different therapies with their transgender clients than marriage and family therapists or feminist and narrative post-modern clinicians. Given that few clinicians have had extensive training in gender-related issues, the lack of clarity of language and expectations in this section leaves gender nonconforming clients at the mercy of treatment modalities and psychotherapists whose goal may be to eliminate gender dysphoria through reparative therapies.

The fourth revision of the *SOC* specified that mental health professionals needed to demonstrate "specialized competence in sex therapy and theory as indicated by documentable training and supervised clinical experience in sex therapy" (Walker, 1979), a provision that has been removed presumably since so many evaluators did not have this "specialized competence." (The fourth revision addressed many issues in-depth regarding the role of the MHP that were removed in later versions.)

The terms "mental health provider" and "clinical behavioral scientist" which is used extensively in the current *SOC* are specialized titles, not commonly used to describe social workers or psychotherapists. It is unclear whether the *SOC* is referring to "*qualified* mental health providers [QMHP]," which describes those with advanced degrees capable of receiving insurance reimbursements in the United States, surely a salient issue for countries without national health care programs. According to a survey of U.S. state boards, MHPs can include the specialties of Doctor of Osteopathy (DO) and Certified Alcohol and Substance Abuse Counselors (CASAC). A DO generally has little training in mental health evaluation, although they do have an advance degree; a CASAC may have extensive training in clinical evaluation, although not have the requisite master's degree. It is unclear if the MHP is expected to have an advanced degree, *and* a license (this will vary across professions), and if an academic degree is considered a "training facility," although many academic degrees do not require clinical internships.

The impact of the weakness of the current language is evidenced in the controversy over Michael Bailey's book, *The Man Who Would Be Queen*. One of the allegations levied at Bailey is that he was practicing psychology without a license by writing referral letters to surgeons for transsexual women seeking treatment (Dreger, 2008). He was reported to the Illinois state licensing board, since as a PhD

academic he was technically not a clinician and, therefore, not trained to evaluate clients for medical treatments. Dreger places the onus on the surgeon as to whether she or he accepts the letter and bypasses the issue of whether this was within Bailey's skill-set to offer; however, few surgeons will question the qualifications of a letter written and signed by a "doctor." Some may argue that indeed a transgender person living full time s*hould* be able to simply get a referral letter from a well-established friend with an academic degree. However, it is doubtful that this was the intent of the current *SOC*, and the credentialing *standards* should be explicit as to "who" *can* write letters, precisely to avoid the kind of legal conundrum that Bailey could have (perhaps *should* have) faced. The fourth version of the *SOC* explicitly stated, "Possession of an academic degree in a behavioral science does not necessarily attest to the possession of sufficient training or competence to conduct psychotherapy, psychologic counseling, nor diagnosis of gender identity problems" (Walker, et al., 1979), but this statement was removed during later revisions.

Given the variations in training and licensing, and the broad scope of the mental health professional's skills, qualifications, and affiliations, it is essential for the *SOC* to specifically define what a "mental health professional" is and exactly who is qualified and has the necessary training to provide services, including evaluation, assessment, referral, and psychotherapy, for the purposes of evaluation of gender dysphorias.

The subsection on the Adult-Specialist outlines the requirements for "basic general clinical competence in diagnosis and treatment of mental or emotional disorders" (p. 12) and then lists four "recommended minimal credentials for special competence with the gender identity disorders" (p. 12). The first competency, as discussed previously, is simply too broad and needs to be carefully operationalized to be useful. Its ambiguity is mirrored in the other three competencies that follow:

> 2. Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders).
> 3. Documented supervised training and competence in psychotherapy.
> 4. Continuing education in the treatment of gender identity disorders, which may include attendance at professional meetings, workshops, or seminars or participating in research related to gender identity issues. (p. 12)

These three competencies use the terms "specialized training," "documented supervision," and "continuing education," although it is not clear exactly what specialized training is, how it should be documented, or where exactly a person should receive continuing education. The *SOC* requires that MHPs be trained in the "Sexual Disorders" section of the DSM-IV. However, in-depth sexuality education is uncommon in most social work, psychology, nursing, or medical programs, and there are few specific training centers, university departments, or clinical training programs that offer specialized courses in transgender clinical treatment. To require "specialized training and competence" is logical, and even necessary, but in fact, such training is not currently easily available, especially given the increasing need for services. Exactly where do MHPs go to receive their specialized training?

Assuming that training were available, the *SOC* request that this be "documented," although it is not clear who is doing the documentation and for whom it is being kept. Since there are no licensure or credentialing processes for MHP who specialize in gender identity issues, how can WPATH judge if someone has received the necessary training? Many current "experts" in this field would have difficulty outlining how they received gender-specific education and might not be able to document the academic institutions or training centers where they studied.

This highlights the ambiguous relationship between WPATH and the *SOC*; currently it seems that WPATH produces the *SOC*, but does not monitor them, publicize them, or in any way ensure that clinicians follow these guidelines. At the time of this writing there were 64 members of WPATH who identified themselves as social workers, 130 who identified themselves as having a specialty in psychology, and 11 who

are nurses (T. L. Tieso, personal communication, August 11 2007). This figure must represent only a small number of those who specialize in transgender health. It is not known how many of those who are members of WPATH even adhere to the standards. Why are not more clinicians who specialize in gender issues members of WPATH? Part of providing SOC also requires that they are publicized (not just published) so they become utilized by training programs and institutions.

Additionally, to have SOC that are not institutionally monitored begs the question of why they exist and whom they serve. If WPATH continues to establish guidelines for care, the organization must also create some way to monitor adherence to the guidelines. Although, it may be beyond the scope of the current organizational possibilities of WPATH, serious consideration should be placed on the development of a credentialing program to ensure that there is are *standard* educational and licensing expectations for gender therapists (see Table 3). Since the purpose of the SOC rests on proper evaluation of gender dysphoria and those who serve the gender community are perceived to have a unique skillset, it is essential to clarify exactly "who" is competent to provide these services, what training and experience they need to have, and how and with whom expertise is documented. Finally, if WPATH expects gender specialists to have training, supervision, and continuing education, the organization needs to consider providing it, or at least serving as a contact point for other training institutions that do provide the training.

The field of addictionology and chemical dependency treatment in the United States has increased professional standards in the past few decades, developing credentialing programs (that vary from country to country and state to state) and providing academic and clinical training opportunities. Practitioners are awarded a certificate upon completion of training and a credential to practice and are required to complete continuing education units to maintain their credential. This provides relative uniformity of knowledge within the discipline, although it also provides for great freedom in actual practice techniques and treatment procedures. It elevates the field of practice so that expert status is conferred on those who have received training, yet does not disallow anyone else from providing the services (i.e., many psychologists and social workers provide addiction-specific services without holding chemical-dependency credentials).

The development of trans-health and transmedicine as a field of specialty requiring nonpathologizing gender-specific training allows the WPATH to be a world leader in establishing guidelines for practice. Therefore the SOC committee should establish a credentialing process for gender specialists, whereby professionals can document their academic degree, clinical supervision hours, and continuing education units and receive a credential that reflects their expert status. Provisions should be made to "grandparent" those who have been in long-term clinical practice specializing in gender issues. This might include some kind of "testing" process, which could be completed online or through an interview with an established professional (which could be conducted on the phone), to establish basic levels of competence. Additionally, continuing educational credits could be offered through the WPATH newsletter and post-test questions be mailed-in to WPATH.

Additionally, WPATH should develop a comprehensive resource area on their Web site, a clearinghouse, where academic institutions and clinical-training associations could announce their gender-specific training programs. Online training opportunities, peer supervision, as well as conferences, could be listed as potential resources for those seeking credentialing. Eventually, an "approval" or "sponsorship" procedure could be developed, whereby educators would apply to have their trainings authorized by WPATH. Please note that these last two recommendations could also be potentially revenue-producing opportunities for WPATH.

WPATH may not be in a position currently to take on a task of this nature, financially or organizationally. However, the whole section of the *SOC* regarding licensing, documentation, and professional expertise rests on having some way to ensure that those providing the services have been approved by a credentialing body. WPATH

TABLE 3. Recommendations Regarding the Training and Credentialing of Gender Specialists

No.	Recommendations
14.	Before the tasks of the gender specialist are listed, the *SOC* should outline specifically the requirements for gender specialists. Below are some suggestions for how this section might look:
	A. Gender specialists should have at least a master's degree, or its equivalent, from an established academic program that can grant a PhD, a PsyD, an MS, or an MA in psychology or an MEd, RN, etc. (Each professional field of study should be examined with all accepted degrees, or their international equivalents, explicitly included.)
	B. Gender Specialists should have received and be able to document *x* number of supervised clinical hours in general psychotherapy or family therapy. (A review of other credentialing associations and training programs, as well as surveying established WPATH members, would assist the SOC committee in a reasonable number of hours.)
	C. Gender Specialists should have received and be able to document specific training in gender identity, gender dysphorias, sexual identity, gender role development and sexual problems, including knowledge of diagnosis of gender identity disorders as they are currently explained in the DSM and the ICD.
	D. Gender Specialists should be knowledgeable about sociopolitical, legal, and activist issues currently being raised within the transgender, intersex, and transsexual communities.
	E. Gender Specialists should be knowledgeable about family-related concerns for gender-variant people and the needs of family members, as well as the normative stresses involved in living with gender dysphoria, especially during the process of transition.
	F. Gender Specialists should be able to recognize, diagnose, and treat comorbid mental health issues, including addictions, and distinguish them from the identity concerns of gender-variant people.
	G. Interns and those who are just beginning to work with gender-variant clients should be under the supervision of a trained Gender Specialist.
	H. Gender Specialists should adhere to these SOC and follow the ethical guidelines established by WPATH.
15.	The SOC committee should establish a credentialing process for Gender Specialists, through which they document their academic degree, clinical supervision hours, and continuing education units and receive a credential that reflects their expert status. Provisions should be made to "grandparent" those who have been in long-term clinical practice specializing in gender issues.
16.	WPATH should develop a comprehensive resource area on their Web site, a clearinghouse, where academic institutions and clinical training associations could announce their gender-specific training programs. Online training opportunities, peer supervision, as well as conferences, could be listed as potential resources for those seeking credentialing. Eventually, an "approval" or "sponsorship" procedure could be developed, whereby educators would apply to have their trainings authorized by WPATH.

is the only international organization positioned to take on this role.

ORGANIZATION AND CONTENT DILEMMAS

The gender specialist has numerous tasks when working with clients seeking assistance for gender dysphoria. Although ten specific tasks are listed in this section, therapeutic and clinical responsibilities are embedded in many other sections of the *SOC* that seem to fall within the domain of the MHP. For example, the section "Assessment and Treatment of Children and Adolescents" (Section V) discusses in great depth issues related to assessment and therapy, which are absent in the adult section. The section "The Real-life Experience (RLE)" (Section IX) relies extensively on the clinical assessment of a MHP, who is expected to monitor the success of social gender transition, and should be placed within this section "Psychotherapy with Adults."

The specific tasks are listed without any descriptive directions or definitions, and have not been significantly altered since they were first outlined in the fifth version of the *SOC* (Levine, et al., 1998). Some of the tasks are explained directly below the listing of the tasks (i.e., eligibility and readiness) and others appear in different sections (i.e., engagement in psychotherapy). Some tasks are the focal point of entire sections whereas other tasks are never referred to again in the document. For example, task number four, "to engage in psychotherapy," is the subject of Section VI, and yet task number nine,

TABLE 4. Recommendations Regarding the Organization and Tasks Outlined

No.	Recommendation
17.	All of the information related to the Roles, Tasks, and Responsibilities of the Gender Specialist (i.e., Mental Health Professional) should be located in one inclusive section that contains the descriptions for the Adult Specialist and the Child Specialist and should add a section for the Adolescent Specialist. The section on medical treatment of the child and adolescent should be separate from the psychological treatment, as it is with adults.
18.	Additionally, psychotherapy recommendations (for adults, children, youth, and families), and any suggestions involving the monitoring of transition (much of which is currently listed under Section IX ("The Real-Life Experience") should be included in this section (either in subsections or separate sections that directly follow this section).
19.	Sections not specifically related to the MHP's tasks should be moved into other or separate sections. This includes the subsection entitled "Options for Gender Adaptation" (currently listed in Section VI, "Psychotherapy with Adults"), which should be expanded (and potentially renamed) under a separate session preceding medical, hormonal, and surgical interventions. Eligibility and readiness criteria could be included in this section also.
20.	The Tasks of the Gender Specialist that are listed should be explained directly in the text of this section, following each description. Each task needs to be examined for its current usefulness and inclusion. Some tasks could be removed, some could be easily coupled, and still others could be further developed.
21.	Psychosocial assessment of gender issues should expand beyond a binary medical model. Developmental trajectories and narrative perspectives offer alternative lenses through which to examine gender identity and should be recognized within the *SOC* alongside the diagnostic criteria.
22.	There should be a separate section focusing on family issues that outlines tasks regarding spouses, partners, children of transgender parents, parents of transchildren, and extended family members.
23.	Trans-health care involves the entire life cycle of the client, not just their initial referral process. Gender specialists should be prepared to work with clients at many stages of the life cycle, including post-operatively and at all stages following their transition process, and this should be reflected in the *SOC*.
24.	Treatment-team collaboration can improve clinical care, but the responsibility of being a team player must rest equally on all the team members. MHP and physicians need to work together (for example, follow-up reports should be made by endocrinologists and surgeons). If it is necessary to document the MHP's role in the treatment team as one of the tasks, then the same expectations for physicians should also be noted in the medical section.

"to educate family members, employers, and institutions about gender identity disorders," is a stand-alone statement without any further guidance as to how exactly the MHP should provide this education. Larger issues involving family therapy during gender transition processes are not addressed at all. The tasks of the gender specialist should not be simply listed, but be explained directly in the text of the tasks section, following each item (see Table 4 for recommendations).

The ten tasks listed need to be examined for their usefulness; ten is a lovely number, but is there a reason for *ten* tasks? Some tasks seem redundant, for example, numbers 6 and 7 are "to make formal recommendations to medical and surgical colleagues" and "to document their patient's relevant history in a letter of recommendation" (p. 12); both are part of a standard psychosocial evaluative process. The majority of the tasks seem focused on referral issues, rather than guidelines for gender assessment or psychotherapy. Finally, task number 10 seems self-evident; why would a gender specialist not be available for follow-up, unless they had a personal problem or were no longer practicing?

There are a few additional areas that have not been addressed previously in the *SOC*, or have not been addressed in significant depth, and are essential tasks for the gender specialist (briefly outlined in this list). These concerns should be incorporated in the reorganization of the tasks.

1. A binary diagnostic model for transgender care is inadequate for the diverse gender expressions human beings exhibit. In recent years a number of gender specialists have suggested developmental models that show the maturational process of gender identity and expression through time, as well as narrative models that recognize the salience and uniqueness of the personal autobiography (i.e., Bockting & Coleman, 2007; Devor, 2004; Lev, 2004;

Rachlin, 1997; Vanderburgh, 2007). These developmental trajectories and narrative perspectives offer an alternative lens with which to examine gender identity and should be recognized within the *SOC* in addition to the medical model. This can be added to the subsection entitled "Options for Gender Adaptation" (currently listed under in Section VI, "Psychotherapy with Adults"), which can be expanded (and potentially renamed) in a separate section, preceding medical, hormonal, and surgical interventions, or preceding the section on the MHP. These alternative treatment perspectives are not limited to the work of the MHP and should be information available to all professionals utilizing the *SOC*.

2. Trans-health care involves the entire life cycle of a client, not just the initial referral process. Gender specialists should be prepared to work with clients at many stages in the process, including post-operatively (Schaefer, Wheeler, & Futterweit, 1995) and at all stages following the client's transition process (Vanderburgh, 2007). The *SOC* as they are currently written focus extensively on the referral process and the initiation of medical treatments.
3. The field of trans-health has ignored the importance of family in the lives of transgender people (Erhardt, 2007; Lev, 2004). Even contemporary attempts to address this do not pay adequate attention to the needs of families. For example, Bockting, Knudson, and Goldberg (2007) wrote an excellent overview of contemporary trans-health treatment, "Counseling and Mental Health Care of Transgender Adults and Loved Ones," and recognized the salience of families in their choice of a title, but the authors actually direct fewer than four paragraphs detailing how to work with family members in the nearly 50-page document. The current *SOC* states the need "to educate family members, employers, and institutions about gender identity disorders," but does not describe how this should be accomplished. Families undoubtedly need "education," but they surely need more than just education to adjust to a family member's gender dissonance and desire for gender congruence.

In order to support their loved one, family members themselves need support; sometimes the struggles of addressing gender variance in a family member can create stress-related illnesses or exacerbate other emotional problems. As important as it is to educate "employers and institutions," lumping those issues into the section on family issues is problematic. The skills in community psychology, organizational development, and educational training are vastly different than the skills needed to help a teenage boy manage the confusion and fury he may experience watching his father "become" a woman.

Adult clients will often seek therapy on their own, but many will come in to session with partners or spouses. All efforts should be made to see clients with their families and to provide adjunctive counseling for the entire system. If significant others are not included in the initial interview, attempts should be made to bring them into the clinical process. When agency protocols, personal style, or clinical training preclude family-systems work, referrals should be made to appropriate colleagues to work with the larger family system. When working with children and youth, it is often the parents who seek out counseling, and indeed they may sometimes seek out therapy for themselves before they seek treatment for their child. The needs of families with young gender nonconforming children and those of trans-youth are very different, clinically and medically. Separate protocols need to be developed for these populations (see de Vries and Cohen-Kettenis, 2009/this issue). When families are seeking support for children or youth, or when adults who are parents are seeking treatment for themselves, the family should be viewed as a system, and each member's needs should be addressed individually, as well as together as a family unit. Separating the adult section from the child section in the *SOC* muddies a holistic view of families coping with gender transitions.

4. Task number 8 in the current *SOC*, requires the gender specialist to be "a colleague on a team of professionals," which is an

admirable goal, but this task should also be listed clearly under the tasks for physicians. Unless the gender specialist is in the position of being a case manager, or a team leader of a gender team, the responsibility of being a team player must rest equally on all the players. Furthermore, it is suggested that the communication between gender specialists and physicians be a two-way street, including follow-up reports from endocrinologists and surgeons, as originally suggested by Israel and Tarver (1997). If this task is to be retained, it should be clarified what it means to be on a team, and what responsibilities each team member has. Maintaining ongoing clinical contact is necessary for the provision of coordinated and consistent clinical care. Treatment-team collaboration can improve clinical care, but this is not just the work of the gender specialist: it must be shared by all professionals working with an individual.

The Tasks of the Gender Specialist for Adults

Suggested revised "Tasks of the MHP/Gender Specialists for Adults" are listed below. This section should be followed directly by "The Tasks for Gender Specialists Working with Children and Adolescents." Both sections should be organized in similar ways, listing the specific tasks. These two sections should follow one another in a similar organizational pattern. **The words in italics are quoted from the extant *Standards of Care, Version 6.***

The Gender Specialist serves clients and their families in many ways: as an advocate, an educator, a diagnostician, a psychotherapist, and a family therapist, depending on the needs of the client. The tasks below are general guidelines to effectively serve people struggling with issues related to their gender.

1. Create a Supportive Environment and Determine Purpose of the Visit

The first, and most important, task for the Gender Specialist is to create a supportive and welcoming environment for clients seeking assistance for gender identity concerns, including gender dysphoria. This includes creating a nonjudgmental atmosphere in order to establish a reliable trusting relationship. Ideally, the clinician's work is with the whole of the person's complexity. Part of the initial interview should include the Gender Specialist sharing his or her background, training, expertise, and experience in working with clients with gender concerns. Issues regarding confidentiality, fees, and insurance reimbursement should also be established in the initial sessions.

The Gender Specialist should determine the purpose of the visit and clarify whether the client is seeking evaluation and referral for medical services or psychotherapeutic assistance to explore gender issues and potential resolution. Clients who are seeking an evaluation should be informed of the length of time the process will take, the cost involved, and assured that if there are any potential concerns that would delay referral for medical treatment, the client will be notified of this promptly. Clients who are seeking more in-depth psychotherapy should be apprised of the therapist's clinical background and theoretical approach to ensure compatibility.

2. Assessment of Gender Identity Concerns

The Gender Specialist must assess the client's gender concerns through a psychosocial evaluation process, including the history of gender identity issues, current feelings and experiences, exploration the client's self-definition (i.e., transsexual, genderqueer, etc.), discussion of previous attempts at resolution and adaptation, and reasons for currently seeking professional assistance. This process may include diagnosis utilizing the most current edition of the DSM or ICD, developmental trajectories, or may involve employing a broader understanding of the range of gender expressions available. The focus of the clinical interaction must be transpositive and affirming, not pathologizing.

The clinician's role is to assess for gender identity issues as precisely as possible with the current available information reported by the patient.

3. Assessment of Mental Stability

All clients need to be assessed for a range of mental health issues that can impact gender issues and/or transition, including substance abuse, depression, anxiety, cognitive impairments, psychotic disorders, personality disorders, and developmental or learning difficulties. This can include information from previous psychological treatment, general assessment by the Gender Specialist, or referral for more extensive exploration or testing with a Psychiatrist, Developmental Psychologist, or other professional. Additionally, the Gender Specialist will assess other issues in the client's environment, including familial relationships, work and career issues, and financial stability in order to evaluate additional psychosocial stressors.

The presence of psychiatric comorbidities does not necessarily preclude referral for *hormonal or surgical treatment, but some diagnoses pose difficult treatment dilemmas and may delay* or prevent medical treatments. Some issues, like active substance abuse, chronic and persistent mental illness, complex personality disorders, cognitive impairment, and developmental disabilities, may require treatment, stabilization, or ongoing monitoring concurrent with or preceding medical treatment for gender identity issues. In addition to treating the mental health or medical conditions, clients should be assessed for their ability to provide educated and informed consent.

The Gender Specialist's job is not to serve as a psychological detective seeking reasons to disqualify the client but, rather, to provide a general mental health assessment to rule out any serious comorbid psychiatric difficulties. The Gender Specialist's role is to determine if clients are "mentally, cognitively, and emotionally capable of making an informed decision that will permanently alter their bodies, and their social relationships" (Lev, 2004, p. 226). Additionally, if the Gender Specialist should determine that clients have "serious mental health problems that are likely to interfere with their ability to adjust to a life in a new gender, or with the process of transition" (p. 226), the Gender Specialist must ensure that this is being addressed clinically in order to assist the client in resolution of his or her gender issues.

4. Education Regarding Treatment Options and Advocating for Support

Clients seeking medical treatments as well as those seeking psychotherapeutic help are often misinformed, confused, and overwhelmed with their gender dysphoria and the therapeutic, medical, and social dilemmas they are facing. An important task of the Gender Therapist is to educate and inform clients of their treatment options (including nonmedical options), the range of adaptations available, the pros and cons of treatments, and the psychological, social, sexual, occupational, and financial implications of the transition and how these decisions may affect family members and their overall social environment. The Gender Specialist should be able to provide the client with reading material, information about support groups, and Internet resources, as well as assist the client in connecting with other treatment professionals (endocrinologists, electrologists, etc.). Exploration of sources of support should be part of the evaluation, including local and online support groups. Additionally, knowledge of procedures on name and gender change for legal documents would also be an important resource for clients.

5. Responsibility for Integrated Services for Family Members

Clients seeking services for gender-related issues invariably are part of larger family systems. They may have spouses or partners, significant others, parents and/or children, and siblings and extended relatives who are impacted by the client's

gender dysphoria as well as any life changes they make to resolve them. It is the responsibility of the Gender Specialist to assist the client in making thoughtful decisions about communicating with their family members, as well as to be available to family members or to make referrals to colleagues trained in family systems issues for education, ongoing support, clinical advice, and referral to other professionals as necessary. Reality-testing regarding potential job loss, child custody problems, and relationship separation is necessary to explore, especially for how it may impact those who are financially dependent on the transitioning person.

6. Determine Eligibility and Readiness for Referral to Medical Treatment

Eligibility is defined as meeting the basic requirements necessary to receive a particular service. To be eligible for a medical referral a client must have been assessed for gender identity issues; have been assessed and treated when necessary for any comorbid mental health issues; have been educated about the medical treatments requested and their associated risks; and be able to give informed consent to the procedures. A client who is eligible meets the basic qualifications for receiving medical treatment. Readiness implies that the person is psychologically prepared to cope with the effect of the medical treatments in terms of occupation, family responsibilities, finances, and social reactions. A client who is eligible and ready has consolidated a gender identity that will be supported by medical treatments, is mentally stable, and will be responsible regarding following medical advice (e.g., will take hormones in a responsible manner, will comply with post-surgical treatment recommendations).

7. Completion of Psychosocial Assessment

The Gender Specialist is expected to complete a psychosocial assessment that is defined as an "in-depth investigation of the psychosocial dynamics that affect the client and the client's environment . . . with particular focus on the environmental impact on the client and the resources available for responding to the problem" (Lum, 1992, p. 167). Lum suggests that in assessing ethnic-minority clients, it is important to identify positive cultural strengths in the client's ethnic background; indeed a psychosocial assessment should always highlight the client's strengths. A psychosocial evaluation includes: client identification, reason for evaluation, familial history, current living situation, work and educational background, thorough evaluation of gender issues, social supports, and psychosocial stressors, including eligibility and readiness. Hepworth & Larsen (1990) emphasize the need to explore (1) the nature of clients' problems, including special attention to developmental needs and stressors associated with life transitions that require major adaptations; (2) coping capacities of clients and significant others (usually family members), including strengths, skills, personality assets, limitations and deficiencies; (3) relevant systems involved in clients' problems and the nature of reciprocal transactions between clients and these systems; (4) resources that are available or are needed to remedy or ameliorate problems; and (5) clients' motivation to work on their problems (p. 193).

The basic outline for complete psychosocial assessment is available from the American Psychiatric Association and includes risk assessment, information from collateral sources, diagnostic tools, and working with a treatment team (APA, 2006). Coolhart, Provancher, Hager, and Wang (2008) developed an assessment tool to examine client readiness for medical treatments and outline the important areas to review in a psychological evaluation. A general outline for a psychosocial assessment should be included in the revised *SOC* (see Appendix).

8. Documentation Letter for Hormone Therapy or Surgery

A referral to initiate medical treatment for gender confirmation to alleviate gender

dysphoria or assist a client in gender congruity can be written to any physician who can provide services, including an endocrinologist, internist, family or general practitioner, surgeon, etc. A letter can be written for any client who is seeking medical treatment who does not exhibit any comorbid mental illness and/or has been treated for these conditions, and who has been educated and informed about treatment choices. Clients must be, to the best judgment of the Gender Specialist, capable of providing informed consent. The letter should follow the form of a general psychosocial assessment that would be used in any mental health setting, with an emphasis on the person's history of gender dysphoria. A shorter letter detailing the gender issues, eligibility, and readiness may be sent; however the psychosocial history should be maintained on file with the Gender Specialist. (The letter, which is essentially a medical referral, is not intended to be used as an "identity document" by clients. If clients request a letter from a therapist to acknowledge their chosen gender, in case they are stopped by the police, this should be a separate document, less psychological and more factual.) When working with a physician for the first time, a letter of introduction from the referring clinician stating their credentials and experience can help establish a working relationship.

9. Provision of Collaborative Services

The relationship between the referring Gender Specialist and the physicians or other professionals working with the same client should remain collaborative. The Gender Specialist should have clients sign a consent letter to release information from all other professionals with whom they are working, and clinical dialogue should take place as necessary. Open and consistent communication may be necessary for consultation, referral, and post-operative concerns. [This task should also be clearly stated in the section pertaining to physicians.]

10. Be Available to Educate or Train Employers, Schools, and Institutions

Many clients will have difficulties in jobs and professional settings, school and university settings, and various institutions as they actualize their gender and especially if they are transitioning or changing their gender presentation. Gender Specialists should be able to talk with human resources, personnel managers, employers, heads of schools, deans, and agency directors regarding gender identity issues and how to facilitate necessary changes in institutions regarding bathrooms, training of staff, and respectful treatment. Gender Specialists may also serve as expert witnesses in the judicial system. If a Gender Specialist is not comfortable educating and training, they should be able to refer to another qualified professional in the community.

Requirements for Referral Letters

In the current *SOC*, one letter is required from a MHP for hormones, and two for surgical procedures. The *SOC* states, "Because professionals working independently may not have the benefit of ongoing professional consultation on gender cases, two letters of recommendation are required prior to initiating genital surgery." It is the responsibility of the professional to ensure that they have all the professional support, supervision, and consultation necessary to make an informed decision for surgical referral. The onus of financial cost should rest with the professional, not the client forced to pay for the second consultation.

Additionally, the *SOC* states, "If the first letter is from a person with a master's degree, the second letter should be from a psychiatrist or a Ph.D. clinical psychologist, who can be expected to adequately evaluate co-morbid psychiatric conditions." The inference is that master's-level clinicians are not capable of adequately assessing psychiatric conditions. This is condescending and feeds into a clinical hierarchy that is unnecessary in an international, multidisciplinary organization. Many master's-level clinicians are

TABLE 5. Recommendation Regarding Letters of Referral

No.	Recommendation
25.	One letter each should be required for hormones and one letter should be required for surgery. If two letters for surgery are required, the letters should be acceptable if written by any MHP/Gender Specialist who is approved to write the first letter. If the surgeon has any further concerns, they can request an additional evaluation at that time.

qualified health professionals and experts in psychiatric disorders. Any gender specialist who is capable of assessing gender issues (especially if the guidelines are clearly delineated in the *SOC*), should be capable of writing referral letters and assessing comorbid mental health concerns (see Table 5).

CONCLUSION

In conclusion, it is important to remember, "Everyone has a right to their own gender expression; Everyone has a right to make informed and educated decisions about their own bodies and gender expressions; Everyone has the right to access medical, therapeutic, and technological services to gain the information and knowledge necessary to make informed and educated decisions about their own bodies and lives" (Lev, 2004, p. 185). It is the responsibility of the gender specialist to facilitate that process with as much ease as is possible when dealing with complex, expensive, and life-altering and irreversible medical procedures.

Gender specialists must remember that there is currently a dearth of scientific evidence backing up much of the current *SOC*. There is a great need for evidence-based research to determine the efficacy and effectiveness of the SOC, and until the guidelines are determined to be effective, they must be considered flexible guidelines. Steinbrook (2007) says, "Guidelines rely on both evidence and opinion; they are neither infallible nor a substitute for clinical judgment" (p. 332). This article recommends some ways to minimize the "gatekeeping" function of the MHP and also recognizes the unique professional skill-sets that gender specialists bring to this work serving the transgender community as compassionate advocates and skilled, professional caregivers.

REFERENCES

Albany Law Review. (2001). Health law standards of care for transsexualism. *Albany Law Review, 64*(3), 1067–1072.

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

American Psychiatric Association (APA). (2006). *Practice guideline for the psychiatric evaluation of adults* (2nd ed.). Washington, DC: American Psychiatric Association (APA).

Agency for Healthcare Research and Quality (AHRQ). (2007). *U.S. Department of Health and Human Services, National Guideline Clearing House.* Retrieved August 16, 2007, from http://www.guideline.gov/browse/guideline_index.aspx

Anderson, B. F. (1997). Ethical implications for psychotherapy. In G. Israel and E. Tarver (Eds.) *Transgender Care*. Philadelphia: Temple University Press.

Baldé, A., Légaré, F., Labrecque, F. (2006). Assessment of needs of men for decision support on male sterilization. *Patient Education and Counseling, 63*, 301–307.

Batty, D. (2007). Sex change doctor guilty of misconduct. (2002, May 25). *The Guardian*. Retrieved August 16, 2007, from http://www.guardian.co.uk/uk_news/story/0,3604,1126835,00.html

Blanchard, R., Steiner, B. W., Clemmensen, L. H., & Dickey, R. (1989). Prediction of regrets in postoperative transsexuals. *Canadian Journal of Psychiatry, 34*, 43–45.

Bockting. W. O. (2009) Are gender identity disorders mental disorders? Recommendations for revision of the World Professional Association for Transgender Health's *Standards of Care*. *International Journal of Transgenderism, 11*, 53–62.

Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In R. Ettner, S. Monstrey, & E. Evan (Eds.). *Handbook of Transgender Medicine and Surgery.* New York: Haworth Press.

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2007). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9*(3/4), 36–82.

Bodlund, O., & Kullgren, G. (1996). Transsexualism: General outcome and prognostic factors—A five-year follow-up study of nineteen transsexuals in the process of changing sex. *Archives of Sexual Behavior, 25*, 303–316.

Breitbart, V. (2000). Counseling for medical abortion. *American Journal of Obstetrics and Gynecology, 183*(2), 26–33.

Burns, C. (2004). Something rotten in the state of the profession. *Press for Change.* Retrieved August 16, 2007, from http://www.pfc.org.uk/pfclists/news-arc/2004q4/msg00069.htm

Burns, L. H., & Covington, S. N. (Eds.). (2000). *Infertility counseling: A comprehensive handbook for clinicians*. Nashville, TN: Parthenon Publishing.

Butler, J. (2004). *Undoing gender*. New York: Routledge.

Carroll, R. (1999). Outcomes of treatment for gender dysphoria. *Journal of Sex Education and Therapy, 24,* 128–136.

Coolhart, D., Provancher, N., Hager, A., & Wang, M. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies, 4*(3), 301–324.

Crea, T. M., Barth, R. P., & Chintapalli, L. K. (2007). Home study methods for evaluating prospective resource families: History, current challenges, and promising approaches. *Child Welfare Journal*, *86*(2), 141–159.

Dahl, M., Felman, J., Goldberg, L., & Jaberi, A. (2006). *Endocrine therapy for transgender adults in British Columbia: Suggested guidelines*. Vancouver, Canada: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and Canadian Rainbow Health Coalition.

Denny, D. (1992). The politics of diagnosis and a diagnosis of politics: The university-affiliated gender clinics, and how they failed to meet the needs of transsexual people. *Chrysalis: The Journal of Transgressive Gender Identities, 1*(3), 9–20.

Denny, D. (2004). Changing models of transsexualism. In U. Leli & J. Drescher (Eds.), *Transgender subjectivities: A clinician's guide* (pp. 25–40). Binghamton, NY: Haworth Medical Press.

Denny, D., Green, J., & Cole, S. (2007). Gender variability: Transsexuals, crossdressers, and others. In M. Tepper & A. Owens (Eds.), *Sexual health.* Portsmouth, NH: Greenwood Publishers.

Denny, D., & Roberts, J. (1997). Results of a questionnaire on the standards of care of the Harry Benjamin International Dysphoria Association. In. B. Bullough, V. L. Bullough, & J. Elias (Eds.), *Gender blending* (pp. 320–336). Amherst, NY: Prometheus Books.

Devor, A. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay and Lesbian Psychotherapy, 8*(1/2), 41–67.

De Vries, A. L. C, & Cohen-Kettenis, P. T. (2009/this issue). Review of World Professional Association for Transgender Health's *Standards of Care* for children and adolescents with gender identity disorder: A need for change? *International Journal of Transgenderism, 11*, 102–111.

Docter, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior.* New York: Plenum Press.

Dreger, A. D. (2008). The controversy surrounding *The Man Who Would Be Queen*: A case history of the politics of science, identity, and sex in the internet age. *Archives of Sexual Behavior, 37*, 366–421.

Ehrbar, R. D, Witty, M. C., Ehrbar, H. G., Bockting, W. O. (2008). Clinician judgment in the diagnosis of gender identity disorder in children. *Journal of Sex & Marital Therapy, 34*, 385–412.

Ely, G. E. (2007). The abortion counseling experience: A discussion of patient narratives and recommendations for best practices. *Best Practices in Mental Health, 3*(2), 62–74.

Erhardt, V. (2007). *Head over heels: Wives who stay with cross-dressers and transsexuals*. Binghamton, NY: Haworth Press.

Feldman, J. L., & Goldberg, J. (2007). Transgender primary medical care. *International Journal of Transgenderism, 9*(3/4), 3–34.

Fraser, L. (2009/this issue). Psychotherapy in the World Professional Association for Transgender Health's *Standards of Care*: Background and recommendations. *International Journal of Transgenderism, 11*, 112–128.

Goldberg, J. (2007). Training community-based clinicians in transgender care. *International Journal of Transgenderism, 9*(3/4), 219–231.

Green, J. (2004). *Becoming a visible nan*. Nashville, TN: Vanderbilt University Press.

Grimaldi, J., & Jacobs, J. (1998). The HIV hormone bridge: Connecting impoverished HIV+ transsexual sex workers to HIV medical care. *AIDSLine,* ICA12/98406957. Retrieved November 9, 2007, from http://www.aegis.com/aidsline/1998/dec/m98c1575.html

Gross, B. H. (2001). Informed consent. *Annals of the American Psychotherapy Association, 4*, 24.

Hale, J. C. (2007). Ethical problems with the mental health evaluation standards of care for adult gender variant prospective patients. *Perspectives in Biology and Medicine, 50*(4), 491–505.

Hartmann, U., Becker, H., & Rueffer-Hesse, C. (1997). Self and gender: Narcissistic pathology and personality factors in gender dysphoric patients—Preliminary results of a prospective study. *International Journal of Transgenderism, 1*(1). Retrieved August 16, 2007, from http://www.symposion.com/ijt/ijtc0103.htm

Hepworth, D. H., & Larsen, J. (1990). *Direct social work practice: Theory and skills.* Belmont, CA: Wadsworth.

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

Karasic, D. H. (2000). Progress in health care for transgendered people. *Journal of the Gay and Lesbian Medical Association, 4*(2), 157–158.

Karasic, D. H., & Drescher, J. (Eds.). (2006). *Sexual and gender diagnoses of the diagnostic and statistical manual (DSM): A reevaluation.* Binghamton, NY: Haworth Press.

Kinney, E. D. (2001). The brave new world of medical standards of care. *Journal of Law, Medicine, and Ethics, 29*, 323–334.

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

Lawrence, A. (2001, November). *SRS without a one year RLE: Still no regrets.* Paper presented at the XVII Harry Benjamin International Symposium on Gender Dysphoria, Galveston, Texas.

Lev, A. I. (2004). *Transgender emergence: Counseling gender-variant people and their families.* Binghamton, NY: Haworth Press.

Lev, A. I. (2005). Disordering gender identity: Gender identity disorder in the DSM-IV-TR. *The Journal of Psychology and Human Sexuality, 17*(3/4), 35–70.

Lev, A. I. (2006). Transgender communities: Developing identity through connection. In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 147–175) (2nd ed.). Washington, DC: American Psychological Association.

Levine, S. B., Brown, G., Coleman, E., Cohen-Kettenis, P., Hage, J., Van Maasdam, J., et al. (1998). *The standards of care for gender identity disorders—Fifth version.* Retrieved August 16, 2007, from http://www.tc.umn.edu/~colem001/hbigda/hstndrd.htm

Levine, S. B. (in press). Real life experience: Recommendations for revisions of the World Professional Association for Transgender Health's *Standards of Care*. *International Journal of Transgenderism.*

Lewins, F. (1995). *Transsexualism in society: A sociology of male-to-female transsexuals.* South Melbourne, Australia: MacMillian.

Lewin, K. (1947). Frontiers in group dynamics. *Human Relations, 1*(2), 5–41.

Lindheim, S. R., Frumovitz, M., & Sauer, M. V. (1998). Recruitment and screening policies and procedures used to establish a paid donor oocyte registry. *Human Reproduction, 13,* 2020–2024.

Lombardi, E. (2001). Enhancing transgender health care. *American Journal of Public Health, 91*(6), 869–872.

Lombardi, E. L., & van Servellan, G. (2000). Building culturally sensitive substance use prevention and treatment programs for transgendered populations. *Journal of Substance Abuse Treatment, 19*(3), 291–296.

Lum, D. (1992). Social work practice and people of color: A process-stage approach. Pacific Grove, CA: Brooks/Cole.

MacDonald, M. (1999). *A horse designed by committee: A highly personal view of the 1998 version of the Harry Benjamin International Gender Dysphoria Association's standards of care.* Retrieved August 16, 2007, from http://www.pfc.org.uk/node/638

Meyer, J. K., & Reter, D. (1979). Sex reassignment: Follow-up. *Archives of General Psychiatry, 36*(9), 1010–1015.

Meyer, W., Bockting, W., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., et al. (2001). The Harry Benjamin International Gender Dysphoria Association's standards of care for gender identity disorder—Sixth Version. *International Journal of Transgenderism, 5*(1). Retrieved December 8, 2008, from http://www.symposion.com/ijt/soc_2001/index.htm

Newman, L. K. (2000). Transgender issues. In J. Ussher (Ed.), *Women's health: Contemporary international perspectives* (pp. 394–404). Leicester: BPS Books.

Olsson, S. E., & Miller, A. (2006). Regret after sex reassignment surgery in a male-to-female transsexual. *Archives of Sexual Behavior, 35*, 501–506.

Papadakis, M. (2003, August 31). Second thoughts after sex change. *Herald Sun.*

Parkes, G., & Hall, I. (2006). Gender dysphoria and cross-dressing in people with intellectual disability: A literature review. *Mental Retardation, 44*(4), 260–271.

Pfäfflin, F., & Junge, A. (1998). *Sex reassignment thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961–1991* (R. B. Jacobson & A. B. Meier, Trans.) [Electronic]. Düsseldorf, Germany: Symposion Publishing. Retrieved August 16, 2007, from http://symposion.com/ijt/pfaefflin/1000.htm

Pilgrim, D. (2005). Defining mental disorder: Tautology in the service of sanity in British mental health legislation. *Journal of Mental Health, 14*(5), 435–443.

Pollack, R. (1997). What is to be done? A commentary on the recommended guidelines. In G. E. Israel and D. E. Tarver II (Eds.), *Transgender Care: Recommended Guidelines, Practical Information, and Personal Accounts* (pp. 229–235). Philadelphia: Temple University Press.

Pratt, J. S., Cummings, S., Vineberg, D. A., Graeme-Cook, F., & Kaplan, L. M. (2004). Case 25-2004: A 49-year-old woman with severe obesity, diabetes, and hypertension. *New England Journal of Medicine, 351*, 696–705.

Prosser, J. (1998). *Second skins: The body narratives of transsexuality.* New York: Columbia University Press.

Rachlin, K. (1999). Factors which influence individual's decisions when considering female-to-male genital reconstructive surgery. *International Journal of Transgenderism, 3*(3). Retrieved August 16, 2007, from http://www.symposion.com/ijt/ijtvo06no01_03.htm

Rachlin, K. (1997, June). *Partners in the journey: Psychotherapy and six stages of gender revelation.* Paper presented at the Second Congress on Sex and Gender, King of Prussia, Pennsylvania.

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*(2). Retrieved August 16, 2007, from http://www.symposion.com/ijt/ijtvo06no02_04.htm

Schaefer, L. C., Wheeler, C. C., & Futterweit, W. (1995). Gender identity disorders (Transsexualism). In G. O. Gabbard (Ed.), *Treatment of Psychiatric Disorders* (2nd ed., vol. 2). Washington, DC: American Psychiatric Press.

Singer, J. (2004). Options counseling: Techniques for caring for women with unintended pregnancies. *Journal of Midwifery & Women's Health*, *49*(3), 235–242.

Snyder, T. A., & Barnett, J. E. (2006). Informed consent and the process of psychotherapy. *Psychotherapy Bulletin, 41*, 37–42.

Speer, S. A. (2006). Gatekeeping gender: Some features of the use of hypothetical questions in the psychiatric assessment of transsexual patients. *Discourse & Society, 17*(6), 785–812.

Steinbrook, R. (2007). Guidance for guidelines. *New England Journal of Medicine, 356*(4), 331–333.

Stone, S. (1991). The empire strikes back: A posttranssexual manifesto. In J. Epstein & K. Straub (Eds.), *Body guards: The cultural politics of gender ambiguity* (pp. 280–304). New York: Routledge.

Stryker, S. (1993). Transgender rage against the psychiatric establishment. Retrieved August 16, 2007, from http://www.spunk.org/texts/pubs/cf/sp000562.txt

Vanderburgh, R. (2007). *Transition and beyond: Observations on gender identity.* Portland, OR: Q Press.

Vitale, A. (1997). The therapist versus the client: How the conflict started and some thoughts on how to resolve it. In G. E. Israel and D. E. Tarver II (Eds.), *Transgender care: Recommended guidelines, practical information, and personal accounts* (pp. 251–255). Philadelphia: Temple University Press.

Walworth, J. (1997). Sex reassignment surgery in male-to-female transsexuals: Client satisfaction in relation to selection criteria. In B. Bullough, V. L. Bullough, & J. Elias (Eds.), *Gender blending* (pp. 352–373). Amherst, NY: Prometheus Books.

Walker, P. A., Berger, J. C., Green, R., Laub, D. R., Reynolds, C. L., & Wollman, L. (1979, 1990). *The "Standards of Care"* (Version 4, 1990). Harry Benjamin International Gender Dysphoria Association. Retrieved on August 16, 2007, from http://www.pfc.org.uk/node/636

Wilchins, R. A. (1997). *Read my lips: Sexual subversion and the end of gender.* Ithaca, NY: Firebrand.

Winters, K. (2005). Gender dissonance: Diagnostic reform of gender identity disorder for adults. *Journal of Psychology and Human Sexuality, 17*(3/4), 71–91.

Whittle, S. (1998). The trans-cyberian mail way. *Social & Legal Studies, 7*, 389–408.

APPENDIX: PSYCHOSOCIAL ASSESSMENT

A. *Client identification:* This should include client's legal name as well as other names the client may use, address, phone number, e-mail, and any other client contact information. Additionally, information on the client's birth date/age, relational and family status, and employment and/or educational situation should be briefly outlined. The client should be referred to by the preferred pronoun, except when he or she is still living in the natal sex. (It is acceptable to use natal pronouns when discussing childhood and history.) Race/ethnicity, religion, disability, or any other pertinent information about the client's identity should be mentioned, as appropriate.

B. *Reason for evaluation:* This section should include information about the length of evaluation and/or psychotherapy and the results of any psychological testing, ecomaps, or genograms. The reason the client is seeking medical treatment at this time should be noted.

C. *Familial history:* Information regarding the client's family of origin should be described, including parent and sibling relationships, past and current. A basic outline of the client's upbringing should be described including information on familial deaths, divorces, the functioning of the family as a whole, salience of any cultural themes in the family, values expressed within family, and characteristics of their communication style. Any pertinent information regarding the client's childhood (for example, poverty, health issues, family member's disability, involvement in the military, frequent moving, living in multiple households, adoption or fostering, additional members living in the home) should also be listed here. When possible, the therapist is basing this knowledge on information corroborated through contact with family members.

D. *Current living situation:* Information regarding the client's current living situation

should be described. If the client is in a significant intimate relationship, and/or is parenting children, this should be noted, as well as any past marriages or committed relationships. Identify who is living in the current household, the quality of the client's relationship with his or her child or children, and whether the child or children are currently living with the client. Describe the quality, duration, and communication patterns of any intimate relationships, including issues of power and decision-making. Note whether the family is supportive of the client's decision.

E. *Work and Education:* Discuss the client's educational background or current schooling. Identify any history of learning problems, or developmental challenges that have impacted schooling or work life. The client's current work and career goals should be outlined, including the likelihood of maintaining employment through his or her transition and plans for transition at work.

F. *Gender Issues:* The client's relationship to his or her gender, from early childhood through the present, should be thoroughly outlined. This establishes the history of gender-related issues. Examples of cross-dressing, discomfort in his or her gender role, body dysphoria, development of transgender identity, and family reaction to the gender issues should be discussed. Information about the current gender expression, and the anticipated trajectory regarding transition should be outlined.

G. *Social Support:* This section should identify the client's social supports, including hobbies, community involvement, friends, and social activities. Relationship to transgender-community resources and access to information (including Internet access) is also important to identify. Familial support, or resistance, for transition should be noted. If the client is living at home with parents, or living on a college campus or in a work situation that is problematic, education and counseling should be offered, as appropriate, to those in ongoing relationships with the client beginning medical treatments.

H. *Psychosocial Stressors:* Any mental health or medical issues, criminal history, and pending legal problems or probation should be outlined, as well as the current status of those issues. A thorough drug and alcohol evaluation should be part of the assessment. Any history of domestic violence, sexual assault, childhood sexual or physical abuse or neglect, or being the victim of a bias-related crime should be thoroughly explored. An assessment of the client's relationship to his or her fertility, desire to have biological children, and potential plans to preserve fertility should be thoroughly explored. Previous therapy should be noted, including in- or outpatient mental health or substance-abuse treatment or psychiatric hospitalization. The client should be evaluated for anxiety, depression, characterological disturbances, and suicidality. Skills of daily living, including basic hygiene, eating and sleeping patterns, and relationship to social service agencies should also be noted. Approval for hormones depends on the client's stability, and issues that may prove stressing should be addressed so that the treatment team (i.e., the mental health counselor making the referral and the physician receiving the referral) can work together to support the client through any difficulties.

I. *Summary:* A description of the client's behavioral characteristics, attitudes, affect, maturity level, attitudes toward self, ability to cope with stress, familial and social supports, strengths, and general outlook on life should be outlined. In the final section, the clinician shares his or her observations of the client, including any concerns about transition issues that might require continuing psychotherapy. Diagnostic eligibility and readiness are established—potentially including an appropriate diagnosis—and the recommendation for medical treatment is clearly stated.