Guidelines for Psychological Practice with Transgender and Gender Non-Conforming Clients

Introduction

This document provides guidelines for psychological practice with transgender and gender non-conforming (TGNC) people. For the purposes of these guidelines, TGNC describes a person whose gender identity does not fully align with their sex assigned at birth. It also may describe a person whose gender expression or gender role differs from gender norms related to their assigned birth sex, regardless of gender identity. These guidelines contain foundational information necessary for the provision of culturally competent, TGNC-affirmative psychological practice, which includes being proactively respectful, aware, and supportive of the needs of TGNC people.

There have been significant developments in research over the past two decades due to increased visibility and societal awareness of TGNC communities. Survey research has shown that TGNC people experience discrimination and prejudice at a higher rate than the average population (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Grant et al., 2011). In addition, TGNC people experience microaggressions (everyday experiences of discrimination) and macroaggressions (institutional discrimination and acts of violence) in multiple areas of their lives (Nadal, Skolnik, & Wong, 2012; Shelton & Delgado-Romero, 2011). These experiences of transprejudice can lead to increased mental health stressors and negative mental health outcomes, including increased rates of depression, suicidality, and homelessness (Bockting et al., 2013; Fredriksen-Goldsen et al., 2013; Haas et al., 2011). Research has also shown that TGNC people experience discrimination when accessing mental and physical health care (Fredriksen-Goldsen et al., 2013; Garofalo, Deleon, Osmer, Doll, & Harper, 2006;
Psychologists or other mental health professionals who are unprepared to offer TGNC-affirmative care may cause harm to TGNC clients through overt or covert transprejudice or ignorance about gender diversity (Mikalson, Pardo, & Green, 2012; Xavier et al., 2012). Assisting psychologists to avoid harm and maximizing the effectiveness of services psychologists offer to TGNC people offers a compelling need for these psychological practice guidelines.

These guidelines will assist practicing psychologists and psychology trainees to cultivate a culturally-responsive approach to working with TGNC clients. These guidelines can serve as an introductory resource for those interested in working with the TGNC community and may also serve as the catalyst for the development of more advanced training and advocacy.

**Purpose**

These guidelines describe psychological practice with TGNC clients. The guidelines offer foundational knowledge about the construct of gender identity to prepare psychologists to provide competent care to TGNC people. The guidelines also address the unique challenges and strengths of TGNC people, ethical and legal issues, lifespan considerations, research, education and training, healthcare, and advocacy. These areas of focus were selected after reviewing the extant scholarship about TGNC people and selecting content most pertinent to the practice of psychology with TGNC clients. Issues of gender identity are often conflated with issues of gender expression or sexual orientation. It is important to emphasize that psychological practice with the TGNC population warrants the acquisition of specific knowledge about concerns unique to TGNC people that are not addressed by other practice guidelines (American Psychological Association [APA], 2012). These guidelines are intended to assist psychologists in addressing the diverse contexts and social justice concerns that influence the lives of TGNC clients. This
The APA has made an important distinction between *standards* and *guidelines* (Reed, McLaughlin, & Newman, 2002). Standards are mandates to which all psychologists must adhere (e.g., Ethical Principles of Psychologists and Code of Conduct; APA, 2010), whereas guidelines are aspirational. These practice guidelines are intended to provide psychologists with a general understanding of the concerns that arise when working with TGNC clients. Psychologists should use the current guidelines in tandem with the “Ethical Principles of Psychologists and Code of Conduct” and be aware that state and federal laws may override these guidelines (APA, 2010).

In addition, these guidelines refer to psychological practice rather than treatment. Practice guidelines are practitioner-focused and provide guidance concerning professionals’ “conduct and the issues to be considered in particular areas of clinical practice” (Reed et al., 2002, p. 1044). Treatment guidelines are client-focused and address intervention-specific recommendations for a clinical population or condition (Reed et al., 2002). These practice guidelines are intended to complement treatment guidelines for TGNC populations, such as those set forth by the World Professional Association for Transgender Health (WPATH) Standards of Care (Coleman et al., 2011) and the Endocrine Society (Hembree et al., 2009).

**Background and Process**

In 2008, after an extensive report on the current state of psychological practice with TGNC people (APA Task Force on Gender Identity and Gender Variance [TFGIVG], 2009), the APA Council of Representatives issued a resolution stating its support of accessible mental and physical health care services for people of all gender identities and gender expressions. The resolution called upon psychologists to provide nondiscriminatory and appropriate treatment to
To strengthen the guidelines, Task Force members met with TGNC community groups and consulted with subject matter experts within and outside of psychology. When the Task Force discovered a lack of professional consensus, every effort was made to reflect the divergent opinions in the field.

Definitions

Terminology within the health care field and within the TGNC communities is dynamic and constantly evolving (Coleman et al., 2011). Language to describe the identities and experiences of this population arise from multiple sources, through TGNC communities themselves and through the professional literature. The evolution of terminology has been especially rapid in the last decade as the profession’s awareness of gender diversity has increased, as more literature and research in this area has been published, and as the voice of the TGNC community has strengthened. Some terms or definitions are not universally accepted, and there is some disagreement in the field as to the correct word or definition. Terminology varies
across culture, generation, and geographic region. Some common concepts are seen as affirming and others are seen as outdated or demeaning. The task force assembled the definitions below by reviewing existing definitions put forward by professional organizations (e.g., WPATH, Institute of Medicine [IOM], APA), health care systems serving TGNC clients (e.g., Fenway Health Center), TGNC community resources (Gender Equity Resource Center, National Center for Transgender Equality), and professional literature. Psychologists are encouraged to refresh their knowledge and familiarity with evolving terminology on a regular basis to stay abreast with changes. The definitions below include terms frequently used within the Guidelines, by the TGNC community, and within professional literature.

**Ally:** A cisgender or non-TGNC person who strives to support and advocate for TGNC individuals and/or communities.

**Cisgender:** An adjective to describe a person whose gender identity and gender expression align with sex assigned at birth; a non-TGNC person.

**Cisgenderism:** A system of oppression that privileges cisgender identities and experiences over TGNC identities and experiences, or perpetuates prejudicial attitudes and discriminatory behaviors that result in ignoring, denigrating or stigmatizing TGNC people or any forms of behavior or gender expression that lie outside of the traditional gender binary.

**Coming Out:** A process by which individuals affirm and actualize a stigmatized identity. Coming out as TGNC can include disclosing a gender identity or gender history that does not align with sex assigned at birth or current gender expression.

**Cross Dressing:** Wearing clothing, accessories, and/or make-up and/or adopting a gender role not associated with a person’s assigned sex at birth. Cross-dressing is not always reflective of gender identity or sexual orientation.
Drag: The act of dressing in gendered clothing, often as part of a performance. Drag kings express gender in a range of men’s gender roles and drag queens in a range of women’s gender roles. Drag may be enacted as a political comment on gender, as parody, or as entertainment and is not necessarily reflective of gender identity.

Female-to-Male (FTM): Individuals who are assigned a female sex at birth and wish to change, are changing, or have changed their body and/or gender role to a more masculine body or gender role. FTM persons are also often referred to as transgender men or transmen.

Gender Affirming Surgery (Sex Reassignment Surgery or Gender Reassignment Surgery): Surgery to change primary and/or secondary sex characteristics to better align a person’s physical appearance with that person’s gender identity. Gender affirming surgery can alleviate gender dysphoria and may include mastectomy, hysterectomy, metoidoplasty, phalloplasty, breast augmentation, orchiectomy, vaginoplasty, facial feminization surgery, and/or other surgical procedures.

Gender Binary: The classification of gender into two dichotomous, fixed categories of male/man/boy and female/woman/girl.

Gender Dysphoria: Discomfort or distress related to incongruence between a person’s gender identity, assigned birth sex assigned, gender role, and/or primary and secondary sex characteristics (Knudson, De Cuypere, & Bockting, 2010). In 2013, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) adopted the term gender dysphoria as a diagnosis characterized by “a marked incongruence between” a person’s gender assigned at birth and gender identity (American Psychiatric Association, 2013, p. 453). In the
previous version of the DSM (American Psychiatric Association, 2000, p. 532-533), the diagnosis was named Gender Identity Disorder.¹

**Gender Expression**: An individual’s presentation, including physical appearance, clothing choice and accessories, and behavior that communicates aspects of gender or gender role. Gender expression may or may not conform to a person’s gender identity.

**Gender Identity**: A person’s deeply-felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender non-conforming, boygirl, ladyboi) which may or may not correspond to a person’s sex assigned at birth or to a person’s primary or secondary sex characteristics. Since gender identity is internal, a person’s gender identity is not necessarily visible to others. ‘Affirmed gender identity’ refers to a person’s gender identity after coming out as TGNC or undergoing a social and/or medical transition process.

**Gender Marker**: An indicator (M, F) of a person’s sex or gender found on identification (i.e., drivers license, passport) and other legal documents (i.e., birth certificate, academic transcripts).

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¹ **Gender Identity Disorder (GID)**: A diagnosis in the DSM-IV-TR (American Psychiatric Association, 2000). The diagnosis of Gender Identity Disorder (GID) was characterized by a “strong and persistent cross-gender identification… and a persistent discomfort… with one’s assigned sex or sense of inappropriateness in the gender role of that sex”, that causes “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association, 2000, p. 532-533). This diagnosis was controversial, with some professionals and TGNC community members finding it pathologizing and stigmatizing.
Gender Non-Conforming (GNC): An adjective and umbrella term to describe individuals whose gender expression, gender identity, or gender role differs from gender norms associated with their assigned birth sex. Subpopulations of the TGNC community can develop specialized language to represent their experience and culture, such as the term “masculine of center” that is used in communities of color to describe a GNC identity.

Gender Questioning: An adjective to describe individuals who may be questioning or exploring their gender identity and whose gender identity does not fully align with their sex assigned at birth.

Genderqueer: A term to describe a person whose gender identity and/or gender role does not align with a binary understanding of gender (i.e., a person who does not fully identify as a man or a woman). People who identify as genderqueer may redefine gender or decline to define themselves as gendered altogether. For example, people who identify as genderqueer may think of themselves as both man and woman (bigender, pangender, androgyne); neither man nor woman (genderless, gender neutral, neutrois, agender), moving between genders (genderfluid); embodying a third gender.

Gender Role: Refers to a pattern of appearance, personality, and behavior that, in a given culture, is associated with being a boy/man/male or being a girl/woman/female. A person’s gender role may or may not conform to what is expected based on a person’s sex assigned at birth. Gender role may also refer to the social role one is living in (e.g., as a woman, a man, or another gender), with some role characteristics conforming and others not conforming to what is associated with girls/women or boys/men in a given culture and time.
Hormone Suppression (Gonadotropin-Releasing Hormone [GnRH]): A treatment that can be used to temporarily suppress the development of secondary sex characteristics that occur during puberty in youth, often called puberty delaying hormone therapy or puberty blocking.

Hormone Therapy (Gender Affirming Hormone Therapy; Hormone Replacement Therapy): The use of hormones to masculinize or feminize a person’s body to better align that person’s physical characteristics with gender identity. People wishing to feminize their body receive anti-androgens and/or estrogens; people wishing to masculinize their body receive testosterone. Hormone therapy can be an important part of medically necessary treatment to alleviate gender dysphoria.

Intersex (Disorders of Sexual Development [DSD]): Intersex refers to individuals born with ambiguous genitalia or with variations in sex chromosomes or gonads. A person may have anatomy that is inconsistent with chromosomal sex (e.g., Complete Androgen Insensitivity Syndrome). Some people may not become aware of having an intersex condition until the development of secondary sex characteristics during puberty. Intersex conditions may be considered as natural variations in biological diversity (Diamond, 2009) rather than disorders; therefore, some prefer the terms intersex, intersexuality, or differences in sex development rather than ‘disorders of sexual development’ (Coleman et al., 2011)

Male-to-Female (MTF): Individuals with an assigned sex of male at birth who wish to change, are changing or have changed their body and/or gender role to a more feminized body or gender role. MTF persons are also often referred to as transgender women or transwomen.

Passing: The ability to blend in with cisgender women and men and not being recognized as transgender based on appearance or gender role and expression; appearing cisgender.
Sex: Sex is assigned at birth based on the appearance of external genitalia. When the external genitalia appear ambiguous, other indicators (e.g., internal genitalia, chromosomal and hormonal sex) are considered to assign a sex of male or female that is most likely to be congruent with gender identity, which cannot be ascertained until later in life (MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972). For most people, gender identity is congruent with sex assigned at birth (see cisgender); for TGNC individuals, gender identity differs to varying degrees from sex assigned at birth.

Sexual Orientation: A component of identity that includes a person’s sexual and emotional attraction to another person and the behavior that may result from this attraction. An individual’s sexual orientation may be lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual. A person may be attracted to men, women, both, neither, genderqueer, androgynous or have other gender identities. Sexual orientation is distinct from sex, gender identity, gender role and gender expression.

Stealth: A person’s choice not to reveal TGNC history, experience or identity. A person may be completely stealth or may be stealth in some settings and not others (i.e., stealth at work but not with family).

TGNC: An abbreviation used to refer to people who are transgender or gender non-conforming.

Trans: A common short-hand for the terms transgender, transsexual, and/or gender nonconforming. While the term “trans” is commonly accepted, not all transsexual or gender nonconforming people identify as trans.

Trans-Affirmative: Being proactively respectful, aware and supportive of the needs of TGNC people.
**Transgender**: An umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. While the term “transgender” is commonly accepted, not all TGNC people identify as transgender.

**Transgender Man, Trans Man or Transman**: An individual who was assigned the female sex at birth and who identifies as a man (see FTM).

**Transgender Woman, Trans Woman or Transwoman**: An individual who was assigned the male sex at birth and who identifies as a woman (see MTF).

**Transition**: A process some TGNC individuals progress through when they change to a gender role that differs from the one associated with their sex assigned at birth. The length, scope, and process of transition are unique to each person’s life situation. For many people, this involves developing a gender identity and expression that is most comfortable, and may include learning how to live socially in another gender role. A transition typically occurs over a period of time, and may involve disclosing a TGNC identity to family, friends, co-workers, and other social networks. TGNC people may proceed through a social transition (e.g., changes in gender expression, gender role, name, and gender marker)) and/or a medical transition (e.g., hormone therapy, surgery, and/or other interventions) and/or

**Transprejudice (Transnegativity, Transphobia)**: Prejudicial attitudes and discriminatory behaviors that result in the devaluing, dislike, hatred or attack of people whose gender identity and/or gender expression do not conform to their sex assigned at birth. TGNC and cisgender people may experience transprejudice. When a TGNC person holds these negative attitudes about themselves and their gender identity, it is called internalized transphobia (a construct
analogous to internalized homophobia). Transphobia may contribute to violence in the form of hate speech, homicide, and suicide.

**Transsexual:** Term to describe TGNC people who wish to change, have changed, or are changing their bodies through medical interventions (e.g., hormones, surgery) to better align their bodies with a gender identity that is different than sex assigned at birth. Some individuals distinguish between transsexual and transgender, with the former denoting a gender identity that conforms to the gender binary and is “opposite” sex assigned at birth and the latter denoting a gender *variant* identity that does not conform to the gender binary (Coleman et al., 2011)

**Transvestite:** Someone who wears clothing, jewelry and/or make-up and/or adopts a gender role expression not traditionally associated with a person’s sex assigned at birth. The term is controversial and is considered pejorative and outdated by some community members and professionals, instead preferring the term cross dresser (see cross dresser).

**Transvestic Disorder:** A diagnosis in the DSM-5 (American Psychiatric Association, 2013) characterized by “recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges and behaviors…that cause significant distress or impairment” (p. 702). (The DSM-IV-TR (American Psychiatric Association, 2000) lists a diagnosis of transvestic fetishism with almost identical diagnostic criteria but which required clinicians to specify if GID was also present and described some different diagnostic features).

**Two-Spirit:** Term used by Native American people who identify with both male and female gender roles; in many Native American cultures, Two-spirit people are respected and carry unique spiritual roles for their community.
Guideline 1. Psychologists understand that gender is not a binary construct but is instead one that allows for a range of gender identities, and that a person’s gender identity may not align with sex assigned at birth.

Rationale

In many cultures, gender has typically been perceived as a binary construct, with mutually exclusive categories of male or female, boy or girl, man or woman. These mutually exclusive categories include an assumption that gender identity is always in alignment with sex assigned at birth (Tobin et al., 2010) and that all people are cisgender. While the majority of people are cisgender, a notable portion is TGNC (Conron, Scott, Sterling Stowell, & Landers, 2012; Gates, 2011; Meier & Labuski, 2013). For TGNC people, gender identity may be experienced and expressed outside of the gender binary and can differ from sex assigned at birth to varying degrees (Bockting, 2008; Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012). Some individuals define their gender identity outside of the gender binary (e.g., genderqueer, bigender, gender neutral) and/or express their gender in ways that are feminine, masculine, both, or neither in appearance and behavior. Binary views of gender have been central to many religious traditions, especially the monotheistic traditions of Judaism, Christianity, and Islam (Hopwood, 2013, Mollenkott, 2001; Rosser, Oakes, Bockting, & Miner, 2007; Tanis, 2003). Religiously influenced views of gender carry over into society at large and affect TGNC persons regardless of their identification with any particular religion (Hopwood, 2013).

Gender as a non-binary construct has been described and studied in the past (Benjamin, 1966; Herdt, 1994; Kulick, 1998). Several cultures show historical evidence of recognition, societal acceptance, and sometimes reverence of diversity in gender identity and gender
expression (Coleman, Colgan, & Gooren, 1992; Feinberg, 1996; Miller & Nichols, 2012; Schmidt, 2003). Many gender nonconforming cultural groups were diminished by westernization, colonialism, and oppression (Nanda, 1999). In the 20th century, transgender expression became medicalized (Hirschfeld, 1910/1991), and options to treat gender dysphoria with medical interventions became available (Meyerowitz, 2004).

As early as the 1950s, research found variability in how people described their gender, with a proportion of participants reporting a gender identity different from the culturally-defined, mutually exclusive categories of male or female (Benjamin, 1966; Money, Hampson & Hampson, 1955). In a recent large online study of TGNC population in the U.S., 33% of participants identified their gender identity as other than male or female (Harrison et al., 2012; Kuper et al., 2012). While some studies have cultivated a broader understanding of gender, the majority of surveys provide a forced choice between two traditional gender categories, thus failing to represent or depict those whose gender identities are not captured by these options (Conron, Scout, & Austin, 2008; IOM, 2011). Research over the last two decades has demonstrated the existence of a wide spectrum of gender identity and gender expression (American Counseling Association [ACA], 2010; Bockting, 2008; Harrison et al., 2012; Kuper et al., 2012) which includes people who identify as either male or female, neither male nor female, a blend of male and female, or a unique gender identity. An individual’s identification as TGNC can be healthy and self-affirming and is not inherently pathological (Coleman et al., 2011). However, individuals may experience distress associated with discordance between their gender identity, gender role, body or sex assigned at birth (Coleman et al., 2011; Knudson et al., 2010). Additionally, the effects of societal stigma and discrimination (Bockting et al., 2013).
Between the late 1960s and the early 1990s, health care to alleviate gender dysphoria largely reinforced a binary conceptualization of gender (APA TFGIGV, 2009; Bockting, 1997, 2008; Bolin, 1988, 1994). At that time, it was considered an ideal outcome for clients to conform to an identity that aligned with either sex assigned at birth or, if not possible, with the “opposite” sex, with a heavy emphasis on blending into the cisgender population or “passing” (Bolin, 1994). Variance from these options could raise concern about a client’s ability to transition successfully and could act as a barrier to accessing surgery or hormone therapy (Bess & Stabb, 2009). Largely due to TGNC community empowerment in the 1990s and research advancements, the paradigm shifted toward recognition of a spectrum of gender diversity and corresponding individualized, TGNC-specific health care (Bockting, Knudson, & Goldberg, 2006).

**Application**

Evolving the construct of gender to move beyond the gender binary is a fundamental conceptual change required to provide affirmative care for TGNC clients. Psychologists are encouraged to adapt or modify their understanding of gender, broadening the range of variation viewed as healthy and normative. By understanding gender as a construct that encompasses experience across a spectrum of gender identity and gender expression and by understanding that an individual’s gender identity may not be in full alignment with sex assignment at birth, psychologists are better able to assist TGNC individuals, their families and their communities. Respecting and supporting clients’ efforts to personally articulate their gender identity and gender expression, as well as their lived experience, can improve clients’ health, well-being, and quality of life (Gorin-Lazard et al., 2011; Newfield, Hart, Dibble, & Kohler, 2006).

Given some clients’ limited access to visible, positive TGNC role models, many TGNC individuals are isolated and must cope with the stigma of gender nonconformity without
guidance and support, compounding the negative impact of stigma on mental health (Bockting et al., 2013; Fredriksen-Goldsen et al., 2013). Psychologists can assist TGNC clients to challenge gender norms and stereotypes and explore their unique gender identity and gender expression. TGNC individuals, partners, families, friends, and communities can benefit from education about the healthy variation of gender identity and gender expression, and the incorrect assumption that gender identity automatically aligns with sex assigned at birth.

Psychologists can model an acceptance of ambiguity as TGNC individuals develop and explore aspects of their gender, especially in childhood and adolescence. A nonjudgmental stance toward gender nonconformity can help to counteract the pervasive stigma faced by many TGNC individuals and provide a safe environment to explore gender identity and make informed decisions about gender expression.

**Guideline 2. Psychologists recognize that gender identity and sexual orientation are both distinct and interrelated constructs.**

**Rationale**

Clients and professionals alike frequently confuse the constructs of gender identity and sexual orientation. Although interrelated, the constructs of gender identity and sexual orientation are theoretically and clinically distinct, demonstrating separate but concurrent linked development across the lifespan (APA, 2009; Iantaffi & Bockting, 2011; Kuper et al., 2012; Nagoshi, Brzuzy, & Terrell, 2012; Nuttbrock et al., 2009). Whereas the definition of sexual orientation is a person’s sexual, or emotional attraction to another person (Klein, 1993; Shively & De Cecco, 1977), gender identity is defined as an individual’s deeply felt, inherent sense of being a girl, woman, or female; a boy, man, or male; a blend of female and male; or an alternate gender (Bockting, Rosser, & Coleman, 1999; Nagoshi et al., 2012). Gender identity occurs on a
developmental pathway which is distinct from the development of sexual orientation and which typically occurs earlier in the lifespan (Devor, 2004). Gender identity is usually established in young toddlerhood (American Academy of Child and Adolescent Psychiatry [AACAP], 2012; Kohlberg, 1966; Money & Ehrhardt, 1972), in comparison to awareness of same sex attraction, which occurs around age 10 (AACAP, 2012; D’Augelli, 1993; Herdt & Boxer, 1993; Ryan, 2009; Savin-Williams & Diamond, 2000). While childhood is usually the age at which gender identity is established, individuals may become aware that their gender identity is not in full alignment with sex assigned at birth in childhood, adolescence, or adulthood. The developmental pathway of gender identity typically includes a progression through multiple stages of awareness, exploration, expression, and identity integration (Bockting & Coleman, 2007, Devor, 2004; Lev, 2004; Vanderburgh, 2007).

A person’s gender identity may or may not fully align with that person’s sex assigned at birth or primary or secondary sex characteristics. Because gender and patterns of attraction are used to identify a person’s sexual orientation, the articulation of sexual orientation is made more complex when sex assigned at birth is not congruent with gender identity. It is important to note that, like gender identity, a person’s sexual orientation cannot be determined by simply examining external appearance or behavior; therefore, psychologists strive to respect the self-identification of TGNC clients with regard to these constructs. Attempts to categorize and/or assume the sexual orientation of TGNC people, may not be relevant to treatment and may neglect the potential fluidity in sexual attraction that some TGNC people experience (Schroder & Carroll, 1999).

**Application**
Psychologists can help their clients differentiate gender identity and sexual orientation, as well as become aware of previously hidden or constrained aspects of their gender identity or sexuality. The experience of gender incongruence can create significant confusion for some clients, especially for clients who themselves are unfamiliar with the range of gender identities that exist. To explain any discordance they may experience between their sex assigned at birth, related societal expectations, patterns of sexual and romantic attraction, gender role nonconformity and gender identity, some TGNC clients may assume that they must be gay, lesbian, bisexual, or queer (Bockting, Benner, & Coleman, 2009). Focusing solely on sexual orientation as the cause for discordance may obscure awareness of a TGNC identity. In addition, many TGNC adults have disguised or denounced their experience of gender incongruence in childhood or adolescence to conform to societal expectations and minimize fear of difference (Bockting & Coleman, 2007; Bockting et al., 2006; Byne et al., 2012). Psychologists are in a unique position to help clients better understand and integrate the various aspects of their identities. Psychologists can assist their clients by introducing and normalizing differences in gender identity and expression. As a client finds a comfortable way to actualize and express gender identity, psychologists may notice that previously incongruent aspects of a client’s sexual orientation may become more salient, better integrated, or increasingly ego-syntonic (Bockting et al., 2009; Devor, 1993; Schleifer, 2006). This process may allow clients the comfort and opportunity to explore attractions or aspects of their sexual orientation that had previously been in conflict with identity, or repressed or hidden. Following transition, a person’s sexual orientation may change (e.g., renewed exploration of sexual orientation in the context of TGNC identity, shift in attraction or choice of sexual partners, widened spectrum of attraction, shift in
Psychologists may need to provide clients with foundational information about TGNC identities and offer clients a language to describe the discordance and confusion they may be experiencing (Lev, 2004). To accomplish this learning process, psychologists can introduce clients to some of the narratives written by TGNC people that reflect a range of outcomes and developmental processes in exploring and affirming gender identity (e.g., Bornstein & Bergman, 2010; Boylan, 2003; Green, 2004; Krieger, 2011). These resources may potentially aid clients in distinguishing between issues of sexual orientation and gender identity and in locating themselves on the gender spectrum. Psychologists may also educate families and broader community systems (e.g., schools, medical systems) to better understand how gender identity and sexual orientation are different but related; this may be particularly useful when working with youth (Lev, 2009; Singh & Burnes, 2009; Whitman, 2013).

The frequent blending of gender identity, gender expression, and sexual orientation in the field of psychology and in the professional literature has the potential to confuse professionals and clients alike. As such, psychologists strive to carefully examine resources that claim to be LGBT-affirmative and to confirm which are truly sensitive to and inclusive of the needs of TGNC people before offering referrals or recommendations to clients and their families.

**Guideline 3. Psychologists recognize that gender identity intersects with other cultural identities and may not always be the most salient aspect of a TGNC person’s life,**

**Rationale**
Gender identity and gender expression may have profound intersections with other aspects of identity (Collins, 2000; Warner, 2008). These aspects may include, but are not limited to: race/ethnicity, age, education, socioeconomic status, immigration status, occupation, disability status, sexual orientation, relational status, and religion and/or spiritual affiliation. Some of these aspects of identity may afford privileges, while others may create significant disadvantages (Burnes & Chen, 2012). In addition, clients who transition may not be prepared for changes in privilege or societal treatment based on gender identity and gender expression. To illustrate, an African American trans man may gain male privilege, but may face societal stigma particular to African American men (Feder & Hollar, 2006). An Asian American trans woman may experience the benefit of being perceived as a cisgender woman, but may also experience sexism, misogyny, and objectification particular to Asian American women (Nemoto, Operario, Keatley, & Villegas, 2004; Operario & Nemoto, 2005).

Psychologists are mindful that the intersection of multiple identities within TGNC clients’ lives is complex and may facilitate or obstruct access to necessary support (Daley, Solomon, Newman, & Mishna, 2007; Vidal-Ortiz, 2008). TGNC people with less privilege and/or multiple oppressed identities may experience increased stressors and restricted access to resources, but they may also develop resilience and strength for coping with disadvantages (Singh, Hays, & Watson, 2011). Conflict between religious beliefs or traditions and gender identity may be especially salient for TGNC persons and their families, while finding an affirmative expression of their religious and spiritual perspective can be an important resource for TGNC persons (Bockting & Cesaretti, 2001; Glaser, 2008; Hopwood, 2013; Mollenkott, 2001; Tanis, 2003; Xavier, 2000).

Application
Psychologists seek to acknowledge the salient identities of TGNC people and understand the impact of a client’s unique identities on coping, experiences of discrimination and resilience. Psychologists are encouraged to recognize that gender identity may not always play a significant role in a TGNC client’s presenting concerns (Spade, 2006). Improved rapport and therapeutic alliance are likely to develop when psychologists avoid overemphasizing gender identity and gender expression when not directly relevant to clients’ needs and concerns (Bess & Stabb, 2009). Even when gender identity is the main focus of treatment, psychologists appreciate that a client’s experience of gender will likely be shaped by other important aspects of identity (e.g., age, race/ethnicity, sexual orientation) and that the salience of different aspects of identity may evolve as the client transitions and continues psychosocial development across the lifespan (Singh & Chun, 2012).

At times, a client’s intersection of identities may result in conflict, such as a TGNC client’s struggle to integrate gender identity with religious upbringing and beliefs (Kidd & Witten, 2008; Levy & Lo, 2013; Rodriguez & Follins, 2012). Despite the potential conflict, religious and spiritual beliefs may also serve as an important source of strength and resilience for TGNC individuals, particularly for TGNC people of color (Dowshen, Johnson, Kuhns, Rubin, & Garofalo, 2011; Singh, 2012). Psychologists seek to support TGNC clients in navigating identities that may be differently privileged within systems of power and oppression (Burnes & Chen, 2012). Psychologists can highlight and strengthen the development of competencies and resilience as clients learn to manage the intersection of stigmatized identities (Singh, 2012).

Guideline 4. Psychologists recognize the impact of stigma, prejudice, discrimination, and violence on the lives and mental health of TGNC people.

Rationale
Many TGNC people experience significant discrimination when accessing housing, healthcare, employment, education, public assistance and other social services (Bazargan & Galvan, 2012; Bockting et al., 2013; Bradford, Reisner, Honnold, & Xavier, 2013; Dispenza, Watson, Chung, & Brack, 2012; Grant et al., 2011). Subtle forms of discrimination might include assuming a person's assigned sex at birth is fully aligned with that person’s gender identity, using the wrong name or pronoun to address someone, asking TGNC people inappropriate questions about their bodies, or making the assumption that psychopathology exists given a specific gender identity or gender expression (Nadal et al., 2012; Nadal, Rivera, & Corpus, 2010). Blatant discrimination ranges from refusing access to housing or employment to extreme acts of violence (e.g., sexual assault, murder). TGNC people who hold multiple marginalized identities are more vulnerable to discrimination and violence. Trans women and people of color disproportionately experience severe forms of violence and discrimination, including police violence, and are less likely to receive help from law enforcement (Edelman, 2011; National Coalition of Anti-Violence Programs, 2011; Saffin, 2011).

Transprejudice leads to significant economic disparities between TGNC people and cisgender people. Research has shown that TGNC people are underemployed and have a lower household income than cisgender people (Bockting et al., 2013; Fredriksen-Goldsen et al., 2013; Rosser et al., 2007). TGNC people often face workplace discrimination both when seeking and maintaining employment. In a national study of TGNC people, 97% reported having experienced workplace harassment or discrimination based on their gender identity or gender expression (Davis & Wertz, 2010). Employment discrimination may be related to stigma based on a TGNC person’s appearance, discrepancies in identity documentation, and lack of access to pre-transition references. Given widespread workplace discrimination, TGNC people may engage in sex work,
forced sex, or sell drugs to generate income (Grant et al., 2011; Hwahng & Nuttbrock, 2007; Operario, Soma, & Underhill, 2008; Stanley, 2011). This increases the potential for negative interactions with the legal system such as harassment by the police, bribery, extortion, and arrest (Edelman, 2011; Testa et al., 2012). Incarcerated TGNC people report harassment, isolation, forced sex, and physical assault, both by prison personnel and other inmates (American Civil Liberties Union National Prison Project, 2005; Baus, Hunt, & Williams, 2006; Daley, 2005; Sylvia Rivera Law Project, 2006). TGNC people are often subjected to involuntary solitary confinement, which leads to severe negative mental health and physical health consequences and may block access to services (Baus et al., 2006; National Center for Transgender Equality [NCTE], 2012).

TGNC people have difficulty accessing necessary health care (Fredriksen-Goldsen et al., 2013). Even when TGNC people have health insurance, some plans may explicitly exclude coverage related to gender transition (e.g., hormone therapy, surgery). TGNC people may also have difficulty accessing trans-affirmative primary health care if coverage for procedures is denied based on gender. For example, transmen may be excluded from necessary gynecological care based on the assumption that men do not need these services. These barriers often lead to a lack of preventive health care for TGNC people (Bess & Stabb, 2009). In addition, TGNC people often feel unsafe sharing their experiences of transprejudice with health care providers (Grant et al., 2011; Lurie 2005; Singh & McKleroy, 2011). TGNC persons commonly face discrimination in their religious communities (Glaser, 2008; Hopwood, 2013; Xavier, 2000).

TGNC people are also at risk of experiencing transprejudice in educational settings. In a national survey of TGNC young people in K-12 settings, participants reported significant levels of transprejudice in the form of verbal harassment (69%), physical harassment (27%), and
physical assault (12%; Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). As a result of such transprejudice, almost 15% of TGNC adults reported prematurely leaving their school settings as youth (Grant et al., 2011). Additionally, many schools do not include gender identity and gender expression in their school non-discrimination policies; this leaves TGNC young people without needed protections from bullying and aggression in schools (Gonzalez & McNulty, 2010; Singh & Burnes, 2010).

Application

Awareness of and sensitivity to the effects of transprejudice can be helpful for psychologists in assessing, treating, interacting with, and advocating for TGNC clients. When a TGNC client faces discrimination based on gender identity or gender expression, psychologists can facilitate emotional processing of these experiences and work with clients to identify supportive resources and possible courses of action. Specific needs of clients might vary from developing self-advocacy strategies to navigate public spaces to seeking legal recourse for harassment and discrimination in social services and other systems. Additionally, TGNC people who have been traumatized by physical or emotional violence may need therapeutic support. Psychologists can play an educative and facilitative role in assisting TGNC clients to access relevant social service systems. For example, psychologists may be able to assist clients in identifying health care providers and housing resources that are affirming and affordable. Psychologists may provide documentation or official correspondence that affirms gender identity for the purpose of accessing appropriate public accommodations (Lev, 2009; Meyer, 2009). Psychologists may also assist TGNC persons in finding affirming religious and spiritual communities (Glaser, 2008; Hopwood, 2013; Porter, Ronneberg, & Witten, 2013).
Additionally, psychologists can help TGNC clients acquire information and services to address workplace discrimination. For clients who maintain employment through transition, psychologists can assist with strategizing about how to come out at work. For clients who are seeking employment, psychologists can help strategize about how and when to share information about gender history. Psychologists can also work with employers to develop supportive policies for workplace gender transition or to develop training to help employees adjust to the transition of a co-worker.

In educational settings, psychologists can serve as advocates for TGNC youth (see Boulder Valley School District, 2012). Psychologists can consult with administrators, teachers, and school counselors to provide resources and trainings on transprejudice and developing safer school environments for TGNC students (Singh, 2013). Psychologists can develop peer-based interventions to facilitate greater understanding and respectful treatment of TGNC youth by cisgender peers. Psychologists can also help TGNC youth and their families locate important resources, such as school policies that protect gender identity and gender expression (Gonzalez & McNulty, 2010), on-line resources and referrals to TGNC affirmative organizations. Peer support from other transgender people has been shown to buffer the negative impact of stigma on mental health (Bockting et al., 2013).

**Guideline 5. Psychologists recognize how their understanding of and attitudes about gender identity and gender expression impact the quality of care they provide to TGNC clients and their families.**

**Rationale**

Psychologists’ assumptions, biases and attitudes about TGNC clients impact the quality of services they provide and the potential for developing an effective therapeutic alliance with
clients across a range of gender identities (Vasquez, 2007). Even clinicians experienced with
LGB clients may not be familiar with the unique needs of TGNC clients (Israel, 2005). Research
has shown that many mental healthcare providers lack basic knowledge and skills (Bradford,
Xavier, Hendricks, Rives, & Honnold, 2007; Xavier, Bobbin, Singer, & Budd, 2005) and receive
little training to prepare them to work with TGNC people (Jensen, 2010; Lurie, 2005). Although
overt acts of hostility toward TGNC people may be less likely to occur in the context of service
delivery, microaggressions (e.g., refusing or forgetting to use appropriate gender pronouns) are
common and can take many forms (Nadal et al., 2010). The National Transgender
Discrimination Survey (Grant et al., 2011) found that 50% of respondents shared that they had to
educate their healthcare providers about TGNC care, 28% postponed seeking medical care due to
transprejudice, and 19% were refused care due to discrimination.

APA emphasizes the need for psychologists to utilize evidence-based practice (APA
Presidential Task Force on Evidence-Based Practice, 2006), which is especially relevant to
psychological practice with TGNC clients given how easily assumptions or stereotypes could
influence treatment. APA has also promoted collaboration with clients concerning clinical
decisions, including issues related to costs, potential benefits, and the existing options and
resources related to treatment (APA Presidential Task Force on Evidence-Based Practice, 2006).
Given their historical disenfranchisement and disempowerment in health care, TGNC people
could benefit from such collaboration and active engagement in treatment-related decision
making. In addition, the APA Ethics Code (APA, 2010) stipulates that psychologists practice in
areas only within the boundaries of their competence (Standard 2.01) and participate in proactive
and consistent ways to enhance their competence (Standard 2.03). Competence can be developed
through a range of activities, such as education, training, supervised experience, consultation,
study, or professional experience. Psychologists may engage in practice with TGNC people in various ways and, depending on the type of service and the complexity involved, different types and levels of corresponding knowledge and competence would be required. Many, if not most, of the services psychologists provide to TGNC people require a basic understanding of the population and its needs, and the ability to respectfully interact in a trans-affirmative manner (ACA, 2010; AACAP, 2012).

**Application**

Psychologists are encouraged to be aware that addressing specific needs related to gender identity and gender expression requires a level of clinical competence beyond general cultural competence (Coleman et al., 2011). Psychologists are encouraged to identify how their knowledge and attitudes about TGNC people impact their professional activities. They are encouraged to carefully examine their beliefs regarding the fluidity of gender and sexuality, gender stereotypes, and TGNC identities, identifying gaps in knowledge, understanding, and acceptance (Nadal, 2013). This examination may include exploring one’s own gender identity and gendered experiences related to privilege, power, or marginalization.

Cultural competence in working with TGNC individuals and their families involves striving to maintain up-to-date basic knowledge and understanding of gender identity and expression, the diversity among TGNC people, the continuously evolving terminology that TGNC people use to describe their identities and experiences, and a preparedness to interact with TGNC individuals and their families in an appropriate and nonjudgmental way. Such TGNC related cultural competence can be achieved and maintained in various formal and informal ways, ranging from exposure in the curriculum of training programs for future psychologists and continuing education at professional conferences, to respectful involvement as allies in the
TGNC community. Beyond acquiring general cultural competence, psychologists who choose to specialize in working with TGNC people presenting with gender identity related concerns are strongly encouraged to obtain advanced training, consultation and professional experience, whether through postdoctoral specialization, continuing education or supervision by an experienced provider (Bockting & Goldberg, 2006).

Psychologists are encouraged to seek opportunities to gain knowledge about the TGNC community through first-hand experiences (e.g., attend community meetings and conferences, read narratives written by TGNC people) and become familiar with the complex social issues that impact the lives of their TGNC clients. Psychologists are encouraged to examine their own beliefs, including their religious beliefs and determine ways to eliminate bias toward TGNC persons based on their beliefs. If psychologists are unable to maintain a TGNC-affirmative stance in their clinical practice due to personal beliefs or attitudes that impede effective work with this population, it is recommended that they refer clients to other psychologists or providers who are knowledgeable and willing to provide trans-affirmative care to TGNC individuals and their families.

Guideline 6. Psychologists recognize that TGNC individuals supported in their gender identity and gender expression are more likely to experience positive life outcomes.

Rationale

Supporting an individual’s gender identity and gender expression may result in improved outcomes and quality of life (Murad et al., 2010, Pinto, Melendez, & Spector, 2008). Several studies (Bockting et al., 2013, Grant et al., 2011, Hendricks & Testa, 2012; Liu & Mustanski, 2012; Ryan 2009) suggest that family acceptance of TGNC adults and adolescents is associated with decreased rates of negative outcomes, such as depression, suicide, and HIV risk behaviors
and infection. Research over the past two decades has shown progressively more positive outcomes for TGNC adults and adolescents who accessed TGNC-affirmative treatment (i.e., psychotherapy, hormones, surgery; Byne et al., 2012; Carroll, 1999; Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; De Cuypere et al., 2006; Dhejne et al., 2011; Kuhn et al., 2009).

In a meta-analysis of the treatment literature with TGNC adults and adolescents, researchers found that 80% of participants experienced an improved quality of life, decreased gender dysphoria, and experienced a reduction in other psychological symptoms when provided affirmative care (Murad et al., 2010).

Research has suggested that family support may be a strong protective factor for TGNC adults and adolescents (Bockting et al., 2013; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). TGNC individuals, however, frequently experience blatant or subtle transprejudice, and even violence, within their families (Bradford et al., 2007). This family rejection is related to higher rates of HIV infection, suicide, incarceration, and homelessness for TGNC adults and adolescents (Grant et al., 2011; Liu & Mustanski, 2012); and, lower levels of social support and family rejection are significantly correlated with depression (Clements-Nolle, Marx, & Katz, 2006; Ryan, 2009). Therefore, many TGNC individuals seek support through their peer relationships, chosen families, and communities, where they may be more likely to experience acceptance (Nuttbrock et al., 2009). In addition, peer support from other TGNC individuals has been found to be a moderator between transprejudice and mental health, with higher levels of peer support associated with better mental health (Bockting et al., 2013). Support from religious and spiritual communities can be an important source of resilience for some TGNC persons (Glaser, 2008; Hopwood, 2013; Porter et al., 2013). Research has shown that TGNC persons,
especially FTM persons, may find that defining a spirituality affirming of their experience is important (Hopwood, 2013; Kidd & Witten, 2008)

**Application**

Given the strong evidence for the positive impact of affirmative care, psychologists are encouraged to empower and validate TGNC adult and adolescent clients’ experiences and to nurture a sense of agency and autonomy in many aspects of their lives (e.g., social, employment, school). Psychologists can explore both the challenges TGNC people face, as well as protective factors that foster resilience (Singh et al., 2011).

Psychologists are encouraged to be aware of the importance of affirmative social support and assist adult and adolescent clients to build social support networks in which their gender identity is accepted and affirmed. Psychologists can assist TGNC clients in negotiating family dynamics that may arise in the course of exploring and establishing gender identity. Depending on the context of psychological practice, these issues might be addressed in individual work with TGNC clients, conjoint sessions including members of their support system, family therapy, or group therapy. Many clients may request help in deciding how and when to come out to family members. Similarly, psychologists can help TGNC people decide how and when to reveal their gender identity at work or school, in religious communities, and to friends and contacts in other settings.

Due to the importance of family acceptance and support for TGNC individuals’ well-being, psychologists strive to assist family members in exploring feelings about their loved one’s gender identity and gender expression. Psychologists may employ models of family adjustment (Emerson & Rosenfeld, 1996; Lev, 2004) to help reduce isolation and to normalize the process family members go through upon learning that they have a TGNC family member. It can be
helpful to normalize significant others’ feelings of loss or fear of what may happen to current
relationships as clients disclose their gender identity and expression to others. Psychologists can
help significant others adjust to changing relationships and consider how to talk to extended
family, friends, and other communities members about their TGNC loved ones. Providing
significant others with referrals to TGNC affirmative providers, educational resources and
support groups can have a profound impact on their understanding of gender identity and their
communication with TGNC loved ones. Psychologists working with couples and families may
also identify ways to invite significant others’ participation, if applicable, in a client’s social
and/or medical transition.

**Guideline 7. Psychologists strive to create TGNC-affirmative environments and to assist
their clients in accessing and navigating systems.**

**Rationale**

Cisgenderism and society’s adherence to the gender binary influences the well-being of
TGNC people within their families, schools, healthcare, legal systems, workplaces, religious
traditions, and communities (Gonzalez & McNulty, 2010; McGuire, Anderson, & Toomey,
2010). Many TGNC clients have negative experiences of being pathologized by practitioners and
may be distrustful of care providers (Lev, 2009). Mental health providers can have specific
conversations with TGNC clients about their experiences of the mental health system to foster
TGNC-affirmative environments.

Previous experiences of discrimination and prejudice with healthcare providers can
problematize power differentials in the therapeutic relationship. For instance, TGNC clients
have been routinely required to obtain an endorsement letter from a psychologist attesting to the
stability of their gender identity to access an endocrinologist, surgeon, or legal institution (e.g.,
The frequent mandate to obtain such documentation from a psychologist can influence rapport and add to clients’ worry that documentation will be withheld, and health care access delayed or blocked, if they do not please or appease a treating provider (Bockting et al., 2006; Wharton, 2007). Whether a TGNC person has personally experienced interactions with providers as disempowering or has learned from community members to expect such a dynamic, it may be common for TGNC people to initially be very cautious when entering into a therapeutic relationship. If a TGNC client feels validated and empowered by a psychologist, the therapeutic relationship will benefit and the client may be more willing to explore their authentic selves and share uncertainties and ambiguities that are a normal part of identity development.

**Application**

Because TGNC people experience transprejudice, psychologists strive to ensure that their work settings are welcoming and respectful of TGNC clients and are mindful of what TGNC clients may perceive as unwelcoming environments. To do so, psychologists can educate themselves about cisgenderism and the many ways it may be expressed. As a result, when TGNC people access various treatment settings and public spaces, they may experience less harm, disempowerment, or pathologization, and will be more likely to avail themselves of resources and support allowing them to thrive.

Psychologists are encouraged to be proactive in considering how overt or subtle cues in their workplaces and other environments may affect the comfort and safety of TGNC clients. Psychologists are encouraged to display TGNC-affirmative resources in waiting areas and avoid the display of items that reflect cisgenderism or transprejudice to improve TGNC client comfort (Lev, 2009). Psychologists are encouraged to examine how their language (e.g., use of incorrect
pronouns and names) may reproduce the gender binary in overt or in subtle and unintentional ways (Smith, Shin, & Officer, 2012). A psychologist may consider making changes to paperwork, forms or outreach materials to ensure that these materials are more inclusive of TGNC people (Spade, 2011b). For example, demographic questionnaires can communicate respect through the use of inclusive language and the inclusion of a range of gender identities. Psychologists also endeavor to ensure that their support staff provides welcoming environments for TGNC people.

Psychologists are encouraged to be aware of challenges TGNC clients face accessing gender-neutral restrooms and the discomfort that can result from being forced to use a men’s or women’s room (Transgender Law Center [TLC], 2005). In addition to the emotional distress a public, forced restroom choice may create, TGNC people are frequently concerned with others’ reactions to their presence in a specific restroom (TLC, 2005). TGNC people will sometimes avoid using any facility, placing themselves in physical distress, rather than utilizing a men’s or women’s room. Psychologists are encouraged to identify the private or gender-neutral restrooms that TGNC clients can use and have signs to denote the placement of these restrooms so they are accessible. When psychologists work in buildings that do not have a gender-neutral restroom, they endeavor to create one or identify the nearest gender-neutral restroom and share this information with clients.

Psychologists can help empower TGNC people by providing psychoeducational information and support for their family members, friends, coworkers and community members (Lev, 2004, 2009). Working with TGNC clients to actualize their plan of disclosing their gender identity to others, including family, friends, employers and co-workers, may be a vital part of the clinician’s role. Additionally, a psychologist can be a liaison and advocate for a TGNC person in
a variety of care and institutional settings (e.g. inpatient medical and psychiatric hospitals, substance abuse treatment settings, nursing homes, foster care, religious communities, and prisons) to help ensure that the TGNC person’s mental health needs are being addressed and that the person’s gender identity is being respected and accommodated to the extent possible (Glezer, McNiel, & Binder, 2013; Merksamer, 2011).

Guideline 8. Psychologists recognize that mental health concerns may impact the course of psychological assessments and interventions with TGNC individuals.

Rationale

Mental health problems experienced by a TGNC person may or may not be related to that person’s gender identity and may complicate assessment and intervention. A number of studies have reported high rates of mental health problems among TGNC people, higher than found among the general population (Bockting et al., 2013; Bradford et al., 2007; Clements-Nolle et al., 2006; Fredricksen-Goldsen et al., 2013; Grossman & D’Augelli, 2007; Xavier et al., 2005). In some cases, there may not be any relationship between a person’s gender identity and a co-occurring condition (e.g., depression, PTSD, substance abuse). In other cases, the client’s gender identity has led to or contributes to a co-occurring mental health condition, either directly by way of gender dysphoria or indirectly by way of minority stress and oppression (Hendricks & Testa, 2012; Meyer, 1995, 2003). In extremely rare cases, a co-occurring condition can mimic gender dysphoria (i.e., a psychotic process that distorts the perception of one’s gender; Baltieri & De Andrade, 2007; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2004). Given the infrequency with which this occurs, psychologists are strongly encouraged to consult with clinicians that specialize in working with TGNC clients before determining that a psychotic process is producing characteristics of gender nonconformity or dysphoria.
Gender identity may affect how a TGNC individual experiences a co-occurring condition and/or a co-occurring condition may complicate the client’s gender expression or identity. For example, an eating disorder may be influenced by a TGNC person’s gender expression (i.e., rigid eating patterns used to manage body image or menstruation may be related to gender identity; Ålgars, Alanko, Santilla, & Sandnabba, 2012; Murray, Boon, & Touyz, 2013). In addition, the presence of an autism-spectrum condition may complicate a client’s articulation and exploration of gender identity concerns (Jones et al., 2012). Administration of feminizing or masculinizing hormone therapy can positively or negatively affect existing mood disorders, further complicating assessment and treatment (Coleman et al., 2011).

A significant amount of research has demonstrated the relationship between stress related to stigma associated with gender nonconformity and various mental health problems that may be experienced by TGNC people. Given that TGNC people experience higher than average rates of physical and sexual violence (Clements-Nolle et al., 2006; Kenagy & Bostwick, 2005; Lombardi, Wilchins, Priesing & Malouf, 2001; Xavier et al., 2005), harassment (Beemyn & Rankin, 2011), employment and housing discrimination (Bradford et al., 2007), and general harassment and discrimination (Factor & Rothblum, 2007), they are likely to experience significant levels of minority stress. Studies have demonstrated the disproportionately high levels of negative psychological sequelae related to minority stress, including substance abuse, suicidal ideation and suicide attempts (Clements-Nolle et al., 2006; Nuttbrock et al., 2010; Xavier et al., 2005), and completed suicides (Dhejne et al., 2011; van Kesteren, Asscheman, Megens & Gooren, 1997). Recent studies have begun to demonstrate an association between sources of external stress and psychological distress (Bockting et al., 2013; Nuttbrock et al., 2010), including suicidal ideation and attempts (Goldblum et al., 2012; Testa et al., 2012).
The minority stress model accounts for both the negative mental health effects of stigma-related stress and the processes by which members of the minority group may develop resilience and resistance to the negative effects of stress (Meyer, 1995, 2003). This model has been adapted to TGNC populations (Hendricks & Testa, 2013). TGNC people can develop resilience when they connect with other TGNC people who provide information on how to navigate transprejudice, and access necessary care and resources (Singh et al., 2011). TGNC people may need help developing social support systems to nurture resilience and bolster their ability to navigate transprejudice (Singh & McKleroy, 2011).

Application

Because of the increased risk of stress related mental health conditions, psychologists are encouraged to conduct a careful diagnostic assessment, including a differential diagnosis, when working with TGNC clients (Coleman et al., 2011). Taking into account the intricate interplay between the effects of mental health symptoms and gender identity and gender expression, psychologists are encouraged to neither ignore mental health problems a TGNC client is experiencing, nor incorrectly assume that those mental health problems are a result of the client’s gender identity or gender expression.

A comprehensive and balanced assessment may include information about a client’s past experiences of discrimination or victimization, anticipation of future victimization or rejection, and internalized transprejudice (Coolhart, Provancher, Hager, & Wang, 2008), as well as coping strategies and sources of resilience. Gathering information about negative life events directly related to the client’s gender identity and gender expression may assist psychologists to understand the sequelae of stress and discrimination, distinguishing them from concurrent and potentially unrelated mental health problems (Wharton, 2007).
Psychologists are encouraged to help clients understand the pervasive impact of minority stress and discrimination that may exist in their lives, assisting them to distinguish between the impact of their gender identity and others’ reactions to that identity (Hendricks & Testa, 2012). With this support, clients can better understand the origins of their mental health symptoms and normalize their reactions when faced with challenging circumstances outside of their control.

Guideline 9. Psychologists working with TGNC individuals recognize the importance of an interdisciplinary approach to providing care and strive to work collaboratively with other providers.

Rationale

The potential interplay of biological, psychological and social factors in diagnosis and treatment can make collaboration across disciplines crucial when working with TGNC clients (Hendricks & Testa, 2012). Outcome research and TGNC-serving organizations support a need for interdisciplinary care and comprehensive, integrated services for TGNC clients (APA, 2010; Coleman et al., 2011; Dhejne et al., 2011; Hembree et al., 2009; Rachlin, 2002; Spack et al., 2012). In addition to psychologists, team members may include surgeons, primary health care providers, endocrinologists, nurses, OB/GYNs, social workers, nutritionists, psychiatrists, geneticists, pastoral counselors and chaplain, and career or educational counselors. Just as psychologists often refer clients to medical providers for assessment and treatment of medical issues, medical providers may rely on psychologists to provide documentation TGNC clients will use to initiate a medical transition and to address the psychological and social aspects of transition with the client before, during, and after hormone therapy or surgery (Coleman et al., 2011, Hembree et al., 2009; Lev, 2009). In addition to working collaboratively with other providers, psychologists who obtain additional training to specialize in work with TGNC clients
may also serve as consultants in the field (e.g., providing additional support to providers working with TGNC clients or assisting school and workplaces with diversity training).

Application

Psychologists are encouraged to collaborate with colleagues in medical and allied health disciplines involved in TGNC clients’ care (e.g., hormonal and surgical treatment, primary health care; Coleman et al., 2011; Lev, 2009). Collaborative care enhances the effectiveness of all treatment offered and minimizes barriers to care for TGNC clients. Collaborative care may take many forms. At a basic level, collaboration may entail the creation of required documentation clients present to surgeons or medical providers to access gender affirming medical interventions (surgery, hormone therapy; Coleman et al., 2011). Psychologists may need to offer support, information, and education to interdisciplinary colleagues who are unfamiliar with issues of gender identity and gender expression to assist their clients in obtaining TGNC-affirmative care (Holman & Goldberg, 2006; Lev, 2009). For example, a psychologist who is assisting a trans woman with obtaining gender affirming surgery may, with the client’s consent, contact the client’s new gynecologist in preparation for the client’s first medical visit. This contact could include providing the gynecologist with general information about the client’s gender history, coaching on respectful ways to communicate with and about the client, and discussing how both providers could most affirmatively raise the continued need for appropriate health checks to ensure the client’s best physical health (Holman & Goldberg, 2006).

Psychologists in interdisciplinary settings could also collaborate with medical professionals able to provide hormone therapy, educating clients and and ensuring clients are able to make fully informed decisions prior to starting hormonal treatment (Coleman et al., 2011; Deutsch, 2012; Lev, 2009). Psychologists working with adolescents play a particularly important
role on the interdisciplinary team due to the added layers related to cognitive and social
development, along with family dynamics, including degree of support, that are present. This
role is especially imperative when providing psychological evaluation to determine whether a
medical intervention is in the adolescent’s best interest and timely. When psychologists are not
part of an interdisciplinary setting, especially in isolated or rural communities, they can identify
interdisciplinary colleagues with whom they may collaborate and/or refer. For example, a rural
psychologist could identify a trans-affirmative pediatrician in a surrounding area and collaborate
with the pediatrician to work with parents raising concerns about their TGNC and questioning
children and adolescents. Psychologists are also able to collaborate with social service colleagues
to provide their clients with TGNC-affirmative referrals related to housing, financial support,
vocational/educational counseling and training, TGNC affirming religious or spiritual
communities, and peer support and other community resources (Gehi & Arkles, 2007). This
collaboration might also include assuring that minor clients who are in the care of the state have
access to culturally appropriate care.

Guideline 10. Psychologists working with TGNC children and adolescents acquire the
requisite knowledge, skills, and awareness.

Rationale

Many children develop stability (constancy across time) in their gender identity between
ages 3 to 4 (Kohlberg, 1966) while gender consistency (recognition that gender remains the same
across situations) often does not occur until ages 4 to 7 (Siegal & Robinson, 1987). This can
create significant complexity in working with children who demonstrate gender nonconformity
in pre-school and early elementary years. Existing research suggests that a significant portion of
gender-questioning children ultimately do not identify as TGNC or pursue medical interventions
(hormone therapy, surgery) as an adult, whereas between 12% and 50% of children diagnosed with GID may persist in their identification with a gender different than sex assigned at birth into adolescence (Drummond, Bradley, Peterson-Badaali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008). However, this research often includes both children diagnosed with GID and those who are considered sub-threshold (i.e., GID Not Otherwise Specified per DSM IV-TR), which might artificially inflate the number of “desisters” reported. A recent study found that children who identify more intensely with a gender different than sex assigned at birth in childhood are more likely to persist in this gender identification into adolescence (Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013). Gender questioning children who do not persist may be more likely to later identify as gay or lesbian (Bailey & Zucker, 1995; Drescher, 2014; Wallien & Cohen-Kettenis, 2008). Current research suggests that when gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term TGNC identification increases (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Wallien & Cohen-Kettenis, 2008; Zucker, 2008b).

Mental health providers working with TGNC pre-pubertal children use two primary treatment approaches to address gender identity concerns (Byne et al., 2012; Drescher, 2013). One approach encourages an affirmation and acceptance of children’s expressed gender identity, emphasizing the importance of allowing a child’s gender identity to unfold without expectation of a specific outcome (Ehrensaft, 2012). Clinicians using this approach believe that open exploration and affirmation can assist youth to develop coping strategies and emotional tools to integrate a positive TGNC identity should gender questioning persist (Edwards-Leeper & Spack, 2012). This approach does not assume that a child will ultimately develop a TGNC identity, but allows the child room to explore gender identity options. This may include assisting
children in their desire to socially transition and, if gender questioning persists, discussing available medical interventions with the family when children’s bodies have reached an appropriate physical developmental stage (i.e., Tanner stage 2) (deVries & Cohen-Kettenis, 2012; Edwards-Leeper & Spack, 2012; Hembree et al., 2009). A second approach encourages children to embrace their given bodies and their assigned gender roles. This may include endorsing and supporting behaviors and attitudes that align with the child’s sex assigned at birth. This approach attempts to support children in aligning with their assigned gender identity prior to the onset of puberty (Zucker, 2008a; Zucker, Wood, Singh, & Bradley, 2012). It highlights the research showing that only a minority of gender-questioning children will persist with TGNC identification into adolescence and adulthood. Clinicians using this approach believe that undergoing multiple medical interventions and living as a TGNC individual in a world that stigmatizes gender nonconformity is a less desirable outcome if children can be assisted to successfully and happily align with their sex assigned at birth (Zucker et al., 2012).

It is important to note that neither approach to working with TGNC children has been adequately empirically validated, nor is there consensus regarding best practice. Lack of consensus may be due, in part, to divergent ideas regarding what constitutes optimal treatment outcome for TGNC and gender questioning youth (Hembree et al., 2009). There is significant dissension in the field regarding the efforts to encourage children to develop behaviors and attitudes that align with sex assigned at birth (AACAP, 2012).

Adolescents presenting with gender identity concerns bring their own set of unique challenges. This may include having a late-onset (i.e., post-pubertal) presentation of gender non-conforming identification with no history of gender role nonconformity or gender questioning in childhood (Edwards-Leeper & Spack, 2012). In these cases, parents are often taken off guard by
the news that their teenager does not identify with the sex assigned at birth, making it more
difficult for parents to be initially supportive. Complicating their clinical presentation, many
gender-questioning adolescents also present with co-occurring psychological concerns, such as
suicidal ideation, self-injurious behaviors (Liu & Mustanski, 2012; Mustanski, Garofalo, &
Emerson, 2010), drug and alcohol use (Garofalo et al., 2006), and autism spectrum disorders (de
Vries, Noens, Cohen-Kettenis, van Berkelar-Onnes, & Doreleijers, 2010; Jones et al., 2012).
Additionally, adolescents can become intensely focused on their immediate desires, resulting in
outward displays of frustration and resentment when faced with any delay in receiving the
medical treatment from which they feel they would benefit and to which they feel entitled
(Angello, 2013). This intense focus on immediate needs can create challenges in assuring that
adolescents are cognitively and emotionally able to make sometimes life-altering decisions to
permanently change their name or gender marker, begin hormone therapy (which may impact
fertility) or pursue surgery.

The use of puberty suppressing medication or “blockers” (GnRH analogue) is a fully
reversible medical intervention used to delay puberty for appropriately screened adolescents with
gender dyshoria. This medical intervention provides TGNC adolescents time to clarify and
solidify their gender identity without the added stress of developing irreversible secondary sex
characteristics that may be incongruent with their affirmed gender identity (Hembree et al.,
2009). This intervention has been shown to result in positive treatment outcomes and can serve a
diagnostic purpose, allowing providers working with adolescent clients to assess whether gender
dysphoria and/or co-occurring psychological issues improve or resolve when puberty is halted
and the adolescent feels supported in their gender exploration (de Vries et al., 2011). The high
cost of the GnRH analogue and exclusions from health insurance coverage of this treatment restricts access for youth and families with limited financial resources.

**Application**

Psychologists working with TGNC and gender-questioning children and adolescents strive to regularly review the most current literature in this area, recognizing the limited available research regarding the potential benefits and risks of different treatment approaches. Psychologists are encouraged to offer parents and guardians clear information about available treatment approaches, regardless of the specific approach chosen by the psychologist.

Psychologists endeavor to provide psychological service to TGNC children and adolescents that draws from empirically validated literature when available, recognizing the impact their values and beliefs may have on the treatment approaches they select (Ehrbar & Gorton, 2010). Psychologists are encouraged to remain aware that what one child and/or parent may be seeking in a therapeutic relationship may not coincide with a clinician’s approach. In cases in which a child and/or parent identify different preferred treatment outcomes than a clinician, it may not be clinically appropriate for the clinician to continue working with the child and family, and alternative options might be considered. Psychologists may also find themselves navigating family systems in which youth and their caregivers are seeking different treatment outcomes (Edwards-Leeper & Spack, 2012). Psychologists are encouraged to carefully reflect on their personal values and beliefs about gender identity development in conjunction with the available research, and to keep the best interest of the child or adolescent at the forefront of their clinical decisions at all times.

Because gender non-conformity may be especially transient for younger children in particular, the psychologist’s role may be to help support the child and family through the
process of exploration and self-identification. Additionally, psychologists can provide parents with information about possible long-term trajectories children may take in regard to their gender identity, along with the available medical interventions for adolescents whose TGNC identification persists.

When working with adolescents, psychologists recognize that some adolescent clients will not have a strong history of childhood gender role nonconformity or gender dysphoria either by self-report or family observation. Some of these adolescents may have withheld their feelings of gender non-conformity out of a fear of rejection, confusion, conflating gender identity and sexual orientation, or a lack of awareness of the option to identify as transgender or TGNC. Parents of these adolescents may need additional assistance in understanding and supporting their child, given that late onset gender dysphoria and TGNC identification may come as a significant surprise. Although moving more slowly and cautiously in these cases is often advisable, these adolescents can still be considered for medical treatment despite the lack of apparent gender dyphoria in childhood. Given the possibility of adolescents’ intense focus on immediate desires and strong reactions to perceived delays or barriers, psychologists are encouraged to validate these clients’ concerns and desire to move through the process quickly while simultaneously remaining thoughtful and deliberate in treatment. Adolescents and their families may need support in tolerating ambiguity and uncertainty with regard to gender identity and its development; care should be taken not to foreclose this process.

For adolescents who exhibit a long history of gender non-conformity, psychologists can inform parents that the adolescent’s self-affirmed gender identity is most likely stable (de Vries et al., 2011). The clinical needs of these adolescents may be different than those who are in the initial phases of exploring or questioning their gender identity. It is important for psychologists
to identify the client’s level of preparedness for requested interventions and avoid unnecessary stalling for those who are ready to move forward while not rushing for those who are still exploring or questioning.

Psychologists working with TGNC children and adolescents are encouraged to be familiar with available medical treatment options for adolescents (puberty suppressing medication, hormone replacement therapy) and work collaboratively with medical providers to provide appropriate care to clients. Since the ongoing involvement of a knowledgeable mental health provider is encouraged due to the psychosocial implications and often also a required part of the medical treatment regimen offered to TGNC adolescents (Coleman et al., 2011; Hembree et al., 2009), psychologists often play an essential role in assisting TGNC and gender-questioning youth in this process.

Psychologists can work with parents and caregivers of TGNC and gender-questioning children and adolescents to identify ways they can support their child or adolescent in expressing their gender (Brill & Pepper, 2008), recognizing how various power differentials make this challenging for many gender questioning youth (Singh & Jackson, 2012). To this end, psychologists, parents, and caregivers are encouraged to involve their children and adolescents in developmentally appropriate decision-making about their education, healthcare, and peer networks as these relate to children’s and adolescents’ gender identity and gender expression (Ryan et al., 2010). Psychologists are encouraged to educate themselves about the advantages and disadvantages of social transition during childhood and adolescence, and discuss these factors with both their young clients and clients’ parents. Psychologists can also encourage parents and caregivers to assess how youth are being treated by adults and by peers in schools and other settings in which they interact, especially related to the level of affirmation these
environments can offer (Grossman & D’Augelli, 2006). Stressing to parents the importance of allowing their child the freedom to return to an earlier gender identity or a gender identity that aligns with sex assigned at birth at any point cannot be overstated, particularly given the research that suggests that only a minority of young gender role nonconforming children will ultimately choose a gender identity different from that assigned at birth (Wallien, & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Psychologists strive to acknowledge and explore the fear and burden of responsibility that parents and caregivers may feel as they make decisions about the health of their child or adolescent (Grossman, D’Augelli, Howell, & Hubbard, 2006). Parents and caregivers may benefit from a supportive environment to discuss feelings of isolation, explore loss and grief they may experience, vent anger and frustration at systems that disrespect or discriminate against them and their children, and learn how to communicate with others about their child’s or adolescent’s gender identity or gender expression (Brill & Pepper, 2008).

In supporting families in their decisions about whether a social transition is in the best interest of a child or adolescent, psychologists are encouraged to include discussions of the anticipated degree of acceptance in the environment or community where the social transition may occur, paying particular attention to potential safety issues in less accepting environments. In some cases, psychologists can strive to offer families options for making a social transition to varying degrees, such as allowing children to choose their clothing, but keeping the given name and gender pronouns. Psychologists may be asked to advocate for TGNC children and adolescents who choose to make a social transition, particularly in the school environment.

**Guideline 11.** Psychologists strive to understand the impact that changes in gender identity and gender expression can have on romantic and sexual relationships.

**Rationale**
Relationships involving TGNC people are both similar to and different from relationships that involve only cisgender people. TGNC people have been significantly impacted by inaccurate assumptions about their sexuality and relationships. Relationships involving a TGNC partner(s), can be healthy and successful (Kins, Hoebeke, Heylens, Rubens, & De Cuypere, 2008), as well as challenging (Brown, 2007; Iantaffi & Bockting, 2011), therefore psychologists should strive to be aware of common presenting issues partners have.

Historically, it was assumed that all TGNC people’s sexual orientation would be heterosexual post-transition (e.g., trans female with a cisgender male; Benjamin, 1966). This assumption prescribed only certain relationship partners (American Psychiatric Association, 1980; Benjamin, 1966; Chivers & Bailey, 2000), denied access to surgery for trans males identifying as gay or bisexual (Coleman & Bockting, 1988), and even required that TGNC individuals’ existing legal marriages (heterosexual relative to assigned birth sex) be dissolved before they could gain access to transition care (Lev, 2004). The field now recognizes that TGNC people have a range of sexual orientations (dickey, Burnes, & Singh, 2012).

Alignment between gender identity and gender expression through dress, behavior or physical alterations (i.e., hormones, surgery) does not necessarily effect to whom a TGNC person is attracted (Coleman et al., 1993). TGNC people may become more open to exploring their sexual orientation and/or may redefine sexual orientation as they move through transition (Daskalos, 1998; Devor, 1993; Schleifer, 2006). Through increased comfort with gender identity, gender role, and/or body, clients may explore aspects of their sexual orientation that were previously hidden or that felt discordant with clients’ sex assigned at birth. Following a medical and/or social transition, a TGNC person’s sexual orientation may shift (e.g., renewed exploration of sexual orientation in the context of TGNC identity, shift in attraction or choice of sexual
partners, widened spectrum of attraction, shift in sexual orientation identity) or remain constant (Samons, 2008). For example, a trans man who had identified as lesbian in the past may later find himself attracted to men (Bockting et al., 2009; Coleman et al., 1993). A trans woman who was married to a woman pre-transition may remain in this relationship post-transition (Lev, 2004).

Although there is not full consensus in the field (APA, 2009), an increasing number of psychologists working with TGNC clients believe that a client’s gender identity, not the sex assigned at birth, is most appropriately used to anchor a person’s sexual orientation (Bockting et al., 2009; dickey et al., 2012). For example, a female-identified person attracted to women would be considered to be lesbian (TGNC woman attracted to women).

**Application**

Psychologists may help foster resilience in relationships by addressing issues specific to partners of TGNC people. Psychologists may provide support to partners of TGNC people who are having difficulty with their partner’s evolving gender identity or transition. Partner peer support groups may be especially helpful in navigating internalized transprejudice, shame, resentment, and relationship concerns related to a partner’s gender transition. Meeting or knowing other TGNC people, other partners of TGNC people, and couples who have successfully navigated transition may also help TGNC clients and their partners, and may act as protective factors (Brown, 2007).

Patterns of sexual attraction and sexual orientation may shift temporarily or permanently following transition, therefore TGNC people and their partners may fear the loss of sexual attraction and shifting gender roles in the relationship. Female partners of TGNC men who identify as lesbian may struggle with the idea that being in a relationship with a TGNC man may
cause others to perceive them as a heterosexual couple (Califia, 1997; Lev, 2004). Similarly, women in heterosexual relationships who later learn that their partner is a TGNC woman may be unfamiliar with navigating stigma associated with sexual minority status when they may be viewed as a lesbian couple (Erhardt, 2007). Additionally, partners may find they are not attracted to a partner after transition. As an example, a lesbian whose partner transitions to a male identity may find that they are no longer attracted to this person because her sexual orientation is toward female-identified individuals. Partners of TGNC people may also experience grief and loss as their partners engage in social and/or medical transitions.

In working with TGNC people, psychologists can help clients address the complexities of negotiating relationships and sexuality (dickey et al., 2012). Psychologists may aid TGNC clients in deciding when and how to come out to current or potential romantic and sexual partners, communicating about sexual desires, renegotiating intimacy, navigating potential effects of hormonal and surgical changes, and exploring boundaries regarding touch, affection, and safer sex practices (Bockting & Coleman, 2007; Iantaffi & Bockting, 2011; Lev, 2004; Sevelius, 2009). TGNC people may experience increased sexual self-efficacy through transition. At the same time that partners and family members are asked to be understanding of the TGNC person’s transition decisions, TGNC people also need to understand the ways in which these decisions have an impact on the lives of these family members and other friends.

**Guideline 12. Psychologists strive to understand how parenting and family building take a variety of forms in the lives of TGNC people.**

**Rationale**

Psychologists work with TGNC clients across the lifespan to address parenting and family building issues (Kenagy & Hsieh, 2005; Murphy, 2012; Wierckx et al., 2012). Some
TGNC people follow a traditional model of having intercourse as a method of conceiving a child, while others may consider adoption, surrogacy, and assisted reproductive technologies such as sperm or egg donation to build or expand a family (De Sutter, Kira, Verschoor, & Hotimsky, 2002; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001). Current or past use of hormone therapy may limit fertility and restrict a TGNC person’s assisted reproductive options (Darnery, 2008; Wierckx et al., 2012; Zhang, Gu, Wang, Cui, & Bremmer, 1999). Others TGNC people may have children or families before coming out as TGNC or beginning a gender transition.

Children raised with a TGNC parent do not differ appreciably from those raised by cisgender parents (White & Ettner, 2004). However, the medical or social transition of a TGNC parent may shift family dynamics, developing unique challenges and opportunities for partners, children, and other family members. Children of TGNC parents have reported the shifting of family dynamics and fearing the loss of their relationship with a TGNC parent to be of greater concern than the gender transition itself (White & Ettner, 2004). Although clients’ transitions do not typically have an effect on their parenting abilities (Minter & Wald, 2012), preexisting partnerships or marriages may not survive the disclosure of a TGNC identity or a subsequent transition, and may result in divorce or separation, which could impact the children in the family.

A positive relationship between parents, regardless of marital status, has been suggested to be an important protective factor for children of TGNC people (White & Ettner, 2007). This seems to be the case especially when the child is reminded of the parent’s love and continued presence in their life. It is generally the case that younger children are able to incorporate the transition of a parent more easily than those children who are adolescents (Lev, 2004). If separated or divorced from their partners or spouses, TGNC parents may be at high risk for loss of custody or visitation...
rights as a result of their gender identity or gender expression (Flynn, 2006). This effect of transprejudice is especially common for TGNC people of color (Crozier, 2012; Grant et al., 2011).

**Application**

TGNC clients may present with a range of parenting and family building issues. Some clients will seek support to address issues within preexisting family systems, some will explore the creation or expansion of a family, and some will need to be introduced to potential fertility issues related to hormone therapy, pubertal suppression, or surgical transition. Psychologists are encouraged to attend to the unique parenting and family building concerns of TGNC clients and to remain aware that some TGNC people have previous parenting experience (Freeman, Tasker, & Di Ceglie, 2002; Grant et al., 2011; Wierckx et al., 2012). Being a parent may impact a client’s decision to come out as TGNC or begin transition. Clients may choose to delay disclosure until their children have grown and left home. Psychologists can work with clients to plan for disclosure to a partner, previous partner or children, paying particular attention to resources that assist TGNC people to discuss their identity with children of various ages (Bockting et al., 2006). It may be important to address the pros and cons of this decision process in a thoughtful and deliberate manner. This does not mean that there will be no difficulties as a result of disclosure, but it might serve to avoid significant concerns that could develop, including loss of trust. Psychologists may provide family counseling to assist a family in managing disclosure, improve family functioning to embrace the TGNC client’s identity and contribution, and assist the TGNC person in attending to the ways that their transition process has impacted their family members (Lev, 2004; Samons, 2009).
In discussing family building options with TGNC people, psychologists are encouraged to remain aware that some of these options require medical intervention, are not available everywhere and can be extremely costly (Coleman et al., 2011). Although reproductive services should not be denied to TGNC people, TGNC people may find it challenging to find medical providers who are willing to offer them treatment and may struggle to afford the cost (Coleman et al., 2011). Psychologists can work with clients to manage feelings of loss, grief, anger and resentment that may arise if they are unable to access or afford the reproductive services they need (Bockting et al., 2006; De Sutter et al., 2002) and provide support when making decisions about family building.

When TGNC clients consider beginning hormone therapy, psychologists seek to engage clients in a conversation about the possibly permanent effects on fertility to better prepare clients to make a fully informed decision. This may be of special importance with TGNC adolescents and young adults who often feel that family planning or loss of fertility is not a significant concern in their current daily lives and therefore disregard the long-term reproductive implications of hormone therapy or surgery (De Sutter, 2009). Psychologists can play a critical role in educating adolescent and young adult clients and their parents about the long-term effects of medical interventions on fertility and assist them in offering informed consent prior to pursuing such interventions. While hormone therapy may limit fertility (Coleman et al., 2011), psychologists can encourage TGNC people to refrain from relying on hormone therapy as the sole means of birth control, even when a client has amenorrhea (Gorton & Grubb, in press). It is also encouraged to discuss contraception and safer sex practices with TGNC clients given that clients may still have the ability to conceive even when taking hormone therapy (Bockting, Robinson, & Rosser, 1998).
Depending on the timing and type of options selected, psychologists may explore the physical, social, and emotional effects of delaying or stopping hormone therapy or undergoing fertility treatment to becoming pregnant with their clients. TGNC people who choose to halt hormone therapy during attempts to conceive or carry a pregnancy may need additional psychological support. For example, psychologists can assist their clients and their clients’ families in managing the additional transprejudice and scrutiny that may result when a TGNC person with stereotypically masculine features becomes visibly pregnant. It can also be of assistance to help TGNC clients address grief when they cannot engage in reproductive activities that are consistent with their gender identity or when they encounter barriers not typically faced by cisgender people (Vanderburgh, 2007).

For TGNC people with existing families, psychologists can support their clients in seeking legal counsel regarding the procurement or maintenance of legal parental rights, such as adoption or custody. Depending on the situation, this may be desirable even if the TGNC parent is biologically related to the child (Minter & Wald, 2012). Being TGNC is not a legal impediment to adoption in the U.S., although there is the potential for covert discrimination and barriers. The question of whether to disclose TGNC status on an adoption application is a personal one. However, given the extensive background investigation frequently conducted it may be difficult, to avoid disclosure. Many lawyers favor disclosure to avoid any potential legal challenges to the adoption process (Minter & Wald, 2012).

Guideline 13. Psychologists strive to understand the unique experiences of middle-aged and older TGNC adults.

Rationale

Cohort and generational differences have been widely addressed in the scholarship on
adult development and aging (Auldridge, Tamar-Mattis, Kennedy, Ames, & Tobin, 2012), and these differences impact the lives of TGNC people. TGNC people’s experiences may be influenced by the chronological age at which they self-identify as TGNC and the age at which they begin identifying as transgender, come out, or transition socially and/or medically (Birren & Schaie, 2006; Bockting & Coleman, 2007; Cavanaugh & Blanchard-Fields, 2010; Nuttbrock et al., 2010; Wahl, Iwarsson, & Oswald 2012). Their generational or historical cohort may also play a role in these experiences (1950 vs. 2010; Fredrikson-Goldsen et al., 2011) and influence their socialization in gender role behaviors and expectations based on their assigned sex and the extent of a client’s adherence to these societal standards.

Individuals who transitioned before the 1990s were more likely affected by the prevailing view of gender as binary and may have felt greater pressure to pass, even to be “stealth” (attempt to pass as cisgender and hide their TGNC identity or experience) after transition and to avoid interactions with social services or other TGNC people (Benjamin, 1966; Green & Money, 1969). Some who were already established in careers were encouraged to find new ones. Middle-aged and older TGNC adults who transitioned at an early age and are stealth may struggle to find social and peer support. These TGNC elders may be at heightened risk for depression and anxiety due to keeping information regarding their transition status from family, friends and community. Due to their hidden gender identity, older TGNC individuals may also have had difficulty connecting with same age peers. TGNC elders may not feel comfortable attending high school or college reunions or connecting with childhood friends on social networking sites (Fredrikson-Goldsen et al., 2010, 2013). Even decades after a medical or social transition, elder TGNC clients may still be guided by the predominant gender binary that existed at the time of their transition (Knochel, Croghan, Moore, & Quam, 2011). This “lost generation” (Services and
Advocacy for GLBT Elders [SAGE] & NCTE, 2012, p. 27) of middle-age and elder TGNC people is understudied and ill understood (Auldridge et al., 2012). Generational issues within the TGNC community may further impact client’s feelings of being isolated, judged, or misunderstood even by their own community.

Recent survey research has identified that older TGNC clients experience under-employment and gaps in employment, often from discrimination (Auldridge et al., 2012; Beemyn & Rankin, 2011; Factor & Rothblum, 2007; Rosser et al., 2007). These obstacles to employment may lead to economic disparities that result in increased needs for housing and other social services (NCTE, 2012; SAGE & NCTE, 2010). A Transgender Law Center survey found that, despite having a higher than average educational level for their age group, TGNC and LGB elders were found to have less financial well-being (Hartzell, Frazer, Wertz, & Davis, 2009). Individuals may be frightened to apply for social security benefits fearing that their TGNC identity may become known (Hartzell et al., 2009). Medical care may also be avoided for the same reasons, increasing the likelihood that a TGNC elder may ultimately need a higher level of medical care (e.g., home based care, assisted living, or nursing home) than their same age cisgender peers (Hartzell et al., 2009; Maddux, 2011; Mikalson et al., 2012). These types of care settings are rarely sensitive to the physical needs of TGNC elders (National Senior Citizens Law Center, 2011). TGNC elders may make greater use of LGBT affirming religious organizations than their LGB peers (Porter et al., 2013), despite the limited availability of these resources in their local area. Hospice care systems may lack awareness of specific fears of TGNC people, such as anxiety about others discovering their hidden gender identity or sex assigned at birth when they die (Thomas, 2004).

Application
Much has been written about the resilience of elders who have endured trauma (Fuhrmann & Shevlowitz, 2006; Hardy, Concato, & Gill, 2004; Resnick, Gwyther, & Roberto, 2011; Rodin & Stewart, 2012). TGNC elders have likely experienced significant trauma related to their gender nonconformity and isolation from the TGNC community. Psychologists may aid TGNC elders by helping them to identify the sources of their resilience and by demonstrating how they may act as role models to younger TGNC people. TGNC people who begin hormone therapy later in life may have a smoother transition process due to hormone levels naturally waning with age (Witten & Eyler, 2012). TGNC people who transition later in life may not be able to maintain normal hormone dosages due to complicating medical concerns (Feldman & Safer, 2009). Removing reproductive organs may be less of a concern for TGNC men who no longer have a menstrual cycle. Health care providers may also address prostate concerns of TGNC clients by lowering testosterone levels in people with male sex assigned at birth (Witten & Eyler, 2012). A TGNC elder over the age of 60 who wishes to socially or medically transition may be at risk from transprejudice that questions the value of transition at an older age or suggests that the client is not invested in transition given the length of time they have waited to do so (Auldridge et al., 2012). They may also struggle with grief over lost time and missed opportunities (Bockting, 2013). Psychologists can assist their elder TGNC clients to cultivate authentic, dynamic lives regardless of the age at which they identify issues of gender incongruence or the age at which the decide to alter their gender expression.

Psychologists strive to understand the biopsychosocial needs of TGNC elders and to facilitate treatment of their psychological, social, and medical concerns. Many of these individuals are socially isolated (Auldridge et al., 2012). Even if they were comfortable telling others about their TGNC identity when they were younger, they may choose not to reveal their
identity at a later stage of life (Ekins & King, 2005; Maddux, 2011). This can be a consequence of feeling more physically vulnerable in a youth oriented culture in which elder abuse can occur among those most socially isolated. For those middle and older aged TGNC people who continue to feel the effects of hiding their gender identity, psychologists can assist them in resolving issues of shame, guilt, and internalized transphobia. Clinicians can also provide validation and empathy when older TGNC people have chosen a model of transition that avoids any disclosure of gender identity and is heavily focused on passing as a cisgender person. While connection with other TGNC people could be a potential source of support for these elders, seeking such support might require changing how transition is understood, facing fears associated with coming out, and navigating generational differences in TGNC communities.

Guideline 14. Psychologists respect the welfare and rights of TGNC participants in research, strive to represent results accurately, and are aware of the potential misuse or misrepresentation of findings.

Rationale

The APA Ethical Principles of Psychologists and Code of Conduct (APA, 2010) directs psychologists to conduct research and distribute research findings with integrity and respect for their research participants, to refrain from making assertions concerning research findings that are untrue, and to ensure a strong clinical or scientific foundation for their services. Principles A and E guide psychologists to do no harm, benefit those with whom they work, and safeguard the welfare and rights of those with whom they interact professionally (APA, 2010). These standards and principles are particularly important for TGNC people who are vulnerable to stigma and discrimination (Bockting et al., 2013; IOM, 2011).

Little psychological research has included TGNC options in collected demographic data.
When forced to choose between two inadequate options (male and female), TGNC people become invisible, potentially distorting research findings, and dismissing the experience and existence of TGNC people (IOM, 2011). For example, the HIV prevalence, risks, and prevention needs of TGNC people have historically been subsumed within larger demographic categories (men who have sex with men, women of color), rendering the impact of the HIV epidemic on the TGNC population invisible (Mikalson et al., 2012). This invisibility fails to draw attention to the needs of TGNC populations that experience the greatest health disparities, including TGNC people who are immigrants, low income, homeless, incarcerated, or have disabilities (Hanssmann, Morrison, Russian, Shiu-Thornton, & Bowen, 2010). In addition, some research with TGNC populations has been misused and misinterpreted, negatively impacting TGNC people’s access to health services to address issues of gender identity and gender expression (Bockting, 2005). This has resulted in warranted skepticism and suspicion in the TGNC community when invited to participate in research initiatives. The research to advance the evidence base to inform practice, including guidelines for care to affirm gender identity and gender expression, is still of great necessity. While sufficient evidence exists to support current standards of care (Byne et al., 2012; Coleman et al., 2011), much is yet to be learned to optimize quality of care and outcome for TGNC clients (IOM, 2011; Mikalson et al., 2012).

**Application**

Psychologists conducting research are encouraged to provide a range of options for gender identity outside of the gender binary when collecting demographic information (Conron et al., 2008). Even when research is not specific to TGNC populations, psychologists are encouraged to pay special attention to how information about gender identity is obtained so that TGNC people may be included and accurately represented. For research specific to TGNC
people, this will prevent findings from being generalized to a greater TGNC population when, in fact, findings only pertain to a specific subgroup. For example, findings from a study of transwomen of color with a history of sex work who live in urban areas (Nemoto, Operario, Keatley, Han, & Soma, 2004) do not generalize to all transwomen of color or to the larger TGNC population (Bauer, Travers, Scanlon, & Coleman, 2012; Feldman, Swinburne Romine, & Bockting, in press; Operario et al., 2008).

When conducting research with the TGNC population, psychologists strive to be aware of the challenges associated with studying a relatively small, geographically dispersed, diverse, and, because of the stigma attached to gender nonconformity, hidden and hard to reach population (IOM, 2011). Therefore, as psychologists conduct or use research to inform their practice, they are encouraged to consider the strengths and limitations of various methods to study this population and to interpret and represent findings accordingly.

Psychologists are encouraged to use TGNC-collaborative research models (e.g., Community-Based Participatory Research or Participatory Action Research) where members of the target community are integrally involved in research activities (Bockting et al., 1999; Clements-Nolle & Bachrach, 2003; Singh, Richmond, & Burnes, 2013). In addition, psychologists strive to safeguard against some of these challenges, ensure that the research does not exploit members of this vulnerable population and that findings are represented and disseminated in a meaningful way so as to protect against potential misuse, misinterpretation, and misrepresentation. In conducting research, psychologists strive to be mindful in their communications about research. For example, in communicating research findings in the popular media, psychologists are encouraged to consider that journalists may have limited knowledge about the scientific method and balance the opportunity to educate the public with the risk of
Guideline 15. Psychologists strive to include issues of gender identity and gender expression in professional education and training.

Rationale

Despite its explicit inclusion as an important element of diversity in the training of doctoral students, interns and postdoctoral residents (APA, 2010), education about gender identity and expression is often neglected or inadequate in undergraduate and graduate training in psychology (Anton, 2009; APA, 2009; Jensen, 2010; Pickering & Leinbaugh, 2006) and in continuing education training offered to practicing mental health clinicians (Lurie, 2005). The 2010 APA Ethics Code includes gender identity among a list of essential components of cultural competency, including age, gender, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language or socioeconomic status (APA, 2010). Therefore, psychologists are encouraged to incorporate gender identity and the experiences of TGNC people in broader education and training. Despite this, studies with TGNC individuals suggest that many mental healthcare providers lack even basic knowledge and skills required to offer trans-affirmative care (Bradford et al., 2007, Xavier et al., 2005).

Training in gender identity is frequently subsumed under discussions of related yet distinctly different aspects of diversity, most notably sexual orientation, or in general classes on human sexuality. Psychologists and students may mistakenly believe they have obtained adequate knowledge and awareness about TGNC people through training on lesbian, gay, and bisexual populations (Harper & Schneider, 2003). The absence of distinct, accurate information about TGNC populations in psychology training perpetuates misunderstanding and the continued
marginalization of TGNC people in the field of psychology and in society as a whole (Nadal et al., 2010, 2012).

Many, if not most, psychologists and psychology students will at some point encounter TGNC people among their clients, colleagues, and trainees (APA TFGIGV, 2009). However, only 52% percent of psychologists and graduate students who responded to a survey conducted by APA’s Task Force on Gender Identity and Gender Variance reported having had the opportunity to learn about TGNC issues in school; of those respondents, only 27% reported feeling “sufficiently familiar with transgender issues” (N = 294; APA TFGIGV, 2009). Without a concerted effort to ensure that psychology students and psychologists are adequately informed about gender identity, gender expression, and TGNC populations, psychologists and trainees may be unprepared to offer TGNC-affirmative care (Jensen, 2010; Pickering & Leinbaugh, 2006).

**Application**

The provision of affirmative and respectful care to TGNC clients requires foundational education in issues of gender identity and gender expression. Educators are encouraged to infuse their curriculum with issues of gender identity and gender expression in a manner that is “…sequential, cumulative, and graded in complexity…” (APA Commission on Accreditation, 2007, Implementing Regulation C-23). Psychologists are encouraged not only to integrate information about gender identity, but to require students to demonstrate how this knowledge may be applied in clinical practice and research (ACA, 2010). In addition to basic foundational education, psychology programs are also encouraged to provide advanced coursework and training on issues of gender identity and gender expression.
Psychologists offering education, training, and supervision strive to provide affirmative, accurate and current information on TGNC populations that does not sensationalize (Namaste, 2000), exploit or pathologize these clients (Lev, 2004). Psychologists are encouraged to support students in developing a professional, nonjudgmental attitude towards people who may have a different experience of gender identity and gender expression from their own. Educators and supervisors may need to seek out information and resources to integrate information about TGNC people into the training they offer (Catalano, McCarthy, & Shlasko, 2007; Lev, 2004; Stryker, 2008; Wentling, Schilt, Windsor, & Lucal, 2008). Given many psychologists’ lack of exposure to TGNC populations and fundamental understanding of issues related to gender identity and gender expression, inclusion of respectful information about TGNC people and related issues in continuing education and training may be beneficial. Psychologists providing education can incorporate activities that increase awareness of cisgender privilege and transprejudice, host a panel of TGNC people to offer personal perspectives, or include narratives of TGNC people in course readings (ACA, 2010).

Guideline 16. Psychologists strive to reduce stigma and related challenges to health that affect TGNC people and to promote positive social change.

Rationale

In most areas of the U.S. TGNC people are not afforded protection from discrimination and crime (Marzullo & Libman, 2009; Taylor, 2007) and are not treated equally under the law. Many policies that protect the rights of cisgender people, including gay and lesbian individuals, do not protect the rights of TGNC people (Currah, Minter, & Green, 2000; Spade, 2011a). A lack of inclusion in public policy can create a significant hardship for TGNC people (Taylor, 2007).
Public policy should include TGNC people so that providers are better equipped to serve and accommodate them.

TGNC people can experience challenges obtaining gender-affirming identity documentation (e.g., birth certificate, passport, social security card, driver’s license). For TGNC people in poverty or experiencing economic hardship, requirements to obtain this documentation may be impossible to meet, in part due to the difficulty of securing employment without identity documentation that aligns with their gender identity and gender expression. Documentation requirements can also assume a universal TGNC experience that marginalizes TGNC people, especially those who do not undergo a medical transition. This may affect clients’ social and psychological well-being, interfere with accessing employment, education, housing and shelter, health care, public benefits, and basic life management resources (e.g., opening a bank account).

**Application**

Psychologists endeavor to engage in public policy to reduce negative systematic impact on TGNC people and to promote positive social change. Psychologists strive to identify and challenge systems that permit violence, educational and employment discrimination, housing discrimination, lack of access to healthcare, unequal access to other vital resources, and other instances of oppression that TGNC people experience (ACA, 2010; Singh & Burnes, 2010). Many TGNC people experience stressors from constant barriers, inequitable treatment, and forced release of sensitive and private information about their bodies and their lives (Hendricks & Testa, 2012). To obtain proper identity documentation, TGNC people may have been required to provide court orders, proof of having had genital surgery, and documentation of psychotherapy or psychiatric diagnosis. Psychologists can assist TGNC clients by normalizing their reactions of fatigue and traumatization after interacting with legal systems and
requirements; TGNC clients may also benefit from guidance about alternate avenues of recourse, self-advocacy or appeal. When a TGNC client feels that it is unsafe to advocate for themselves, psychologists can consider actions to voice their concerns regarding the inequitable treatment often accorded to TGNC people and refer to appropriate advocacy resources in the community.

Psychologists endeavor to be sensitive to the challenges of attaining gender-affirming identity documentation, and how the receipt or denial of such documentation can affect clients’ social and psychological well-being, and their ability to obtain education employment, find safe housing, access public benefits, obtain student loans, and access health insurance. It can be of significant assistance to clients for psychologists to understand and offer information about the process of a legal name change, gender marker change on identification, or the process to access other gender-affirming documents in their jurisdiction. Psychologists may consult the National Center for Transgender Equality, the Sylvia Rivera Law Project, or the Transgender Law Center for additional information on identity documentation for TGNC people.

Psychologists may choose to become involved with an organization that seeks to revise law and public policy to better protect the rights and dignities of TGNC people. Psychologists may participate at the local, state, or national level to advocate for TGNC-affirmative health care accessibility, human rights in sex-segregated facilities, or policy change regarding gender-affirming identity documentation. Psychologists working in institutional settings may also expand their roles to work as collaborative advocates for TGNC people (Gonzalez & McNulty, 2010).
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Correspondence concerning this article should be addressed to Clinton Anderson, Public Interest Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002.
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