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**Towards a Transpositive Therapeutic Model:  
Developing Clinical Sensitivity and Cultural Competence in the Effective Support of  
Transsexual and Transgendered Clients**

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**Abstract**

Traditionally, the research, assessment and treatment of 'gender dysphoria' (GD) and 'gender variance' (GV) has tended to pathologize transvestites/crossdressers, transsexuals and transgendered people, including 'transqueers'. This article will cite examples of clinical 'transphobia' to underscore the need to revolutionize our way of doing therapy with transpeople. To optimize the recent trend towards a more respectful, collaborative relationship between GD/GV clients and the mental health community, we must ensure that our clinical orientation is truly responsive to the changing real-life needs of a highly-diversified trans population, including the rights to self-determination and comprehensive health care. To help meet this goal, this paper will develop a generic transpositive therapeutic model, building from existing trans-affirmative approaches.

A series of nine major guidelines to build the theoretical framework for a transpositive model of psychotherapy is proposed, with specific recommendations around: 1) clinical orientation/treatment philosophy, 2) assessment considerations, 3) treatment considerations (including psychotherapy, diversified subpopulations and marginalized subpopulations), 4) the therapeutic relationship, 5) comprehensive case management, 6) accountability/quality assurance, 7) advocacy/alliance building, 8) knowledge base/professional development, and 9) research.

**Keywords:** transsexual, transgendered people, therapeutic support, transpositive clinical model.

**Introduction**

Historically (and into the present, in some cases), the research, assessment and treatment of 'gender dysphoria' (GD) and 'gender variance' (GV) has tended to pathologize transvestites (also known as crossdressers), transsexuals (TSs) and transgendered (TG) people, in addition to 'transqueers' (see Appendix A for an explanation of these and related terms). Select examples of such clinical 'transphobia' will be cited to illustrate the need to revolutionize our way of doing therapy with transpeople. Encouragingly, this transphobic psychological paradigm is shifting to a more 'transpositive' one as a response to political pressure by TS/TG consumers and trans-identified mental health and sexual health providers, and also as a result of more information about transpeople. To optimize this increasingly respectful, collaborative relationship between

GD/GV clients and the mental health community, we must ensure that our clinical orientation is one that is truly responsive to the changing real-life needs of a highly-diversified trans population, including the rights to self-determination and comprehensive health care.

To help meet this overall goal, the development of a generic transpositive therapeutic model - building from existing gay- and trans-affirmative approaches - is suggested. This generic framework can subsequently be modified to 'best fit' the specific treatment subpopulation (TSs, transgenderist, crossdresser/transvestite, TG, androgyne, 'two-spirit', GV or intersexed) and adapted for application in a variety of settings (clinical-organizational, clinical-private practice, institutional or community-based health care - addressing either/both mental health and sexual health).

Further recommendations include:

1. a) ongoing training and professional development for both mental health and sexual health practitioners;  
b) role enhancement of these care providers to also act as professional allies/advocates;
2. encouragement and support for the emergent stream of TS/TG mental health and sexual health providers;
3. similar support for non-professional community and peer-support workers;
4. appropriate quality assurance for gender identity support services and programs.

A preliminary section outlining some basic terminology follows as a grounding to optimize the reader's incremental understanding of the complex issues involved.

### **Some Key Definitions and Concepts: Clinical and Cultural**

Any intelligent discussion of GD and GV must first be grounded in a solid conversance with the current and ever-changing jargon of the day, both clinical (diagnostic labels employed by the professional health care provider) and cultural (self-descriptors used by the consumer community). Knowledge of this 'dual-dimensional' nomenclature is the initial step in the ongoing development of 'clinical sensitivity' and 'cultural competence' in this specialty area because it alerts one to the diversity of gender transpositions involved, ergo, the sophistication of classification required for a better understanding of what makes transpeople 'tick' from both an empirical and a phenomenological perspective (cf. Allen, 1997; Benestad Pirelli, 2001; Boswell, 1998; Bullough et al., 1997; Cole and Meyer, 1998; Devor, 1998; Henkin, 1998; Israel and Tarver, 1997; Money, 1998; Pollack, 1997; Vitale, 1997). The latter is particularly important in the context of cross-cultural gender and sexual phenomena (cf. Bolin, 1994; Cromwell, 1999; Denny, 1997; Green, 1966; Jacobs et al., 1996; Herdt, 1994; Katz, 1976; Katz, 1992; Nanda, 1989; Roscoe, 1990; Williams, 1986).

Additionally, I wish to introduce some new terminology to highlight certain relevant concepts potentially operative within the clinical context of working with transpeople: 'therapist transphobia', 'therapist transqueerphobia,?' 'client transphobia (internalized)' and 'client transqueerphobia (internalized)' - which can all be subsumed under the umbrella term, 'clinical transphobia'. Similarly, specific terms like 'therapist transpositivity' and 'client transpositivity' are equally important and can be included in the overall context of 'clinical transpositivity'. Noteworthy here is the antithetical nature between clinical transphobia and clinical transpositivity for it is just this critical distinction which informs the foundation for a truly therapeutic transpositive model.

For our purpose here, I operationally define 'clinical transphobia' as follows: within the context of the professional working relationship between clinician and client, any belief, attitude, act or behavior (whether therapist- and/or client-generated) *which negatively values, denies, undermines, discourages or disempowers* trans-identified or GV clients in terms of their unique identities and subjective realities (including, but not restricted to, physical sex, gender identity, sexual orientation and sexual identity), quality of life, the pursuit of self-determination and human rights, and the right to comprehensive health care. (If clinical transphobia is initiated by the therapist, we can call this 'therapist transphobia', and if internalized by the client, 'client transphobia (internalized)'. By comparison, 'clinical transpositivity' can be defined as its diametrical opposite, substituting, where appropriate, the phrase: *positively values, affirms, supports, encourages and empowers*.

What I call 'clinical transqueerphobia', can be operationally defined in this way: within the

clinical context, a particular form of transphobia which discriminates against a specific subgroup of the overall trans-identified population, namely, transqueers (lesbian or bisexual-identified TS women and gay or bisexual-identified TS men).

### **Psychological Paradigm Shift: from Transphobia to Transpositivity**

A literature search turned up a number of references to transphobia within a clinical context (Gainor, 2000; Hill, 2002; Zandvliet, 2000), as well as several allusions to clinicians' marginalization or discrimination of those who identify as transqueer (also known as transhomosexual) (Benjamin, 1966; Blanchard, 1985; Coleman and Bockting, 1988; Devor, 1998; Pauly, 1974; Pauly, 1998; Rachlin, 1997; Zandvliet, 2000).

Some specific forms of clinical transphobia enacted by gender clinicians (predominantly psychiatrists) include, but are not limited to, the following:

1. a tendency to pathologize GD/GV clients as personifying a mental illness, often including psychiatric diagnoses of personality disorders or psychoses (Lothstein, 1983; Socarides, 1968; Steiner, 1985; Stoller, 1970);
2. perpetuating myths and enforcing stereotypes about transpeople by imposing expectations around compliance (Denny, 1992), and by generating psychological theories based on methodologically-flawed empirical research (Gainor, 2000);
3. employing ethically questionable psychological assessments of genetically-male GD/GV applicants to gender identity programs, such as the use of the 'penometer' (an electrode device attached to the penis to monitor erotic responses to certain designated visual stimuli: women's clothing, men's clothing, naked women, naked men, etc.) (Freund et al., 1979);
4. conducting dubious experiments on vulnerable TS clients, many of whom complied solely to obtain hormones and/or surgery (Denny, 1992);
5. carrying out psychoanalytic psychotherapy (Stoller, 1970) that is counter-therapeutic in terms of the stated needs, goals and genuine well-being of transpeople, including the use of so-called 'reparative' (conversion) (Socarides, 1968) and 'supportive psychopathology' therapies (Lothstein, 1983);
6. similar re-conditioning behavior-modification therapies used with GD or GV youth to prevent the adult manifestation of either transsexualism or homosexuality Zucker and Bradley, 1995);
7. the virtual denial of the existence of female transvestites (Steiner, 1985);
8. transqueerphobic discrimination, often resulting in the exclusion of gender program participation or the denial of sex hormones or sex reassignment surgery (SRS) (cf. Coleman et al., 1993; Denny, 1992; Rachlin, 1997);>
9. a double standard around granting approval for hormone therapy and SRS to lesbian transwomen while withholding the same from gay transmen and/or the outright denial of the existence of the latter (Blanchard, 1985; Steiner, 1985);
10. marginalization of transpeople who do not work or attend higher education full-time as proof of the 'real-life test', thus excluding those on welfare, unemployment or disability benefits and indirectly, newcomers who cannot always readily access jobs;
11. exclusion or penalization of trans-identified sex workers on the grounds that prostitution is not considered legitimate employment (Namaste, 2000; Steiner, 1985);
12. an all-or-nothing treatment approach that insisted on SRS as the final resolution for approved TS candidates, while withholding hormone therapy for non-operative TSs and transgenderists (Denny, 1992), and
13. excessive 'gatekeeping' - withholding of recommendations for desired gender reassignment procedures (Denny, 1992; Pollack, 1997; Stryker, 1995).

A distinct form of clinical transphobia has, on occasion, been enacted by some gay and lesbian clinicians. Such an instance of transphobia (involving the specialized forms of biphobia and transqueerphobia) can occur (although I would predict less commonly now than in the past) when a monosexual and/or binary-gendered gay or lesbian therapist consciously or unconsciously tries to influence the decision-making process of the client to self-declare as heterosexual or homosexual, or TS or transvestite, with little patience for intermediary or alternative 'shades of gray' on the sexual and gender spectra (e.g., bisexual, transensual, polysexual, autosexual, asexual; androgynous, transgenderist, bi-gendered, TG, 'two-spirit', intersexed), and not much support for either the client's own felt ambivalence (discomfort) or desired gender/sexual ambiguity (comfort) (Zandvliet, 2000). (Of course, heterosexual therapists who are likewise monosexual/binary-gendered are equally at risk for committing the same errors of clinical misjudgement and contraindicated interventions). A related potential for transphobia might arise if the queer therapist has a personal investment in the client's outcome to identify as gay or

lesbian, rather than TS, with a further possibility of harboring transqueerphobia if he or she were to invalidate a client's self-identity as transqueer on the grounds that the client's genitalia disqualifies such a queer sexual identity (Coleman et al., 1993).

A perhaps related phenomenon is a (hopefully unintended) form of clinical 'erasure' on the part of queer researchers, which effectively renders invisible the very existence and identities of transpeople (cf. Namaste, 2000; Zandvliet, 2000) - in particular, a tendency to exclude transgender issues from clinical journals and handbooks focusing on lesbian, gay and bisexual clients. Promisingly, this situation is changing as more therapy guides and psychological journals addressing queer-issues are now starting to include the clinical concerns of the GD/GV population (cf. Mallon, 1999a; Neal and Davies, 2000).

Notwithstanding, the traditional psychological paradigm is starting to shift from a transphobic to a transpositive one. The most noteworthy example of this new direction in mental health is the growing tendency of mental health providers to de-pathologize TS/TG clients as 'normal' people with normative - or even better than normative - mental health (Cole and Meyer, 1998), whose GD or GV is an isolated phenomena *perhaps* requiring medical intervention, and who should be encouraged to freely express their GV presentation without the condemnation of either society or psychiatry (Lev, in press; Zandvliet, 2000). An extension of this normalization of GD and GV is reflected in the not so radical notion ('therapeutic policy') put forward by Benestad Pirelli (2001) that it is a homophobic/transphobic society which is 'diseased' and in need of 'treatment'.

A further indication of this changing trend is strikingly illustrated by a comparison of the titles, dedications and editorship of the following two books: *Gender Dysphoria: Development, Research, Management* (Steiner, 1985): 'dedicated to our colleagues who work in the field of gender identity, to those who had the courage in the past, and with hope to those who will follow in the future', and *Transgender Care: Recommended Guidelines, Practical Information and Personal Accounts* (Israel and Tarver, 1997): dedicated 'to the health and well-being of all transgender individuals in pursuit of self-determination and full human rights'. Note the marked shift in focus from psychopathological disorder (GD) to normalized health concerns (transgender care) and from clinical provider to client-consumer. Moreover, whereas the former text was edited by a non trans-identified clinician, the latter text was co-authored by an 'out' TS therapist (Israel) - and this was soon followed by another professional reference, *Current Concepts in Transgender Identity* (Denny, 1998), edited by a similarly public trans-identified mental health provider. The recent inclusion of mental health providers who are/were also consumers is a significant turning point in terms of the new power dynamics being played out in the mental health community in relation to transpeople generally. More importantly, it is a substantive redefinition of the professional relationship between trans- and non trans-identified clinicians that approaches a collegial one.

Still another recent milestone reflecting this shift is the growing number of non trans-identified, non trans-focused (Benestad Pirelli, 2001) and gay/lesbian therapists who wish to clinically support transpeople, as well as the increasing inclusion in both mainstream and gay psychology/social work publications of works specifically focusing on TG/TS issues (Gainor, 2000; Mallon, 1999a; Northridge, 2001; Neal and Davies, 2000).

### **Changing Trends in the Transsexual/Transgendered Community**

To be therapeutically effective in working with transpeople, any clinical model of real validity and integrity has to be responsive to client need by taking into account a range of significant issues and changing trends, outlined as follows:

1. the increasingly heterogeneous nature of the GD/GV population (Allen, 1997; Boswell, 1998), including subgroups with specialized needs (e.g., transvestites versus transgenderists versus TSs, transqueers, transpeople of color, trans-identified youth/seniors, transpeople living with HIV/AIDS, trans-identified parents/children, transpeople who use substances, trans-identified sex workers, transpersons with disabilities, transpeople in conflict with the law, etc.);
2. the new stream of trans-identified mental health providers and sexual health providers who are conducting psychotherapy and sex education, respectively, with the modified, ever-changing and highly diversified GD/GV client population;
3. the ways such therapeutic and educational work are being conducted and how they differ from before (what clinical models are out there and how they compare in terms of client need, responsiveness, access and self-determination);
4. how the recent de-listing of SRS by government medical insurance plans (e.g., in Ontario, Canada) impacts on:

- a) equitable consumer access to requisite comprehensive medical care, and
- b) the nature of the gradually changing client-therapist relationship, specifically, in terms of the clinician's gatekeeping function;
- 5. how gender therapists (trans- and non trans-identified) can be better trained and supported in this highly-specialized area to provide the best possible mental health care to their TS/TG clients;
- 6. how a generic transpositive (clinically-sensitive and culturally-competent) model of psychotherapy can be utilized as a set of universal guidelines to help ensure a therapeutic paradigm that effectively precludes clinical transphobia, in general, and clinical transqueerphobia, in particular.

## **Current Models of Transpositive Therapy: Benefits and Limitations**

### **A continuum of transpositive models**

In a search for existent transpositive therapy models, this writer came across one published (Bockting and Coleman, 1992; Bockting, 1997) and one unpublished (Rachlin, 1997) process model for psychotherapy with GV/GD clients, a grounded theory approach to cross-dressing and sex-changing (Ekins, 1993); a series of recommendations for the therapeutic support of transitioning clients (Israel and Tarver, 1997: 21-55); as well as several 'best practices' guides for therapists (Lev, in press; Mallon, 1999a: 147-149, 148-149; Zandvliet, 2000: 188-189), and a list of criteria to help evaluate models of TG/TS behavior and suggested guidelines for future research (Denny, 1997: 34, 40-42). All are highly useful, each in their own way, contributing to the overall body of work in this specialty area and helping to lay the groundwork for a truly transpositive model. Although many commonalities exist, there are also some significant differences in philosophy, focus and practice.

As a way to schematize this recent trend towards increasingly trans-supportive models of therapy, I have developed a 'continuum of transpositive care models' (see Appendix B). This ranges from a 'clinician-directed, psychiatric, medical management model' at one extreme to a 'consumer-dictated, de-medicalized, self-determination model' at the other. The first endorses a gatekeeping function of the clinical provider, who sets up eligibility criteria and clinical thresholds, while the second *demands* hormones and surgery, with the consumer challenging the need for clinical assessment. These two antithetical positions are moderated by the two alternate paradigms in the middle: a 'client-directed/collaborative, self-determination, medical management model' and a 'client-directed/collaborative, de-medicalized, self-determination, social diversity model'. This writer embraces both of these in-between models of compromise, given their customized ('best fit') applications for a GD (desires/requires gender-related medical intervention) and a GV (does not desire/require gender-related medical intervention) client base, respectively. Theoretically, of course, degrees of collaboration exist along the continuum, such that there could be an intermediary model between the clinician-directed and the client-directed models.

Without intended presumption, I have taken the liberty of placing a few selected models on this *transpositive* continuum, moving from left to right: clinician-directed (Bockting, 1997; Bockting and Coleman, 1992), client-directed/collaborative medical management model (Brown and Rounsley, 1996; Denny, 1997; Ettner, 1999; Israel and Tarver, 1997; Rachlin, 1997); client-directed/collaborative social diversity model (Benestad Pirelli, 2001; Denny, 1997; Lev, in press; Mallon, 1999a: 49-64; Zandvliet, 2000), and consumer-dictated (Pollack, 1997; Stryker, 1995). (See the section on gatekeeping for further elaboration of some of the main distinctions of these paradigms). Of course, some of the clinicians I have assigned to only one or the other of two possible client/collaborative models might actually utilize both. I also do not wish to criticize proponents of either of the two extreme perspectives, given that these respective proponents are highly articulate about their separate positions. Indeed, the fact that Bockting and Coleman (1992) precisely state their gender program requirements up front provides potential applicants with clear-cut choices as to which therapeutic model is the best fit for their individual needs.

In addition to more generalized models, this writer discovered a number of clinical models for one-to-one counseling with GD/GV youth (Cooper, 1999; Glenn, 1999; Israel and Tarver, 1997: 132-141; Klein, 1999; Mallon, 1999a: 49-64; Pazos, 1999), families (Rosenfeld and Emerson, 1995), and youth and families (Benestad Pirelli, 2001; Mallon, 1999a: 49-64). As well as individual counseling, several clinicians provide examples of group therapy for TS/TG sex workers (Klein, 1999) and for GD heterosexual males (Stermac et al., 1991). Specialized forms of therapeutic support include telephone 'hotline' counseling (Cook-Riley, 1997) and dance/movement therapy (Thomas and Cardona, 1997). While outside the scope of this paper to comment on each of the above, I wish to draw the reader's attention to the urgent need for clinical

support for each of these subpopulations, in particular, trans youth and sex workers, as well as the equally-important need to support family members (including current and former partners), and to also work closely with extra-family significant others (e.g., teachers, psychiatrists, psychologists, social workers, government officials) to provide broad systemic support for GD/GV youth and their families (Benestad Pirelli, 2001). Further research into the development and implementation of creative clinical strategies and sociopolitical solutions is critically indicated to more effectively serve specific subgroups of the overall trans community, some of which might be at higher risk than others.

### **Gatekeeping**

A key challenge for clinicians and clients alike is the gatekeeping function that many mental health providers exercise (which also has a potential for economic exploitation by unscrupulous clinicians: Ettner, 1999: 109). Gatekeeping refers to the pre-requirements for sex hormones and SRS, as dictated by the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders (SOC) (Meyer et al., 2001), and the gender therapist's gatekeeper role to either recommend or withhold approval for such hormonal and surgical therapies. As outlined earlier, it is the dynamics of this gatekeeping function - and how this is played out, both in philosophy and in practice - that determines placement on the continuum of any one transpositive therapy model (see Appendix B). Many mental health providers struggle with this potential barrier to establishing the trust of clients so necessary to delivering truly transpositive mental health care. While some are comfortable as gatekeepers, explicitly stating their position as medical managers (Bockting, 1997; Bockting and Coleman, 1992), others are somewhat more flexible, adopting a more collaborative approach of mutual negotiation (Israel and Tarver, 1997; Rachlin, 1997; Vitale, 1997). Still others object to the three-month cross-living requirement for hormonal therapy (AEGIS, 1992), and a few consumers even want to dispense with this function entirely (which they perceive as a barrier), demanding treatment as their right (Pollack, 1997, Stryker, 1995). Anderson (1997) suggests a dual-provider form of psychotherapy to try to overcome this barrier, with one mental health provider functioning as evaluator (gatekeeper) and the other as therapist (healer).

Transpositivity within a clinical context implies a collaborative working relationship based on mutual trust and respect, with a joint commitment to operate in good faith. Outcome objectives for client-directed psychotherapy, by definition, aim at fostering the development of the individual's self-actualization and self-empowerment. Effective therapeutic support, therefore, should also include the facilitation of clients' rights to self-determination and to competent and compassionate mental health care. In practice, this means adapting the model to 'best fit' the unique needs of the client. When working transpositively, this means putting the therapeutic contract to the test in terms of the gatekeeping function: the willingness of the therapist to be open to honest negotiation around certain SOC (Meyer et al., 2001) guidelines involving reasonable requests for sex hormones or surgery, and the client's willingness to accept the realistic limits dictated by clinical discretion, where such requests are deemed detrimental to the client's well-being, or a violation of the therapist's ethical and legal responsibilities.

### **Specific therapeutic modalities**

A variety of specific therapeutic modalities are available to the clinician who wants to offer effective and creative solutions to their trans-identified clients. These modalities include: constructionalist and essentialist theories as therapeutic applications (Hart, 1984), dream analysis (Miller, 1996), existential-humanist therapy (Vitale, 1997), expressive (dance) therapy (Thomas and Cardona, 1997), gestalt therapy (Miller, 1996), Jungian therapy (Miller, 1996) and narrative/constructivist therapy (Benestad Pirelli, 2001). This writer has also had some limited clinical experience with Adlerian psychology (including the 'life style assessment' as a therapeutic tool), brief solution-focused therapy, cognitive-behavioral therapy, metaphor therapy and narrative therapy. Eclectic/integrative methods are likely practiced by a number of transpositive mental health providers. Investigation of each of these therapeutic methods and of practitioners' individual techniques, while beyond the scope of this paper, is recommended for future research. For the specific purpose of this paper, however, I wish to highlight two contrasting therapies (essentialist and constructionalist) to demonstrate their respective potential applications for certain individuals or distinct subgroups, according to differing client needs.

### **Transsexual versus transgendered and essentialist versus constructionist therapy**

One of the greatest challenges facing mental health providers who work with transpeople is to provide the most effective therapeutic support for their specific individual clients - be they TS, transvestite/crossdresser, TG, androgynous, bigendered, 'two-spirit', or intersexed. There are, of course, many possible interventions to strategically support each of these distinct subgroups - and each unique client who presents - depending on the therapist's clinical and cultural sensitivity,

flexibility and creativity, confidence and competence. Broadly speaking, these subgroups can be divided into two larger groups: those who subscribe to a concept of self that is both 'essentialist' (biogenic) and binary-gendered (male or female) and those who adopt a 'constructionist' (sociogenic) and non binary-gendered self-concept (both/neither male and/or female). Typically, TSs embrace an essentialist and a binary self-view (and recent research has shown brain differences between TS and non-TS subjects - compare Zhou et al., 1995), whereas many of those with other gender minority presentations espouse a constructionist/non-binary self-identity. These divisions of client presentation have definite implications for clinical efficacy, such as, the use of either essentialist or constructionist interventions in working with a diversified trans population.

A clinically innovative strategy implemented by Hart (1984) elucidates the controversy around therapeutic implications of viewing the development of sexual identity in terms of essentialist versus constructionist theories (cf. Plummer, 1981; Raymond, 1979). Through his clinical work with gay and TS clients, Hart attempted to present a constructionist view of sexual orientation and social sex-roles, which involved applying constructionist therapy to 'provide people with a personal and political history of their lives that emphasizes the 'choices' they have made - consciously or not, identifies the restrictions and stigmatizing events that they have experienced [and] - enables people to see their individual reactions as part of an experience they can share with others'. With many gay clients, this intervention proved successful, resulting in a therapeutic outcome of self-acceptance - including the clinician's normalization of bisexuality as a viable option for those self-identified gay men who were also attracted to women; with others, this approach had limited use. In terms of TS clients, their essentialist beliefs often proved resistant to constructionist therapy, however, some benefits did result in some cases. Hart (1984: 51) concludes that it is just such client adherence to essentialist beliefs that necessitates clinicians let go of their investments in either a 'fixed' or a 'labile' sexual identity for neither of these shed adequate light on clients' experienced sexual identities, and, he adds: 'To argue that either of these is 'true' [...] is bad therapy, and inadequate sexology.'

This writer concurs with this conclusion and further suggests that the treatment of choice depends on three key factors: a) the individual, b) specific subgroup membership - noting the critical distinctions between TS and non-TS (Zandvliet, 2000), and c) current life context and 'immediacy' (i.e., how the client might identify at this moment in time, always allowing for the possibility that he or she might identify or present his or her gender differently at some future time). That is, given the predominantly essentialist view held by TSs, it would appear logical to apply a parallel intervention. Similarly, given the largely constructionist view of TGs, a corresponding paradigm would seem in order. Alternatively, where the client might be 'questioning' or otherwise experiencing confusion around gender and/or sexual identity/identities, the constructionist/narrative therapeutic approach might be the most viable and allows for the greatest flexibility around self-identification, without being constrained by society's binary gender norms (Benestad Pirelli, 2001). At the end of the day, however, the clinical strategy selected should always be driven by the unique reality of the client (person-centered) and the immediate presenting problem (solution-focused), employing the therapy that 'best fits' the individual, without excessive regard for theory.

## **Towards a Generic Transpositive Therapeutic Model**

Some minimal criteria for any clinical model which aspires to be transpositive are proposed below, with appropriate rationale and research citations in parentheses. (In many cases, the specific guideline has application to health care practitioners above and beyond therapists/counselors/clinicians - and to social service providers).

### **Preamble**

There currently exist very few transpositive models for the treatment of GD, ranging from comprehensive medical management to social diversity models, therefore, there is no definitive model, as such. Some of these models are specifically adapted to working with GD adults, GV youth, mixed groups of transpeople, and partners or families of TS/ TG. Without discounting the diversity of the broader trans population and the multiple specialized needs of certain subgroups (e.g., persons of color, sex workers, people living with HIV/AIDS, youth, seniors, children and parents, people with disabilities, substance users, etc.), only the basic essentials for a generic transpositive therapeutic model are proposed here. These take the form of nine major 'best-practice' guidelines (including a series of sub-recommendations) relating to the theory and practice of work with transpeople and their significant others.

## 1.0

### Clinical orientation/treatment philosophy

#### 1.1

Clinical orientation and approach - whether assessment, treatment or research - must be transpositive (gender affirming) and same-sex positive, clinically sensitive and culturally competent. Additionally, clinicians should strive to operate from an anti-oppressive framework which is anti-racist, anti-sexist, anti-heterosexist, etc., with a view towards facilitating the self-empowerment of the person and the fulfillment of his/her right to access quality health care.

In practice, this means expressing an attitude that is respectful, sensitive, accepting, validating, affirming, empathic, caring, compassionate, encouraging, supportive, and mutually trusting and trustworthy. In brief, the therapist is expected to affirm/validate any form of gender or sexual variance expressed by the client, and to appropriately support the client's right to self-determination wherever possible (i.e., within the context of a collaborative professional provider-consumer relationship, which fosters honest negotiation along with professional discretion, informed by a mutual contract of respect and trust, based on realistic expectations and reasonable limits). The driving dictum of care providers should be 'to operate in good faith within the context of a client-affirming agenda'.

#### 1.2

The use of clinically-sensitive, culturally-competent and client-affirming language is encouraged to adequately reflect this reconceptualized model of client self-empowerment.

This means language which is non-pathologizing, demystifying, phenomenological, consumer-friendly, sensitive to cultural diversity (Zandvliet, 2000), and conducive to client self-determination and collaboration with health care providers (Israel and Tarver, 1997). For instance, transpositive language would strike from its clinical taxonomy the redundant classification of normative behaviors such as those 'psychiatrized' by the label 'autogynephilia' (Blanchard, 1989), and would strive to replace such stigmatizing phrases as 'comorbid psychopathology', 'gender identity disorders' and 'clinical management' with client-validating ones like 'multiple mental health issues', 'gender distress/discomfort', 'gender variance/diversity' and 'transgender care'. Furthermore, outdated clinical designations such as 'hermaphrodite', 'transvestite', 'reassigned males' and 'reassigned females' would be superseded by consumer-driven/culturally-current terms like 'intersexed', 'crossdresser', 'transwomen' and 'transmen'.

#### 1.3

The therapeutic model will ideally be client-centred and modified to 'best fit', wherever possible, the particular person and subpopulation.

Client- or person-centeredness is the keystone of any effective means of therapeutic change (Duncan et al., 1992; Hubble et al., 1999). An 'individual treatment plan', therefore, would be most appropriate and most effective in attaining the client's desired outcome objectives. That is, what might be medically or therapeutically 'sound' for one TG person might not be the best course of action for another TG, and similarly, for different TS individuals. Of course, client-centeredness includes the minimal clinical ethic to 'do no harm'.

## 2.0

### Assessment considerations

#### 2.1

The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders (SOC) (Meyer et al., 2001) are recommended as the basic guidelines for the patient and health care provider.

Flexibility is encouraged around adherence to specific standards ('gatekeeping'), leaving the door open, in certain situations, to interpretation and negotiation, provided all parties are operating in good faith. Access to additional guidelines for transgender (mental) health care to complement the SOC are urged, such as, for instance, the recommendations set out by Israel and Tarver (1997) and others. Critical input from TS/TG (mental) health practitioners and consumers (Denny, 1997) is further recommended.

Operating from a strictly essentialist or binary-gendered perspective serves to effectively exclude sensitive treatment of TG and 'two-spirit' people, some of whom, while they agree with the non-

binary or constructionalist view, might still wish to partially modify their bodies by means of hormonal and/or (in some cases) surgical intervention, without necessarily 'going all the way' as TSs generally prefer to do. This rigid view is reflected by the SOC's adherence to triadic therapy, which insists on both hormonal and surgical interventions as the logical outcome objectives.

## 2.2

The 'real-life experience', as set out in the SOC (Meyer et al., 2001), is recommended for those who seek sex-reassignment surgery.

Formerly known as the 'real-life test', the 'real-life experience' is strongly urged for candidates considering irreversible genital surgical procedures because this can provide a critical opportunity for the candidate to resolve any lingering doubts around gender or sexual identity confusion, to consolidate one's chosen gender identity in a public way, and to conduct a real-life 'rehearsal' of negotiating the world in the new sociosexual (gender) role. (See Israel and Tarver, 1997).

As a rigid pre-requisite, however, for those desiring sex hormone treatment (a partially reversible intervention), open dialog between provider and consumer is encouraged, recommending negotiation and flexibility, wherever possible. Clinical discretion to waive this requirement ultimately depends upon the specific situational realities of the individual, such as, for example, a potential risk to the safety of those who might be vulnerable to transbashing because their biological sex status would be detected without the benefit of opposite-sex hormones (AEGIS, 1992; Pollack, 1997).

## 3.0

### Treatment considerations

## 3.1

### Psychotherapy

### 3.1.1

Supportive psychotherapy is encouraged for self-identified transsexuals who seek hormonal and surgical interventions, however, not all transsexuals might need or desire this kind of clinical support.

Transpositive (i.e., gender-affirming) therapeutic support should be accessed and made available prior to and during the transitional process, and should further be encouraged post-transitionally for those who require (and wish) it, provided it speaks to the client's real-life, everyday needs (whether gender-related or not), in alignment with the client's stated goals. The therapeutic benefits at each of these distinct developmental stages cannot be underestimated, helping clients to consolidate their gender and sexual identities as transwomen and transmen, and to enhance self-confidence. This is especially true of the post-surgical phase of gender reassignment when therapy can facilitate individuals' identity consolidation and social integration (Bockting, 1997; Bockting and Coleman, 1992; Rachlin, 1997).

Group therapy is suggested as an affordable and less isolating means for viable post-transitional support, allowing participants the opportunity to share experiences with their peers, and to address issues of self-esteem, intimacy in relationships, career concerns and the consolidation of multiple new and evolving identities (Ettner, 1999: 125-126). An integrative therapeutic approach, incorporated into an individualized, comprehensive, clinical management program is the ideal treatment plan (Bockting and Coleman, 1992; Di Ceglie, 2000). (Note: In this writer's view, supportive therapy is, both in principle and practice, opposed to so-called 'reparative' psychodynamic and behavior modification therapies, as cited in 3.1.2).

### 3.1.2

'Reparative' psychodynamic and behavior modification interventions - used to redirect the individual's preferred gender identity to match the birth sex - are discouraged insofar as they are counter-therapeutic in terms of meeting the client's goals of positive self-identification, an ego-systonic self-image and psychophysical integrity. (Note: Synonyms for 'reparative' therapy include: 'rehabilitative', reconstructive, aversive or conversion therapy).

Those supportive therapeutic interventions (as cited in 3.3.1) which aim to affirm, rather than disaffirm, individual choices around self gender-identification are, by definition, transpositive, and as such, are urged as the treatment of choice over that of non-transpositive interventions (such as 'reparative' and conversion therapies).

The long-term clinical efficacy of behavior modification interventions - that is, the consolidation

some years into adulthood of the reoriented gender identity in a therapeutically positive way - has been seriously questioned or otherwise challenged by a number of sex researchers (Di Ceglie, 2000; Smith et al., 2001, etc.), nor has it been proven effective in the long-term clinical eradication of behaviors specifically associated with homosexuality or transvestism (Stermac, 1990). Moreover, the goal of psychotherapy, in the view of trans-supportive clinicians, is not to cure cross-gender identification (or gender dysphoria, per se), but rather, to assist individuals to function more comfortably in the world within their chosen gender identity/role, and further, to effectively manage non gender-related concerns (Meyer et al., 2001). (See also: 3.3.1.3).

### 3.1.3

Counseling can be beneficial for non-transsexuals who might be 'questioning', confused and/or conflicted around their gender and/or sexual identity/identities and how these might impact on their lives.

Non-TSs could include crossdressers, transgenderists, or TG, 'two-spirit', intersexed, bigendered, GV or queer individuals who might wish for an opportunity to work through, in a therapeutic setting, their exploration, confusion and/or conflict around gender identity and/or sexual orientation (Benestad Pirelli, 2001; Zandvliet, 2000). Such ambiguity and ambivalence can often be accompanied by discomfort or distress, which might find partial relief through talking with a therapist.

### 3.1.4

Clinicians working with a gender-diverse client base must exercise vigilance around potential counter-transference issues which might arise in gender therapy.

An example of such counter-transference might include 'over-encouragement' - that is, a situation where the open-minded therapist wishing for the intrinsic reward of therapeutic change becomes overly-invested with a particular outcome for the client: the 'ultimate change' of sex (Zandvliet, 2000). A counter-example might be the desire for an antithetical outcome: that of influencing (consciously or otherwise) the client to relinquish his/her transsexual self-identity - and attendant pursuit of sex reassignment (changing one's sex = body) - in favor of adopting a gender identity of transgenderism (changing one's gender = 'mind') and/or a sexual identity as gay/lesbian/bisexual/queer.

## 3.2

### Diversified subpopulations

#### 3.2.1

To effectively meet the specialized needs of this highly-diversified client population, appropriate assessments and treatments most likely need to be tailored for each distinct subgroup found under the umbrella category, 'transgendered'.

These specific subpopulations include: transsexuals (TSs), transgenderists, transgendered people (TGs), androgynes, crossdressers, bigendered, 'two-spirit', intersexed and gender-variant (GV) individuals. Additionally, within any trans-identified clientele, it is very likely that males will differ from females, whites from people of color (Gainor, 2000), gays from straights, queer-identified from non-queer identified, adults from youth, and perhaps more importantly, those who adopt the binary gender system (e.g., TSs, transgenderists and crossdressers, in general) and those who do not (e.g., typically, TGs, androgynes, bigendered, 'two-spirit' and intersexed people). (Transgenderists and crossdressers might fit into either category depending on individual self-definition, and, of course, there are always exceptions.)

This diversity of gender presentation has direct practical implications for the appropriate strategies required to support such variable subpopulations as TSs (who often desire both sex hormones and sex-reassignment surgery unless they specifically identify as non-operative TSs) as opposed to TG people (who might only want hormones or surgery, not both, or who might not desire any form of medical intervention). A similar situation exists when comparing TS adults with trans-identified or GV children or adolescents (who might or might not grow up to be TS).

## 3.3

### Marginalized subpopulations

Above and beyond the diversification of the trans population, there exist a number of marginalized or 'special' subpopulations within the greater trans community, namely: youth, seniors, parents, people of color, sex trade workers, people living with HIV/AIDS, and incarcerated or institutionalized individuals.

#### 3.3.1

##### Youth

#### 3.3.1.1

Given that one of the most challenging, complex and often contentious areas of clinical gender work is the effective assessment and treatment of youth, it is recommended that youth be treated differently from adults. It is further suggested that children and adolescents be treated as two distinct groups.

The reason for separating the treatment of adults and non-adults, and adolescents and children is based on the importance of critical milestones in the development of the child's early life, including the development of a self-concept. This, in turn, according to some developmental theorists, includes the early formation of a 'gender schema' (Unger and Crawford, 1996: 57) or 'core gender identity' (Stoller, 1968). A time-sensitive 'window' in terms of gender identity differentiation has been postulated, whereby full identification as a boy or girl might not reach its fullest expression until adolescent sexual maturity (Money and Ehrhardt, 1972).

Therapists are further encouraged to become conversant with the clinical literature around the ethical (Swann and Herbert, 1999), legal, psychosocial, psychosexual and therapeutic (Israel and Tarver, 1997: 132-141) issues involved in working with a youth population. A key resource are the minimum guidelines set out by the Harry Benjamin International Gender Dysphoria Association: the Standards of Care for Gender Identity Disorders - sixth version. Assessment and Treatment of Children and Adolescents (Meyer et al., 2001). Additional research focusing on clinical/medical (psychiatric, hormonal, surgical) interventions are cited in the following three subguidelines. (For an excellent summary and discussion of the disparate treatment approaches undertaken by the medical-psychological community in the care of trans-identified and gender-variant youth and their families, see Lev, in press).

#### 3.3.1.2

Clinicians need to become familiar with the two major subclassifications of gender-anormative behavior in youth: Gender Identity Disorder and gender variance.

The literature has shown that a minority of gender-anormative youth fulfill the criteria for Gender Identity Disorder for Children or Gender Identity Disorder for Adolescents (as listed in the DSM-IV-TR: American Psychiatric Association, 2000), identifying as transsexual in childhood and/or adolescence and continuing on into adulthood. This group (i.e., transsexuals) tend to have a 'fixed' gender identity (Cohen-Kettenis and van Goozen, 1997) and typically experience gender *conflict*. (Gender *confusion* might or might not accompany this sense of 'gender dysphoria', given the predominantly fixed nature of the gender identification). In contrast, a higher percentage of gender-anormative youth tend to fall into the gender-variant classification and generally grow up to be homosexual or bisexual, but not transsexual (Meyer et al., 2001). Gender variance might include some aspects of cross-dressing and/or cross-gender behavior, but does not also include a core cross-gender identity (as transsexualism does); gender-variant individuals (i.e., non-transsexuals) tend to have a more 'fluid' gender identity (Cohen-Kettenis and van Goozen, 1997) and often experience gender *confusion* as well as, in some cases, but by no means all, gender *conflict*.

Moreover, some researchers believe there might be a biological basis to transsexualism, or more precisely, 'primary' or 'early onset' transsexualism (Asscheman, personal communication, 2002; Zhou et al., 1995), thus, justifying medical interventions for carefully selected candidates (including adolescents aged 16 or over) who have been diagnosed as 'transsexual'.

It would be counter-therapeutic (physically and emotionally damaging), therefore, for a gender-variant child or teenager who was not, in fact, transsexual, to ingest potentially irreversible cross-sex hormones with the attendant tragic results of unwanted secondary sex characteristics of the other sex. It is therefore important to note that although gender identity and sexual orientation are distinct, these dimensions sometimes intersect to the point where clear differentiation is not always possible.

#### 3.3.1.3

A gender-affirmative versus a 'reparative' treatment approach for children and adolescents who identify as transsexual, transgenderist, transgendered, 'two-spirit', intersexed, transvestite or gender variant is strongly urged.

Gender affirmation (i.e., validating, affirming and encouraging the identification and presentation of any and all manifestations of gender: masculine, feminine, androgynous, neuter and/or sex: male, female, intersexed, asexed) is both encouraged and practiced by the more progressive clinicians (Bockting and Coleman, 1992; Brown and Rounsley, 1996; Cohen-Kettenis and van Goozen, 1997; Devor, 1998; Di Ceglie, 2000; Ettner, 1999; Israel and Tarver, 1997; Lev, in press; Mallon, 1999a; Meyer et al., 2001; Miller, 1996; Rachlin, 1997). In contrast, reparative (also known as 'rehabilitative', conversion, aversion or behavior modification) therapies - aimed

at reorienting the young person's chosen gender identification to accord with his/her natal sex - are still exhorted by traditionally conservative clinicians (Coates, 1992; Lothstein, 1983; Rekers and Kilgus, 1995; Socarides, 1968; Stoller, 1970; Zucker and Bradley, 1995; Zuger, 1984). (See also 3.1.2). In the same vein, affirmation of sexual-orientation identity and preference of trans-identified clients, including those who do not conform to the dominant heterosexual sexual orientation (i.e., transqueers) (cf. Coleman and Bockting, 1988; Coleman et al., 1993) on the part of gender clinicians is critical for optimizing the outcomes of self-acceptance and overall positive psychosocial functioning of the young person.

Additional arguments for a gender-affirmative approach include both constructivist formulations (Benestad Pirelli, 2001; Hart, 1984; Zandvliet, 2000) and essentialist theories hypothesizing a possible biogenic etiology (Asscheman, personal communication, 2002; Di Ceglie, 2000; Zhou et al., 1995).

#### 3.3.1.4

Clinicians who work with youth are urged to exercise caution, and to fully pursue with the client and his/her personal and professional caregivers (if under legal age) all of the options and attendant risks prior to prematurely recommending any medical interventions which might be irreversible.

It is important to note that interventions can be fully reversible (LHRH agonists or medroxyprogesterone), partially reversible (cross-sex hormones), or irreversible (surgical procedures) (Meyer et al., 2001).

In the event that consolidation of gender identity in the child or young teenager has not yet taken place, and because, to date, there exists no litmus test to definitively diagnose transsexualism, many clinicians warn against the pre-pubertal administration of cross-sex hormones (i.e., not before age 16) (Asscheman, personal communication, 2002; Cohen-Kettenis and van Goozen, 1997; Meyer et al., 2001; Smith et al., 2001). On the other hand, the administration of irreversible puberty-delaying agents (i.e., depot forms of antagonists or luteinizing hormone-releasing hormone (LHRH) agonists or medroxyprogesterone) from T2 (Tanner puberty stages) onwards, might be indicated for certain well-functioning youths of 16 or over (Asscheman, personal communication, 2002; Meyer et al., 2001), provided that stringent criteria, over and above those required for adult candidates, are put in place (Cohen-Kettenis and van Goozen, 1997, 1998; Smith et al., 2001).

#### 3.3.1.5

While medical interventions for trans-identified youth under the age of 18 are generally considered to be premature (excluding those exceptional cases cited in 3.3.1.4), there are, on a 'continuum of support', specific non-medical interventions which might otherwise benefit the child or teenager.

Non-medical interventions include psychotherapeutic, psychosocial, educational and legal (see Appendix D). Examples of both therapeutic and psychosocial support might include fostering the young person's exploration of a variety of options in terms of gender and sexual identities and presentations, and helping to creating a safe environment (in the counseling room, at home, at school, in the community) for the trans-identified youth to adopt the name and dress, and to act and play according to societal gender norms traditionally ascribed to the 'other' gender/sex (Boenke, 1999; PFLAG-T Net). Further therapeutic interventions might involve working with family members, school officials, religious leaders and medical/health providers (Benestad Pirelli, 2001).

Additional psychosocial/community support could include linking the child/teen with community and peer-based resources (such as trans-identified/positive support groups like Trans Youth Toronto and the Trans\_Fusion Crew and LGBT Parenting Network in Canada, PFLAG-T Net in the USA, Mermaids in the UK and Humanitas in The Netherlands.<sup>1</sup>

Provision of printed resources (e.g., books, magazines, articles) is a useful educational/informational support for trans youth and their significant others. The same is true for electronic resources (e.g., websites, list servers, chatrooms) and 'Internet working' can be a life-saver, especially for those living in remote areas.

Legal support might involve providing assistance around a legal change of name, child protection rights and anti-discrimination suits.

### 3.3.2

Parents and prospective parents

#### 3.3.2.1

Trans-identified parents potentially require therapeutic assistance with a variety of issues involving the parenting of existing children. Similarly, prospective parents who identify as TS or TG might benefit from counseling support around their consideration to become new parents.

These two populations create a unique set of challenges in terms of identifying and prioritizing issues and developing and implementing appropriate therapeutic interventions for all parties involved. (See Lev, in press).

In terms of trans-identified parents, counseling concerns might include decision-making processes involved in coming out and/or transitioning, disclosure of their gender identity status and/or desire to transition to their children, balancing the needs, rights and responsibilities of both parents, providing therapy for children of trans parents who are experiencing transphobic reactions from peers, as well as other issues. With respect to TS or TG individuals who are contemplating becoming new parents, a therapist can help in the decision-making process as to the various options available (i.e., natural parenting prior to hormonal and surgical sex reassignment, or post-transitionally, donor insemination or adoption).

In addition to providing counseling for the particular individual or couple involved, family therapy and/or psychoeducational group work with other parents/couples/families might also be indicated (such as the programming put on for transparents by the LGBT Parenting Network at the David Kelley Program, an initiative of the Family Service Association of Toronto). Further clinical research and resources are needed in this fast-emerging area and practitioners who work with couples, parents and/or families are encouraged to expand to a trans-identified clientele. (See Cook-Daniels, 2001a for an online resource on trans families).

### 3.3.3

#### Seniors and grandparents

##### 3.3.3.1

Seniors who identify as TS or TG commonly experience multiple forms of marginalization and invisibility, often compounded by inaccessibility to transpositive psychotherapists. Trans-identified grandparents face unique challenges in relating to their existing or prospective grandchildren and might require clinical assistance.

In this writer's experience, many trans-identified seniors (not only those 60 and over but, in some cases, those as young as 50-59) are likely to be disabled, poor, lacking in affordable housing and/or psychosocial and community support. As such, these older people are potentially at risk in terms of accessing proper mental health care for a variety of conditions, namely, bereavement, loneliness, isolation, unresolved religious guilt/shame, depression, anxiety, alcoholism, suicidality, dementia, Alzheimer's, elder abuse (Cook-Daniels, 1997), transpositive care in nursing homes (Cook-Daniels, 2001b; Moore, 2002). An additional challenge is sourcing therapists who are knowledgeable in Geriatrics and who can relate inter-generationally, if need be. Effective therapeutic and social/community support for this population, therefore, are critical.

TS and TG grandparents, similar to trans-identified parents, might also benefit from supportive counseling interventions in terms of role identification, disclosure management, reworking relationships with children and grandchildren, etc. As noted above, mental health research around the specific needs of this group (including longitudinal outcome studies around post-transitional adjustment) is urgently required. (See Cook-Daniels, 2002, and the Transgender Aging Network, for an online resource around the needs of trans seniors).<sup>2</sup>

### 3.3.4

#### People of color and newcomers

##### 3.3.4.1

Given that transpeople of color and newcomers are doubly disadvantaged insofar as they are vulnerable to racism and transphobia, and often also encounter cultural alienation, there is an urgent need for white practitioners to develop clinical sensitivity and ethnoracial cultural competence in the effective support of minority-culture clients. Of equal importance, is the need to foster opportunities for the emergence of mental health practitioners of color who are trained in trans-cultural competence.

Many clinicians recognize that racism impacts health and well-being as drastically as sexism, homophobia or transphobia does, and that transpeople of color are doubly at risk in terms of potential mental health and sexual health hazards. Related to this reality, is the fact that one of the most glaring gaps in service for this population is the need for, and yet the lack of, psychotherapists who identify as people of color - and who are, in addition, trans-identified, or at least, transpositive and have some expertise in gender identity issues. Due to this lack of

ethnoracial peer mental health providers, a number of transpeople of color and trans-identified immigrants and refugees purposefully do not seek out white therapists because of the critical trust issue around power dynamics and access and equity within the therapeutic relationship. If and when this population does access mainstream (white) counseling resources, in some cases the therapeutic alliance-building process never gels, or takes excessive time and energy to consolidate.

Therapy can potentially benefit transpeople of color with issues pertaining to experienced racism and transphobia on the part of their families and/or communities of origin, and discrimination from society, in general. Newcomers (immigrants and refugees) face the additional challenge of adjusting to a new country, culture and community, so settlement issues might be an additional appropriate goal to address within the counseling session. Refugee claimants might require further support around issues of religious harassment or political torture (as experienced in their countries of origin), and referrals for legal aid in terms of battling deportation and winning refugee status in their newly-adopted country. Clinical research is strongly urged with this marginalized population, with a view to identifying their unique needs and developing specific therapeutic support.

### 3.3.5

#### Sex trade workers

##### 3.3.5.1

A critical review of the current exclusion of TS and TG sex trade workers from many gender identity programs, and the denial of access to sex hormones and sex reassignment surgery strictly on the grounds of not having fulfilled the criteria for the 'real-life experience'.

Given that most transpeople who earn a living through the sex trade (prostitution and/or pornography) would fail to meet the two basic criteria of the 'real-life experience', namely, education or employment - insofar as sex trade is not considered 'legitimate' work by most gatekeepers (Namaste, 2000: 205-213), in spite of the fact that the Standards of Care do not explicitly exclude TS or TG prostitutes (Meyer et al., 2001) - this is seriously problematic in that a large percentage of the trans community (cited as high as 36% in one research study - Namaste, 2000: 158) is not accessing needed medical supports. Approximately one-third of the trans population is being effectively excluded by discriminatory mental health providers because sex trade work is not deemed to be a viable means of earning a living, and therefore, inadequate fulfillment of the 'real-life experience' (Namaste, 2000).

Two suggested recommendations are to either waive the requirement for 'legitimate' employment for trans-identified street-active prostitutes, or alternatively, to require only a small commitment of volunteer community work to complement the sex trade work, given that volunteerism is also a criterion of the 'real-life experience'. Moreover, this situation warrants ongoing discussion, negotiation and review between gatekeeping care providers and TS/TG consumers.

### 3.3.6

#### People with disabilities

##### 3.3.6.1

A large proportion of trans-identified individuals experience multiple physical, emotional and/or mental disabilities, coupled with social isolation, necessitating comprehensive care management.

Transpersons with disabilities are, like trans-identified seniors, typically dually-disabled, considering that many of these individuals are also economically compromised (on a fixed lower income) and, in some instances, might not even have access to a disability pension or to affordable housing.

A fundamental barrier for some TS or TG people with disabilities is one of physical mobility (often coupled with financial constraints around taxi fees) and/or psychological 'availability' (readiness, motivation and commitment) in terms of accessing therapists' offices for the purpose of regular counseling sessions. Suggestions to try to remedy this situation could include house calls, telephone sessions or cyber-counseling (where the individual can afford the cost of therapy), or alternatively, hooking up the client with a transpositive psychiatrist (who can see the individual on a periodic basis or when emergencies arise) as well as linking him or her to local community support. Advocacy work in this area around innovative interventions to overcome accessibility to needed mental health care resources is called for.

### 3.3.7

#### People living with HIV/AIDS

Insofar as transpeople living with HIV/AIDS sometimes still face stigmatization on the part of sex reassignment surgeons or other medical care providers, often resulting in the exclusion of desperately-sought for surgical and other medical interventions, care providers need to develop increased clinical sensitivity and responsivity to this population, including referral for psychotherapeutic support, as indicated. Cited as high as 63-74% of transsexual and transgendered people who have HIV/AIDS (Namaste, 2000: 237), this group represents an extremely high portion of the overall transpopulation.

Hormonal administration (androgens or antiandrogens and estrogens) and/or surgical intervention (genital reconstructive surgery) for trans-identified individuals diagnosed with HIV/AIDS should be undertaken on a case by case situation only, involving appropriate screening, monitoring and support procedures, as required. AIDS phobia is not a bona fide reason for surgeons or physicians to withhold medical care, as prescribed by the American Medical Association (see Israel and Tarver, 1997).

Although a fair number of clinical research studies (AFAO, 1998; Bockting, 1998; Bockting and Kirk, 2001; Lombardi, 2001; Lombardi and van Servellen, 2000; Namaste, 1999; Namaste, 1996; Namaste, 1995b; Reback and Lombardi, 1999; Scott and Lines, 1999) have recently been undertaken in North America and other parts of the world, additional research is called for, focusing on longitudinal studies of transpeople living with HIV/AIDS (including those who have been taking cross-sex hormones for a period of time, and those who have undergone sex-reassignment surgery) to highlight any areas of concern. The Participatory Action Research model and similar consumer-participant research models are highly recommended to maximize valid and reliable results.<sup>3</sup>

In addition to empirical research pursuits, a series of preventative education programs targeting a trans-identified population have recently been implemented in North America and abroad as an effective means to involving and empowering this historically-marginalized community (Bockting, 1998:55). More of the same on the part of sexual health researchers and promoters is strongly urged.

### 3.3.8

#### Low-income and homeless people

##### 3.3.8.1

The insidious impacts of poverty and homelessness must always be factored into the mental and emotional health, wellness and well-being needs of transpeople who are socioeconomically comprised.

Fiscal ill-health (socioeconomic disparity), as with racism, sexism, heterosexism, homophobia and transphobia, cannot be separated from the physical, psychological, sexual, social and spiritual well-being of poor or homeless transpeople. One of the key barriers for trans-identified individuals who are on a low income or cannot afford adequate housing is the inability to financially access private practice therapists (including those offering sliding-scale fees). A suggested alternative to this situation is for the counselor to provide the client or referring individual with referrals to appropriate, no-cost, community counseling services and community support. Some compelling empirical research has already been initiated in this area (Namaste, 1995a; Namaste, 2000); ongoing research is further indicated.

### 3.3.9

#### Incarcerated or institutionalized individuals

##### 3.3.9.1

Given the extreme vulnerability of transpeople who are incarcerated or institutionalized, provisions for safety and security, as well as improved access to transpositive medical care are urgently recommended.

Trans-identified prisoners, mental health in-patients or other TSs and TGs housed in institutional settings, are potentially at risk for physical, sexual and/or emotional abuse or neglect from care providers and/or fellow inmates or institutionalized patients/residents (Namaste, 2000). The mental health provider can play an advocacy role here in terms of helping his/her client to access and maintain an environment that is free of personal threat or danger (which might involve securing a separate space within the larger prison, hospital or facility).

In addition to the safety factor surrounding incarcerated/institutionalized transpeople, most of these individuals are also acutely medically marginalized in terms of being able to access transpositive primary medical care, including administration of sex hormones and/or approval for sex reassignment surgery (Namaste, 2000), not to mention trans-supportive psychotherapy. In

this regard, the therapist, in addition to offering supportive therapy to the client (where viable) can also be an effective ally with regards to assisting the individual in securing appropriate primary medical care, including the administration of sex hormones and/or the approval for sex-reassignment surgery (as indicated), in conjunction with the appropriate medical personnel. (Israel and Tarver, 1997).

#### **4.0**

##### **Therapeutic relationship**

#### **4.1**

The professional working relationship between counselor and client should ideally be one that is collaborative, not adversarial.

This recommendation has been made by a number of clinicians (Duncan et al., 1992; 1999; Hubble et al., 1999; Israel and Tarver, 1997; Lev, in press; Rachlin, 1997; Vitale, 1997; Zandvliet, 2000). In practice, this would constitute a contractual interactive relationship that is mutually based on open communication, information and education, negotiation, flexibility and trust. The therapist's 'gatekeeper' role should be clearly outlined as part of the mutually agreed upon therapeutic contract (Bockting, 1997), while always keeping open the door to honest discussion and reasonable negotiation (within the parameters of realistic client expectations and benign clinical discretion) around potentially contentious treatment issues. A suggestion around gatekeeping as a potential barrier to developing a therapeutic alliance based on trust is the division of roles, such that one clinician acts as assessor (gatekeeper) while a second functions as therapeutic support ('healer') (Anderson, 1997).

#### **4.2**

To ensure a therapeutic alliance based on collaboration and mutual trust, clear goal alignment must exist between the client's stated needs and the therapist's outcome objectives.

Such an aligning of agendas (Duncan et al., 1992; Hubble et al., 1999) would necessitate clinicians to put aside any moral, political or personal values incongruent with those of the client's aspirations (e.g., transphobia, homophobia, transqueerphobia, etc.). If unable to do so, the therapist should clearly state this up front and refer the client elsewhere. The client's wishes should take priority wherever possible, unless, in the clinician's sound judgment, these desires are deemed to be detrimental to the client's well-being, or alternatively, compromise the clinician legally, ethically or professionally. Examples of the latter instance might involve a youth, someone with extreme emotional instability or a person who is cognitively impaired.

In practice, goal alignment (which often results in increased therapeutic efficacy) involves: primary importance of client presentation rather than therapist orientation in the determination of counseling goals, validation of the client's experience, empowerment of client-ascribed meaning, and ethical guidelines regarding conscious therapist deceit and interventions outside of client awareness. (Duncan et al., 1992; Hubble et al., 1999).

#### **5.0**

##### **Comprehensive case management**

#### **5.1**

A holistic health care approach is recommended which genuinely strives to address the individual's physical, emotional-mental, sexual, 'social' and 'spiritual' health.

This multidimensional view of health is one that was envisioned by the organizers of the Saskatoon-based conference: '2001: A Health Odyssey'.<sup>4</sup> Social health would include effective family and/or community support (including those of the trans and/or queer communities), as appropriate. Where the primary care provider is unable to offer specific resources, appropriate referrals and follow-up should be conducted with the client's consent. Spiritual health is a broad concept which addresses the spiritual, religious and/ or existential concerns of the individual, with a view towards optimum well-being, and ideally, self-actualization. Pastoral counseling or similar clerical support might be indicated (Bockting and Cesaretti, in press).

#### **5.2**

The care model should ideally be designed and delivered by a multidisciplinary team - optimizing the clinical expertise of a wide variety of health care providers and behavioral scientists - in collaboration with the client.

The care team could include a combination of a number of the following: psychotherapist, psychiatrist, psychologist, social worker, family physician, endocrinologist, surgeon(s), electrologist. Other care providers, such as, addictions therapists, anger and stress management therapists, psychospiritual therapists, etc., can be added to the team as indicated.

### 5.3

One of the most urgent needs of the trans population is comprehensive community-based health care that would integrate transpositive mental health services as a cornerstone of effective support.

This need has been repeatedly cited in the literature (Feinberg, 2001; Lombardi, 2001; Namaste, 1995a). The design and delivery of effective therapeutic support services should ideally incorporate the principles of community psychology/psychiatry, advocating for community and home care settings, wherever possible, as opposed to hospitals and similar medical institutions, especially given the not uncommon 'incarceration' in the past of many transpeople in psychiatric facilities (as gleaned through the author's clinical and peer-based experience over the past 30 years, as well as through personal and community-based anecdotal sources). The rationale for a community care approach is evident, given the interrelated aspects of physical, sexual, mental, 'social' and 'spiritual' health. Some examples of this are: self-esteem, depression, anxiety, anger, stress, body image, physical/sexual abuse, addictions and HIV-related issues.

The immediate development of holistic health care services and programs for a GD/GV client base that has been extremely marginalized for many years is critically overdue. Fortunately, a number of larger cities in the US and a couple in Canada (Vancouver and Saskatoon) have already established community health centers for lesbian, gay, bisexual, TG and queer (LGBT) populations, and several others are following suit (in Canada: Toronto, and hopefully Ottawa and Montreal).

## 6.0

### Accountability and quality assurance

#### 6.1

Ensure at the outset that clients are completely informed of their legal rights and of therapists' legal and ethical responsibilities ('informed consent').

This key requirement has been variably cited by Ettner, 1999 and Namaste, 2000. Ideally, a consumer handbook outlining such rights and responsibilities (as specified professional regulations and government legislation in each province, state or country) should be made available to clients.

#### 6.2

Periodic quality assurance evaluation of mental health care providers and services is integral to a 'truly' responsive transpositive health care model.

Therapist attitudes and knowledge base around gender identity issues (cf. Harris et al., 1995; Mallon, 1999a: 147-149), client measures of therapists' phobic or positive attitudes (Liddle, 1999), consumer satisfaction surveys around gender identity programs/services (Blanchard et al., 1993), client measures of SOC effectiveness and responsivity (Denny and Roberts, 1995), and of gender clinics' adherence levels to SRS and to the SOC (Petersen and Dickey, 1995), are all vital to ensure effective support and quality care, making needed changes in design and delivery of support services, as indicated. The challenge here is to design and deliver instruments which will effectively capture those responses necessary to the substantive improvement of existing clinical support services.

#### 6.3

To help evaluate the variable results of sex-reassignment surgery as performed by individual surgical teams, and the attendant sexual functioning of their post-surgical TS patients, valid, reliable outcome studies are encouraged. (See also 9.1: Friedmann, and Junge, 1998; and Rehman et al., 1999.)

#### 6.4

Consultation with - and client referrals to - a variety of community resources, in particular, the TS/TG community, is imperative in order to ensure a responsible and responsive mechanism of accountability.

Ideally, viable partnerships can result between clinicians and TS/TG community and peer-workers to the mutual benefit of all concerned. This is in keeping with a community health care

model - an approach highly suited to a marginalized population such as the trans community, which has been historically under-served and mis-served by the mental health care and social service systems.

A knowledge of community- and peer-based resources (local, regional, national and international; support groups; print and online resources) is vital, both for purposes of research/consultation and referral. Of particular interest to clinicians are those dealing with mental, sexual and primary health issues.

## **7.0**

### **Advocacy and alliance building**

#### **7.1**

An important aspect of the therapeutic alliance when working with a largely marginalized population like transpeople - who are often subject to discrimination - is the therapist's enhanced role as a professional ally and advocate.

Therapist alliance and advocacy of this type is cited by Ettner (1999: 111). Such alliance might also be 'political' in nature (Harrison, 2000: 43), advocating for the initiation, amendment, implementation and/or enforcement of policies and procedures (on an individual and/or an organizational level) that preclude and penalize transphobia, and instead, promote a transpositive mandate, practices, culture and environment. Mallon (1999b) calls for just such 'organizational trans-formation', offering workable concrete strategies that address transpositive hiring practices, in-service training, welcoming strategies, integrated policies and public information, and advocacy efforts. Kooden (1994) urges clinicians to expand their own awareness and function as social change agents by means of community activism, thereby, practicing what they preach - that social activism is a component of mental health (similar to the Adlerian notion of 'social interest') - and role modeling this expression of power for their clients. Lev (in press) does just that by helping her TS/TG clients to develop their own self-advocacy skills. Further investigation is encouraged to identify the different possible ways mental health providers can optimize their function as a helping professional.

#### **7.2**

Highly recommended is the encouragement, training and support of mental health providers and sexual health providers who are TS or TG.

Given that there is already a growing number of people pursuing these professions (some in leadership roles effecting much-needed change in mental and sexual health, respectively), the benefits to clients of having access to trained professionals who are both consumer and provider (similar to the case of gay/lesbian clients and therapists) can be substantial. (The intention here is not to replace, but to complement, the valuable resource of non trans-identified mental health providers who are effective transpositive care providers). Benefits would ideally include a high degree of therapist empathy and understanding, appropriate self-disclosure and role modeling, and a high level of client comfort and safety.

Of course, adherence to the highest of professional standards is imperative: professional training (Rachlin, 2001), objectivity and boundaries) if trans-identified mental health providers and sexual health providers wish to maintain credibility and compete with their non trans-identified professional peers. A community resource recently set up for just this kind of support is the American Transgender Scholarship and Education Legacy Fund sponsored by the International Foundation For Gender Education.<sup>5</sup> An additional need is similar support for non-Americans, as well as a resource of established mental health providers and sexual health providers who could offer mentoring to up and coming TS/TG care providers.

#### **7.3**

The affiliation of trans- and non trans-identified mental health providers and sexual health providers is strongly urged.

Traditionally, GD/GV issues have been the domain of both sexologists (including sex therapists, educators and researchers) as well as clinicians (including psychiatrists, psychologists, psychotherapists and social workers). Currently, the increasing rates of HIV/AIDS prevalence in TS/TG populations (Bockting, 1998; Clements-Nolle et al., 2001; Lombardi and van Servellen, 2000; Namaste, 2000) has a direct impact on how sexual and mental health issues potentially interrelate, and by extension, how mental health providers and sexual health providers can inform one another in terms of expanding their knowledge base and the tools of their respective areas of specialization: assessment, counseling/therapy, education, support, referral, follow-up and/or case

management. A working affiliation between these two specialists - including those who are trans-identified - can only serve to enrich the combined resources available to clients in need of both of these services.

#### 7.4

Integral to any transpositively-accountable service model is the partnering with trans-identified peer community workers.

A transpositive model, by definition, actively reaches out to the community that care providers serve to elicit needed input into programs and services and to build viable partnerships with trans-identified peer community workers. Community partnering is an integral part of the collaborative relationship between consumer and provider and is becoming standard practice in community-based health care. Research is suggested to look at how clinicians (and researchers and educators) might creatively utilize TS/TG community partners to better serve their clients, including an examination of some current uses: consumer-led workshops to broaden mental health providers' familiarity with the issues, informal consulting to source community resources and highlight relevant issues, client referrals for peer support and focus groups to help design therapy groups. Perhaps therapists can learn from the example of researchers of trans populations who employ a Participatory Research Model (PRM) (Clements-Nolle et al., 2001). The PRM is also applicable to quality assurance and accountability; knowledge and professional development; and research issues.

### 8.0

#### **Knowledge base and professional development**

#### 8.1

At the outset, a basic conceptual understanding is called for around the fundamental distinctions, as well as the complex intersections, of gender identity (how one experiences one's inner self), physical sex (how the world perceives one's outer self), sexual orientation (who one is sexually or romantically attracted to), and sexual (orientation) identity.

For elaboration of the concept of sexual identity, see Lev (in press), and for the related concept, sexual orientation identity, see Devor, 1998. See also Appendix C: Four Continuous Dimensions: Physical Sex, Gender Identity, Sexual Orientation and Sexual Orientation Identity.

In specific, the clinician must be able to develop an adequate level of sophistication (complementing clinical expertise with 'transcultural' competence) in order to appreciate how each of these four axes (although distinct in theory) intersect in practice - indeed, how these four ways of being-in-the-world (i.e., physical sex, gender identity, sexual orientation, sexual [orientation] identity) mutually impact one another, with the potential for full integration into a consolidated self. The logical extension of such reasoning ought to lead the therapist to an increasing understanding of and appreciation for the diverse 'partner-preference potentials' of GV individuals (Coleman et al., 1988; Pauly, 1998), including, for instance, transmen who identify as gay, transwomen who are lesbian and others who might be bisexual (collectively known as transqueers), transensual, polysexual or asexual.

One of the most important therapeutic goals and interventions is the affirmation and validation (on the part of both therapist and client) of not only clients' gender identity (as a man or woman, neither or both), but also of their sexual identity (as straight, gay, lesbian, bisexual, TS, polysexual or asexual), and of their comfort level with their current body configuration (Diamond, 1995). In this way, both transphobia and 'transqueerphobia' can be prevented or worked through a) in the client, diminishing guilt/shame and enhancing self-esteem, and b) in the therapist, promoting greater objectivity and a respect for both diversity and individuality.

#### 8.2

Given the diverse and fluid nature of both gender and sexual identity presentation, the multiplicity of client issues and the complex challenges facing practitioners today, comprehensive specialized training and ongoing development - in addition to a rudimentary knowledge base - is imperative for clinicians who wish to effectively support transpeople.

This imperative is underscored by practitioners in the field (Gainor, 2000: 155-156; Israel and Tarver, 1997; Mallon, 1999a: 147-149; Zandvliet, 2000). Such competency-building should include the basics of clinical sensitivity and cultural competence, incorporating a viable diversity model. To help achieve this goal, relevant resources should be accessed from both the mental health and the trans communities, including a rich mix of clinical (scientific/theoretical/case histories), and cultural (anecdotal/observational) data. The benefit of this bimodal educational

approach lies in the two types of information gathered: empirical and phenomenological.

In practice, effective professional development should comprise academic and clinical training - including supervision and consultation (Ettner, 1999: 109; Rachlin, 1997), personal growth, and a 'pulse' on the client population with regards to current sociopolitical issues, changing cultural trends and existing community resources. Some clinicians specializing in this area urge the need for a competency-based model of professional knowledge, recommending that credentials of gender practitioners include a high level of specialization, namely, formal accreditation as a Gender Specialist, and eventually, as a Senior Gender Specialist (Israel and Tarver, 1997: 12-13).

The first classification includes professional, paraprofessional or peer-support care providers who are actively practicing psychotherapy, counseling or education with a specific focus on gender-identity issues. The authors suggest a minimum of two years of direct supervision or consultation with a practicing Senior Gender Specialist with advanced consulting experience. The second classification is limited to professionals with advanced degrees in psychology, medicine, sexology, clinical social work or other mental health fields, and who have received at least two years' consultation from a Senior Gender Specialist while practicing as a Gender Specialist for five years. The proposed training program for gender specialists should include: 1) suicide- and crisis-intervention skills, 2) an ability to identify differential mental health diagnoses and refer to appropriate support, 3) a capacity to promote consumer awareness of critical gender-oriented needs, 4) adequate educational and intervention skills around sexually-transmitted diseases and safer-sex strategies, and 5) an overall understanding of basic gender and sexual identity concerns.

While the level of gender specialization espoused by Israel and Tarver (1997) is a worthy ideal to work towards (and one which this writer is currently pursuing), the real-life practicalities of economically-compromised clients who are in desperate need of immediate therapeutic support dictate a compromise: what I shall call 'a continuum of expertise'. That is, a range of possibilities that would encourage professionals to specialize as gender experts, while still allowing non-specialists an opportunity to serve the needs of transpeople (Zandvliet, 2000), provided they attain a high professional standard of knowledge attainment and consult with dedicated gender specialists as needed (Rachlin, 1997). Such knowledge should take the form of a multimodal approach.

Towards this end, Mallon (1998) has identified seven key sources to such an 'ecological' knowledge base: 1) practice wisdom arising out of the narrative experiences of the profession and of professional colleagues and clients, 2) the practitioner's personal experiences, 3) familiarity with the clinical literature, 4) an awareness of historical and current events (including the sociopolitical context of the lives of transpeople), 5) research issues which inform practice,<sup>6</sup> 6) conceptual and theoretical analyses, and 7) specific information offered by the case at hand.

Mallon (1999a) and Harrison (2000) also add the critical component of therapist self-awareness, with a view towards examining counter-transference issues when treating a GD/GV client base. Both have drafted guides for 'exemplary' (Mallon, 1999a: 147-149) and 'good practice' (Harrison, 2000: 48), as have Lev (in press) and Zandvliet (2000: 188-189). A focus on mental health providers' attitudes towards gender and sexual minorities is echoed by others (Eliason, 1995; Harris et al., 1995) and has clear implications for sensitivity training around gender diversity (Kane, 1997).

In terms of comprehensive curriculum development in graduate schools for medicine, psychiatry, psychology, sexology, sociology, social work, education and law, while course inclusion of lesbian/gay sexual orientation studies has recently been making headway, there still exists a glaring omission as far as transgender identity issues are concerned (Mallon, 1999a: 147-149). A few universities are the exception to this rule (e.g., the University of Toronto and Ryerson University in Toronto, Canada) and it is hoped that others soon follow suit.

Similarly, with respect to formalized guidelines for clinicians working with a TS/TG client base, other than those formulated by a handful of individual clinicians, there exists a big gap in this area. Promisingly, there is some activity currently underway in this direction by Division 44 of the American Psychological Association (APA). Division 44 had recently drafted *The Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients*, which the APA approved on February 26, 2000 (APA, 2000).

## **9.0 Research**

### **9.1**

Further research is required in the form of well-designed and methodologically-sound outcome studies of post-transitional TS in terms of social adjustment and satisfaction with surgical results and sexual functioning.

See Friedmann, and Junge, 1998; and Rehman et al., 1999. These, as well as other relevant consumer outcome issues, are vital sources of information for consumers and providers alike to help in the decision-making process around the treatment of choice.

## 9.2

Research is indicated to specifically work out how a generic or universal transpositive model can be applied, in practice, to a variety of settings (clinical - organizational, clinical - private practice, institutional, community-based), and effectively tailored to meet the differential needs of the specific subgroup or individual.

Firstly, research is required to identify the specific requirements of particular settings, secondly, to try out creative adaptations of the model to meet the needs of that setting, and thirdly, to critically evaluate the efficacy of implemented solutions towards the future development and refinement of a viable model that best fits within that client setting.

## 9.3

In addition to the scant process models cited in the literature, further research, development and evaluation of other process (staged) models - identifying, outlining and supporting the GD/GV client through each of the developmental stages of the transitional process - is highly encouraged.

Process models cited in the literature include Bockting, 1997; Bockting and Coleman, 1992; and Rachlin, 1997. Process or staged models can be tailored to the particular needs of GD or GV clients, including trans youth and non-operative TSs, as well as significant others, such as partners, children, parents and families (Rosenfeld and Emerson, 1995) - an area of support that is still much needed.

## 9.4

Ongoing research is encouraged on the development, implementation and evaluation of specific clinical treatment modalities as applied to a GD/GV client base - comparing the benefits and limitations of each, and the possibilities around complementary therapies.

Further suggested is a focus on some of the more 'creative' or interactive interventions (e.g., dream analysis, expressive therapy, Adlerian life style assessment, metaphor therapy, narrative/constructivist therapy, life skills newstart model, etc.), as well as relevant therapeutic support like addictions management, anger management, stress management, trauma therapy, couple counseling, family therapy and group therapy). Narrative therapy can be particularly useful in providing TS and TG an opportunity to relate their 'back', 'dominant' and 'alternate' stories, thus providing a therapeutic mechanism to clarify their options and to effect change accordingly (Benestad Pirelli, 2001).

Publication of these various methods of therapeutic support is critical for other mental health providers to access, develop and customize according to their own style, preferences and client needs. See Neal and Davies's (2000) 'pink' therapy handbook on gay, lesbian and bisexual clients for ideas on what a TS/TG reference could look like. It would be useful to compare, for example, essentialist and constructionalist approaches, as well as therapeutic interventions of affirmation and validation, and of creative ways to reorient discouragement to encouragement (popularly used by Adlerians and others). Additionally, research as to the potential uses and benefits of multimodal strategies could be useful.

## Conclusion

This paper has presented an historical overview of the psychological paradigm shift from a transphobic to a transpositive assessment and treatment approach in the more effective support of GD/GV clients. Clinical models were identified on a continuum, ranging from medical management to social diversity models, and from clinician-directed to consumer-dictated perspectives, with the collaborative and client-directed positions occupying the middle. The need for a sophisticated degree of clinical sensitivity and cultural competence was highlighted, given the fluid nature and continually changing needs of an increasingly diverse trans community.

Transqueers were identified as one of many subgroups requiring specialized clinical and community support, and mental health practitioners were alerted to the possibility of clinical transqueerphobia. Trans youth were cited as another emergent, 'at risk' population, requiring

sensitivity and substantive support: early intervention (as indicated) as well as ongoing support. Clinicians and care providers were also urged to thoroughly familiarize themselves with the contentious issues and divergent models surrounding treatment options for this population prior to implementing strategies prematurely. A selected range of trans-affirmative therapy models were presented and evaluated to aid in the development of a generic transpositive therapeutic model, with a potential for a variety of practical applications.

A set of nine major guidelines for developing the theoretical framework for such a model was proposed, including specific recommendations around clinical orientation/treatment philosophy, assessment considerations, treatment considerations (including psychotherapy, diversified subpopulations and marginalized subpopulations), the therapeutic relationship, comprehensive case management, accountability/quality assurance, advocacy/alliance building, knowledge base/professional development, and research. Finally, implications for both a clinical transpositive model and for professional care providers were outlined. In particular, the need for specialized professional training was emphasized, role enhancement as professional ally and advocate was urged, and the specific support of trans-identified mental health providers and sexual health providers and community peer-workers was encouraged.

The transpositive therapeutic model proposed in this paper is a work in progress, requiring further development, refinement and eventual implementation and evaluation. Critical input from other mental and sexual health care providers is welcomed as it is the hope of this writer to continue to fine-tune the model and to publish further commentary on the therapeutic and clinical implications of such a blueprint for transpositive therapy - including specific applications for the support of trans-identified youth, in addition to other marginalized subpopulations within the broader trans community.

## Appendix A

### A selected glossary of some key terms

#### Key to abbreviations:

*n.:* noun

*adj.:* adjective

*coll.:* collective

*sing.:* singular

**androgynous:** *n.* A person with androgynous presentation who contrasts with a transgenderist by adopting characteristics of both genders or neither. Examples of individuals who identify as androgynes include those who present bigender mannerisms, those who intentionally wear androgynous or gender-neutral clothing, and those who do not wish to be identified as either male or female. An androgyne might wish to be identified as both male and female. Some individuals might self-identify as androgynes to fulfill identity needs; others might do so to challenge social stereotypes. (Israel and Tarver, 1997: 15-16). Androgyny was first popularized in the modern era by Jungian psychologist June Singer (1973: 20), however, the androgynes of today appear to have transcended Singer's stricter definition of androgyny as an archetype of male and female inherent in the psyche of all human beings. See also: *bigendered* and *transgenderist*.

**bigendered:** **1.** *n., coll. sing.* People who have both a male and a female side to their personalities. (Nataf, 1996: 63). **2.** *adj.* bigendered. See also: *androgyne* and *transgenderist*. 'Based on the concept of two existing gender majorities, and thus, two major options of gender identities (women and men), some individuals identify as both female and male. To obtain a sense of belonging to both gender majorities - in which they are actually perceived by others the way they perceive themselves (as bi-gendered) - these individuals express themselves socially as female- and male-gendered. Many bigendered people experience themselves as belonging to the transgendered community. There is a need for bi-gendered individuals to shift back and forth, therefore, for some, it is rewarding to support a gender-oscillating capacity through the aid of masculinizing or feminizing hormones, permanent beard removal and/or minor surgical alterations.' (Benestad Pirelli, personal communication, 2002).

**biphobia:** **1.** *n.* A dislike or suspicion of bisexuals and bisexuality, referring as much to disapproving attitudes among non-bisexual lesbians and gay men as it does to prejudices held by heterosexuals. (Hogan and Hudson, 1998: 86). A fear of people who cannot be neatly categorized into binary sexual categories (Ochs, 1996: 217-239), therefore, closely related to transphobia (Hill, 2002). **2.** *adj.* **biphobic.** See also: *homophobia*, *gender phobia* and *transphobia*.

**gender dysphoria (GD):** *n.* Originally termed Gender Dysphoria Syndrome (Fisk, 1974: 7), this clinical condition described a set of psychosocial symptoms and/or behaviors reported by a group of deeply troubled and often desperate patients (self-identified TS) seeking gender reorientation, including surgical sex conversion. The term is now superseded by the more comprehensive DSM-IV-TR classification, Gender Identity Disorder (GID) (APA, 2000) which also includes 'fetishistic transvestites' and intersexed individuals. Most people who embrace a cross-gender or GV identity find the label, GID, pathologizing, preferring more humanizing terms like *transpeople*, 'trans-identified' or *gender diverse*. Many also believe that it is non-transpeople who experience gender dysphoria (Cromwell, 1999: 25). *Adj.* GD. See also: *gender variance*.

**gender phobia:** **1.** *n.* Targets women who are not feminine and men who are not masculine. Closely related to transphobia (Feinberg, 1996: 116) and biphobia. Sometimes the synonym, 'genderism' is used. (Bornstein, 1994: 74; Hill, 2002). Extreme examples of this form of bigotry can result in attacks of physical violence ('gender bashing'). **2.** *adj.* **gender phobic.** See also: *biphobia*, *homophobia* and *transphobia*.

**gender variance (GV):** *n.* Synonym: **gender diversity:** *n.* Cultural expressions of multiple genders (i.e., more than two) and the opportunity for individuals to change gender roles and identities over the course of their lifetimes. (Jacobs and Cromwell, 1992: 63). Cromwell subsequently preferred the use of the non-deviant and de-stigmatizing term, 'gender diversity'. It is not yet known if this term will eventually supersede gender variance (Cromwell, 1999: 159, n. 4). **2.** *adj.* **GV/gender-diverse.** Compare to *gender dysphoria*.

**genderqueer:** **1.** *n.* Anyone who challenges societal gender norms, including, but not limited to: transsexuals, transgendered people, intersexed individuals, crossdressers, bi-gendered persons, drag kings and queens and those who live in a way that questions gender assumptions. Similar to the umbrella usage of the term, 'transgendered'. Each individual has the choice to self-identify and identities might change over time. **2.** *adj.* **genderqueer.**<sup>6</sup>

**homophobia:** **1.** *n.* The dread of being in close quarters with homosexuals, or more generally, revulsion towards gay men and lesbians. (Weinberg, 1972). An unreasonable fear or hatred of homosexuality, especially in others but also in oneself (internalized homophobia). Although technically non-gendered, some writers use the word, 'lesbophobia', for specifically anti-lesbian manifestations of homophobia. (Hogan and Hudson, 1998: 290). **2.** *adj.* **homophobic.** See also: *biphobia*, *gender phobia* and *transphobia*.

**intersexed (IS):** *n., coll. sing.* Synonyms: **intersexual** *n.* and **hermaphrodite:** *n.* A person who was born with the condition of intersexuality or hermaphroditism (the latter term is rarely used because it and the related terms, 'true hermaphrodite' and 'pseudohermaphrodite', are now considered politically incorrect).

**intersexuality/ hermaphroditism:** **1.** *n.* A congenital condition of ambiguity of the reproductive structures so that the sex of the individual is not clearly defined as exclusively male or exclusively female. (Money and Ehrhardt, 1972: 285-286). **2.** *adj.* **intersexed/intersexual, hermaphroditic.**

**polysexual:** **1.** *n.* **2.** *adj.* Synonym: **polyamorous:** Sexually and/or romantically attracted to more than one sex or gender, with the attendant belief there exists more than two sexes or genders, thereby, transcending a bisexual identity. Herdt (1994) documents a third sex and third gender, and Fausto-Sterling (2000) has identified no less than five sexes.

**transgendered (TG):** *adj., coll. sing. a)* In general, an umbrella term for all transpeople or members of the trans community; *b)* in particular, those individuals who identify as transgenderist (on a gender identity continuum in between TSs and TVs).

**transgenderism:** *n.* A fluid term without a universally-accepted definition. Therefore, its meaning is highly dependent upon the subjective experience of each unique individual within the overall trans community. The term was first introduced by Virginia/Charles Prince (1976; 1980) and subsequently elaborated upon by Docter (1988: 21-22). Transgenderism is not currently classified as a diagnostic condition, nor is this 'clinically invisible' (in the official sense) group of transgenderists covered by the SOC (Meyer et al., 2001), thus, reflecting a situation where the mental health community is not clinically or culturally sensitive to the ever-changing identities and realities of the trans population. Refer to Gilbert (2000) See also: *transgenderist* and *transpeople*.

**transgenderist:** **1.** *n.* An individual who lives in role part or full-time as a member of the opposite sex. Sometimes the transgenderist identity is carried into the workplace; more often it is not. Emotionally, this person needs to maintain certain aspects relating to both his/her

masculinity and femininity. Understanding this process can be difficult, particularly in situations where an individual's gender identity fluctuates or where he or she is unaware that the transgenderist identity exists. The transgenderist is frequently interested in hormones and occasionally in cosmetic surgery and castration, but not genital reassignment surgery. Because professional literature regarding transgenderists is sparse, the vast majority of these persons are unrecognized by care providers and have difficulty obtaining services or validation. Occasionally he or she might identify with the label, bigender. (Israel and Tarver, 1997: 15). **2. transgenderist** *adj.* See also: *bigendered* and *transgendered*.

**transhomosexual:** **1. n.** A person who exhibits transhomosexuality. **2. adj. transhomosexual.**

**transhomosexuality:** *n.* A special 'pendant' for, identification with, or attraction to homosexual persons of the opposite sex on the part of self-identified transsexuals. A subcategory termed androgynous focused on the bisexuality or androgynous aspects of the love object as of predominant importance. (Clare, 1984; Tully, 1992: 21, 259-260). In addition to gay or lesbian transsexuals, some transsexuals identify as bisexual (Weinberg et al., 1994:59-65, 230-238). See also: *transqueer*.

**transpeople:** *n.* An umbrella term for individuals who respectively identify as transsexual, transgenderist, transgendered, transvestic/crossdressed, 'two-spirit', bigendered, androgynous, gender variant or intersexed/hermaphroditic. This writer prefers this humanizing personal term (common in the trans community) to the de-humanizing clinical classification: 'people suffering from Gender Dysphoria or Gender Identity Disorder'.

**transphobia:** **1. n.** Manifested by skepticism about the existence of transpeople or a dislike or hatred of, and occasionally hostility toward, them. (Denny, 1994). Some transpeople manifest [internalized] transphobia by expressing dislike, hatred, and hostility toward other transpeople - most frequently those who are out. (Cromwell, 1999: 166, n. 3). A fear and hatred of changing sexual characteristics. (Wilchins, 1997: 230). Refer also to: Califia (1997), Feinberg (1996: 116), Hill (2002), Namaste (2000: 139) and Nataf (1996: 63). **2. adj.: transphobic.** Contrast with its opposite, *Transpositivity*. See also: *biphobia*, *gender phobia*, *homophobia* and *transqueerphobia*.

**transpositivity:** *n.* This writer has introduced the term, transpositivity, solely as a grammatical convention to provide a corresponding noun for its antonym, *transphobia*, but prefers its adjectival form: **transpositive**. The latter essentially means a respect for and acceptance of people who identify as 'trans': transsexual, transgenderist, transgendered, transvestic/crossdresser, 'two-spirit', bigendered, androgynous, GV or intersexed/hermaphroditic. On the continuum of diversity and acceptance, truly transpositive people go beyond mere acceptance to appreciation and celebration of transpeople and trans culture. Understanding, not a requirement, is a bonus. Contrast with its opposite: *transphobia*.

**transqueer:** **1. n.** An individual who is sexually and/or romantically attracted to others of the same gender identity. Transqueers identify as gay, lesbian, transsexual, bisexual or polysexual in their chosen gender). **2. adj.** The author of this article first used this term in 1994, which he introduced in an abstract for a paper on transqueers he was planning to present at the 1995 International Congress on Cross-Dressing, Sex and Gender at California State University, Northridge, CA. See also: *transhomosexual*.

**transqueerphobia:** **1. n.** A particular form of transphobia directed specifically towards transqueers. Combines transphobia, homophobia and biphobia and, by extension, gender phobia. **2. adj.:** transqueerphobic. See also: *transqueer*, *transphobia*, *homophobia*, *biphobia* and *gender phobia*.

**transsensual:** **1. n.** An individual who is sexually and/or romantically attracted to transpeople. A form of sexual orientation distinct from hetero-, homo- or bisexual. Transsensuals include transpeople who are primarily or exclusively attracted to their trans-identified peers. **2. adj. transsensual.** The word was probably coined by Divinity (an American trans-identified person), as used in her Carolina Trans-Sensual Alliance of 1992.

**transsexual (TS):** **1. n.** A person who manifests the phenomenon of transsexualism. **2. adj.** transsexual: Behaviorally, the act of living and passing in the role of the opposite sex, before or after having attained hormonal, surgical, and legal sex reassignment; psychically, the condition of people who have the conviction that they belong to the opposite sex and are driven by the appearance, and social status of the opposite sex. (Money and Ehrhardt, 1972: 291). Compare to: *transgendered* and *transgenderist*.

**transvestite (TV):** *n.* Synonym: **crossdresser (CD):** An individual who dresses in clothing of the opposite gender for emotional satisfaction or erotic pleasure, or both. The transvestite not

wishing to permanently alter his/her biological sex express little or no desire for hormones or gender reassignment surgery. Frequently, a recurring desire to crossdress provides an outlet for the individual to explore feelings and behaviors associated with the opposite gender. At times, a sexual fetish might be emphasized or an individual might wish to completely crossdress and discretely pass as a member of the opposite gender for a limited time. The individual is generally heterosexual, less frequently bisexual, gay, or lesbian. Traditionally, the majority of these individuals prefer to be known and referred to as crossdressers rather than transvestites, which is the more clinical term. (Israel and Tarver, 1997: p. 15). **2. adj. transvestic, crossdressed.** Compare to: *transgenderist* and *transsexual*.

**'two-spirit': adj.** An inclusive term used by historians and anthropologists to describe indigenous peoples of the Americas who have a gender identity and role which differs from their biological sex, thus, a form of gender variance or gender diversity. 'Two-spirit' people include biological males (originally labelled 'berdache' by the European colonists) and biological females (originally called 'amazons'). Native Peoples object to the label, berdache, as pejorative, preferring 'two-spirit' and specific Native American words like the Lakota 'wingkte', the Navajo 'nadle' and the Zuni 'we'wha'. See also: Cromwell (1999: 44-61, and 92-100), Feinberg (1996: 21-29, 110), Jacobs et al., (1996), Katz (1976: 281-334), Roscoe (1990) and Williams (1986).

## Appendix B

Figure 1a: A continuum of transpositive care models (a consumer-provider focus)

| CLINICIAN-DIRECTED                   | CLIENT-DIRECTED/COLLABORATIVE                               | CONSUMER-DICTATED                        |
|--------------------------------------|---|--|
| Psychiatric Medical Management Model | 1. Self-Determination Medical Management Model              | De-medicalized Self- Determination Model |
| ('gatekeeping')                      | 2. De-medicalized Self-Determination Social Diversity Model | (hormones/surgery 'on demand')           |

Figure 1b: A continuum of transpositive care models (a treatment model focus)

| PSYCHIATRIC MEDICAL MANAGEMENT MODEL | 1. SELF-DETERMINATION MEDICAL MANAGEMENT MODEL<br>2. DE-MEDICALIZED SELF-DETERMINATION SOCIAL DIVERSITY MODEL | DE-MEDICALIZED SELF-DETERMINATION MODEL |
|--------------------------------------|---|---|
| Clinician-Directed                   | Client-Directed/Collaborative   | Consumer-Dictated                       |

N.b. Where the word 'client' is used, this implies a collaborative contractual relationship between clinician and client; alternatively, the term 'consumer' is employed in the case where the person has no interest in contracting the services of a mental health professional, identifying exclusively as a consumer of a particular service (e.g., electrolysis, hormones, surgery). The alternative usage of 'dictated' and 'directed' is deliberately intended to demonstrate the differential power dynamics within these contrasting professional relationships. In the case of a 'clinician-dictated' model, this, by definition, would not be transpositive.

## Appendix C

Figure 1: Four continuous dimensions: physical sex, gender identity, sexual orientation and sexual (orientation) identity

### PHYSICAL SEX (Body = including Genes/Gonads/Genitals)

Male

Transsexed / Intersexed

Female

### GENDER IDENTITY (Psyche = Core Being/Essential Self)

Masculine                      Androgynous / Transgendered /  
Bigendered / 'Two-Spirited'                      Feminine

### SEXUAL ORIENTATION (Affectional Attraction = Love/Lust)

Heterosexual (Straight)                      Bisexual / Asexual / Transsexual /  
Polysexual                      Homosexual (Gay / Lesbian)

### SEXUAL (ORIENTATION) IDENTITY (Sexual Persona)

Top / Master / Butch /  
Butch / Leather Daddy                      Both / Neither                      Bottom / Slave / Queen / Femme /  
Baby Boy

## Appendix D

Figure 1a: A continuum of transpositive support

| PSYCHO-THERAPEUTIC   | PSYCHOSOCIAL  | LEGAL   | PARA-MEDICAL | PSYCHOLOGICAL/PSYCHIATRIC/MEDICAL  |
|--|---|---|--------------|--|
| Exploration of options re: gender identity, sexual orientation and sexual identity | Peer and community support (trans, queer communities) | Legal change of name;<br>Legal change of sex;<br>Child protection issues;<br>Custody battles;<br>Human rights suits | Electrolysis | Psychological/Psychiatric assessments re GID;<br>Letters of Recommendation;<br>Medical Assessment;<br>Hormone therapy;<br>Sex-reassignment surgery |

Figure 1b: A Continuum of Transpositive Para-Medical and Medical Interventions

| PARA-MEDICAL                  | MEDICAL   |
|-------------------------------|---|
| <b>Electrolysis</b>           | <b>Puberty-delaying agents</b>                      |
| (beard and body hair removal) | (LHRH agonists or medroxyprogesterone)              |
|                               | <b>Cross-sex hormones</b>                           |
|                               | (androgens/estrogens and progesterones)             |
|                               | <b>Sex-reassignment surgery</b>                     |
|                               | (breast removal/augmentation; genital construction) |

## Footnotes

1. LGBT Parenting Network: an initiative of the David Kelley Lesbian/Gay and HIV/AIDS Services - a program of the Family Service Association of Toronto. Contact Rachel Epstein at: [rachelep@fsatoronto.com](mailto:rachelep@fsatoronto.com) and <http://familypride.uwo.ca/talk.html>.  
Mermaids: a British support group for families of young people who exhibit gender identity disorder. Contact Linda at: [mermaids@freeuk.com](mailto:mermaids@freeuk.com); [www.mermaids.freeuk.com/](http://www.mermaids.freeuk.com/).  
PFLAG-T Net: Parents, Friends and Families of Lesbians and Gays - Transgender Network. Contact: [www.youth-guard.org/pflag-t-net/](http://www.youth-guard.org/pflag-t-net/).

Trans Youth Toronto: a Canadian, community-based, peer-support service for trans-identified youth. Contact Program Coordinator at: [mealtran@the519.org](mailto:mealtran@the519.org); [www.icomm.ca/the519/programs/transyouthtoronto/e-group.html](http://www.icomm.ca/the519/programs/transyouthtoronto/e-group.html).

Trans\_Fusion Crew: a Canadian support group for trans-identified youth - an initiative of Supporting Our Youth, a program operating out of Central Toronto Youth Services. Contact Program Coordinator at: [soy@soytoronto.org](mailto:soy@soytoronto.org). <http://www.soytoronto.org/frame.html>.

Humanitas: a Dutch support group for transsexual people, parents and children co-facilitated by a social worker. Contact Gert Master and Petra Klene (social worker) at: [virgin@wgtrans.nl](mailto:virgin@wgtrans.nl). <http://wgtrans.nl/>.

2. Transgender Aging Network: an American-based, online network for older transpersons. Contact Loree Cook-Daniels, Founder and Director, at: [LoreeCD@aol.com](mailto:LoreeCD@aol.com); [www.forge-forward.forge/TAN](http://www.forge-forward.forge/TAN)).
3. Participatory Action Research (PAR) is a collaborative endeavor between the researcher(s) and the individuals/populations under study, with a view towards invoking positive social change (i.e., policies, procedures, practices) which will primarily benefit the participants/respondents surveyed. The PAR model is a revolutionary scientific paradigm, ideally combining politics (the voice of the people) and science (the tool of the empirical researcher) in such a way as to transform knowledge and power into a democratic dynamic of empowerment, especially for those most marginalized ('from the margins to the centre'). PAR has been variously referred to as 'transformative research', 'collaborative research', 'participatory feminist research', 'popular participation in development', 'power and participatory development', 'a voice for the excluded', 'voices for change', etc. (See Barnsley and Ellis, D. 1992; de Koning, and Martin 1995; Freire 1999; Hall 1992; Kirby and McKenna 1989; McTaggart 1991; Nyden and Wiewel 1992; Park 1992; Yeich and Ralph 1992.)
4. Saskatoon declaration of LGBT health and wellness: 2001: A Health Odyssey - Building Healthy Communities took place from 31 August to 3 September, 2001 in Saskatoon, Saskatchewan. It was organized by the Fabulous People of Canada, later known as the Canadian Rainbow Health Coalition.
5. For more on the International Foundation For Gender Education see their website: <http://www.tself.org/>.
6. Genderqueers: a Canadian social and political group based in Victoria, B.C. for anyone interested in fighting all forms of oppression, especially gender oppression. Contact [genderqueers@hotmail.com](mailto:genderqueers@hotmail.com); list serve: [vicgenderqueers@yahoogroups.com](mailto:vicgenderqueers@yahoogroups.com).

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